Here’s a 10-step modest proposal for helping seniors and others with their drug costs:

1. Congress should pass the Medicare Beneficiaries (QMBs), Specified Low Income Medicare Beneficiaries (SLIMBs) and Qualifying Individual (QI–1&2) with an additional phase-out group to 175% of poverty to qualify for state Medicaid drug programs. States could continue to use their current administrative structures and implementation could be done quickly. About a third of Medicare beneficiaries would be eligible, especially those most in need, and the drug benefit would encourage those who qualify to sign up. A key feature of this program would be that the State programs are entitled to the best price that the manufacturer offers to any purchaser in the United States. Judging from estimates of the Bipartisan Medicare Commission, this expansion of benefits would probably cost about $60–80 billion over ten years.

2. Congress should fix the funding formula (the Annual Adjusted Per Capita Cost—AAPCC) that puts rural states and certain low-reimbursement urban areas at such a disadvantage in attracting Medicare-Plus plans that offer drug coverage. The GOP plan increase was from $560, but this increase is grossly inadequate. Testimony from the executive director of the American Association of Health Plans indicates that Medicare HMOs are leaving markets where the payment is already $550. We should raise the floor to a minimum of $600 per month per beneficiary, and not make an across-the-board increase in payment which would disproportionately increase reimbursement to areas with AAPCCs already over $780.

3. 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. The FDA has sent notices to people that importing drugs is against the law. The FDA should not send a warning notice regarding the importation of a drug without providing the person involved a statement of the underlying reasons for the notice. Mr. GUTKNECHT, my colleague from Minnesota, has introduced legislation called the “Drug Import Fairness Act of 1999” (H.R. 2925), the Medicare Beneficiary Prescription Drug Assistance and Stop-loss Protection Act of 1999 which encourages states to expand their drug assistance programs with federal matching funds and assistance to beneficiaries up to 25% of their poverty. I think QMB, SLMB solution would work quicker and more certainly, but this option deserves a more complete debate than it has received.

4. I believe that Congress should revise the FDA Reform Act of 1997 and restrict direct marketing to consumers by the pharmaceutical companies. There is no question that seniors are being bombarded with ads on the latest, greatest new drug with very little data on contraindications, alternatives, and potential complications, much less cost. At a minimum, drug companies should be required to fully discuss their major potential complications of these drugs in their radio and T.V. advertising.

5. Finally, I think Congress could actually get signed into law a combination of the above in a bipartisan fashion. Yes, this approach is more limited than either the Clinton plan or the House GOP plan. However, a more comprehensive drug plan should, in my opinion, be a part of over-all Medicare reform where all the pieces fit together so as to do no harm to one part while benefiting another. It won’t do lowa seniors much good to have an unlimited drug benefit if they don’t have a local hospital to go to.

6. There are 11 million children without any health insurance and, of course, no prescription drugs. Roughly 7 million of these kids already qualify for Medicaid or the State Child Health Insurance Program which do provide prescription drug services. These children should be enrolled. This requires a commitment on the part of the federal government to find these individuals and get them signed up. We need to streamline the system to help these states.

7. Many pharmaceutical companies do have programs where they provide drugs to low income individuals free of charge. These companies programs are commendable, but most people who meet the company requirements don’t know about these programs. Both physicians and patients need to be better educated to take advantage of free or discounted drugs.

8. Currently 16 states have pharmaceutical assistance programs targeted to Medicare beneficiaries. Some of these programs could serve as models for state grant program options. Congressmen Mike BILIRAKIS and COLLIN PETERSON have introduced H.R. 2925, the Medicare Beneficiary Prescription Drug Assistance and Stop-loss Protection Act of 1999 which encourages states to expand their drug assistance programs with federal matching funds and assistance to beneficiaries up to 25% of poverty. I think QMB, SLMB solution would work quicker and more certainly, but this option deserves a more complete debate than it has received.

As for me, I will find it very difficult to vote for a bill of this magnitude that doesn’t go through regular order. That means a chance to improve it in the Commerce Committee. Regardless of what happens in the next week, I remain committed to seeing a bill signed into law. Let’s just make sure that it is a good one.