In New York's First Congressional District, where the cost of living is higher than in many regions of our Nation, the tax relief package we have approved will help jump start our local economy and put the money back where it belongs, in the pockets of the hard-working families.

We have helped our families through the Marriage Penalty and Family Tax Relief Act, and the Economic Growth and Tax Relief Act, and our small family businesses and farmers will benefit from our efforts here today to repeal the death tax. Through all of the components of this tax relief package, we are providing the reasonable and meaningful tax relief that our farmers, our small businesses, and our families have been calling for.

For far too long, hard-working married couples have been unfairly taxed by an average of $1,400 a year simply for the privilege of living inside the institution of marriage. In New York's First District alone, an estimated 56,134 families will receive significant tax relief under this measure. These 56,134 families could potentially put their savings towards their children's education, home improvements, a new computer, investments in their future, or a down payment on their first car.

According to the CBO, most marriage penalties occur when the higher-earning spouse makes between $20,000 to $75,000. The current Tax Code punishes working married couples by placing them in a higher tax bracket. The marriage penalty taxes the income of the second wage earner at a higher rate than if the wage earner were taxed as a single individual. This is just simply unfair.

The death tax currently taxes up to 60 percent of a family's farm or business, killing the small family-owned businesses and the stores that line the Main Streets of our downtown communities throughout this great land. These families who own farms on the east end of Long Island and the small businesses that compromise the very fabric of Long Island's economy have worked hard all of their lives. Working together with their families, they reached for the American dream, paying their taxes all the way along the way and made positive contributions to our society. They should not be penalized by being taxed again in death. That is just simply immoral, unfair, and wrong.

The Economic Growth and Tax Relief Act will give hard-working middle-class families more of their hard-earned money to be used better to offset rising costs for each and every family, costs like a college education for our young people, a mortgage payment, or they will support our small businesses and local economy. These middle-class working families earning $50,000 will see a $1,600 reduction in their taxes. That is a 50 percent cut. A family of four earning $35,000 would see a 100 percent cut. That is fair and that is reasonable.

Mr. Speaker, that is real tax relief for our middle-class working families. This package of reasonable tax relief incentives will leave more money in New York State. New York already contributes about $17 billion more in taxes to Washington than it gets back.

The Economic Growth and Tax Relief Act of 2001 alone will cut that deficit by $9.7 billion.

Now, as a former town supervisor, Mr. Speaker, I know firsthand how reasonable tax relief can help families and our local economy create thousands of new jobs and create millions of dollars of surplus. The hard-working middle-class families of the First District of New York and throughout our Nation should have their tax dollars back. We have accomplished this while we protected and locked away Social Security and Medicare funds and reduced our national debt at historic rates and set aside a trillion dollar contingency fund.

Last of all, Mr. Speaker, I would like to thank my colleagues on both sides of the aisle for working together on these critical initiatives, and I urge my colleagues in the Senate to take swift action.

MEDICARE PRESCRIPTION DRUG COVERAGE

The SPEAKER pro tempore. Under the Speaker's announced policy of January 3, 2001, the gentleman from Iowa (Mr. GANSKE) is recognized for the remainder of the majority leader's hour, approximately 30 minutes.

Ms. KAPTUR. Mr. Speaker, will the gentleman yield?

Mr. GANSKE. I yield to the gentlewoman from Ohio.

THE U.S. ECONOMY

Ms. KAPTUR. Mr. Speaker, I am very grateful to the gentleman from Iowa (Mr. GANSKE) for yielding to me to continue a Special Order that I began last night during this 5-minute segment on the condition of the U.S. economy. I am very grateful for these few minutes just to continue, as I will every evening where I have a chance.

Mr. Speaker, this relates to America's great need for a new declaration of economic independence and my great disappointment at the debate that occurred in the Congress here in the House last week concerning the tax measures that were before us and then again today, where if we count up the cumulative total of all of these measures we are talking about $3 trillion over the so-called 10-year window. This is an enormous amount of money for a country that currently has over $5.6 trillion worth of debt that we have to pay back, and every year we are paying more and more in the way of interest on that debt.

This year alone we are projected to spend well over $450 billion just on the debt alone.

In addition to that, the United States has the worst-ever current account trade deficit amounting to over $500 billion last year, that essentially requires that we sell our assets or borrow $1.5 billion a day net from foreign interests. Now, the trade deficit is basically about more goods coming into our country than our goods going out. This essentially results from flawed trade agreements that have enabled countries like the People's Republic of China, that is now holding 24 of our military personnel, to gain perhaps a $100 billion advantageous this year from their net exports to this country versus our ability to export into that economy.

So what is wrong with the Bush tax and budget plan? First, the President's tax and budget plan does not pay down the overall debt. In fact, his budget is based on what I would call wildly optimistic, 10-year projections that, in fact, cause the debt to spiral, particularly when over $3 trillion is being returned in that period to a country that still owes $5.6 trillion.

