



Congressional Record

PROCEEDINGS AND DEBATES OF THE 108th CONGRESS, FIRST SESSION

Senate

Statement of Senator Dianne Feinstein

"Support for the Medicare Prescription Drug Conference Report"

Mrs. FEINSTEIN. Mr. President, I listened to the distinguished Democratic leader and find that I agree with much of what he said. This may not be a perfect bill, but clearly there are positive and negative features to the bill.

I worked a year ago, and through an individual's help, was able to run the numbers with respect to a prescription drug plan and tried to make them come in within \$400 billion and found it to be extraordinarily difficult. In my view, the most positive feature of this bill is that it delivers voluntary prescription drug coverage to this Nation's Medicare beneficiaries. I find the low-income benefits of this bill to be one of its biggest strengths. It is better than anything we ran that came in at \$400 billion or below last year.

These benefits affect about 1.4 million Californians who have limited savings and low incomes and who will qualify for prescription drug benefits under this bill. Some of these are low-income seniors who do not qualify for Medicaid. Because of \$3,000 in savings, they are ineligible to receive prescription drug coverage through the California Medicaid Program. They will now have prescription drug coverage which is much better than I had hoped. So 351,000 low-income Californians who are not eligible for Medicaid and have no prescription drug benefits now will have them under this bill. This was important to me. It is one of the strengths of the bill.

Analysis shows that this bill will increase the percentage of Medicare beneficiaries with prescription drug coverage from 79 percent to approximately 95 percent. (source: Muse & Associates)

To begin with, this bill, as I said, expands the drug coverage to the 351,000 Californians who are not eligible for Medicaid and had no prescription drug coverage. The reason it does that is because it has a much more relaxed assets test. So where the assets tests were so stringent for Medicaid, they are more relaxed here; and, therefore, those 351,000 people who found themselves without Medicaid coverage will now have coverage under this bill.

Secondly, the bill provides a 16-percent increase in Medicaid disproportionate-share hospital payments in fiscal year 2004. This has always been important to me. Every year we have had to

fight for it because these are the payments that go to our county hospitals. In California, the county hospitals receive most of the people who have no coverage who are bereft and who are extraordinarily low income. California hospitals who qualified to receive Medicaid DSH money lost \$184 million this year due to cuts enacted in the Balanced Budget Act in 1997.

This bill restores approximately \$408 million to California's hospitals over the next 10 years including \$121 million in fiscal year 2004. I must tell you, with about 25 hospitals that have closed in my State in the last few years, this is a major item for me. The DSH money in this bill will go a long way toward protecting California's fragile health care safety net, which is dependent on a complex combination of local, State, and Federal funding.

Thirdly, the bill improves payments for indirect medical education in fiscal year 2004 and beyond. Teaching hospitals will receive a 6-percent increase in payments in the second half of fiscal year 2004 and will have their payments spelled out in future years so they can begin to plan ahead. Now, they do go down in some years. So there will be advanced knowledge of that so hospitals can begin to plan for that.

This is money that reimburses teaching hospitals. My State has some of the greatest teaching hospitals in the Nation. This money would reimburse those hospitals for costs associated with educating our Nation's next generation of physicians. That is important to me. I think it is essential funding, and it will allow our major hospitals to continue training tomorrow's caregivers.

Fourthly, the hospitals and physicians in California will benefit from this bill. Hospitals will see a full market basket update for fiscal year 2004 and have the opportunity to receive a full market basket update for the 3 years that follow. With more than 58 percent of California's hospitals losing money treating Medicare beneficiaries, and all hospitals facing Federal and State unfunded mandates, the full market basket update is vital to my hospitals as they struggle to meet staffing, seismic, and privacy compliance requirements.

I have heard overwhelming opposition from doctors in my State to the projected 4.5-percent payment cut that physicians and other health care providers would have faced in fiscal year 2004. In other words, without this bill, doctors in my State -- and I do not know about elsewhere -- but doctors in my State were going to face a projected 4.5-percent payment cut.

This bill prevents that payment cut from happening, and it includes an increase in payments for fiscal years 2004 and 2005 of 1.5 percent each year. This means that doctors in my State will be paid more for their services. It may not sound like a lot, but we have doctors leaving California and going to other States because they cannot meet the high cost of living in the State of California and practicing medicine. So even a small amount helps them stay in business.

