REPUBLICANS ACCOMPLISH MEDICARE REFORM

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

GENERAL LEAVE

Mr. BILIRAKIS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on the subject of this Special Order.

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

There was no objection.

□ 1900

Mr. BILIRAKIS. Mr. Speaker, we are here tonight, I guess it is tonight, to talk about the Medicare Modernization Act. I will say that I was proud to be a part of that small conference committee that worked hours, weekends, weeks that produced this landmark bipartisan legislation. I am the first to say, and I have said it oftentimes to many of my colleagues, and certainly members of the staff, that this law is not perfect. It is far from perfect. But it targets an awful lot of money towards the areas where it will do the most good; towards the areas that will do the most good. The poorest and the sickest among us will certainly benefit the most from this new law.

Back in the mid 1960s, Mr. Speaker, the Congress passed the Medicare bill. Since then, there have been very few major changes made to it. The bill today, the law today regarding Medicare would offer Medicare beneficiaries the basic part A and part B coverage. It would offer very, very little preventive care. In fact, until a few years ago, it offered no preventive care at all.

We added a few things in a few years ago. The gentleman from California (Mr. THOMAS) and the gentleman from Maryland (Mr. CARDIN) and I got together and we added some preventive care to the bill. No prescription drug coverage available. Very little choice in plans available. If you live in a rural area, much harder to get access to that Medicare.

Today, we have a plan as a result of what this particular Congress did that adds some form of prescription drugs to those benefits. It also adds in an awful lot of preventive health care by way of what we call ''Welcome to Medicare,'' so that when a person is eligible to get on Medicare, Medicare will cover a physical, which is intended, of course, to pick up things that can get an awful lot worse as time goes on. It certainly will result in a lot of savings of money. But the point of the matter is that, hopefully, it will result in a better quality of life for that particular beneficiary because you are picking up something early.

It also provides for much better access in rural areas. One of the fears that Medicare beneficiaries have, those that have retired or their families are retired from some of the larger companies that have given them tremendous retirement coverage, particularly in health care, there is concern as to whether or not they would lose that particular coverage in spite of the fact that over the last few years, and it has nothing at all to do with this Medicare bill, but something like 40 percent of all coverage has been dropped as the result of the high cost of medical costs. But there is some form of protection in this bill. And an additional preventive health care provision is disease management. And there are other areas in it, but those are the additional things.

So, what are the fears or what are the concerns among the beneficiaries out there? God knows an awful lot of Members of this body are certainly working on those fears and on those concerns. Many are concerned that they will lose their traditional fee-for-service coverage. We keep harping on the fact that the bill does not take away that option from them. They can retain traditional fee-for-service and not do anything at all regarding this piece of legislation. There is nothing mandatory whatsoever about it. They can retain fee-for-service and decide to additionally pick up this legislation. So they have the best of two worlds, if you will, if they are in love with the traditional fee-for-service plan that they now have.

I have already said it is not a mandatory plan. People can keep exactly what they have. We have placed money in there to try to encourage employers to keep from dropping. Something has been happening, like I have already said, something like 40 percent over the past few years have already dropped their plans. But we have put some seed money in here, if you will, if you can call $80 billion seed money, to keep employers from dropping plans, and, of course, better accessibility to rural areas.

Mr. Speaker, the history of, let us say the other party, the Democrats, insofar as prescription drug coverage is concerned, is that back in 1999, during the 106th Congress, my friends from the left introduced a bill for prescription drugs, H.R. 1495, which they called the Access to Prescription Medications Act of 1999. Given this legislation, I am puzzled as to why they are having so much difficulty with the benefits in our bill. Why are they having so much difficulty with those benefits? What did that bill, led by the gentleman from California (Mr. STARK), the gentleman from Michigan (Mr. DINGELL), the gentleman from California (Mr. WAXMAN), the gentleman from Ohio (Mr. BROWN), et al, offer?

It offered a $200 deductible. It offered a 20 percent cost sharing up to $1,700. It offered catastrophic coverage after $3,000 out-of-pocket. I would ask Members of Congress, through you, Mr. Speaker, to relate those particular provisions with what we are doing in this bill. And there was no defined premium. The program would have used PBMs, which is what we call pharmacy benefit managers. They take issue with that in our bill, but this is what they would have done. Now, you may ask how a PBM would have been selected? How? By competitive bidding, no less. Furthermore, the contracts would be awarded on, among other things, shared risk, capitation or performance.

I make these points, Mr. Speaker, to highlight how far we have come and how obvious it is that Democrats simply want to play politics with seniors' medication needs. Now, the bill they had was not perfect, and I have already said, nor is ours. But what I am wondering about is if it was good enough for them in 1999, what is wrong with it in 2003 when this legislation passed?

I would also be remiss not to address the notion that some of the fatal flaws in their legislation back in 1999 is that they would have placed numerous onerous requirements under the winning bidder, which would have likely raised drug prices for seniors.

In 2000, the Democratic budget substitute for fiscal year 2001, offered by the gentleman from South Carolina (Mr. SPRATT) their ranking member on the Committee on the Budget, included $155 billion for a Medicare prescription drug benefit. All of their leading leaders over there supported this figure. Our bill is at $390 billion, $395 billion, depending on what figure you want to believe. They had $155 billion. We are well over twice that.

In 2001, the Democratic budget substitute for fiscal year 2002, offered by the gentleman from South Carolina (Mr. SPRATT), upped the ante and called for a $330 billion reserve fund to help create a Medicare prescription drug benefit. Their leadership all supported that figure.

I wish I could tell you what the Democrats support in 2002 and their fiscal year 2003 substitute, but I cannot, because they did not offer one. Of course, that did not stop them from offering a $1 trillion benefit during committee consideration of H.R. 4954, the Medicare Modernization and Prescription Drug Act of 2002.

The fiscal year 2004 budget resolution offered, Mr. Speaker, by the Democrats this year, does not reference a specific dollar figure regarding Medicare modernization and prescription drugs. It just says that the cumulative effect of Medicare reform and programs for the uninsured cannot increase the deficit by more than $528 billion over a 10-year period. Yet they still busted their own budget by offering a drug bill that CBO estimated would cost, what? $1 trillion.

So I think, Mr. Speaker, the point here is obvious. No matter what Republicans commit to Medicare reform and prescription drugs, the Democrats will always outbid us in an attempt to scare seniors and score political talking points. Unfortunately, for them, the Republican majority, along with President Bush, has put $400 billion on

the table to craft a prescription drug benefit that will greatly assist our Nation's seniors. And that is why it was endorsed by AARP and a long list of others that I might read into the record as time goes on.

