

**H.R. 1, MEDICARE PRESCRIPTION  
DRUG AND MODERNIZATION ACT  
OF 2003**

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**HEARING**  
BEFORE THE  
**COMMITTEE ON RULES**  
**U.S. HOUSE OF REPRESENTATIVES**  
ONE HUNDRED EIGHTH CONGRESS  
FIRST SESSION

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LEGISLATIVE DAY OF WEDNESDAY, JUNE 25, 2003



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**H.R. 1, MEDICARE PRESCRIPTION DRUG AND  
MODERNIZATION ACT OF 2003; H.R. 2596,  
HEALTH SAVINGS ACCOUNT AVAILABILITY  
ACT; H.R. 2559, MILITARY CONSTRUCTION  
APPROPRIATIONS, FISCAL YEAR 2004; AND  
H. RES. 297, PROVIDING FOR CONSIDER-  
ATION OF MOTIONS TO SUSPEND THE  
RULES**

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**WEDNESDAY, JUNE 25, 2003**

HOUSE OF REPRESENTATIVES,  
COMMITTEE ON RULES,  
*Washington, DC.*

The committee met, pursuant to call, Thursday, June 26, 2003, at 12:50 a.m., in room H-313, The Capitol, Hon. David Dreier (chairman of the committee) presiding.

Present: Representatives Dreier, Linder, Pryce, Diaz-Balart, Hastings of Washington, Sessions, Reynolds, Frost, Slaughter, McGovern and Hastings of Florida.

The CHAIRMAN. The Rules Committee will come to order. Thank you all very much for being here for this extraordinarily unusual early-morning meeting. As you know, we have had a pattern of trying to—we are going to wait overnight for Members to come in the morning, but since we had the prospect of 30—some-odd witnesses testifying on this very important issue, we felt it important that we proceed with our witnesses.

We are here for consideration of three rules that will allow for consideration of the Medicare Prescription Drug and Modernization Act of 2003, the Health Care Savings and Affordability Act, and the military construction appropriations bill, and the rule to provide for consideration of motions to suspend the rules.

As we begin, let me first call on the Ranking Minority Member Mr. Frost for some opening statements.

Mr. FROST. Mr. Chairman, I am going to submit a full opening statement for the record.

The CHAIRMAN. Without objection, Mr. Frost's statement will appear in the record.

Mr. FROST. However, I would like to make some comments. This is a major example of major pieces of legislation being heard at outrageous times by this committee, outrageous in the sense that it is difficult for all the Members who want to testify, and it is, of course, difficult for the press to cover their testimony.

When the new Majority took over and began this practice, my original assumption was that they were simply learning how to be a Majority Party. I later decided that they were simply incompetent. I reluctantly have now come to the conclusion that this is intentional, and that they have no interest of having substantive hearings at a time when Members of the House can testify and that they can be covered by the media.

And, Mr. Chairman, I want you to know, this is one of the single most important pieces of legislation that will be considered this Congress and perhaps during any of our careers. And I consider this to be an outrage. And I want to serve notice that should the Majority conduct themselves in this way on another major piece of legislation while I serve as the Ranking Minority Member, I will recommend to our leadership that we do everything within the rules of the House to disrupt the proceedings and make it impossible for the House to proceed.

The CHAIRMAN. Thank you very much, Mr. Frost.  
[The prepared statement of Mr. Frost follows:]

PREPARED OPENING STATEMENT OF HON. MARTIN FROST A REPRESENTATIVE IN  
CONGRESS FROM THE STATE OF TEXAS

The Republican leadership and this Committee have a well-documented record of rushing legislation through the House, often before anyone outside the Republican leadership—and that includes the press, the public or Members—has the chance to read the fine print.

We saw the perils of this strategy last month after the 2nd Republican tax bill—what I call Part 2 of the Pioneers Enrichment Act—was signed into law. Many Republicans were embarrassed to discover that in their hurry to give millionaires \$90,000 in tax breaks, they left out millions of working and military families.

I mention this today because I want to sincerely counsel my friends in the Majority to avoid the temptation to employ their normal “rush-it-through-before-anyone-can-read-it” strategy to pass their so-called prescription drug bill.

No one outside the Majority leadership has seen the final Republican bill, but it's clear that Republicans are making a big, big promise to senior citizens. And it's equally clear that when seniors read the fine print, they will be very, very disappointed.

For instance, they'll be shocked to discover that the plan Republicans call “comprehensive” actually contains a massive loophole for them to fall through. This “donut hole” provision—it's really a “sickness penalty”—means that the Republican plan abandons seniors when they need help the most, forcing them to pay all of their own drug costs between \$2,000 and \$4,900.

Seniors will discover that when Republicans say “Medicare reform,” what they really mean is that they dismantle Medicare—turning it over to HMOs and insurance companies—in the year 2010, just 4 years after this prescription drug plan goes into effect.

And they'll discover that when Republicans say coverage is “guaranteed,” what they really mean is that they get health coverage as long as HMOs and insurance companies get big profits. And we all know that won't work—just ask the hundreds of thousands of seniors who have been dropped by HMOs over the past few years.

My friends, senior citizens are going to be furious when they realize what a bill-of-goods you've sold them. They'll remember your promise to provide all seniors with guaranteed and affordable prescription coverage. And they'll notice—believe me, they'll notice—that their premiums are higher, their choices are fewer, and their Medicare coverage has turned into an unreliable and expensive HMO plan.

Frankly, I don't know how you'll explain it to seniors. I'm pretty sure that it won't be enough to repeat your mantra of “promises made, promises kept.” And you won't be able to say you warned them—unless you stop misleading seniors about your bill right now.

That's why I strongly recommend that you allow the House to fully debate and fairly vote on every plan and substantive amendment submitted to the Rules Committee. And I strongly recommend that you give Members and the press adequate time to analyze the full text of your bill—once you finally make it available.

That way, at least you can say that you didn't completely hide the details of your plan from the public. And then maybe, just maybe, you won't have a full-fledged senior-citizen revolt on your hands.

The CHAIRMAN. Let me just observe that it appears to me that every seat assigned for the press corps is filled, and we have a complement of Members. There are three empty Member seats. All the other Member chairs are filled, and we have a table with two very able representatives from both the Ways and Means Committee and the Energy and Commerce Committee.

So let me begin by welcoming my friend from Connecticut Ms. Johnson, and please proceed, and whatever prepared remarks that you have will appear in the record.

Mr. FROST. We have some other Members who would like to make opening remarks.

Ms. SLAUGHTER. I would like to make an opening statement.

The CHAIRMAN. Mr. Frost didn't indicate anyone else did.

Ms. SLAUGHTER. I would like to, if I may, because I am very much concerned. Mr. Frost had already pointed out this defies common sense that we would rush consideration of vitally important legislation affecting almost 40 million people. The final bill was filed an hour ago, and we hardly had to time to look to see what was in it, and certainly superficial at best, and heaven only knows what is buried in the fine print.

Now, we are not naming a post office here. This is considered the largest change to Medicare since its creation. Every senior citizen in our Nation will be impacted by this proposal, and I think if they had any inkling how this Congress and committee worked, they would be outraged.

The American people tell us time and time again they are profoundly disturbed with the rising costs of prescription drugs. I know it does nothing to address the skyrocketing costs of prescription drugs. It doesn't make it more affordable. And I am very curious to know if it still contains a portion of this bill that says that HHS is prohibited by this law from trying to negotiate for cheaper drugs.

We believe the fact that the cost for most seniors is likely to rise. We don't believe that seniors want to privatize, and they saw what happened with Medicare+Choice. They are suspicious that drug programs modeled after that failed Medicare+Choice program will not address their immediate needs. You need to remember, too, that the Senate has worked on this bill for weeks, days of deliberation on the floor. We will have less than 3 hours.

Because private industry 40 years ago didn't want to provide health insurance to older people, Medicare was born. We have no indication that anything has changed since then, and the private industry does not want to provide a prescription drug benefit for seniors. It is not a money-maker now, and it was not a money-maker then. In the 1960s, the private sector had no reason to create insurance plans.

This legislation deserves a full and complete airing, and I am afraid we are not going to get it this evening. And I needed to express my concern that something of this magnitude would come to us an hour ahead of time and be at this hour in the evening when almost everybody is asleep. But I am pleased to see some witnesses

here, but nonetheless I think we are shortchanging the American people.

The CHAIRMAN. Thank you very much, Ms. Slaughter.  
Mr. McGovern.

**OPENING STATEMENT OF HON. JAMES MCGOVERN A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS**

Mr. MCGOVERN. Just for the record, you mentioned there were some Members here, but we have a long list of Members, and it appears that many of them are not here because of this late hour. So because we are meeting at this late hour, I think a lot of Members of both parties are not going to be able to participate in this hearing.

And let me just say very briefly that I think this is a new low even for this committee, and the leadership on your side of the aisle, I think, has outdone itself, and that is hard to do, given what we have seen transpire in this House during these last several months.

As my colleague has said, this House is about to consider an extraordinarily complex and controversial \$400 billion bill that will affect the lives of 40 million Americans. I mean, every one of us here, no matter what our party affiliation, when we go home, we hear from our senior citizens all the time about the importance of trying to get a prescription drug benefit passed into law, something that means something. Now, the other body has spent 2 weeks of talking about this issue, debating and discussing and amending their prescription drug bill. They seem to get it that this is a big deal. Over 70 amendments have been offered on the Senate floor so far, some 40 hours of debate. They expect another 16 hours of debate before they conclude the deliberations. So how much time are we going to get to consider this important bill that all of us say is so important to our constituents? Not 2 weeks, not 40 hours, not 16 hours. We only get a few hours tomorrow on the House floor to do this under what most likely will be a very restrictive rule.

When I asked the Chairman of the Rules Committee last night when as a Member of the House I could examine this unusually important bill which is about 692 pages, we are now told, I was told if I woke up early this morning, that I could just go online, and I could read this bill line for line. Well, I got up early this morning, and it wasn't there online; wasn't there this afternoon. In fact, at midnight it wasn't even online. So members of our staff were busily trying to go through a hard copy, trying to figure out what is in this bill and what is not in this bill, and quite frankly, we don't know what is in this bill. We don't know if there are any special fixes in this bill. We don't know what has changed. We don't know fully what the differences between the Ways and Means bill and the Energy and Commerce bill are.

After 38 years Medicare has served this country pretty well. Most senior citizens think it is a pretty good program. After 38 years, we haven't messed around with the program, and here we are in the middle of the night in the Rules Committee about to report out a bill that, quite frankly, has significant implication for the future of Medicare because it is a bill that ends Medicare as

we know it and turns it into a convoluted, complicated voucher program of HMOs and PPOs and shifting coverages. It is a bill that leaves a huge gap in coverage, penalizing people for getting sick. It is a bill that moves us toward privatizing Medicare and leaves our seniors at the mercy of the insurance industry. It is a bill that only a CEO would love.

Now, given all of that, I guess it is understandable why the Republican leadership doesn't want anyone to see it or read it. What they want is to strong-arm just enough of their Members so they can ram this bill through the House and before the American people know what hit them.

And I want to say another thing in this bill that I thought we had dealt with, given the fact that the Energy and Commerce Committee overwhelmingly rejected this provision, but in this bill, from what I understand, we have—there is a sick tax on senior citizens on a fixed income. They have implemented a copay on home health care. So all of you in this—in this committee who get up and give your speeches about how you want no new taxes on the American people, we will give an opportunity to vote on an amendment that I will offer, to strip the sick tax copay, that new tax on senior citizens, from this bill. And I would hope that, given the fact that the Energy and Commerce Committee overwhelmingly unanimously rejected that, that we should at least be able to have an opportunity to offer this on the floor.

I want to conclude, Mr. Chairman. I think every amendment and every substitute brought before this committee should be made in order. We should have a debate on it. We should vote up or down on it. I don't care if it takes 2 weeks or 3 weeks or 4 weeks. The people who are most affected by this legislation, our senior citizens, should know what they are getting, and we need to get this right. Thank you.

The CHAIRMAN. Thank you very much, Mr. McGovern.

Any other opening statements?

Mr. Hastings.

Mr. HASTINGS of Florida. Mr. Chairman, firstly, these are amendments—I don't have a copy of the 692-page bill, and I am curious, do any of the other Members on either side of the aisle have a copy of the 692 pages?

Mr. FROST. I had one copy, which I have now been returned and loaned it to a Member to look at. I do have one copy.

Mr. HASTINGS of Florida. Today's Washington Post—you don't have a copy in front of you, Mr. Chairman?

The CHAIRMAN. Yes, I do, right here.

Mr. HASTINGS of Florida. Martin's copy.

Today's Washington Post had a comment from a gentleman whose last name is Urban. He says the politicians seem to say it is better than nothing, and we should be grateful. To some retirees here who clip coupons, follow the news, Washington's Medicare is just the latest example of the doings of out-of-touch elitists.

Mr. Chairman, I wish that tonight's hearing could be filled with commendation for the Chair and the Majority and all of us for reconciling two extremely contentious and technical bills into one. While you did accomplish such a task amongst adversity of two obviously—I am very delighted to have it for the good it will do me—

what is the gentleman that died that wrote Exodus? It will be me like trying to read that when I was in the fourth grade. I understand the Chairmen from the Ways and Means and Energy and Commerce Committees are demanding persons, and rightly they should be as Representatives here.

I should note that I am appalled, as I am sure a lot of us are, that the Rules Committee is forcing its members to meet within minutes of completion of this bill. The rules that this committee adopted on January 7, 2003, state that the Chair shall provide each member of the committee with a copy of each bill or resolution and any committee reports at least 24 hours before the time of the meeting. Now, this rule was established to ensure that we have adequate time to review the scheduled legislation.

Rules Committee makes allowances for emergency meetings, but not once—except in an e-mail in my office received just a few moments ago from a constituent named Carl Keelman from Pompano Beach, wondering why he called and he wrote this time of night. I don't know him, but he wrote to me and said, Dear Representative Hastings: Please vote against the Republicans' Medicare reform proposal when it comes up for a vote this week in the House. Letting private insurance companies run Medicare is a terrible idea. In fact, I would say in the history of bad ideas, this one has got to rank near the top. Medicare has done a great job for 37 years. It has not dropped a single person from coverage. Private insurance companies are not able to guarantee coverage like Medicare can because they have to think about their profits first and the needs of seniors second. That is why Congress should not turn Medicare over to private insurance companies and HMOs. Seniors need coverage for their prescription drugs, but this bill would take us one step forward—not one step forward, but two steps backward. This is not a good deal for seniors. The drug coverage being offered is limited, and the bill would begin to unravel the Medicare program. Please vote against this legislation.

I can tell Carl that I will live up to his request. When we established this rule, the Rules Committee made these emergency allowances, and I guess that is what we are having is an emergency hearing. I don't know what the hell the emergency is. We all have plenty of time, and as has been mentioned, the Senate seems to have found a way to give their membership sufficient time in order to at least discuss this intelligently. Members of this body, Members right in here on both sides of this aisle have spent years campaigning and discussing and debating a prescription drug plan under Medicare, yet almost immediately after the committees of jurisdiction completed their work in the 108th Congress, years of promises now run the risk of being slashed by the refusal of the Majority to allow members of the Rules Committee, the last committee standing before floor consideration, adequate time to review the bill and properly consider the many amendments which Members have submitted.

Furthermore, many Members have sought to offer technical amendments that address specific amendments in this prescription drug bill. However, because the Majority refused to release the text of the bill until just an hour ago, Members have not had a fair opportunity to draft substantive amendments to the bill that will be

on the floor. In drafting the two amendments that I may offer during this hearing, House legislative counsel could not even get me tentative text because, to quote one attorney at Counsel Office at 1:15 this afternoon, there is as of yet no firm target to amend.

Tell me, Mr. Chairman, are we being honest to America's seniors by ram-rodging this bill through the Rules Committee this morning? Are we being honest to ourselves this morning considering a bill that none of us have read and few know its contents? And I doubt seriously if the people that patched and pasted it together, any of them on Commerce or any of the other committees, have a real firm grip on what is in this mess.

I think the answers to these questions are self-evident. The little we do know about this bill is startling. For starters, this bill establishes a new voluntary prescription drug benefit, and we learned this in bits and pieces from each other, that will be provided through a private insurer. Yet Medicare was created in 1965 with not one Republican vote primarily because private insurers were not interested in offering health care policies to older, sicker people.

Second, the \$400 billion allocation for Medicare prescription drugs is not enough money to provide affordable benefits for our deserving senior citizens, period. And every man and woman in here that thinks \$400 billion is going to get it, they haven't been living near my house where I take care of my mama, and it is \$360 a week for prescription—\$360 a month for prescription drugs, \$850 a week for in-home care. And I am proud to be able to do that, as I am sure many of you are, but there are people that live not too far from me and people that I represent that there is no way in the world that they could afford that kind of care.

Third, this bill allows the IRS to share income tax information with the HHS, which can then share this information with the private insurer. This bill not only fails to provide adequate Medicare benefits to our Nation's senior citizens, it fails to provide adequate privacy protections as well.

Mr. Chairman, based on the cursory information that has been battered about here on Capitol Hill, I have been able to go on this bill just with the time allotted those few things. I am certain there are countless issues in this bill that are worthy of careful attention and debate. It is a travesty that we are not permitted adequate time to give this important legislation the time and attention it deserves. We are doing ourselves and the millions of people that we all represent a great disservice. In short, this bill will help an already robust set of insurance companies at the expense of a whole whale of a lot of frail senior citizens, some of whom are mothers and our daddies and our grandpapas and our grandmamas. It is scandalous that we would put ourselves in this kind of position, and it doesn't mean so much that the Majority may win something. I think one damn day you are going to lose everything.

The CHAIRMAN. Thank you very much, Mr. Hastings.

Let me just say that this meeting does comply with the rules under the emergency meeting status.

Mr. HASTINGS of Florida. What emergency?

The CHAIRMAN. And based on the four statements we have heard from our four colleagues, there is a pressing need out there to deal

with the issue of prescription drugs, and that is why in the last Congress we passed this measure—excuse me—that is why in the last Congress we dealt with this issue, and that is the reason we are about to hear from our colleagues from the Ways and Means.

Mr. MCGOVERN. Would the Chairman yield?

The CHAIRMAN. Mr. Linder.

Mr. LINDER. The statement that not a single Republican voted for Medicare is simply untrue, and I have a significant number of constituents who are grateful that at least some Congress is willing to offer some prescription drug benefit under Medicare for the first time in 38 years.

Thank you, Mr. Chairman.

Mr. MCGOVERN. Would the Chairman yield?

The CHAIRMAN. Please.

Mr. MCGOVERN. I would ask the Chairman to answer the question that Mr. Hastings put forward, and that is what is the emergency? What is the emergency that this needs to be done at this hour of the night, rushing it on the floor, versus doing it right and giving us a chance to go back to our districts and talk to our senior citizens and doctors and hospitals? I am trying to understand what the emergency is. How do you define an emergency; not the political spin, but what is the emergency that justifies us bringing this up at this hour under these kinds of circumstances?

The CHAIRMAN. We all know that over the past several months that there has been a real attempt to try to put together legislation in a bipartisan way to deal with this pressing need that all four of our colleagues on the Minority here have outlined, and which we on our side agree exists. And we have come to the point where we have, we believe, fashioned a piece of legislation which will address that need. And it is for that reason that I as Chairman of this committee made the determination that we were going to call an emergency meeting to deal with this. That is my prerogative as Chairman of this committee, and I have done so.

And I would like to recognize the gentlewoman from Connecticut Ms. Johnson, who is here representing the Committee on Ways and Means. And we are happy to have you. Without objection, any prepared remarks you have will appear in the record, and we welcome your presentation.

**STATEMENT OF HON. NANCY JOHNSON, A REPRESENTATIVE  
IN CONGRESS FROM THE STATE OF CONNECTICUT**

Mrs. JOHNSON. I thank you, Mr. Chairman, and as Chairman of the Health Subcommittee of the Ways and Means Committee, I am honored to bring this bill before the Rules Committee and respectfully request that the Committee on Rules provide an appropriate rule for floor consideration of House H.R. 1, which would waive all points of order against the bill and against its consideration. I would further request the bill be considered as read, and that you provide an appropriate amount of time for general debate equally divided, and one motion to recommit with or without instructions.

Mr. Chairman, I would like to provide a brief overview of the bill and a brief set of changes that were made in the Ways and Means jurisdiction and yield to my colleague from Energy and Commerce

for his comments and for his review of the changes that were made in the bill.

First of all, to clarify, the House has passed legislation in this area two preceding times. We bring you a refinement of that bill. This is the most mature, well-thought-out legislation in this area that has ever come before the House. It is the first major expansion of Medicare, and it is not just about prescription drugs. That is what makes it different from any other initiative on the table in the Senate or by the Democratic Party. And I want you to understand the modernization in this, because this bill doesn't just bring prescription drugs to seniors, as important as that is, this bill modernizes Medicare and prepares it to deliver to our seniors the next generation of quality health care.

Science has focused on diagnosis. It has focused on treatment. The most cutting edge development in health care is focusing on the progress of chronic illnesses, such as the progression through which someone goes from being a diabetic to dependency on dialysis. And it is the preventive initiative in this bill to prevent the progression of chronic illnesses that is unique and dramatic and is going to radically alter the lives of your constituents.

One-third of Medicare recipients have five or more chronic illnesses, and Medicare is not structured to address those chronic illnesses or to support or help those patients. This bill provides fee-for-service Medicare the power to do that and will require that the plans do that. It will put in place both the technology and the medical science to help our seniors with chronic illness enjoy a much higher quality of life and at the same time stay out of hospitals, stay out of ERs, and stay out of doctors' offices, all of which are high-cost settings for Medicare. So it is the honest and right way to improve the quality of care Medicare is prepared to deliver and at the same time control its costs over the long term as we enter the era with the baby-boom generation.

The prescription drug benefit is simpler, it is more generous, and it is fairer. It is simpler because it is 80 percent of all coverage of up to \$2,000 of costs. Considering that the average use of drugs is \$1,200 per beneficiary, most seniors will be fully covered at 80/20 under this bill.

Secondly, it income relates the catastrophic level. It is not fair in America that seniors with \$200,000 of income who live in gated communities have exactly the same catastrophic threshold as someone living on \$20,000 income. And that is not fair. And I am proud that this bill is fairer, its benefit is simpler, and its benefit is generous. It is well targeted to the low income, and for the first time in any bill, to my knowledge, we count the State subsidies toward the catastrophic limit so it not only targets the very poor, but also targets the really low-income seniors who would have a hard time meeting the catastrophic threshold. So it is better targeted both by virtue of its support for those 150 and 200 percent of poverty income and by virtue of the income-related catastrophic benefit; more generous, more fairly targeted, a strong benefit plan, the biggest expansion of Medicare in its history.

Lastly, it mandates electronic prescribing in 2 years. This is going to have a dramatic impact on the infrastructure of medicine, but it is going to dramatically reduce errors. The Institute of Medi-

cine report demonstrated that prescribing was the source of the majority of errors. It will also protect seniors from over-prescribing. It will protect seniors from interactions. And it will also give seniors the power to know when there is a cheaper alternative available that explicitly requires that pharmacists oversee the medication therapies that our seniors are on. If they are on multiple medications, they have to be on a medication therapy program, and it requires that the pharmacist get paid for that. It is a tremendous advance in not only giving seniors medication, but providing the oversight to ensure that they are a good thing in their lives and not a cause of illness, death and destruction.

By mandating chronic care management and pharmacy therapy, the bill really goes a long way toward changing the dynamic in Medicare from an incident-based illness treatment program to a health-supporting preventive program. So I don't want you to miss what a dramatic expansion this is regardless of the circumstances under which we are considering the bill.

In addition, it adopts the regulatory reform proposals that went through the House—the Senate never considered them—a radical reform, completely bipartisan, of the regulatory burden in Medicare that is draining hours away from patient care.

It has a reimbursement package that includes the very best rural health reimbursement package ever to pass this House or ever to come before this House, as well as two dramatic improvements in hospital reimbursement. We changed the system to bring technology into the system more rapidly and pay for it, and we do a much better job of paying for outpatient drugs using hospital settings.

We also attacked the issue of fraud and abuse. We have been paying for a lot of care that should have been paid for by auto insurance companies, and we save \$9 billion through that reform.

There are other aspects of this program that are interesting and useful. The ability of plans to compete in a way that will save seniors dollars will in the long run be a very great force for providing affordable care and efficient care to our seniors across the board.

Let me highlight a few of the things that have changed in the bill since it came out of the Ways and Means Committee. We added a drug card in our jurisdiction as a result of the thoughtful consideration of many of our colleagues. So not only upon passage will the President have the authority to offer a drug card, but people who have less than 135 percent of income will get \$800 to spend with that card. People between 135 and 150 percent of income will get \$500 toward drug costs. And people above 150 percent of poverty will get \$100. So you get a smart card that moves right through from the discount card of your choice and behind it some real money, particularly if you are low income, to help with the cost of prescriptions in the 2 years it will take to set up the program.

There are other changes, but none of them major. I would be glad to go through them in more detail, but I don't want to take too much time.

The CHAIRMAN. Thank you, Mrs. Johnson, and we appreciate your testimony. Thank you for those very thoughtful remarks which address many of the issues that have come forward in the last few minutes.

Mr. Walden, we are happy to have you here representing the Energy and Commerce Committee. Without objection, your prepared remarks will appear in the record in their entirety.

**STATEMENT OF HON. GREG WALDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON**

Mr. WALDEN. Thank you very much, Mr. Chairman, Ranking Member Frost, members of the Rules Committee.

Let me point out that the Energy and Commerce Committee, we spent nearly 23 hours working on this legislation in markup. We considered 63 amendments and held 28 recorded votes. So this in contrast to last year I believe we went 22 hours and had nearly as many amendments. So as my colleagues from the Ways and Means Committee said, this a major bill that has been well vented not only this year, but in the prior 2 years by the Energy and Commerce Committee and the Ways and Means Committee.

Our committee worked very closely with the Ways and Means Committee to make major improvements that passed the House last year. One of the most significant changes we made was to improve the drug benefit. We substantially increased the amount of coverage beneficiaries receive for their 2,000 in drug spending. They will now only pay 20 percent of these drug costs after paying a \$250 deductible. This change and others make our proposal an even more attractive benefit for seniors who are Medicare beneficiaries.

H.R. 1 also provides beneficiaries more options for receiving their health care. Building on the recommendations first proposed by the President, the bill gives seniors the full array of health plan choices available to the under-65 population including PPOs, HMOs and private fee-for-service plans, along with the option with remaining in the traditional Medicare program. So they have choices.

This bill creates enhanced fee-for-service regions encompassing both urban and rural areas for the delivery of new private plan options, thus bringing improved choices to seniors throughout the country; also takes important steps towards reforming the Medicare program, as my colleague said. The base bill also retains the best features that were combined in the version passed last year by the House because our bill allows beneficiaries to harness competitive free market forces to substantially lower Medicare beneficiaries' drug costs.

The bill also provides substantial assistance to low-income beneficiaries, providing full subsidies for beneficiaries with incomes up to 135 percent of poverty level, and covers a portion of the premiums on a sliding scale to beneficiaries with incomes of 150 percent of poverty.

Further H.R. 1 contains amendments to the Hatch-Waxman generic drug law that will benefit all Americans, not just our seniors, by expanding—by expediting, that is, the arrival of generics in the marketplace. The language in the bill, which is similar to that proposal passed by the Senate 94 to 1, would provide brand drug companies with only one 30-month stay on the approval of a generic competitor. And, of course, generics would forego their exclusivity if they do not bring a product to market within a specified time pe-

riod. These reforms will save billions of dollars to American consumers.

Mr. Chairman, if I could touch just on a few items here as they differ from the committee mark. As I mentioned, Hatch-Waxman changes, including new changes as similar to that proposed by the Senate, which I just referenced. There is a re-importation provision that has been added; contains provisions that provide the Secretary with the authority to prevent reimportation and the personal importation of FDA-approved drugs from Canada. Unlike current law, these provisions are more likely to go into effect because they provide FDA with the authority to regulate the flow of reimported drugs to designated ports of entry for the FDA to concentrate its inspectors.

Canada-only reimportation: This provision requires HHS to issue regulations allowing pharmacists and wholesalers to reimport drugs that comply with the FDA standards. The provision provides that biologics, controlled substances and certain other drugs are exempted. Drugs must be contained in tamper-resistant and counterfeit-proof packaging. Drugs must contain a statement to inform the consumer that the drug has left the country. Drugs may only be shipped back to the country by the first Canadian recipient. HHS is given the authority to limit reimportation to certain ports of entry; import requirements to keep detailed records and to conduct drug testing; a manufacturer must provide an importer with an approved labeling of the drug. In the Canada-only personal importation provision, it allows the Secretary to waive the prohibition on personal importation of drugs from Canada when the drugs are for personal use and when drugs are presented at the border. This activity is presently illegal under the Food and Drug Act, but could become legal under this act. The provision provides that drugs must be in the possession of the individual when entering the United States. They must be for personal use for that individual with a valid prescription, and drugs must be FDA-approved and in final dosage form.

In reference to the discount drug card, I would also, adding to what my colleague from the Ways and Committee said, point out that in addition to the money that would be pointed into these accounts, individuals, employers and charitable organizations will be able to contribute up to \$5,000 annually to this card. This program terminates when the comprehensive drug benefit comes online in 2006.

There are also changes to AWP, Medicaid, and of course we are proud of the improvements in the rural health policies. This is very good for rural communities when it comes to rural health.

And with that, Mr. Chairman—

The CHAIRMAN. Thank you very much, Mr. Walden.

And let me say to both of you that the proposal that you have just outlined clearly does protect and strengthen and improve on the Medicare program, which we all know has faced many difficulties over the past several years. And obviously, if action is not taken, we know that the future of Medicare is seriously in doubt. And the proposals that you have just brought before us, I believe, will go a long way towards mitigating the threat of that.

I thank you both very much for going through the litany of proposals that were offered here today, that were offered in your committee.

Mr. LINDER.

Mr. LINDER. I want to thank you both. You are bringing before us the first opportunity in its lifetime for Medicare to offer a drug benefit for seniors.

I just have one question: Do you consider having seniors paying a modest copay to be a sin tax?

Mr. MCGOVERN. On health care?

Mrs. JOHNSON. No, I don't. I feel it is important for seniors to make some copayment, because if they don't, they lose track of the cost, and they lose track of their responsibility to think about whether a lower-cost alternative is available. It is extremely important to have copayments, and in this bill we do not allow the sharing of the total amount of the copayment.

Mr. LINDER. Isn't it true that one thing we can do to get some control over health care costs in this country is to have some kind of consumer involvement or patient participation? And isn't that what copay is designed to do?

Mrs. JOHNSON. There are two things that are going to get people very powerfully involved. Copayments are certainly one of them, but one of the important aspects of disease management is that the patient is very involved, and part of what you do is to educate the patient about how to care for themselves, educate their family and support group, keep much closer contact with them, provide technology in the home that supports. So the patient involvement is what makes that such a powerful approach to preventing illness from progressing.

So this is going to dramatically alter the way we do health in America because our senior population is going to be able to participate in the kinds of delivery systems that today, themselves, are key to their own health.

Mr. LINDER. In 1964, when President Johnson was outlining his proposed Great Society for Medicare and Medicaid, he promised this country that by 1990, Medicare would only cost \$9 billion, and Medicaid would only cost \$1 billion, using easily quantifiable user statistics. And we discovered that by 1990, Medicare cost about 108 billion, and Medicaid cost 73 billion, because people don't spend other people's money as wisely as they spend their own.

Isn't the whole idea of copay to get the patient involved in those decisions and understand they are spending their own money, too?

Mrs. JOHNSON. Absolutely. But there is another factor. He did not anticipate. He did not anticipate the rapid progress of medical science. It is astounding what we have learned in the last 30 years, and that expansion, explosion really, of diagnostic techniques, of treatment techniques, of surgical options that are pushing costs up, and now prescription drugs, that makes it even more important that the patient be involved, because we all know there is unnecessary surgery being done because the patient isn't part of the decision-making process. We know that overprescription is one of the biggest dangers of the prescription drug plan for seniors, and unless they are more involved in their care, their use of pharmaceuticals, and they have the guidance—on the part of multiple

pharmaceuticals—of a pharmacist, they will be victims of overprescribing, overusage, and all the problems that result therefrom.

Mr. WALDEN. Mr. Chairman, if I might as well. This whole issue of copay is an interesting one because when Part B Medicare was begun, it was a \$100 copay. That represented 44 percent of the cost. Today it represents less than 3 percent of the cost. So if you look at this as how the program was started versus how it is today, the percent of copay is negligible in terms of Medicare Part B compared to how the authors, founders and supporters of Medicare envisioned copay to work when it was created in the 1960s.

