United States Senate
Committee on Finance

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Floor Statement of U.S. Senator Chuck Grassley of Iowa
After the Cloture Vote on S.3, legislation to allow a government takeover
of negotiations of Medicare Part D prices
Wednesday, April 18, 2007

Mr. President, I want to make a couple of points in response to comments made about this morning's vote on S. 3.

Members on the other side of the aisle, including the Assistant Majority Leader, said that Republicans don't want this debate. Don't want the debate? This body has debated the so-called prohibition on government negotiation. The Senate has had four votes on this issue. What's rather amusing to me about the statement that we don't want the debate, is that they didn't seem to want the debate when the Senate considered S.1.

S. 1 was the Senate version of the Medicare drug law. That bill had a non-interference clause in it just like the current law does. And, it's that clause that the other side has distorted to come up with their absurd claim that no negotiations occur under the Medicare drug benefit.

Not once, I repeat not once, during the entire time that S.1 was on the Senate floor did anyone on the other side of the aisle bring this issue up. That's because this isn't an issue of merit. It's simply one borne out of political pandering.

Mr. President, the Assistant Majority Leader also talked again about how Medicare should look like the VA because it gets lower prices. The VA gets lower prices because the government passed a law to guarantee itself an automatic discount no one else can get. By law, that price is automatically 24 percent less than the average price paid by basically all non-federal purchasers. That's not a negotiation. That is a federally-mandated 24 percent discount.

I agree that the logical question then is: "Why not have Medicare get that price?" Experts who testified at the Senate Finance Committee, even the VA itself at a 2001 hearing before the Veterans Affairs Committee, gave us the answer: They said that giving Medicare VA prices will increase prices for veterans. Increases prices for veterans.

Now I want to turn to how the VA uses its own pharmacy benefits manager or PBM. That's right a PBM. In 1995, as part of an effort to better manage and monitor drug usage, purchasing, and utilization oversight across the VA, the VA established its own PBM. The VA

did it because it wanted to have its pharmacy operations work more like the private sector. They did it because, as stated in a VA news release, they wanted to maximize a developing business strategy in the private sector. That business strategy was getting lower prices on drugs in the private sector.

So here we have people holding out the VA as a model, which uses its own PBM to negotiate, and at the same time they're saying using PBMs in Medicare is bad. I can't help but see more than a bit of irony when people say they want Medicare to negotiate like the VA negotiates. Well, the V-A- negotiates through its PBM. So the funny thing is, the VA actually negotiates like Medicare drug plans. You heard that right. The VA's system for negotiating is just like the one already used by Medicare through its prescription drug plans. If the VA's PBM looked at itself in the mirror it would see a Medicare drug plan's PBM staring back at it.

There's another important difference between the VA and Medicare. The VA prescription drug benefit is just one part of the VA's health care delivery system. It is a very different system than Medicare's. The VA delivery system requires Veterans to use: VA hospitals, VA physicians, the VA's national formulary, VA pharmacies, and the VA's mail-order pharmacy. Don't get me wrong, the V-A has a good system that works for veterans. But what it comes down to are choices.

Under the Medicare Prescription Drug Benefit, beneficiaries have choices. They can choose the plan they want, a plan that covers all their medicines. They can choose the doctor and the hospital they want. They can go to their local pharmacy. Even the VA recognizes this fact. On its own website, in the Frequently Asked Questions page, the VA does not recommend that veterans cancel or decline coverage in Medicare because a veteran may want to consider the flexibility afforded by enrolling in both VA and Medicare.

For example, veterans enrolled in both programs may obtain prescription drugs that are not on the VA formulary if prescribed by non-VA physicians and filled at local pharmacies. Making all Part D programs look like the VA and its formulary will severely restrict access and choice to Medicare beneficiaries. Now the other side, says, "No, no, we're not going to limit access to drugs." Yet, as I pointed out this morning, every Democrat on the Finance Committee cast a vote against my amendment that would have prohibited the Secretary from creating a national preferred drug list. I had thought that, for all the talk of not allowing a government formulary, the proponents of S.3 would embrace a provision banning preferred drugs lists. If they really don't want to limit beneficiaries' access to drugs, my amendment should have been an easy thing for them to support. But by voting against my amendment, they were voting in favor of the government setting a preferred drug list.

Now a preferred drug list might sound like a good thing, but in reality, it's not. It's a government-controlled list of drugs that you can or cannot have. It operates like a formulary. In my opinion, if it walks like a duck and quacks like a duck, then it's a duck. But that's not what the courts have found.

So what does that mean for Medicare and beneficiaries? It means that even though S.3 prohibits the Secretary from using a formulary, it does not prohibit the Secretary from using a

preferred drug list. It's clear now that supporters of the Senate bill want the government to set a preferred drug list. They want to government to determine which drugs seniors can get coverage for. A number of states have implemented preferred drug lists. Michigan, for example, has a preferred drug list. Here's what the Kaiser Family Foundation found in a 2003 case study on that preferred drug list: “Fearing opposition from the pharmaceutical industry, the state sought virtually no input from providers, pharmacists, beneficiaries, and manufacturers. ... “Ultimately, the Department made only a few changes to the list of drugs on the Michigan preferred drug list in response to beneficiary and provider concerns.”

In both the Illinois House and Senate, resolutions were introduced in 2002 to establish a committee to oversee that state's preferred drug list. The resolution noted that the creation of the Illinois preferred drug list: “could lead to unintended consequences such as inferior healthcare, increased hospitalizations and emergency care, increased admissions into long-term care and unnecessary patient suffering and potentially death.”

In a statement about his bill, S.345, the Assistant Majority Leader said that the Medicare-administered plan envisioned under his bill would have a preferred drug list.

Mr. President, this morning I talked about fitting all the pieces of this legislative puzzle together. Here are some of those pieces: The bill approved by the House allows price controls. The bill that was before the Senate doesn't prohibit the Secretary from dictating the drugs beneficiaries can get. We have Senator Durbin's statement about his own bill and how he envisioned a preferred drug list.

Mr. President, despite claims by those on the other side of the aisle, this bill is not harmless. If this Trojan Horse attack succeeds in a government takeover of the drug benefit here's what seniors can look forward to. They can look forward to fewer choices and fewer opportunities to chose a plan that best meets their needs. If the Senate bill were to pass, seniors will get only the drugs the government selects for them. All other Americans will see higher prices for their prescription drugs. If that's what the other side calls harmless, I shudder to think about what their definition of harmful might be.

Mr. President, we should have and did stop this bill in its tracks. Voting no was a vote against: government-controlled drug lists; government setting prices; and government restrictions on seniors' access to drugs. That was the right thing to do. I yield back the floor.