

In addition to these financial burdens, a decision was made recently by the Secretary of Veterans Affairs to create a new priority group of veterans which is called Priority Group 8. These are veterans who have need for medical care but their conditions are not directly related to their military service, and they can make as little as \$22,000 a year in certain regions of the country because the standard for the income levels changes regarding where the person lives. If they live in one part of the country, the standard may be a little different than it is in a different part of the country. But in my part of the country, where there is high unemployment and poverty, a veteran can make as little as \$22,000 a year and be considered higher income and be told, "You cannot participate in the VA health care service. You served our country and were discharged with an honorable discharge, but you make too much money, and you are in Priority Group 8, so you can no longer sign up for VA health care services."

I just think that is wrong. We spend a lot of money around here, and it is just wrong that we would charge our veterans more for drugs, charge them more for the health care they need and the health care that many of them cannot get anywhere else. Many veterans have lost their jobs, they have been downsized, their plants have closed, and they simply have nowhere else to go.

So I call this to the attention of this Chamber, Mr. Speaker. I think we should take action to make sure that our veterans are properly cared for.

REFORMING MEDICARE AND PROVIDING PRESCRIPTION DRUG COVERAGE

The SPEAKER pro tempore (Mr. FRANKS of Arizona). Under the Speaker's announced policy of January 7, 2003, the gentleman from Georgia (Mr. BURNS) is recognized for 60 minutes as the designee of the majority leader.

Mr. BURNS. Mr. Speaker, I rise tonight to begin the discussion of probably one of the most critical things we will consider during the 108th Congress. Tonight we are going to begin to talk about a need that America has had for a long time, and that is a prescription drug benefit for our seniors and the reform of Medicare.

I am delighted that the Speaker has allowed me to represent the leadership tonight, along with other members of the freshman class, as we begin to talk about the things that are important to America, and to begin the discussion, to begin the debate and to work toward a solution to all of our seniors.

Mr. Speaker, to begin that discussion, I would like to yield to the distinguished gentlewoman from Michigan (Mrs. MILLER).

(Mrs. MILLER of Michigan asked and was given permission to revise and extend her remarks.)

Mrs. MILLER of Michigan. Mr. Speaker, Medicare was enacted in the

1960s to address a serious problem, and that problem, of course, was the lack of quality health care for our Nation's elderly.

In the past 40 years, Medicare has become actually one of the most popular Federal programs ever. But so much has changed in the days since Medicare was first enacted. In the 1960s, quality health care usually meant going to the doctor's office and receiving treatment for a particular ailment, and, in many cases, it meant hospitalization. But today, things are very much different. Advancement in the development and effectiveness of prescription drugs has made the trip to the doctor, and, more importantly, a trip to the hospital, unnecessary in many, many cases.

Prescription drugs are helping America's seniors to live longer lives, and healthier and happier lives as well. And yet, Medicare has not changed to cover those life-extending drugs, and too many seniors are being forced to make the impossible choice between their prescriptions and their other basic needs like food or rent. That, of course, is simply wrong. No senior should ever have to make the choice between bills and pills.

The high cost of prescription drugs are forcing seniors to find less expensive ways to get the drugs that they need. I represent a district that shares an international border with Canada. I was meeting actually just this morning with my counterpart in the Canadian Parliament. We spoke about a number of issues, and we spoke about health care generally. But, more specifically, we spoke about a cottage industry that is springing up, prescription drug outlets on the Canadian side of the border.

For many reasons, prescription drugs are less expensive in Canada, and many American seniors are driving across the Blue Water Bridge, in my district, between the cities of Port Huron and Sarnia, to have their prescriptions filled in Canada.

What happens is they receive a script from an American doctor. Then they have it transmitted to a Canadian doctor, and it is rewritten in Canada and filled at one of its Canadian pharmacies that literally dot the border area there now. Again, it is just simply wrong for America's seniors, that they have to go to such lengths just to get the drugs that they need.

So it is time for Congress to act. We must address the requirements of our senior population, and we need to bring Medicare in line with the medical system of the 21st Century.

When I was campaigning for this office, I met with literally thousands of senior citizens and I asked them what they thought they needed in a prescription drug benefit. Through those conversations, I came up with what I consider to be four main goals, four fundamental caveats that need to be met with any new benefit:

Number one, the benefit absolutely needs to be voluntary, so that many seniors who already have an existing

drug benefit are not forced into a government plan that might not provide equal assistance that they have currently.

Number two, there needs to be immediate assistance so that seniors are no longer forced to make the decision between their prescription drugs and other needs.

Number three, it needs to be permanent so that it cannot be taken away or used as a political weapon against them in some future Congress.

Number four, it must substantially reduce out-of-pocket costs so that seniors can enjoy their retirement years and health and without draining their life savings to pay for drugs.

I am very hopeful that the plans that are now being debated by the other body, in the Committee on Energy and Commerce and the Committee on Ways and Means, will meet each of these tests. One of the big concerns about the prescription drug benefit being debated is, of course, the cost of such a program. In these very tight budgetary times, or at any time, for that matter, we must keep a very close eye on the bottom line.

But I truly believe that this benefit in the long run could actually save taxpayers money. How is that so? Because if we work together to keep seniors healthy through therapeutic drugs, we will actually lower the instances of hospitalization, which costs much more than giving seniors prescription drugs. Of course, that is the old adage that an ounce of prevention is worth a pound of cure. I think it is very appropriate in this instance.

I also truly believe that you can judge a society by the way that society treats its seniors. Our seniors have given so much to our Nation. Their hard work, their sacrifice is what has made America into the greatest country the world has ever known. These are the people that have fought wars, to defeat fascism, to defeat communism, to spread freedom across the globe. They have worked to build industry, to build strong communities, to raise their families that continue the American dream.