In my State, approximately 33 percent of all Medicare beneficiaries get their health care coverage from Medicare+Choice. Now, Medicare+Choice has not been a positive experience in every case. I think we all know this. This bill, though, strengthens the Medicare+Choice Program, renames it Medicare Advantage, and it provides payment increases to HMOs. Some find that

objectionable. I, frankly, do not, because these increased payments to HMOs and preferred provider organizations should provide some premium stability throughout the State. I intend to watch and see if, in fact, it does happen.

Now, I have many concerns about this bill. The Democratic leader pointed out some of them. This is certainly not a perfect bill. I am not on the committee. I did not write the bill. I struggled to have a little bit of input into the bill, probably much less than I would have liked.

I am deeply concerned about the number of Californians, though, who have lost their retiree health benefits as a result of rising health care costs. This is happening right now without a bill. It is projected that 10 to 12 percent of retirees who have private health care plans are losing their benefits each year. That is happening without this bill. The reality is -- and I know people do not like to look at this -- if we do not pass this bill, employers in my State will continue to drop coverage for their retirees at this estimated rate of 10 to 12 percent a year. Many of these employers who have chosen to retain coverage for their retirees have required their retirees to pay higher copayments and premiums -- not under this bill but today.

Through direct subsidies and tax provisions, this bill actually reduces the number of seniors in California who will lose their retiree health coverage from approximately 431,420 in the Medicare bill that passed the Senate, that a majority of us voted for, to approximately 198,000 in this bill. These are California numbers, true. I cannot speak to other States. But what I am saying is, because of this bill, the number of retirees in California who would lose their retirement benefits will drop from 431,420 to 198,000.

Now, I wish the number were zero, but the point is, the bill makes it better, not worse. I think that is a good thing.

Now, I find it very difficult that this bill does not restore access to Medicaid and SCHIP for legal immigrant children and pregnant women at the State's option. The Senator from Florida, Mr. Graham, authored legislation which I voted for which did do this. I intend to introduce -- and I hope with him -- legislation to restore Medicaid and SCHIP benefits to California's legal immigrant children and pregnant women next year.

I find it, frankly, troubling that this bill actually provides \$250 million per year for 4 years to reimburse hospitals for providing emergency care services for undocumented immigrants, and California's hospitals will receive approximately \$72 million a year to reimburse them for their care to undocumented immigrants, but we take away the coverage for legal immigrants.

I expressed my concern to Senator Breaux, to Senator Baucus, to Senator Frist about this issue. I was told the House would not accept this language. I hope next year the Senate will once again pass a bill to restore these benefits. This is a big item in California, and I deeply believe people who come to this country legally should be entitled to these benefits.

My State spent \$3.7 billion in 2002 in uncompensated care, so the additional money that California gets for the care of illegal immigrants of \$72 million a year at least will go some

distance in covering that deficit.

In my role as vice chair of the National Dialogue on Cancer and cochair of the Senate Cancer Coalition, I have a very serious concern about this bill's Medicare reimbursement cuts for cancer care, particularly oncology physicians. It is my strong view that every suffering cancer patient should be able to have a so-called quarterback physician, an oncologist, someone who is with them who can go through all of the terrible choices and decisions that have to be made by a cancer patient and stay with them through it all.

I have talked to both Senators Baucus and Breaux and also to Senator Frist. They have all said this bill will leave the oncology community better off. I don't see that, candidly. In looking at this complicated Average Sales Price versus Average Wholesale Price issue, I don't see where they will be better off. I want the Record to reflect that I have received those assurances. I don't know whether they are true or not, but I can promise my colleagues, I intend to follow very closely the impact this bill will have on cancer care up and down the State of California. My staff and I will be watching the cancer care situation, and I am certainly prepared to introduce legislation making technical corrections to Medicare reimbursement for cancer care if the bill has the impact the oncology community predicts it will.

It is my understanding that our leadership will appoint an independent commission to be headed by my good friend, former Senator Connie Mack. The commission will monitor the impact of this bill on cancer care throughout the country and will report and make policy recommendations to Congress.

