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Note: Senator Grassley gave this speech this afternoon.

Senator Chuck Grassley  
Comprehensive Floor Statement -- Tripartisan 21<sup>st</sup> Century Medicare Act  
July 18, 2002

Since 1965, the Medicare program has provided life-saving health care services to our nation's senior and disabled populations. Hundreds of millions of Americans have had their quality of life improved and their health protected because of the Medicare program. We must ensure that Medicare continues the exemplary service it has provided beneficiaries since its inception in 1965. Unfortunately, Medicare has not kept up with advances in medical treatment.

Medical advances in delivering health care have moved us light years beyond 1965, but the Medicare program has not been changed to reflect those health care advances. In order to ensure that Medicare is meeting the needs of today's and tomorrow's seniors, the program needs to be brought into the 21<sup>st</sup> Century. That's why, after a year of work, I introduced legislation to do just that with a bipartisan – tripartisan, in fact – group of my distinguished colleagues: Olympia Snowe, John Breaux, Jim Jeffords, and Orrin Hatch.

Our 21<sup>st</sup> Century Medicare Act is designed to bring Medicare up-to-date by adding a comprehensive prescription drug benefit and by making other improvements to the program. The Congressional Budget Office has estimated our bill will cost \$370 billion over 10 years. I understand Senator Daschle's bill, however, has not even been scored by CBO. I want to take a moment and walk through the elements of our 21<sup>st</sup> Century Medicare Act.

#### MEDICARE DRUG BENEFIT

First, the 21<sup>st</sup> Century Medicare Act adds a comprehensive, voluntary, permanent drug benefit to Medicare. Our monthly premium of \$24 is the lowest premium of any comprehensive proposal before Congress. Our drug benefit is focused on providing money where it's needed the most — on the needs of low income senior citizens and those with high out-of-pocket costs. For seniors with low incomes – starting with those below 135% of poverty - which equals \$11,961 for an individual and \$16,119 for a couple, Medicare will first pay the entire amount of their monthly drug premiums.

Medicare will assist them in paying for drugs at every level of spending. They will pay only \$1-2 for their prescriptions. On average, this group of low income older people will see a 98% reduction in their total drug costs. Next, I want to talk about seniors with incomes above 135% of

poverty but below 150% of poverty. This includes individuals with incomes below \$13,290 and couples with incomes below \$17,910. These enrollees will receive Medicare assistance on a sliding scale to help pay for their monthly premiums.

Also, Medicare will assist them in paying for drugs at every level of spending. There is no gap in coverage for these beneficiaries. Next, beneficiaries with incomes above 150% of poverty — that's \$13,290 for an individual and \$17,910 for a couple — will pay an average monthly premium of \$24 for the Medicare drug benefit. Again, that's the lowest monthly premium of any comprehensive drug bill before Congress. They will pay a \$250 deductible. After they have reached the deductible, Medicare will cover 50% of their drug costs up to a benefit limit of \$3,450 in total drug spending. Furthermore, Medicare will cover 90% of all drug costs after beneficiaries have paid \$3,700 out of their own pocket for drugs.

Let me say a bit more about our drug benefit for Medicare beneficiaries above 150% of poverty. First, I wish we didn't have a gap in coverage between \$3450 and \$3700. But the problem is that we're working with a limited amount of money, \$370 billion. We have adopted a policy of using funds to benefit the largest possible number of Medicare beneficiaries, particularly those with lower incomes. This approach requires trade-offs.

It's important to point out and to stress that fully 80% of all Medicare beneficiaries will spend less than the initial benefit limit, or will have access to low-income protections, and therefore will have no gap in coverage. Let me repeat that number: 80 percent.

For the 20 percent of Medicare enrollees who are exposed to the gap in coverage, our bill requires that Medicare drug plans pass negotiated drug discounts along to Medicare enrollees at all times. So all of those enrollees will be able to purchase drugs at reduced prices.

Our bill may include a small "donut hole". But the Graham proposal includes a black hole since its drug benefit ends after 2010, leaving Medicare enrollees without any drug benefit whatsoever.

## MEDICARE DRUG BENEFIT DELIVERY SYSTEM

How did we arrive at our approach to delivering drugs? Basically, by working with the Congressional Budget Office. And remember, the Congressional Budget Office is the independent, non-partisan congressional staff office which analyzes legislative proposals for cost and for workability. They don't have an axe to grind, and we here in the Congress rely heavily on their expertise.

According to CBO, spending on drugs for seniors over the next decade will grow at an astronomical rate. They told us that the only way to contain the cost of a drug benefit is to ensure that drugs are delivered efficiently. In turn, CBO says that the only way to have drugs delivered efficiently is to have true competition.