Mr. Speaker, I will now yield at this point to the gentleman from Pennsylvania (Mr. GREENWOOD), a member of the Subcommittee on Health to supplement and complement my remarks

Mr. GREENWOOD. Mr. Speaker, I thank the chairman for yielding to me, and I thank him for hosting this special order. I worked with the chairman and other members of the Republican conference for years to try to bring this prescription drug benefit into law. And while I did, there were two images that I kept in my mind that drove me as many long hard nights as it took to get this legislation passed.

One of them was a letter I received from an 86-year-old woman that was handwritten several years ago. I do not know if she is still alive, but she described in detail how she has to take six medications. She had no prescription drug benefit whatsoever. She had to pay for those medications out of the little meager Social Security check that she received. And she said to me in this letter that she can barely afford, but she could manage to buy her heart medicine, because that she needed or she would not stay alive. She would die. She could scrape enough money to pay for the medicine that kept the diabetes she was suffering from from killing her.

She was able to get blood pressure medicine that she needed to stay alive, and even pay for the cholesterol-lowering drugs. But she had no money left for the medication that she needed to end her pain from arthritis, and she had no money left to end the emotional pain she suffered from her depression.

So there she was, in a dilemma: Able to pay for the drugs necessary to keep her alive, but not able to pay for important drugs that would make her life worth living.

The other image that I recall vividly is that in one of my offices in the district there is a watchman, a security guard. An elderly gentleman. A wonderful fellow. And every time I walk through the doors, I would go past his desk. And particularly years ago when my daughters were younger, he would always give me two lollipops for my daughters. And he would say, How are you guys in Washington doing on that prescription drug benefit? Because my wife is very ill and she needs so much medication, and we have no benefit. And the reason I have to work at my age is just to make enough money to try to pay for her drugs. And every day I would say, we are working on it, we are working on it, we are going to get it done. And I would almost be afraid to go in a week later and say we had not succeeded.

In fact, we passed a prescription drug benefit in this House in the year 2000. We did it again; it died in the Senate. We did it again in 2002; died in the Senate. Finally, in 2003, we got the bill passed in the House, as we all know by one vote. The Senate passed it with bipartisan support and the President signed it. And finally, finally, after all of these years, after seniors waiting for nearly 40 years for a prescription benefit, we have created it.

Now, what happens? We are subject to criticism night after night. As I am working in my office, I am looking on the monitor watching C–SPAN and I see some of the Democrats on the other side railing and railing against the prescription drug benefit, which, as the chairman just pointed out, amazingly, amazingly, the most liberal Members of the Democratic party had, not too long ago, introduced a bill that did precisely the same thing; used precisely the same mechanisms.

The problem is, they have a political problem. The political problem they have is that the Democratic party has always said, oh, we are the party that loves the senior citizens. We are the party that will deliver them the benefits under Medicare. But they failed. And they failed for all of the time in which they had control of the Congress. And it kills them that it was a Republican House and a Republican Senate and a Republican President that actually got it enacted in law. It is driving them crazy.

So what do they do? They have no choice but to come and trash the very bill that parallels the bill they introduced and try to scare senior citizens into not taking advantage of it. In my district, we hold meetings to explain the new Medicare drug card so seniors understand it. But in the districts of those who come to the floor and oppose it, there is no one there to even help them. Their Congressperson and staff does not help the seniors to understand and navigate the system.

Fortunately, the Medicare program over at CMS has a wonderfully helpful Web site that seniors can go to. They just go to the Web site, and if they do not have access to a computer, they can go to a library or a senior center and get help there. They put in the drugs they take, and they look at the variety of discount cards and pick the one that is best for them.

But it is when you do something, it is when you actually accomplish something and get it done that you are subject to criticism. It is hard to criticize someone in detail about something they never accomplished. We got the job done, so we suffer the criticism. That is fine. The bottom line is that the seniors and those who are physically disabled in America now have the benefit.

The full benefit could not come overnight. You cannot go from zero to 100 miles an hour overnight. You have to set up a system. So we have this interim period with the drug cards. If you are poor, $600 of free drugs and a discount.

□ 1915

If you are not poor, you get the discount; and you get a discount tailored to your needs.

In January of 2006, the full benefit becomes available to every Medicare recipient, every elderly person, every disabled person in the country, a historic occasion, a historic occasion for this country. Finally, everyone in America in those categories will have access to a first-rate pharmaceutical program.

I am proud to say that in Pennsylvania my constituents in my State will have the best program in the country, because what we did in Pennsylvania is we made sure that the Pennsylvania Pace Program, which is now spending $400 million a year, dollars derived from our lottery, that $400 million a year is no longer going to be needed to pay for drugs for the poor people in Pennsylvania, because our Medicare program will do that.

So now with that extra money, we are going in Pennsylvania to be able to fill in some of the shortages in coverage, the so-called doughnut hole, and be able to pay some of the shared cost for our recipients. The people in Pennsylvania will have an exquisitely generous program, and people across the country will have a very good program beginning in January 2006.

I am proud to have worked so hard to gain the success. I am proud of the chairman, the gentleman from Florida (Mr. BILIRAKIS), for his work; proud of the President for supporting this bill and signing it; and I think it is high time that instead of fear-mongering for political purposes, every Member of Congress ought to get on with the business of encouraging their seniors back home to take advantage of this program. It is in their interest to do so and explain to them how it is to their benefit to do so. That is public service. Public service is helping the elderly and the disabled in their district get access to a very helpful program. It is not public service to simply malign the program for political purposes.

Mr. BILIRAKIS. Mr. Speaker, I thank the chairman, the gentleman from Pennsylvania (Mr. GREENWOOD). He has worked hard; and he has been a real leader on this subject and, frankly, on all health matters, because I chair the Committee on Energy and Commerce Subcommittee on Health, and he is a very vocal and active member of it.

I would like to say that we have heard all sorts of arguments against what we have done. The doughnut hole, which is a gap in terms of dollars and what benefits can be acquired during that time and before and after that, the Democrats, as I have already said, have in their 1999 bill a $200 deductible and they had a cost sharing up to $1,700 and then catastrophic coverage after $3,000 out of pocket. So they had a doughnut hole from $1,700 to $3,000. We also have a doughnut hole because of the limited dollars that were available.

Our doughnut hole goes from $2,250 to $3,600. So they had a $1,700, as I understand it, as I interpret it, up to $3,000; and we have a doughnut hole from $2,250 up to $3,600. So we learned about the doughnut hole from them.