Now, it is interesting that the 10-year window is used for projections when, in fact, the President is only elected for 4 years and we here in Congress only budget one year at a time. So we cannot use a 10-year window. If experience is a good teacher, as it surely should be, we know that projections in the past have been off by vast magnitudes, sometimes as much as 75 percent in one year.

Now major revenue hemorrhages are going to occur after the year 2005 because Social Security and medical care bills will rise as more people from the baby boom generation begin retiring. The administration budget risks ratcheting up what is already a spiraling debt burden, particularly after 2005. So his proposals threaten long-term economic growth and the long-term solvency of both Social Security and Medicare.

Moreover, the administration's budget is inherently unfair, because nearly half of the tax benefits go to people earning over $900,000 a year, only the top 1 percent of earners in this country. It is no question in my mind that the President's powerful allies are setting their own table for slashing corporate income tax rates from 35 percent to 25 percent, as most corporations, many of them, do not pay taxes even now; none at all. I will be reading into the RECORD, when we return later in the month, the names of many of the corporations in our country that pay absolutely no taxes at all.

Many of these same interests want to cut the corporate capital gains tax, repeal the corporate alternative minimum tax and other technical changes like faster depreciation for faster write-offs. These corporate titans, the ones that are pushing us to make these changes here, saw their pay increases at over 535 percent over the last 10 years. Imagine that. Imagine your salary quintupling over the last 10 years. And now they want that to double again in the next decade.

Now, is there any doubt whatsoever that the measures that have been before us are truly lopsided? The shower of tax cuts for the wealthy and corporations will dramatically increase the tax burden on millions of people in the middle class. All one has to do is look at the fine print of the bill. It does nothing for low-wage workers and literally leaves out over 12½ million families with children.

The President claims that the typical family of four would get a $1,600 tax cut. However, more than 85 percent of taxpayers will get tax cuts less than that amount and many will get nothing at all. One-third of families with children in our country will get nothing from the entire package. The basic tax grab for those at the top end, along with lowering rates for only some, does absolutely nothing to lift those in our society burdened by low wages and high taxes, largely payroll taxes.

We know that the regressive payroll tax has to be adjusted, but the plan that came before us did absolutely nothing about that.

So while the rich get richer, thanks to the Bush plan, the impact of his tax schemes will cut funding for the environment in half over the next 10 years; spending on veterans will be slashed; Justice programs such as the COPS program and in-schools and community policing programs all will be cut; agriculture will be cut; transportation will be cut by nearly one-fifth with our roads jammed and our air control towers not being the most modern in the world.

We are going to see cuts in Medicare and cuts in Social Security if that program is adopted by the other body.

Not only is the administration doing nothing to ease the California energy crisis, their budget cuts certain critical Department of Energy programs as much as 30 percent.

So America really does need a new declaration of economic independence because rising interest payments on the Federal debt are at a post-World War II record high, as American family savings rates move downward.

□ 1730

U.S. trade deficits are at record levels, with China now being the largest holder of U.S. dollar reserves, $100 billion more this year alone. The number of Americans who believe Social Security will be there for them when they retire is down, at the same time as we see so many families losing their 401(k) assets because of what has been happening in the stock market. The relative portion of taxes being paid by the middle class and poor Americans is going up. At the same time, the relative portion of taxes paid by American and foreign corporations making record profits in the United States as they ship jobs to the Third World is going down. Enforcement of antitrust laws is down.

So, Mr. Speaker, let me just say that the administration and its powerful allies will be back for more bites of our Republic's apple. I really do think that we need a responsible budget. We expect the President of our country to lead us to a higher calling. The future of our country and its stability should be our primary goal, not the gratification of powerful special interests that was so evident here during last week and, in fact, today.

Mr. Speaker, I want to thank the gentleman from Iowa, who has been such a voice for attention to the problems of agricultural America, for yielding to me.

Mr. GANSKE. Mr. Speaker, how much time is remaining on my time?

The SPEAKER pro tempore (Mr. GRAVES). The gentleman from Iowa (Mr. GANSKE) has 46 minutes.

Mr. GANSKE. Mr. Speaker, prescription drugs have been a health blessing for Americans. Millions of lives have been saved, prolonged, and enhanced by prescription drugs. But those same drugs have also been an economic burden for American consumers and taxpayers. The problem of rising drug costs is too important to ignore any longer, and I will tell my colleagues, this is not just a problem for the elderly.

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

How about Mr. James Weinman of Indianola, Iowa, and his wife Maxine. When they make their annual trip to Texas, the two take a side trip as well. They cross the border to Mexico, and they load up on prescription drugs, which are not covered under their Medigap policies. Their prescription drugs cost less than half as much in Mexico as they do in Iowa.

