

U.S. Senator Chuck Hagel

**Testimony before the House Committee on Government Reform
Human Rights and Wellness Subcommittee**

**“A Medicare Prescription Drug Safety Net: Creating a Targeted Benefit for
Low-Income Seniors”**

Wednesday, September 24th, 2003 at 12 P.M.

Thank you, Mr. Chairman, for asking me to testify before the House Government Reform Committee today.

Medicare is one of the two largest programs in the federal government. Today, Medicare covers over 40 million Americans, including 35 million over the age of 65 and nearly 6 million younger adults with permanent disabilities. Medicare serves all eligible beneficiaries without regard to income or medical history.

It is projected to pay out \$269 billion in both Part A and Part B benefits this year. This accounts for 13% of the federal budget and one out of every five dollars spent in America on healthcare.

In 1965, when Medicare was created, only about half of America’s seniors had health insurance, and fewer than 25 percent had adequate hospitalization insurance. Now, because of Medicare, nearly all seniors have coverage.

Medicare has been good for seniors, and has become a dominant part of the U.S. healthcare system. But Medicare does more for seniors than protect their health. Medicare improves their quality of life. Since Medicare was enacted, people are living longer, and living better.

Life in America has changed dramatically over the last 40 years, particularly healthcare. Medicine today addresses all conditions and diseases, with a special emphasis on preventive medicine and management of chronic conditions. This includes prescription drugs, diet, exercise and lifestyle - health dynamics that were not given much consideration when Medicare was enacted in 1965.

Medical technology has exploded, and we have experienced a revolution in the development of new and effective pharmaceuticals. Outpatient treatment and prescription drugs have become mainstays of medical care.

But Medicare is a 1960's model trying to operate in a 21st century world. It does not reflect these changes in healthcare. Like medicine itself, the Medicare program must adjust and reform to address these new realities in healthcare, delivery, consumer demand, and costs.

Our goal in Congress should be to bring this valuable program in line with today's healthcare needs in a responsible and sustainable manner, and prepare Medicare for the future.

For example, Medicare does not currently cover outpatient prescription drugs. Since 1999, drug prices have risen about 20%. The average cost of these life-saving pharmaceuticals will likely continue to increase, placing further pressure on seniors with fixed incomes. More than one quarter of Medicare beneficiaries have no prescription drug coverage. Adding a responsible, sustainable, and meaningful drug benefit is a top priority for most of us in Congress.

We must recognize, however, that in doing so, we are greatly expanding America's largest health entitlement program. In making decisions, we must not discount or minimize what we know has worked, and what has not worked. A Medicare drug benefit must deal with the realities that people are living longer and better, and have higher health care expectations than ever before. A new drug benefit should pay particular attention to those in greatest need who have no options today, while not excluding other seniors.

We must also take care that we do not inadvertently stifle innovation in the private pharmaceutical, medical research, and healthcare sectors. We know advances in research and medicine have been critical factors in our increased lifespans, better health, and improved quality of life. Public-private relationships in these areas have been essential to that success. The United States leads the world in medical innovation. Our actions must not jeopardize that continued innovation, but rather strengthen it for the future.

Tough choices and difficult decisions will have to be made. Most seniors could use some help, but we have limited resources, and thus we need to target benefits to those who need it most: those with low incomes, and those with very high drug expenditures.

That is why I am participating in this hearing today. My colleagues Senators Ensign, Lugar and Inhofe and I have again introduced legislation that would give seniors assistance with drug expenses, as well as security and protection from unlimited out-of-pocket prescription drug costs.

Our bill, S. 778, the Medicare Prescription Drug Discount and Security Act of 2003, would provide America's seniors peace-of-mind regarding escalating drug expenses. The program would be available to every beneficiary in need of coverage, and would provide access to price discounts on prescription drugs and protection from unlimited out-of-pocket costs.

The benefit would have no premiums, deductibles, or gaps in coverage, and would target help to seniors with low incomes and high drug expenditures. The simple, easy to understand benefit would also be affordable to seniors and taxpayers.

All non-Medicaid eligible Medicare beneficiaries would have the option of enrolling in a discount drug card program that would give them access to privately negotiated discounts on prescription drugs.

Seniors enrolled in the program would also be protected from unlimited out-of-pocket prescription drug expenses. No longer will seniors have to pay retail for their prescription drugs or defray catastrophic drug costs by having to mortgage their home, declare bankruptcy, or spend down their life savings in order to qualify for Medicaid.

The plan has two components:

1. Discount drug card: Medicare beneficiaries could choose to enroll in a drug card program, giving them access to privately negotiated discounts on prescription drugs. These plans would provide seniors with drug prices matched to the lowest negotiated price the plan receives for the drug.

Seniors would pay no premiums. Beneficiaries wishing to participate in the plan would pay a modest annual enrollment fee of \$25, which would be waived for those below 200% of poverty.