True competition, according to CBO, requires that we must use private plans that assume a reasonable degree of risk. What I mean by risk is this: if they are efficient, they will make money, and if not, they will lose money. If they drive hard bargains with drug manufacturers, they will make money, and if not, they will lose money.

A limited degree of risk is all the tripartisan bill requires: no more than 25 percent. Put another way, the federal government is protecting Medicare Prescription Drug Plans from 75 per cent

of program costs. CBO assures us that this level of risk is high enough to promote efficient drug delivery, and low enough to assure that plans participate in a stable, reliable drug delivery system. It's the optimal level of risk.

And insurers, who were so unhappy with the House bill in 2000, have indicated that they can live with the level of risk in our bill. Mr. President, they would be crazy not to participate. Our opponents are saying that if the federal government lays \$340 billion dollars on the table – by far the largest entitlement expansion ever – that plans will not participate. Well, they're wrong. But you don't have to take my word for it. CBO says they're wrong, the insurers themselves say they're wrong, and common sense says they're wrong.

Unfortunately for our opponents, Mr. President, no one has invented a prescription drug that gives you common sense. We need to make the dollars we have go as far as they can. Whatever our individual thoughts, CBO is the arbiter, and they tell us that our bill, the 21<sup>st</sup> Century Medicare Act, does that.

### RURAL PROTECTIONS

I want to address the question of whether the system our bill would establish will work for rural areas. I represent a rural state. I wouldn't support a Medicare drug bill that would put the rural areas of our nation at risk. Our bill guarantees that every Medicare enrollee will have a choice of two Medicare drug plans – and that's a minimum. The government will establish service areas for plans to offer the Medicare drug benefit. These service areas must be the size of a state – at a minimum. That means that a plan wanting to offer a drug benefit in Des Moines, Iowa, must also offer the same drug benefit in my small home-town of New Hartford.

Another point I want to make concerns pharmacies. Our bill ensures that Medicare beneficiaries will have convenient access to a “bricks and mortar” pharmacy. The standards outlining what is “convenient” will be determined by the government. Furthermore, in developing the “convenient access” standards, the government is explicitly required to take into account Medicare beneficiaries in rural areas. Mr. President, doesn't Senator Daschle trust the government?

### CONSUMER PROTECTIONS

Our drug benefit proposal puts into place important consumer protections for Medicare enrollees. First, all Medicare drug plans will be put through a comprehensive approval process to ensure they will deliver quality drug benefits to seniors. The new Medicare Competitive Agency in the federal Department of Health and Human Services will have to review and approve the application of a plan before that plan can participate in the program.

Standardized information on each drug plan will be sent by HHS to all Medicare enrollees. If Medicare drug plans want to advertise to enrollees, all marketing materials must be approved by HHS. All seniors will have access to necessary prescription drugs. HHS will determine therapeutic classes of drugs, and Medicare drug plans will be required to offer drugs in all therapeutic classes. If Medicare drug plans use formularies, they must establish a pharmacy and therapeutic committee to develop and review the formulary. Physicians and pharmacists must be represented on the committee. The P&T committee shall base formulary decisions on scientific evidence and standards of practice. Now, while I've outlined a few ways in which our bill differs from the Daschle bill, I'd like to add a few more ways in which our bill differs from his proposal.

## DRUG PRICES

First of all, Senator Daschle's plan is overly bureaucratic and extravagant. Therefore, it does nothing to curtail or even slow skyrocketing prescription drug costs. That's why it's essential that any new prescription drug benefit contain proper cost management controls that moderate growth in price while ensuring Medicare enrollees access to prescription drugs.

While guaranteeing comprehensive drug coverage for all seniors, our proposal imposes reasonable cost-sharing obligations on beneficiaries and promotes competition among prescription drug plans, which lead to a better overall effect on drug prices. That's a benefit to Medicare beneficiaries and to all Americans not yet eligible for the program.

## FLEXIBILITY OF MEDICARE DRUG BENEFIT

Under the Daschle plan, seniors face fixed copayment amounts that in many instances mean they will actually pay more for drugs than they would under a system such as the one we propose that gives prescription drug plans more flexibility to offer lower cost copayments.

Senator Daschle also writes into law the monthly premium seniors will pay for their drug benefit. But what happens if a plan has been efficient and wants to attract more Medicare enrollees by lowering their premium below that of other plans? Under the Daschle approach, Congress would have to pass legislation for the plan to lower their premium.

Our bill gives plans the freedom to offer premiums, copayments and deductibles that save seniors money.