That problem is not localized to Iowa; it is everywhere. The problem that Dot Lamb, an 86-year-old woman from Portland, Maine, who has hypertension, asthma, arthritis and osteoporosis, was paying for her prescription drugs is all too common. She takes 5 prescription drugs that cost over $200 total each month, and that is over 20 percent of her monthly income. Medicare and her supplemental insurance do not cover prescription drugs.

Mr. Speaker, about a year ago I received this letter from a computer-savvy senior citizen who volunteers at a hospital I worked in before coming to Congress:

''Dear Congressman GANSKE: After completing a University of Iowa study on Celebrex, 200 milligrams for arthritis, I got a prescription from my M.D. and picked it up at the hospital pharmacy. My cost was $2.43 per pill with a volunteer discount.''

He goes on, ''Later on the Internet I found the following: I can order these drugs through a Canadian pharmacy if I use a doctor certified in Canada, or my doctor can order it on my behalf through his office for 96 cents per pill, plus shipping. I can order these drugs through Pharma World in Geneva, Switzerland, after paying either of two American doctors $70 for a phone consultation, at a price of $1.05 per pill, plus handling and shipping. I can send $15 to a Texan and get a phone number at a Mexican pharmacy, which will sell it without a prescription at a price of 52 cents per pill.''

Well, this constituent closes his letter to me by saying, ''I urge you, Dr. GANSKE, to pursue the reform of medical costs and stop the outlandish plundering by pharmaceutical companies.''

Well, Mr. Speaker, I want to make it very clear. I am in favor of prescription drugs being more affordable not just for senior citizens, but for all Americans. Let us look at the facts of the problem and then talk about a commonsense solution.

There is no question that the prices for drugs are rising rapidly. A recent report found that the prices of the 50 top-selling drugs for seniors rose much faster than inflation. Thirty-three of those 50 drugs that are most frequently used by seniors rose in price at least 1½ times as fast as inflation; half of the drugs rose at least twice as fast as inflation; 16 drugs rose at at least 3 times inflation; and 20 percent of the top 50 drugs that are used by senior citizens rose at least 4 times the rate of inflation.

The prices of some drugs are rising even faster. Furosemide, a generic diuretic, rose 50 percent in 1999. Klor-con 10, a brand-name drug, rose 43.8 percent. That is not just a 1-year phenomenon; 39 of those 50 drugs have been on the market for at least 6 years. The prices of three-fourths of that group rose at least 1.5 times inflation; over half rose at twice inflation; more than 25 percent increased at 3 times inflation; and 6 drugs at over 5 times inflation. Lorazepam rose at 27 times inflation, and furosemide, a diuretic, rose at 14 times inflation.

Prilosec is one of the two top-selling drugs prescribed for senior citizens. The annual cost for this 20-milligram gastrointestinal drug, unless one has some type of drug discount, is $1,455 a year. For a widow at 150 percent of poverty, so that is an income of $12,500 a year, the annual cost of that one drug, Prilosec alone, would consume more than 1 in $9 of her total budget.

My friend from Des Moines, the Iowa Lutheran Hospital volunteer senior citizen, as do the Weinmans from Indianola with their shopping trips to Mexico for prescription drugs, know that drug prices are much higher in the United States than they are in other countries.

A story in USA Today last year, towards the end of last year, compared

U.S. drug prices to prices in Canada, Great Britain and Australia for the 10 best-selling drugs, and it verifies that drug prices are higher here in the United States than overseas. For example, Prilosec is two to two-and-a-half times as expensive in the United States. Prozac was two to two-and-three-quarters times as expensive. Lipitor was 50 to 92 percent more expensive. Prevacid was as much as four times more expensive. Only one drug, Epogen, was cheaper in the U.S. than in other countries.

Look at some of the comparison of prices between the United States and Europe. Here we have Premarin, 280 .6-milligram tablets, in the U.S., $14.98; in Europe, $4.25. How about Coumadin; that is the blood thinner. For 25 10-milligram pills in the United States, you would have to pay $30.25, but in Europe it would cost $2.85. How about Claritin? Claritin is one of the most commonly used antihistamines, very popular drug in the United States. Twenty 10-milligram tablets in the United States will cost $44; in Europe it will cost $8.75. That just gives us an example of some of the disparity between the drug costs in the United States and in other countries.

Mr. Speaker, this has been a problem for the past decade. Two GAO studies in 1992 and 1994 showed the same results. Comparing prices for 121 drugs sold in the United States and Canada, prices for 98 of the drugs were higher in the U.S. Comparing 77 drugs in the U.S. to the United Kingdom, 86 percent of the drugs were priced higher in the United States, and 3 out of 5 were more than twice as high.

Now, the drug companies claim that drug prices are so high because of research and development costs. I want to be clear. I think there is a lot of need for research. For example, around the world, we are seeing an explosion in antibiotic-resistant bacteria like tuberculosis, and we are going to need research and development for new drugs to take care of these antibiotic-resistant bacterias, as well as other types of drugs.