I am also concerned about the impact this bill will have on 50,000 low-income Californians who are living with HIV/AIDS. We have heard a lot from the HIV/AIDS community. My concern is with their access to drug treatment therapy under the Medicare prescription drug benefit.

What happens in AIDS/HIV treatment is that very often a cocktail of drugs, three or four different drugs, proves to be the most beneficial. The type of drugs varies with the individual, just as any drug would with any of us.

I have shared this belief, and the concern is that the formularies would limit an individual to two drugs. I spoke at length with Health and Human Services Secretary Tommy Thompson Friday night about it and asked him to put in writing exactly what would happen. Directly following my remarks, I ask unanimous consent to print in the Record his Department's response to my concerns.

I will read just a couple of key points made by the Secretary in response. Let me quote the Secretary:

"The Secretary may only approve a plan for participation in the Part D program if the Secretary does not find that the design of the plan and its benefits, including any formulary and any tiered formulary structure, will substantially discourage enrollment in the plan by certain classes of eligible Medicare beneficiaries. Thus, if a plan limits drugs for a group of patients (such as AIDS

patients), it would not be permitted to participate in Part D."

I also note that upon completion of this bill, Senators Grassley and Baucus and I will enter a colloquy into the Record to emphasize this point.

This bill says that if a plan doesn't carry or doesn't treat a drug that is needed by a person with AIDS as a preferred drug, a simple note from a doctor explaining the medical need for that particular drug would get that drug covered at the preferred price. It cannot take more than 72 hours for seniors to get a drug under this expedited appeals process. This is my understanding based on conversations with the Secretary. I am delighted this understanding is now in the Congressional Record so that we can all follow it.

I want to say a word about something that is very controversial in the bill that I happen to support and why I support it. That is income relating the Medicare Part B premium. Let me tell you why I support it. I have a great fear that as I watch entitlement spending grow, and I have watched that happen for a decade in the Senate, our children and our grandchildren will not have access to Social Security or Medicare. Let me tell you why I believe this.

Since 1993, at my constituent breakfasts we have been using charts to illustrate outlays, meaning the money the Federal Government spends every year. I believe they are the truest way to judge Federal spending. When I began this, in 1993, entitlement spending was \$738 million. About 50 percent of the outlays in a given year were entitlement spending. That was welfare, veterans benefits, Social Security, Medicare, et cetera. Interest on the debt was 13 percent. So 63 percent of the outlays in a given year could not be controlled by our budget.

This year, entitlement spending is \$1.174 billion. Entitlements have risen to 54.4 percent, a 4.4 percent increase. Interest has dropped some, to 7.5 percent.

Now, if we look at the projection -- and this is with the \$400 billion prescription drug plan -- if you look at entitlement spending in 2013, 10 years from now, you see that it is \$2.048 billion. So in 10 years it has gone from \$738 million to \$2.48 billion. That is the problem. Entitlements will be 58 percent of the outlays, and interest on the debt, 11.6 percent. What does that mean? That means 70 percent of everything that is spent by the Federal Government in fiscal year 2013 cannot be controlled.

The other two pieces, of course, are defense, projected at about 16.9 percent, and discretionary spending, dropping from 20 percent this year down to 13.6 percent. Discretionary spending is everything else we have to do. It is everything in the Justice Department, the Education Department, the Park Service. All the rest of the Federal Government in 10 years will be about 13 percent of what is being spent. That is the enormity of the entitlement picture.

I know it is hard for people to look at this because those people who had the dream of Medicare decades ago looked at it as a program that everyone who paid in got out the same benefit. But what the income relating in this bill talks about is just the Part B Medicare premium, the cost of which today is \$3,196.80. That is the full cost of the Medicare Part B premium in 2004.

Now, what is Part B? Part B is physician care, other medical services; it is outpatient hospital care, ambulatory surgical services, X-rays, durable medical equipment, physical occupational and speech therapy, clinical diagnostics, lab services, home health care, and outpatient mental health service.

The premium is \$3,196.80. The income-relating provisions in this bill are very mild, much milder than what Senator Nickles and I presented on the Senate floor.

In this bill, beginning in 2007, individuals with incomes of more than \$80,000, or couples with incomes of more than \$160,000, will have, instead of 75 percent of their Medicare Part B premium subsidized, 65 percent of it will be subsidized by the Federal Government.