Our senior citizens deserve no less than our very best efforts to finally solve the problem of a prescription drug benefit within Medicare, because that is exactly what they have given us throughout their lives. I look forward to working with my colleagues to, once and for all, get the job done.

Mr. BURNS. Mr. Speaker, we have heard from the distinguished colleague from Michigan as she shares with us the challenges that her constituents face.

I would like to now yield to the distinguished gentlewoman from Florida (Ms. HARRIS), to gain a perspective from that area.

(Ms. HARRIS asked and was given permission to revise and extend her remarks.)

Ms. HARRIS. Mr. Speaker, despite the large amount of attention that

matters of national security have demanded, the House has remained steadfast in confronting the threats to security here at home. We passed decisive measures to revitalize our financial security and our economy. Moreover, we continue to confront the corporate greed that has threatened the life savings of millions of Americans. These dramatic efforts to restore America's economic security will mean little, however, until we address the moral obligation to our seniors. After all, they are the people who built America's prosperity in the first place.

The enactment of the Medicare program constituted a sacred pact with our seniors. It reflected our Nation's belief that the health concerns associated with advancing age should not raise the specter of grinding poverty. Nevertheless, while our society enjoys an unprecedented level of wealth and material comfort, our seniors still suffer sleepless nights worrying about how they will afford critical medical and life saving prescription drugs. Far too often, good politics has taken precedence over good policy. Meanwhile, men and women who spent their lives investing in this country have paid the price of political inaction.

Yet, thanks to the visionary leadership of the gentleman from Illinois (Speaker HASTERT), the gentleman from California (Chairman THOMAS) and the gentleman from Louisiana (Chairman TAUZIN), our seniors at least have reason to hope.

The Speaker has articulated four principles for improving Medicare and providing our seniors with a real prescription drug benefit.

First, we must lower the cost of prescription drugs now.

Second, all seniors must have prescription coverage.

Third, Medicare must have more choices and more savings.

Finally, Medicare must be strengthened for the future.

The bill that the gentleman from California (Chairman THOMAS) and the gentleman from Louisiana (Chairman TAUZIN) have proposed passes these four essential tests with flying colors. It recognizes our seniors deserve the right to choose their doctor, their health care plan and their prescription drug plan.

Most important, this bill completely covers the prescription drug costs of low income seniors, as well as the catastrophic medication needs of every senior. Further, it modernizes the Medicare system through the use of new technology, health, education and preventive care.

Mr. Speaker, I applaud our leadership for developing this outstanding legislation, and I look forward to a strong bipartisan effort to achieve its passage.

Mr. BURNS. Mr. Speaker, we enjoy in the freshman class two distinguished colleagues within the medical profession. Tonight I would like to yield to the distinguished gentleman from Texas (Mr. BURGESS), a medical physi-

cian who has treated thousands of patients and can speak authoritatively to this subject.

Mr. BURGESS. Mr. Speaker, I rise tonight to continue the dialogue about the important work that this House will undertake in regards to modernization of the Medicare program over these next 2 weeks.

For too long, seniors in this country have gone without a prescription drug benefit. We are at a point in time where the United States Congress is at the threshold of passing a comprehensive drug benefit for America's seniors. It is time, indeed, it is past time that we modernize the Medicare system. Medicare is a 38-year-old government program that has done little to adapt to the practice of medicine in the 21st Century.

There can be no doubt that Americans have benefited from the development of new and innovative medicines. New drugs can improve and extend lives. New drugs exist that can dramatically reduce cholesterol, fight cancer and alleviate debilitating arthritis.

For example, Mr. Speaker, there is a whole new class of medications that collectively are called selective estrogen receptor modulators. You perhaps know them by the other term as Aromatase inhibitors.

□ 2015

But, Mr. Speaker, these new class of medications are reducing breast cancer mortality, and they hold promise for actually one day preventing this disease.

Mr. Speaker, drugs that fight prostate cancer, diabetes, and other life-threatening diseases are not available as a basic part of Medicare, forcing beneficiaries to often make difficult choices related to their health. Medicare beneficiaries should have access to these drugs, just like so many of us have access to prescription medications through our own health plans.

Medicare was put in place to improve the health and well-being of America's seniors; and to that end it has functioned very well. But because the current program does not provide prescription drugs as part of its basic benefit, it is hard to say that Medicare, as is, continues to live up to that promise.

With nearly 40 million people enrolled in Medicare, it is important that we approach this issue with clarity and foresight. Many of my colleagues and, indeed, myself included, are concerned with the entitlement nature of this new program. If we are not careful, if this new entitlement is not implemented properly this, in fact, could threaten to imbalance future Federal budgets and displace other important priorities. However, the bill that has worked its way through the Committee on Commerce and the Committee on Ways and Means, the bill that they are working on this week, meets the needs of seniors today and into the future, and attempts to balance future Federal spending commitments.

But we must also be aware of other ways that we can hold down the price of prescription drugs and, further, the taxpayer resources that will be devoted to Medicare and a Medicare prescription drug benefit. The United States, through our trade representative, must actively work with foreign countries to dismantle their drug price control regimes and embrace free market principles. No longer should our uninsured and our elderly bear the cost of pharmaceutical research and development for France, Germany, Canada, Japan, and a multitude of other countries. By bringing the purchasing power of the Federal Government to bear, we should be able to positively impact the price of pharmaceuticals sold in this country through free market principles. However, if we do not get serious with other countries that put our most vulnerable citizens at risk, we will have been negligent in our obligation to protect the American people from the policies of foreign governments that can be described as predatory at best.