The industry has spent a lot of money. They spent an estimated $26 billion in research and development last year. That is up from $15 billion 5 years earlier. According to PhRMA, an industry trade group, only 1 in 5,000 compounds tested in the laboratory becomes a new drug, and it takes quite a while to get a new drug, anywhere from 12 to 15 years to bring it to market. It may cost as much as $500 million, although some suggest that that is a somewhat higher number than is actual cost, because some of those costs are actually borne by U.S. taxpayers who are involved with doing some of the basic research.

But, I would say this: Even with the cost and the risk of drug development, the industry is doing pretty good. Data from PhRMA that I saw presented in Chicago last year showed actual little increase in the last couple of years in research and development, especially in comparison to significant increases in advertising and marketing expenses. Since the 1997 FDA reform bill, advertising by drug companies has gotten so frequent that Healthline reported that consumers watch on average nine prescription drug commercials every day. Just the other night I was watching the NCAA championship game. Anyone who was watching that would know how many drug commercials were on during that game.

Take 1998 figures for the big drug companies. Marketing, advertising, sales and administrative costs exceed research and development costs. In 1999, four of the five companies with the highest revenue spent at least twice as much on marketing, advertising, and administration as they spent on research and development. Only 1 of the top 10 drug companies spent more on research and development than on marketing, advertising and administration. The real increase has been in advertising expenses.

For the manufacturers of the top 50 drugs sold to seniors, profit margins are more than triple the profit rates of other Fortune 500 companies. The drug manufacturers have a profit rate of 18 percent, compared to approximately 5 percent for other Fortune 500 companies. Furthermore, as recently cited in The New York Times, of the 14 most medically significant drugs developed in the past 25 years, 11 had significant government-financed research. For example, Taxol is a drug developed from government research which earns its manufacturer, Bristol-Myers-Squib, millions of dollars each year.

As I said at the start of this Special Order, I think the high cost of drugs is a problem for all Americans, not just the elderly, but many nonseniors are in employer plans, and they get a prescription drug discount. In addition, there is no doubt that the older one is, the more likely one is to need prescription drugs.

□ 1745

So let us look at what type of drug coverage is available to senior citizens today.

Mr. Speaker, Medicare pays for drugs that are part of treatment when the senior citizen is in the hospital or in a skilled nursing facility. Medicare pays doctors for drugs that cannot be self-administered by patients; i.e., drugs that require intramuscular or intravenous administration.

Medicare also pays for a few other outpatient drugs, such as drugs to prevent rejection of organ transplants, medicine to prevent anemia in dialysis patients, and anti-cancer drugs that are taken by mouth.

The program also covers pneumonia, hepatitis, influenza vaccines. The beneficiary is responsible for 20 percent of the co-insurance of those drugs.

About 90 percent of Medicare beneficiaries have some form of private or public coverage to supplement Medicare, but many with supplemental coverage have either limited or no protection for prescription drug costs, those drugs that we buy in a pharmacy with a prescription from our doctor.

Since the early 1980s, Medicare beneficiaries in some part of this country have been able to enroll in HMOs which provide prescription drug benefits. Medicare pays the HMOs a monthly dollar amount for each enrollee. Some areas, like Iowa, my home State, have had such low payment rates that no HMOs with drug coverage are available. This is typically a rural problem, but some metro areas have unfairly low reimbursements, as well.

Employers may offer their retirees health benefits that include prescription drugs, but fewer employees are doing that. From 1993 to 1997, prescription drug coverage of Medicare-eligible retirees dropped from 63 percent to 48 percent.

Beneficiaries with MediGap insurance typically have coverage for Medicare's deductibles and co-insurance, but only three of the 10 standard plans offer drug coverage. All three impose a $250 deductible.

Plans H and I cover 50 percent of the charges, up to a maximum benefit of $1,250. Plan J covers 50 percent of the charges, up to a maximum benefit of $3,000. Premiums for those plans are significantly higher than the other seven MediGap plans because of the high cost of the drug benefit.

So let me repeat, there are three MediGap plans that currently do offer prescription drug benefits, but the premiums are significantly higher for those plans.

This chart shows the difference in annual costs to a 65-year-old woman for a MediGap policy with or without a drug benefit. For a MediGap policy of moderate coverage, she pays $1,320 for a plan that does not have a drug benefit, but she pays $1,917 for a policy with a drug benefit. If she wants more extensive coverage, she can buy a MediGap policy without drug coverage for $1,524, but it would cost her $3,252 for insurance with drug coverage.

So why is there such a price gap between the plans that offer drug coverage and those that do not? Well, it is because the drug benefit is voluntary. One has a choice whether to sign up for that, and usually only those people who expect to actually use a significant quantity of prescription drugs will sign up for a MediGap policy that has drug coverage. But because only those with high costs choose that option, the premiums have to be higher because there is a higher average expenditure.