This goes up four tiers so that individuals with incomes of more than \$200,000 a year, or a couple with an income of more than \$400,000 a year, will have just 20 percent of their Medicare Part B premium subsidized by the Federal Government. Why should hard-working taxpayers pay for a millionaire's health care premium? That is my view.

I don't see income relating as bringing about the downfall of Medicare. I see it as making the program more solvent.

There is one significant missed opportunity in this bill that concerns me deeply, and that is the whole area of the cost of prescription drugs. I am particularly concerned about the amount of money spent on prescription drug promotion by pharmaceutical companies. Perhaps I have reached the age where I remember when there was no advertising of prescription drugs. We were just as well off then as now, and without huge costs.

Let me give you some examples. Promotional spending by pharmaceutical manufacturers has more than doubled, from \$9.2 billion in 1996 to \$19.1 billion in 2001. That is an annual increase of 16 percent.

Most troubling to me is the rapid spending growth of direct-to-consumer advertising of prescription drugs, which has increased an average of 28 percent.

Bottom line, Mr. President: I intend to support this bill, and not because it is perfect, but because I believe it brings substantial help to people who need that help in my State of California.

I yield the floor.

**Medicare Conference Report Cancer Care Changes
Minority Staff, Senate Committee on Finance**

1. Payments for Part B drugs are currently based on Average Wholesale Price (AWP). The difference between the AWP and the actual sales price results in a profit to providers when they administer such drugs. For example, an oncologist can buy a chemotherapy agent, called doxorubicin, for \$10.08, while Medicare's reimbursement for that same dose was \$42.92,

resulting in a profit to the physician of \$32.84. Because beneficiaries must pay 20% co-payments on Medicare covered drugs, beneficiaries are paying \$8.58 for a dose of doxorubicin. That is 20% of the \$42.92, rather than 20% of the \$10.08 that the oncologist paid for the drug, which is \$2.02. The HHS Inspector General estimated that inflated AWP's caused beneficiaries to pay an extra \$175 million in coinsurance in 2001.

The Medicare conference agreement reforms the Part B drug payment system, saving \$4.2 billion from in the oncology specialty over the 10-year period 2004-2013. This reform is effected by using an Average Sales Price (ASP) system, which accounts for the true costs of these drugs. An additional \$7.3 billion is saved by applying the ASP reform to other physician specialties. Most of these savings occur in the later years of the budget window. Under the Medicare conference agreement, oncologists will actually receive a \$100 million increase in payments in 2004, net of reductions in reimbursement for Part B drugs.

Following is an overview of what oncologists will receive in increased practice expense payments, starting in 2004.

2004

- \$500 million increase (in practice expense; increase to oncology in 2004, net of drug payment reductions, is \$100m)

2005

- ASP+6%
- \$600 million increase (\$200m for Average Sales Price+6%, \$400m increase in practice expense)

2006 and thereafter

- ASP+6%
- \$560 million increase (\$200m for Average Sales Price+6%, \$360m increase in practice expense)

Secretary Tommy Thompson's Response: Access to Drugs for Aids Patients Under the Bipartisan Agreement

Question: Will AIDS patients have access to all drugs within a therapeutic class under the Bipartisan Agreement? Can a PDP limit the number of drugs that are covered within a therapeutic class? Are dual eligibles in a Medicare drug plans losing coverage available to them in Medicaid?

Answer: In the Bipartisan Agreement there are significant safeguards in the development of plan

formularies that will ensure that a wide range of drugs will be available to Medicare beneficiaries.

Plans have the option to use formularies but they are not required to do so. If a plan uses a formulary, it must include "drugs" in each therapeutic category and class under section 1860D-4(b)(3)(C)(i). A formulary must include at least two drugs in each therapeutic category or class unless the category or class only has one drug.

The Secretary will request the U.S. Pharmacopoeia, a nationally recognized clinically based independent organization, to develop, in consultation with other interested parties, a model guideline list of therapeutic categories and classes. How categories and classes are designed is essential in determining which drugs are included on a plan's formulary. USP is clinically based and will be cognizant of the needs of patients. We expect they will design the categories and classes in a way that will meet the needs of patients.