I would now gladly recognize the gentleman from Texas (Mr. BURGESS) to talk more specifically about the Medicare-endorsed prescription drug card program, because as the gentleman from Pennsylvania (Mr. GREENWOOD) has already shared with us, the prescription drug provisions go into effect in January of 2006. So during that interim period of time, we wanted to be able to afford some help to the potential beneficiaries, and that is where the discount card program came into effect.

Mr. Speaker, I yield to the gentleman from Texas (Mr. BURGESS).

Mr. BURGESS. Mr. Speaker, I thank the gentleman from Florida (Mr. BILIRAKIS) for yielding the time and especially for his leadership in calling this hour this evening, because I do think it is so important that we get the word out, that we get the story out to seniors across the country of what is available.

Mr. Speaker, I sat on the floor of this House in January of 2003 and heard the President deliver the State of the Union message, the first State of the Union message that I had ever heard as a United States Congressperson; and the President said in that State of the Union message that the Medicare prescription drug benefit was so important that it would not wait for another President, and it would not wait for another Congress.

True to his word, he proposed legislation that worked its way through two committees and came to the floor, just about a year ago, the end of June 2003. We voted on the conference report in November, and the President signed it into law in December. And this bill provided what has been the missing link in Medicare for the past 38 or 39 years, and that is a prescription drug benefit.

Now, Mr. Speaker, I was in my former life a simple country doctor, a practicing physician. I was not around when Medicare first came along; but back in those days, if a senior faced a hospitalization or a doctor bill, those would be the primary medical expenses that he could expect to encounter; but nowadays, we can do so much more with prescription drugs.

Back in 1965, it perhaps was not important to have a prescription drug benefit, because there were only two medications, antibiotics and corticosteroids, and they were interchangeable; but now we can do so much more with prescription drugs.

In January 1, 2006, the prescription drug benefit is going to come online; but between now and then, starting the first of this month of June of 2004, until that January 1, 2006 date, the prescription drug discount card is going to become available; and for the first time, for the first time seniors will have available to them complete transparency in the marketplace. They can call 1–800–Medicare. They can log on if they have the Internet or have their grandchildren log on for them to www.medicare.gov.

You need to know a couple of things before you make that telephone call or before you log on. You need to know your ZIP code, and you need to know the medications that you are taking and the dosages that you are taking.

You do need to know the specific medication names. It will not do to say that I have a little white pill in the morning and a little green pill at noon. You have got to know the specific medication names, but that is not that difficult.

If you have those pieces of information, you can log on or call the 1–800 number, and get information that never before has been available to any group of consumers buying drugs in this country. That is, you can get very powerful market-driven transparent information about what the costs of drugs are.

Mr. Speaker, what we have found in the first few weeks of this program is indeed the cost of drugs on those programs has come down as that transparency has worked its magic in the marketplace. I believe it was important to offer this discount prescription drug card as a transitional benefit. The chairman has already correctly pointed out that you cannot just start up with that part B Medicare that is going to be coming online in 18 months, but this is also giving us an opportunity to make sure that benefit when it comes online on January 1, 2006, is going to be the best benefit possible and there is going to be an enormous amount of data that is accumulated during that 18 months' time.

Seniors starting the first of this month, June, so they can already be going onto the Medicare Web site, www.medicare.gov, or call 1–800–MEDICARE and enroll for a prescription drug discount card. They can either be walked through the process on the telephone or take themselves through that process online, but what they will get at the end of that interview or the end of that online session is a printout of what prescription drug cards are available in their market and what the costs of those cards are.

By law it can be no more than $30. Many of those cards cost less than $30, and some are at no charge at all. Then they can comparison price. Do they want to shop at their neighborhood pharmacy, or do they want to use a mail order pharmacy? That pricing information will be available to them on that printout that they received at the end of the online session or calling into the 1–800–MEDICARE number. Mr. Speaker, it is easy. I did it myself. My hope is that as this process goes forward that caregivers, doctors, nurses will help patients with that; if patients are unsure how to negotiate the system, caregivers will help them chart those waters themselves and find out for themselves what the benefits for seniors out there are.

A very important part of this, and the chairman has already alluded to that, it was important to cover the people who were sickest and the people who were poorest. Of those seniors who are at 135 percent of the Federal poverty level, there is going to be a $600 subsidy available this year, right now, on the prescription drug card, and there will be a similar benefit available next year. In fact, since this year is relatively short, what is left with this year, if there is money not used from that $600 benefit, it will roll over into next year. So there is basically a $1,200 benefit for the 18 months between now and the time the prescription drug card comes online.

Again, Mr. Speaker, I would stress, this is a competitive, market-based solution that is available. It is the first time for any group of purchasers of prescription drugs that they are going to have the power of that transparency in the marketplace. I think we are going to find a number of good things come from that. I for one am very proud to have been part of the process. I realize that I came late to the table, but I appreciate very much having been here last year and watching that process through to its fruition.

Mr. BILIRAKIS. Mr. Speaker, day after day we hear a good deal of criticism about many aspects of this new Medicare discount card that the gentleman from Texas was referring to. We hear, of course, criticism about the entire thing, but particularly that. Some will say that the savings are not large enough. To that I would say that the savings available through these cards, and, more importantly, as the gentleman from Texas said, the $600 per individual transitional assistance for the poorest of our seniors, are a heck of a lot better than what many seniors were getting before this Congress and this President acted to provide Medicare beneficiaries with prescription drug coverage. I have always maintained, I have already said it, that since we have limited resources available to us, we should target our resources to those who need help the most, the poorest and the sickest. The transitional assistance available under these cards will provide a lot of help to an awful lot of people.

Mr. Speaker, I am aware that other Members will argue that the high number of drug discount card sponsors will needlessly confuse seniors. We have had a presentation, and there are a large number. Granted there is some confusion there. The system still has a few kinks that need to be worked out. I agree that some beneficiaries will need extra assistance in choosing the card that is right for them. But, Mr. Speaker, I would enter into the RECORD here a 1966 article in The Washington Post that is entitled Medicare Bug, Thousands Fail to Pay Premiums. It

goes on to say, Thousands of elderly workers have gotten off to a bad start with Medicare by failing to pay their premiums on time. The Social Security Administration has reported delinquency rates for the $3-a-month payments are running as high as 50 percent in some parts of the South, a spokesman said. Nationally it is about 30 percent. The payments were due July 1. The slow payments, it goes on to say, represent only one of several bugs to appear in the massive machinery of Medicare during its first 6 weeks of operation. It goes on to say, however, the program generally is working better than expected and an official said, he is quoted in here, We think there is some confusion.