So what is the lesson we can learn from the current plan? The lesson is, adverse selection tends to drive up the per capita cost of coverage, unless the Federal Treasury simply subsidizes lower premiums.

The very low-income elderly and disabled Medicare beneficiaries are also eligible for payments of their deductibles and co-insurance by their

State's Medicaid program. These are called dual eligibles. They are eligible for Medicare, and they are also eligible for Medicaid.

The most important service paid for entirely by Medicaid is frequently the prescription drug plans offered by all States under their Medicaid plans. There are several groups of Medicare beneficiaries who have more limited Medicaid protection. Qualified Medicare Beneficiaries, QMBs, otherwise known as QMBS here in Washington parlance, have incomes below the poverty line, $8,240 for a single and $11,060 for a couple, and assets below $4,000 for a single person and $6,000 for a couple. Medicaid pays their deductibles and their premiums.

Specifically Low-Income Medicare Beneficiaries, known as SLIMBs, have incomes up to 20 percent of the poverty line, and Medicaid pays their Medicare Part B premium.

Qualifying Individuals, Q1s, have income between 120 percent and 130 percent of poverty. Medicaid pays only their Part B premium, but not deductibles. Qualifying Individuals, Q2s, have incomes from 135 percent to 175 percent of poverty, and Medicaid pays part of their Part B premium.

But the QMBs and the SLIMBs are not entitled to Medicaid's prescription drug benefit unless they are also eligible for full Medicaid coverage under their State's Medicaid program. Q1s and 2s are never entitled to Medicaid drug coverage.

A 1999 HCFA report, that is Health Care Financing Administration, the agency that runs Medicare, showed that despite a variety of potential sources of coverage for prescription drug costs, beneficiaries still pay a significant proportion of drug costs out-of-pocket, and about one-third of Medicare beneficiaries have no coverage at all.

It is also important to look at the distribution of Medicare enrollees by total annual prescription drug expenditure. This information will determine, based on the cost of the benefit, how many Medicare beneficiaries would consider the premium cost of a ''voluntary'' drug benefit insurance policy to be ''worth it.''

This chart from the Medicare Payment Advisory Commission, known as MEDPAC, report to Congress, shows that in 1999, 14 percent of Medicare recipients had no drug expenditures, 36 percent had from $100 to $500, 19 percent had from $500 to $999. We had 12 percent with expenses from $1,000 to $1,499; 14 percent from $1,500 to just about $3,000, and 6 percent above $3,000.

I want Members to note something here. Some of these figures are a little different today. These are about 2 years old now, but they will not be that much changed.

If we add up senior citizens who have no drug expenditures, that is 14 percent, plus those that have less than $500, that is 36 percent, so we now have 50 percent of Medicare beneficiaries, plus another 19 percent that have less than $1,000, and we have a pretty high percentage of senior citizens that have less than, say, $1,000 of expenses.

As we look at plans to change Medicare to better cover the cost of prescription drugs, we are going to have to face some difficult choices for which there is not public consensus, and for that matter, there has not been consensus among policy-makers. There are many questions to answer. Here are a few.

First, should coverage be extended to the entire Medicare population, or should we target the elderly widow who is not so poor that she is in Medicaid, but is having to choose between paying her home heating bill and her prescription drugs?

Should the benefit be comprehensive or catastrophic?

Should the drug benefit be defined?

What is the right level of beneficiary cost-sharing?

Should the subsidies be given to the beneficiaries, or directly to the insurers?

How much money can the Federal Treasury devote to this subsidy?

Can we really predict the future cost of this benefit?

I think we need to go back and look at what Congress has done in the past on this, so let us look at the fact that the desire to add a prescription drug benefit is not a new idea. It was actually discussed back in 1965, when Medicare was started. It has been discussed many times since then.

The reason why adding a prescription drug benefit is such a hot issue now is because there has been an explosion in the new drugs available; huge increases in the demand for those new drugs, fueled in large part by all the advertising that we see on TV; and there has been a significant increase in the cost of these drugs in just the past few years.

Many of these drugs are life-preserving, as those that my dad takes. They are important. That is why this issue is on the table for this Congress, and I think we need to do something about this.

Before I discuss previous Democratic and Republican proposals, I think it is instructive to look at what happened the last time that Congress tried to do something about prescription drugs in Medicare. That is because the outcome of the reform bill that became law in 1988 has seared itself into the minds of the policymakers who were in Congress then and are committee chairs now.

The Medicare Catastrophic Coverage Act of 1988 would have phased in catastrophic prescription drug coverage as part of a larger package of benefit improvements. Under the Medicare Catastrophic Coverage Act, catastrophic prescription drug coverage would have been available in 1991 for all outpatient drugs, subject to a $600 deductible and 50 percent co-insurance.

The benefit was to be financed through a mandatory combination of an increase in the Part B premium and a portion of the new supplemental premium which was to be imposed on higher-income enrollees.