Mrs. JOHNSON. We do require everybody to have a copay, even people on Medicaid, \$2 copay and \$5 for prescription. So we want everyone to participate in this program both financially and personally.

Mr. LINDER. Worth noting that when the VA finally decided to have copay for its pharmaceutical program, the numbers of prescriptions declined dramatically.

Mrs. JOHNSON. I would like to point out to the gentleman Mr. Hastings on this copay for home health—

Mr. MCGOVERN. I was the one who raised it.

Mrs. JOHNSON. I have been a long and close strong advocate of the home health industry, and I fought copays for many years because it was per visit. Now we have changed the way we reimburse for home health visits. We are reimbursing per episode. A single copay for episode does give seniors the opportunity to think whether this is appropriate or not. And I have had seniors walk up to me and family members, walk up to me and say, we could do this ourselves, and we decided not to do it because of the copay. This was actually in regard to home-delivered meals, but it was the same thing. The home-delivered meal copay was at \$5 for the week, and you were getting both lunch and dinner. And this retired friend of mine on the local council said, for that I will do it myself.

Well, we need to at least promote that thought. So for a single copayment of 1.5 percent, we will be able to give people the opportunity to think do they need home health care. You will be surprised how much of Medicare is on automatic pilot. You get out of the hospital, they give you all this equipment whether you need it or not, and then line you up for home health care whether your children are there or not. So copays represent an opportunity to think about whether I am going to pay for this and taxpayers are going to pay for this.

Mr. MCGOVERN. But—

The CHAIRMAN. Mr. McGovern, Mr. Frost has just asked that I go in regular order, and so I plan to do that.

Mr. LINDER.

Mr. LINDER. Thank you for clarifying the copay idea and its importance in terms of the responsibility part. And I would like—when you talk to, for instance, pharmacists at a hospital, and you talk about when they go in to see a patient, they will say the first thing is they take them all off their medicine. They are overmedicated, and they are overmedicated because they are not responsible for paying for things.

I congratulate you on what you are doing and congratulate you on the responsibility portion.

Mrs. JOHNSON. They are overmedicated because they are not paying, but also because there is no communication amongst their caregivers. And by having electronic prescribing and a single plan, some plans will know exactly all the pharmaceuticals you are taking. This is a vast improvement. You can't provide prescription drugs without providing to that senior in a sense a single point of the payment so we know exactly what complex of drugs they are getting.

The CHAIRMAN. Mr. Frost.

Mr. FROST. Mr. Chairman, I am going to be fairly brief because we have a lot of witnesses here who waited a very long time tonight to have the opportunity to testify, and I do know other members of the committee have questions.

I do have a question, and either witness can respond. The question is we repeatedly hear from members of your party that the drug plan will have a monthly premium of \$35. Can you point me to the section in your bill where it guarantees that all seniors' monthly premiums will be \$35? Is there anything in statute, statutory language, that sets out the premium at \$35?

Mrs. JOHNSON. There is nothing in statutory language that sets out the Part B premium, and there is nothing in the statutory language that sets out the drug premium. However, there is in statutory language not only the actuarial equivalence for the whole package, but section by section. So if anybody wants to vary from 80/20 in the distribution of cost, they can do that, but it has to be actuarially equivalent.

So it is hard to see how much variation there will be. Section by section there has to be equivalency. So the likelihood when the actuaries look at this that there will be a consistent premium is very great. But you see if we set it in statute, then we don't allow those plans that are more efficient or if they can negotiate a better deal with the manufacturer to charge you less, and we want seniors to have access to a plan that charges less.

Mr. FROST. I understand this. My understanding is when proponents of the bill are attempting to sell this package to the public and Congress, they say there will be a \$35 premium. Is it possible in the way that the bill is fashioned that that premium can be higher than \$35 a month, not necessarily lower?

Mrs. JOHNSON. It is possible that it could be slightly higher or lower. It is impossible that it would be significantly higher or, frankly, significantly lower.

Mr. FROST. Well, that is a debatable matter, and that issue will be discussed more fully on the floor, and you responded to my question that there is nothing in the statutory language that sets out a \$35-a-month fee.

Mrs. JOHNSON. Precisely.

The CHAIRMAN. Ms. Pryce.

Ms. PRYCE. Thank you, Mr. Chairman.

I have been very involved in this over the last couple of weeks, and I just want to commend our witnesses today and their committees for working so closely together. I think this is something that is historic as long as I have been around here, and the cooperation and—to bring this together, this complex matter, the way they have done it, I want to commend them. And I will not take up the

committee's time with any questions. I want to thank them very much and tell them we all appreciate it.

The CHAIRMAN. Thank you very much, and thank you, Ms. Pryce, in your leadership role in making this happen.

Ms. Slaughter.

Ms. SLAUGHTER. Mr. Chairman, I only have three questions that I would like to ask; first, that I am told that on the reimportation of drugs section there is an amendment by Senator Cochran that the Secretary must certify the safety of the importation of drugs in order to have it go into effect. And Secretary Thompson has said he will not do that, and in which case this is not really going to happen. Is that true?

Mr. WALDEN. If I might, Mr. Chairman. In the past, neither Secretary Shalala nor Secretary Thompson can certify the importation to be done safely. It will be much easier for a Secretary to demonstrate safety by limiting the reimportation in Canada only. And as I outlined in the bill, there are some safeguards built in.

Ms. SLAUGHTER. And the Secretary has agreed to do that?

Mr. WALDEN. I can't speak for the Secretary.

Ms. SLAUGHTER. My concern is that was one of the sweeteners in the bill. There is no question about it, because most of us think what we need to do is really get down the price of drugs. And I understand that the drug manufacturers object most strenuously to even bringing it in from Canada. But it was troubling to me if that provision is in the bill—stated in the bill, and the Secretary won't do it, then we are wasting our time talking about that; are we not?

Mr. WALDEN. If I might, Mr. Chairman.

As you know, I am Vice Chairman of the Oversight and Investigations Subcommittee, Energy and Commerce Committee. We had a hearing just this week—it seems last week—this week on this issue of reimportation with experts from the FDA and the Customs Department, complete with slides, pictures and evidence of very extensive pharmaceutical drugs. And I must tell you that one of the packages of evidence had a series of five boxes of drugs that I am led to believe are used for HIV. Price tag is \$4,000 for those five boxes. They were sealed with hologram seals. They were identical to one box in another bag. I presumed the five with the hologram seals and the printing and all were the correct imports. They were knock-offs. And they had pile after box after pile, and I am telling you could not tell the difference. And I think there is a legitimate issue.

And I supported the issue of reimportation. I voted in favor of it, but I also believe that we must make sure our seniors and anybody else that goes to a Web site, who thinks that they are getting a drug to combat an illness that could threaten their life, knows with some level of certainty that those drugs actually have in them what they could get if they went to the corner drugstore. And that is why this has been framed in a way to try achieve that, so they are not getting rat poison when they expect something like Viagra.

Mrs. JOHNSON. There is a difference in this bill.

Ms. SLAUGHTER. However, the proviso, unless the Secretary certifies it. Therefore, that section of this bill cannot take effect; isn't that correct?

Mrs. JOHNSON. That is correct, but there are two different structural aspects to this bill that make it likely he will be able to do that. First of all, it requires tamper-proof packaging. And there are tremendous advances now, very tiny chips that get put in, so on and so forth. We think there are packaging alternatives that will allow inspectors at these gates to be able to quickly determine counterfeit from noncounterfeit. This is a new advance. We have encompassed that advance in this bill, and we think this is a workable compromise that the Secretary could put in place.

Ms. SLAUGHTER. One other point I wanted to bring up, too, is the cost of Part B, the rise in premium. The bill in 2000 said that the premiums for Part B would rise 47 percent. There is no figure.

Mrs. JOHNSON. In Part B. I don't know where they got that 47 percent.

Ms. SLAUGHTER. 2000 bill, not this one.

Mrs. JOHNSON. We do allow in this bill for the Part B premium of—excuse me, Part B deductible of \$100 to increase with inflation. It is essential we get Medicare on a sounder track, and that is one of the small things we do.

Ms. SLAUGHTER. I think we all—

Mr. WALDEN. If I might. Again, on that issue, I believe the \$100 fee was established in the 1960s as the copay or the deductible, and at that time represented 44 percent of the cost of what was being provided. Today that figure is less than 3 percent, so in terms of just keeping up with inflation, you have to have a much higher rate.

Ms. SLAUGHTER. But it is not in the bill. There is no stated amount.

Mr. WALDEN. No. It is a rate of inflation.

Ms. SLAUGHTER. One of the questions is the issue of negotiation between the private Medicare plans and the drug companies. Can you explain why that is—why they don't want to negotiate lower prices?

Mrs. JOHNSON. It prohibits what?

Ms. SLAUGHTER. Prohibits the MBA from negotiating with—interfering into drug negotiations, price negotiations.

Mrs. JOHNSON. We want the plans to negotiate with the drug companies. The plan that they come up with has to be reviewed and certified by the board that runs the program, but they are to do the negotiation. We are not to do the negotiation.

Ms. SLAUGHTER. Given the fact that the Veterans' Administration has negotiated and has been successful, it seems odd that the administrator of the program is being prohibited by law from interfering.

Mrs. JOHNSON. But you are not going to get diverse and competitive programs, some of which will then drive the price down. The VA has a very good price on a narrow spectrum of drugs, but it gets the good price because it is a narrow spectrum. If you are a veteran that needs a drug that is not given by the VA, you don't get any break at all.

We want seniors to get a break on every single drug. So that is an interesting model, but there are two ways in which we go beyond it. First of all, our program will offer a much greater variety of drugs. And secondly, by piercing what is called the best price

law that requires that the best private sector price be passed on to Medicaid, we save \$18 billion. We are going to depress drug prices through the bringing Medicare to the market in a way that is absolutely unprecedented. We will go below the current best price structures, which build an artificially high floor into current pricing processes.

Mr. WALDEN. We are going to harness 40 million Medicare beneficiaries in this competitive effort. It is what is happening in the private sector in private insurance today that drives down the cost of what they are paying. And we believe you will be able to achieve anywhere from 15 to 30 percent reduction, depending upon the drugs, in just the base cost to the drugs as a result. So even though you are paying the part that is out of your pocket, you are going to pay less. Then you couple that with the insurance 80/20. We think seniors are going to see a significant reduction than certainly what they are paying today if they have no coverage.

Ms. SLAUGHTER. These are the seniors that opt out of Medicare?

Mrs. JOHNSON. No. No. In fact, the requirement is that in every area there be a plan that is drug only, as well as a plan that can be a plan.

Ms. SLAUGHTER. Negotiated between private plans, not Medicare?

Mrs. JOHNSON. No. Medicare doesn't do the negotiating. But Medicare has to certify the plan once it is negotiated, that it meets our actuarial specifications and the standards of the plan. But we do not do the negotiation on purpose, because we want multiple plans. That is the whole point. We want seniors to have choices. That way they get lower premiums, lower cost, lower prices.

Ms. SLAUGHTER. Thank you.

The CHAIRMAN. Thank you very much, Mrs. Slaughter. Let me just say that we all share your concern to ensure that no one gets rat poison when they are anticipating Viagra.

Mr. WALDEN. It is a possibility, Mr. Chairman.

The CHAIRMAN. Mr. Diaz-Balart.

Mr. DIAZ-BALART. I thank you, Mr. Chairman. I thank these two witnesses for bringing this work product forward. It is tremendous work that these committees have done, and I am very proud that it is this Congress.

This is something that can't be stressed enough; right now there is no benefit, and the fact that we in this Congress—this Congress is going to provide an important benefit to help seniors pay for their medicines, I think is extraordinary, something that we all should be proud of.

I am not going to take the committee's time further, I but I wanted to thank you for their hard work and the reputation of the committee for their very appropriate, illustrative descriptions.

The CHAIRMAN. Thank you.

Mr. McGovern.

Mr. MCGOVERN. Thank you, Mr. Chairman.

Mr. Chairman, first I would like to ask unanimous consent to insert into the record the testimony of Congressman Mike Thompson, the testimony of Congressman Tom Allen of Maine, the testimony of Congressman Jim Langevin of Rhode Island, the statement of Congressman Paul Kanjorski, and the testimony of Congressman

John Tierney, all who have amendments, but I guess couldn't make it here at 10 of 2:00 in the morning.

The CHAIRMAN. Without objection, the statements of our colleagues will appear in the record at this point.

[The prepared statements of Mr. Thompson, Mr. Allen, Mr. Langevin, Mr. Kanjorski, and Mr. Tierney follow:]

PREPARED STATEMENT OF HON. MIKE THOMPSON, A REPRESENTATIVE IN CONGRESS  
FROM THE STATE OF CALIFORNIA

Last night, the Blue Dog Coalition formally endorsed legislation based upon the bipartisan Senate Medicare bill (S. 1). We are bringing this proposal before Rules tonight as an alternative to the House Republican plan.

As you know, the Blue Dogs are a group of fiscally conservative Democrats, who are committed—as a coalition—to the passage of a prescription drug benefit that fits within our \$400 billion budget window.

However, we are not willing to sacrifice the principles of the Medicare program to reach that goal.

The Senate has come together to develop a strong bipartisan benefit. It is not perfect. But, in recent years, the perfect has become the enemy of the good and, unfortunately, the perfect is out of our price range.

The Senate offers America's seniors a good benefit. It carries a monthly premium of \$35. A deductible of \$275. A 50% cost-share through the first \$4500 of drug spending. And, it offers a catastrophic benefit that kicks in after beneficiaries have spent \$3700 out of pocket.

Further, it corrects a variety of inadequacies in our Medicare reimbursement system for rural providers. And, it does all of this without putting Medicare on the path to privatization.

But, with a score of \$389 billion, there was some room for improvements. And, that is just what the Blue Dog Coalition has done.

We have strengthened the rural provider package by accelerating the start dates to 2004. And, we have improved the adjustments made to the wage index labor share—dropping the labor share to 62%.

We have built upon the Senate's critically important fall-back provisions. The fall-back means that seniors—such as those living in rural areas without two or more plans providing service—will always have access to a drug benefit. We have provided an additional layer of stability for those seniors, by requiring the fall-back plans to contract for two years as opposed to one. We have included the Senate Generic drug amendment, which has been scored by CBO as a cost-saver because it streamlines and clarifies the process by which generic medications can be brought to market. This will increase the amount of affordable medications available to all of our seniors. We have incorporated disclosure requirements, to ensure that our plans are fully demonstrating how savings are passed on to our beneficiaries. We allow the Secretary to negotiate on behalf of all Medicare beneficiaries for the best prices possible. We permit the re-importation of medications from Canada, provided that the Secretary certifies that such action would not jeopardize the health and safety of the American public. We allow Medicare to operate as the primary payor for all dually eligible beneficiaries, lifting some of the financial burden off of the shoulders of our states. We allow a portion of employer contributions to be counted towards the beneficiary out of pocket limits, encouraging our employers to continue sponsoring retiree health plans. And we are able to make these improvements within the confines of the \$400 billion budget allocation.

Unfortunately, the Congressional Budget Office was not able to complete a score on our legislation prior to the convening of the Rules Committee. However, the majority of the changes we have made to the already-scored Senate bill were based upon Senate amendments that have either been introduced and passed or are pending introduction. As such, they have all been scored by CBO for their sponsoring offices. The availability of that information has allowed the Blue Dogs to say with certainty that this legislation fits within the \$400 billion budget window.

We know that the Committee would have preferred that CBO underscore our claims. We would have preferred that as well. So, to lie to rest any lingering worries the Committee may have about the final cost of our legislation, we have incorporated a budget safeguard within this Substitute.

Specifically, the language requires the Secretary, in consultation with OMB, to determine the exact cost of this legislation prior to enactment. The Secretary is specifically directed to adjust the percentage of employer contributions that are applied

towards the out of pocket limit accordingly—if necessary—to ensure that the legislation will not exceed the specified allocation.

I respectfully request that this Committee give the Blue Dog Substitute its full consideration. On behalf of the entire Blue Dog Coalition, which has formally endorsed this proposal, I urge you to allow a debate of and a vote upon this Substitute on the floor of the House of Representatives.

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PREPARED STATEMENT OF HON. TOM ALLEN, A REPRESENTATIVE IN CONGRESS FROM  
THE STATE OF MAINE

Thank you, Mr. Chairman. This amendment is designed to provide doctors with valid, evidence-based information on how drugs that treat particular diseases and conditions compare to one another. It will ensure that physicians and their patients have access to credible, unbiased, evidence-based data on the comparative-effectiveness and cost-effectiveness of prescription drugs.

This amendment is based on H.R. 2356, the Prescription Drug Comparative Effectiveness Act of 2003, a bipartisan bill which was introduced by Representative JoAnn Emerson and me, along with five Democratic and five Republican original cosponsors on June 12. The amendment requires the National Institutes of Health (NIH) to conduct research, and the Agency for Healthcare Research and Quality (AHRQ) to conduct studies, on the comparative effectiveness and cost-effectiveness of prescription drugs that account for high levels of expenditures or use by individuals in federally funded health. In addition, the amendment directs AHRQ to submit an annual report to Congress delineating its findings and make the report publicly available on the internet. This amendment does not create a formulary. It does not restrict access. Rather, it provides more information to doctors and consumers.

This amendment provides a sound, bipartisan approach to a fundamental challenge: to ensure that our prescription drug spending is based on evidence-based research and not the latest television ad or marketing campaign in doctor's offices. Currently, drug companies promote their drugs as safer or more effective than competing drugs, but this promotion is too often based on poorly designed studies or other questionable sources of information.

The FDA is responsible for determining safety and effectiveness of prescription drugs (does the drug treat the condition its label says it treats), but there is no government entity responsible for examining the comparative effectiveness of prescription drugs (e.g., is drug A more effective at treating a particular condition than drug B). FDA judges the effectiveness of drugs compared to a placebo but does not ordinarily make judgments about the comparative effectiveness of drugs for the same indication, nor does it take into account relative costs.

This type of evidence-based review is happening at the state level, with the state of Oregon leading the way. Beginning in 2001, the state of Oregon implemented evidence-based review of drug effectiveness in its Medicaid program. To date, the program has examined five classes of drugs, including non-steroidal anti-inflammatories; long acting opiate analgesics; proton pump inhibitors for treating heartburn/acid reflux; statins for lowering cholesterol; and estrogens for treatment of menopausal symptoms and prevention of low bone density and fractures. Oregon has seen reductions in drug spending in their Medicaid program of almost 5 percent, and Michigan, with a similar program, has seen overall savings of nearly 10 percent. Several states plan to develop programs similar to Oregon's, including North Carolina, California, Idaho, Washington, and Arkansas.

The amendment recognizes that doctors need a range of treatment options in order to make informed choices based on individual patient needs. The amendment would ensure that physicians have access to objective, evidence-based, non-biased information on which drugs are likely to be most effective at treating a particular condition. I urge the committee to adopt this amendment.

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PREPARED STATEMENT OF HON. JIM LANGEVIN, A REPRESENTATIVE IN CONGRESS  
FROM THE STATE OF RHODE ISLAND

Mr. Chairman, I feel it is essential that we allow the bulk purchasing power of 40 million Medicare beneficiaries to be used to lower the high cost of their prescription medications. As this bill expressly forbids the Administrator of the prescription drug benefit from doing that, I am before you today to ask that the Members of our chamber have the opportunity to vote to remove that restrictive language.

Like many other parts of the country, my home state of Rhode Island uses bulk purchasing power of seniors eligible for Medicaid to negotiate discounts for this population. This program has met with a great deal of success. Eligible Rhode Island

seniors are able to purchase prescription medications at a price negotiated by the state, which is currently 13 percent below the average wholesale price. However, due to financial constraints, the program can only cover a portion of the cost, and many seniors find themselves just above the income cap and ineligible for any assistance.

Here we have a situation with over 40 million people with a common and basic need, yet instead of taking advantage of that purchasing power to negotiate lower prices for the most rapidly increasing component of health care costs, the federal government is actually considering outlawing that practice. America's seniors have made it clear that they want the government to assist them in obtaining their prescription drugs at a fair price. The Secretary of the Veterans' Administration and the Medicaid programs have the authority to use the bulk purchasing power of their constituencies to negotiate lower prices. Seniors without access to the VA or to Medicaid, who rely on Medicare, deserve no less.

Earlier this week, I joined with the Rhode Island Academy of Family Physicians in releasing a survey showing that a third of seniors in Rhode Island are relying on physician samples for their necessary medications and 20 percent are failing to take them as prescribed because of cost—skipping prescriptions to make them last longer and failing to refill them. The survey reiterates what we already know—that cost is the greatest barrier to seniors taking their prescriptions. These issues are not unique to Rhode Island, and this situation will not fix itself. An analysis of H.R. 2473 by the Consumer's Union shows that national spending on prescription drugs continues to grow, and if we don't take action to curb costs now, seniors will pay more out of pocket in 2007 with the prescription drug benefit than they are paying in 2003 without it. All Members of the House of Representatives should be given the opportunity to vote on an amendment that would open the door for the government to take action to lower drug prices for our seniors. By forbidding cost control, we essentially take the meaning out of the benefit we have fought to offer our seniors for so long.

Mr. Chairman, I thank you and the Committee for considering my amendment and for the opportunity to testify this evening. I am happy to respond to any questions you might have.

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PREPARED STATEMENT OF HON. PAUL E. KANJORSKI, A REPRESENTATIVE IN  
CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. Chairman and Members of the Committee, I appreciate the opportunity to offer my thoughts about competitive bidding for durable medical equipment. This issue is of great concern to the people of my Congressional district in Northeastern Pennsylvania.

As you consider the Medicare reform legislation before you, I urge to remove the provision authorizing a competitive bidding procedure for durable medical equipment.

Such a competitive bidding process would jeopardize countless small business jobs across the country, and limit patients' choice of providers as small companies producing durable medical equipment go out of business. Within my district, over 1,200 workers in just one local company, Pride Mobility Products, could lose their jobs due to a dramatic shift in the type and amount of products purchased by customers if a competitive bidding program were implemented.

I recognize that cost-saving measures are an important aspect of this legislation. However, within the realm of durable medical equipment, I believe these cost savings could better be achieved through an approach utilized in the Senate version of the bill. There, savings on durable medical equipment are attained by imposing a seven-year CPI-U price freeze on the fee schedules for durable medical equipment. According to the Congressional Budget Office, this measure would provide equivalent cost savings, yet would eliminate the damage to patients and small businesses that a competitive bidding system as contemplated in the House bill would create. A price freeze would further not require the development and administration of a new bureaucracy.

In closing, I recognize that this is a highly complex issue, but one that is extremely important to my congressional district. Thank you again for giving me the opportunity to present these facts to you today.

PREPARED STATEMENT OF HON. JOHN F. TIERNEY, A REPRESENTATIVE IN CONGRESS  
FROM THE STATE OF MASSACHUSETTS

Mr. Chairman, Mr. Chairman, I thank you and the other members of the Committee on Rules for giving me the opportunity to present testimony on an amendment I hope to offer to the Medicare Prescription Drug and Modernization Act which will protect the private prescription drug benefits for Medicare-eligible retirees.

As many as 7 million American retirees have already fallen victim to post-retirement cutbacks or elimination of health care benefits—benefits they worked their entire life to attain. Without my amendment, this legislation will accelerate that process.

Under the Medicare bill, retirees who receive coverage from their former employer would not be able to count employer-paid costs toward the \$3,500 out of pocket catastrophic coverage threshold. Thus, retirees with employer-based health care (and their former employers) are penalized because this employer coverage is not considered spending.

The Congressional Budget Office estimates that 32 percent of retirees that have a drug benefit through their employers will lose coverage as a result of this legislation, because there will be no incentive for employers to provide it.

Unfortunately, some corporations are likely to use the excuse that Congress provided a Medicare prescription drug benefit at all to cut their retirees off from this promised benefit.

The consequences are twofold:

First and foremost, employees will be denied a key component of the health care benefits that they were promised upon their retirement. These retirees lived up to their end of the employment bargain during years of hard work; they earned this benefit; now the companies that they faithfully served will not be held up to the same standard.

And the impact may be dramatic—roughly 12 million Medicare beneficiaries (about one third of all beneficiaries) currently have retiree coverage through a former employer.

Second, the cutback in private coverage will place increased pressure on the Medicare system when these retirees turn to the program for full coverage. This change will unfairly shift the cost burden for their prescription drugs from private companies—who took on the burden willingly as an explicit incentive they offered to their employees—over to the federal government.

My amendment would protect retirees and bring common sense and fairness back to retiree health. Specifically:

My amendment will protect retirees by prohibiting employers from making post-retirement cancellations or reductions of prescription drug benefits that Medicare eligible retirees were entitled to when they retired;

It will protect taxpayers by allowing retirees to retain their private coverage;

And it will both protect retirees and employers by allowing employer-paid prescription drug expenses (and retiree cost sharing under the former employer's plan) to count as beneficiary "out of pocket" expenses for purposes of reaching the catastrophic coverage threshold.

This amendment is strongly endorsed by the National Retiree Legislative Network and it's over 1.6 million members across the country. They have joined together to address the crisis in retiree health care, which—without my amendment—the Medicare Prescription Drug and Modernization Act threatens to make far worse.

Again, Mr. Chairman, I thank you and the other members of the Committee for your consideration. I hope you will make my amendment in order.

Mr. MCGOVERN. I would also like to ask unanimous consent to insert in the record a letter that was addressed to John Dingell from Senator Kennedy of Massachusetts in opposition to the House bill, in which he called it "opening the door to privatization of Medicare." I would like that to be in the record as well, sir.

The CHAIRMAN. Without objection.

[The information follows:]

EDWARD M. KENNEDY  
MASSACHUSETTS

**United States Senate**

WASHINGTON, DC 20510-2101

June 18, 2003

The Honorable John D. Dingell  
U.S. House of Representatives  
2238 Rayburn  
Washington, DC 20515-2215

Dear John,

Thank you for asking for my views on the Medicare legislation currently before the House. I share your concern that this bill opens the door to the privatization of Medicare and should be opposed.

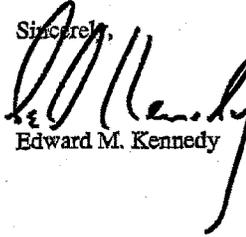
Of particular concern are the so-called "premium support" provisions in the House bill. If this proposal had been included in the Senate bill, bipartisan cooperation would not have been possible, and I would not have supported the Senate agreement.

The premium support proposal could destroy the Medicare that millions of senior citizens rely on today, and force them to join HMOs or PPOs. It could dramatically raise Medicare premiums and victimize the oldest and sickest of the Medicare population. In fact, a study by the Medicare actuary, conducted in 2000, concludes that this proposal could increase premiums by 47%, forcing many to leave conventional Medicare.

In addition, I am concerned that the means testing provisions of the bill depart from Medicare's commitment over four decades to help all seniors, regardless of income. All workers pay into the Medicare trust fund, and all retirees should benefit from it. Furthermore, this requirement will mean that data drawn from senior citizens' tax returns must be shared with insurance companies and pharmacy benefit managers to determine which seniors are eligible for benefits. I doubt that many seniors would appreciate this invasion of their privacy.

All of us want to find common ground to move forward to provide a Medicare prescription drug benefit for our nation's senior citizens. In the Senate, I believe we have established a solid and constructive basis for progress, which I hope can be strengthened and improved as this important legislation moves forward.

Sincerely,

A handwritten signature in black ink, appearing to read "E. Kennedy". The signature is fluid and cursive, with a long, sweeping tail on the final letter.

Edward M. Kennedy

Mr. MCGOVERN. I just have a few brief questions.

On the issue of copays for home health care, because that is what I was talking about earlier, Mrs. Johnson, you say it is only 1.5 percent, it is not that big of a deal. But, on average, that could be \$40 per episode or \$60 per episode, in some cases even \$100 per episode. That is a pretty big deal to a lot of seniors on fixed incomes.

We can debate whether it is a good idea or not, but I guess my question to you is, given the fact that the Energy and Commerce Committee voted one way on this and the Ways and Means voted the other, my question to both of you is, at a minimum, would you be in favor of allowing us to have an amendment on the floor that we can debate this issue?

I mean, everybody has their different opinions on it. We can argue it. But given the fact that the two committees of jurisdiction were split, wouldn't it be appropriate for us to have that amendment on the floor? That is my question.

Mrs. JOHNSON. That is certainly a decision for the Rules Committee.

This is kind of an age-old debate. It is an easier debate, I think, when we are talking about per episode than when we are talking about per visit. It is just a question of whether you think—if your copayment—

Mr. MCGOVERN. But \$100 per episode is a lot of money.

Mr. WALDEN. If I might, you are limited to \$40 per episode, and people under 135 percent of poverty don't pay the copayment at all. And you get 4 visits.

Mr. MCGOVERN. But, you know, that is still significant—I guess in your committee you voted to remove this?

Mr. WALDEN. I did. I also voted and the committee voted to increase the reimbursement rate by 5 percent the next 2 years.

Mr. MCGOVERN. My only question to you is, we can argue the merits of this and we can do it on the floor and/or here as well, but—would you object to an amendment that you had the privilege to vote on in your committee?

Mr. WALDEN. Well, again, as I say, my amendment covered two points, one was the copay and the other was increasing, which I think is even more important, the 5 percent reimbursement rate in both of the next 2 years.

And what I have seen in a very rural district is that home health is getting hit hard and going out of business. I represent a district that is bigger than your State.

Mr. MCGOVERN. Believe me, it is not just in rural areas. We are having a problem in urban as well.

Mr. WALDEN. I understand that. But I think with the change in how the copay will work in home health care, I am satisfied with the bill the way it is.

Mr. MCGOVERN. I appreciate your satisfaction. I am not satisfied. But I guess I would like the opportunity to be able to have the freedom to vote on some of these things. That is all my point is.

Mrs. JOHNSON. I should, though, clarify the fact, five or fewer visits are exempted. The average per episode cost is \$3,400, so we are talking about a \$40 copayment for an average taxpayer cost of \$3,400.

Mr. MCGOVERN. But, again, depending on your income level. Let me ask you another question.

Mrs. JOHNSON. Way below income.

Mr. MCGOVERN. The other question is, you both represent two different committees here. And you mentioned the drug importation bill as being a new provision that wasn't in either of the Energy and Commerce mark or the Ways and Means mark.

Are there any other provisions that are in this bill that we haven't read yet, that were in neither the Energy and Commerce mark nor the Ways and Means mark?

Mrs. JOHNSON. Yes, the Hatch-Waxman and the discount card.

Mr. WALDEN. I went through some of them, and I referenced the others, the AWP.

Do you want me to go through them? Would that be helpful?

The CHAIRMAN. Whatever Mr. McGovern would like.

Mr. MCGOVERN. Yes.

Mr. WALDEN. There are only three, so that I can get into detail for the sake of time.

AWP, the final language establishing house CMS reimbursements for drugs administered in a physician's office setting is similar to policy passed by the Energy and Commerce Committee last week, similar to committee passed bill, H.R. 1, will ensure that physicians will retain the ability to obtain their drugs through either a contractor or through a market reimbursement system known as the "average sales price system."

At the markup, the committee added an amendment that increased reimbursement to ASP from 100 percent to 112 percent. The language is largely retained in H.R. 1.

Medicaid DSH, also H.R. 1, also contains neither the Medicaid disproportionate share hospitals—the legislation expands upon the marked-up Energy and Commerce Committee policies, provided all States with a one-time, 20 percent increase in their Medicaid DSH allotments. This policy targets dollars to those hospitals that need resources the most.

And, finally, rural policies. In addition to some of the party rural provisions that were passed out of the Ways and Means Committee, the Energy and Commerce Committee contains specific provisions that increase payments for providers in rural areas.

First, we establish a floor on the reimbursements for the component fee schedule. This policy will help ensure physicians in rural areas are reimbursed adequately for their services.

Second, we also bump up payment levels 5 percent annually for 2 years to home health agencies operating in rural areas. This policy will ensure that those home health agencies located in some of our most vulnerable areas receive some added help.

Both of those provisions are contained in H.R. 1.

Mr. MCGOVERN. Are there any provisions, or is there any language in this new bill that would apply to any single corporation or industry or interest group?

And the reason why I ask that question is because I just—I don't want to wake up on Monday morning and read the New York Times and find out, like we did on the Homeland Security bill, that there is a deal for, you know, Eli Lilly or some company. I mean, I am just asking for you—I haven't gone through all of this.

Mr. WALDEN. I am not aware of any such provision.