2. Catastrophic Coverage: All participating beneficiaries would be protected from unlimited out-of-pocket drug expenses through a cap on their private expenditures. The annual out-of-pocket limit for low income seniors would be

\$1500. Higher income seniors have a graduated out-of-pocket limit based on income, targeting help to those who need it most:

<u>Income Levels:</u>	<u>Limit on Out-of-Pocket Expenses:</u>
Below 200% of poverty *	\$1,500
Between 200% - 400% of poverty	\$3,500
Between 400% - 600% of poverty	\$5,500
Above 600% of poverty	20% of income

** The 2003 Federal Poverty Level is \$8,980 for an individual and \$12,120 for a couple.*

Once the out of pocket limit is reached, beneficiaries are only responsible for 10% of drug expenses.

Specifically, our bill would:

Utilize Marketplace Tools: Our plan would be delivered by entities experienced in managing pharmaceutical benefits. Eligible providers include: Pharmacy Benefit Managers (PBMs), private insurers, employer-sponsored plans, Medicare+Choice plans, states, and even retail pharmacy networks.

Plans would be approved by the Secretary of Health and Human Services, who would also have the flexibility to negotiate and contract with reputable and experienced entities to offer beneficiaries what they want and need. These contracts and plans can evolve and change as technology and needs change.

We're not asking private companies to create a new product or service they don't already provide in the private sector. Many companies, including some insurers, associations, and pharmacy benefit managers, already offer a drug card that allows participants to receive negotiated discounts on prescription drugs. The more beneficiaries plans enroll, the greater market leverage they have to negotiate for better prices - not just for Medicare beneficiaries - but for all their participants.

Although private entities would be responsible for negotiating discounts, determining which drugs are covered, and administering the plan, they would not bear any risk for the catastrophic benefit.

However, plans still have the incentive to negotiate for better discounts. The better the plan's discounts, the more beneficiaries they enroll. The more beneficiaries they enroll, the greater the plan's negotiating power. The greater the plan's negotiating power, the more money the plan saves. If seniors are dissatisfied with the prescription drugs and discounts available under their drug card plan, they may choose to enroll in a different plan the following year.

The federal government would not be selling, setting, or negotiating prices for prescription drugs. Private entities or states, not the federal government, would determine what prescription drugs are covered. The drug formulary would be determined by each individual drug card plan, in accordance with clinical guidelines and formulary standards established by the Secretary.

Put simply, this legislation would use existing free-market mechanisms such as consumer choice and competition to control costs and secure discounts on prescription drugs for seniors, rather than imposing federal controls that would limit innovation.

Immediate Impact: Our program would take effect six months after enactment - possibly as early as the first half of 2004. Other bills under consideration would not take effect until 2006 or later.

Affordable For Both Seniors and Tax Payers: Beneficiaries would not have to pay monthly premiums or deductibles. Seniors would only pay a \$25 annual fee to participate, as well as a small co-payment for prescriptions after they reach their out-of-pocket limit. The \$25 fee would be waived for beneficiaries with incomes less than 200% of poverty.

CBO has scored this legislation at \$335 billion over ten years, assuming 100% uptake by seniors. This cost is well within the \$400 billion set aside in the FY2004 Budget Resolution, and even leaves funds for Medicare reforms.

Permanent: It is an immediate step that can be taken to help seniors. Moreover, the program complements, rather than replaces, the private prescription drug coverage that two-thirds of retirees have now. Finally, our legislation does not sunset, allowing plans to continue to build enrollment and negotiate discounts.

Complement existing coverage: This legislation would preserve, complement, incentivize and improve private employer coverage. Two-thirds of seniors already have some form of prescription drug coverage through private insurers and

employers. Most of these plans already offer front-end or first dollar coverage for prescription drugs.

As a result, any legislation offering front-end coverage would likely cause private insurers and employers to restrict their prescription drug benefit or drop it altogether. But by offering discounts and protection from high out-of-pocket drug expenses, this legislation would complement -- rather than replace -- the private front-end drug coverage that two-thirds of seniors already possess.

Conclusion:

Our bill would ensure that every senior could afford to take part and benefit from their participation. But prescription drugs are just one piece of the Medicare puzzle, albeit an important one. There are still a number of significant problems with Medicare that can only be addressed through a comprehensive restructuring of the entire program. Medicare is still in danger of becoming insolvent. Beneficiaries don't have access to eye-glasses, hearing aids, dental care or preventive services. Providers continue to be micro-managed, underpaid, and immersed in a sea of paperwork and arcane regulations that force them to spend more time filling out forms than caring for patients.

Clearly, we have much work to do. But a benefit targeted to those who need it most and that protects seniors from catastrophic drug expenses is a good first step.

Thank you for the opportunity to appear before this committee today.