The Congress stands at the threshold of improving the lives of America's seniors. As we enter into this debate, we must remain vigilant to make sure that the program that we establish in the next weeks and months is accountable not only to the seniors that it serves today, but for those who foot the bill, but, most importantly, to the young people, to the citizens who will come after us in the generations to come.

Mr. Speaker, I thank my colleagues for their indulgence this evening. I feel obligated to bring up one other point. I heard a news report today that the drug Lipitor, a cholesterol-lowering medication, a study involved with type 2 diabetes, its effect was so promising in reducing the incidence of heart attacks and strokes that the study was in fact opened up and no longer were people given the placebo medication, but the actual drug was offered to all of the individuals enrolled in that study. It is that type of power, Mr. Speaker, that we need to make sure that we put in the hands of all of America's citizens.

I thank the gentleman from Georgia for putting this together this evening. I think this is an extremely important part of the debate that is going to go on over the next several weeks, and I look forward to participating at several levels.

Mr. BURNS. Mr. Speaker, I thank my colleague from Texas for his input and, like him, I look forward to the discussions and debates over the next several weeks as we work through this challenging process.

I have a colleague I would like to recognize now. I know the distinguished gentleman from Georgia, a physician, someone who again has treated thousands of patients in Georgia and understands the prescription medication field, understands Medicare, and can speak directly to the challenges we face. I yield to the gentleman from Georgia (Mr. GINGREY).

Mr. GINGREY. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, as a physician Member of this 108th Congress, I just want to say that I practiced medicine, an OB-GYN practice, for over 28 years; and, of course, most of my patients were fairly young, in the child-bearing age range, and I did not really see a lot of Medicare patients. However, if I were back in that practice today and doing just the gynecology part of that specialty, my practice would be predominantly Medicare patients like my precious 85-year-old mom who has been on Medicare now for 20 years.

This program, as we all know, came to us in 1965. I was a freshman medical student in 1965. I really did not understand the system too well. But I knew that back then, prior to Medicare, physicians gave away a lot of their services. They made a lot of house calls. They took a bushel of corn sometimes in lieu of any other financial payment for their services; and they were glad to do that, especially for the neediest of our citizens, many of them seniors. In 1965, Medicare, in a way, was good for these doctors. They were able to get paid for some of this care that they were rendering and at least maybe break even.

Over the past 25, 30, 35 years, of course, medicine has changed very much now. And it is extremely difficult, especially for our primary care physicians, our family practice specialists, our general internists, our physicians who are treating cancer, our medical oncologists who see a lot of the seniors. They are not able to continue to provide this care. It is costing too much. The reimbursements are not there. And so many of our physicians, these primary care doctors that are so essential to our precious senior citizens, no longer can they afford to take Medicare patients. So as we go forward and talk about a prescription benefit for our seniors, we need to keep in mind that there have to be providers there, there have to be primary care physicians there to write these prescriptions.

So that is why I say that in this 108th Congress, of which I am proud, of course, to be a Member, a freshman Member, this President; this administration; this leadership; this Speaker of the House, the gentleman from Illinois (Mr. HASTERT); this majority leader, the gentleman from Texas (Mr. DELAY); this majority Republican Party, and, yes, hopefully the minority party and their leadership, we are ready. We need to address this issue, not only of providing a prescription benefit, especially for the neediest of our seniors, but also of reforming and revitalizing Medicare and bringing it from 1965 to the 21st century. We are dealing now really with what is the equivalent of an Edsel. It is time to get a Thunderbird on the market in regard to health care.

Let me just tell my colleagues, Mr. Speaker, and to all of the seniors who

are out there, hopefully, listening to this great C-SPAN program tonight, let me tell my colleagues what is wrong with Medicare as it exists today. Not only did we not have any prescription benefit, no prescription benefit whatsoever in 1965, also there was no emphasis on preventive health care. One cannot go to the doctor today under traditional Medicare and have a routine screening physical examination done. One cannot go under Medicare and have a routine cholesterol screening, lipid profile to determine if you are on the verge and at risk of having a serious heart attack or a stroke. If you get that service, you pay for it out of your pocket. And, of course, many of our seniors can ill afford to do that.

And the other thing, and maybe most significant in regard to Medicare, is there is absolutely no catastrophic coverage. These seniors, maybe they can, many of them, afford to pay \$2,000, \$3,000, possibly \$5,000 a year in out-of-pocket expenses for a prescription benefit. But once they get to the point of needing four or five or six medications, very expensive medications, I might add, just to sustain the quality of life and to relieve them from suffering, they can no longer afford that. And pretty soon, yes, they do reach the point where they have to choose between paying the rent, buying the groceries, paying the utilities, or getting their prescription drugs filled.

So this is the situation that we find ourselves in today. It is imperative that we do something for our seniors. This issue has been with us for several years, long before I became a Member of this Congress. But I am proud to stand here today as part of this majority, realizing that they understand the big picture. The gentleman from California (Mr. THOMAS), the gentleman from Louisiana (Mr. TAUZIN), the gentleman from Florida (Mr. BILIRAKIS), and the gentlewoman from Connecticut (Mrs. JOHNSON), they understand what needs to be done and they realize that this is not just one leg of a stool, but that there are three legs to this stool; and it includes not only a prescription drug benefit for our seniors, but of course it includes a reform of this outdated, antiquated, 1965-era health care system that looks nothing like what my colleagues and I and other Members of Congress have available to us under our Federal health insurance benefit plan.

We do not have to worry about being put in the poor house once we get into a situation of serious illness. We have prescription coverage after a copay. So this is the same thing that we want to offer to our seniors. I am proud of the commitment that we have this year, this year, today, hopefully within the next several weeks, that we will have a bill on President Bush's desk that he can sign to give this very, very important relief to our seniors and to reform of the Medicare system.