Mr. MCGOVERN. We have your assurance that there are no special provisions in here for any single corporation?

Mrs. JOHNSON. There are no provisions for any single corporation, to my knowledge. But there is a change in how we respond to employer-provided retirement plans to try to prevent companies from dropping those plans. And the estimate is that far fewer companies will drop those plans than would have under any other scenario.

One of the differences between the Democratic alternative and our alternative is that under the Democratic alternative, a great majority of the employer-provided plans will drop out because the plan is very good. Why should they be in it?

Under our plan, we provide them with an incentive to stay in by providing them with a portion of the subsidy of the plan. We don't provide them with the equivalent subsidy for the whole plan because their people don't meet the out-of-pocket requirement for catastrophic coverage. But we do give them a capitated amount that represents the 80/20, proportionate to their drug spending if their drug benefit is as good as ours.

Mr. MCGOVERN. Finally, one last question, Mr. Walden. How many Medicare HMOs offer plans in your district today?

Mr. WALDEN. You know, most of the Medicare+Choice plans have left my district, in part because Oregon has one of the lowest AAPCC reimbursement rates in the country, proving that the Federal Government believes no good deed should go unpunished.

We have one of the shortest stays and least costly delivery systems. I would be happy to compare ours against any other State that has \$700 per person per county, when we get \$400, and equalize those rates. I would love to have that amendment, Mr. Chairman, if I could.

Mr. MCGOVERN. Why I raised it is, if those plans can't make it in your district, how can the new plans make it that are called for in this bill?

Mrs. JOHNSON. There are two ways in which the new plans will reach more broadly than the old plans did.

First of all, the Choice plans will be funded at the same level as Medicare. They will get 100 percent fee-for-service, just like we spend on ordinary fee-for-service beneficiaries.

And then their future growth and reimbursements are tied to fee-for-service, so it is certain and predictable. That helps them stay in the market.

And then, in 2006, they have the right to bid their own premiums and not be dependent on the vagaries of congressional action, but they have to bid around the fee-for-service costs. So if they bid above that, beneficiaries will have to pay more. If they bid below that, but they can give lots more benefits—if they bid below that, the beneficiary can have a premium reduction.

So that will give us a good understanding of whether or not those plans are any more efficient than Medicare. And, in addition, the enhanced plans will be required to be regional.

That is the nature of them, there will be 10 regions. So under that scenario, Oregon would be a very good deal for an enhanced plan, because they are a cheap delivery area; but on the other

hand, their AAPCC would be brought up by the regional average. So the likelihood that Oregon would be part of a regional plan and enjoy the benefits of better technology, of better disease management and integrated care, regionally, is very great.

If you listen to Tommy Thompson, he really thinks—and, remember, he is an old hand at rural health from Wisconsin, and he really thinks that the enhanced—bucking up of the rural providers to the reimbursement package and the enhanced plan is going to improve the quality of rural health dramatically. And all of the actuaries say there will be a 40 percent penetration, or take-up rather.

Mr. MCGOVERN. With all due respect, I will believe it when I see it. But I appreciate your comments here.

Mr. FROST. If the gentleman will yield, I wanted to be clear on Mr. Walden's answer because for the last 10 years, up until 2 years ago, I had a significant rural area in my district also; and all of the HMOs withdrew from my two rural counties. Not a single HMO serves my two rural counties.

Are there any HMOs that currently serve your rural areas?

Mr. WALDEN. For Medicare or in general?

Mr. FROST. In Medicare.

Mr. WALDEN. In terms of the Medicare+Choice plans?

Mr. FROST. Yes.

Mr. WALDEN. I do not believe there are. There is a hybrid of sorts that is left, I believe, in one county. But, Mr. Frost and Mr. McGovern, you have got to understand my district if you want to understand rural. I understand Texas understands rural, but I have got three counties with no hospitals, no doctors, and you drive 100 miles to find the nearest physician. And so we are talking frontier medicine out there.

The few doctors that do deliver babies are going out of business because the malpractice rates are skyrocketing. We need to do something about that, too. So we are in crisis out there.

Mrs. JOHNSON. I do want the record to show that the reason those plans dropped out is that they would be totally reimbursed at 95 percent. Gradually, their reimbursements shrank, and many of them were down to between 80 and 85 of AWP as a reimbursement subsidy. First, they shrank benefits and then they left the market.

One of the reasons you have to not only bring them back in at a reasonable reimbursement, but the reimbursement has to be predictable. And so we tie it to simply growth in fee-for-service. We will pay no more or no less than we paid for the average Medicare beneficiary under the plans. So we will now finally see whether stable plans can offer seniors more under integrated care.

We also mandate, although we don't pay them any more, that they do disease management across the board.

Mr. FROST. I would be happy to provide this, but I would point out, in addition to the fact that there were—my two rural counties, all of the HMOs went away; in my two urban counties, where there were eight HMOs under Medicare, now there is only one.

Mrs. JOHNSON. It was all the same mechanism. It is a tragedy. When I lost my last HMO, the people who complained the most were the people who were in the cardiac disease management programs, and there was nothing in Medicare that they could go to.

So I can't tell you what an advance this is going to be in health care, to not only require the plans to do this, but set Medicare up to do this.

Mr. FROST. Can you understand why there is a healthy skepticism on the part of many of us in relying on the private plan that didn't work under Medicare+Choice?

Mrs. JOHNSON. We think we have dealt with those problems, regulatory, reimbursement-wise, and there are a couple of other things that are there.

The CHAIRMAN. Mr. McGovern.

Mr. MCGOVERN. I yield.

The CHAIRMAN. Mr. Hastings.

Mr. HASTINGS of Washington. Thank you, Mr. Chairman.

I would like to know, if this can be confirmed, that the scoring on this bill is less than the \$400 billion that we had within our budget program parameters.

Mrs. JOHNSON. Yes, 393 billion.

Mr. HASTINGS of Washington. I just—Mr. Chairman, I would like to make note, in my first term, I recall, in 1995, the Medicare trustees gave a report to Congress; and they said, unless there are structural changes made in Medicare, Medicare would be dead broke, if my memory serves me correctly, by the year 2001—if my memory serves me correctly.

I recall that many of us, particularly on our side, were looking at ways to reform Medicare; and I know I can speak personally for myself, spent a lot of time in my district talking about the options of even talking about it.

Of course, nothing, unfortunately, happened in 1995 or in 1996. As a matter of fact, I also recall that in 1996 the issue of Medicare reform became a huge political football. In other words, our seniors were trying to help whipsaw all of this, so we came back in 1997. And, again if my memory serves me correctly, we discovered that the Medicare trustees came back and said we got some bad news. The 2001 date now has been accelerated to 2000. So we had a 3-year window to try to fix it before it went dead broke.

We did make some fixes that moved that ahead. We can debate and nitpick on whether they were exactly the right things to do.

But I want to commend Nancy. I know you have been in the forefront of this all of the time that I have been here—and, of course, Energy and Commerce also—and to recognize that prescription drugs have a therapeutic value that ought to be part of this whole thing, but it wouldn't work unless you had basic reforms, I think that you have, in the product that you are coming up with here, accomplished that.

I think and I hope that there will be some time so that we can go back and review some of these things on a regular basis and make sure that they are working, that they are not set in concrete.

I think the product that you have come up with is a product that is certainly worthy of support.

Based on this, we tend to forget past history, and if we forget past history, we are bound to repeat it again. The sooner we confront this, the better off we are.

I commend both of you and the committees for doing this work. It is something that needs to be done; the time is right. And for

those that say this is being imposed upon us in a very short period of time, I think you have simply forgotten that we talked about taking this up all along. This is something we knew we were going to take up the first part of this year.

So I wanted to commend you and thank you very much.

The CHAIRMAN. Thank you very much.

Mr. Hastings.

Mr. HASTINGS of Florida. Thank you very much, Mr. Chairman.

First, Mr. Chairman, when an errata occurs, people should be big enough to admit it. Let me say to Mr. Linder that he is absolutely correct; I made the fatal mistake of quoting colleagues that have made the fatal mistake of not having read the legislative history.

I ask unanimous consent that the legislative history with reference to the origin of Medicare, dated March 23, 1965, be submitted into the record. And it would include, Mr. Chairman, that there were 237 yeas that were Democrats. And Mr. Linder is correct, there were 70 Republicans that voted yes; there were 47 Democrats that voted no and 69 Republicans that voted no.

With your permission, I think it would help a lot of people.

[The information follows:]

LEGISLATIVE HISTORY: VOTE TALLIES FOR THE PASSAGE OF MEDICARE IN 1965

*House and Senate Votes: D = Democrat R = Republican*

*House Vote—July 27, 1965*

YEAS: (307)

Adams-D; Addabbo-D; Albert-D; Anderson, Tenn.-D; Annunzio-D; Ashley-D; Ashmore-D; Aspinall-D; Ayres-R; Baldwin-R; Bandstra-D; Barrett-D; Bates-R; Beckworth-D; Bell-R; Bingham-D; Boggs-D; Boland-D; Bolling-D; Brademas-D; Brooks-D; Broomfield-R; Brown, Calif.-D; Broyhill, N.C.-R; Broyhill, Va.-R; Burke-D; Burton, Calif.-D; Byrne, Pa.-D; Byrnes, Wis.-R; Callan-D; Cameron-D; Carey-D; Carter-R; Cederberg-R; Celler-D; Chamberlain-R; Chelf-D; Clark-D; Cleveland-R; Clevenger-D; Cohelan-D; Conable-R; Conte-R; Conyers-D; Corbett-R; Corman-D; Craley-D; Cramer-R; Culver-D; Cunningham-R; Curtin-R; Daddario-D; Dague-R; Daniels-D; Dawson-D; de la Garza-D; Delaney-D; Dent-D; Denton-D; Diggs-D; Dingell-D; Donohue-D; Dow-D; Dulski-D; Duncan, Oreg.-D; Dwyer-R; Dyal-D; Edmondson-D; Edwards, Calif.-D; Ellsworth-R; Evans, Colo.-D; Everett-D; Evins, Tenn.-D; Fallon-D; Farbstein-D; Farnsley-D; Farnum-D; Fascell-D; Feighan-D; Finer-R; Flood-D; Fogarty-D; Foley-D; Ford, William D.-D; Fraser-D; Friedel-D; Fulton, Pa.-R; Fulton, Tenn.-D; Gallagher-D; Garmatz-D; Gettys-D; Giaimo-D; Gibbons-D; Gilbert-D; Gilligan-D; Gonzalez-D; Goodell-R; Grabowski-D; Gray-D; Green, Oreg.-D; Green, Pa.-D; Greigg-D; Grider-D; Griffin-R; Griffiths-D; Grover-R; Gubser-R; Gurney-R; Hagen, Calif.-D; Halpern-R; Hamilton-D; Hanley-D; Hanna-D; Hansen, Iowa-D; Hansen, Wash.-D; Hardy-D; Harris-D; Harvey, Mich.-R; Hathaway-D; Hawkins-D; Hays-D; Hechler-D; Helstoski-D; Henderson-D; Herlong-D; Hicks-D; Holifield-D; Holland-D; Horton-R; Hosmer-R; Howard-D; Hull-D; Hungate-D; Huot-D; Hutchinson-R; Ichord-D; Irwin-D; Jacobs-D; Jennings-D; Joelson-D; Johnson, Calif.-D; Johnson, Okla.-D; Johnson, Pa.-R; Jones, Ala.-D; Karsten-D; Karth-D; Kastenmeier-D; Kee-D; Keith-R; Kelly-D; King, Calif.-D; King, N.Y.-R; King, Utah-D; Kirwan-D; Kluczynski-D; Krebs-D; Kunkel-R; Landrum-D; Leggett-D; Lindsay-R; Long, Md.-D; Love-D; McCarthy-D; McClory-R; McCulloch-R; McDade-R; McDowell-D; McEwen-R; McFall-D; McGrath-D; Macdonald-D; Machen-D; Mackay-D; Mackie-D; Madden-D; Mailliard-R; Martin, Mass.-R; Mathias-R; Matsunaga-D; Matthews-D; Meeds-D; Miller-D; Mills-D; Minish-D; Mink-D; Minshall-R; Moeller-D; Monagan-D; Moore-R; Moorhead-D; Morgan-D; Morris-D; Morrison-D; Morse-R; Mosher-R; Moss-D; Multer-D; Murphy, Ill.-D; Murphy, N.Y.-D; Natcher-D; Nedzi-D; Nix-D; O'Brien-D; O'Hara, Ill.-D; O'Hara, Mich.-D; O'Konski-R; Olsen, Mont.-D; Olson, Minn.-D; O'Neill, Mass.-D; Ottinger-D; Patman-D; Patten-D; Pelly-R; Pepper-D; Perkins-D; Philbin-D; Pike-D; Pirnie-R; Powell-D; Price-D; Pucinski-D; Purcell-D; Race-D; Randall-D; Redlin-D; Reid, N.Y.-R; Reifel-R; Reinecke-R; Resnick-D; Reuss-D; Rhodes, Pa.-D; Rivers, Alaska-D; Roberts-D; Robison-R; Rodino-D; Rogers, Colo.-D; Rogers,

Fla.-D; Ronan-D; Roncalio-D; Rooney, N.Y.-D; Rooney, Pa.-D; Roosevelt-D; Rosenthal-D; Rostenkowski-D; Roush-D; Roybal-D; Ryan-D; St. Germain-D; St. Onge-D; Saylor-R; Scheuer-D; Schisler-D; Schmidhauser-D; Schneebeli-R; Schweiker-R; Secrest-D; Senner-D; Shipley-D; Sickles-D; Sikes-D; Sisk-D; Slack-D; Smith, Iowa-D; Smith, N.Y.-R; Stafford-R; Staggers-D; Stalbaum-D; Stanton-R; Steed-D; Stratton-D; Stubblefield-D; Sullivan-D; Sweeney-D; Talcott-R; Taylor-D; Teague, Calif.-R; Tenzer-D; Thomas-D; Thompson, N.J.-D; Thompson, TeX.-D; Todd-D; Trimble-D; Tunney-D; Tupper-R; Tuten-D; Udall-D; Ullman-D; Van Deerlin-D; Vanik-D; Vigorito-D; Vivian-D; Walker, N. Mex.-D; Watkins-R; Watts-D; Weltner-D; Whalley-R; White, Idaho-D; White, Tex.-D; Widnall-R; Wilson, Charles H.-D; Wolff-D; Wright-D; Wyatt-R; Wydler-R; Yates-D; Young-D; Zablocki-D.

## NAYS: (116)

Abbott-D; Abernethy-D; Adair-R; Anderson, Ill.-R; Andrews, George W.-D; Andrews, Glenn-R; Andrews, N. Dak.-R; Arends-R; Ashbrook-R; Baring-D; Battin-R; Belcher-R; Bennett-D; Berry-R; Betts-R; Bolton-R; Bray-R; Brock-R; Brown, Ohio-R; Buchanan-R; Bursleson-R; Burton, Utah-R; Cabell-R; Callaway-R; Casey-D; Clancy-R; Clausen, Don H.-R; Clawson, Del.-R; Collier-R; Cooley-D; Curtis-R; Davis, Ga.-D; Davis, Wis.-R; Derwinski-R; Devine-R; Dickinson-R; Dole-R; Dorn-D; Dowdy-D; Downing-D; Duncan, Tenn.-R; Edwards, Ala.-R; Erlenborn-R; Findley-R; Fisher-D; Flynt-D; Ford, Gerald R.-R; Fountain-D; Frelinghuysen-R; Fuqua-D; Gathings-D; Gross-R; Hagan, Ga.-D; Haley-D; Hall-R; Halleck-R; Hansen, Idaho-R; Harsha-R; Harvey, Ind.-R; Hebert-D; Jarman-D; Jonas-R; Jones, Mo.-D; Kornegay-D; Laird-R; Langen-R; Latta-R; Lennon-D; Lipscomb-R; Long, La.-D; McMillan-D; MacGregor-R; Mahon-D; Marsh-D; Martin, Ala.-R; Martin, Nebr.-R; May-R; Michel-R; Mize-R; Morton-R; Murray-D; Nelsen-R; O'Neal, Ga.-D; Passman-D; Pickle-D; Poage-D; Poff-R; Pool-D; Quie-R; Quillen-R; Reid, Ill.-R; Rhodes, Ariz.-R; Rivers, S.C.-D; Rogers, Tex.-D; Roudebush-R; Rumsfeld-R; Satterfield-D; Scott-D; Selden-D; Shriver-R; Skubitz-R; Smith, Calif.-R; Smith, Va.-D; Springer-R; Stephens-D; Teague, Tex.-D; Thomson, Wis.-R; Tuck-D; Utt-R; Waggoner-D; Walker, Miss.-R; Whitener-D; Whitten-D; Williams-D; Wilson, Bob-R; Younger-R.

## NOT VOTING: (10)

Blatnik-D; Bonner-D; Bow-R; Cahill-R; Colmer-D; Keogh-D; Toll-D; McVicker-D; Watson-D; Willis-D.

## FINAL SENATE VOTE—JULY 28, 1965

## YEAS: (70)

Aiken-R; Anderson-D; Bartlett-D; Bass-D; Bayh-D; Bible-D; Boggs-R; Brewster-D; Burdick-D; Byrd, W. Va.-D; Cannon-D; Carlson-R; Case-R; Clark-D; Cooper-R; Cotton-R; Dodd-D; Douglas-D; Fong-R; Fulbright-D; Gore-D; Gruening-D; Hart-D; Hartke-D; Hayden-D; Hill-D; Inouye-D; Jackson-D; Javits-R; Jordan, N.C.-D; Kennedy, Mass.-D; Kennedy, N.Y.-D; Kuchel-R; Lausche-D; Long, Mo.-D; Long, La.-D; Magnuson-D; Mansfield-D; McClellan-D; McGee-D; McGovern-D; McIntyre-D; McNamara-D; Metcalf-D; Mondale-D; Monroney-D; Montoya-D; Morse-D; Moss-D; Muskie-D; Nelson-D; Neuberger-D; Pastore-D; Pell-D; Prouty-R; Proxmire-D; Randolph-D; Ribicoff-D; Russell, S.C.-D; Russell, Ga.-D; Saltonstall-R; Scott-R; Smathers-D; Smith-R; Symington-D; Talmadge-D; Tydings-D; Williams, N.J.-D; Yarborough-D; Young, Ohio-D.

## NAYS: (24)

Allott-R; Bennett-R; Byrd, Va.-D; Dominick-R; Eastland-D; Ellender-D; Ervin-D; Fannin-R; Hickenlooper-R; Holland-D; Hruska-R; Jordan, Idaho-R; Miller-R; Mondt-R; Mundt-R; Murphy-R; Pearson-R; Robertson-D; Simpson-R; Stennis-D; Thurmond-R; Tower-R; Williams, Del.-R; Young, N. Dak.-R.

## NOT VOTING: (6)

Church-D; Curtis-R; Dirksen-R; Harris-D; McCarthy-D; Sparkman-D.

## SUMMARY OF PARTY AFFILIATION ON MEDICARE VOTE

	Yea	Nay	Not voting
Senate:			
Democrats .....	57	7	4
Republicans .....	13	17	2
House:			
Democrats .....	237	47	8
Republicans .....	70	69	2

The CHAIRMAN. Thank you.

I frankly thought that you were talking about the 1993 tax bill when you were referring to the 1965 Medicare bill. You would have been correct.

Mr. HASTINGS of Florida. I understand you very well. That is what kind of saved Medicare.

But now, by 2010, it is dark and the rest of you all don't pay attention, it will probably be gone, out of business, by that time, thanks to what we have done since then in the way of tax cuts. It could have paid for all of this.

But, that said, let me ask either of our witnesses who—I echo the thanks that have been offered to them by colleagues for your work—why does this bill go into effect in 2006?

Mrs. JOHNSON. Our bill goes into effect in 2006, and I believe every other initiative does. It takes 2 years to set up a nationwide prescription drug plan. To compensate for that, we put in the immediate drug card.

Incidentally, I appreciated your reading that e-mail from your constituent. Unfortunately, there are a lot of misunderstandings behind that, and I hope after the sort of political debate gets done, that we will all spend some time after the break and be able to give our constituents a clear understanding of what the real deal is and what has to be resolved in conference.

Mr. HASTINGS of Florida. I am certain that I will do my best. I won't have very much choice. I don't go around very much trying to talk about parochial interests in places that I represent.

I have the good fortune of representing urban and rural areas. It is challenging on every given occasion, and I doubt very seriously, based on the recent census statistics, if there is any Member of Congress—perhaps those that live in South Florida, Republican and Democratic, may have as many people that this bill will affect as do I. But I don't approach it from that standpoint.

I am just as worried about what is happening in Greg's and your district as I am in mine, as it pertains to this matter. The people, for example, 12 million of them that are covered by employer plans, CBO estimated that 32 percent of them would lose their existing coverage.

And I heard you in response to Mr. McGovern, Mrs. Johnson, talking about the fact that the proposed subsidy would encourage employers to keep people in the plan. But there is evidence rife throughout America that employers are already dropping coverage. Now, hopefully, this will be correct, but what in the bill, specifically—explain to us, if you will, what is going to really encourage these employers?

Mrs. JOHNSON. Okay. In the—first of all, in our bill, it is predicted—I don't know how much reliability these predictions have, but that 32 percent will go out. Some of those would have gone out anyway. The Senate bill is 37 percent, and the Democratic substitute is 100 percent. So that is sort of the lay of the land.

In our bill, what we do—and the employers are very enthusiastic about this—we have negotiated a capitated payment, so they don't have to restructure their plan. The union plans and the business plans don't have to be restructured, but as they spend—remember, they don't get any benefit unless they spend. As they spend, then we give them 28 percent of their drug costs up to \$5,000.

That was the way that was worked out, that they preferred, and that we felt was a fair estimate of the benefit they would get from the 80/20 if we went person by person.

They don't get any benefit from the catastrophic provision.

Mr. HASTINGS of Florida. I have just one other question of either of you, and that is in the area of low-income protection, because that is where a lot of us are impacted. The restrictive asset provisions that I looked at just a minute ago don't give me any great comfort, and I would wonder how we are improving the protection for low-income beneficiaries?

Mrs. JOHNSON. Well, we are improving the protections, and I will let Greg speak to this, too.

Mr. WALDEN. Yes. In fact, in this bill, it becomes three times the SSI.

Mrs. JOHNSON. The asset test.

Mr. WALDEN. So it is triple that.

So we have tried to open it up to care for as many low-income as possible. Plus, by having the phase-out at the top end—a cap, if you will, on the richest of the rich in American seniors—starting at 60,000 and then phasing out at a higher level than that, we are able to take the dollars available to us under the budget resolution, target more of them to the lower-income folks who need it most, people in your district, people in my rural district.

It doesn't matter, if you are low income, where you live; the drugs are expensive and the need is great. So we felt that was the most appropriate use of the expenditure that we had available to us, to target the most possible to the lower-income level.

That is why on the home health copay, 135 percent of poverty, you don't pay it. On the premiums for this program, I believe 135 percent, we pick up the premium, the deductible.

And so it really is targeted to help those most in need, sir.

Mrs. JOHNSON. And then excluded from the asset test is the value of your home, without limit; a car used for necessary transportation, regardless of value, or a car not used for transportation \$4,500 value.

There are some other exclusions.

Mr. HASTINGS of Florida. When all of this is finished, I didn't care too much for HCFA before, but I am not going to like the administrator that has to try to implement all of this stuff.

But I appreciate you all, Ways and Means and Energy and Commerce. I am with my colleague, Mr. McGovern; I just have to wait and see. And, hopefully, hopefully, as you all suggested, it will work out that way.

The CHAIRMAN. Thank you very much, Mr. Hastings.  
Mr. Sessions.

Mr. SESSIONS. Thank you, Mr. Chairman. I would like to join Mr. Hastings and thank the Commerce Committee and Ways and Means for not only their attention to this very important issue, but for the long deliberation and, I think, improving upon the product, in the delivery over those last few years, that I have seen.

My observations are not unlike many of my colleagues that believe that a modern day program would have to include prescription drug coverage, prescription drug coverage for those people who cannot afford it. I think that prescription drugs nowadays, as the result of a very robust and dynamic industry, provide help not just with symptoms but with actual cures of many things. That is why I am glad that we have taken the perspective that we have to ensure that drug companies will be incented to go and produce the next leading-edge drug that will take care of the world's needs, whether it be AIDS or whether it be something else that would happen across this world.

America, I believe, does have a demand put on it to produce answers to problems wherever they exist. So I am very, very proud of what you have done. I am, in particular, pleased that so many people have shown up here this evening; and would like to impress upon you and let you know that I believe this committee, hopefully, will be looking at some perfecting amendments to take the hard work that you have done, but would allow us the opportunity to perhaps enrich this product that you have done and take as much time with it.

And I want to thank both of you for your time and effort. I think it was a job well done, and thank you very much.

The CHAIRMAN. Thank you very much, Mr. Sessions.

Let me just say that we do know, as we heard from our opening statements, that we began this meeting at 12:50, and we have spent nearly 90 minutes. And I would just like to say that this is my fifth year as chairman of the Rules Committee, and I don't recall when we have had any more thoughtful exchange between both Democrats and Republicans and the witnesses representing the respective committees.

We all know that this is designed to address a very important and pressing need out there. Democrats and Republicans alike very much want us to provide for the American people a package which will ensure that they have access to affordable prescription drugs, and at the same time, as I said at the outset, improve, strengthen, protect the Medicare system.

Both of you should be very proud. I know I speak for every member of this committee when we express our appreciation for your very thoughtful presentations. Thank you very much.

Mrs. JOHNSON. Thank you.

Mr. WALDEN. Thank you.

The CHAIRMAN. Our next witnesses, representing the minority from both the Ways and Means and the Energy and Commerce Committees, are Mr. Sandlin and Mr. Brown.

Gentlemen, please come forward. And let me say, as I did with the other witnesses, that, without objection, any prepared remarks

that you have will appear in the record in their entirety, and we welcome a summary.

Mr. Brown, if you would like to proceed.

**STATEMENT OF HON. SHERROD BROWN, A REPRESENTATIVE  
IN CONGRESS FROM THE STATE OF OHIO**

Mr. BROWN. Mr. Chairman and members of the Committee, The Minority on the Energy and Commerce Committee would ask for an open rule. If that request is not honored, the minority would ask that an array of substitutes and amendments be allowed on the floor, so that divergent views can be represented when the House debates this issue.

To produce a fair debate, it is important that members have the opportunity to consider substitutes such as those offered by Mr. Rangel and Mr. Dingell, the Democratic Blue Dogs, Mr. Dooley, and the Republican "Rump Group," as well as individual amendments addressing specific provisions of H.R. 1.

The Committee on Energy and Commerce met in markup for three days. During that markup, my Democratic colleagues offered many worthy amendments, and I would certainly suggest that all of them be made in order under the rule.

Without amendment, H.R. 1 dismantles Medicare, replacing the program's defined benefits, its guaranteed coverage, with a defined contribution premium voucher.

Medicare not only secures this nation's retirement system and sustains this nation's health system, it is enduringly popular with the American public. It is fundamentally wrong for Congress to strip Medicare beneficiaries of guaranteed, reliable health insurance under the guise of adding a drug benefit to the program.

Amendments are also called for to address serious flaws in H.R. 1's drug coverage.

Rather than simply adding a drug benefit to Medicare, this bill forces seniors to either join an HMO or purchase stand-alone drug coverage. There is no commercial market for stand-alone plans today. Insurers are balking at the prospect of offering stand-alone plans. This bill would subject millions of seniors to a private insurance experiment that is already on shaky ground.

And the drug coverage itself is woefully inadequate. Seniors with \$5,000 in drug expenses would still pay nearly \$4,000 out of pocket. The bill's coverage gap forces beneficiaries to pay 100 percent of their drug costs after the first \$2,000 of drugs have been purchased until the beneficiary has spent another \$2,900 out of pocket.

And for the first time, benefits would be means-tested, transforming Medicare from a retirement savings program into a federal welfare program.

The substitute which Mr. Rangel and Mr. Dingell offered in their respective committees is different from H.R. 1 in several key ways. The substitute strengthens Medicare rather than privatizing it. The substitute does not erect a new private insurance system and force seniors into it; reliable, guaranteed drug benefits are added to the core Medicare program.

These benefits represent true insurance. They are comparable to those available to members of Congress. All seniors who contribute

into Medicare would receive the same benefits out of Medicare. There is no means testing.

And there are several potent cost control mechanisms in the substitute, because it would be irresponsible to pass drug coverage legislation without them.

The substitute enables the federal government to harness the collective purchasing power of 40 million Medicare enrollees and secure discounted drug prices.

When you think about the sales volume 40 million beneficiaries represents, deep discounts are fully appropriate. Yet, H.R. 1 prohibits the federal government from securing those discounts. The substitute also includes measures to increase access to lower cost generic drugs and provide for the reimportation of drugs that are deemed safe by the Secretary of Health and Human Services. These amendments are identical to those recently adopted by the Senate.

H.R. 1 does not address the prescription drug coverage gap in Medicare; it perpetuates that gap with grossly inadequate drug benefits. H.R. 1 does not strengthen Medicare; it abandons it to the private insurance industry.

I urge my colleagues to seriously consider whether it is in the best interests of this nation to take Medicare down such a reckless path, and I urge my colleagues on the Rules Committee to allow Members the opportunity to consider a range of substitutes and amendments.

The CHAIRMAN. Thank you very much, Mr. Brown. We appreciate you being here. Thank you for your remarks.

Mr. Sandlin.

**STATEMENT OF HON. MAX SANDLIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. SANDLIN. Due to the time, I would just like to associate myself with what my good friend, Mr. Brown, has enumerated about the bill as a whole.

I would like to say, I too join in hoping that the committee would allow an open rule and allow the substitutes, such as Mr. Dingell, Mr. Dooley, the Blue Dogs and all of the other individual amendments in an attempt to make the bill better.

Let me make one specific point on an amendment that I have offered specifically, along with Representative Green from Texas, Gene Green, who is on the Commerce Committee.

As you know, the original bill, H.R. 1, has what is commonly referred to—we refer to as “the doughnut.” It makes beneficiaries 100 percent financially liable for all prescription drug costs between \$2,000 and \$4,900. That leaves beneficiaries with a gap of \$2,900 where they still are paying the premiums each month, but they are getting no coverage from their plan.

And really the only way that they are going to know that, they are going to remember that they have coverage is when they send that check in every month. So all of that has to be paid for by the beneficiary in that range.

This amendment offered by me and by Gene Green from Houston simply extends the 20 percent beneficiary cost-sharing up to the

\$4,900 after the \$250 deductible, closes the doughnut hole. Thank you.

Sandlin/Green (TX) #10

Amendment offered by Rep. \_\_\_\_\_

Mr. Chairman. I have an amendment to the rule. I move the committee make in order the amendment numbered **10** offered by Representatives **Sandlin and Green** of Texas and ask that the amendment be given the appropriate waivers.

The amendment would eliminate the bill's so-called "doughnut hole" by extending 20% cost-sharing up to the beneficiary's annual out of pocket threshold.

The CHAIRMAN. Thank you very much, Mr. Sandlin. Appreciate that.

Mr. Linder.

Mr. LINDER. No.

Mr. FROST. Mr. Chairman, at this point I would like to submit for the record a letter from the AARP on the subject of this legislation.

The CHAIRMAN. Without objection, the letter will be entered.

Mr. FROST. This is to the Honorable Bill Thomas.

[The information follows:]

June 25, 2003

The Honorable Bill Thomas  
 Chairman  
 House Ways and Means Committee  
 Washington, D.C. 20515

Dear Chairman Thomas:

AARP is encouraged by the advancement in the House of legislation to add prescription drug coverage to Medicare. Relief from the high cost of drugs is long overdue. Our members, and all older Americans and their families, expect and need legislation this year. We appreciate your efforts and leadership toward this end.

Several important provisions for a successful benefit are included in the bills pending before the House. These include: a voluntary prescription drug benefit that is available to all beneficiaries; the same benefit subsidy for beneficiaries in both fee-for-service and other Medicare coverage options; assistance for low-income individuals; and a cap on catastrophic health care costs in the new Enhanced Fee-for-Service and Medicare Advantage programs.

Congress is closer than ever to enacting a much-needed drug benefit. However, more needs to be done to ensure that what passes will work in practice and will provide needed relief for beneficiaries. We continue to be concerned with affordability and benefit stability, as well as the long-term implications for the Medicare program.