There was confusion in the mid-1960s. If the Congress had taken a look at that confusion and all those problems and whatnot and done what so many in this body on the other side of the aisle do, complaining about it and calling it names and trying to discourage the seniors from going into it, we would not have Medicare today.

[From the Washington Post, Aug. 21, 1996]

MEDICARE ''BUG,'' THOUSANDS FAIL TO PAY PREMIUMS

(By Philip Meyer)

Thousands of elderly workers have gotten off to a bad start with Medicare by failing to pay their premiums on time the Social Security Administration has reported.

Delinquency rates for the $3-a-month payments are running as high as 50 per cent in some parts of the South, a spokesman said. Nationally, it is about 30 percent. the payments were due July 1.

The slow payments represent only one of several bugs to appear in the massive machinery of Medicare during its first six weeks of operation. However, the program generally is working better than expected.

The problem of delinquent payment affect only the group of 2 million Medicare beneficiaries who are still working. Those who have retired have the monthly $3 checked off their retirement benefits.

Elderly workers who signed up for Plan B, the part of Medicare that covers doctor bills, were billed for $9 to cover the program's first three months. Payments of $3 or $6 also are accepted.

3 MONTHS GRACE PERIOD

No one has yet lost any benefits for failure to pay, a Social Security spokesman said. The grace period is three months.

Biggest lag in premium payments is in Southern States, where as many as 50 percent of the beneficiaries who are supposed to pay in cash failed to send in the money on time.

''We think there's some confusion,'' an official said.

The $3 premium is matched by another $3 from the Federal Treasury to support the program. It pays 80 percent of doctor bills after the first $50.

That $50 deductible is also causing some confusion, the official reported.

''Some people thought they had to pay the first $50 charged by each doctor they saw,'' he said, ''Others thought it was a premium they had to pay whether they needed a doctor or not.''

As the rule actually works, the $50 deductible must be met only once in each calendar year.

Another problem reported to the Social Security Administration headquarters by district offices is that many people who turn 65 are late in signing up for Plan B.

SHOULD JOIN BEFORE 65

Those who wait for their 65th birthday to enroll miss the first month of eligibility. The proper time for joining is from one to three months before the birthday.

Once enrolled, many persons have caused themselves unnecessary inconvenience by becoming ''overly protective'' of their Medicare cards.

The wallet-sized cards are issued to identify beneficiaries to doctors and hospitals. Some people are so afraid of losing them, they have rented safe deposit boxes to store them in. Others have sent them to sons or daughters in distant cities for safekeeping.

''The card isn't all that important,'' the Social Security spokesman said. ''It's nice to have, but losing it won't keep you from getting benefits. The worst that can happen is the inconveniences of apply for a new card.''

Mr. Speaker, I would also say in that connection, there are companies which have already said that they would offer pharmacy assistance programs around the low-income subsidy for the drug card. So once these poorest seniors among us use up that $600 that they have available, the $600 per individual, $1,200 per couple, these companies have come into the picture and said they would go ahead and not charge them anything extra.

Merck. Under the Merck program, once a beneficiary has exhausted his or her annual $600 traditional assistance allowance, Merck will provide its medicines free to that beneficiary's participating discount card plan.

Johnson & Johnson. After Medicare beneficiaries who are eligible for the government's $600 transitional assistance allowance have exhausted this benefit, they can receive medicines made by Johnson & Johnson-operating companies free of charge.

Eli Lilly will partner with government-approved programs to make the LillyAnswers program available to seniors with incomes below 200 percent, considerably better than just the real low-income, below 200 percent of the Federal poverty level and who do not currently have prescription drug coverage.

Abbott will partner with drug-discount cards approved by the Centers for Medicare and Medicaid Services to offer Synthroid tablets for $5 per monthly prescription. It goes on and on.

Pfizer. The Pfizer Share Card program provides qualified low-income Medicare beneficiaries, those with gross incomes less than $18,000 single and $24,000 couple, with access to up to a 30-day supply of any Pfizer prescription medicine for a flat fee of $15 per prescription.

As a result of what we have done here, we have partnered with an awful lot of the pharmaceutical companies.

Mr. Speaker, I yield to the gentleman from Illinois (Mr. SHIMKUS), another terribly valuable member of our committee.

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Mr. SHIMKUS. Mr. Speaker, I thank the chairman for yielding to me, and I appreciate this special order.

I will be brief. I know I have got colleagues here on the floor who also want to address this issue.

Sometimes in this whole Medicare prescription drug debate, we focus on the prescription drug benefit, and I am glad we do because it is the first time we have ever offered real help to seniors, especially the poor, those in need. And I was talking to a group of homecare folks on Saturday morning at their in-service and educating them on the 1–800 number and the www.medicare.gov so that they can help their clients access this needed program.

So that is what we have got to continue to do, and that is what I hope all of my colleagues, whether they were for the bill or against the bill, if they are for their seniors, they ought to be educating them on the benefits of this package.

But, also, before I even go on the Medicare prescription drug debate, I always tell the folks in rural Illinois, and I represent 30 counties south of Springfield down to Indiana and Kentucky, that in this bill is the best rural package for hospitals ever passed.

And that is why we have got a good bipartisan vote by some Democrats who represent rural America and realize that in the debate on funding aspects, there was always the concern, well, if it is rural, it must cost less so we can pay less. But when we talk about buying the needed high-tech fancy equipment that is needed today and they do not have the buying power of a major network, those pieces of equipment come almost more costly than they would if they are buying multiple copies of this equipment.

So for anyone who represents rural America, this bill was a huge victory in making sure that our rural community hospitals can operate and keep their doors open. And I want to thank the leadership of the chairman to make sure that that was part of the package.

The other thing that I am very excited about and I like to talk about it all the time because I want feedback from my constituents. In fact, Bob Ney, who is the mayor of the District of Columbia, he is our mayor, I have asked him countless times to make sure that we get options for health care and insurance packages, do your best to make sure we have a health savings account provision that we ourselves can look at as part of our buying options and your working options for our insurance. The health savings accounts are probably, I think, our last great chance to reform an entitlement system and get individuals back in control of their buying decisions and costs. Making health care decisions based upon quality service, timeliness, people they like, and cost.