In designing formularies, plans must use pharmacy and therapeutic committees that consist of practicing physicians and pharmacists who are independent and free of conflict with respect to the plan, and that have expertise in care of elderly and disabled. The committee has to use scientific evidence and a scientific basis for making its decisions relating to formularies.

Further, the Secretary may only approve a plan for participation in the Part D program if the Secretary does not find that the design of the plan and its benefits, including any formulary and any tiered formulary structure, will substantially discourage enrollment in the plan by certain classes of eligible Medicare beneficiaries. If a plan complies with the USP guidelines it will be considered to be in compliance with this requirement. Thus, if a plan limited drugs for a group of patients (such as AIDS patients) it would not be permitted to participate in Part D.

Under the Bipartisan Agreement, the beneficiary protections in the Medicare drug benefit are extremely comprehensive to ensure access to a wide range of drugs and are more comprehensive than the protections now required of state Medicaid programs.

For example, there are extensive information requirements in Part D so beneficiaries will know what drugs the plan covers before they enroll in the plan.

The plans must set up a process to respond to beneficiary questions on a timely basis.

Beneficiaries can also appeal to obtain coverage for a drug that is not on their plan's formulary if the prescribing physician determines that the formulary drug is not as effective for the individual or has adverse effects. As a result, there should be access to all drugs in a category or class when needed.

Because the Medicare drug benefit will be offered through private plans, plans will have an incentive to offer multiple drugs in a therapeutic class in order to attract Medicare beneficiaries to join their plans.

Because of the optional nature of the Medicaid drug benefit today, states can drop their coverage entirely. According to a recent Office of the Inspector General report, states have identified prescription drugs as the top Medicaid cost driver (FY 2002, Medicaid prescription drug expenditures totaled approximately \$29 billion or 12% of the Medicaid budget). From 1997 to 2001, Medicaid expenditures for prescription drugs grew at more than twice the rate of total Medicaid spending.

Pressures on state budgets have led to Medicaid coverage restrictions for drugs and the use of cost control measures that will not be used in the Part D program.

Eighteen states contain Medicaid drug costs by limiting the number of prescriptions filled in a specified time period, limiting the maximum daily dosage or limiting the frequency of dispensing a drug. Some states also limit the number of refills.

Six states have pharmacy lock-in programs, which require beneficiaries to fill their prescriptions in one designated pharmacy.

States already have the authority to limit the number of drugs that may be provided in a therapeutic class, and nineteen states are using preferred drug lists in their Medicaid programs. Thus, dual eligible beneficiaries will have the same access in Part D that they have in Medicaid, with expanded beneficiary protections and appeal rights.

Concerns have been expressed that the Medicare benefit will result in a loss of coverage for dual eligibles. This is not the case for low-income beneficiaries, the Bipartisan Agreement provides generous coverage.

The Bipartisan Agreement preserves the universality of Medicare for all eligible beneficiaries including those now dually eligible for both Medicare and Medicaid. Unlike Medicaid, the new Medicare Part D benefit will provide a guaranteed benefit to all eligible seniors--a benefit they can count on without fear of loss of benefits when state budgets become tight.

Dual eligibles, who currently have full Medicaid benefits, will automatically be given generous subsidies and pay no premium, no deductible and minimal cost-sharing regardless of their actual income (which can be higher than 135% of poverty based on states' special income rules).

In addition, full dual eligibles with incomes under 100% of the Federal Poverty Level (FPL) will pay no premiums, no deductible and only nominal copayments of \$1 for generic and other multiple source preferred drugs and \$3 for all other drugs. These copayments will increase only at the rate of inflation, the same rate as the Supplemental Security Income (SSI) payments on which many low-income individuals rely.

Dual eligible nursing home patients and other institutionalized persons who only have a small personal needs allowances will be exempt from copayments altogether.

The copayment levels in the Bipartisan Agreement are similar to what dual eligibles now pay in

what is an optional Medicaid benefit in their states. In fact, because of the optional nature of the Medicaid drug benefit today, states can drop their coverage entirely. Current regulations permit states to increase coinsurance to 5%, which is more than what will be permitted for dual eligibles under the new Medicare benefit.