There are a number of issues that we believe need to be addressed to ensure that the drug benefit can succeed and win the support of our members and other Americans:

- **Premium Support:** We do not oppose the addition of new private plan options in Medicare. However, the provision that would establish a premium support structure beginning in 2010 could destabilize the traditional Medicare program and lead to much higher costs for beneficiaries. We recognize that efforts have been made to mitigate the harmful effects of this provision, but the changes do not correct the inherent problems with this structure. Rather than expand choice, this provision could limit choice by leading to substantially higher costs for beneficiaries who want to stay in the traditional Medicare program. Those who choose not to enroll in private plans should not be put at a financial disadvantage.

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- **Adequacy of the Drug Benefit:** Of primary concern is that the coverage be affordable and attractive enough to ensure enrollment of a large enough pool of beneficiaries to allow the program to work. Our research has consistently shown that beneficiaries' enrollment decisions are influenced by the adequacy and complexity of the benefit. While the benefit is attractive for those up to the coverage gap, this gap remains among their top concerns. It is not good policy, is unnecessarily confusing, and will prove to be a disincentive to enrollment. We urge you to close this coverage gap.
- **Indexing:** Another key affordability issue is that benefit levels are indexed to the cost of drugs. Drug costs have been rising at levels well above general inflation. Failure to contain the costs of drugs in the future means that the benefit will rapidly become unaffordable over time. For example, the initial deductible amount of \$250 in 2006 is projected to nearly double by 2013. Since older Americans' cost-of-living adjustments are linked to the general inflation rate, they will swiftly fall behind a benefit indexed to drug costs. We urge you to index the benefit level to another measure more closely related to the growth in beneficiaries' ability to pay, to ensure that the coverage will remain affordable over time.
- **Means Testing:** Medicare has always been and must remain a social insurance program. Altering the catastrophic coverage benefit based on beneficiary income would erode the universal nature of the program. Workers pay into Medicare, based on their full salaries, all their working lives. Their support is due to the fact they can depend on Medicare's specified benefit coverage when they retire. Weakening this social contract -- even if it at first only narrowly affects higher income beneficiaries -- threatens to move the program toward being perceived as welfare and will weaken public support.
- **Reliable Federal Fallback:** Whether or not beneficiaries actually have access to an affordable drug benefit depends almost entirely on whether, and at what price, private plans are willing to offer coverage. Experience with the private market raises serious questions about the availability and stability of private plans in all parts of the country, as well as the variability of premiums. While many of our members value greater choices, for most of them the stability of the program is paramount. It is therefore critical that the bill include a viable, guaranteed federal "fallback" with a defined benefit and defined premium, where private plan options do not exist. It also is critical to address the need for equitable premiums across the nation.

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- **Retention of Employer-Sponsored Retiree Coverage:** Employer plans are the single largest source of prescription drug coverage for Medicare beneficiaries, covering about 12 million people. Consequently, the bill correctly provides subsidies to encourage the continuation of such coverage. However, the Congressional Budget Office (CBO) estimates that 32 percent of Medicare beneficiaries with existing coverage will still lose their employer plan. We urge you to ensure adequate incentives for employers – who are already dropping coverage – to maintain their plans.
- **Low-Income Protections:** We are encouraged by the bill's inclusion of all Medicare beneficiaries, including "dual eligibles", in the prescription drug benefit. However, the protection for low-income seniors with income above Medicaid eligibility should be improved. Poor and near-poor individuals would pay for all drug costs in the benefit gap, which could be a significant amount of their annual income. In addition, eligibility is limited by a restrictive assets test that keeps otherwise low-income beneficiaries from paying reduced cost sharing. We urge you to improve the protections for low-income beneficiaries.
- **Cost Containment:** The high cost of prescription drugs continues to be a top concern of our members. To ensure the affordability of the benefit for both individuals and the program, greater efforts are needed to put downward pressure on health care costs, particularly the price of drugs. Additional cost containment strategies are needed, including the promotion of generic drugs, development and dissemination of comparative effectiveness information, greater authority for states to negotiate lower prices, improvements in safety, quality and prevention, and chronic care management. We urge you to build in more control over the growth of prescription drug costs.

I also want to reiterate AARP's position on the use of funds from the \$400 billion allocation for provider reimbursement increases. Providers should be paid fairly for treating Medicare patients, but beneficiaries have waited long enough for relief from high prescription drug costs. Every dollar allocated to "givebacks" means one dollar less available to improve the drug benefit. Increases in provider reimbursements also substantially increase beneficiary out-of-pocket costs through higher premiums and coinsurance.

We appreciate that objective analyses by MedPAC and others demonstrate legitimate need for some provider payment adjustments. However, we also note that these analyses demonstrate need for decreases in some areas as well. Any reimbursement changes should be based on sound, objective analyses, and result in no net increase that would diminish the amount of funding for a drug benefit or add to total beneficiary cost-sharing obligations.

We are also concerned about the imposition of other cost-sharing requirements – specifically a new copay for home health services. This could create a financial burden for some of the Medicare program's sickest beneficiaries.

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AARP members and their families want a prescription drug bill enacted into law this year. We believe that the concerns outlined above can and should be addressed as the bills move forward. Mr. Chairman, we look forward to continuing to work with you to ensure that needed improvements are made and that we enact – this year – the best possible bill to fulfill the promises made to older Americans

Sincerely,

William D. Novelli

Ms. PRYCE. No questions.

Mr. MCGOVERN. I wanted to thank you both for being here at almost 2:30 in the morning. And I hope, and those of us on this side of the aisle on the committee are going to fight for an open rule, because I believe this is a big enough deal, where all members should have an opportunity to participate in shaping what this legislation should look like.

And by restricting the rule, quite frankly, and restricting the substitutes that may be offered and restricting the amendments, you are not only locking out Democrats, you are locking out Republicans, but you are locking out the voices of the American people who have very significant concerns about this.

And I just would say, as I said in the beginning—I mean, for the life of me, I can't quite understand what the emergency is, why this has to be rushed right now, why we can't take this product, whatever it is, because no one has read it yet and actually go through it and be able to go back to our districts, whether we are Republicans or Democrats, talk to our senior citizens, lay out the plan. Does this make sense? Doesn't it make sense? What are the concerns?

Everyone talks about copays like they are no big deal. Well, for a lot of seniors on fixed incomes, \$40 is a big deal, or any kind of copay is a big deal depending on their economic situation.

And I worry too about the fact that we are opening the door to privatizing Medicare. You know, people—I am reading this article that just came over the Web from, I guess MSNBC.com. There is a quote from Chairman Bill Thomas: "To those who say that the bill would end Medicare as we know it, our answer is, 'We certainly hope so.'"

Well, I like Medicare, and most of my constituents think it is a pretty good program. They want to see Medicare expanded to provide a prescription drug benefit; they don't want to see it weakened or privatized. And so I am concerned that we are not going to get the kinds of debate and the kinds of openness that this deserves.

Mr. LINDER. Would you be so generous as to consider that Mr. Thomas might have said it should be the end of Medicare without prescription drugs, as he knows it?

Mr. MCGOVERN. I am reading the quote. And to be honest with you, listening to some of Mr. Thomas' previous statements on Medicare, I assume the worst intentions with regard to protecting and preserving the program.

Mr. LINDER. This is the end of Medicare as he knows it because Medicare, as we have known it, had no prescription drug.

Mr. MCGOVERN. I would like to see Medicare have a prescription drug benefit that is real, that remains real, that doesn't get undercut, as your bill goes into effect.

I yield.

Mr. BROWN. I find Mr. Thomas' comments and the resultant spin from his ideological soul mates, sort of metaphorically similar to Newt Gingrich's "wither on the vine." As soon as he said it, he knew that he shouldn't. Republicans responded in ways that it had something to do with HCFA and all of that.

Mr. LINDER. Would the gentleman yield?

Mr. BROWN. It is his time. Sure.

Mr. MCGOVERN. Let me answer his question. I didn't yield.

Mr. BROWN. I am certainly willing to enter into a dialogue with Mr. Linder about it. I just found that it is—I will answer it this way.

I heard Mr. Hastings' comments about Medicare, saying this and then correcting himself. Well, the real answer there is not that it passed, not that 74 Republicans voted for final passage and 73 voted against, with two abstentions—which is what happened. The real history and the real vote, as we know on motions to recommit, is that only 11 Republicans in the House voted for the creation of Medicare during the motion to recommit, the important vote. The other 60-some were doing what people always do here in final passage when they get politically jittery.

What actually always happened was, all mainstream Republican leaders opposed the creation of Medicare. Gerald Ford, later to be minority leader, John Rhodes, Bob Dole, Strom Thurmond, and my favorite, Donald Rumsfeld, all opposed the creation of Medicare in 1965.

So your party has a history of opposition to this program, and not just the far right of your party, but the mainstream of your party, from what happened in 1965 to Speaker Gingrich's tax cuts and Medicare cuts, the crown jewel of the Contract with America, to Bill Thomas, to Bob Dole saying—bragging to a conservative lobbyist in 1995 that he was there fighting the fight against Medicare, proudly doing it, to Newt Gingrich's "wither on the vine," to Dick Arme saying something along the lines of "a civilized society wouldn't have a program like Medicare," to all of Bill Thomas' line.

This is a family tree of opposition to and hostility to this program that has served the great majority of Americas seniors very well.

Mr. LINDER. Well, the comment would be interesting if it were true.

Mr. Chris Jackson did a special on CNN that played the entire Newt Gingrich line. It wasn't what the unions put on TV. He said giving seniors choices, giving them the opportunities to choose in a system, the Health Care Financing Administration "would wither on the vine." He didn't say the Soviet-style system we now have would go away; as soon as we choose, consumers would come back.

Mr. BROWN. Did he say "Soviet-style system" in that statement? So you saw the whole program, but he didn't say "Soviet-style," but meant Soviet style?

What Mr. McGovern—what he said was, HCFA would wither on the wine, not Medicare. And CNN exposed that lie in prime time.

Mr. MCGOVERN. I yield.

Mr. FROST. Just to set the record straight, I believe it was Mr. Linder who called it a Soviet-type system.

Mr. LINDER. I did.

Mr. SANDLIN. Well, certainly the quote did say, Social Security would wither on the vine. I have read that quote specifically. I know exactly what it said.

But I think that is exactly right. It will wither because with legislation such as this, you are making HMOs on parity with Medicare. And if the funding goes down, we will begin to say that the government can't afford Medicare, and all of the people will be pushed into HMOs.

And this is particularly important in rural America, where I live and as—Mr. Frost referred to this a moment ago. In Texas alone, from 1999 to 2001, 330,000 people were dropped by HMOs, and 80 percent of the people in rural areas that are Medicare-eligible live in areas that are not served by HMOs. And you can just bet your boots that when this goes into effect and moves forward, soon there will be no Medicare, it will wither on the vine, as Mr. Gingrich predicted.

And recently—the one that you left out, Senator Santorum said something that can't be interpreted in any way. He said, "We should phase out traditional Medicare."

That is the goal of this legislation, and if that is what you want to do, that is what this does.

Mr. MCGOVERN. I take it the answer to—Mr. Linder and others in the Republican Party have said enough to cause us heartburn, those of us who think that Medicare is an important program. I think it makes the case why we should do this thoughtfully and not rush through this. But at a minimum—since we are not going to do this in anything short of rushing it to the floor, at a minimum, we should have everybody's amendments and everybody's substitutes be made in order. So I support you in that regard.

Thank you Mr. Chairman.

The CHAIRMAN. Thank you.

Let me just say that when Mr. Frost submitted the statement into the record, he wanted to ask some questions. So please proceed.

Mr. FROST. I just have a question, if either one of you can answer this.

The bill, the majority's bill, contains a means-testing provision where seniors with annual income higher than \$60,000 have to pay more money out of pocket before they qualify for catastrophic drug coverage.

Now, there are some basic privacy issues related here. How are they going to get that information? What is going to happen? Is there going to be contact between the IRS and Health and Human Services? What happens to seniors?

Mr. SANDLIN. That is my understanding, that information will be transferred and shared between the IRS and the provider and the insurance companies, and certainly will have serious constitutional issues and privacy issues as this information is disseminated across America by the seniors.

If you are making \$60,000 a year, you would have a coverage gap rising up to about \$11,200. You are paying for a premium and not really getting any benefit.

Mr. BROWN. I would add that—I mean, this sounds eerily like some kind of class warfare waged by the Republicans. But I would—I am concerned about that kind of proposal, because it really does undercut and actually fracture the universal coverage system that we know as Medicare. And if it is 60,000 today, then as the Republicans continue their assault on Medicare, to privatize it, it becomes 50, 40, to the point that Medicare, public Medicare, public fee-for-service Medicare, becomes a welfare program, and where the sickest and the oldest and the poorest find themselves; and for

more affluent—Members of Congress and others—we end up in private plans. And that should concern all of us of any income level.

Mr. FROST. That is my only question.

The CHAIRMAN. Thank you, Mr. Frost.

Ms. Pryce.

Ms. PRYCE. No.

Mr. DIAZ-BALART. No questions. Thank you.

Mr. HASTINGS of Florida. Mr. Chairman, I thank both of the witnesses. In the interest of time, I will reserve my comments.

Mr. HASTINGS of Washington. No questions.

Mr. SESSIONS. Thank you.

Mr. BROWN. Mr. Chairman, if I could, I won't keep the committee long. I have four other amendments that I will just submit and ask for support.

The CHAIRMAN. Thank you very much. We appreciate that. They will appear in the record.

[The information follows:]

**AMENDMENT TO H.R. 1**  
**OFFERED BY MR. BROWN OF OHIO**

**(Amendment is to Medicare Prescription Drug and  
Modernization Act of 2003)**

In section 1860D-2(b) of the Social Security Act (relating to standard coverage) (as proposed to be inserted by section 101), add at the end the following new paragraph:

1           “(6) MINIMUM COVERAGE.—Notwithstanding the pre-  
2           vious provisions of this subsection, in no case shall qualified  
3           prescription drug coverage be less for a year than the out-  
4           patient prescription drug coverage provided for covered out-  
5           patient drugs under the standard option of the Service  
6           Benefit plan referred to in section 8903(1) of title 5,  
7           United States Code, for that year.

**AMENDMENT TO H.R. 1**

**OFFERED BY MR. BROWN OF OHIO**

**(Amendment is to Medicare Prescription Drug and  
Modernization Act of 2003)**

Add at the end of title I the following new section:

1 **SEC. 108. LIMITATION ON BENEFITS.**

2       Notwithstanding any other provision of law, during 2004  
3 and each subsequent year, the actuarial value of the prescrip-  
4 tion drug benefit of any Member of Congress enrolled in a  
5 health benefits plan under chapter 89 of title 5, United States  
6 Code, may not exceed the actuarial value of any prescription  
7 drug benefit under title XVIII of the Social Security Act, as  
8 amended by this Act.

**AMENDMENT TO H.R. 1**  
**OFFERED BY MR. BROWN OF OHIO**

**(Amendment is to Medicare Prescription Drug and  
Modernization Act of 2003)**

In the title relating to reimportation, strike the subsection relating to **[conditions or effectiveness]** and insert the following:

- 1       “( ) EFFECTIVENESS OF THIS SECTION.—
- 2       “(1) IN GENERAL.—This section shall become effective
- 3       unless the Secretary of Health and Human Services cer-
- 4       tifies to the Congress that the implementation of this sec-
- 5       tion will—
- 6               “(A) pose a greater risk to the nation’s health and
- 7       safety than the prescription drug rationing necessitated
- 8       by non-competitive prescription drug prices in the
- 9       United States; or
- 10              “(B) not result in a significant reduction in the
- 11       cost of covered products to the American consumer.
- 12       “(2) DETAILED CONGRESSIONAL EXPLANATION.—If
- 13       the Secretary makes the certification described in para-
- 14       graph (1), the Secretary shall, within 7 calendar days of
- 15       the date of making the certification, provide to Congress a
- 16       detailed, written explanation of the basis for such certifi-
- 17       cation and the analysis conducted to support the certifi-
- 18       cation.
- 19       “(3) RECOMMENDATIONS FOR CHANGES IN LAW.—If
- 20       the Secretary makes the certification described in para-
- 21       graph (1)(A), the Secretary shall, within 6 months of the
- 22       date of making the certification, provide to Congress a
- 23       written set of detailed recommendations for changes in fed-
- 24       eral law and regulation appropriate to address any safety
- 25       concerns detailed in the Secretary’s certification.

**AMENDMENT TO H.R. 1**  
**OFFERED BY MR. BROWN OF OHIO**

**(Amendment is to Medicare Prescription Drug and  
Modernization Act of 2003)**

At the end of subtitle B of title II, add the following

new section:

1 **SEC. 238. MEDICARE ADVANTAGE ADMINISTRATIVE**  
2 **COST ACCOUNTABILITY.**

3 (a) **IN GENERAL.**—Section 1857(c) (42 U.S.C. 1395w-  
4 27(c)) is amended by adding at the end the following new para-  
5 graph:

6 “(6) **MEDICARE ADVANTAGE ADMINISTRATIVE COST**  
7 **ACCOUNTABILITY.**—Each contract with a Medicare Advan-  
8 tage organization under this part shall provide that the or-  
9 ganization shall comply with the provisions of part 31 of  
10 the Federal Acquisition Regulation, relating to ‘Contract  
11 Cost Principles and Procedures’.”

12 (b) **EFFECTIVE DATE.**—The amendment made by sub-  
13 section (a) shall apply to contracts entered into or renewed on  
14 or after the date of the enactment of this Act.

The CHAIRMAN. Our next witness is the gentleman from Indiana, Mr. Buyer. Please come forward. And without objection, your prepared statement will appear in the record and we welcome a summary. Thank you very much for your forbearance.

**STATEMENT OF HON. STEVE BUYER, A REPRESENTATIVE IN  
CONGRESS FROM THE STATE OF INDIANA**

Mr. BUYER. Thank you, Mr. Chairman, Mr. Frost, members of the committee.

About 5 months ago there were five senior members of the House Energy and Commerce Committee that came together because we had very strong policy concerns; and it was really led by Richard Burr, John Shadegg, Charlie Norwood, Joe Barton and myself. We tried to think outside of the box.

We are here representing just the four of us, excepting out Joe Barton, so I am representing Richard Burr, John Shadegg, Charlie Norwood and myself—are asking that our drug value card be a substitute to Title I along with the catastrophic coverage.

And if I could ask the Rules Committee to indulge me for just a second—because this was a 5-month product outside of the committee, the work product, and it was a very serious level of effort—what we had hoped to do here was, how do we extend the drug benefit to the traditional fee-for-service Medicare and, at the same time, keep employers in the game? How do we make sure that they hold the fidelity of the commitments to their employees and retirees and, at the same time, keep the best minds in America continuing to press the bounds of science for the benefit of America?

We came up with a value drug card. We permit any organization that is eligible to offer a CMS-approved drug card—it can be AARP or employers or pharmacists organizations, pharmacy benefit managers, drug wholesalers—you name it. If it is approved by CMS, they can come up with their formularies and offer a drug card, and have the purchasing power and have those drug savings; a senior can expect 15 to 35 percent savings on their drug value cards.

A senior could only select one value card. Seniors would pay an annual \$30 dollar enrollment fee. Everyone is in, and you have to opt out.

We also, though—when you have this drug account, you have this value card that comes with a drug account; and what we do is, we say this is a defined contribution so the government knows exactly what is going to go on that account.

So from zero to 100 percent of poverty, the government would put down \$2,500; from 100 to 125, they put in \$1,500; from 126 to 175, they put down \$1,100; From 176 to 250 percent poverty, you put \$600; from 251 to 350, you put \$300; anyone above 351 percent, it is \$100. So there is a defined contribution, so we know, as a government, exactly what we are putting into the program.

At the same time, we create a tax deductible opportunity that individuals can put up to \$5,000 into that drug account. And very often, we like to say, parents take an active role in the lives of your children. Now, what we should also be saying is, children take an active role in the lives of your parents.

What is happening in society, I think is shameful. Children are so anxious to get hold of an inheritance that they spend down the

assets to get mom and dad Medicaid-eligible and throw them in a nursing home. That is not right.

We have become family friendly here, and we want the children to be able to get a tax deduction to put money on the value drug card. We also then say to employers, you can make a contribution into that card.

And then with regard to the catastrophic benefit, all beneficiaries that select a drug value card are required to purchase a \$10,000 private catastrophic coverage to avoid risk selection. And to encourage participation, the Federal Government will pay 100 percent of the premiums for those up to 175 percent of the Federal poverty level, and then there is a sliding scale percentage of the premium from 176 to 250.

And I won't go into it further, but what I want you to know, Mr. Chairman and the committee, this was a very serious level of effort. What happened in the Commerce Committee was, we negotiated with the chairman, and it ended up being a transition, and then a fall-back piece; then it got scored pretty high. And so it has really been scaled down tremendously.

I wish this could have been a base bill. I would have loved the opportunity to take this to the floor. We had introduced it. It is one of those tough times.

The CHAIRMAN. Well, thank you very much. We appreciate your very hard work on this, and thanks for the presentation.

Mr. LINDER. What was it scored at?

Mr. BUYER. This was scored at 385 billion.

Mr. LINDER. Over 10?

Mr. BUYER. Over 10.

Mr. FROST. Interesting.

I am not sure that I would support it on the floor, but I think that you should have the right to offer it. And if no one on your side will offer it when we vote on the rule, I will offer your amendment. I doubt that it will be accepted on your side, but you should have the opportunity to have a vote.

Mr. BUYER. Thank you.

Ms. PRYCE. Thank you. I admire the work that this group did. They worked very hard. They have a product that I believe, with a little more time and a little bit more vetting, may have made its way to the base bill. There was just not enough time to see where it would go.

I just want to say that I don't think that you should give up on it, because I really thought it was very innovative and tremendously "out of the box" in ways of thinking that we have never gotten to.

So I would just encourage the gentleman not to give up on this.

Mr. BUYER. Thank you.

The CHAIRMAN. Mr. McGovern.

Mr. MCGOVERN. I think that is a polite way of telling you that you are not going to have the opportunity to offer your proposal on the floor. But I will associate myself with the remarks of my ranking member, Mr. Frost, and say that I probably wouldn't vote for your proposal on the House floor.

But when he offers your amendment here, I will certainly vote for it, to make it in order, because I do think that this issue is im-

portant enough where everybody should be able to bring their proposals to the floor and debate these proposals up or down and let the entire House work its will.

So I thank the gentleman for being here. I will support his right to offer the amendment in this committee.

The CHAIRMAN. Thank you.

Mr. Diaz-Balart.

Mr. DIAZ-BALART. I thank Mr. Buyer for his hard work.

Mr. HASTINGS of Florida. Mr. Chairman, I just say to Mr. Buyer, 2 years ago I would have voted for it on the floor. But a \$1.3 trillion tax cut later, I don't think that I would, for the reasons that I don't think that the 1.3 trillion was family friendly. And this is a measure, I agree with you, that may very well be family friendly.

I do agree with my colleagues that you should have a right to present it. But if we could repeal some of those taxes, we could pay for that and a whole bunch of other things; and pay for what Americans want, and that is affordable drug prices. But we can't do it, unfortunately.

Thank you.

The CHAIRMAN. Thank you.

Mr. Hastings.

Mr. HASTINGS of Washington. Thank you, Mr. Chairman.

You said that the bill we are considering there is a transition period. As I understand it here, what your concept is doing, the transition is in here?

Mr. BUYER. There is a very small, minuscule piece of this.

Mr. HASTINGS of Washington. I recognize that point.

But I think that that may be a very, very important part of this, because my view is that we have had a Medicare system that has been in place with very few innovations over the last generation and a half, and I think that we ought to be thinking outside of the box; and this body sometimes doesn't want to accept that change until we have had a pilot program.

If I might say, this may be one of those pilot programs that hopefully it will surprise us in a positive way. I congratulate you.

Mr. BUYER. Mr. Hastings, I will embrace that, along with Mrs. Pryce's recommendations. We have a great staff that also can help put this together. That is exactly what we wanted to do, not think along the lines of traditional Medicare and say, we will just let the government do the program. Or if you have concerns in the private sector, will it happen; will there be two competitive plans in a region? What is another way of doing this?

That is what 5 months of effort brought us.

Mr. HASTINGS of Washington. Even though this may be minuscule—and I recognize the hard work that you have put in on this, but this could be very, very important as we look at this 2 years hence.

Mr. BUYER. What it does do, Mr. Hastings and Mr. Chairman, is, if this bill passes and is signed into law, you have that 3-year void. Even though I say it is minuscule, you do have an opportunity to cover those individuals who are at that 175 percent below poverty, so you are extending to people who really need it, who are making the tough choices out there.

So, for that, I compliment you for your compassion.

Mr. HASTINGS of Washington. Thank you.

The CHAIRMAN. Thank you.

Mr. Sessions.

Mr. SESSIONS. Thank you, Mr. Chairman. I also want to heap praise on you, Steve and your colleagues, for the great work that you have done. I think I might have started from about the same perspective that you did, that is, to see what impediments are in the way for people to be able to fully participate and to help themselves, whether it be tax components or other things, rather than just taking the whole thing on by the government.

I think solving the problem through simpler ways can be done, and I think that is what you started to do. I think it is a great opportunity, and perhaps can be a model for us to look at. So thank you.

I yield back.

The CHAIRMAN. Steve, thank you for your hard work. Thank you very much for being here.

Next, from the Energy and Commerce Committee, I would like to ask Mr. Pallone, Mr. Strickland and Ms. Capps to come forward.

Please proceed as you see fit. Thanks to all three of you for your patience, and we appreciate your being here. Without objection, your prepared remarks will appear in the record. And Mr. Pallone, please begin.

**STATEMENT OF HON. FRANK PALLONE, A REPRESENTATIVE  
IN CONGRESS FROM THE STATE OF NEW JERSEY**

Mr. PALLONE. Thank you, Mr. Chairman and members of the committee. I have two amendments, and I will try to summarize them together.

And I guess I would start out by saying that, as my colleague, Mr. Brown, from the committee mentioned earlier, what we really would like to see is an open rule, and to allow all of these amendments. And certainly the substitute, the substitute that was put forward by the leadership of the Ways and Means and the Commerce Committee, that is the most important amendment that we would like to see put in order. And my two amendments actually are included in that substitute. So if you didn't allow the substitute, it would not be necessary to include these two amendments. But they go to the heart of the issue in the substitute, and I would put it this way. I think—I believe and I think most of my Democratic colleagues on the committee believe that Medicare is essentially a good program. It is a program that works. It is not broken. I know I have heard many, not necessarily you, but other people in Republican leadership and others on the floor say that Medicare is broken. Medicare needs to be fixed and doesn't work. When I talk to seniors in my district, they all say they like Medicare, and they like the program, but the one thing they don't like is it doesn't include a prescription drug benefit, and they would like it to be added.

So essentially the Democratic substitute does just that. It keeps traditional Medicare—keeps Medicare the way it is, the way it has been, but it adds a prescription drug benefit in the same way that Part B was added for your doctor bills. In other words, you just add the benefit, you have a low premium, and for \$25 you have a low

deductible, \$100, and you have 80 percent of the costs paid for by the Federal Government. And it is all exactly that. In other words, it doesn't change. Those figures are exactly what they are, and they don't vary. So one of my amendments does that.

Mr. Frost mentioned it before, which is to say that under the plan, even the Republican plan, those things must be fixed. There must be a set deductible, either 250 or 275; there must be a set catastrophic; and also there should be a set premium. And I think if you vary from that, you make it very difficult for the seniors to make real choices. I think many of you have talked about choice, but, I mean, the bottom line is there can be choice in terms of services and competition between services, but I think if you don't set a standard benefit and say this is what the premium is going to be, this is what the catastrophic is going to be, this is what the deductible is going to be, it just makes it that much more difficult for seniors to make choices and understand what they are getting.

So that is one amendment. One amendment would simply define the benefit and say that those figures have to be what the Republicans have been advertising. You have been saying \$35; you have been saying 250, 275. You have been saying a specific amount for catastrophic. It shouldn't vary. That is one amendment.

The other amendment deals with the issue of negotiated price. And I maintain that if you don't put some language in the bill, regardless of the Republican or Democratic bill, that allows the Secretary or the Administrator of the Medicare programs to negotiate price and bring prices down, we will never be able to afford a prescription drug benefit that you are now applauding and advocating. The reason why the Republican bill has a huge doughnut hole and the reason it has so many problems is because you are trying to fit it within a certain budget amount, which is the \$400 billion, and you are not using the price or negotiating the price as a way of bringing the cost down. And I think what you will find over the next few years if you don't allow the Secretary or the Administrator to negotiate the price, you will simply not be able to afford the program. It will go way beyond the \$400 billion that you are proposing.

And so my second amendment would simply say that the Secretary or the Administrator has the authority to negotiate price to reduce the costs, and it makes sense. You have the same thing in the veterans program. You have the same thing in the military. And we are saying now the Secretary is going to have 400—40 million seniors in the country, and he has real opportunity to negotiate price and bring prices down and save for the program. Instead you go to the exact opposite. In the House Republican bill, you actually have a noninterference clause that says the Secretary or the Administrator cannot negotiate price and cannot actually interfere in the process in that way. I think that is a huge mistake. I don't know if you have it there for ideological reasons or you have it there because that is what the drug companies want, but I think in the long run it is going to be impossible for you to deliver on the very benefit that you are promising.

So I ask that you adopt those two amendments, but, more important, I ask that you allow the full House to consider the substitute, the Democratic substitute, because that would include my two

amendments and would allow for a real debate on the issue of what kind of benefit we would be providing.

Mr. LINDER [presiding]. Mr. Strickland.

**STATEMENT OF HON. TED STRICKLAND, A REPRESENTATIVE  
IN CONGRESS FROM THE STATE OF OHIO**

Mr. STRICKLAND. Mr. Chairman, I am offering a common-sense amendment. My amendment is based on the idea that all seniors, regardless of where they live, should pay the same premium to participate in Medicare prescription drug benefit; and moreover, that all seniors should have a reasonably good idea every year of what they are going to owe each month for their prescription drug plan.

Now, I know that some of my colleagues claim that seniors under the Republican bill will pay about \$35 monthly premium for a prescription drug benefit created by this bill, but there is nothing in the text, as Ms. Slaughter was able to elicit from our colleagues from the Ways and Means and Commerce earlier, there is nothing in the text of the bill that indicates what the premium will be. It does not require a \$35 premium. In fact, the bill does not even contain a range of premiums that would be acceptable under this bill. Therefore, my amendment would just simply ensure that all seniors are charged a \$35-a-month premium for their Medicare drug benefit regardless of where they live. The \$35-a-month premium would then be indexed each year, just like the rest of Medicare is indexed.

This amendment, I believe, is essential to the constituents who live in a district like mine. My district stretches for 330 miles along the Ohio River. If the plan before us today were to be passed into law, it is likely that the seniors living in the more densely populated northern part of my district would have access to a drug benefit that could vary widely in terms of the premium from the seniors who live in my more rural southern counties. Since plans will have to be paid more to induce their participation in rural areas, premiums in these rural areas will likely be higher.

And then the Commerce Committee, I asked the counsel what guarantee there would be that a plan would even be there, a drug-only plan or an HMO plan would be there for seniors in rural areas. There is no guarantee that such a plan will be there. My district borders Pennsylvania, West Virginia, Kentucky. It is likely that seniors in those States will have access to prescription drugs at very different monthly rates. These disparities in costs will create disparities in access to prescription drugs, which is exactly the problem that this bill purports to solve. And since Medicare+Choice plans, as has been noted many times here this evening, move in and out, that they moved out of my area, 6 of my 12 counties have no access to Medicare+Choice now. They were there, and they left, and seniors were left in the lurch. So seniors know all too well what happens when a plan decides to pull out.

If it is true, as many of you say, that the average monthly premium under this bill will be \$35, then it only seems reasonable that we would put it in the bill so that seniors can have predictability, they can know how much this is going to cost them from year to year, and it will be indexed, and that is a reasonable thing to do.

So I just urge you to accept this amendment. I think it is the only way that we can give seniors any kind of competence that their premium will be \$35 rather than \$85, as it was in Nevada, or even higher. So I ask you to consider the amendment and to rule on it in a positive manner.

Mr. LINDER. Mrs. Capps.

Mrs. CAPPS. Thank you, Mr. Chairman, for allowing me to make this presentation.

Mr. LINDER. Only 3 o'clock in the morning.

**STATEMENT OF HON. LOIS CAPPS, A REPRESENTATIVE IN  
CONGRESS FROM THE STATE OF CALIFORNIA**

Mrs. CAPPS. I have two amendments, and because of the emergency nature of this hearing, I will be as brief as I can be. The first is I think it is titled number 001, called the national plan amendment. A better title would be a backup plan. In this amendment, Centers for Medicare and Medicaid Services, we know them as CMS, would offer standard coverage as a prescription drug plan throughout the United States as a backup plan. The coverage that would be offered would be the benefit outlined in the Majority bill. So there would be no difference, but it would make sure that in the event that the insurance plans did not stay in a particular area that traditionally has been underserved, a senior would know that there would be this fall-back plan that would give them the same benefits that would only be used in reserve.