What has happened, in my humble opinion, because I am not an expert in this field, is that we do not know what we are paying for health care delivery and services, and we do not know actually who is paying and how much they

are paying because there are multiple levels.

I have got a farmer in my district that has moved to a health savings account plan, and he is saving $10,000 a year on his catastrophic plan. And the deductible portion, which, if he does not use or even if he uses a portion of that, that can roll over. Think of the great benefits to young kids getting married now. This health savings account, if it is going to be offered and if they take advantage of that, having that tax-free savings continue to roll over and what it will do in the buying decisions and costs, and they are shopping around for the basic health care services, eyewear, dental visits, things that now are put in this big pool of insurance that some offer and some do not. If they need it, they have got it. If they want the preventative care, go get it. It is going to save money in the long run. And the more money one saves in this health savings account, the more that rolls over in the next years.

So I want to thank the chairman for letting me butt in line, and I want to thank my colleagues for allowing me to do that. I would ask our colleagues, when we talk about the benefits of the Medicare prescription drug bill, spend time on the prescription drug benefit. It is a great benefit and people should take advantage of it. But look at other portions of the bill. For the rural hospitals, we did great. And the future of getting people back in control of their health care costs and decisions on their health care savings accounts, I am hoping that it is everything that it is going to be advertised to be.

And I am asking people to let me know if it is doing what we think it should do because no piece of legislation that we pass here on the floor of the House is perfect. We all know that. We will get another look at it. We will have hearings. We will try to reform and adjust. And we only do that by getting good feedback from our constituents.

Mr. BILIRAKIS. Mr. Speaker, I yield to the gentleman from Georgia (Mr. GINGREY) to continue on this subject.

Mr. GINGREY. Mr. Speaker, I would, first of all, like to thank the chairman of the Health Subcommittee of the Committee on Energy and Commerce and the committee members who are bringing this hour to us tonight on such an important subject.

When we passed this bill in December of 2003, this was a bipartisan bill. This is a bipartisan Medicare plan. There were Members on both sides of the aisle, my colleagues, who usually sit on the right, the Democrats, who usually sit on the left, there were those on the right who opposed who felt that this bill, the $400 billion, or maybe it is $500 billion, was too costly, that we just simply wanted to do it but could not afford it to. And I think some 24 or 25 of my Republican colleagues voted against the bill because they just did not think we could afford it.

On the other side of the aisle, the Democrats, some voted for the bill, but those who opposed it opposed it because they did not think we were doing enough, that we were not spending enough. And they kept talking about the doughnut and the hole in the doughnut and emphasizing, Mr. Speaker, that the hole was too big. And now that the bill has passed, we hear all this what I refer to as ''Mediscare'' rhetoric, and one of the first and foremost ''Mediscare'' tactics about that hole in the doughnut.

We see it on television ads. So they are saying to seniors do not eat the doughnut. Do not eat the doughnut. Eat the hole. And I can tell people the hole has no taste, it has no calories, it has nothing because there is nothing there. And I think it really is unconscionable, particularly in regards to this interim program, the Medicare discount prescription card program to suggest to seniors or to advise them not to sign up for the prescription card.

Mr. Speaker, I cannot think of any reason, not one reason, for a senior to not sign up for their prescription discount card. The benefits are tremendous for those who need it the most. And we have heard my colleagues speak about the $600 credit not just one time but 2 years and that can roll over into the next year.

So a senior might have as much as $800 the second year of credit, not to mention the 15 to 20 percent overall discount, not that some discounts may be higher on certain drugs and lower on certain drugs but overall a 15 to 20 percent discount.

And I say this, Mr. Speaker, to my seniors when I when I do town hall meetings in the 11th district of Georgia, South Cobb County and 16 counties of West Georgia, and we talk about this, and I say to them take advantage of this discount card. The most it can cost them, the most it can cost them, is $30; but if they are a low-income senior and they are eligible for the $600 credit, if their income is below 135 percent of the federal poverty level, and there is no assets means testing, it is just strictly based on income, and they are eligible for that, then they get the $600 credit, and they pay nothing for their card, and they get that 15 to 20 percent discount on each and every medication on an average that they purchase. I mean it is an opportunity for anyone. Whether they voted against the bill because they thought that it was too expensive and we could not afford it or whether they voted against it because they thought we were not doing enough, I say that it is unconscionable to advise those seniors not to sign up for the prescription drug discount card.

There are other things, and I do not want to take up too much of the time that the chairman has been so kind to allot to me tonight, and I know there are other speakers that are coming, but that is just one of these ''Mediscare'' tactics. And the other one, and I will just briefly mention that, is this idea of this Medicare plan, prescription drug plan and Medicare modernization, is nothing but a giveaway to the pharmaceutical industry. We have heard that. I know all my colleagues have heard that, and hopefully people listen and will understand as I explain why that is so fallacious. If that were true, if the new Medicare part D prescription drug plan was nothing but a giveaway to the pharmaceutical industry, then one could certainly say the same thing about part A and part B, going back to 1965, as the chairman did earlier in his remarks.

Part A, of course, one could say was nothing but a giveaway to the hospitals, and one could equally say that part B was nothing but a giveaway to the doctors because after all, they are the ones who provide the services under part A and part B respectively. But talk to any of them, and, believe me, they will say very quickly that it is hard to see Medicare patients and provide that care, and in many instances they are doing it out of the goodness of their heart. The pharmaceutical industry certainly will sell more drugs, but they will sell them cheaper, just like an automobile dealer who sells 100 new cars a month can sell them cheaper than if he just sells 10. And that is what is happening. That is what is going to drive these prices down.

Mr. Speaker, I love to come before my colleagues and talk about this bill. We are in the interim phase now, the prescription drug discount card. Again, I can think of no reason why a senior should not sign up for that and take full advantage of it. In a year and a half, there may be some seniors who will have a better plan. Nobody will be forced out of Medicare as we know it, traditional Medicare. It is a choice. But this is a good bipartisan bill, and it is time to stop all the politicking and the rhetoric against it and let the seniors take advantage of something that this President and this Congress have finally delivered on.

And I thank the chairman so much for giving me the opportunity to be with him tonight.

Mr. BILIRAKIS. Mr. Speaker, I thank the gentleman for his comments.

Mr. Speaker, I very much appreciate particularly the gentleman's emphasizing the discounts because fortunately for America's seniors, and we will not hear this from the other side, the principles of competition that drive this new benefit are already showing real, real results. And CMS found during the first week, and I am talking about the first week in May now, the first week in May, which was really when all this started in terms of posting prescription drug discount card pricing information, et cetera, the CMS found that the discounted prices available through the program had already fallen 11½ percent for brand names and 12½ percent for generics over that first week.