Mr. Speaker, I appreciate this opportunity to present this information to-

night and to talk especially, especially to our senior citizens, our moms and dads, our grandparents and, indeed, us in the very near future. It is critical. We need to do it now, and we are going to get the job done.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. FRANKS of Arizona). The Chair would remind Members to direct their remarks to the Chair and not to the television audience.

Mr. BURNS. Mr. Speaker, since we do have two fine representatives of the medical profession with us tonight, I would like to have an opportunity to engage in a bit of a dialogue as we discuss the critical issue of prescription drug benefits and Medicare reform.

First of all, I would like to get the input on access. How important is it for our seniors to choose their physicians? And that is, I believe, a key point in the legislation that we are considering now. I yield to the gentleman from Texas (Mr. BURGESS).

Mr. BURGESS. Mr. Speaker, I thank the gentleman; in fact, I thank both of the gentlemen from Georgia for allowing me to speak on this. I will just have to say to the gentleman from Georgia, while I was listening to his comments, and they certainly were apropos, I think one of the most amazing things I heard was that the gentleman was a freshman medical student in 1965. I had no idea that there was someone who is that old who is serving in Congress.

Mr. GINGREY. Mr. Speaker, if the gentleman will yield, my wife told me not to dare admit that, but I did it anyway.

Mr. BURGESS. Well, I appreciate the gentleman bringing that up. My father was a surgeon and was practicing at the time; and I remember very well, as a very young child, watching the evolution of the genesis of Medicare.

But the gentleman from Georgia (Mr. BURNS) brings up a very good point and it is the point of access, and the gentleman from Georgia (Mr. GINGREY) touched on it a couple of times in his remarks, and that is that we certainly have suffered over the last 3 or 4 years with the way Medicare reimbursements have impacted physicians and physician practices; and the net result has been the loss of physicians to the Medicare system, and the net result of that has been loss of access for our patients.

Just like the gentle doctor from Georgia, my practice too was obstetrics and gynecology; but even within an obstetrics and gynecology practice, one would have ample opportunities for interacting with the Medicare population. I have written more than my share of prescriptions for drugs that will prevent osteoporosis, for example, a debilitating disease that unfortunately affects primarily women, with a 25 percent rate of fracture of the hip. Of course, as the gentleman knows, there is a 25 percent mortality rate within the first year after sustaining that hip fracture. So we have means at

our disposal for significantly improving the lives of seniors if we will only preserve the ability to have doctors there to see them and then, of course, the ability of the patients to afford the prescriptions that the doctors then write. I yield back to the gentleman from Georgia.

Mr. GINGREY. Well, I thank the gentleman from Texas. Some of the things I think that we need to point out is that, as I mentioned in my remarks earlier, in 1965, when this plan was devised, there was not a great emphasis on drug therapy. It seemed back then that the main emphasis on health care was the opportunity, of course, to see a physician, to see a health care provider; and many people did not do that because of lack of access, and there just was not that great emphasis on preventive health care certainly.

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Then a lot of things were cured, quite honestly, by the surgical approach, and as we know today, surgery is extremely important, and our surgeons and our subspecialty surgeons do a great job, but thank goodness a lot of people today, and I think the gentleman from Texas (Mr. BURGESS) would agree with me, we would love to keep people out of the hospital.

We would love to be able to prevent very expensive surgery, and I can certainly give a personal testimony to that, having recently undergone open heart surgery. Maybe if 15 years ago I had been taking that drug to lower the cholesterol and improve that so-called lipip profile, or if I had been taking a little bit of a blood thinner or something to lower my blood pressure a little bit, I would not have had to undergo that very, very expensive somewhat dangerous and definitely painful surgical procedure.

That is why today it is so important, it is so important that our seniors at least have an opportunity not just to go to the emergency room to treat that episode of health emergency care or to be admitted to the hospital after a motor vehicle accident or those who need to after an extended period of stay go to a nursing home, they need prescription medication to keep them out of the hospital.

In the final analysis, we know the CBO, the committee on Medicare and Medicaid service and their actuarial services, we know that this prescription benefit, Mr. Speaker, will save money in the long run.

Mr. BURGESS. Mr. Speaker, if the gentleman would yield again for a moment, the gentleman from Georgia is exactly right, and I recognize we have other Members who want to speak to this, so I will be brief.

In 1965, the major health care expenditures that a senior might face would be the expense of a surgery or, if they got pneumonia and were hospitalized for 7 to 10 days, however long the drug therapy would run, and Medicare was put in place to protect the family from

those very serious expenditures. Of course, the fact remains that nowadays, most of us are not going to die of our acute illnesses. We are going to live with chronic conditions and hopefully live with them for a long time, and that requires the interplay of prescription drugs.

One other thing I feel honor bound to mention is the issue of medical liability reform which we took up in this House 2 months ago, and I thought did a masterful job of getting a good bill out of this House, and off and on its way. I would implore members of the other body to look seriously at taking up this important legislation before much more time goes by because, as my colleagues know and as I know, the cost of defensive medicine really drives up the medical expenditures, not just for Medicare, but for private insurers as well, and we can no longer afford that type of very expensive defensive medicine in this country.

Again, I thank both the gentlemen from Georgia.

Mr. GINGREY. Mr. Speaker, if the gentleman will yield, just as a follow-up to what the gentleman from Texas (Mr. BURGESS) was saying about this other issue, and as everybody knows, we dealt with the HEALTH Act of 2003 earlier in this 108th Congress, H.R. 5, the Medical Malpractice Tort Reform Accountability Act, and of course, we hope that the other body will soon pass that and we will have that legislation before our President. He is so much supportive of this. Let me tell my colleagues the reason why he is so supportive.