I actually think this would really go a long way to help sell, if you will, this new Medicare plan, because my experience with seniors, with the only knowledge they have had about insurance companies combined with Medicare, the Medicare+Choice plans, has been rather negative because they have seen the plans come in in underserved areas like I represent, the rural area. The plans come in and offer a lot, and then pretty soon they raise their premiums and cut back on the benefits, and then pretty soon they have gone. And I have already heard some concern about the idea of having the same kind of insurance companies be this partner with Medicare.

So I am hopeful that you will look seriously at this idea only as a reserve plan, but having the senior know that in the event that there wasn't any HMO available in their area, that they wouldn't be left high and dry. That is the first amendment.

And then the second amendment is one that I am submitting called the Norwood-Capps cancer cap amendment, and I think the number is 59. The actuality is that the base bill that we went through in the commerce energy committee, this base bill threatens quality cancer care. It actually cuts cancer care funding by 30 percent, or \$500 million. This is because of the way that the average wholesale price has been indexed for oncologists. And we need to fix this. This is our responsibility as part of how Medicare is financed. We also have to make sure that oncologists are paid properly.

And so this amendment is based on H.R. 1622, which I have co-authored with Representative Norwood, which this bill has already gained strong bipartisan support. This amendment, then, based on this bill, offers a more accurate payment for oncology drugs, just

really comes clean with how we have been doing it. But what oncologists have been doing since Medicare came into being before there really was oncology service in the full sense of the word in comprehensive cancer care, oncologists have used the overpayment of the drug to pay for the services.

The CHAIRMAN. Average wholesale price.

Mrs. CAPPS. Exactly. And that is wrong. We need to fix it. But we also need to make sure that cancer care continues to be delivered. And so the amendment would allow for that delivery of services by the oncology community really, nurses and other professionals who deliver the care.

Oncology treatment is rather severe in many instances and needs to have this service to make it work, so I hope these amendments will be considered by the Rules Committee.

Mr. LINDER. Ms. Pryce.

Ms. PRYCE. Thank you all.

I am interested in your second amendment. Do you know how it differs from the average sales price plus 12 percent that is in the base bill?

Mrs. CAPPS. It has a different formula for doing it. It would reimburse the oncologists for the medication. The way the base bill does it, the patients would have to come 2 days in a row because the oncologist would have to see the patient, do the blood work and all that, and, based on that, order the medications. So they would have to make two trips. The base bill would be very costly for the Medicare recipient.

This bill would allow the oncologists to stockpile, if you will, so that they can have the medications on hand, but it would charge I think it is 12 percent more, which is a standard rate, than the actual wholesale price. It is based on the sales price.

Ms. PRYCE. The Chairman explained to me that the base bill provision would allow a stockpile, and so that is why I am just concerned, and he worked with Charlie on it. I will try to clear that up in my own mind.

Mrs. CAPPS. In my discussion in Energy and Commerce, it did not do that. There has been a lot of work since that happened, and if we can improve it, we should. But that is only one of the issues that is of concern to us. The wider issue is the lack of ability to reimburse for the oncology services.

Ms. PRYCE. The practice expense.

Mrs. CAPPS. Which also need to be transparent and need to be acknowledged as part of cancer care.

Ms. PRYCE. It is my understanding it is well tended to in this bill, so thank you.

Mr. LINDER. Mr. Frost.

Mr. FROST. I support the gentlewoman's amendment on oncology and hope we have the opportunity to vote on it.

Mr. LINDER. Mr. Hastings.

Mr. HASTINGS of Washington. No questions.

Mr. LINDER. Mr. McGovern.

Mr. MCGOVERN. I support all of your amendments, and, Lois, especially the one on oncology. And I think it raises the issue I think that a lot of us are concerned about. No one really knows what has been taken care of and what has not. People on the Majority side

can't tell you definitively that this has been fixed or hasn't been fixed. That is not good enough on something like this.

Ms. PRYCE. How good would you like it to be?

Mr. MCGOVERN. I would like definitively.

Ms. PRYCE. I can tell you what the Chairman said.

Mr. MCGOVERN. And he said a lot of things in the past, quite frankly, that haven't come true.

The fact of the matter is all these things affect real people. For us to sit up here and say, well, I can assure this, or I think this might be, or this might be the case, or that might be the case, it is just not good enough. There are a lot of questions, and we are rushing this thing through here tonight. Nobody has read this thing, and tomorrow it is up on the floor. We are going to have a structured rule, limited debate, and people are not going to have an opportunity to offer different perspectives.

This is outrageous, and there is no excuse for it. We are told this is an emergency, and we have to be here under emergency situation. The Chairman of the Rules Committee, all he said when it was an emergency was that he wanted to do it. That was it. That is all we need to do to declare an emergency so we don't have 24 hours to review this bill. I mean, that is absurd. This stuff is important. And the only emergency here is they want to rush this thing to the floor before anyone reads it, and then they might not vote for it.

Here is a description of how you get your prescription drugs under the Republican plan. I don't know about the senior citizens you represent, but my senior citizens are looking for simplicity and a guaranteed benefit. They don't want thousands of bureaucrats telling them they can do this, they can't do that. They want something that is understandable. And clearly this bill that is coming through here is anything but simple. It is convoluted and doesn't provide people security, and this whole process just stinks. And I can't—I mean, here we are at 3 o'clock in the morning, and we can't answer some basic questions about what is in this bill and what is not, and it is the wrong way to do this.

Mr. PALLONE. If the gentleman would yield for a moment. I think you are very much on point. I have been listening to what the Republicans have been saying tonight in the committee, and essentially almost everyone has said that there is a real problem here with Medicare, and we have to fix it. We have to come up with all kinds of ways to change it and do different things because the assumption is that there is a huge problem with Medicare, and it is simply not true. I think seniors don't feel that there is a problem.

Ms. PRYCE. Would the gentleman yield? You don't think the imminent bankruptcy is a problem? I mean, it is a serious problem. If you want it to go bankrupt, then we do nothing, and we have done nothing. And if you don't, we have to fix it.

Mr. PALLONE. The gentlelady from Ohio, let me just say I respect you a lot, and I like you, but the bottom line is that the crisis in terms of the funding has been created by the Republicans because of their fiscal and tax policies.

Ms. PRYCE. And we can argue that until the cows come home.

Mr. MCGOVERN. I would simply say we are jeopardizing Medicare by tax cuts that were not paid for. And I am all for making

sure that we can keep Medicare alive and well, but privatizing Medicare is not the way to do it. But I support your amendments, and we are going to try to make them in order.

Mr. LINDER. Mr. Sessions.

Mr. SESSIONS. I have no questions.

Mr. LINDER. Mr. Hastings.

Mr. HASTINGS of Florida. I support all three of the very thoughtful proposals, Mrs. Capps' and our colleagues', and support the statements that Mr. McGovern said. Four o'clock, I am going to say my statement more vigorously.

Mr. LINDER. Mr. Reynolds.

Mr. REYNOLDS. No questions.

Mr. LINDER. I would like to call to the table Mr. Gutknecht and Ms. Kaptur. Welcome to the Rules Committee at the delightful hour of 3:10. Ms. Kaptur, any statement you might have will be submitted to the record.

**STATEMENT OF HON. MARCY KAPTUR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO**

Ms. KAPTUR. Thank you, Mr. Chairman, very much. I will summarize in view of the time. I thank you, and I thank Mr. Frost and all of the Members here. I know it is not your choice to be here so late. I feel sorry for all of you and feel sorry for us, and I know I am going to feel sorry for the American people after tomorrow.

But I am here tonight to try to make this bill better, from what I know of the bill, and I am heartened in my appearance this evening by Claude Pepper looking over our shoulders. I can remember as a new Member here in March of 1983 him giving one of the most magnificent speeches I have ever heard as we refinanced the Social Security System, which has now served us another 23 years, and kept millions and millions and millions of American families whole, and given their parents and grandparents dignity in their last years, and it was one of the finest votes I have ever cast.

We have a very important vote in front of us likely tomorrow, maybe Friday. I am not sure. And the amendment that I am proposing here would try to deal with the issue that Ms. Pryce talked about, and that is the cost of prescription drugs. And my amendment essentially would provide the authority to the Secretary of Health and Human Services to provide for the negotiation of prices of covered outpatient drugs under prescription plans and what are termed MAFFS prescription plans in the same manner as the Secretary of Veterans Affairs provides for the negotiation of prices of prescription drugs in conjunction with the procurement of those drugs.

Remember back after 9/11 when Secretary Thompson did such a good job of negotiating price on the procurement of immunizations for smallpox, and it was pretty tough, but he did it, and he got a better price for America. And all we are asking for here is that same type of rigor. The idea of our amendment is for getting the best competitive bid for a given drug. For example, if any of us were to go out to a pharmacy out there today and try to buy a commonly used drug for high blood pressure, I will just use one name, Norvast, it is likely we would pay about \$134.99. The Department of Veterans Affairs has negotiated a price of \$102.11 cents. That

is a \$32.88 difference, and that is not only a difference for any one of us, but for the senior citizen, who can save \$32. That is a very significant savings. In many cases, the Department of Veterans Affairs has a lot better pricing than even under the Canadian system; not always, but many, many times. The same is true with the Department of Defense.

This amendment, in sum, would essentially replace section—I want to give you the exact number here—1809(c)(1), and would add this—would add this section as a replacement.

Let me just say that if you think about our country and our free enterprise system, the idea of competitive bidding is really essential to getting the best price. That is how you really determine price in the market. And we also know that insurance plans—one of the Members was talking about, having sold insurance, if one looks at the whole concept of insurance pricing, and they could group people in order to get the best price, this is the same concept obviously in the acquisition of prescription drugs. It is the same that we do with bulk buying. Whether you are buying milk for children in schools, or whether you are buying widgets for automotive manufacturing, bulk buying makes sense.

And so we just ask the committee's indulgence to offer this amendment tomorrow or Friday, whatever the day is. And let me just say that as I speak here tonight, I can think of lots of people over my years in Congress that have come to me, but one in particular. A man came up to me in Columbus, Ohio, recently, terminated worker out of a major manufacturing company. He had big tattoos on both arms. I said, sir, are you a marine? Yeah; 58 years old, 28½ years at that company that closed its doors. But his—he was there because of his wife, whose drugs were costing \$1,800 a month, and I really couldn't help him.

And so I know the extraordinary importance of this measure that we will be debating, but I also know that with this amendment, we would get the best price, better than the market would offer by itself, because a group buying provision always saves money. So I would ask the committee's indulgence, and I would hope that you would find a way to allow this amendment to be put in order and let us debate it on the merits and find the best answer for the American people. Thank you very much.

Thanks, Claude. I love you.

Mr. LINDER. Mr. Gutknecht.

**STATEMENT OF HON. GIL GUTKNECHT, A REPRESENTATIVE  
IN CONGRESS FROM THE STATE OF MINNESOTA**

Mr. GUTKNECHT. Well, Mr. Chairman, it is late, and I will try to be brief, but the issues before us are big, and the questions that you have raised and others have raised with regard to what the ultimate cost of this provision is going to be, this bill, are serious matters, and we ought to consider them for a while.

We asked what the Congressional Budget Office estimates the costs are going to be, and it is somewhere between \$390 and \$400 billion over the next 10 years. But, Members, I would at least caution you that the Congressional Budget Office has been wrong far more often than they have been right, even in estimating their own budget. They have been off by \$1 trillion in their estimates. Now,

that is not a small amount, and my estimate is that they are off in the estimates of the cost of this bill.

The reason I say that—and I am not by any means an expert, but I have spent a good part of the last 4 years learning about the prescription drug industry and the way prices are set, and it is the most confusing thing I have ever seen. With all due respect to my colleague from Ohio, the idea that we will be able to negotiate better prices is not exactly true, and let me give you an example, and this is from the Office of Personnel Management. The prices that they are able to negotiate on behalf of the Federal Employees Health Benefit Plan, let me give you some of the prices very quickly. For a drug like Coumadin, the BlueCross BlueShield Federal Employees Plan's price is \$55.31; for the mailhandlers' plan, which is a fairly large group, is \$72.24; for the HMO plan that you can participate in here in Washington, it is \$69.58. That same drug can be bought in Europe for \$15.80. That story gets repeated again and again.

Now, in some respects I probably should be doing a victory dance because they did put a provision in here which supposedly will open up the market to Canada, but there are two, as was alluded to by Ms. Slaughter—there are poison pills that are included in that provision. Let me read them for you. The conditions are that, number one, that this pose no additional risk to the public health and safety; and, number two, that they result in a significant reduction to the cost of prescription drugs to American consumers. I am not sure what "significant" is. Is it half? And more importantly, who will determine that?

And so we have crafted an amendment on a bipartisan basis that would, first of all, put in place a regimen to require the Secretary to begin to do what the Congress has said repeatedly we want done, and that is to open up markets so Americans can have access to prescription drugs from the industrialized countries. We are not talking about Mexico or developing countries. We are only talking about the industrialized countries. I think that makes sense.

The second thing that is in the amendment that will be before you, and hope we get a chance to vote on it, is a provision from Congresswoman Emerson that is identical to the Senate language relative to generic drugs. We simply have to stop the pharmaceutical industry from gaming the system.

And the third provision, perhaps Congressman Engle can speak about in terms of getting some kind of rate of return from the enormous amount of taxpayers' dollars that we invest for research.

Mr. LINDER. Mr. Emanuel.

**STATEMENT OF HON. RAHM EMANUEL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS**

Mr. EMANUEL. Thank you very much. Good morning.

The basic point of this bill was to use market forces to reduce prices, whether that is generic versus name brand; access here in America versus the same prices that our German consumers are paying, England's consumers are paying, French, Italian, New Zealand and Israel; using that market to drive prices down.

And the third component of this is that through our NIH funding, taxpayer-based funding, we are funding, all the cancer drug

products and cancer drugs on the market are developed with taxpayer-based dollars. All the AIDS drugs are developed with taxpayer-based research.

And in the private sector usually you look for a 30 percent return on investment. We are talking about 10 percent return here for the taxpayer dollars. And that would give basically—the truth is the NIH is one of the—it would return money to the taxpayers for the research they have been funding. And basically over 10 years, the NIH becomes self-funded.

So it uses the market principles, whether it is name brand versus generic, and access here in the United States, competitive prices around Europe, and also making the NIH what it really is. And it doesn't demand prices, doesn't command prices; it uses market forces to reduce prices.

And everybody, regardless of where you live or where you are from, knows that one of the debates here is about affordability. I believe in the free market. I have seen it work, and this bill in a bipartisan fashion uses the market forces to bring prices down.

Mr. LINDER. Thank you.

Ms. KAPTUR, before you go much further in touting the value of the smallpox negotiations, I would like to inform you that the \$13 per liter of immunoglobulin that was negotiated is now \$265 per liter.

Ms. KAPTUR. Could I say, because Mr. Gutknecht commented on my proposal, I didn't comment on their proposal, if I could just respond that the operative provision of our measure is the Department of Veterans Affairs.

I referenced the Secretary's negotiation, which received very good press. I wasn't aware of that.

Mr. LINDER. This was recently.

Ms. KAPTUR. And also Mr. Gutknecht and Mr. Emanuel's bill does not have the Department of Veterans Affairs regimen on here, and I think it has good experience, and maybe Secretary Thompson could use it.

Mr. HASTINGS of Washington. No questions.

Mr. FROST. No questions.

Mr. LINDER. Mr. Sessions.

Mr. SESSIONS. No questions.

The CHAIRMAN [presiding]. Mr. McGovern.

Mr. MCGOVERN. I support your amendments, and I think they are very thoughtful, because the issue of affordability is key to many people. That is the big issue. I mean, we could talk about a benefit or a subsidy that we are going to provide to people, but if the cost of drugs go up, then what are we doing here?

So I think all of you maybe have different approaches to this, but clearly they deserve to be debated on the House floor. And again, I appreciate your thoughtfulness here.

Mr. GUTKNECHT. Mr. Chairman, if I could say this issue is not going to go away. If 1 year from now our consumers are still paying \$360 for tamoxifen, and the Europeans are buying it for \$60, it is not going to be shame on the pharmaceutical industry, it will be shame on us.

Mr. MCGOVERN. What do you think is the reluctance of the administration to embrace your proposal?

Mr. GUTKNECHT. You would have to bring them in.

The CHAIRMAN. Mr. Reynolds.

Mr. REYNOLDS. No questions.

The CHAIRMAN. Mr. Hastings.

Mr. HASTINGS of Florida. Thank you, Mr. Chairman.

You know, this bill specifically prohibits the Secretary of Health and Human Services from negotiating cheaper prices for prescription drugs, and I don't know how that helps the people Medicare is designed to serve. For the life of me, I don't. And I don't know Secretary Thompson, who happens to be the Secretary at this time. But I had the good fortune of being at the Ambassador of the United States to Italy's dinner that I was invited to by Mel and Betty Sembler, who are Republicans, and big heavy-hitters, and Tommy Thompson was there, and he made a speech that night. And he had just come from America, and he was talking about the fact that he had knocked heads with drug companies trying to get them to lower prices. So apparently this present Secretary isn't hesitant at all to undertake to do something.

And, Ms. Kaptur, perhaps you can answer it best. I support all three of your very thoughtful amendments. To prove I don't have a life, I have been up at night listening to Mr. Gutknecht talk about this in Special Orders. I know very well what it is like, but how is it going to help people that the Secretary is prohibited from negotiating?

Ms. KAPTUR. I was baffled to read that provision in the original draft that came out of the committee. I don't know if it has been removed or not, but on the thought that it has not been removed, I really don't understand, because what it essentially does it sets up an entitlement for the pharmaceutical companies to charge the highest price. There really isn't any competition in the system and—

Mr. GUTKNECHT. I agree absolutely, and I wasn't trying to undercut what Ms. Kaptur was trying to do. It is just that there is a belief among some of our people that we are going to be able to negotiate some of these great prices. My point that I am making with the Federal employees plan is we don't negotiate very good prices now relative to the rest of the world. If you are really serious about bringing prices down, you have to introduce some level of competition. It is called parallel marketing. And that is why the Europeans have cheaper prices.

Mr. HASTINGS of Florida. Do you have any comments on that?

Mr. EMANUEL. I just think that if you want to get the \$400 billion or whatever it ends up being, if the spread is 5-, you are going to get the most bang out of the buck. You bring competition. We are not only talking about adding prescription drug benefits to Medicare. One of the things we all care about is affordability. We are talking about here in our amendment to use the market forces to bring to bear, and allows people in the United States who have paid many ways for the research for these drugs to get the same prices that people in Germany, people in France, people in England, people in Italy or Israel and Canada are paying.

And using market forces to reduce prices—globalization is supposed to be a benefit. Let us make globalization work for taxpayers, government, Medicare, private sector—and a lot of businesses are

drowning by the price of their health care. Of course, that is being driven not only by the uninsured, but by the costs of medication. I have faith in the private sector, and I hope every Member has the same faith that we have in the private sector to bring down—and in the marketplace to bring down prices.

Mr. HASTINGS of Florida. The fact of the matter is that this new Medicare agency is precluded from using its marketing power.

And I want to follow up what I said about Secretary Thompson. I thought he was very forthcoming on that particular evening and was really riding high that he accomplished something. What he was talking about is that the VA directly negotiates with drug companies for prescription drugs, and Secretary Thompson negotiated with the manufacturer of the antibiotic Cipro and was able to cut prices by more than half. Now, if he can do that in that instance, I don't understand why we would pass a measure—and it just happens to be Tommy Thompson. Today it may be somebody, tomorrow or some other point in the future, that would have that authority that would allow this kind of market power to be negotiated rather than all of this talk about markets and competition. I mean, that is real power, and to take it away from the Secretary to me is beyond the pale.

The CHAIRMAN. Thank you very much, Mr. Hastings, and thanks, all of you, for being here. We appreciate your testimony.

Next I would like to call the gentleman from Texas, Dr. Burgess, and the gentleman from Georgia, Dr. Gingrey. If the two of you would come forward.

**STATEMENT OF HON. MICHAEL BURGESS, A REPRESENTATIVE  
IN CONGRESS FROM THE STATE OF TEXAS**

Mr. BURGESS. Thank you, Mr. Chairman.

We just heard some discussion about drug affordability affecting accessibility for our seniors, and I think we have got to keep first and foremost in our minds patients' safety.

I actually have two amendments that I would like to discuss this evening. The first does deal with affordability of medications. This amendment would require the General Accounting Office to conduct a study on foreign prescription drug prices to show how they impact the United States consumers. The amendment would also require the General Accounting Office to determine if and to what extent the United States Trade Representative engages in negotiations with foreign governments to facilitate the elimination of price controls under the Trade Promotion Authority Act of 2002.

With the approval of a multibillion-dollar Medicare entitlement that will increase the utilization of prescription drugs, it will be important that our government is able to implement market-based solutions to hold down the cost and to ensure patient safety. In order to do so, policymakers must have important information as to the extent of foreign price controls that impact the United States consumer market. To complement this data, the study authorized by this amendment would also look into the United States Trade Representative efforts in eliminating anti-free-market regulations as part of free trade negotiations under the Trade Promotion Authority Act of 2002.

And let me just add, never in my wildest dreams did I ever think that I would be up here on the side of the FDA, but after hearing the other comments coming from the individuals, it is clear to me that we need data in order to make these decisions, and with all respect to the gentleman from Minnesota, who has done his own data collection, I believe we need data collection done for this body and not as independent practitioners. We have an incredible record of safety in this country that I do not believe we should sacrifice. We do not want drugs for our seniors at any price. I think we do need to ascertain where the interference with the free market has occurred, and to the extent with other governments that have engaged in predatory practices, I believe that should be corrected.

The second amendment that I have is largely technical in nature and deals with section 409 of the—of at least the bill that I saw from the Ways and Means Committee from last week. And this amendment, the current bill would allow a nurse practitioner to act as an attending physician, perhaps contrary to state medical licensing regulations, to provide Medicare and hospice care. This amendment would not prohibit a nurse practitioner from providing care as an attending physician, but would allow them to do so in accordance with State practice guidelines and under the supervision of a physician.

A physician is responsible for managing the health care of patients in all practice settings. Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license as defined by State law. In an integrated practice with the nurse practitioner, the physician is responsible for supervising and coordinating care with the appropriate input of a nurse practitioner, ensuring the quality of care provided to patients.

And I understand that it was felt that the language that was contained in the original bill did not actually give the nurse practitioner the amount of authority that I assume that it did. I would ask that this technical amendment be made to clarify this issue so it will be clear and unambiguous for those coming after us.

The CHAIRMAN. Dr. Gingrey.

**STATEMENT OF HON. PHIL GINGREY, A REPRESENTATIVE IN  
CONGRESS FROM THE STATE OF GEORGIA**

Mr. GINGREY. Thank you, Mr. Chairman and members of the Rules Committee.

My amendment is—first amendment is in title 5 regarding the funding of the hospitals, and this has to do with the market-basket issue. The Hospital Market-Basket Index is a measure of inflation in the price of items and services hospitals must purchase in order to provide care. Like similar measures, such as Consumer Price Index or Producer Price Index, a hospital market-basket index measures changes in price, not changes in volume. If, for example, hospitals use more drugs to keep up with increased patient need, the corresponding increase with hospital drug costs would not be captured by the Hospital Market-Basket Index. Only changes in the base price of drugs would be reflected. The increased use of drugs not reflected in the Hospital Market-Based Index would have

to be included in the science and technology or other components of the update framework.

Market basket reductions. The House bill contains approximately \$22 billion for target payments for hospitals. However, \$12 billion in savings from the hospital market basket reductions, the minus .4, brings the total net benefit of the hospitals to about \$10 billion. The Senate bill contains \$22 billion in hospital relief and no reductions. Under the Senate bill hospitals will receive the full market basket for the foreseeable future. If the House passes legislation including payment reductions, that vote could bring down the value of a hospital provision in conference.

The new prescription drug benefit will keep beneficiaries out of the health care system and thus create an overall systemwide cost savings; however, as volume decreases, economic trends indicate that first service costs will increase. Therefore, Congress should not preemptively reduce payments to providers at the same time when costs are likely to increase. Providers in general should be allowed inflationary adjustments to keep pace with overall rising costs of health care. We should not reduce provider payments to pay for prescription drugs even before the bill is enacted. Again, the Senate has not had to resort to this.

Medicare is the largest health care program, making up almost 50 percent of all hospital payments. Mr. Chairman, in my district, this provision would cause my hospitals to lose \$2 million. If this amendment is accepted, we gain about \$14 million, this bill, this \$400 billion prescription bill that we are going to provide for our seniors, and I think that is a wonderful thing. And I think that in the final analysis that this \$400 billion cost estimate will save us money, because I think basically what is going to happen is that when people have an opportunity to take needed prescription medications for blood pressure or diabetes or whatever, you are going to have less expenditures on hospital care. You are going to have less hospital admissions, fewer hospital admissions, shorter lengths of stay, hopefully, because you are going to reduce the number of heart attacks and stroke. You are going to have less admissions to skilled nursing homes and extended periods of stay.

Basically what this provision is going to do, it is going to create a benefit for our seniors that they never had before, and I think that is great, but it is going to cut down on the volume that hospitals are seeing today. It is just like if you cut down on the number of admissions to a hotel chain and the length of stay there, it is going to cost them a lot of money. I think from the standpoint of hospitals, they are going to have to take that hit. But also at the same time reduce this market basket below 100 percent is hitting them with a double whammy, and I don't think it is right, and they can't afford that, and I know the hospitals can't afford it.

The CHAIRMAN. Thanks to both of you.

Mr. Linder.

Mr. LINDER. I would like to ask unanimous consent to submit the statement of Dr. Weldon, a physician in the House, who has an amendment.

The CHAIRMAN. Without objection, Dr. Weldon's statement will appear in the record.

[The prepared statement of Mr. Weldon follows:]

PREPARED STATEMENT OF HON. DAVE WELDON, A REPRESENTATIVE IN CONGRESS  
FROM THE STATE OF FLORIDA

Mr. Chairman, I, along with my colleagues Rep. Sessions (TX), Rep. Fletcher, M.D. (KY), Rep. Burgess, M.D. (TX), Rep. Gingrey, M.D. (GA) who have joined me in offering this amendment, strongly urge the Rules Committee to either strike Section 942(d) from the Medicare bills reported out by the Ways & Means and Energy & Commerce Committees or allow me to offer an amendment to strike this provision from the bill when it is brought before the House for consideration. We know what an onerous burden this would mean to every physician involved in private practice across this country.

Mr. Chairman, my amendment (numbered WELDON.001) strikes section 942(d) of the bill. Section 942(d) would allow the Secretary of HHS to bypass the requirement that the Secretary receive a report from the National Committee on Vital Health Statistics (NCVHS) prior to considering whether to adopt a new, untested coding/billing system (ICD-10) for physicians. The amendment would simply allow the NCVHS to report, so that the Secretary has the full information prior to making a decision regarding ICD-10.

In 2002, the House of Representatives passed legislation to provide physicians and other providers with regulatory relief by a vote of 409-0. Just before marking-up a similar bill this year—H.R. 810, “Medicare Regulatory and Contractor Reform Act of 2003”, a new provision was slipped in concerning the coding system ICD-10 (International Classification of Diseases, 10th Revision). This provision would allow the Secretary of HHS to adopt ICD-10 without receiving a recommendation from the National Committee on Vital Health Statistics (NCVHS).

Now this problematic provision has been inserted into the prescription drug legislation, H.R. 2457/2473, “Medicare Prescription Drug Modernization Act of 2003.” This language is so onerous that it has divided the coalition which once strongly supported the regulatory relief legislation, H.R. 810. Though slightly different, both the Ways and Means version and the Energy and Commerce version of section 942(d) present substantial problems for virtually all physicians, providers, and payers (private, state, and federal).

ICD-10 Provisions Increase the Regulatory Burden on Health Care Providers—Section 942(d) undercuts one of the underlying purposes of Medicare modernization by increasing the regulatory burden that the Centers for Medicare and Medicaid Services (CMS) imposes on physicians and other providers. In part, the regulatory relief legislation was intended to reduce the unnecessary burdens associated with the Medicare program—not exacerbate them.

The ICD-10 provision would dramatically increase the administrative hassles associated with coding for physicians, providers, contractors, payors, and the federal government. Every physician will be forced to master 170,000 new procedure codes and a foreign vocabulary.

Rushing to ICD-10 is a Government Takeover of a Private Sector Process—Rushing swiftly to ICD-10 amounts to a government takeover of a now private process. CPT, the coding system all physicians now use, is developed and maintained by private sector experts and a representative from CMS. Led by the American Medical Association (AMA), CPT is managed by a multi-specialty, cross-disciplinary editorial panel that provides CPT at no cost to the federal government.

The challenge of moving to ICD-10 in lieu of CPT will require significant government efforts to develop and maintain the code set itself, replacing a successful private sector partnership that costs the government nothing.

The Cost of Moving to ICD-10 Could Be Significant to Government and Private Sector—A Coopers and Lybrand 1989 cost analysis of the costs for a newly developed code set and its implementation in 1997 dollars approached one billion dollars. CBO did not score section 942(d), because the Secretary “may” implement ICD-10.

The direct and indirect costs of implementing ICD-10 should not be underestimated. It is vastly different in terms of design, intent, structure, and maintenance. Setting up this structure will require significant investments to convert existing software or acquire new hardware to complete billing and medical records, including training and hiring more sophisticated staff coders. Not unlike the ripple effects of new HIPPA regulations, the complete reorganization of a physician’s office to comply with this rule would be required.

ICD-10 Was Not Designed for Physician Office Use In Mind—ICD-10 is an entirely new system to impose on American medicine and would come at great expense to the private sector and the government. The current ICD-10 system has no billing codes for physician office visits, which account for 30% of physician services. The language would impose a new lexicon on physicians, because it does not conform to traditionally named body systems and instead adopts clinically meaningless distinc-

tions. Currently named and used medical procedures (i.e., Whipple procedure) will instead be replaced with a host of different codes based on clinically meaningless distinctions, making the practice of medicine and billing a new, unfamiliar bureaucratic nightmare. While some countries partially use ICD-10 diagnostic codes, no country uses the ICD-10 PCS codes that Section 942(d) would allow to be imposed on physicians.

ICD-10 Language Unnecessarily Circumvents an Advisory Body Doing Its Job—Section 942(d) allows the Secretary of HHS to adopt ICD-10 before receiving a recommendation from its own advisory body. The NCVHS, the statutory public advisory body that provides HHS with recommendations on health data, statistics and national health information, is currently considering adoption of ICD-10 as a replacement for ICD-9.

Before making a decision, NCVHS is awaiting the results of a RAND study measuring the cost and impact of implementing ICD-10 on the inpatient hospital environment. The study will be completed in August 2003. A recommendation based on the results of that study is expected by the end of this year. Therefore, rushing action by including the ICD-10 language in the Medicare prescription drug legislation is completely unnecessary.

The Transition to ICD-10 Would Disrupt Payments—The transition would likely require a system-wide disruption to revise all resource-based relative value scale (RBRVS) units used in reimbursement methodology, another cost to the government, which will also delay physician payments.

RBRVS has annual government expenditures of over \$59 billion per year and is tied inextricably to the coding system for Part B services. Moving from a coding system of fewer than 10,000 codes for physician services to a coding system of more than 170,000 codes would result in a massive upheaval in payments to physicians and other Part B providers. Further, the potential for inaccurate coding would increase exponentially. With a seventeen-fold increase in the number of codes, more inaccurate payments would occur which, in turn, could increase fraud and abuse concerns.

Finally, I would commend to you the attached list of medical specialty organizations representing tens of thousands of physicians across this nation, who are supporting our efforts to have this provision removed from the bill.

Let's removed this onerous provision and allow NCVHS to complete the report that they were asked to do. Let's not thwart the process by rejecting the successful government-private sector partnership that has worked so well. Let us protect the federal government and the private sector from potentially huge costs, and prevent a serious disruption in payments to healthcare providers by striking section 942(d), the ICD-10 Language.

[The information follows:]

## American Medical Association

Physicians dedicated to the health of America



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June 25, 2003

The Honorable J. Dennis Hastert  
Speaker  
United States House of Representatives  
235 Cannon House Office Building  
Washington, DC 20515

Dear Mr. Speaker:

The medical organizations listed below wish to register our strong objections to including any provision within H.R. 1, the "Medicare Prescription Drug and Modernization Act of 2003," that could generate a new regulatory requirement that physicians use the ICD-10-PCS coding system to report their services.