I do not know what the current picture is. I have not looked into that.

But the fact of the matter is we can see what will happen here with competition. And these discounted prices are already less, already less, than what seniors without drug coverage are paying for their medications.

And that is why, Mr. Speaker, it is so disappointing that some continue to demagogue this issue. When I learn of a partisan analysis, if you will, of the prescription drug discount card benefit that concludes that the program is a failure, before a single beneficiary uses the card, before a single beneficiary uses the card, it makes us all wonder. But I guess we do not have to wonder too much. Scare tactics are designed to frighten, to confuse seniors. That will only ensure that some beneficiaries would choose, as the gentleman from Georgia (Mr. GINGREY) said, not to access a benefit that could save them hundreds, if not thousands, of dollars annually.

Mr. Speaker, I yield to the gentleman from Oklahoma (Mr. SULLIVAN) to continue on in this conversation. Newly added to the Committee on Energy and Commerce, I am very proud to say.

Mr. SULLIVAN. Mr. Speaker, I thank the gentleman from Florida (Mr. BILIRAKIS) for all his work on this very important measure.

Unfortunately, the chairman is right, how this gets demagogued. I go back to my district, and seniors are excited about this, but unfortunately they get things in the mail and they hear all this misinformation. And this is a great bill. This is a historic measure and something that is very important.

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Mr. Speaker, I would like to bring to your attention an often overlooked provision in H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003, that will better the lives of America America's seniors.

As a result of the Medicare reform law, Medicare beneficiaries will receive an expansion of coverage that will help them to prevent and manage many life-threatening diseases, such as cancer, diabetes and cardiovascular disorders, without incurring large medical bills.

For instance, H.R. 1 provides for an extensive initial medical preventative physical examination. This free exam includes measurements of height, weight, blood pressure and an electrocardiogram. Health care professionals will be on hand during these physicals to offer education, counseling and referrals related to other preventative services covered by Medicare. These preventative services include but are not limited to vaccinations, screening, mammography, prostate and colon cancer screening, as well as cardiovascular and diabetes screening.

It is worth noting that cardiovascular and diabetes screening tests do not have deductible copays, so beneficiaries do not have to incur any cost. This is an additional incentive for those with limited resources to go to the doctor and have these vital tests performed so that these diseases can be detected as early as possible.

Many of these diseases, if caught early, can be treated and effectively managed resulting in far fewer serious health consequences. Such conditions as obesity, diabetes and heart disease could be far less severe for millions of Medicare beneficiaries. These are diseases that are impacting millions of Americans every year.

For example, approximately 129 million U.S. adults are overweight or obese. Additionally, an estimated 18 million, or 6.2 percent of the United States population, have diabetes. This is not to mention the fact that heart disease and stroke are the first and third leading causes of death in the United States. In 2003 alone, 1.1 million Americans will have a heart attack.

By providing an initial physical examination for all newly enrolled Medicare beneficiaries, seniors and disabled Americans will have an opportunity to discuss with their physician the importance of preventative care and living a healthy lifestyle. These examinations will not only save lives, but also save the United States Government hundreds of millions of dollars, as catching these diseases early lessens the cost of treatment.

One program that will help many seniors towards the realization of a better quality of life is the Chronic Care Improvement Program, which was announced as a pilot project by CMS in April. It establishes and implements a Chronic Care Improvement Program under fee-for-service Medicare to improve clinical quality and beneficiary satisfaction, while also achieving spending targets for beneficiaries with certain chronic health conditions. This program will help patients manage their diseases in a way that will help improve case outcomes and patient care when they need it most.

As a member of Speaker HASTERT's Prescription Drug Task Force, I have spent many hours meeting with senior citizens and listening to their concerns. I know the Medicare reform law we passed in November is already having a positive effect on many seniors as they are seeing their drug prices fall and their health improve.

We should all be proud of the fact that we delivered our promise to seniors to give them a prescription drug benefit. We should also be proud about giving them an opportunity to live happier and healthier lives in their golden years by expanding their benefit to include the prevention and management of serious diseases.

Thus, it is my sincere hope, Mr. Speaker, that more American senior citizens will take advantage of the prescription drug benefit, as well as the preventative service Medicare offers, as they could truly help prolong millions of people's lives.

Mr. BILIRAKIS. Mr. Speaker, I thank the gentleman.

Before I yield again to Mr. GREENWOOD, I have in my hand four pages worth of supporters of the Medicare conference report. These are all patient groups. I am going to read off just a handful of the long list:

AARP; ALS Association; Alzheimer's Association; American Autoimmune Related Diseases Association; American Diabetes Association; Arthritis Foundation; Coalition to Protect America's Health Care; Coalition to Protect Health Care Access; Cuban-American National Council; Epilepsy Foundation of Florida; Florida Coalition on Hispanic Aging; Hepatitis C Global Foundation; Kidney Cancer Association; Latino Coalition; Mental Health Association of Central Florida; Montel Williams Foundation; National Alliance For Hispanic Health; National Alliance For the Mentally Ill; the National Council on the Aging; Polycystic Kidney Disease Foundation; Robbie Vierra-Lambert Spinal Cord Organization; Sickle Cell Disease Foundation of California; 60-plus Association; United Seniors Association; We Are Family Foundation; Women Heart Group.

This is just a handful of the long list here, Mr. Speaker, which I will include for the RECORD.

GROUPS SUPPORTING THE MEDICARE CONFERENCE REPORT

PATIENT GROUPS

AARP
ALS Association
Alzheimer's Association
Alzheimer's Association, Mid South Chapter
American Autoimmune Related Diseases Association
American Diabetes Association
American Sepsis Alliance
Arthritis Foundation
Coalition to Protect America's Health Care
Coalition to Protect Health Care Access
Cuban American National Council
Epilepsy Foundation, Florida
Erin K Flatley Foundation
Florida Coalition for Access to Quality Medicine
Florida Coalition on Hispanic Aging
Florida Drop-In Association
Hepatitis C Global Foundation
International Patient Advocacy Association
Kidney Cancer Association
Larry King Cardiac Foundation
Latino Coalition
Louisiana Community Volunteers Association
Louisiana Progressive Alliance
Louisiana Safe Neighborhood Action Plan
Louisiana Women's Network
Loving Others Together Foundation
Mental Health Association of Central Florida
Montel Williams MS Foundation
National Alliance for Hispanic Health
National Alliance for the Mentally Ill
National Alliance for the Mentally Ill—Kansas
National Alliance for the Mentally Ill, Idaho
National Art Exhibitions By The Mentally Ill, Inc.
The National Council On The Aging
National Right to Life Committee, Inc.
Polycystic Kidney Disease Foundation
Prevent Blindness Ohio
Pueblo Health & Educational Programs
RetireSafe.org
Robbie Vierra-Lambert Spinal Cord Organization