It is also important to note that the Congressional Budget Office estimated the cost back then at $5.7 billion. Only 6 months after the bill became law the cost estimates had more than doubled, because both the average number of prescriptions used by the enrollees and the average price had risen more than estimated.

The plan passed the House by a margin of 328 to 72, passed the Senate, and President Ronald Reagan enthusiastically signed that law into place as the largest expansion of Medicare in history.

The only problem was that once seniors learned that their premiums were going up, they did not like the bill very much. They even started demonstrating against it. We had scenes of the Gray Panthers hurtling themselves onto the car of the chairman of the Committee on Ways and Means, Dan Rostenkowski. Those scenes were then broadcast across the Nation on the nightly news programs.

Talk to some of the Congressmen who were here in 1988 and 1989. The switchboards here at the Capitol were flooded with phone calls from angry senior citizens. So what happened? The very next year, the House voted 360 to 66 to repeal the Medicare Catastrophic Coverage Act of 1988, and President Bush, then President, signed the largest cut in Medicare benefits in history, 1 year after President Reagan had signed the largest increase in Medicare benefits in history.

That experience has left scars on the political process ever since, and it is evident in both the Republican and the Democratic proposals that we debated here on the floor last year.

□ 1800

What was the lesson? Last year former Ways and Means Chairman Don Rostenkowski wrote an article for the Wall Street Journal that I think should still be required reading for every Member of this Congress. His most important point was this, the 1988 plan was financed by a premium increase for all Medicare beneficiaries. Rosty said in his op-ed piece in the Wall Street Journal: ''We adopted a principle universally accepted in the private insurance industry. People pay premiums today for benefits they may receive tomorrow.''

Apparently, the voters did not agree with those principles. And by the way, the title of his op-ed piece was ''Seniors Won't Swallow Medicare Drug Benefits.'' He does not think that seniors have changed much since 1988.

Last year we voted on two comprehensive Medicare prescription drug benefit bills whose drafters apparently agreed with him, because the key point the spokesmen for each of those bills made was that their plans were voluntary.

There were shortcomings in both of those bills. The insurance model plan that passed was estimated to cost seniors $35 to $40 a month in 2003 with possible projected increases of 15 percent a year. Premiums could vary among the plans. There would be no defined benefit package; the insurers could offer alternatives of ''equivalent value.'' There would be a $250 deductible and the plan would then pay half of the next $2,100 in drug costs. After that, patients were on their own until they had out-of-pocket expenses reaching $6,000 a year, when the government would pay the rest.

This insurance plan would pay subsidies to insurance companies for people with high drug costs. If subscribers did not have a choice of at least two private plans, then a ''government'' plan would have been available. A new bureaucracy called the Medical Benefits Administration would oversee these private drug insurance plans.

Under the insurance plan, the government would pay for all the premium and nearly all of the beneficiary's share of covered drug costs with people with incomes under 135 percent. For people with incomes from 135 percent to 150 percent, the premium support would have been phased out. It was assumed that drug insurers would use generic drugs to control costs.

The costs of that plan was estimated to be $37.5 billion over 5 years and about $150 billion over 10 years, but the Congressional Budget Office had a pretty hard time predicting the costs because there was not a standard benefit definition.

The premiums under the Democrat bill, the second plan that was debated, were estimated to cost those seniors who signed up. Remember, it was a voluntary plan like the first plan, $24 a month in 2003 rising to $51 a month in 2010, but the bill's sponsors later added a $35 billion expense for a catastrophic component, and that would have increased the premiums more.

Under their plan, Medicare would pay half of the costs of each prescription, and there would be no deductible. The maximum Federal payment would be a $1,000 for $2,000 worth of drugs in 2003, and it would rise to $2,500 for $5,000 worth of drugs in 2009.

And under the Democratic plan debated last year, the government would assume the financial risk for prescription drug insurance; but it would hire private companies to administer benefits and negotiate discounts, similar to what HMOs do today. They are called pharmaceutical benefit managers. It would have aided the poor similarly to the Republican bill that passed the House.

But here is the crucial point on both of those bills. In order to cushion the costs of the sicker with premiums from the healthier, both plans calculated that their premiums based on an 80 percent participation rate for all of those in Medicare. They both thought that 80 percent of seniors would sign up. The attacks on both plans began immediately. The supporters of the Democratic bill basically said that the supporters of the insurance plan were putting seniors in HMOs; that HMOs provide terrible care; and that it was not fair to seniors.

Supporters of the Republican bill said that the Democratic bill was ''a one-size-fits all plan, that it was too restrictive and puts politicians and Washington bureaucrats in control.''

I could criticize both plans in some depth, but I do not have that much time remaining. Suffice it to say that the details of each of those plans was very important on how they would work or, for that matter, if they would work.

