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Senate

Medicare Debate

Mr. CARPER. I don't know that Winston Churchill, one of the great leaders of Britain, ever said anything about Thanksgiving or turkeys. He is somebody we like to quote a lot. He used to say there are two things people should not see made: One of them is sausages and the other is laws.

That could be said of the process we have gone through to modernize Medicare and add a prescription drug benefit. It has been a difficult debate and a difficult process.

Churchill also said democracy is the worst form of government devised by wit of man, except for all the rest. That is also something I would have us keep in mind today as we reflect on this bill.

Mr. President, 38 years ago a Democratic President, Lyndon Johnson, signed into law legislation creating Medicare. At the time it was hailed as a milestone. It was hailed as a landmark in providing a benefit to millions of our senior citizens who did not have access to health care, did not have access to hospitals, did not have access to doctors and nursing care. With the signing of that bill by then-President Johnson, the whole world changed for millions of Americans. Today it continues to change for tens of millions more.

Initially, Medicare, when it was fashioned, was designed to provide access to hospitals for people who needed to get hospitalized to get well. They would have that under Medicare if they were old enough. Similarly, if folks were in need of access to a doctor's care or nurse's care, they would have it under that legislation he signed 38 years ago.

There are a number of things that bill did not provide. It did not provide for home health care. It did not provide for outpatient care. It did not provide for access to prescription medicines or enable senior citizens, those Medicare eligible, to obtain help buying prescription medicine. Over time Medicare has evolved, as we know. Over time we have learned. Today we are a lot smarter. We can keep people out of hospitals and treat them on an outpatient basis. We are far wiser about keeping elderly people out of hospitals and, where it makes sense, treating them in their homes.

We also know today, in 2003, we can prevent a lot of illnesses and we can cure a lot of illnesses. We can enhance the quality of life for senior citizens by making sure they have access to prescription medicines we did not have in 1965, and frankly we did not dream about in 1965.

If we were creating Medicare anew today, this week or this month, it would be a no-brainer. We would have home health care. They would provide for outpatient services and care. It would also include a prescription medicine component.

When I was Governor of Delaware and running for the Senate in 2000, I talked a fair amount about prescription drug programs that were proposed in the Congress, principally one proposed by Senator Graham of Florida. I thought and still think it is a better alternative than what we have adopted here today. Adopting this legislation today is an example of not letting the perfect be the enemy of the good.

There are a number of principles I have said for some time we should attempt to adhere to when putting in place a Medicare prescription drug benefit. Foremost among these is that the program should be voluntary. If senior citizens want to participate, they can. If they choose not to participate, then they will not have to.

Second, I suggested that among the principles we adhere to is the prescription drug plan we adopt be one that would provide help where the help was most needed—for folks who do not have any kind of coverage, those whose incomes were very low, and those whose need for prescription drugs is exorbitantly high.

A third principle I have suggested is that middle-income senior citizens should find some help, some benefit from this legislation.

A fourth principle is we should do our very best to harness competition and market forces, to use those market forces to help contain the dramatic increase in the cost of prescription medicines.

A fifth principle is there should be no gaps and no caps in coverage. We violated that principle in this legislation. We violated one other principle that I have talked about as well, and that is this prescription drug plan should be consistent with a balanced budget.

The unfortunate reality is that a plan with no gaps or caps has become inconsistent with a balanced budget. We find ourselves today as a country in a huge hole, a fiscal hole, because of unwise tax cuts, a war on terrorism, a war in Afghanistan, a war in Iraq, and a slumbering economy that is slow to revive. Because of the size of that budget deficit, we are unable to pass the kind of prescription drug program many of us would like, one that has no gaps and one that has no caps.

I have listened with some fascination to the debate here in the Senate and raging across Capitol Hill and across the country. On the one hand, my friends on the left say the bill we have just adopted here is the end of Medicare as we know it. They say that it is not just the nose of the camel under the tent, it is the camel under the tent.

On the other hand, I have heard folks from the far right, who oppose this with equal vehemence, say there are no changes of consequence to Medicare, that it will be more of the same, that we have adopted a new entitlement program with scarce efforts at serious cost containment.