Sacramento Hepatitis C Task Force
Seniors Coalition
Sickle Cell Disease Foundation of California
Sickle Cell Foundation of Florida
60 Plus Association
TMJ Society of California
United Seniors Association
We Are Family Foundation
WomenHeart

HEALTHCARE ORGANIZATIONS

AAHP–HIAA
AdvaMed
Aetna
Alliance for Aging, Florida
Alliance for Quality Nursing Care
Alliance of Specialty Medicine
Alliance to Improve Medicare
American Academy of Dermatology Association
American Academy of Family Physicians
American Academy of Ophthalmology
American Academy of Pharmaceutical Physicians
American Association of University Women, Louisiana
American Association of Clinical Endocrinologists
American Association of Neurological Surgeons
American Association of Nurse Anesthetists
American Association of Orthopedic Surgeons
American College of Cardiology
American College of Cardiology—MI Chapter
American College of Emergency Physicians
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Radiology Association
American College of Surgeons
American Gastroenterological Association
American GI Forum
American Hospital Association
American Medical Association
American Medical Group Association
American Occupational Therapy Association, Inc.
American Osteopathic Association
American Physical Therapy Association
American Society Anesthesiologists
American Society for Therapeutic Radiology and Oncology
American Society of Cataract and Refractive Surgery
American Society of Plastic Surgeons
American Speech Language Hearing Association
Anthem
Association of American Medical Colleges
BayBio
BIOCOM
BioFlorida
Biotechnology Council of New Jersey
Biotechnology Industry Organization
BlueCross BlueShield Association
California Healthcare Association
California Healthcare Institute
California Hep C Task Force
California Medical Association
Cardinal Health
Catholic Health Association
Cigna
Coalition for a Competitive Pharmaceutical Market
Coalition to Ensure Patient Access
College of American Pathologists
Colorado Bioscience Association
Congress of Neurological Surgeons
Disease Management Association of America
eHealth Initiative
Federation of American Hospitals
Florida Academy of Family Physicians
Florida Hospital Association
Florida Osteopathic Medical Association
Generic Pharmaceutical Association
Healthcare Institute of New Jersey
Healthcare Leadership Council
HealthNet
Hep and Vet Action Now Foundation
Highmark, Inc.
Hispanic Health Care Professional Association, Texas Chapter
Hospital & Healthsystem Association of Pennsylvania
Humana
InterAmerican College of Physicians and Surgeons
Iowa Biotechnology Association
Iowa Healthcare Access Network
Iowa Medical Society
Maryland Bioscience Alliance
Massachusetts Biotechnology Council
Massachusetts High Tech Consortium
Mayo Clinic
Medco Health Solutions
Medical Society of New Jersey
Medical Society of the State of New York
Medical Society of Virginia
Memorial Regional Health Systems
Missouri State Medical Association
MNBIO
National Association of Children's Hospitals
National Association of Community Health Centers
National Association of Health Underwriters
National Association of Public Hospitals and Health Systems
National Association of Rehabilitation Providers and Agencies
National Association of Spine Specialists
National Hospice and Palliative Care Organizations
National Medical Association
National Rural Health Association
New York Biotechnology Association
Ohio Advocates for Health Care Access
Ohio Hospital Association
Ohio State Medical Association
Oklahoma State Medical Association
Omeris
PacifiCare
Pennsylvania Biotechnology Association
Pennsylvania Healthcare Technology Network
Pharmaceutical Care Management Association
Premier
Private Practice of the American Physical Therapy Association
Rural Hospital Coalition
Scripps Research Institute
Society of Thoracic Surgeons
South Carolina Biotechnology Association
South Florida Hospital and Health Care Association
Texas Health and Bioscience Institute
United Health Group
University of California Health System
Utah Life Science Association
VHA
Wisconsin Biotechnology Association
Wisconsin Healtcare Access Network

EMPLOYERS

3M Company
American Benefits Council
American Chemistry Council
AT&T
Bank of America
BellSouth Corporation
Bituminous Coal Operators Association
California Hispanic Chambers of Commerce
Cargill, Inc.
Case New Holland, Inc.
Caterpillar, Inc.
Cigna
Coors Brewing Company
Corporate Health Care Coalition
Cox Enterprises
Cummins, Inc.
DaimlerChrysler
Deere & Company
Delphi Corporation
Dow Chemical Company
DuPont Chemical Company
Eastman Kodak Company
EDS
Employer Health Care Alliance Cooperative
Employers' Coalition on Medicare
ERISA Industry Committee
Financial Executives International
Fisher Scientific International, Inc.
Florida Hispanic Chamber of Commerce
Food Marketing Institute
Ford Motor Company
General Dynamics Corporation
General Motors Company
Georgia Pacific Corporation
Hershey Foods Corporation
Hewlett-Packard Company
Honeywell
HR Policy Association
IBM
International Mass Retail
International Paper Company
Jostens
Kellogg Company
Louisiana Versai Management
LPA, the HR Policy Association
Lucent Technologies, Inc.
Monsanto
Michigan Manufacturers Association
Motor & Equipment Manufacturers Assoc.
Motorola
National Association of Manufacturers
National Federation of Independent Businesses
National Mining Association
National Retail Federation
National Rural Electric Cooperative Association
Northrop Grumman Corporation
Peabody Energy Company
Pitney Bowes
Pittsburgh Plate and Glass
PPG Industries, Inc.
Printing Industries of America
PSEG
RAG American Coal Holding, Inc.
Raytheon
Rohm Haas
SBC Communications
Sears, Roebuck and Co.
Southern Company
Southwest Florida Hispanic Chamber of Commerce
Sprint
Texas Instruments
The Aluminum Association
The Boeing Company
The Business Roundtable
The Goodyear Tire & Rubber Company
The Timken Company
U.S. Chamber of Commerce
United States Steel Corporation
UPS
Verizon
Washington Business Group on Health
West Virginia Chamber of Commerce

OTHERS

American Legislative Exchange Council
Archer MSA Coalition
California State Association of Counties
Robert Goldberg, Manhattan Institute
New Orleans Coalition
The National Grange
Women Impacting Public Policy

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

Mr. GREENWOOD. Mr. Speaker, I thank the gentleman from Florida (Chairman BILIRAKIS) for yielding.