Title IX of the Act is intended to reduce regulatory burdens for physicians and others providing health care to senior and disabled patients covered by Medicare. A switch to ICD-10-PCS, however, would dramatically increase administrative costs and burdens for medical practices, the federal government, and state Medicaid programs, as every physician and payer would have to convert to ICD-10-PCS.

In addition, as physician payment schedules are grounded in the coding system, all the payment schedules would need to be reconstructed. The most significant of these, the relative value scale used by Medicare, involves payments to physicians and other health professionals of more than \$60 billion annually. Besides the significant costs of making the switch, adoption of ICD-10-PCS with its nearly 200,000 codes is likely to greatly magnify the error rate for Medicare and Medicaid coding and billing.

The National Committee on Vital and Health Statistics (NCVHS) has deferred making any recommendations to Secretary Thompson on conversion to ICD-10 until it concludes an assessment and cost/benefit analysis of how such a migration would affect all elements of the health care industry. This assessment is scheduled for completion in a few months. Congressional interference with the ongoing work of the NCVHS on this matter is not justified, therefore, as the committee has made steady progress and its Subcommittee on Standards and Security discussed the ICD-10 impact analysis as recently as last month.

Further, NCVHS' caution in making recommendations to the Secretary is well-advised. The impact of ICD-10 is completely unknown and untested, whereas the current coding system for physician and health professional services has been working for decades. It is maintained entirely by the private sector, with input from major payers, including the federal government, and organizations representing physicians, health professionals, and technology manufacturers. In contrast, the ICD coding systems currently in use have been maintained by the federal government at taxpayer expense with scarce opportunity for meaningful public input.

The undersigned medical organizations urge Congress to stay the course and allow NCVHS to continue its evaluation so that it can report to the Secretary based on complete information. Physicians need the regulatory reforms in Title IX, not the new regulatory burden of ICD-10-PCS.

Sincerely,

American Academy of Child and Adolescent Psychiatry  
American Academy of Facial, Plastic and Reconstructive Surgery  
American Academy of Family Physicians  
American Academy of Otolaryngology-Head and Neck Surgery  
American Academy of Physical Medicine and Rehabilitation  
American Association of Clinical Endocrinologists  
American Association for Vascular Surgery  
American Association of Clinical Urologists  
American Association of Neurological Surgeons  
American College of Chest Physicians  
American College of Emergency Physicians  
American College of Obstetricians and Gynecologists  
American College of Occupational and Environmental Medicine  
American College of Osteopathic Family Physicians  
American College of Osteopathic Surgeons  
American College of Physicians  
American College of Radiology  
American College of Rheumatology  
American College of Surgeons  
American Medical Association  
American Medical Directors Association  
American Osteopathic Academy of Orthopedics  
American Osteopathic Association  
American Society of Anesthesiologists  
American Society of Plastic Surgeons  
American Thoracic Society  
American Urological Association  
College of American Pathologists  
Congress of Neurological Surgeons  
Infectious Diseases Society of America  
Medical Group Management Association  
National Association for Medical Direction of Respiratory Care  
Renal Physicians Association  
Society for Vascular Surgery  
Society of Critical Care Medicine  
Society of General Internal Medicine  
Society of Hospital Medicine  
Society of Interventional Radiology

The CHAIRMAN. Mr. Frost.

Mr. FROST. I would like to welcome my colleague from Texas. He is a very instructive new Member of this body, and he brings a lot of expertise and enthusiasm.

The CHAIRMAN. Ms. Pryce.

Ms. PRYCE. Thank the gentlemen.

Very thoughtful provisions. We have been working with the hospital association, and we have improved the association from where it began, and I understand my district is even worse than yours, way worse than yours. So I understand where you are coming from.

The CHAIRMAN. Mr. McGovern.

Mr. MCGOVERN. I want to thank both Dr. Gingrey and Dr. Burgess for their testimony. I am not sure if I will vote up or down on the floor, but I support your right to offer them.

Dr. Burgess, maybe I am not quite reading correctly, but your GAO study, your first amendment you are talking about, it almost sounds as if you are kind of trying to figure out a way to get Europeans and the Canadians to raise their drug prices so that our prices don't sound so bad.

Mr. BURGESS. I believe they should pay their fair share. I believe that that cost should be distributed equally across all populations that are enjoying the benefits of pharmaceutical advances that we have made in this country. I think it is outrageous that we ask our poor and our uninsured and our Medicaid seniors to pay the highest cost for prices, thereby subsidizing drug purchases in other countries. It is a scandal.

Mr. MCGOVERN. I agree with you it is a scandal. We are gouging our own people, but I think there has to be a way to make sure it is affordable for people in this country and other people as well.

Mr. BURGESS. With all due respect, I honestly don't care what drug prices are in Canada. Canada has a system that is largely dependent upon the largesse of the United States. They would not have a medical care system if it were not for us, and the fact that we are subsidizing their citizens' pharmaceutical purchases, I can't understand why we allow that to continue.

Mr. MCGOVERN. I agree with your frustration in the sense that we don't seem to care much about our own people here and allow the gouging to go on here, and these pharmaceutical companies get away charging huge amounts. So I was trying to follow what the point was, but you have explained. Thank you.

The CHAIRMAN. Mr. Diaz-Balart.

Mr. DIAZ-BALART. I thank both of you.

The CHAIRMAN. Mr. Hastings.

Mr. HASTINGS of Florida. Mr. Chairman, this is a good example of having expertise from persons that have been on the firing line while a whole lot of people that had—a lot of people who had responsibility putting this bill together wouldn't have a clue about what Dr. Burgess and what Dr. Gingrey have talked about; might have gone to visit somebody in the hospital, but don't know anything about what they do. I think we should listen to Members who have expertise and have been on the firing line like both these gentlemen. I admire them for coming forward in a forthright manner. How in the world could we not make in order an amendment that does what Dr. Burgess requests? And all of us—although Dr.

Gingrey didn't say so, but all of us have hospitals in very similar situations to what he is talking about, and if there is to be a benefit, then I would hope that all of us would want to make his amendment in order.

So I support them and would make that request that we at the very least give them an opportunity to have it voted up or down.

The CHAIRMAN. Thank you very much, Mr. Hastings.

Mr. Hastings.

Mr. HASTINGS of Washington. No questions.

The CHAIRMAN. Mr. Sessions.

Mr. SESSIONS. Thank you so much for being here.

Dr. Gingrey, I think—well, I know that I hope that your words of encouragement about the future that you have about the success of the prescription drug industry to keep people out of the hospital will come true. I believe that more of our seniors should have an opportunity to participate long term with these drugs. The bottom line is that there will be fewer people then, hopefully, going to the hospital, which would be a lessening demand upon us and our system to build hospitals.

In Dallas, Texas, where I am from, we are virtually at full capacity, and we have problems with getting enough nurses, and it is just a huge stress on the system. So I share your enthusiasm for this drug plan, robust plan, that will now make this available. And I hope that your professional insight, Dr. Burgess, and your comfort with what we are looking at will mature and come forward. And I thank you for being here. I support what you are talking about also.

Mr. GINGREY. I appreciate that, Mr. Sessions, and I think that is exactly what is going to happen. I truly believe that this prescription drug benefit to our seniors, which they needed for a long time, the success of that program is going to result—you know, somebody gains, somebody loses. Hospitals are definitely going to lose, and that is good. That means that fewer people are going to have to be admitted to hospital with very expensive care, long-term care. Same thing with nursing homes. Same thing with surgical procedures. A lot of my surgeon colleagues are, hopefully, going to be doing less open heart procedures. I know well about that because our seniors are going to be on medication to lower cholesterol, to thin their blood, to do things to keep them out of those hospitals and those expensive procedures. And bottom line is that is going to cost the hospitals a lot of money, and that is why I feel like cutting that market-basket index to minus .4 percent is half the double whammy.

And as Mr. Hastings says, it is not just the 11th District of Georgia, it is everybody's district. And, unfortunately, not all hospitals in our district are disproportionate share hospitals. But that is just a very small percentage of these small community hospitals that are not disproportionate shares. So I think it is very important we consider this amendment.

Mr. BURGESS. Could I just add to Mr. Sessions' comments? When I trained at Parkland Hospital in 1970, breast cancer was entirely a surgical illness. In the year 2003, it is becoming more and more a medical illness treated with medications, not surgery. The hospitalization part will no longer be necessary.

Mr. FROST. If the gentleman would yield, that is why I believe in Ms. Kaptur's proposal. Oncology is very important. I had a personal experience in my family with this recently, and the follow-up treatment, the follow-up chemotherapy treatment administered by oncologists is really remarkable in terms of the progress that has been made.

Mr. SESSIONS. And that is an exact reason, as Mr. Frost knows that cancer strikes many of our families, and the inclusion of that in what we are doing—I guess I say it is not only just money, but it is also the heart and soul of this country because we care about this. And I think that our kindness is to take care of people who at times don't have the ability to get the most leading-edge drugs.

So I am just real proud of it, and I share your enthusiasm for what the future is.

Mr. FROST. It is money in terms of oncology because it is very expensive, and it is very important, and it does save a lot of lives.

Mr. BURGESS. If we are not careful what we do on that particular issue, we will drive that therapy from the physician's office back into the hospital, which is more expensive, and I don't believe that is the intent of the bill.

Mr. SESSIONS. If the outpatient clinic, so to speak, does not get it either through efficiency or through the ability to perform this, we will drive people back into the hospital and have to have more people in the hospital and build more hospitals, and I think we will have a reverse.

I thank the gentleman and Mr. Frost for your feedback, and I yield back.

The CHAIRMAN. Mr. Reynolds.

Mr. REYNOLDS. No questions.

The CHAIRMAN. Thank you very much.

Mr. GINGREY. Mr. Chairman, I am a cosponsor on the Weldon amendment. Can I speak to that?

The CHAIRMAN. His statement has been submitted for the record, and if you have a statement that you would like to submit as well, we would certainly welcome it.

Mr. GINGREY. Could I make a statement?

The amendment that Dr. Weldon is presenting is in regard to the ICD 10 codeine provision that is in the mark. And I just want to say this: The physicians are faced with a tremendous burden with recordkeeping and, of course, HIPPA regulations now that we have got a final ruling on that. And as part of this provision, to put an additional burden on them with immediately going to this ICD 10 change, I mean, I think—we got a study that we are waiting on in the next couple of months. I don't think it is necessary to make that change right now. Our providers are worried about waste, fraud and abuse and trying to comply, and mistakes are made, and it is just a very costly burden on them, and I would respectfully ask the committee to remove that from the bill and let us wait for another day to do that. And let us wait for the study to come back.

The CHAIRMAN. Thank you very much, and appreciate you both being here.

Next I would like to call Messrs. Cooper, Dooley, Larson and Sanders.

Mr. Dooley.

**STATEMENT OF HON. CALVIN DOOLEY, A REPRESENTATIVE IN  
CONGRESS FROM THE STATE OF CALIFORNIA**

Mr. DOOLEY. Thank you, Mr. Chairman.

As we are rapidly approaching sunrise, we almost have the opportunity to have our amendment in the nature of a substitute considered in the light of day.

Mr. FROST. But not quite.

Mr. DOOLEY. Many of us have been working on a substitute that actually has bipartisan support, which we would ask you to be allowed to be considered on the floor. What the substitute does is that we take the \$400 billion that the President has said that he would allow for a prescription drug benefit—it was also in the budget that passed the Republican House—and put that in Medicare Part B, which then we would offer a zero premium benefit that would incorporate a prescription drug card, much of what President Bush has offered, that would provide a high-cost benefit for all seniors under Medicare when they have \$4,000 in drug costs.

We also recognize that a lot of our seniors do not have the ability to pay—or to pay for their \$4,000 in drug costs before this high-cost benefit kicks in, so we provide a low-cost benefit for people on low income, which provides a 90/10 benefit up to 150 percent of poverty. And then we also allow in those States that will match contributions at the SCHIP rate, which varies from anywhere from a 65 to 35 split to an 80/20 split, a benefit of up to 200 percent of poverty. Up to 200 percent of poverty we cover almost 50 percent of all the seniors on Medicare today.

So this is a plan that is very simple, and it is a plan that would allocate our scarce Federal resources to those seniors with the greatest need, and those are the seniors with very high drug costs and those seniors with the least ability to pay. It also eliminates some of the inherent problems that are part of the Chairman's bill that will be considered on the floor, and one of those is just the structure of the bill that is going to be offered, and that is that the insurance—using a private insurance model, which we have many analysts from Wall Street who have recently said they have serious doubts whether anyone in the private insurance sector will offer this model, whether anything will be available. We think that is a gamble to go down that path. And also, when we set up as an insurance policy, recognize that it might not be something that they are going to be excited about, so we set up a separate system in the bill that would actually allow for the Federal Government to buy down the underwriting risk.

Mr. DOOLEY. Well, we are sending a message to any insurance company out there under the chairman's mark, that if you withhold from the market, is that the Federal Government will come in and assume a greater portion of your risk. And, you know, this is something that we think is a serious, serious flaw.

The other issue which I think that we have to be very concerned with, is we alleviate in our bill, because we use total drug cost to trigger your catastrophic benefit, versus the chairman's bill, which uses basically out of pocket, which will inevitably lead to private sector employers leaving the system and no longer providing that prescription drug benefit.

CBO says that that can be as high as 32 percent. The response by Nancy Johnson today was, no, we are going to overcome that 32 percent withdrawal of the private sector from this prescription drug benefit by subsidizing the private sector companies.

Well, so what we are doing here is we are basically using taxpayer monies to subsidize private sector companies to try to keep them in, to provide a benefit, which we think they should be doing on their own. Again, I think this is a very convoluted approach. And why would we be designing a prescription drug benefit that would sacrifice private sector dollars for taxpayer dollars and provide a prescription drug benefit?

And my last point that I will make before I turn to Mr. Cooper, goes to the point that Mr. Sessions made time and time again, is that another benefit of our bill is when you integrate the drug benefit into Medicare Part B, you are ensuring that you are not going to have a degree of adverse selection that you are going to have on the stand-alone insurance-only proposal.

Because, when you acknowledge that we have some tremendous advantage in drugs, which I acknowledge and I am very supportive of, is that those drugs may be very expensive. But if it is a stand-alone drug policy, that premium could quite likely escalate, because of costs of those drugs, and yet you get no consideration of the savings in your inpatient and your outpatient that might be generated.

And we have a structural flaw in the underlying bill that our measure overcomes because of the integration into the Medicare Part B. And that is why I think we ought to allow this bill to be considered as a substitute on the floor.

The CHAIRMAN. Thank you very much.

Mr. Cooper.

Mr. COOPER. I just want to support Cal Dooley's bill. And having lived through Clinton health reform, and catastrophic health reform, as I think only one or two members of this committee have also done, I think it is very important that we learn those lessons.

Doc Hastings mentioned earlier that those who do not learn from the lessons of history are doomed to repeat them. I know no one on this panel and no one in this Congress wants to repeat those lessons. I fear that we are dangerously close.

For example, the Clinton health plan was not bipartisan. Nor is the bill we are likely to put on the floor—there might be a sprinkling, but this is not a genuine bipartisan bill. The Clinton bill was way too complicated. Our colleagues on the other side of the aisle made great hay by showing us postcards and stuff like that.

This bill is also very hard to diagram, even if you use fine print. But there is another clincher, which is asking seniors to pay even amounts like \$35 a month, when they can't see a clear benefit. When they can see for example, the first half of the donut is really only in the bill, to overcome the terrific adverse selection problem that is set up.

So within the same CBO budget scores, in fact less \$367 billion Dooley and his team have come up with a bill that is beautiful and simplistic, fair to seniors, and remarkably efficient in the way it spends taxpayer dollars.

I think I have been as bipartisan as anybody in this Congress on health care issues in particular. And I could have supported pretty

much any bill. But I wanted to find the best one. And Cal has got the best one. So I hope this committee has the courage to let the House vote its will on a measure like this, to let the American people see what you can do within the same budget window. It is a bill that seniors are going to prefer dramatically over what you are considering, and I think this House should have a chance to work its will.

Read the Washington Post editorial. I am not the biggest fan of the Post in the world. They are not the only folks who supported this bill. But now it is yesterday's paper, this hearing has gone on so long. That will show you at least some objective observers, looking at the debate right now. And I mean, they have a chance to pick out a bill that makes sense, and they are picking the Dooley bill.

So give it a chance. There are a couple of technical things we can get into. Some people shy away from the \$4,000 number. That is total drug costs, that is not out of pocket.

75 percent of seniors already have some sort of drug help already. It probably means for most seniors in terms of out-of-pocket expenditures, 2- or \$3,000 they are going to be able to benefit from this bill, plus the 200 percent poverty provision. It is really a remarkably efficient use of government dollars.

So I urge to you make it in order, as a substitute.

The CHAIRMAN. Thank you very much, Mr. Cooper. Let's go to Mr. Larson and then Mr. Sanders.

Mr. LARSON. Thank you very much, Mr. Chairman, Mr. Frost, and members of the committee. First just an observation. I have been in Congress for 5 years. I agree with much that has been said by the members of this committee earlier this evening, that this is perhaps the most important piece of legislation that we are going to vote on.

And so it is with a profound and deep sense of respect that all of us take this issue so seriously. For 5 years—I have been in Congress for 5 years, I have gone back to my district and spoken to seniors. I can't tell you how difficult it is to tell them that this is a piece of legislation that will take effect 3 years from now. That is extraordinarily disheartening. But even more so, is the fact, and the reason that I am here, and I respect all of the commitments that you have.

But, the reason that I am here at this hour is because I know realistically I am not going to get a chance in this Congress to speak on an issue that I care so deeply about, and have been addressing the citizens of my district for the past 5 years. That is the reality.

That is why I am hopeful, though I am a realist, that so much of this debate that we have heard in this committee this evening for those of us that aren't on Commerce or Energy or Ways and Means, we care and feel as strongly about senior citizens as you do here on the Rules Committee for them.

And as a person who cares deeply about this institution, what is hurt here the most, aside from seniors from my perspective, is the institution. And the other body, as Mr. McGovern has seen fit to have far longer debate, I understand the realities of what we have to deal with here in the committee.

But do I think with so many intelligent and thoughtful proposals they ought to be made in order so that we can debate them? Very simply, I would also like to compliment a dear friend and colleague, Nancy Johnson. I think that her energy, her temerity, her conscientious manner in which she has approached this issue, certainly her good intentions have always been there.

I disagree with the approach and associate myself with the comments that Mr. Dooley made in terms of this whole issue of subsidies that the doctors also addressed. I say it from a sense of conviction, that as I know all members on the Rules Committee, and here that come before this body do, I come from Hartford, the insurance capital of the world. I know a little bit about actuarial assumptions. I know a little bit about adverse selection.

I know a little bit about the reality of making a profit important to any business, and the scarcity of a chance that that has under this proposal. And how do we, for God's sake, go back and explain that to our seniors? In the meantime, what we are doing, as the doctors have said, are forcing them to subsidize not only the private plans, the ones that the Federal employees have, but the rest of the free world.

My proposal is very straightforward. And I say this with respect to all plans. Cost is the issue. If you don't go in and have the full faith and credit and leverage of the Federal Government, and all of its agencies, and whether it is the VA or whether it is the DOD or whether it is HHS, without that leverage, there can be no cost control. Because, the program just is unfeasible in terms of its profitability for people to underwrite in an affordable manner.

Ronald Reagan said: Facts are a stubborn thing. This is a stubborn, stubborn, thorny issue. But by telling people that it will take place in 2006 and bursting another bubble in front of the seniors, while they continue to subsidize the rest of the world, is a wrong-headed approach. That is why I offer this amendment and I thank you.

The CHAIRMAN. Thank you.

Mr. Sanders, thank you for being here. I know you are here on a different amendment.

Mr. SANDERS. I don't usually get to work this early. I think that the evidence is clear, and all due respect, that the proposals that you are offering is a weak proposal in terms of methods. The reality is that if I am a senior citizen, and I spend \$1,000, or I have \$1,000 worth of prescription drug needs, I am going to end up paying \$807 out of my own pocket. It is very hard for you to go back in your district and say to your constituents that this a serious proposal. We pay 17 percent, 13 percent I am sorry. And I pay 87 percent. That is a weak proposal. It doesn't get much better as we spend \$5,000.

Now, why is it a weak proposal? Are you mean guys? No, I don't think that. It is a weak proposal because you don't have cost containment in your proposition. And if the government is going to pay the highest prices in the world for prescription drugs, and you want to only spend \$400 billion you ain't going to get much. That is the reality. So your proposal is flawed significantly because you are not standing up to the pharmaceutical industry, and are you

continuing to pay the highest prices in the world for prescription drugs.

And the bottom line is, and I think we should be honest, and let me put this on the record. The pharmaceutical industry is the most powerful industry in the world. They are spending \$150 million this year, just the industry, not to mention the separate companies, to make sure we do not lower prices. In the last few years they have spent hundreds of millions of dollars and they are succeeding. We should be honest about that.

Now, what should we be doing? What should we be doing? Well, it seems to me, and I was—I have to tell you the very first Member of the United States Congress to go across the Canadian border. I did that 4 years ago. And people who were with me, women bought Tamoxifen, the breast cancer drug, for one-tenth of the price. And let me tell you, let's not demagogue the Canadian Government. They are doing the right thing. They are doing the right thing by negotiating with the drug companies. Their prices are not the lowest in the world, as you know, in Europe they are lower. Every other country in the world's government is standing up to the industry except ours.

When people come before you and say the problem is the rest of the world, not us, I think we have got it backwards. It is us, not the rest of the world. They are doing the right thing, we are doing the wrong thing. So what should we do? I have two amendments. The first one is a very comprehensive amendment, and interestingly enough, you have heard components of it all evening long. If we are going to talk about cost containment, let's do three things then I will tell you what you get.

First of all, I am not going to spend any more money than you are. I am going to spend 400 billion. You are spending 400 billion. This is what I get compared to what you get. I get premiums of \$24. I get no deductible. I get an 80/20, and I get catastrophic coverage at \$2,000.

And I have very strong protections for senior citizens, stronger than yours. And I don't spend any more money than you do. Now how do I do that? Am I a magician? No. It is because I have cost containment, you don't. What is my cost containment? Well, interestingly you have heard it all evening. I combine what everybody else has talked about, reimportation.

The argument that you cannot bring in safe prescription drugs from Canada is a total fraud. There is 1 million people who are doing it. Do you know how many of them have been sick or died? Anyone here know? The answer is zero. We had the FDA before our committee. The Canadian Regulatory System is exactly similar to us. We had a CRS report done on that.

You have free trade—you, Dave, are a free trader aren't you, right? You get on the floor of the House, you say how great free trade is.

I don't often agree with you. But if you have free trade in pork bellies coming over the Canadian border, if you get lettuce and tomatoes from Mexico from God knows where, why does anyone here think that you cannot bring in regulated safe prescription drugs from Canada, a system which has a strong regulatory system, the same as ours.

Nobody with a straight face can make that argument.

So that is number 1. You do reimportation. Number 2, we do what a number of people have talked about. You do exactly what the Veterans Administration is doing. You use the clout of the Federal Government to negotiate the strong price. And the third thing you do, which we have also heard earlier, we are spending billions and billions of dollars to go to the NIH that are used for research. If we are doing that, then the companies cannot just charge outrageous prices. It is called reasonable pricing. The taxpayers paid for the development of the product, they should get a break on that. I think that is common sense.

You add those things together, you know what, you have lowered the cost of prescription drugs for senior citizens, for the government, for the taxpayer. And that is why I can do far more than you can do, and spend the same amount of money that you can, because I am getting the product a lot cheaper. That is what I am doing.

And, I have to tell you, the pharmaceutical industry doesn't contribute very much to me. I have got to be honest about that. They don't. But that is the issue. The issue is that we have the guts to stand up to the industry. That is my first amendment. That is the major one, that I would ask you to put in order.

The second one is a more simple one. If you don't want to go that far, then do what you played a game with doing. Earlier we had the first people from the Commerce Committee talk about reimportation, go through the whole reimportation, but then buried away in there is this little section called the Cochran amendment. It says it has to be approved, the Secretary of HHS has got to say that it is safe and can save money.

The Secretary has already told us publicly he isn't going to do it. So all of that language, and you shouldn't play a game. If you don't believe in reimportation, don't put it in. Gutknecht was right. We should do those things. Like putting it in, but you are not really serious about it.

My second amendment would simply say, limit it to Canada, because of the same regulatory system that we do, and not have the Secretary have to get the approval. So it is a reimportation bill. You do that, and you lower prescription drug prices in the country by 30 or 40 percent.

I will bet you, I will get a better benefit just by doing that without one nickel of taxpayers dollars than you get. People from Vermont, they get in the car and go across the border. They will save more money just going across the border than you will in your bill, and it doesn't cost \$400 billion and it won't cost a penny.

So those are the two options, be bold, do the whole thing or just take the Canadian piece. You will be far better off than what you have got.

The CHAIRMAN. Thank you.

Mr. SANDERS. I thank you for your support, Mr. Chairman. I know it will be there.

Mr. LINDER. Thank you.

Mr. FROST. You know, I am struck by a couple of ironies now that we are winding down here. The first irony, Mr. Dooley, I think you are probably aware of this, that your proposal is basically what

the President was for originally. I remember, you know thinking about it, because I remember when he put it in a State of the Union, or somewhere, thinking that, well, it is an interesting proposal. I am not personally for it.

But, I am pretty sure that your proposal is very similar to what the President originally proposed, which was to take care of people at the bottom by a system of subsidies and to have catastrophic at the top. Interesting that you wound up the same place that he started at.

The second irony is that even though we started very late tonight, 12:50, this has been one of the best committee hearings we have had. We have actually had a very good discussion on a very important issue. It is too bad that it was at a time when there was virtually no press coverage. I think there are two reporters here, maybe a couple of other people. I recognize two reporters in the room.

And these are—this type of meeting should be held at a time when it can be covered by the public's representatives, by the press. And it wasn't.

Now, the other part is that clearly your amendment should be made in order. It is not going to be. And there are some other amendments that clearly should be made in order if you were going to have a fair consideration on the floor. These amendments might all fail. I mean, the majority, I assume, has the votes to pass their bill. I don't understand what they are afraid of. Why wouldn't they give you a vote?

Now, they are going to give Dingell and Rangel a vote, because they are not worried about that. They think they can beat that. They probably can. But, why won't they give you a vote? Why won't they give Mrs. Capps a vote? Why won't they give Dr. Burgess and Dr. Gingrey a vote? That is the type of rule that ought to come out of this committee, where you have serious people with serious proposals. If the majority has their act together, they will beat all of those proposals. And if they don't, they don't deserve to. I mean you have come up—a group of members, and Mr. Sanders has a very serious proposal that deserves to be voted on.

And yet we have had this meeting, that has gone on for 3 hours and none of you who have come up here are going to get your amendment in order, except the Dingell-Rangel, and that is too bad, because this is such an important piece of legislation that the House ought to have the opportunity, just as the Senate has done. I am not suggesting this should be on the floor for 2 weeks, but there is a way to structure a rule with time limits where all of the major proposals can be voted on.

Now, we are under the airplane imperative. The majority has decided that they want to give away Friday. And so they want to—they are going to have this go on the floor Thursday, today, under a very tight rule. This bill could be on the floor for 2 days, Thursday and Friday, and all of you could have a vote on your amendments.

You might all lose. But you should have that right. It is unfortunate that the majority will not give you the opportunity to present very sensible proposals and to have the House vote on those.

And that was the thing—I am sorry if my remarks were overly harsh at the beginning of this proceeding. But that is what I was talking about, Mr. Chairman, is there is no reason why this House should not have the opportunity to cast votes on serious proposals made by serious and thoughtful members on this—what may be the single most important piece of legislation that this House will consider during this 2 year session of Congress.

The CHAIRMAN. Thank you very much.

Ms. Pryce.

Ms. PRYCE. I have no questions. Thank you.

The CHAIRMAN. Mr. McGovern.

Mr. MCGOVERN. I want to thank Mr. Dooley and Mr. Cooper and Mr. Sanders and Mr. Larson for being here at 4 in the morning, because it shows their seriousness and their commitment to this issue.

I want to associate myself with the remarks of our ranking member. I think these proposals absolutely should be made in order. They should be debated. Even if it takes a week or two, how many suspensions have we voted on this week alone? I have to believe this is a little bit more important than some of these suspensions.

And, this is an issue that impacts 40 million senior citizens. And, quite frankly, it deserves not only to have your amendments in order on the floor, but you deserve more than 10 minutes for this amendment and 5 minutes for that amendment, because we should have a debate, a real debate rather than screaming soundbites at each other.

I agree with Mr. Frost, that I thought that the testimony by Republicans and Democrats here tonight was very thoughtful and very productive. And I also agreed with something Mr. Larson said in his opening remarks, that he is not on the Energy and Commerce Committee, he is not on the Ways and Means Committee, but there were members who were not on the relevant committees that nonetheless have an opinion on this issue. Every one of us does.

And, this idea that well, the committees have worked their will, and we should all just respect that. We had a defense authorization bill that came through this committee. And not all of us are on the Armed Services Committee, but the chairman of our committee had a very thoughtful amendment that was made in order. I agreed with him on it and voted for it, but it was brought to the floor. It illustrates the fact that there are members who are not on the committees of jurisdiction that do have interesting and thoughtful and productive ideas. And, I think it is just a shame that we are not going to have that kind of thoughtful debate on the floor.

So I thank you all very much for your comments.

The CHAIRMAN. Mr. Diaz-Balart.

Mr. DIAZ-BALART. I thought the presentations, all of the presentations, that were made here were very interesting and helpful. I appreciate the hard work.

The CHAIRMAN. Mr. Hastings.

Mr. HASTINGS of Florida. Thank you very much, Mr. Chairman. Mr. Chairman, I appreciate all of the amendments of our colleagues. All of them have studied very carefully and for a very long period of time. Mr. Cooper was with us at one point and then away,

and back once again discussing the same issues. And Mr. Dooley has been a continuing leader on this.

Of course, none of us have the nerve that Bernie Sanders has to really do what is right, and none of us have the nerve to say what is really needed here, that is universal health care notwithstanding all of the ups and downs and back and forth and everything that we talk about.

The reality is, that we are better people than that, and we ought to be about that business, Mr. Chairman, I also want to say to John, I did not know or ask the nature of your child's illness. But I am delighted to see you back. And I know that from a personal standpoint, like our colleague, Ms. Pryce and others of our colleagues, Mr. Sessions, all of us have these complications in our personal lives that ought to cause us to want to dramatically do something that would be beneficial for all of us.

I can't imagine what the medical costs may have been for the period of time that you were away from here. And when I talk frequently, as I do about my mother, I am not talking about somebody that is a stranger, I am not talking about people who are constituents, I am talking about somebody that brought me here on earth, and I pay for, gladly, every inch of this mile that we are walking toward her death.

And I may very well precede her, not being God, but the fact of the matter is, it is extremely expensive. And all I know is that we are doing things sometimes that are helping people that don't need help.

And we are not doing things that we ought to do to help people that do need help. Today, when we pass this measure, or Friday, we will not have done what we could have done had we just given ourselves the time and attention to undertake to do what is necessary.

With that, Mr. Chairman, I thank our colleagues and I am sure that each of them should have the privilege as well as every other member to have their measures brought to the floor and let the will of the House be worked.

The CHAIRMAN. Thank you very much, Mr. Hastings.

Mr. HASTINGS of Washington. No questions.

Mr. SESSIONS. Mr. Chairman, I would just agree with my colleagues. I think it was a wonderful debate that we had this evening. I will tell you that I was personally impressed with, I think every single speaker that came up that talked about their thoughts and ideas. I think it shows the extreme need for us to address this issue.

And I too would like to single out Nancy Johnson for her clear articulation and her vision of ideas about what this great Nation has in mind for us, a plan. And I feel like this was well worth my time to be here, even at this late time.

I will not be representing the Rules Committee in the morning at the baseball game practice.

The CHAIRMAN. Why not?

Mr. SESSIONS. I choose not to. Mostly because we have seen what happens with one colleague who stayed up too late and misspoke, so I am not going to do that.

But I think this is worth our time, and thank everyone for hanging in on this.

The CHAIRMAN. Thanks. Let me say that the evening is not over yet.

Mr. Reynolds.

Mr. REYNOLDS. No questions.

The CHAIRMAN. Thank you very much, gentlemen. We appreciate your being here.

Mr. DOOLEY. Just ask unanimous consent to insert into the record a statement from Ellen Tauscher.