Both those sides cannot be right. My own view is neither of them are right. For folks old enough to participate in this program, they will have a choice. If they want to participate, they can. If they want to pay \$35 a month for a premium, they can participate in this program. If they are poor, that \$35 per month premium is forgiven. There is a

\$250 annual deductible that must be satisfied before the Medicare benefit kicks in. For people who are poor, that \$250 deductible will be essentially eased or eliminated.

Between \$250 and roughly \$2,250, Medicare will pay 75 percent of drug costs for most seniors who participate in this program. Medicare will pay more for those who have low-incomes. I am told the average cost of prescription medicines for people 65 and older in this country is roughly \$2,200. That would suggest to me that many who elect to participate in this benefit, including middle-income seniors, will benefit from it.

Between \$2,250 and \$5,100 in drug costs, Medicare continues to provide comprehensive coverage for low-income seniors. However, for middle-class seniors, the benefit does not provide any coverage at all for spending in this range. That is the gap in coverage. I wish it was not there. I hope we can eliminate this gap in coverage as we get our fiscal house in order.

Seniors will have a drug discount card as part of this program. The discounts they will receive may be worth 10 to 20 percent. If someone's prescription use is \$4,000 or \$5,000 a year, they will fall in the coverage gap, but the benefits from that discount card I think will equal or exceed the cost of their premium. But that is still a very modest benefit for those whose drug needs are between \$2,250 and \$5,000 a year. On the other hand, for people who have very large prescription drug needs, whose costs exceed \$5,000, the catastrophic benefit is generous. Medicare pays for 95 percent of those costs that exceed \$5,000.

I have heard any number of concerns about this legislation, raised not just by my

colleagues but by folks back home in my State of Delaware. They have raised questions and legitimate concerns that we need to address.

First of all, with respect to cost containment, is there enough in this bill? I don't think so. There are those who suggest we ought to consider the approach adopted by the VA, whereby the Veterans' Administration negotiates with the pharmaceutical industry in order to buy pharmaceuticals for veterans at lower prices. I think that is worth exploring.

We made it easier as part of this legislation for generic drugs to be introduced, to come to market. That will increase competition and push down prices. It is a modest effort. We need to do more in this respect.

But what we have with this bill is an opportunity. I sometimes talk about the glass being half full or half empty. I think we have an opportunity—certainly in my State, and I suspect in other States as well—to take this basic Medicare drug benefit and to build on it. Since I know my State best, I will talk about Delaware. We have a number of employers who provide prescription drug coverage to their retirees. Roughly 40 percent of our employers in Delaware today still provide that benefit. Some of those benefits are provided as a result of collective bargaining agreements. I hope we are smart enough—employers, labor unions, and individuals—to find a way to take those same dollars to provide first dollar of coverage for pensioners. I hope we are smart enough to take those same dollars and perhaps use them to pay the \$35 monthly Medicare prescription drug premium for retirees; to pay for the \$250 deductible; to pay for some of the costs Medicare will not cover between \$2,250 and \$5,000.

Similarly, I hope we are smart enough in States such as my State, and in cities and counties and those units of government that have in many cases prescription drug benefits for their pensioners, to have the wherewithal and farsightedness to modify the kind of coverage we now provide to build on the basic Medicare prescription plan offered as part of this legislation—maybe to pay for the monthly premium, or all the deductible, or maybe to reduce the size of that donut hole between \$2,250 and \$5,000.

But we don't just have to hope that will happen. The legislation includes substantial incentives for employers and States to do just what I have described. For every dollar that a private sector employer provides in qualified prescription drug benefits for their pensioners—benefits that will supplement and enhance the Medicare benefit in this bill—they will realize, as a result of the incentives in this legislation, an after-tax benefit of 50 to 70 cents on that dollar.

Is that going to keep all those employers and all those State and local governments in the game? No, it is not. But in the absence of that kind of incentive, what has happened? Well, go back in time. In 1988, roughly two-thirds of the large companies in America provided health benefits for their pensioners and provided a prescription drug benefit for their pensioners—roughly two-thirds, 15 years ago.