I believe that if you let plans design all sorts of benefit packages, as did the Republican bill, it would be very difficult for seniors to be able to compare plans from one to another.

I also think that plans could tailor benefits to try to get the healthier into their plans and leave the sicker seniors out. And it was interesting, because representatives of the insurance industry seemed to share that opinion in a hearing before my committee. In my opinion, a defined benefit package would have been better.

I have concerns about the financial incentives that the bill that passed the House would have offered to insurers to offer and enter markets where there were not any drug plans available. Would those incentives encourage insurers to hold out for more money?

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

In testimony before the Committee on Commerce on June 13 of last year, Mr. Kahn said ''private drug-only coverage would have to clear insurmountable financial, regulatory and administrative hurdles, simply to get to market. Assuming that it did, the pressures of ever-increasing drug costs, the predictability of drug expenses, and the likelihood that the people most likely to purchase this coverage will be the people anticipating the highest drug claims would make drug-only coverage virtually impossible for insurers to offer a plan to seniors at an affordable premium.''

And Mr. Kahn predicted that few, if any, insurers would have offered the product.

I could similarly criticize several particulars of the Democrat bill that was offered as a substitute, but I think there was a fundamental flaw to both bills, and that is what is called adverse-risk selection.

Under those bills, let us just look at the Democratic bill that was offered last year. If the Democratic bill had comparable costs for a stop-loss provision for the catastrophic expenses like the Republican bill did, the premium costs would have been comparable in both bills; and under those bills, a person who signed up for drug insurance would pay about $40 a month or roughly about $500 per year.

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

If you put it another way, the enrollee basically in both of the plans that we debated last year would have had to have somewhere between $1,000 to $1,200 in drug costs a year to make it worthwhile for them to sign up for the bill; otherwise, they would have been paying more for their insurance premium than they were getting a benefit for.

Who would sign up for those plans? Would it be the people who had Medicare who do not have any drug costs now? Would it be the people in Medicare who today have less than $500 a year? I do not think so. Why do I not think so? Because we already have a drug benefit bill and Medigap policies. A senior citizen today already can choose a Medigap policy that has a drug benefit, but only the people who have high prescription drug costs sign up for those bills.

Mr. Speaker, I just think that it is highly doubtful that anywhere near 80 percent of seniors would have signed up for either of those plans; and if only those with high drug costs signed up for those plans, then we know what would happen by looking at the current Medigap policies. Only 7.4 percent of beneficiaries enrolled in standard Medigap plans were in the drug coverage plans, H, I, and J.

One way to avoid adverse-risk selection would be to offer the drug benefit for one time only. Another way to do it would be to require all to be in it.

You could try to set up some ways to estimate the sickness of enrollees. We have tried that in the past. Those are called risk-adjustment programs systems. They are very hard to design and implement. It remains to be seen whether our risk-adjustment systems already on the books are going to work.

You could have a similar benefit package, and I think that would help. And as I said, one sure way would be to mandate enrollment, but that was the approach that legislators here took in 1988, and we saw what happened to that law.

To say that mandatory enrollment has little appeal to policymakers today, I would say is an understatement. That gets me to what can we do to fix this, this problem. I introduced a bill today, it is called the Drug Availability and Health Access Improvement Act of 2001. We have bipartisan cosponsors all across the ideologic spectrum on this bill.

It does three things. Here is a modest three-step proposal for helping seniors and others with their drug costs.

Number one, we could allow those qualified Medicare beneficiaries, those select low-income Medicare beneficiaries and qualifying individuals, one and two, up to 175 percent of poverty to qualify for the State Medicaid drug programs. States could continue to use their current administrative structures. This could be implemented almost immediately. About a third of Medicare beneficiaries would be eligible, especially those most in need.

The drug benefit would encourage them to sign up, and a key feature of that is that the program is already in the States. State programs are entitled to the best price that the manufacturer offers to any purchaser in the United States.

Judging from estimates from the Bipartisan Medicare Commission, that expansion of benefits would probably cost somewhere between $60 billion and $80 billion over 10 years.

Second, we could fix the funding formula, what is called the Annual Adjusted Per Capita Cost, that puts rural States and certain low-reimbursement urban areas at such a disadvantage in attracting Medicare+ plans, because those Medicare+ plans offer a prescription drug benefit. My plan would increase the floor to $600 per beneficiary per month. That would be an enticement for the Medicare+ Choice plans to actually go to States like Iowa. That way senior citizens and rural States would have the same opportunities to sign up for an HMO that offers a prescription drug benefit that those in New York, Miami, Los Angeles now can get.

Third, in response to my constituents who want to purchase their drugs in Canada, Mexico or Europe, we should stop the Food and Drug Administration from intimidating seniors and others with threats of confiscation of their purchases when they try to buy their drugs from overseas.