The CHAIRMAN. Without objection, Mrs. Tauscher's statement will appear in the record.

[The prepared statement of Mrs. Tauscher follows:]

PREPARED STATEMENT OF HON. ELLEN TAUSCHER, A REPRESENTATIVE IN CONGRESS  
FROM THE STATE OF CALIFORNIA

Thank you Chairman Dreier and Ranking Member Frost for recognizing me. I would like to voice my support for the Medicare Prescription Now Act to be the substitute to H.R. 1. It is clear that the status quo is not working to make prescription drugs affordable for seniors. It is also clear that our country's current economic situation does not give Congress a lot of options for solving this growing problem. Any prescription drug plan needs to be part of Medicare, which seniors like and trust.

Our plan is managed by Medicare. By leveraging the buying power of all seniors, our plan allows every single person on Medicare to benefit from immediate drug savings, regardless of how many prescriptions they are filling a month. Furthermore, Mr. Chairman, our seniors need to be protected from catastrophic drug costs. Seniors who have high drug costs will be able to access the full benefit sooner because our plan focuses on the total cost of the drug—not the discounted price paid out-of-pocket. Our plan has an extra safety net for those who really need it—people with total drug costs of \$4,000 a year.

Finally, Mr. Chairman, I would like to point out that under our bill, companies that currently provide prescription drug coverage to their retirees will have the incentive to continue doing so because the federal government will assume the risk of drug coverage once beneficiaries reach their deductible. We need to be smart and realistic about how we provide every American senior with prescription drug coverage. Given the current economic situation, our plan is the one that provides this coverage and is fiscally achievable.

The CHAIRMAN. Our next witness is the gentleman from Florida, Mr. Hastings.

Mr. HASTINGS of Florida. Mr. Chairman, I would ask unanimous consent to have both statements that I have made placed in the record. I won't belabor the matter this evening. I do urge that one of my measures is nothing more than a sense of Congress that expresses support for Federal and State funded in-home care for our Nation's elderly.

It doesn't impact this bill in any way, all it does is say that we ought to have better in-home care establishing guidelines, implementing better schooling for the people that do it.

I can't imagine that this couldn't be something that could be in order. With that in mind, I ask unanimous consent that I ask that the statements on both measures that I have offered be placed in the record.

The CHAIRMAN. Without objection.

[The prepared statements of Mr. Hastings of Florida follows:]

ALCEE L. HASTINGS  
23RD CONGRESSIONAL DISTRICT  
FLORIDA  
  
RULES COMMITTEE  
  
PERMANENT SELECT COMMITTEE  
ON INTELLIGENCE  
  
FLORIDA DELEGATION  
VICE CHAIRMAN  
  
UNITED STATES  
HELSINKI COMMISSION  
  
SENIOR DEMOCRATIC WHIP



**Congress of the United States**  
**House of Representatives**  
**Washington, DC 20515-0923**

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**Statement of the Honorable Alcee L. Hastings on his  
Amendment to H.R. 1, The Prescription Drug and  
Medicare Modernization Act**

Mr. Chairman, the amendment I introduce today is a straightforward Sense of Congress that expresses support for federal and state funded in-home care for our nation's elderly.

By increasing financial assistance for in-home care, establishing fee payment guidelines, implementing better schooling for in-home aides, and assembling a supervisory board of care givers, we can help to ensure that the quality of care that the elderly receive in their home is as adequate as the care they receive in hospitals.

Mr. Chairman, this is an important amendment for a number of reasons. Increased financial assistance would allow the elderly to remain independent during the last years of their lives. Numerous studies have shown that seniors who are able to remain in their homes have greater life expectancies than seniors who are moved from everything that is familiar to them and placed in nursing homes. By implementing government funded in-home care that is equal in quality to nursing home care, we will be providing seniors and their families with the opportunity to choose the option that is right for them.

Mr. Chairman, I urge my colleagues to support this amendment. As members of Congress, we have a great opportunity to make a positive impact on this issue, an issue that is of concern to many of our

grandparents, parents, and will be of concern to us. I look forward to working with my colleagues and moving this amendment forward.

ALCEE L. HASTINGS  
23rd CONGRESSIONAL DISTRICT  
FLORIDA  
  
RULES COMMITTEE  
  
PERMANENT SELECT COMMITTEE  
ON INTELLIGENCE  
  
FLORIDA DELEGATION  
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**Statement of the Honorable Alcee L. Hastings**  
**Committee on Rules**  
**Consideration of H.R. 1**  
**Amendment HASTFL\_054**

**June 25, 2003**

Thank you, Mr. Chairman.

The amendment that I am offering at this moment requires the Secretary of Health and Human Services to prepare and publish a consumer guide to prescription drug prices in America. The report is required to contain a list of prices of all prescription drugs and shall

be easy accessible online and in print for all Americans.

If this body is going to consider a bill that is intended to provide affordable prescription drugs for seniors, then it ought to come up with a way to provide Americans with the necessary information to make informative decisions on the cost of the prescription drugs that they are using.

The drug lobby has spent billions of dollars on advertising. Generic drug companies, whose products are just as effective, have chosen to offer their products at an affordable rate in lieu of advertising. More times than not, seniors lack the resources and wherewithal to compare drug costs. It would be

responsible for HHS to provide seniors, and all Americans for that matter, with the tools to make educated and fiscally responsible decisions.

My amendment provides seniors with the ability to compare drug costs *before* they are forced to buy.

Mr. LINDER. No questions.

Mr. FROST. Mr. Chairman, are we to the point where we are going to be voting shortly?

The CHAIRMAN. We have another witness. We are asking questions of Mr. Hastings now.

Mr. FROST. I will save it to the end.

Ms. PRYCE. No.

Mr. MCGOVERN. No.

Mr. DIAZ-BALART. No questions.

Mr. HASTINGS of Washington. No.

Mr. SESSIONS. No.

Mr. REYNOLDS. No.

The CHAIRMAN. Thank you very much. Thank you very much. Our next witness is the gentleman from Arkansas, Mr. Berry, who does not appear to be here. Our next witness is the gentleman from Massachusetts, Mr. McGovern.

Mr. MCGOVERN. Mr. Chairman, I will ask unanimous consent to insert my statement in the record since I talked about it in my opening statement in support of my amendment.

[The prepared statement of Mr. McGovern of Massachusetts follows:]

PREPARED OPENING STATEMENT OF HON. JAMES MCGOVERN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS

Mr. CHAIRMAN, I will be brief. This bill includes a copayment for home health services. My amendment would strike this provision from the bill.

A home health copay will lead to increased costs for seniors, home health care agencies and the states. Seniors will have to pay for these costs out of pocket, a difficult task for seniors living on a fixed income. Agencies will have increased costs due to collection and the paperwork necessary to complete collection of the copay. And, finally, this will be an unfunded mandate on states as Medicaid begins to pick up the costs for home health care patients who can't afford Medicare home health services.

Some groups, like 60-plus and the Seniors Coalition, are labeling this a "sick tax" on home health beneficiaries. I think this an important point. Medicare beneficiaries primarily live on a fixed income and a copay, although it may not seem like a lot of money, will take away from the limited funds these seniors rely on to live a relatively comfortable life.

Mr. Chairman, this is bad policy, plain and simple and I urge my colleagues to support my amendment. I yield back the balance of my time.

The CHAIRMAN. Thank you very much. Our next witness is Mr. Langevin. He appears not to be here. So that will close the hearing portion.

Mr. Frost, you would like to be recognized.

Mr. FROST. Mr. Chairman, it is really, and I am anticipating a rule that the committee is going to be handing out. But I think it is a very sad day. This, as I said a moment ago, this may be the single most important vote that any of us cast this session. And if we should be so fortunate to be back in the majority any time soon, and if I should be so fortunate to be here, and to be the chairman of the committee at that time, I will not tolerate a major piece of legislation going to the floor with this kind of rule, without the House having the opportunity to consider major, carefully thought-out alternatives.

I think that this is an enormous disservice to the House.

The CHAIRMAN. Thank you very much, Mr. Frost.

We will distribute the rule. And the Chair will be in receipt of a motion.

Mr. LINDER. Mr. Chairman, I move the committee grant a rule providing for the consideration of H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003, under a modified closed rule, providing 3 hours of debate in the House equally divided among and controlled by the chairmen and ranking minority members of the Committee on Energy and Commerce and the Committee on Ways and Means.

The rule waives all points of order against consideration of H.R. 1. The rule provides for consideration of the amendment to H.R. 1 printed in the Rules Committee report accompanying the resolution, if offered by Representative Rangel of New York or his designee, which shall be considered as read and shall be separately debatable for 1 hour, equally divided and controlled by the proponent and an opponent. The rule waives all points of order against the amendment printed in the report.

The rule provides one motion to recommit H.R. 1 with or without instructions.

The rule further provides for consideration of H.R. 2596 on the legislative day of June 26 or June 27, 2003, under a closed rule providing 1 hour of debate in the House on H.R. 2596, equally divided and controlled by the chairman and ranking minority member of the Committee on Ways and Means. The rule waives all points of order against consideration of H.R. 2596. The rule provides one motion to recommit H.R. 2596 with or without instructions.

The rule provides that in the engrossment of H.R. 1, the clerk shall add the text of H.R. 2596, as passed by the House as a new matter at the end of H.R. 1, and then lay H.R. 2596 on the table.

The rule provides that during consideration of H.R. 1 and H.R. 2596, notwithstanding the operation of the previous question, the Chair may postpone further consideration of either bill to a time designated by the Speaker.

The rule further provides that it shall be in order to consider concurrent resolutions providing for adjournment of the House and Senate during the month of July.

Finally, the rule provides that the Committee on Appropriations may have until midnight on Thursday, July 3, 2003, to file a report to accompany a bill making appropriations for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes.

The CHAIRMAN. You have heard the motion of the gentleman. Let me take a couple of minutes to make some comments myself and then provide an explanation of the rule that we are proceeding with.

First of all, many people have commented over the last few hours about what a spectacular hearing this was. I observed that there have been no recorded votes on the House floor, no one has been called off to other meetings, and while I am not going to propose that we have our regular meetings begin at 12:50 and extend until 4:30 in the morning, I will say that I think that we have had a great deal of attentiveness on the part of the members of the com-

mittee and witnesses, and that is due to the fact that we haven't had the normal distraction that we often experience.

I also wanted to say that this has been fully covered by some of the top reporters on Capitol Hill. And we appreciate their forbearance.

But, let me just comment on this rule. As you can see, we have taken both the Medicare Prescription Drug and Modernization Act and the Health Savings Affordability Act, and we will allow consideration of both of those measures on the floor tomorrow as outlined by Mr. Linder.

We also will be putting in place provisions in this rule that will ensure that the House does not have to reconvene every 3 days based on the fact that we have yet to complete our appropriations work. And we still are working hard on that.

And as the members know, we will have the rule that will be following this one, complete the second appropriation bill of the 13. We will have 11 more to work on during the month of July. And we hope to have those completed by the August recess. We also called for an allowance for the committee on appropriations to file their defense appropriations bills, so that we will be able to consider that immediately upon our return. And we will meet on Monday, July 7th, and that provision will be in the rule, it will make an allowance for that.

Are there any amendments to the rule?

Mr. FROST. Yes, Mr. Chairman. And I would preface that by saying that when we were in the majority, we often had very lengthy hearings during the daytime. We had no difficulty with members having to leave for votes or distractions. We didn't have to have a hearing late at night to be able to have a hearing without distractions.

Mr. Chairman, I move that H.R. 1 be considered under an open rule.

The CHAIRMAN. You have heard the motion of the gentleman. Any discussion? If not the vote occurs on the Frost amendment. Those in favor will say aye. Those opposed no. In the opinion of the Chair, the noes have it. The noes have it. The motion is not agreed to.

Mr. FROST. Roll call, Mr. Chairman.

The CHAIRMAN. The Clerk will call the roll.

The CLERK. Mr. Goss.

[No response.]

The CLERK. Mr. Linder.

Mr. LINDER. No.

The CLERK. Ms. Pryce.

Ms. PRYCE. No.

The CLERK. Mr. Diaz-Balart.

Mr. DIAZ-BALART. No.

The CLERK. Mr. Hastings of Washington.

Mr. HASTINGS of Washington. No.

The CLERK. Mrs. Myrick.

[No response.]

The CLERK. Mr. Sessions.

Mr. SESSIONS. No.

The CLERK. Mr. Reynolds.

Mr. REYNOLDS. No.

The CLERK. Mr. Frost.

Mr. FROST. Aye.

The CLERK. Ms. Slaughter.

[No response.]

The CLERK. Mr. McGovern.

Mr. MCGOVERN. Aye.

The CLERK. Mr. Hastings of Florida.

Mr. HASTINGS of Florida. Aye.

The CLERK. Mr. Chairman.

The CHAIRMAN. No. The Clerk will report the total.

The CLERK. Three yeas and seven nays.

The CHAIRMAN. The motion is not agreed to. Are there further amendments?

Mr. Frost.

Mr. FROST. I have an amendment to the rule. I move the committee make in order the amendment numbered 52 offered by Representative Dooley and ask that the amendment be given the appropriate waivers. The amendment offers a prescription drug plan with no premiums and universal eligibility. It provides an 80/20 cost share after total drug costs of \$4,000 and enhanced benefits for beneficiaries living up to 200 percent of the poverty level.

The amendment encourages continuation of current drug coverage based on reimbursement agreements with Medicare. It also adds rural provider fixes to address geographic inequalities.

Mr. Chairman, this is a very thoughtful amendment offered by a group of Members who have a distinct and different approach from that being offered by the majority. I do not know if this amendment would pass on the floor, but it is an amendment that deserves to be debated on the floor.

And I would—the reason that I said earlier that this may be the most important piece of legislation we will consider this session, is that the underlying bill, the majority's bill, would dramatically change the Medicare program as your own members have acknowledged, including Mrs. Johnson, it just doesn't provide prescription drugs, it dramatically changes the way that Medicare would operate after 2010.

It is a monumental piece of legislation. And we are—the Members should be entitled to vote on serious alternatives to the approaches. I would ask for a roll call.

The CHAIRMAN. You have heard the motion of the gentleman. Any discussion? If not the vote occurs on the Frost amendment. Those in favor will say aye. Those opposed no. In the opinion of the Chair, the yeas have it. The yeas have it. The motion is not agreed to.

Mr. FROST. Roll call, Mr. Chairman.

The CHAIRMAN. The Clerk will call the roll.

The CLERK. Mr. Goss.

[No response.]

The CLERK. Mr. Linder.

Mr. LINDER. No.

The CLERK. Ms. Pryce.

Ms. PRYCE. No.

The CLERK. Mr. Diaz-Balart.

Mr. DIAZ-BALART. No.

The CLERK. Mr. Hastings of Washington.

Mr. HASTINGS of Washington. No.

The CLERK. Mrs. Myrick.

[No response.]

The CLERK. Mr. Sessions.

Mr. SESSIONS. No.

The CLERK. Mr. Reynolds.

Mr. REYNOLDS. No.

The CLERK. Mr. Frost.

Mr. FROST. Aye.

The CLERK. Ms. Slaughter.

[No response.]

The CLERK. Mr. McGovern.

Mr. MCGOVERN. Aye.

The CLERK. Mr. Hastings of Florida.

Mr. HASTINGS of Florida. Aye.

The CLERK. Mr. Chairman.

The CHAIRMAN. No. The Clerk will report the total.

The CLERK. Three yeas and seven nays.

The CHAIRMAN. The motion is not agreed to. Are there further amendments? Mr. Frost.

Mr. FROST. I have an amendment to the rule. This is the Blue Dog substitute. I move that the committee make in order the amendment in the nature of a substitute numbered 50 offered by Representative Thompson of California, and ask that the amendment be given the appropriate waivers. The amendment in the nature of a substitute generally incorporates the provisions of the bipartisan Medicare bill, that the other body is currently debating. It establishes a prescription drug benefit in Medicare, delivery through private plans, and contains a fallback provision for areas where there are not at least two plans available.

This bill has higher payments for rural health care providers than the House bill, and does not include the premium support provisions that would privatize Medicare in the year 2010. This is the bill that is currently being considered by the other body.

The CHAIRMAN. You have heard the motion of the gentleman. Any discussion?

Mr. MCGOVERN. I have a question. I guess I am just curious, if you can give us an explanation as to why none of these substitutes or amendments will be made in order?

The CHAIRMAN. I don't know that that is the case.

Mr. FROST. They are not in your rule.

The CHAIRMAN. Let me explain. What we decided, if I can answer your question, thank you very much. What we decided in the rule, was as we had discussed for the last several weeks is to make a substitute in order, which was my request, that we make a substitute in order. And we have made a substitute in order, the first substitute that was requested by the representatives of the Energy and Commerce Committee who testified here.

The number 1 request from the Democratic representative at this table, was that we make in order the substitute that we made in order. We made that choice. So, while that was at the top of the list, we chose to make in order that amendment.

Mr. MCGOVERN. Before Mr. Frost responds, I guess that is not answering my question, which is why—the question I have is when we talked to the Blue Dogs, or if we talk to any of the people who you acknowledge were so thoughtful and eloquent tonight as to why they were shut out of this process, I am wondering is because there is not enough time or because they were—their amendments weren't germane or—

The CHAIRMAN. So that you will have an opportunity to explain this very clearly, and quote me well on the House floor tomorrow, I want to say very clearly: We made a determination that we would meet the request of the minority to make a substitute in order.

The first substitute that was requested by the representatives of the Energy and Commerce Committee, Mr. Brown, who testified, his first request was that we make in order the Dingell-Rangel substitute. And that is what I perceived it to be.

So let me just say that, that is what we are going to do. We are going to have a number of recorded votes. We are going to be here through the evening. I know that we have quite a bit of time ahead of us here. I have given my explanation and that is the explanation.

Mr. MCGOVERN. I am going to yield to the gentleman, but let me just simply say that I think you are mischaracterizing the minority position. There was a letter sent to you signed by Mr. Frost and the leader.

Mr. FROST. The position of the minority was that this be an open rule so that all substitutes can be considered. There was a letter sent to your leadership, by every one in our leadership, and I also signed the letter. It is not the position of the Democrats in Congress, it was not the position of our leadership, that only one substitute be made in order.

You have chosen not—the majority has chosen which substitute it wanted to make in order. That was not the position of the minority. That was not the request of the minority. And you have a letter to that effect.

The CHAIRMAN. What was the request of the minority?

Mr. FROST. I just stated it. That every amendment be made in order. That was signed.

The CHAIRMAN. That every substitute amendment be made in order? We chose to make a substitute amendment in order. When testimony was provided, the lead Democratic witness went through the request that you just had. We chose to make one substitute in order on this rule. And what we did was we made in order the first amendment, substitute amendment that was offered by the lead Democratic witness. And I would like to have a vote, if you don't mind, on this amendment.

Mr. FROST. If I may, I would like to submit for the record—

The CHAIRMAN. Without objection.

Mr. FROST [continuing]. The letter signed by Nancy Pelosi, Steny Hoyer, Bob Menendez, Jim Clyburn and myself as ranking member, asking that all substitutes be made in order.

[The information follows:]

**Congress of the United States**  
Washington, DC 20515

June 20, 2003

The Honorable J. Dennis Hastert  
Speaker  
U.S House of Representatives  
H-232, The Capitol  
Washington, DC 20515

Dear Mr. Speaker:

The upcoming debate on Medicare's future is one of the most important matters this Congress will consider. Millions of seniors and disabled Americans have already waited far too long for the prescription drug benefit they have been promised. This issue is serious and complex and deserves a full and fair debate. The Senate has set aside two weeks to meet that standard. The House also must have ample time to fully debate the merits of the bill as well as all substantive amendments.

As you know, House Democrats do not believe that the ~~Thomas-Tauzin bill~~ provides the affordable prescription drug benefit that seniors deserve -- one that does not have huge coverage gaps, provides a guaranteed set of costs and benefits available to all beneficiaries whether they live in rural or urban areas, and reduces the high prices that seniors are forced to pay.

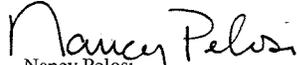
Major amendments must be debated in order to address these concerns, and that debate must be held in the light of day so that seniors are given a clear picture of the benefit that is proposed and how it will impact their finances. If, after a full and fair debate, seniors believe the House Republican plan meets their needs, then support for its passage will grow. If not, we can work together to improve the legislation.

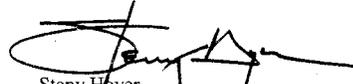
In recent months, the Republican leadership has severely limited debate on many serious matters, including the recent tax cut and the \$1 trillion increase in the federal debt necessary to pay for it. Issues of importance to taxpayers, such as the federal budget, have been brought to the floor after midnight. These actions leave the impression that Republicans don't want the American public to know about the enormous deficits they are creating for our children and the millions of working families their tax and education policies leave behind.

The debate on the creation of a prescription drug benefit and the future of the Medicare program is too important to continue the pattern that the Republican leadership has established. We request that the Rules Committee make in order all substantive amendments, that Members have ample time to fully debate the bill and all amendments, and that the debate occur in the light of day.

Thank you for your consideration of this request. The proposed changes to Medicare will have a significant impact on the lives of seniors and the disabled, and they deserve the opportunity to assess this legislation's merits.

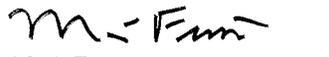
Sincerely,

  
Nancy Pelosi  
Democratic Leader

  
Steny Hoyer  
Democratic Whip

  
Bob Menendez  
Chair, Democratic Caucus

  
James E. Clyburn  
Vice Chair, Democratic Caucus

  
Martin Frost  
Ranking Democrat, Rules Committee

The CHAIRMAN. I understand that minority would like to have an open rule on this, and would like to have every single amendment that was proposed.

Mr. FROST. You are mischaracterizing what the request of the minority was. The request of the minority is that all substitutes be made in order. You are mischaracterizing—

The CHAIRMAN. I did not say that the minority did not ask that all substitutes be made in order. What I said was, that we made the determination that we would give the minority an opportunity to offer a substitute. The first substitute that was mentioned in testimony here by the lead Democratic witness was the substitute that we have made in order.

Mr. FROST. Those were the witnesses from the two committees of jurisdiction. Obviously they are going to be the first ones to testify. Obviously. That doesn't mean that that was the favored position. That doesn't mean—

The CHAIRMAN. Well, actually, Mr. Frost, if I may, that lead witness mentioned all of the substitutes. But he began by first mentioning the Dingell-Rangel substitute before he said, as you just have, that you would like to have the other substitutes made in order.

Mr. FROST. Those two witnesses were there representing Mr. Dingell and Mr. Rangel. They were not representing the leadership of our party, they were representing the ranking members of the two committees of jurisdiction.

Mr. MCGOVERN. If you go back to the opening statements, it began with, we want an open rule.

The CHAIRMAN. I think we have had the vote on that. The vote occurs on the motion of the gentleman.

Those in favor will say aye. Those opposed no. In the opinion of the Chair, the noes have it. The noes have it. The motion is not agreed to.

Mr. FROST. Roll call, Mr. Chairman.

The CHAIRMAN. The Clerk will call the roll.

The CLERK. Mr. Goss.

[No response.]

The CLERK. Mr. Linder.

Mr. LINDER. No.

The CLERK. Ms. Pryce.

Ms. PRYCE. No.

The CLERK. Mr. Diaz-Balart.

Mr. DIAZ-BALART. No.

The CLERK. Mr. Hastings of Washington.

Mr. HASTINGS of Washington. No.

The CLERK. Mrs. Myrick.

[No response.]

The CLERK. Mr. Sessions.

Mr. SESSIONS. No.

The CLERK. Mr. Reynolds.

Mr. REYNOLDS. No.

The CLERK. Mr. Frost.

Mr. FROST. Aye.

The CLERK. Ms. Slaughter.

[No response.]

The CLERK. Mr. McGovern.

Mr. MCGOVERN. Aye.

The CLERK. Mr. Hastings of Florida.

Mr. HASTINGS of Florida. Aye.

The CLERK. Mr. Chairman.

The CHAIRMAN. No. The Clerk will report the total.

The CLERK. Three yeas and seven nays.

The CHAIRMAN. The motion is not agreed to. Are there further amendments?

Mr. Frost.

Mr. FROST. I have an amendment to the rule. I move the committee make in order the amendment number 1 offered by Representative Sanders and ask that the amendment be given the appropriate waivers. The amendment replaces Title 1 of the bill with a Medicare prescription drug benefit structured like Medicare Part B, with a defined premium and a strong benefit.

It also allows the reimportation of drugs from Canada, eliminates price discrimination against seniors and sunsets the program when its expenditures reach \$400 billion.

The CHAIRMAN. You have heard the motion of the gentleman. Any discussion? If not the vote occurs on the Frost amendment. Those in favor will say aye. Those opposed no. In the opinion of the Chair the noes have it. The noes have it. The motion is not agreed to.

Mr. FROST. Roll call, Mr. Chairman.

The CHAIRMAN. The Clerk will call the roll.

The CLERK. Mr. Goss.

[No response.]

The CLERK. Mr. Linder.

Mr. LINDER. No.

The CLERK. Ms. Pryce.

Ms. PRYCE. No.

The CLERK. Mr. Diaz-Balart.

Mr. DIAZ-BALART. No.

The CLERK. Mr. Hastings of Washington.

Mr. HASTINGS of Washington. No.

The CLERK. Mrs. Myrick.

[No response.]

The CLERK. Mr. Sessions.

Mr. SESSIONS. No.

The CLERK. Mr. Reynolds.

Mr. REYNOLDS. No.

The CLERK. Mr. Frost.

Mr. FROST. Aye.

The CLERK. Ms. Slaughter.

[No response.]

The CLERK. Mr. McGovern.

Mr. MCGOVERN. Aye.

The CLERK. Mr. Hastings of Florida.

Mr. HASTINGS of Florida. Aye.

The CLERK. Mr. Chairman.

The CHAIRMAN. No. The Clerk will report the total.

The CLERK. Three yeas and seven nays.

The CHAIRMAN. The motion is not agreed to. Are there further amendments?

Mr. Frost.

Mr. FROST. Mr. Chairman, I have an amendment to the rule. I move the committee make in order the amendment number 49 offered by four Republican Members, Representatives Buyer, Norwood, Burr, and Shadegg, and ask that the amendment be given the appropriate waivers.

The amendment replaces the Title 1 drug benefit of the bill with a discount drug card program.

The CHAIRMAN. You have heard the motion of the gentleman. Any discussion? If not the vote occurs on the Frost amendment. Those in favor will say aye. Those opposed no. In the opinion of the Chair, the noes have it. The noes have it. The motion is not agreed to.

The FROST. Roll call, Mr. Chairman.

The CHAIRMAN. The Clerk will call the roll.

The CLERK. Mr. Goss.

[No response.]

The CLERK. Mr. Linder.

Mr. LINDER. No.

The CLERK. Ms. Pryce.

Ms. PRYCE. No.

The CLERK. Mr. Diaz-Balart.

Mr. DIAZ-BALART. No.

The CLERK. Mr. Hastings of Washington.

Mr. HASTINGS of Washington. No.

The CLERK. Mrs. Myrick.

[No response.]

The CLERK. Mr. Sessions.

Mr. SESSIONS. No.

The CLERK. Mr. Reynolds.

Mr. REYNOLDS. No.

The CLERK. Mr. Frost.

Mr. FROST. Aye.

The CLERK. Ms. Slaughter.

[No response.]

The CLERK. Mr. McGovern.

Mr. MCGOVERN. Aye.

The CLERK. Mr. Hastings of Florida.

Mr. HASTINGS of Florida. Aye.

The CLERK. Mr. Chairman.

The CHAIRMAN. No. The Clerk will report the total.

The CLERK. Three yeas and seven nays.

The CHAIRMAN. The motion is not agreed to. Are there further amendments?

Mr. Frost.

Mr. FROST. Mr. Chairman. I have an amendment to the rule. I move the committee make in order the amendment numbered 59 offered by Representatives Capps and Norwood, and ask that the amendment be given the appropriate waivers. The amendment corrects the overpayments for oncology drugs that goes on today, but increases the compensation oncologists receive for their services.

It also allows a more accurate payment for oncology drugs which by replacing the average wholesale price with the average sales price. It also would pay physicians for the additional work they perform before and after patient visits and consultations.

I would add, Mr. Chairman, that, as you know, I have some personal experience in this area. Over the last year, my wife was operated on for breast cancer and was treated by the oncology department on an outpatient basis at Southwestern Medical Center in Dallas, Texas. She received excellent care. And I know that a Member on your side who is not here tonight, Mrs. Myrick, also has the same situation.

And I am aware that other members of this committee have had members of their family or close associates who have also received this type of treatment.

Mr. Chairman, I think this is an eminently reasonable amendment. And I think it would be very unfortunate if this amendment is not made in order.

Mr. LINDER. Mr. Chairman, I believe that is in the bill. The average wholesale price in the bill has been taken out if you go to a lower actual price and a higher reimbursement fee for oncology.

Mr. FROST. Several parts of this amendment. I do not believe the entire amendment is.

Mr. LINDER. Okay.

Mr. FROST. And, Mr. Chairman, I would ask for a vote.

The CHAIRMAN. The vote occurs on the motion of the gentleman. You have heard the motion of the gentleman. Any discussion? If not the vote occurs on the Frost amendment. Those in favor will say aye. Those opposed no. In the opinion of the Chair, the noes have it. The noes have it. The motion is not agreed to.

Mr. FROST. Roll call, Mr. Chairman.

The CHAIRMAN. The Clerk will call the roll.

The CLERK. Mr. Goss.

[No response.]

The CLERK. Mr. Linder.

Mr. LINDER. No.

The CLERK. Ms. Pryce.

Ms. PRYCE. No.

The CLERK. Mr. Diaz-Balart.

Mr. DIAZ-BALART. No.

The CLERK. Mr. Hastings of Washington.

Mr. HASTINGS of Washington. No.

The CLERK. Mrs. Myrick.

[No response.]

The CLERK. Mr. Sessions.

Mr. SESSIONS. No.

The CLERK. Mr. Reynolds.

Mr. REYNOLDS. No.

The CLERK. Mr. Frost.

Mr. FROST. Aye.

The CLERK. Ms. Slaughter.

[No response.]

The CLERK. Mr. McGovern.

Mr. MCGOVERN. Aye.

The CLERK. Mr. Hastings of Florida.

Mr. HASTINGS of Florida. Aye.

The CLERK. Mr. Chairman.

The CHAIRMAN. No. The Clerk will report the total.

The CLERK. Three yeas and seven nays.

The CHAIRMAN. The motion is not agreed to. Are there further amendments?

Mr. McGovern.

Mr. MCGOVERN. I have an amendment to the rule. I move the committee make in order amendment number 41 offered by Representative Strickland and ask that the amendment be given the appropriate waivers.

The amendment guarantees that all Medicare beneficiaries participating in the bill's new prescription drug programs will pay a \$35 premium in 2006, the first year of the program.

The CHAIRMAN. You have heard the motion of the gentleman. Any discussion? If not the vote occurs on the McGovern amendment. Those in favor will say aye. Those opposed no. In the opinion of the Chair the noes have it.

The noes have it. The motion is not agreed to.

Mr. FROST. Roll call, Mr. Chairman.

The CHAIRMAN. The Clerk will call the roll.

The CLERK. Mr. Goss.

[No response.]

The CLERK. Mr. Linder.

Mr. LINDER. No.

The CLERK. Ms. Pryce.

Ms. PRYCE. No.

The CLERK. Mr. Diaz-Balart.

Mr. DIAZ-BALART. No.

The CLERK. Mr. Hastings of Washington.

Mr. HASTINGS of Washington. No.

The CLERK. Mrs. Myrick.

[No response.]

The CLERK. Mr. Sessions.

Mr. SESSIONS. No.

The CLERK. Mr. Reynolds.

Mr. REYNOLDS. No.

The CLERK. Mr. Frost.

Mr. FROST. Aye.

The CLERK. Ms. Slaughter.

[No response.]

The CLERK. Mr. McGovern.

Mr. MCGOVERN. Aye.

The CLERK. Mr. Hastings of Florida.

Mr. HASTINGS of Florida. Aye.

The CLERK. Mr. Chairman.

The CHAIRMAN. No. The Clerk will report the total.

The CLERK. Three yeas and seven nays.

The CHAIRMAN. The motion is not agreed to. Are there further amendments?

Mr. McGovern.

Mr. MCGOVERN. Mr. Chairman, I have an amendment to the rule. I move the committee make in order the amendment number 18 offered by Representatives McGovern and ask that the amend-

ment be given the appropriate waivers. The amendment eliminates the bill's home health care copayment.

