Committee On Finance
Max Baucus, Ranking Member

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Statement of U.S. Senator Max Baucus (D-Mont.)
U.S. Senate Finance Committee Hearing
on Implementation of the New Medicare Drug Benefit
(as prepared)

Thank you, Mr. Chairman. And thank you for calling this hearing.

The Finance Committee played a key role in enacting Medicare drug benefits. We must be diligent in overseeing their implementation.

In 2003, after years of debate, Congress added prescription drug coverage to Medicare. I was proud to help pass that law. The law was not perfect. But it has the potential to do some good.

It has the potential to make prescription drugs available to millions who could not otherwise afford them. It has the potential to make drugs available that will lessen pain. It has the potential to save lives.

Unfortunately, the administration has implemented the new law poorly. After Congress passed the law, the Centers for Medicare and Medicaid Services — CMS — had the duty to ensure that Medicare drug benefits were up and running by January 1, 2006.

I appreciate CMS's efforts to implement the new law. It's a huge task. CMS worked hard.

But CMS's efforts have come up short, in two major areas.

First, CMS made the new drug benefit needlessly confusing.

As part of the new law, Congress passed a temporary drug discount card, available in 2004. The card was supposed to give temporary relief from high drug costs. Seniors of modest means were eligible for a $1,200 federal subsidy for their drug purchases.

But most Medicare beneficiaries did not sign up for the drug card. Why? They were paralyzed by the choices. CMS approved 40 Medicare drug cards in my state of Montana alone.

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Far from celebrating the array of choices, most Montana seniors found them so confusing that they gave up, and did not sign up..

Less than a year later, CMS was approving drug plans for the new drug benefit. I urged CMS not to repeat the mistakes that they made with the drug card. I urged CMS to approve only plans meeting the highest standards.

But CMS repeated the mistakes of the drug card. CMS approved dozens of plans for participation in the new drug program. CMS approved more than 40 drug plans in Montana.

I support choice, competition, and the free market. It's great that Americans can choose from hundreds of different models when buying a new car.

But when people don't know what they're buying, choice can lead to confusion. That's particularly true of health care.

Ask elderly Americans whether they prefer a four-speed automatic or a five-speed manual, and they will probably choose the automatic. Ask them whether they prefer a drug plan with a four-tiered formulary to a plan with five, and they will probably look at you with a mixture of confusion and anger.

My second concern relates to the warnings that CMS ignored.

Last year, I asked the independent Government Accountability Office to report on CMS's plans for seniors eligible for both Medicaid and Medicare.

I asked: What were CMS's plans for seniors whose drug coverage was moving from Medicaid to Medicare? In December 2005, GAO reported that CMS's plans were insufficient to avoid big disruptions in coverage.

CMS disagreed. CMS said: "[We have] worked diligently on the transition from Medicaid to Medicare drug coverage ... and ... these individuals will get effective, comprehensive prescription drug coverage ... on January 1, 2006."

That did not happen. GAO was right. Data systems failed. Pharmacists and states were stuck with the bill for co-pays that should never have been charged. And some vulnerable seniors left the pharmacy without the medicines that they needed.

We're going to hear about some of these issues today, including from Tobey Schule, an independent pharmacist from Kalispell, Montana. Mr. Schule is one of thousands of pharmacists who have been burdened with the flawed transition from Medicaid to Medicare.

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I appreciate CMS's attempts to fix the problems. But some problems remain unsolved. Dr. McClellan, I look forward to hearing how — and when — CMS plans to fix the problems.

In addition to ensuring that the implementation flaws are fixed, Congress should also address the problem of confusion. We can do that by learning the lessons of Medigap.

In 1980, Congress enacted amendments that I offered to fix marketing abuses and consumer confusion with Medigap. The reforms required Medigap issuers to meet minimum standards and have minimum loss ratios.

Ten years later, Congress again took up Medigap reform, passing legislation to standardize Medigap policies. Ten different Medigap options would be offered, each with a basic set of benefits.

This gave consumers an apples-to-apples comparison of Medigap coverage.

We should do the same with the new drug program. We should standardize the drug plans. We should make it easier for people to make good choices about which plan is best for them. I intend to introduce legislation to do just that.

I understand that the drug benefit is young. But I want this benefit to work. We simply cannot afford another round of confusion. We need broad participation. And that's not going to happen unless we make the program more accessible and understandable.

I supported enactment of the Medicare drug benefit in 2003. I still support it. Health insurance needs to cover prescription drugs.

But we need to make it work. And I look forward to hearing from our witnesses on how we can do so.

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