The savings from bringing a level playing field, we are not in any way wanting to take away the right of anybody to have a redress of their grievances if they have been harmed by their medical care that they received at the practice, either from the physician or from the facility is below the standard of care. Absolutely, they should have their day in court, but just trying to level that playing field, and the estimation, Mr. Speaker, is that there would be \$14 billion in savings to the Federal Government on what we pay reimbursement for Medicare and Medicaid and military and veterans benefits because, as the gentleman from Texas (Mr. BURGESS) pointed out, the number of unnecessary and duplicate tests that are ordered and procedures that are done, the doctors know they are not necessary, but they are forced into a position because of this risk, this tremendous risk of the next case putting them out of practice or causing that hospital, that rural hospital, to have to close its doors. That is the reason defensive medicine is being practiced, and it is costing us \$14 billion. That is 5 percent of our estimated cost of this prescription benefit for our needy seniors.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. FRANKS of Arizona). The Chair would remind Members to refrain from improper references to the Senate.

Mr. BURNS. Mr. Speaker, I thank the distinguished gentleman from Georgia (Mr. GINGREY) and the gentleman from Texas (Mr. BURGESS) for their remarks.

I think it is important that we all recognize that the health care profession and the prescription drug industry have a lot at stake as we deal with this challenging issue, but I would like to remind the Chair that what we are dealing with here are some fundamental principles, that of affordability so that our seniors can have an affordable health care prescription drug plan and our seniors will be protected. It will be widely available to all of our seniors.

I think it is very important that we understand it is voluntary. I have heard critics of this plan say that we are going to force the senior into one plan or another. That is not true. The senior can choose from remaining in the current Medicare system or perhaps adopting a different approach, but certainly to give them the option of looking at some prescription drug coverage.

So this is a voluntary plan. This is a plan that deals with choice so they can choose a physician, choose a health care provider, and then effectively manage their own health care needs, and as my colleagues have also pointed out, that it must be sustainable so we can make sure that this plan is viable not only in 2004, but in 2014 and 2024 and 2048 and beyond.

I think these are key things that we have to remember as we continue this discussion and continue this dialogue and debate and mold the future of medical care for our seniors.

I would like to now yield to the distinguished gentleman from New Hampshire (Mr. BRADLEY).

(Mr. BRADLEY asked and was given permission to revise and extend his remarks.)

Mr. BRADLEY. Mr. Speaker, I thank the gentleman very much for yielding to me.

Mr. Speaker, today I rise to discuss one of the most important topics that faces all senior citizens in our country, a Medicare prescription drug benefit. It is something that is long overdue, and we have the opportunity within a month or two months to do a good job of providing drug care for our senior citizens which they so desperately need.

Mr. Speaker, I have in my hand a letter from a constituent in Chester, New Hampshire, a constituent who knows all too well just how important this legislation is. She writes to me that while she is not of retirement age today, she has a friend who is not able to retire because her drug costs are simply too high, but of course, she needs these drugs because they are essential to her health.

Mr. Speaker, this is not an isolated story. This is a story that is being told at kitchen tables and in living rooms all across our country. It is a story

that is overwhelming for millions and millions of Americans who have fallen victim to the overwhelming costs of high drugs today because they are so essential to our health.

The facts do not lie. Prescription drugs costs have risen at a staggering rate. According to a study by Families U.S.A., which is a nonpartisan organization, the average senior citizen spent \$1,200 on prescription drugs in the year 2000, but by the year 2010, that same senior citizen will spend \$2,800. A Kaiser Family Foundation study found that between 1998 and 2000, the average prescription price increased more than three times the rate of inflation, and since 1995, the annual percentage increases in spending for prescriptions has been more than double the cost increases for hospitalization and doctors' care.

While many Americans have felt the effects of these sharp rises in costs, it is America's senior citizens who are forced to pay the greatest price. Seniors and other Medicare beneficiaries account for 43 percent of this Nation's total drug spending, even though they represent 14 percent of our Nation's population. In total, over 80 percent, 80 percent of America's retirees use a prescription drug every day. With costs increasing at such an alarming rate, more and more seniors are forced to choose between putting medicine in their cabinets and food on their tables. That is an unacceptable choice, and we have the chance to remedy the situation very quickly.

How will this legislation work? First of all, seniors will pay a \$35 monthly premium and a \$250 annual deductible, and then whether they use traditional Medicare fee-for-services or a private plan, after these initial costs, 80 percent of the next \$2,000 of their drug costs will be covered. For many seniors, this means an immediate cost savings.

In addition to this initial benefit, there is a catastrophic benefit. Over \$3,700 of costs for senior citizens will be fully compensated. Seniors will get 100 percent of this coverage, and this is incredibly important for those seniors who have very high bills.

At the other end of the spectrum, for 5 percent of senior citizens who have high incomes greater than \$60,000 to begin with, the drug benefit is income sensitive on a sliding scale. What this provision does, Mr. Speaker, is ensure that those people with the greatest need and who have limited means are treated fairly and treated first, but those with the greater ability to pay for their drugs do so. It makes the program more cost effective not only for the seniors but for all taxpayers.

Finally, and just as importantly as everything else, this bill provides senior citizens with options. At least two prescription drug plans will be available to all seniors. They will have the ability to fill their prescriptions at the pharmacy that they choose, and in addition, regional preferred provider or-

ganizations will compete for beneficiaries, bringing market forces to bear, improving care and coordination and better choices. This, in turn, will also lower costs for seniors and for taxpayers.