## ENHANCED MEDICARE FEE-FOR-SERVICE OPTION

Mr. President, I will now outline something our bill does that none of the other proposals on the table now do: it creates a new Enhanced Option within the Medicare program. This is another fee-for-service program. Let me be clear about this: it's delivered by the federal government just like traditional Medicare. There's been some confusion on that point, so I want to make sure it's understood.

We think it's an option many beneficiaries might find attractive. But here's the beauty of it: we're not going to make that choice for them. They will make it for themselves. Here's the bottom line: if beneficiaries like the Medicare they have now, they can keep it... forever. It's their choice. In fact, even future beneficiaries will always have this same choice – both existing Medicare and the Enhanced Option will continue in perpetuity. There is no "sunset" of the existing Medicare benefit package in our bill, like Senator Daschle's "sunset" of his drug benefit.

In addition, Medicare enrollees can enroll in the Medicare drug benefit whether they are in traditional Medicare fee-for-service, Enhanced Medicare fee-for-service, or in Medicare+Choice. Here's the choice our bill offers seniors. Existing Medicare Parts A and B focus on coverage of routine, predictable medical expenses. But the Enhanced Option, Part E, focuses on preventive care and protection against devastating costs of serious illness. If beneficiaries prefer what they have now, they can keep it. But if they like the idea of better prevention and better insurance when they need it, they can take that.

On the subject of prevention, let me explain our proposal. Medicare's current policy makes

beneficiaries reluctant to seek out preventive services that may identify health problems and prevent more expensive care later. Unlike many private health plans, Medicare today subjects most preventive benefits to the Part B deductible and coinsurance (usually 20%). For those who elect the Enhanced Option, preventive benefits would not be subject to the deductible or to coinsurance. That's an example of moving Medicare into the 21<sup>st</sup> Century.

Let me highlight another improvement the Enhanced Option would offer. Medicare today has no limit on a beneficiary's expenses in a year, creating the potential for crippling costs in the event of serious illness.

The bill would limit beneficiaries' exposure to out-of-pocket costs for Medicare-covered services (other than drugs) to \$6,000 per year. Beyond that amount, Medicare would pay 100% of any costs incurred by the beneficiary. In a given year, it is estimated that 2 to 3% of beneficiaries may have costs that reach this level. Of course, if one looks at beneficiaries over multiple years, their likelihood of such expenses increases accordingly. If beneficiaries want the peace of mind that comes from such protection against serious illness, they should have that choice.

Another issue our Enhanced Option addresses is Medicare's deductible structure. Under current law, the Part A deductible will be extremely high in 2005 – \$920 per spell of illness -- while the Part B deductible will still be only \$100 per year. The Enhanced Option includes a unified deductible of \$300 per year for all services.

Medicare's irrational 2-deductible system is unheard of in private insurance today, so beneficiaries are used to a single deductible from their prior employer-based plans. If they liked that approach, our plan lets them have something similar in Medicare.

Here's another benefit of the Enhanced Option. Because Medicare benefits have so many holes, in contrast to private insurance plans, most beneficiaries are forced to carry supplemental coverage to fill in the gaps. Reducing those gaps will make such supplemental coverage less necessary and more affordable for beneficiaries. Our bill establishes such new, more affordable Medigap plans. And by the way, those employers who offer supplemental coverage will also find it less costly to do so under the Enhanced Option, since it will have fewer holes to fill.

Is the Enhanced Option a better deal? From an actuarial standpoint, yes. CBO tells us it is a more valuable benefit, largely because of the serious illness protection it offers. But not all seniors are actuaries. So we're leaving it up to them to decide what is the better deal.

## MEDICARE+CHOICE IMPROVEMENTS

Let me briefly mention the last title of the bill. Starting in 2005, our bill takes modest steps to improve the Medicare+Choice program. Medicare+Choice has been a big disappointment in my home state of Iowa. But seniors elsewhere rely on it. Our proposal keeps that option alive, without throwing money at the program as we have in the past.

Instead, we create a competitive bidding system under which M+C plans will compete with each other – but not with the Medicare fee-for-service program – for beneficiaries. I want to emphasize that no one in fee-for-service Medicare will be affected by this change. We've made this change because today's bureaucratic pricing system sets arbitrary and inaccurate rates that discourage Medicare+Choice plans from participating. Our approach to Medicare+Choice is based on a bipartisan model embraced by the Clinton Administration and will result in fairer and more accurate

payments to Medicare+Choice plans.

## CONCLUSION

Mr. President, I will be returning to the floor often to discuss our plan further. I look forward to the debate, because I believe when the American people see what we are offering and what Senator Daschle is trying to deny them, they will send us a powerful message to put politics aside and get this done. I yield the floor.