Transcript of Floor Statement by Senator Kent Conrad (D-ND)
on the Prescription Drug and Medicare Improvement Act
June 17, 2003

I rise to discuss the prescription drug bill and the Medicare reform package that is before us now. As a member of the Finance Committee, I was involved in the markup of this legislation.

Let me begin by commending the chairman, Senator Grassley, and the ranking member, Senator Baucus, our former chairman, for the way in which they brought our committee together. That was not easy to do. It is an extraordinarily complex undertaking to have an expansion of Medicare of this magnitude and to do it in a way that will achieve real results.

I thank the chairman and the ranking member for the way they brought us together, and for the tone they set in the committee. We were in markup from 9 in the morning until 9 o'clock at night--12 hours of togetherness that actually went very well.

I think we all know why we are here. When Medicare was first drafted, the world was a very different place in terms of providing health care. As Senator Moynihan used to explain, at the time Medicare was drafted, the Merck Manual that contains all prescription drugs was a very thin volume. Now. when we look at the Merck Manual, it is a very weighty tome. There is a dramatic change in the pattern and practice of medicine. Perhaps no better example is what happens with stomach illness. Twenty years ago, there was not much one could do for somebody who suffered from ulcers other than to have surgery. But now with prescription drugs that address the underlying causes, stomach surgery has been reduced by two-thirds. Yet, in Medicare there is no coverage for those prescription drugs. You can't have a modern Medicare without a prescription drug component.

The problem is millions of Americans don't have any coverage. If we look at an outline of where we are, we see that 38 percent of those who are Medicare eligible have no drug coverage. Ten percent get their coverage through Medicaid, 15 percent through a Medicare HMO, 28 percent employer-sponsored coverage, 7 percent Medigap, and others, 2 percent. But nearly 40 percent have no coverage.

That creates some very tough situations. And we can see there are real differences between where somebody lives, how old they are, and their income level, as to whether they are in that nearly 40 percent of Americans who have no coverage. We see for those over the age of 85, 45 percent have no coverage. For those who live in rural areas--and I represent a rural area, the State of North Dakota--50 percent have no coverage. Forty-four percent of those who have between $10,000 and $20,000 of income have no coverage.

What we see is the situation is going to become more challenging and more difficult as out-of-pocket expenses for prescription drug expenditures jump dramatically. In 2000, those out-of-pocket expenditures averaged $644. By this year, it was up to $999--a 50-percent increase in just 3 years. And in the next 3 years, we anticipate another very large increase to $1,454 a year in prescription drug costs.

The implications of that are outlined on this chart. This shows a study in eight States. It shows the percentage of seniors who reported forgoing needed medicines, and that is listed by chronic condition and prescription drug coverage.

What it shows by the red bar is those without coverage, and it shows the percentage of seniors who did not fill prescriptions one or more times due to cost. For congestive heart failure, 25 percent of the people did not fill their prescriptions because they could not afford it; 31 percent of those who suffered from diabetes did not fill their prescriptions because they could not afford it; and 28 percent of those with hypertension did not fill their prescriptions because they could not afford it.

If we go to the next element of the chart, the percentage of seniors who skipped doses in order to make it last longer: For congestive heart failure, 33 percent of those without coverage skipped doses; 30 percent of those with diabetes skipped doses because they could not afford it; and 31 percent of those with hypertension skipped doses because they could not afford it. Obviously, that reduces the quality of care and ultimately increases the cost. Why? Because those people are more likely to be hospitalized. And it is when a senior is hospitalized that the cost really escalates.

I think it is in all our interest--both in terms of the quality of health care but also in terms of the cost of health care--that we get this right and we make the changes necessary to provide a prescription drug benefit in Medicare.

Here, outlined on this chart, are the specific provisions of this legislation. These are estimates of the basic plan which will take effect in 2006. This excludes the low-income subsidies. We will talk about that in a moment. The premium will average about $35 a month; at least that is the projection at this point. The deductibles will be $275 a year. From $276 to $4,500 of prescription drug costs a year, 50 percent will be paid by Medicare, 50 percent by the senior citizen. Between $4,501 and $5,812 of prescription drug costs a year, there will be no assistance from Medicare. That is the so-called coverage gap, what some refer to as the ``doughnut." This is an area in which there is no assistance, no coverage. The reason for that is not enough money. For $5,813 and above in prescription drug costs, Medicare will provide 90 percent assistance, the senior citizen 10 percent.

I think that is one of the most important parts of this bill. I would support this bill if there were no other provision than just this one. To provide 90 percent assistance to those who have catastrophic drug costs is going to make a meaningful difference.

I was just with one of my staff members in North Dakota. Her mother had a rare form of cancer. At one point her drug costs were running $20,000 a month--$20,000 a month. Thankfully, she was insured. As we see, nearly 40 percent of seniors in the country are not. How many families could withstand a drug cost of $20,000 a month? For this particular family, their drug cost now has been reduced. She is past the acute phase, thankfully. Their drug costs are still running $2,500 a month. That is $30,000 a year.

