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Talking Points, Medicare Press Conference

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Talking Points
Medicare Press Conference
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Thank you Chairman Grassley.
I'd like to thank you for your hard work and dedication that has helped us get to where we are today.

Considering that just about two weeks ago, we were focused on a tax cut, it's quite an accomplishment to be laying out a Medicare reform and prescription drug proposal today.

We're at an important point. We have $400 Billion laying on the table, specifically earmarked for Medicare reform and a prescription drug benefit. We've been at this point before and it passed us by.
This time will be different. The stars are in alignment this year. Chairman Grassley and I have put together a good preliminary package that will help seniors across the country. It's not a perfect package. Sure, there are provisions I would have liked to see in the bill. And others I might not have included if I wrote the bill by myself.

But that's not what Congress is about. None of us can pass a bill by ourselves. The bill we'll pass is a product of many different opinions and many different points of view. Too often lately, it feels like people don't even want to try to work together in a bipartisan manner.
But by not working together, the only people we're hurting are the ones we were elected to serve. Our seniors need a drug benefit included in Medicare. They need a strengthened Medicare program that will remain viable for decades to come.

We have $400 Billion sitting on the table in front of us. We can't squander this opportunity.

**Prescription Drugs -- Rural Seniors**

Over 40 Million Americans depend on Medicare for their health care needs. And this number will grow by leaps and bounds as baby boomers retire. Today, we're talking about ideas that would modernize the Medicare program for the first time since it was enacted in 1965.
Chairman Grassley talked about the main outline. Now, I'd like to focus on how we're working to make sure rural and low income seniors are taken care of in any final bill we pass.

One of the reasons that Chairman Grassley and I were able to agree on a first draft of this proposal is because of our shared dedication to providing for our rural seniors. Iowa seniors, Montana seniors, and seniors throughout rural America will all see benefits from our prescription drug proposal.

We would establish a voluntary drug benefit under a new Part D of Medicare. If a senior decides to join a private managed care or preferred provider plan, then the prescription drug benefit would be rolled into that plan.
If a senior decides to stay in traditional fee-for-service Medicare, then they would receive their drug benefit through a stand alone plan.

Here's the important point: The value of, and the subsidy toward, the prescription drug benefit would be equal for seniors who move into private plans or who stay in fee-for-service.

Unlike the President's proposal, we’re not using carrots to entice or coerce seniors into plans that might not work for them. This is especially important to rural states like Montana where many seniors don't have the option of moving into a private plan because those plans don’t exist.
That leads me to my next point: Chairman Grassley and I have included a strong government fallback. Seniors must have access to at least TWO private plans for a prescription drug benefit, or the government will provide a fall back plan.

That means that whether a senior lives in Los Angeles, California or Wolf Point, Montana, they'll have guaranteed access to a prescription drug program, and it will be a program with a national premium and standard benefit.
Prescription Drugs -- Low Income Seniors

We've also focused on making sure the prescription drug program provides for our low income seniors.

Beginning in 2006, the Medicare program would provide drug cost assistance to low-income seniors on a sliding scale relative to their income.

And for seniors who are eligible for both Medicare AND Medicaid, we'd make sure the Medicaid benefit is comparable to the Medicare benefit. The federal government would provide states with assistance to make sure that happens.
Between the time the bill passes and 2006, we'd provide low income seniors with a drug discount card. The exact benefits of the card are still being determined, but it's important that we provide low income seniors with prescription drug assistance as soon as possible.

Conclusion

I have a good feeling about the progress we've made. We're on the right track. The proposal Chairman Grassley and I are working on is still very much dependant on the CBO score, which we expect to receive in the next few days. I anticipate that changes will have to be made, but we're in a good position.
I'd like to thank Chairman Grassley for seizing this opportunity with me. How often do we have a situation where money has been set aside for a program? $400 Billion is a significant level of funding. We can do a lot of good with that money and help seniors all over the country.

I'd like to extend an invitation today to all of my Finance Committee colleagues and Senate colleagues. I ask them to join me in developing a final Medicare and prescription drug bill that we can pass in the coming weeks.

I'd ask each of us to be open to compromise and new ideas. We need to remember who we're doing this for and that's our seniors. It's time to take advantage of the $400 Billion and pass a good bill. Thank you.
TOUGH QUESTIONS
MEDICARE PRESS CONFERENCE
June 5, 2003

PROCESS

Members from both sides are concerned that there hasn’t been enough opportunity for input. Do you think that’s valid? Will that stop the markup from going forward?

- Members have had many hearings in the Finance Committee to explore issues related to prescription drugs and Medicare reform. Virtually all of the elements of this proposal have been in the public domain for some time. The only new idea this year is the President’s proposal to provide a differential benefit between fee-for-service and private plan enrollees – but we’re not doing that here.

- The whole notion of a private drug delivery system, of a donut in the benefit, of the impact on employer-sponsored plans – those issues all came up last year and the year before that.