At the end of last year, we attempted to solve that problem; however, there were some loopholes in the bill that we passed last year, and we need to clarify current law to allow importers to use FDA-approved labeling without charge. Current law explicitly allows labeling to be used for ''testing purposes'' only and does not prevent drug companies from charging very, very high fees for using the label.

FDA approval for labeling provides safety and efficacy. We can allow importers to obtain the best price available on the market. There are a number of things that we need to do to make sure that our retailers in this country are able to purchase from wholesalers overseas at lower rates so that they can pass on the savings to everyone.

□ 1815

Mr. Speaker, I think that would go a long ways to reducing prescription drug prices in this country vis-a-vis where it is, significantly lower in the foreign countries around the world that I talked about earlier in this talk.

The bill that I introduced today meets those goals and ensures that we provide prescription drug coverage to those who need it most. It gives them access to health insurance and the drugs that they cannot now afford. I hope that we end up with a comprehensive prescription drug bill, something that covers all senior citizens. But when I look at that, I think we ought to do that in the context of a comprehensive Medicare reform bill, something that will help make sure that Medicare is financially sound for when the baby boomers come into retirement.

But I also recognize that today we have some senior citizens who are just barely getting by. They are not so poor that they are in Medicaid, but they are just above that, and they are having to make choices today whether to pay their heating bills or food bills or rent, or whether to fill their prescriptions. These individuals are already getting a discount on their Medigap premiums, the qualified Medicare beneficiaries, the select low-income Medicare beneficiaries, the qualifying individuals one and two.

We could implement that benefit for them immediately. We could give them a Medicaid drug card. They could go to any pharmacy in their State, get their prescription drugs filled at no cost, and we would pay for that from the Federal side. We would not ask for a State match on that, so the Governors and State legislators do not need to worry that we will be adding additional costs to their budgets.

I think we can do that for a reasonable amount of money, and it would not require reinventing the wheel. Every State has this program now. It would be easy to administer. All of those State Medicaid programs are overseen to help prevent fraud and abuse. I think this is the commonsense answer if, Mr. Speaker, later this year or next year we find that we are not moving to a comprehensive Medicare reform bill and we are not moving to a bill that covers a prescription drug benefit for everyone.

I just think that it would be a shame if this Congress does not address high prescription drug costs for the seniors that need it most and try to do something to lower the high cost for everyone. And that is where the reimportation issue comes into play.

So, Mr. Speaker, we have a solution. I encourage my colleagues to look at the bill that I introduced today, the Drug Availability and Health Care Access Improvement Act of 2001. It does not mean that you cannot be for a more comprehensive bill. It simply means at the end of the day, if we are not getting that more comprehensive bill, then we should not leave town before the next election without at least providing help to those who need it the most.

DOMESTIC AND FOREIGN POLICY ISSUES

The SPEAKER pro tempore (Mr. PENCE). Under the Speaker's announced policy of January 3, 2001, the gentleman from California (Mr. SHERMAN) is recognized for 60 minutes as the designee of the minority leader.

Mr. SHERMAN. Mr. Speaker, I want to thank the House for giving me the last hour before our adjournment for the Easter and Passover recess. I want to cover four issues, and hopefully I can do so in less than the 1 hour allotted: first, taxation and the energy crisis in California; and then two foreign policy issues, our airmen being held in China, and our sanctions policy and our use of economic tools in order to achieve our national security purposes.

Mr. Speaker, 2 months ago the President of the United States stood where you sit now and asked us to pass his tax program for a particular waitress. He described this waitress as having an income of $25,000, two kids, no spouse, and said that is the reason that we need his program. And he was compassionate in that description; unfortunately, not compassionate to that waitress or the other waitresses that work with her. You see, under the President's tax program, that waitress with two kids does get a little bit of tax relief, perhaps 2 percent of her income, perhaps a cheap 25-cent tip left under the table or under the plate. But he carefully selected the one waitress in the entire restaurant that gets anything at all.

You see, under the President's plan as passed by this House, if that waitress had had an income of $23,000, she gets not 1 penny, not even a 1-cent insult tip. If the waitress, the exact waitress he described with two kids and $25,000, spends anything for child care, then she gets no additional benefit at all, not 1 penny from the President's program. And if that waitress has an income of $23,000 or $25,000 or $26,000 and has 3 kids instead of 2 kids, not 1 penny.

So we were told to pass a tax program to help hard-working waitresses supporting kids, and virtually every waitress in the restaurant goes home without even a 1-cent tip.

This House has added, this President's rhetoric has added an insult on top of that injury. There is injury to those waitresses from a tax program that this House adopted that the President asked us to adopt, because we are going to see higher interest rates, and every waitress in that restaurant is going to be having a harder time buying an automobile, or if she is very fortunate and can almost afford a house, perhaps will not be able to do so. A worse economy and fewer patrons of that restaurant, all of this will injure those waitresses that get not one penny of tax relief from the plan.

Added to the injury is the insult. The President has again and again before audiences across the country said that his plan provides tax relief to every