In conclusion, Mr. Speaker, I strongly urge that my colleagues support this important legislation so that improved health care for senior citizens does not rely on financial sacrifices. The advancement of medical research and new drugs has better engaged treatment of many diseases that reduce hospitalization, reduce surgery and reduce nursing home care. Senior citizens are better able to live more productive and fulfilling lives, and because of these advancements, it will be made possible by a drug benefit and this important legislation if we act now.

Mr. GINGREY. Mr. Speaker, I just wanted to ask the gentleman from New Hampshire to go over once again because it is so important. His comments were so important in regard to our senior citizens fully understanding what is in this proposed legislation in regard to the neediest, and if the gentleman does not mind kind of repeating himself for emphasis in regard to those needy seniors and what they would have to pay, and what is the cap, if you will, above which they would not have to pay anything for those additional drugs?

Mr. BRADLEY. Mr. Speaker, the catastrophic coverage, the gentleman is absolutely correct. The cap starts at \$3,700, and above that, on the sliding scale, senior citizens would have all drugs paid for based on income sensitivity.

On the other end of the scale, and to me what is very important, is that the Americans, the senior citizens who need this benefit the most will get the care first, and so for up to 135 percent of poverty, all drug costs are covered, and that is absolutely appropriate, that we give those senior citizens who have the greatest need for this drug benefit the care.

Mr. GINGREY. Mr. Speaker, if the gentleman will further yield, this is so important, and I am glad the gentleman from New Hampshire has brought this out because we hear sometimes from constituents proffering the argument that, well, why should we provide a prescription benefit for all seniors, many of whom already have a prescription drug benefit, either through their Medigap supplemental health insurance plan or possibly through their former employer?

□ 2045

And I think the statistic that I have heard quoted is it may be up to 65 percent of seniors that have some type of coverage, and I think the gentleman from New Hampshire agrees with me on that.

But explain to us why it is still necessary, even though 65 percent have some coverage, that there are certainly some gaps in their coverage. Would you not agree?

Mr. BRADLEY of New Hampshire. Well, Mr. Speaker, there certainly are gaps; and for those senior citizens that are at the low end of the spectrum, they often do not have any coverage whatsoever. And so this, unfortunately, and the gentleman, in his profession, knows this all too well, is forcing senior citizens into a terrible choice, paying their rent, their utilities, or having the prescriptions they need to have sound health. And that, in 2003, in the 21st century, is an unacceptable choice and something that we have the opportunity to remedy; and we should avail ourselves of the opportunity.

Mr. BURNS. Is it not correct that the proposals we are considering have not yet been cast in stone? They are still quite malleable; they are still under debate, and we are considering multiple options? And as a point of emphasis, I want to recognize that our neediest citizens, those who would be at or below poverty level, would have full benefit coverage. They would not have a need to pay any of the up-front costs. The premium would be waived, any of the co-pays would be waived as well as the \$250 deductible.

So I believe what we are doing here is looking at the alternatives in this plan, debating it, discussing it, and making sure that what comes out is really in the best interest of America and of our seniors.

Mr. BRADLEY of New Hampshire. Well, certainly my understanding of the work the Committee on Energy and Commerce has done so far, as well as the Committee on Ways and Means, is to dedicate the drug benefit to the senior citizens that need it the most; and that certainly should be the principle that we try to enshrine in this legislation. Those that need it the most are the most deserving and where we should focus scarce resources on serving.

Mr. BURNS. I agree. I think the gentleman is 100 percent right. The proposals I have reviewed indeed focus this benefit on the neediest of America's seniors and ensures that, as the gentleman has suggested, they do not have to make a choice between paying the rent, buying the food, and then providing the prescription drugs that they need to have a high quality of life.

I thank the gentleman for his input, and I thank my good friend from Georgia for his point as far as making emphasis to ensure that America understands what we are talking about here.

Mr. BRADLEY of New Hampshire. I thank the gentleman, Mr. Speaker.

Mr. BURNS. Mr. Speaker, I thank the gentleman from New Hampshire (Mr. BRADLEY) for his input, and I now would like to recognize the gentleman from Utah (Mr. BISHOP) to give us a perspective from our western States.

Mr. BISHOP of Utah. Mr. Speaker, many years ago, when I was in high school, I got my first car. It was new and it was sleek and it was fun to drive, and more than anything I would like to have that car back today. There

is only one problem with having that car back today. It is broken. It does not run. For it to do anything at all, it would require a major overhaul.

That car is the same age as our Nation's Medicare system. And nostalgia for the good old days, which is why I want to have that car back, nostalgia may have warped some of our memories of what Medicare did or did not do or what it promised or did not promise to do; but nonetheless, our Medicare system today has the same problem. It is broken. It does not run. It needs some kind of major overhaul.

Shortly after my election, Henry Kafton, who is a neighbor who used to live around the corner from me in Brigham City, talked to me about Medicare. And I asked him to put his thoughts down on paper. He wrote me a very simple two-page letter, and he delivered it to me the day after Christmas of last year. I still have that letter with me. In fact, I have it with me here this evening, because Henry suggested some good commonsense approaches to solving the problem with Medicare.

However, in the third sentence of his letter, he put a perspective on the debate when he wrote, "As much as we do not like to think of it, when you turn 65, in many ways you become a third class citizen." No American, Mr. Speaker, should ever have to feel less of a citizen because of their age. And, Mr. Speaker, I am happy to report the Republican leadership of this body will be presenting a bill to reform and modernize our Medicare which addresses many of the comments my good neighbor Henry talked about in his particular letter.

This bill may not be a panacea for our system, but we should also not be arrogant or critical enough to dismiss it out of hand, for it is attempting to adjust a program stuck in the 1960s mode of medical mismanagement for the past 40 years. I am encouraged that it will present a program that will have three important principles.