- However, members do feel that they do not have information on this particular proposal, and we understand that. Both sides held a staff walk through of the proposal last night, and as I understand it, had plenty of chance to ask questions at the meeting.

- I don’t want to use process concerns as an excuse to hold up a markup.

What about CBO scores. What if you don’t have those on time or they’re not final? Will THAT delay a markup?

- That is my biggest concern going forward – that we won’t have good scores from CBO. If I feel that we do not have good scores, I believe that could delay things from moving forward as planned.

How many members of the Finance Committee do you expect to vote with you? What about on the floor?

- I think it’s tough to know the answer to that question right now. Members are still digesting information that we gave them about the proposal. Many of them will want to know what the score is and will want to have answers to some specific questions before they decide whether to support the plan or not.

- I think that we’ll be able to gauge more accurately and more fully the level of support we have in the next few days – particularly after we get scores back over the weekend.
What sort of support do you have from groups like AARP and PhRMA?

- Well, we know that AARP would like to put more money into the benefit. And frankly, so would I. But we have $400 billion on the table, and we did the best we could with those limited resources.

- As for the drug industry, I’m sure you read the recent Times piece as I did – they are very interested in getting a drug benefit passed this year. And I share that sentiment. As for whether they support this particular approach, I believe they’ll be comfortable with the drug delivery model but can’t say for sure.

PRIVATE DRUG DELIVERY SYSTEM

How can you ensure rural seniors—the ones you represent—a choice of drug plans?

- I have insisted on two important principles. One, risk should be phased in over time to ensure more stable participation. And two, I have insisted on a fallback plan to ensure that all Seniors have a plan with the standard benefit in any part of the country where two plans are not available.

How do you exactly phase-in risk time?

- Our proposal would hold plans to very limited risk in the first two years of the benefit. Over time, plans would assume more insurance risk, sharing this risk with the federal government. If plans earned excessive profits, the government would share in these profits. If plans experience heavy losses, for example by enrolling sicker patients, the government would less their losses.

MEDICARE REFORM AND PPOs

Does your plan have equal benefits for both the fee-for-service population and for PPOs?

- Yes, our bill will ensure that drug benefits and medical benefits are provided to all beneficiaries and that seniors are not coerced into private plans by receiving extra benefits?

We have heard that you are considering a two percent bump-up in payments to PPOs? How is this equal treatment?

- Our underlying principle is that PPOs should receive no higher federal contribution than if the beneficiary stayed in the fee-for-service program. I am not interested in over-subsidizing PPOs to enter the program. I have agreed to a temporary payment increase—2 percent—to ensure this new program is able to get started.
Do you have assurances from PPOs that they will be interested in this program?

- Our bill would set up fair competition between the fee-for-service program and private health plans. I support the notion that seniors should have a choice of health plans. But plans should be allowed to participate where they are able to achieve savings for beneficiaries AND the taxpayers. I believe our competition proposal will achieve this goal over the long run. If PPOs are able to achieve these savings, then they should be eager participants in this program.

**PROVIDER PROVISIONS**

Senator Baucus, I understand you have billions of dollars of provisions for rural health care. What about urban? IME, DSH, etc.?

- According to the Medicare Payment Advisory Commission, there are many changes that need to be made to ensure equity in the Medicare payment system: equalizing the standardized amount; equalizing Medicare DSH payments; establishing a low-volume payment adjuster. These changes are part of our tentative agreement. And, by the way, the President agrees on the need for changes in payments to help rural areas. He said so in a letter to Sen. Grassley two weeks ago. Finally, we are inclined to help fix the DSH cliff, an area critical to the well-being of many urban hospitals.

What about physician payment, which is set to drop 4.4% next year, with further cuts expected in later years?

- I was proud to help fix the physician fee schedule last year. We spent over $50 billion on that fix. But while I realize the need for adjustments to the physician fee schedule, and I am concerned about physician payment access, I don’t believe we have the resources in this $400 billion package to make another expensive physician fix.

**DUAL ELIGIBLES**

Dual eligibles would continue to receive their drugs through Medicaid, even though there is a Medicare benefit available. Is that fair?

- This bill would ensure that state Medicaid programs maintain a drug benefit for “dual eligibles” that meets standards and safeguards that are consistent with the Medicare drug benefit, but with nominal cost-sharing. The Medicaid program has been successful in covering the drug costs for dual eligibles for many years. Again, with such tight budget constraints, it made sense to keep drug coverage where it already existed.

Why doesn’t the plan provide a federal buyout of drug costs for dual eligibles? Aren’t states really going to suffer under your plan?
States will get some substantial assistance under this plan. First, the federal government will assume the cost of Medicare Part B premiums for so-called "QUIMBIES" (QMBs), which should save states about $15 billion. Second, the generous low-income benefit will buy out existing state pharmacy assistance plans for senior citizens below 150% of the federal poverty level. All of the drug plans from last year envisioned some state contribution or maintenance of effort payments - it’s just a reality considering the tight constraints of $400 billion.