Today, in 2003, that two-thirds is no longer two-thirds. Today, roughly one-third of the larger employers in this country provide a prescription drug benefit for their pensioners. Without this legislation we are adopting today, we have seen a reduction almost by half of those employers that provided a benefit 15 years ago. They have stopped doing so today. If you run it out

over the next 15 years, if this trend continues, by the time 2018 rolls around you may have no private sector employers providing benefits.

That would be an awful thing. We need to do something about it. We need to provide the kind of incentives to employers we have provided in this legislation. We desperately need private sector employers to continue to provide a prescription drug benefit for their pensioners. We desperately need States and local governments to do the same with respect to their pensioners.

There is another source of prescription drug benefits I want to talk about. When I was privileged to serve as Governor, I signed into law legislation to create the Prescription Assistance Program in our State. For pensioners whose incomes go up to 200 percent of poverty, they are eligible for a benefit each year that is worth about \$2,500. We also have in our State a wonderful program called the Nemours Program, funded by a trust left by a wealthy family a long time ago. They provide help to children in my State and they also provide assistance to senior citizens in my State. The DuPont Children's Hospital in Delaware is funded by that trust. It is a wonderful institution. It helps kids all over the country and literally all over the world. The Nemours Plan also provides a prescription drug plan for senior citizens whose income runs from 0 to 135 percent of poverty. They also provide eyeglasses and dentures.

We have to be smart enough in our little State of Delaware to make sure the dollars being spent for prescription medicines under the Nemours Plan continue to be spent on prescription assistance for Delaware seniors. It does not need to be spent in the same way it is today, because the Medicare plan will cover literally all of the needs for very low

income seniors that Nemours currently assists with. But those same dollars can now be used to help fill in the gaps and make more generous the basic Medicare plan, which will be, at best, modest.

Similarly, the millions of dollars the State of Delaware is spending on the prescription assistance plan that we put in place roughly 4 years ago covers between 135 percent and 200 percent of poverty. If we are smart in our State, we will take those same dollars and redirect them—not necessarily to cover the same people; we will not need to. Some of those people who will be advantaged by virtue of the Medicare plan won't need the kind of help they get under the Delaware Prescription Assistance Plan. But we should take those dollars now being spent through that program and redirect them to fill the gaps, to wrap around and supplement the basic Medicare plan.

Similarly, the dollars spent by private sector employers and by public sector employers should no longer, starting in 2006, be spent exactly in the same way, but to the extent that we are smart and wise and farsighted, we can redistribute those dollars to build around the basic Medicare plan, to fill the gaps that obviously are there that need to be filled, and be able to provide in the end a benefit that we can all feel good about and be proud of.

I close by going back to where I started. If we had gathered here this year and had no Medicare Program, and we said let us start from scratch, we would include a prescription drug plan. In 1965, we didn't have the ability to provide prescription medicines for the sort of things we do today. If we had, a lot of people would have lived a lot longer and healthier and better lives.

A couple of days from now, I will be with my own mother. I look forward to being with her, probably the day after Thanksgiving. She is alive today in part because of the love that surrounds her. She is also alive today, I am convinced, because of prescription medicines to which she has access. She has heart failure and takes medicine for that. She has arthritis. She is able to take medicine for the arthritis that afflicts her. My mom suffers from Alzheimer's disease. She and literally hundreds of thousands of Alzheimer's victims around the country today have access to medicines that are beginning to show great promise in making sure that many of us do not end up living the last years of our lives in a state of dementia. She has a better quality of life today because of prescription medicine. She gets a fair amount of help through the employer that my dad used to work for. They provide a prescription benefit and hopefully will continue to do that. We are thankful for the assistance that she gets. For a lot of people in our country who do not have anything at all, who do not have any kind of prescription benefit, who are elderly and need that help, a lot of them will get this help as a result of the legislation we have adopted here today.

Is this legislation all we would like it to be? No. Is this the end of the road? No. Is this a decent beginning? It is. It is incumbent upon Congress to make it a beginning, a good beginning, but not the end.

I yield the floor.