First, there will be a prescription drug policy which will apply to the neediest of our citizens as well as those, especially those, who have catastrophic pressing needs. Secondly, it would be based on the concept of choice and competition. The Medicare+Choice program will always be open for bid. And President Bush has been very consistent from the beginning in his emphasis that any kind of medical program we have in this country must be based on the concept of choice and competition. And, number three, it will be providing information to our seniors so that they can make informed choices.

I also have the opportunity of serving as a voluntary noncompensated board member of my local hospital. And though I am certainly not an expert in health care, my experience has taught me that all of those kinds of principles in developing a health care system has to be based on the idea of choice and information if it is going to be successful.

I also realize that we have a different delivery system than when Medicare was first established. We have changed how we care for people and where the emphasis is. Doctors and hospitals have made that change. Our Medicare system has not kept up with that change and therefore must be reformed in major, major ways.

Mr. Speaker, the Medicare plan that will be coming before this body will encapsulate those principles, and I am encouraged that it will include benefits for rural health care through the disproportionate share rates, and that physicians and hospitals as a goal will not endure reimbursement cuts.

Mr. Speaker, there are 185,603 senior citizens in my State anxiously awaiting this Congress to enact Medicaid reform and Medicare reform and prescription drug access, including my good friend Mr. Kafton. In the last line of his letter he wrote, "I realize there is probably not much that can be done about this due to politics." Well, I am confident that the leadership of this Congress will break the political logjam of the past and make that statement simply inaccurate.

This will be the first step, the first step of many, to reform a Medicare delivery system and a medical delivery system for the seniors of our Nation, and I look forward to proceeding in that particular direction.

Mr. BURNS. If the gentleman will yield.

Mr. BISHOP of Utah. Only if you make it easy on me.

Mr. BURNS. Mr. Speaker, I wanted to point out one thing and highlight a comment the gentleman made. Sometimes we get caught up in perfection, and what we need are good commonsense approaches to problems in America. I think some of the critics of these proposals as we debate them would suggest that they do not go far enough or they do not do everything they should do, and indeed we may agree; but yet we must make sure that what we produce is a viable, sustainable, commonsense approach to the problems that your good friend points out in his letter.

Mr. BISHOP of Utah. The gentleman from Georgia is absolutely correct. We did not get into this situation overnight. It took 40 years to find us in the predicament that we are in right now. We will not solve this problem overnight. This will be the first step of many. But I am positive if we base it on the good common principles of choice, of information, of competition, that indeed we will move forward in the near future to improving our system and, hopefully, moving to that panacea that we are all looking for.

Mr. BURNS. Mr. Speaker, I thank the gentleman from Utah for his input. I appreciate his comments as we begin the discussion in Medicare reform and in the area of prescription drug benefits.

Mr. Speaker, I would like to review the key points that we wanted to dis-

cuss tonight and then summarize what we have discussed on the House floor to make sure that the American people and that the Congress understand the challenges that we face.

First of all, Mr. Speaker, we need to make sure that we understand the principles of strengthening and improving Medicare. We have to guarantee that all citizens, all of our senior citizens, have an affordable prescription drug benefit plan under Medicare. This is an important part, that the seniors that we have now have an affordable prescription drug plan. This needs to be a voluntary plan.

Critics would say that we are going to force a senior to do one thing or another. That is not true. The senior can choose which Medicare prescription plan best fits their needs or they can continue in the current plan if they so choose.

It helps our seniors to immediately reduce their prescription drug cost. Right now many of our seniors have to go out and they have to buy drugs at the highest price, Mr. Speaker. And this gives us an opportunity to provide them a negotiated prescription drug price so that it will immediately lower their cost. It provides special assistance, Mr. Speaker, and additional assistance to our low-income seniors who need this benefit most to ensure their high quality of life.

So, Mr. Speaker, as we begin this debate, let us make sure we understand that the first thing we have to do is to guarantee that all of our senior citizens have an affordable prescription drug benefit plan under Medicare and that it is going to be voluntary, Mr. Speaker.

The second principle we want to deal with, Mr. Speaker, is the fact that we need to protect the senior citizen's right to choose the physician, to choose the medical provider, to choose the druggist, to choose the benefit package that best meets their needs. It is going to provide our seniors with a range of options so that they can best meet their medical requirements.

It is going to cap out-of-pocket costs. I think that is extremely important. We have a catastrophic failure of our drug system now where you can just be eaten alive and into bankruptcy because of the prescription drug cost to our seniors. This is going to cap out-of-pocket costs so that our seniors will be protected and their families will be protected so they will not risk bankruptcy in case of a serious illness.

Now, we are going to debate the amount. I have seen multiple proposals. The Senate has a proposal. There has been several plans here in the House. But I assure you there will with a catastrophic cap on our seniors' cost for prescription drugs. So that as we protect the senior's right to choose, we give every senior an opportunity to pick the plan that best meets their need.

Finally, Mr. Speaker, we have to strengthen Medicare. We need to

strengthen Medicare for all of our seniors and for future generations. It is 2003; and as we work toward the resolution of this problem, we must ensure that it not only meets the needs of our current seniors but we also need to make sure that it will meet the needs of our future generations. We need to ensure the delivery of the needed health care services in both the rural environment and the urban environment.

Mr. Speaker, in the 12th district of Georgia, I have a large number of rural communities that have rural health care systems. I also have multiple urban centers of health excellence. But we have to make sure our rural communities have affordable health care, that they have a Medicare system that allows them to continue in business and service their communities. In order to do that, we will very well need to create some really significant structural improvements so that we can curb the runaway health care costs that have jeopardized Medicare's viability in the past. So we are working on those kinds of things.