The CHAIRMAN. You have heard the motion of the gentleman. Any discussion? If not the vote occurs on the McGovern amendment. Those in favor will say aye. Those opposed no. In the opinion of the Chair, the noes have it. The noes have it. The motion is not agreed to.

Mr. FROST. Roll call, Mr. Chairman.

The CHAIRMAN. The Clerk will call the roll.

The CLERK. Mr. Goss.

[No response.]

The CLERK. Mr. Linder.

Mr. LINDER. No.

The CLERK. Ms. Pryce.

Ms. PRYCE. No.

The CLERK. Mr. Diaz-Balart.

Mr. DIAZ-BALART. No.

The CLERK. Mr. Hastings of Washington.

Mr. HASTINGS of Washington. No.

The CLERK. Mrs. Myrick.

[No response.]

The CLERK. Mr. Sessions.

Mr. SESSIONS. No.

The CLERK. Mr. Reynolds.

Mr. REYNOLDS. No.

The CLERK. Mr. Frost.

Mr. FROST. Aye.

The CLERK. Ms. Slaughter.

[No response.]

The CLERK. Mr. McGovern.

Mr. MCGOVERN. Aye.

The CLERK. Mr. Hastings of Florida.

Mr. HASTINGS of Florida. Aye.

The CLERK. Mr. Chairman.

The CHAIRMAN. No. The Clerk will report the total.

The CLERK. Three yeas and seven nays.

The CHAIRMAN. The motion is not agreed to. Are there further amendments?

Mr. McGovern.

Mr. MCGOVERN. I have an amendment to the rule. I move that the committee make in order the amendment numbered 48 offered by Representatives Emanuel and Gutknecht and ask that the amendment be given the appropriate waivers.

The amendment closes loopholes that brand name drug companies use to block generic drugs from coming into the market. It utilizes the principles of the free market by giving Americans access to FDA approved drugs from other industrialized nations and provides for a return for government sponsored pharmaceutical research.

The CHAIRMAN. You have heard the motion of the gentleman. Any discussion? If not the vote occurs on the McGovern amendment. Those in favor will say aye. Those opposed no. In the opinion of the Chair, the noes have it. The noes have it. The motion is not agreed to.

Mr. FROST. Roll call, Mr. Chairman.

The CHAIRMAN. The Clerk will call the roll.

The CLERK. Mr. Goss.

[No response.]

The CLERK. Mr. Linder.

Mr. LINDER. No.

The CLERK. Ms. Pryce.

Ms. PRYCE. No.

The CLERK. Mr. Diaz-Balart.

Mr. DIAZ-BALART. No.

The CLERK. Mr. Hastings of Washington.

Mr. HASTINGS of Washington. No.

The CLERK. Mrs. Myrick.

[No response.]

The CLERK. Mr. Sessions.

Mr. SESSIONS. No.

The CLERK. Mr. Reynolds.

Mr. REYNOLDS. No.

The CLERK. Mr. Frost.

Mr. FROST. Aye.

The CLERK. Ms. Slaughter.

[No response.]

The CLERK. Mr. McGovern.

Mr. MCGOVERN. Aye.

The CLERK. Mr. Hastings of Florida.

Mr. HASTINGS of Florida. Aye.

The CLERK. Mr. Chairman.

The CHAIRMAN. No. The Clerk will report the total.

The CLERK. Three yeas and seven nays.

The CHAIRMAN. The motion is not agreed to. Are there further amendments?

Mr. McGovern.

Mr. MCGOVERN. I have an amendment to the rule. I move that the committee make in order amendment 20 offered by Representative Cardin and ask that the amendment be given the appropriate waivers.

The amendment directs the Secretary to offer a prescription drug plan with standard coverage throughout the United States and areas not served by private prescription drug plan sponsors.

The CHAIRMAN. You have heard the motion of the gentleman. Any discussion? If not the vote occurs on the McGovern amendment. Those in favor will say aye. Those opposed no. In the opinion of the Chair, the noes have it. The noes have it. The motion is not agreed to.

Mr. FROST. Roll call, Mr. Chairman.

The CHAIRMAN. The Clerk will call the roll.

The CLERK. Mr. Goss.

[No response.]

The CLERK. Mr. Linder.

Mr. LINDER. No.

The CLERK. Ms. Pryce.

Ms. PRYCE. No.

The CLERK. Mr. Diaz-Balart.

Mr. DIAZ-BALART. No.

The CLERK. Mr. Hastings of Washington.

Mr. HASTINGS of Washington. No.

The CLERK. Mrs. Myrick.

[No response.]

The CLERK. Mr. Sessions.

Mr. SESSIONS. No.

The CLERK. Mr. Reynolds.

Mr. REYNOLDS. No.

The CLERK. Mr. Frost.

Mr. FROST. Aye.

The CLERK. Ms. Slaughter.

[No response.]

The CLERK. Mr. McGovern.

Mr. MCGOVERN. Aye.

The CLERK. Mr. Hastings of Florida.

Mr. HASTINGS of Florida. Aye.

The CLERK. Mr. Chairman.

The CHAIRMAN. No. The Clerk will report the total.

The CLERK. Three yeas and seven nays.

The CHAIRMAN. The motion is not agreed to.

Are there further amendments?

Mr. McGovern.

Mr. MCGOVERN. I have an amendment to the rule. I move that the committee make in order the amendment numbered 10 offered by Representatives Sandlin and Green of Texas and ask that the amendment be given the appropriate waivers.

The amendment would eliminate the bill's so-called doughnut hole by extending 20 percent cost-sharing up to the beneficiary's annual out of pocket threshold.

The CHAIRMAN. You have heard the motion of the gentleman. Any discussion? If not the vote occurs on the McGovern amendment. Those in favor will say aye. Those opposed no. In the opinion of the Chair the noes have it. The noes have it. The motion is not agreed to.

Mr. FROST. Roll call, Mr. Chairman.

The CHAIRMAN. The Clerk will call the roll.

The CLERK. Mr. Goss.

[No response.]

The CLERK. Mr. Linder.

Mr. LINDER. No.

The CLERK. Ms. Pryce.

Ms. PRYCE. No.

The CLERK. Mr. Diaz-Balart.

Mr. DIAZ-BALART. No.

The CLERK. Mr. Hastings of Washington.

Mr. HASTINGS of Washington. No.

The CLERK. Mrs. Myrick.

[No response.]

The CLERK. Mr. Sessions.

Mr. SESSIONS. No.

The CLERK. Mr. Reynolds.

Mr. REYNOLDS. No.

The CLERK. Mr. Frost.

Mr. FROST. Aye.

The CLERK. Ms. Slaughter.

[No response.]

The CLERK. Mr. McGovern.

Mr. MCGOVERN. Aye.

The CLERK. Mr. Hastings of Florida.

Mr. HASTINGS of Florida. Aye.

The CLERK. Mr. Chairman.

The CHAIRMAN. No. The Clerk will report the total.

The CLERK. Three yeas and seven nays.

The CHAIRMAN. The motion is not agreed to. Are there further amendments?

Mr. McGovern.

Mr. MCGOVERN. Mr. Chairman, I have an amendment to the rule. I move that the committee make in order the amendment number 30 offered by Representative Kaptur and ask that the amendment be given the appropriate waivers. The amendment would strike language in H.R. 1 that prohibits the Secretary from negotiating prices of prescription drugs, and requires the Secretary to participate in price negotiations such as the Secretary of Veterans Affairs does under the Federal Supply Schedule.

The CHAIRMAN. You have heard the motion of the gentleman. Any discussion? If not the vote occurs on the McGovern amendment. Those in favor will say aye. Those opposed no. In the opinion of the Chair the noes have it. The noes have it. The motion is not agreed to.

Mr. FROST. Roll call, Mr. Chairman.

The CHAIRMAN. The Clerk will call the roll.

The CLERK. Mr. Goss.

[No response.]

The CLERK. Mr. Linder.

Mr. LINDER. No.

The CLERK. Ms. Pryce.

Ms. PRYCE. No.

The CLERK. Mr. Diaz-Balart.

Mr. DIAZ-BALART. No.

The CLERK. Mr. Hastings of Washington.

Mr. HASTINGS of Washington. No.

The CLERK. Mrs. Myrick.

[No response.]

The CLERK. Mr. Sessions.

Mr. SESSIONS. No.

The CLERK. Mr. Reynolds.

Mr. REYNOLDS. No.

The CLERK. Mr. Frost.

Mr. FROST. Aye.

The CLERK. Ms. Slaughter.

[No response.]

The CLERK. Mr. McGovern.

Mr. MCGOVERN. Aye.

The CLERK. Mr. Hastings of Florida.

Mr. HASTINGS of Florida. Aye.

The CLERK. Mr. Chairman.

The CHAIRMAN. No. The Clerk will report the total.

The CLERK. Three yeas and seven nays.

The CHAIRMAN. The motion is not agreed to. Are there further amendments?

Mr. McGovern.

Mr. MCGOVERN. I have an amendment to the rule. I move that the committee make in order amendment number 2 offered by Representative Sanders. I ask that the amendment be given the appropriate waivers.

The amendment includes a Canada-only reimportation provision allowing Americans to benefit from international price competition.

The CHAIRMAN. You have heard the motion of the gentleman. Any discussion? If not, the vote occurs on the Frost amendment. Those in favor will say aye. Those opposed no. In the opinion of the Chair, the noes have it.

The noes have it. The motion is not agreed to.

Mr. FROST. Roll call, Mr. Chairman.

The CHAIRMAN. The Clerk will call the roll.

The CLERK. Mr. Goss.

[No response.]

The CLERK. Mr. Linder.

Mr. LINDER. No.

The CLERK. Ms. Pryce.

Ms. PRYCE. No.

The CLERK. Mr. Diaz-Balart.

Mr. DIAZ-BALART. No.

The CLERK. Mr. Hastings of Washington.

Mr. HASTINGS of Washington. No.

The CLERK. Mrs. Myrick.

[No response.]

The CLERK. Mr. Sessions.

Mr. SESSIONS. No.

The CLERK. Mr. Reynolds.

Mr. REYNOLDS. No.

The CLERK. Mr. Frost.

Mr. FROST. Aye.

The CLERK. Ms. Slaughter.

[No response.]

The CLERK. Mr. McGovern.

Mr. MCGOVERN. Aye.

The CLERK. Mr. Hastings of Florida.

Mr. HASTINGS of Florida. Aye.

The CLERK. Mr. Chairman.

The CHAIRMAN. No. The Clerk will report the total.

The CLERK. Three yeas and seven nays.

The CHAIRMAN. The motion is not agreed to. Are there further amendments?

Mr. McGovern, further amendments?

Mr. MCGOVERN. I have an amendment to the rule. I move that the committee make in order the amendment offered by Representative Brown of Ohio and ask that the amendment be given the appropriate waivers.

The amendment revises the certification provision in the drug reimportation section of the bill to require the Secretary to provide defensible reasons for blocking its implementation to ensure that

the Secretary takes into account the risks associated with failing to address the price discrimination against American consumers.

The CHAIRMAN. You have heard the motion of the gentleman. Any discussion? If not the vote occurs on the McGovern amendment. Those in favor will say aye. Those opposed no. In the opinion of the Chair the noes have it. The noes have it. The motion is not agreed to.

Mr. FROST. Roll call, Mr. Chairman.

The CHAIRMAN. The Clerk will call the roll.

The CLERK. Mr. Goss.

[No response.]

The CLERK. Mr. Linder.

Mr. LINDER. No.

The CLERK. Ms. Pryce.

Ms. PRYCE. No.

The CLERK. Mr. Diaz-Balart.

Mr. DIAZ-BALART. No.

The CLERK. Mr. Hastings of Washington.

Mr. HASTINGS of Washington. No.

The CLERK. Mrs. Myrick.

[No response.]

The CLERK. Mr. Sessions.

Mr. SESSIONS. No.

The CLERK. Mr. Reynolds.

Mr. REYNOLDS. No.

The CLERK. Mr. Frost.

Mr. FROST. Aye.

The CLERK. Ms. Slaughter.

[No response.]

The CLERK. Mr. McGovern.

Mr. MCGOVERN. Aye.

The CLERK. Mr. Hastings of Florida.

Mr. HASTINGS of Florida. Aye.

The CLERK. Mr. Chairman.

The CHAIRMAN. No. The Clerk will report the total.

The CLERK. Three yeas and seven nays.

The CHAIRMAN. Are there further amendments?

Mr. McGovern.

Mr. MCGOVERN. Mr. Chairman, I have an en bloc amendment. I move that the committee make in order amendment number 13 offered by Representative Brown of Ohio, number 8 offered by Representative Pallone, number 34 offered by Representative John, number 33 offered by Representative John, number 32 offered by Representative Green, number 29 offered by Representative Langevin, number 22 offered by Representatives Berry and Emerson, number 27 offered by Representative Capps, and an additional one offered by Representative Brown of Ohio.

The CHAIRMAN. You heard the motion of the gentleman. Any discussion?

Mr. HASTINGS of Florida. Yes, Mr. Chairman.

The CHAIRMAN. Mr. Hastings.

Mr. HASTINGS of Florida. Mr. Chairman, I would like to ask you or Mr. McGovern whether or not Mr. Frost earlier offered an amendment on Dr. Burgess and—

Mr. FROST. No, I did not offer Dr. Burgess.

Mr. HASTINGS of Florida. Then, if it is permissible, I would offer an amendment to the en bloc.

The CHAIRMAN. If Mr. McGovern will agree to offer that.

Mr. MCGOVERN. I am happy to.

The CHAIRMAN. The Burgess-Gingrey amendment will be included in the en bloc.

Mr. MCGOVERN. I think they had two apiece.

Mr. HASTINGS of Florida. Three and four.

Mr. MCGOVERN. Gingrey had two others.

The CHAIRMAN. For the Clerk and all—

Mr. MCGOVERN. Why don't I do this now and offer them separately?

The CHAIRMAN. The vote occurs on the en bloc amendment of the gentleman from Massachusetts Mr. McGovern. Those in favor will say aye. Those opposed, no.

In the opinion of the Chair, the noes have it.

Mr. MCGOVERN. I ask for a roll call.

The CHAIRMAN. The Clerk will call the roll.

The Clerk. Mr. Goss.

[No response.]

The CLERK. Mr. Linder.

Mr. LINDER. No.

The CLERK. Ms. Pryce.

Ms. PRYCE. No.

The CLERK. Mr. Diaz-Balart.

Mr. DIAZ-BALART. No.

The CLERK. Mr. Hastings of Washington.

Mr. HASTINGS of Washington. No.

The CLERK. Mrs. Myrick.

[No response.]

The CLERK. Mr. Sessions.

Mr. SESSIONS. No.

The CLERK. Mr. Reynolds.

Mr. REYNOLDS. No.

The CLERK. Mr. Frost.

Mr. FROST. Aye.

The CLERK. Mrs. Slaughter.

[No response.]

The CLERK. Mr. McGovern.

Mr. MCGOVERN. Aye.

The CLERK. Mr. Hastings of Florida.

Mr. HASTINGS of Florida. Aye.

The CLERK. Mr. Chairman.

The CHAIRMAN. No. And the Clerk will report the total.

The CLERK. Three yeas; seven nays.

The CHAIRMAN. And the motion is not agreed to.

Would you like to—

Mr. MCGOVERN. Mr. Chairman, I have an amendment to the rule; and I move the committee make in order en bloc the following amendments and ask that the amendments be given the appropriate waivers: Burgess numbers 3 and 4 and Gingrey number 25 and number 26.

The CHAIRMAN. You heard the motion of the gentleman. Any discussion?

If not, the vote occurs on the McGovern amendment. Those in favor will say aye. Those opposed, no.

Mr. MCGOVERN. I ask for a roll call.

The CHAIRMAN. The Clerk will call the roll.

The CLERK. Mr. Goss.

[No response.]

The CLERK. Mr. Linder.

Mr. LINDER. No.

The CLERK. Ms. Pryce.

Ms. PRYCE. No.

The CLERK. Mr. Diaz-Balart.

Mr. DIAZ-BALART. No.

The CLERK. Mr. Hastings of Washington.

Mr. HASTINGS of Washington. No.

The CLERK. Mrs. Myrick.

[No response.]

The CLERK. Mr. Sessions.

Mr. SESSIONS. No.

The CLERK. Mr. Reynolds.

Mr. REYNOLDS. No.

The CLERK. Mr. Frost.

Mr. FROST. Aye.

The CLERK. Mrs. Slaughter.

[No response.]

The CLERK. Mr. McGovern.

Mr. MCGOVERN. Aye.

The CLERK. Mr. Hastings of Florida.

Mr. HASTINGS of Florida. Aye.

The CLERK. Mr. Chairman.

The CHAIRMAN. No. And the Clerk will report the total.

The CLERK. Three yeas; seven nays.

The CHAIRMAN. And the motion is not agreed to.

Are there further amendments?

Mr. Hastings.

Mr. HASTINGS of Florida. Yes, Mr. Chairman, before I offer my amendments, I would like to offer an anecdotal situation that is related to two of us.

Judge Pryce and myself have had the responsibility of sentencing people at different times during our career. We were provided a presentence investigation or probation report. It named a lot of things. Generally, before going into the sentencing, I read that report; and judges would make a little numerical note, some of them, indicating how much they were going to sentence the person to after listening to the person and their representative. I never did that, and the reason for that is I wanted to have someone persuade me to do either more or less than what was in the presentence report.

We have sat here as we sit here all the time. We let these people come up here and testify, and then we pass something out. My question to you Mr. Chairman, we pass out our rule—and I guess it is a governing principle question or process question. Do you all meet and discuss all of these amendments and then talk about

them or do you just come in here and listen to these people and somewhere you made a decision as to what the rule is going to be?

Do you understand what I am saying? Is there any—is there ever an opportunity for anybody to persuade us to do anything different?

The CHAIRMAN. If you are posing a question to me, let me explain the process.

First of all, as the gentleman knows, he is fortunate enough to serve in two branches of government. Obviously, the legislative branch is certainly quite different than the judicial branch; and I don't consider the role of the Rules Committee as being anything akin to the judicial branch of government.

This is a law-making body, and the process for determining what amendments are made in order is an ongoing order which we deal with the Speaker that—you know this is known as the Speaker's committee. We have the majority of nine to four, which it has been since I have been around and serving as a member of both the majority and minority; and members of this committee are all given the opportunity to provide their input on both sides of the aisle. We structure the rule from the recommendations that are provided to us, working closely with the Speaker of the House and his staff; and then we come forward.

I will tell you, as I have said on many occasions, I myself, having served 14 years as a member of the minority party, regularly, regularly pitched to make as much of the minority agenda in order for consideration because I feel passionate of the Madisonian spirit of minority rights. I will admit that sometimes I am more successful than others, but I will continue to do that. There are a lot of things that go into the consideration of these rules, and obviously the presentations that are made by our colleagues are one of those.

Mr. HASTINGS of Florida. You know, that is part of the problem; and it was like that in the judiciary, too. People got accustomed to doing things the same old way, and then they couldn't change. I don't care whether it is Democrats or Republicans. They were in power, and we were wrong, and now we are wrong.

All I am saying to you is that it doesn't make good sense for us to make the decision about stuff—I could ask anybody in here to tell me what amendment number 24 is about and whether it is a Republican or Democratic amendment. I mean, these are serious proposals.

I am not asking that this be like the judiciary. I understand the dynamics perhaps as good or better than you do, Mr. Chairman.

The CHAIRMAN. I know you certainly do. You and Ms. Pryce have served in both branches.

The fact is, my opening remarks were that we welcome the input of members of the minority and majority. I will tell you, as you know, on regular occasions on issues we have listened to; and I have tried on occasions to accommodate you every time we can. Because, quite frankly, as we have discussed in the hearing the other day—we had a lengthy discussion about the very narrow majority that we enjoy and the priority that I have set forward, and I am proud to be quoted on it. I have the responsibility, as do my colleagues, to move our agenda; and we are doing that.

Quite frankly, as we found in the testimony provided here today, we are going to do something that has never been done before when we, tomorrow on the floor of the House of Representatives, pass a measure that will for the first time put into place a prescription drug program.

Mr. HASTINGS of Florida. I am not quarreling that. I want to use Dr. Gingrey's measure because there is not one of us that would not have had a hospital that would have benefited from what he talked about. Most of us in here don't have a clue about market basket. And here is somebody who came in here—and what I am saying to you is, I will tell you, after I listened to him, I wanted his amendment to be in order not as a Democrat, as a citizen of the United States.

I think it is an abomination when we can't come in here and change our minds or you change your mind or you go back to the Speaker or all of you go back to the Speaker and all the staff and everybody else and say to them, look, we had some people come in here with some serious stuff that needs to be talked about. If we are going to make up our minds ahead of time, what the hell are we up here for? We ought to mail it in.

I have an amendment.

The CHAIRMAN. Please state the amendment.

Mr. HASTINGS of Florida. Amendment number 9 offered by Representative Pallone and ask that the amendment be given the appropriate waivers. Amendment charges the Secretary of Health and Human Services to use the collective purchasing power of 40 million Medicare beneficiaries to negotiate lower drug prices. The Secretary must take into account the goal of promoting the development of breakthrough drugs.

The CHAIRMAN. You have heard the motion of the gentleman. Any discussion?

If not, the vote occurs on the Hastings amendment. Those in favor will say aye. Those opposed, no.

Mr. HASTINGS of Florida. I ask for a roll call.

The CHAIRMAN. The Clerk will call the roll.

The CLERK. Mr. Goss.

[No response.]

The CLERK. Mr. Linder.

Mr. LINDER. No.

The CLERK. Ms. Pryce.

Ms. PRYCE. No.

The CLERK. Mr. Diaz-Balart.

Mr. DIAZ-BALART. No.

The CLERK. Mr. Hastings of Washington.

Mr. HASTINGS of Washington. No.

The CLERK. Mrs. Myrick.

[No response.]

The CLERK. Mr. Sessions.

Mr. SESSIONS. No.

The CLERK. Mr. Reynolds.

Mr. REYNOLDS. No.

The CLERK. Mr. Frost.

Mr. FROST. Aye.

The CLERK. Mrs. Slaughter.

[No response.]

The CLERK. Mr. McGovern.

Mr. MCGOVERN. Aye.

The CLERK. Mr. Hastings of Florida.

Mr. HASTINGS of Florida. Aye.

The CLERK. Mr. Chairman.

The CHAIRMAN. No. And the Clerk will report the total.

The CLERK. Three yeas; seven nays.

The CHAIRMAN. And the motion is not agreed to.

Are there further amendments? Mr. Hastings.

Mr. HASTINGS of Florida. I have an amendment to the rule. I move the committee make in order amendment number 5 offered by my colleague from Florida, Representative Wexler, and ask that the amendment be given the appropriate waivers.

The amendment creates an affordable, dependable Medicare prescription drug benefit structured like Medicare Part B with the defined premium and a strong benefit. The bill is paid for by freezing or repealing the recent tax cuts which disproportionately benefit the wealthiest Americans.

The CHAIRMAN. You have heard the motion of the gentleman. Any discussion?

If not, the vote occurs on the Hastings amendment. Those in favor will say aye. Those opposed, no.

Mr. HASTINGS of Florida. I ask for a roll call.

The CHAIRMAN. The Clerk will call the roll.

The CLERK. Mr. Goss.

[No response.]

The CLERK. Mr. Linder.

Mr. LINDER. No.

The CLERK. Ms. Pryce.

Ms. PRYCE. No.

The CLERK. Mr. Diaz-Balart.

Mr. DIAZ-BALART. No.

The CLERK. Mr. Hastings of Washington.

Mr. HASTINGS of Washington. No.

The CLERK. Mrs. Myrick.

[No response.]

The CLERK. Mr. Sessions.

Mr. SESSIONS. No.

The CLERK. Mr. Reynolds.

Mr. REYNOLDS. No.

The CLERK. Mr. Frost.

Mr. FROST. Aye.

The CLERK. Mrs. Slaughter.

[No response.]

The CLERK. Mr. McGovern.

Mr. MCGOVERN. Aye.

The CLERK. Mr. Hastings of Florida.

Mr. HASTINGS of Florida. Aye.

The CLERK. Mr. Chairman.

The CHAIRMAN. No. And the Clerk will report the total.

The CLERK. Three yeas; seven nays.

The CHAIRMAN. And the motion is not agreed to.

Are there further amendments? Mr. Hastings.

Mr. HASTINGS of Florida. Three more, Mr. Chairman. I have an amendment and move en bloc Cardin number 58, Allen number 43, Allen number 44, Andrews number 11, Andrews number 12, Engel number 39, Engel number 40, Inslee number 23, Inslee number 24, Larson number 51, Sanchez number 21, and Tierney number 42.

The CHAIRMAN. You have heard the motion of the gentleman. Any discussion?

If not, the vote occurs on the Hastings amendment. Those in favor will say aye. Those opposed, no.

Mr. HASTINGS of Florida. I ask for a roll call.

The CHAIRMAN. The Clerk will call the roll.

The CLERK. Mr. Goss.

[No response.]

The CLERK. Mr. Linder.

Mr. LINDER. No.

The CLERK. Ms. Pryce.

Ms. PRYCE. No.

The CLERK. Mr. Diaz-Balart.

Mr. DIAZ-BALART. No.

The CLERK. Mr. Hastings of Washington.

Mr. HASTINGS of Washington. No.

The CLERK. Mrs. Myrick.

[No response.]

The CLERK. Mr. Sessions.

Mr. SESSIONS. No.

The CLERK. Mr. Reynolds.

Mr. REYNOLDS. No.

The CLERK. Mr. Frost.

Mr. FROST. Aye.

The CLERK. Mrs. Slaughter.

[No response.]

The CLERK. Mr. McGovern.

Mr. MCGOVERN. Aye.

The CLERK. Mr. Hastings of Florida.

Mr. HASTINGS of Florida. Aye.

The CLERK. Mr. Chairman.

The CHAIRMAN. No. And the Clerk will report the total.

The CLERK. Three yeas; seven nays.

The CHAIRMAN. And the motion is not agreed to.

Are there further amendments? Mr. Hastings.

Mr. HASTINGS of Florida. I have an amendment to the rule. I move the committee make in order the amendment number 38 offered by myself and ask that the amendment be given the appropriate waivers. I have explained the amendment and offer a unanimous consent request.

The CHAIRMAN. You heard the motion of the gentleman. Any discussion?

If not, the vote occurs on the Hastings amendment. Those in favor will say aye. Those opposed, no.

In the opinion of the Chair the noes have it. The noes have it, and the motion is not agreed to.

Mr. HASTINGS of Florida. I have one more amendment. I move the committee make in order the amendment number 37 offered by myself and ask that the amendment be given the appropriate waiv-

ers. The amendment is a sense of Congress expressing support of Federal and State funded in-home care for the elderly.

The CHAIRMAN. You heard the motion of the gentleman. Any discussion?

If not, the vote occurs on the Hastings amendment. Those in favor will say aye. Those opposed, no.

In the opinion of the Chair, the noes have it. The noes have it, and the motion is not agreed to.

Are there further amendments? If not, the vote occurs on the motion of the gentleman from Atlanta. Those in favor will say aye. Those opposed, no.

In the opinion of the Chair, the ayes have it.

Mr. FROST. Roll call.

The CHAIRMAN. The Clerk will call the roll.

The CLERK. Mr. Goss.

[No response.]

The CLERK. Mr. Linder.

Mr. LINDER. Aye.

The CLERK. Ms. Pryce.

Ms. PRYCE. Aye.

The CLERK. Mr. Diaz-Balart.

Mr. DIAZ-BALART. Yes.

The CLERK. Mr. Hastings of Washington.

Mr. HASTINGS of Washington. Aye.

The CLERK. Mrs. Myrick.

[No response.]

The CLERK. Mr. Sessions.

Mr. SESSIONS. Aye.

The CLERK. Mr. Reynolds.

Mr. REYNOLDS. Aye.

The CLERK. Mr. Frost.

Mr. FROST. No.

The CLERK. Mrs. Slaughter.

[No response.]

The CLERK. Mr. McGovern.

Mr. MCGOVERN. No.

The CLERK. Mr. Hastings of Florida.

Mr. HASTINGS of Florida. Nay.

The CLERK. Mr. Chairman.

The CHAIRMAN. Aye. And the Clerk will report the total.

The CLERK. Seven yeas, three nays.

The CHAIRMAN. The motion is agreed to.

Ms. Pryce has been working on this for a long period of time, and she will be managing this for the majority and Mrs. Slaughter for the minority.

Let me just say we have two more rules that we are going to be considering: the measure on H.R. 2559, the Military Construction Appropriations bill. We have no witnesses here. We have an open rule that we are going to be having offered by the gentleman from Atlanta, Mr. Linder.

Mr. LINDER. Mr. Chairman, I move the committee grant H.R. 2559, the Military Construction Appropriations Act for fiscal year 2004, an open rule providing one hour of general debate equally di-

vided and controlled by the chairman and ranking minority member of the Committee on Appropriations.

Under the rules of the House the bill shall be read for amendment by paragraph. The rule waives points of order against provisions in the bill for failure to comply with clause 2 of rule XXI—prohibiting unauthorized appropriations or legislative provisions in an appropriations bill. The rule authorizes the Chair to accord priority in recognition to Members who have preprinted their amendments in the Congressional Record.

Finally, the rule provides one motion to recommit with or without instructions.

The CHAIRMAN. You heard the motion of the gentleman.

Any discussion? Mr. Frost.

Mr. FROST. I have an amendment. I move the committee make in order the amendment offered by Representative Obey and ask that the amendment be given the appropriate waivers.

The Obey amendment would increase the amount of the Military Construction Appropriations bill to the level of the President's request. This amendment is paid for by reducing the average tax cut received by millionaires under H.R. 2 from \$88,000 to \$83,000.

The CHAIRMAN. You heard the motion of the gentleman. Any discussion?

Mr. MCGOVERN. I strongly support the gentleman's amendment. We all talk about what a great job our men and women in uniform are doing, and this is underfunded and adequately addresses a whole range of issues.

The CHAIRMAN. Vote occurs on the Frost amendment. Those in favor will say aye. Those opposed, no.

In the opinion of the Chair, the noes have it. The noes have it.

Mr. REYNOLDS. Roll call.

The CHAIRMAN. The Clerk will call the roll.

The CLERK. Mr. Goss.

[No response.]

The CLERK. Mr. Linder.

Mr. LINDER. No.

The CLERK. Ms. Pryce.

Ms. PRYCE. No.

The CLERK. Mr. Diaz-Balart.

Mr. DIAZ-BALART. No.

The CLERK. Mr. Hastings of Washington.

Mr. HASTINGS of Washington. No.

The CLERK. Mrs. Myrick.

[No response.]

The CLERK. Mr. Sessions.

Mr. SESSIONS. No.

The CLERK. Mr. Reynolds.

Mr. REYNOLDS. No.

The CLERK. Mr. Frost.

Mr. FROST. Aye.

The CLERK. Mrs. Slaughter.

[No response.]

The CLERK. Mr. McGovern.

Mr. MCGOVERN. Aye.

The CLERK. Mr. Hastings of Florida.

Mr. HASTINGS of Florida. Yes.

The CLERK. Mr. Chairman.

The CHAIRMAN. No. And the Clerk will report the total.

The CLERK. Three yeas; seven nays.

The CHAIRMAN. And the motion is not agreed to.

Are there further amendments? If not, the vote occurs on the motion of the gentleman from Atlanta. Those in favor will say aye. Those opposed, no.

In the opinion of the Chair, the ayes have it. The ayes have it. Mrs. Myrick will be managing this rule for the majority.

Mr. FROST. Mr. McGovern for the minority.

The CHAIRMAN. Our final rule, as we discussed at the subcommittee hearing committee that Mr. Linder presided over, we will be allowing for the consideration of motions to suspend the rules on Wednesdays through this Congress.

Chair will be in receipt of a motion.

Mr. LINDER. Mr. Chairman, I move the committee report a resolution providing that during the remainder of the One Hundred Eighth Congress the Speaker may entertain motions that the House suspend the rules on Wednesdays as though under clause 1 of rule XV.

The CHAIRMAN. You heard the motion of the gentleman. Any discussion?

If not, the vote occurs on the gentleman's motion. Those in favor will say aye. Those opposed, no.

In the opinion of the Chair, the ayes have it. The ayes have it, and Mr. Linder will be managing this rule for the majority.

Mr. FROST. Mr. McGovern for the minority.

The CHAIRMAN. And Mr. McGovern for the minority.

Thank you all very much for being here. We thank you very much. We appreciate that, and we will see you all in a very short period of time.

The committee stands adjourned.

[Whereupon, at 5:10 a.m., the committee was adjourned.]