This provision will help people like that. It will keep people from bankruptcy. It will

avoid people having to not have treatment. It will prevent crises in many families across the country.

That is not the only part that I think merits support.

As shown on this chart, these are the low-income provisions. I want to direct people's attention to this line. For those who are below 160 percent of poverty, they will get more assistance. So, for example, in that zero to $4,500 range of prescription drug costs, Medicare will pick up 90 percent of the cost for those low-income people. They will have to provide 10 percent of the cost. This, to me, is another strong reason to support this legislation.

A third key element of this bill that I think merits support--certainly for those who have rural areas--is the beginning of the leveling of the playing field between the rural areas and the more urban areas of the country.

Just to give an example, in my home State, Mercy Hospital in Devils Lake, ND, gets exactly one-half as much in Medicare reimbursement to treat a heart ailment or to treat diabetes as Mercy Hospital in New York City--exactly one-half as much. Now, I would be the first to acknowledge there is somewhat of a difference in cost, but it isn't a 100-percent difference. When we go to buy technology for that hospital in Devils Lake, ND, we do not get a discount. When we try to recruit a doctor, he does not say to us: Well, you are a rural area, so I will take half as much money. That is not the way it works.

So this incredible divergence, this disparity that exists in current law, needs to be addressed, and this bill will begin to address it. It does not close the gap, it does not eliminate the problem, but it does make meaningful progress. It permanently and fully closes the gap between urban and rural standardized payment levels. But unlike the legislation I introduced, it does not take effect until 2005. The legislation I introduced, along with 30 of my colleagues, would have taken effect in 2004.

It also adopts all of the other provisions of the bill that I introduced along with Senator Thomas of Wyoming. It equalizes Medicare disproportionate share payments. Those are the ones that are used to cover the costs of treating the uninsured. It establishes a low-volume adjustment payment for small rural hospitals. It improves the wage index calculation which accounts for a hospital's labor costs. It ensures that rural hospitals are reimbursed fairly for outpatient services.

It provides a whole series of improvements to critical access hospitals, including improved payments for ambulance services, increased flexibility in the bed limit, excluding critical access hospitals from the wage index calculation for other hospitals, which will improve payments to other larger facilities, has new incentives to ensure 24-hour access to emergency on-call providers, and has new measures to assure the critical access hospitals will receive timely Medicare reimbursement. It also authorizes a capital infrastructure loan program which will provide $5 million in loans for crumbling rural facilities.

In addition, it provides a series of other provisions which a number of us have cosponsored and put before the body, including extending a 10-percent add-on payment for rural

home health agencies, many of which are under pressure to close; a new 5-percent increase for rural ground ambulance services; a new 5-percent add-on for clinic and ER visits in rural hospitals; and a new automatic10-percent bonus payment for physicians serving in rural areas.

It has measures to address the geographic inequities in physician reimbursement, and an extension of improved payment for lab services in sole community hospitals.

This does not close the gap between rural institutions and more urban institutions, but it does make meaningful progress in leveling the playing field, and that is critically important to rural hospitals.

Let me say, in my own State we have 44 hospitals. At least eight of them are in danger of closing because of this enormous gap in Medicare reimbursement. Over 50 percent of their patients are Medicare eligible. If things don't change, these institutions are going to have to close.

Those are positive aspects of the bill. Let me speak for a moment about what is in the bill that could and should be improved. The first that comes to my mind is the instability in the legislation. Seniors want certainty. They want to know what they are getting. But under this plan, seniors could be bounced back and forth between different plans depending on how many private drug-only plans enter an area. That is the first problem. If a senior is in a fallback plan and two private plans enter the area, they must leave the plan they are in; they have no choice in the matter. The second problem is that every time they switch between drug-only and fallback plans, their benefits could change.

Let me illustrate that for my colleagues. Seniors, when forced to move between plans--and in 4 years, a senior could be forced into four different plans--every time, their premiums could change. The only thing that wouldn't change is the stop loss amount, or at least couldn't change. The deductibles could change. The coinsurance level could change. The coverage gap could change. The covered drugs could change. And the access to a local pharmacy at no extra charge could change. That is the kind of instability about which I am talking.

Let me illustrate with this chart. I hope my colleagues are listening, or at least for those who are busy with other duties, perhaps their staffs are listening. It is very important to understand what could happen to a senior. In 2005, if there is only one private plan offered in their area, they could enroll either in that plan or in the fallback plan. Let's say this particular senior takes the fallback plan and enrolls in that for 2006. But then the next year, another private plan comes into the area. Then the senior would be compelled to drop out of the fallback plan even if they liked it and go into one of the private plans.