I would like to emphasize the fact, as we begin and go through this debate, that there is going to be some give and take. There is going to be some discussion. There will be some things that are going to have to be worked out, but we are prepared to do that. The leadership here in this body, the Republicans, have offered a plan; and we will begin that discussion, that debate.

This evening we have had an opportunity here from a number of Members who have direct experience with health care. We have heard from the gentlewoman from Michigan (Mrs. MILLER); we have heard from the gentleman from Texas (Mr. BURGESS). We have heard from the gentleman from Georgia (Mr. GINGREY). And, Mr. Speaker, I would like to now yield to the gentleman from Georgia (Mr. GINGREY) for his comments on finalizing our discussion here this evening.

Mr. GINGREY. I thank the gentleman, my colleague from Georgia, Mr. Speaker. I really want to thank him for reserving this time tonight to give us this opportunity to present during this past hour what it is that we are all about.

I think my colleague did an excellent job of emphasizing something that is so important for all of us to keep in mind, which is that this is first of all an option that seniors have. And as the gentleman from Georgia was talking about, it would do very little good, in fact, it may do some harm to try to pass a stand-alone prescription benefit even for our neediest of seniors, even for our neediest of seniors, without bringing along with that in this Medicare modernization bill some significant changes.

The gentleman from Georgia talked about that and talked about the Medicare Advantage, which was the old Medicare+Choice, a new and enhanced Medicare+Choice, if you will. He talked

about enhanced Medicare fee-for-service. These are the kinds of options that this President, this leadership, is bringing to the American public and bringing to our seniors.

□ 2100

But as the gentleman from Georgia emphasized, it is a choice. If a senior wants to stay in traditional Medicare, certainly they could do that, but they would be staying in a traditional health care delivery system which gave them no reimbursement for preventive health care and gave them no protection, as the gentleman from Georgia (Mr. BURNS) pointed out, from a catastrophic illness that could literally put them out of their home.

I wanted to ask the gentleman from Georgia to explain to us in the remaining few minutes in regard to the prescription benefit for those seniors who are scared to move into the Medicare Advantage or the enhanced Medicare, which I think would be a better service for them. But let us say they do want to stay in that traditional Medicare, it is an old shoe, it is comfortable, they are nervous about it initially, what benefit, what prescription drug benefit will they get? Is there a difference in the traditional Medicare and these enhanced plans?

Mr. BURNS. Mr. Speaker, certainly as we go through this debate, we will see options. But the gentleman is correct, seniors will have a choice. They can stay with the current Medicare plan, or choose to move forward. But I think we can agree, number one, there is going to be some form of a copay, some form of a limited amount of initial cost associated with this plan, but it is going to be nominal. We are looking at plans that may require a \$250 or some small amount of initial cost share before they begin a part of this plan, and then moving on up to the core part of our plan to cover up to \$2,000 of their health care costs. It is important to remember that the median cost to seniors today is about \$1,285.

But I would like to close by pointing out that Medicare has not kept pace with medical care. Medical care has advanced tremendously, advanced over the last 40 years. Medicare has floundered. It has failed to keep pace with the needs of America's seniors. Talk is cheap and we have heard a lot of talk about Medicare reform and prescription drug plans over a number of years, but now it is time for action. It is time that we get the job done. The debate has begun. It is time that we make something happen here in Washington for our seniors. Let us put America's seniors first. Let us deliver on our promises. Let us implement a prescription drug benefit plan in a reformed Medicare package.

MEDICARE REFORM

The SPEAKER pro tempore (Mr. FRANKS of Arizona). Under the Speak-

er's announced policy of January 7, 2003, the gentleman from New Jersey (Mr. PALLONE) is recognized for 60 minutes as the designee of the minority leader.

Mr. PALLONE. Mr. Speaker, I was very pleased to listen to my Republican colleagues for most of the last hour when they spoke about the issue of Medicare prescription drugs, and I intend to discuss the same subject; but I cannot help but begin the debate on this issue this evening by pointing out how radical the proposal is that the Republican House leadership is putting forth with regard to Medicare. Contrary to most of what we listened to and what was said by my Republican colleagues, the effort by the House Republican leadership to present a Medicare proposal is one that will, in my opinion, would effectively kill Medicare the way we know it. For those who think they would be able to stay in traditional Medicare and they would get a drug benefit that is basically linked to the traditional Medicare program that they are in, nothing could be further from the truth.

The fact of the matter is what the Republican leadership is putting forth in the House is nothing like traditional Medicare, and would make it very difficult if not impossible for most seniors to stay in traditional Medicare. Certainly if they were looking for any kind of drug benefit that was meaningful, they would have to go outside of traditional Medicare in order to secure it. I just wanted to, if I could, just refute some of the statements that were made by some of the Members. I listened to the last three or so speakers, and I just wanted to contrast what they said to what I believe they are really doing with their Medicare proposal.

The gentleman from Utah (Mr. BISHOP) said that Medicare is broken. It does not run. Well, let me say, Mr. Speaker, the opposite is true. Medicare is the best-run government program that we have, and one of the reasons that I believe why the House Republicans, particularly the leadership, want to say that Medicare is broken and does not run is because they want to set the stage to say this is a lousy program and we have to change it dramatically, as I say, radically, in order to improve it or in order to keep it as a program that is somehow good for seniors.

If they start out by saying Medicare is broken and does not run, the consequence is that we have to fix it; and I would say just the opposite is true. Most seniors feel very strongly that Medicare is run well and they benefit greatly from it. The only thing they want is to add a prescription drug benefit. They do not want to change it. They do not believe it is broken. The gentleman from Georgia (Mr. BURNS) went on to say that when you get to be 65 and you are eligible for Medicare, you become something like a second or