Let me say to the chairman, he has had a long and distinguished career in the United States Congress, and I am sure that at the end of that career, the gentleman will look back with pride and say, if he is proud of anything he was able to accomplish in all of the countless 2 o'clock in the morning, 3 o'clock in the morning, 6 o'clock in the morning sessions we have spent here, I would think it would be that you were at the helm when this Congress passed prescription drug benefit for seniors. It is an historic accomplishment, and the gentleman should be proud of it. I know he is.

The other people who are proud of it, interestingly enough, are, as the chairman just said, the AARP, the American Association for Retired Persons, and all of the groups that care and are devoted to the care of patients. So if you are an organization like the AARP, there is no organization more respected by seniors than they, if you are one of the thousands of organizations that are devoted to making sure that people with illnesses get medicine, you are for the bill.

So, how could we imagine that, after 35 years of struggling, nearly 40 years of struggling without success to get a prescription drug benefit, finally the Members of this Congress, the House and the Senate in a bipartisan fashion, with the President of the United States signing the bill, we get it done, we devote half a trillion dollars to these prescription drug benefits, and who in the world would imagine that the reaction would be, from some quarters, let us criticize it. Let us attack it. Let us destroy it.

Let me let you in on a little secret: A Democratic pollster provided some strategic information to the Democratic Party about how to respond to the fact that we had accomplished this great thing as Republicans and they needed a political strategy.

What the pollster said, this is Greenberg Quinlan Rosner Research, Inc., in a Lake, Snell, Perry & Associates memo to the Democratic Party, they said, ''A message of fixing the bill reinforces the AARP message that we have made a good start and might continue to improve it. But that would give the message that the law is not all bad,'' so what she suggested was that we have to ''shift the debate in our favor as the straight negative portrayal of the law.''

So any sort of sensible approach that says, hey, after all these years, we made a great start, let us keep making it better, let us enrich the benefit over time, you do not win the political debate if you do that. So you have to say the whole darn thing is no good, it was done for the worst of reasons, and let us condemn those who tried to make it happen.

It is pretty astonishing hard to believe, hard to imagine that you would come along and spend half a trillion dollars to take care of the prescription drug benefits and needs of the seniors and the disabled, and the response is so negative.

One of the chief critics of the program is the gentleman from Ohio (Mr. BROWN), the ranking member on the committee of the gentleman from Florida (Mr. BILIRAKIS). The gentleman from Ohio (Mr. BROWN) is a friend of mine and a colleague, but he has a penchant for never being able to have a debate. He says you think this way and I think that way, and that is a philosophical debate. He always has to assume the worst of motives.

One of his criticisms is the way this benefit is delivered it through private pharmaceutical benefit managers. We set up a system so various companies can compete in the marketplace to deliver low cost drugs to seniors. What we know is that they are going to want to be able to make some profit on this, so they will go to the drug manufacturers and negotiate hard. ''You want me to cover your arthritis drug, you better give me a darn low price.''

That is the way it works in the marketplace, and they get competition going between the various drug manufacturers to see who is going to give the lowest price. That is why we developed the system that way.

Interestingly enough, every Member of Congress who chooses to receive his or her prescription drug benefit through the Federal Government receives their benefits exactly the same way, private companies. We do not have a special agency full of Federal employees that dispense drugs to Members of Congress, or to the 8 million other Federal employees. Eight million Federal employees, it is shocking that there are so many, but 8 million Federal employees who are eligible to purchase a prescription drug benefit through the government program, they buy it using the exact same model that we have provided for the senior citizens, the exact same model.

Every man and woman in the United States military who participates in the military health programs gets their drugs the same way that we set up for the Medicare program.

Now, the gentleman from Ohio (Mr. BROWN) says no, that is not why you did it. You did not do it because it is efficient. You did not do it because you get the best prices. You did not do it because the private sector can instantaneously put a new drug into the plan, while the bureaucratic process would take months and months to add a new product. He says we did it because of contributions from the drug companies.

I am here to say, as one who has never received a contribution from a drug company, I did it because I believe it is the right philosophical thing to do, it is the right way to benefit the seniors of our country.

Again, Mr. Chairman, I am proud of you for your work on this, and thank you for giving me the opportunity to speak this evening.

Mr. BILIRAKIS. Mr. Chairman, I thank the gentleman so much for his contribution tonight and all through the years. I would again remind all of us that the PBM, the pharmacy benefit managers, was an idea, an invention of the other party, and we did learn a few things from it. We learned about the gap, if you will, or the donut. We learned about the PBM and that sort of thing. We took the best, I think, of their ideas and cranked them into this and made some minor changes.

Mr. Speaker, this new prescription drug benefit also functions, and this is something I guess we do not talk about as much as we should, as a sort of insurance program, when you stop to think about it.

Most senior citizens that I represent are very risk adverse. One of their great fears is to fall victim to a debilitating illness that will wipe out their life savings and burden their families.

Since prescription medications are obviously crucial to the treatment of a myriad of conditions, it goes without saying that a long-term chronic illness will most likely result in high spending on prescription drugs.

Under this bill, seniors who elect to join the program will pay around $35 per month for their Part D coverage. This premium buys them two things: First, it buys them the peace of mind that if they suffer from a catastrophic illness, that seniors will pay only 5 percent of their medications after spending $3,600 out of their own pocket; insurance, if you will, for if they really get sick. We all have life insurance and all sort of insurances that, God help us, we will never use. We do not complain about it.

Beneficiaries who qualify for low income assistance will not pay anything once they reach this threshold. The others will pay 5 percent after spending $3,600 out of their pocket.

Second, the premium buys them very good first dollar prescription coverage. After meeting the $250 deductible, their Medicare prescription drug plan will pay 75 percent of the drug costs up to a $2,250 limit. I have already said the Democrat plan had it up to $1,700, so we even go above that. Over half of Medicare beneficiaries spends less than this in a year, so for them, this is really a great deal.

Mr. Speaker, the benefits of the bill are clear: Superior assistance for those on fixed incomes, peace of mind for all seniors that a catastrophic illness will not devastate them financially, and excellent first dollar coverage that will benefit millions of American seniors.

There are a lot of folks who want to see this new bill fail. They will say and do most anything to scare senior citizens in their quest to discredit this program. I think they are going to fail.