Say they take private plan A for 2007. Then private plan A finds it is not effective for them financially to be in the plan, and they drop out. The next year, our senior citizen could be whipsawed into a third plan in 3 years. They could be over in private plan B. Then perhaps private plan B decides they can't afford to provide this coverage. They drop out, and our senior citizen, in the fourth year, is in their fourth plan. As I say, with different formularies--that is, different drugs--available to them, with different rules with respect to going to the local

pharmacy to get their drugs, with different copays, with different premiums, with different deductibles, all of these changing--if that isn't chaos, I don't know what is. This is an area we must address on the floor with amendments in order to remove some of this uncertainty for seniors moving ahead.

For those of us who represent rural areas, the fact that only 2 percent of rural counties had two or more Medicare+Choice plans in August 2001 ought to tell us that our people are the most likely to be caught up in this whipsaw effect. Our people in rural areas are the most likely not to have two private drug-only plans available to them, or PPO plans or HMO plans. The reality is, they are not there now. In my State, there is virtually no coverage from those kinds of entities, almost none. Those who are suggesting that people are going to rush to this kind of business when the people who run the companies tell us very directly they are not going to--we ought to pay attention to that. We ought to listen to that. We ought to respond to it. I don't think it is going to do any of us any good to create a circumstance in which a senior we represent gets whipsawed back and forth between plans, changing premiums, changing deductibles, changing coinsurance, changing what drugs are covered and what are not.

There is one thing I have learned in dealing with seniors, especially those who are ill: They need simplicity. They need an assurance of what is covered, what isn't covered, and how it works. We should not be subjecting them to a changed plan every single year. That is not a plan that meets the needs of seniors.

I urge my colleagues to pay close attention to the debate when we begin to offer amendments to try to provide some greater certainty and stability to the plan.

I also am concerned about disappointed expectations. As I travel my State, when there is a discussion of prescription drug coverage, I find most people think that means they are going to get something similar to what Federal employees receive, or they think they are going to get something similar to what people in the military receive, or they think they are going to get something similar to what big companies provide. That is not this plan. Let's understand what this plan is and what it is not.

To provide the same coverage that we provide Federal employees would not cost the $400 billion in this plan. It would cost $800 billion. It would cost $800 billion in comparison to the $400 billion in this plan to provide the prescription drug benefit we provide Federal employees.

To provide the same level of benefit to our Nation's seniors that we provide our members in the military would cost $1.2 trillion, three times as much as available in this plan.

It is critically important that we not overpromise, that we not mislead people as to what they are getting and not getting. The fact is, there are some who I have heard say this is a 70 percent subsidy. I don't know where they get that number. That is exactly the kind of language and rhetoric that is going to lead to some very disappointed people. There is no 70 percent subsidy here. There may be for people who have extraordinarily high drug costs. I already indicated they get 90 percent of their bill paid for, over $5,800 in drug costs a year, but that is a

very small percentage of the people.

It is true that very low income people get a higher percentage paid for by Medicare. But overall, we should understand, of the $1.6 trillion of drug costs for our Nation's seniors, this legislation is going to cover 23 percent of that, not 70 percent, as I have heard stated during the debate. Twenty-three percent will be paid for by Medicare.

If you look at this $400 billion legislation, $360 billion of the cost is for prescription drug payments--$360 billion. The total drug cost of our Nation's seniors is $1.6 trillion; $360 billion of $1.6 trillion is 23 percent, it is not 70 percent. So let's not be misleading people about how extensive this benefit is.

That is not to say it is not a good bill because we are limited to $400 billion. This is about as good a bill as you can write for $400 billion. But I hope we don't mislead anyone as to what it really provides.

One of the things we also need to think carefully about as we consider floor amendments is that 37 percent of retirees with employer drug coverage will lose it under the Finance Committee plan. Why? Because the Congressional Budget Office says when employers look at this plan, some substantial number of them will drop their old coverage--the coverage they are providing. That will affect 37 percent of retirees who currently have employer drug coverage. I think we need to take additional steps to provide incentives to those employers to keep on providing the drug coverage they provide. That is in our economic and financial interests, and it is in the interests of seniors to maintain stability in plans that they know and like.

I hope this information is useful to our colleagues. As I say, as a member of the Finance Committee and as ranking member of the Budget Committee, I support this legislation. I voted for it. I think it merits the support of our colleagues. I hope it can pass with resounding support here in the Chamber. I hope it will ultimately become law. We ought to do this with our eyes wide open. We ought to understand exactly what it provides and what its weaknesses are. We ought to communicate that clearly to the American people. We ought not to overpromise or misrepresent. Disappointed expectations can swamp this boat.

I am hopeful these remarks made clear what is provided and what is not and those places where we have an opportunity to improve this legislation. I think it is in all of our interests to commit our best efforts to do that over the coming days. I yield the floor.