Testimony of

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Subcommittee on Health
Implementation of Medicare Part D Prescription Drug Benefit
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Good afternoon, Madam Chairman, Mr. Stark and Members of the Committee. We appreciate the opportunity to share with you our day-to-day experiences assisting people with Medicare obtain good health care. Today, we will report on the gratifying but often heart-breaking work we do with our clients as they struggle to navigate the Medicare Part D prescription drug program.

The Medicare Rights Center (MRC) is the largest independent source of Medicare information and assistance in the United States. Founded in 1989, MRC helps older adults and people with disabilities obtain good affordable health care. Every day we assist people with Medicare as they navigate the health care system, enroll in programs that can help them pay for health care, and overcome barriers to needed care.

The Medicare Rights Center is a not-for-profit consumer service organization, with offices in New York, Washington and Baltimore. It is supported by foundation grants, individual donations and contracts with both the public and private sectors. We are consumer driven and independent, relying on a small staff and hundreds of deeply committed volunteers to carry out our mission. We are not supported by the pharmaceutical industry, insurance companies or any other special interest group. Our non-partisan mission is to serve the 43 million men and women with Medicare.

Through national and state telephone hotlines, casework and professional and public education programs, MRC provides direct assistance to people with Medicare from coast to coast. Each year, the Medicare Rights Center receives over 80,000 calls for assistance from people with Medicare. Our counselors are trained to assist consumers with complex problems and we complement the basic services offered by the 1-800-MEDICARE hotline operated by the Centers for Medicare and Medicaid Services (CMS). Indeed, 1-800-MEDICARE is the largest source of referrals to our hotline; MRC receives no CMS support for its consumer hotline.

MRC also brings to professional counselors, care givers and consumers across the country *Medicare Interactive*, a web-based counseling tool—developed with major foundation support and with a seed technology grant from the United States Department of Commerce. *Medicare Interactive* assists people with Medicare access benefits, including Part D.

We also reach out into low income, minority communities and, in recent months, have concentrated our services on enrolling people with Medicare in low income programs – the Part D Extra Help Program and Medicare Savings Programs, especially QI-1.

We have launched a Part D appeals program, recruiting a battery of volunteer lawyers and physicians to assist people with Medicare obtain medications denied to them by their Part D plans. Drug plans place the Medicare Rights Center's toll free phone number on notices

informing their enrollees that the Part D plan is denying coverage of a prescribed medication. Since we receive no federal or state financial support to assist people with these Part D appeals, we can only make a dent in the great need for this assistance. The Committee should know that without competent, independent representation, the Part D appeals and exceptions process is, for most people with Medicare, a sham.

MRC gathers data on the health care needs of the men and women whom we serve, and devises policy recommendations from those data. MRC is committed to policy recommendations that are grounded in our work with the people we serve. We have the freedom of having no political or commercial interest that interferes with our efforts to propose sensible, non-ideological public policies that serve the interest of people with Medicare.

To that end, we reiterate our appreciation of this opportunity to share with you our experiences, our clients' experiences and the lessons learned from the first four months of the implementation of Medicare Part D.

"Scandalously Wasteful Program"

We intend to avoid the formulaic debates that Part D typically stimulates. As you may know, and as I will explain, we at the Medicare Rights Center consider Part D to be a badly designed, scandalously wasteful program that provides far too little drug assistance, health security and peace of mind to older and disabled Americans. The architects of Part D seem to have forgotten many of the lessons learned on what makes Medicare a national treasure.

But this does not mean that people with genuine need cannot and do not get meaningful assistance from the Part D drug benefit. We have no reason to dispute polls that say up to two of three people enrolled in a plan are saving at least some money. But in a $1.3 trillion program, we must ask about the millions of people in need who do not see savings.

We have no reason to dispute, as the HMO lobby reported, that nearly 90 percent of the impoverished Americans switched from Medicaid drug coverage to Medicare drug coverage were not wrongly denied needed medication during the transition. But what about the ten percent, the 600,000 men and women – some small percentage of whom swamped our hotlines – that were?

People who have managed to enroll in the low income subsidy or Extra Help Program are certainly well served by Part D – so long as they find a plan that covers their drugs. But why have the diligent efforts of the Social Security Administration and hundreds of community organizations like MRC been able only to enroll less that 20 percent of eligible Americans in the Extra Help Program?

It *is* good news that millions of additional people with Medicare now have some drug coverage than had it in 2005. But millions do not and millions more are worse off then before.

Our clients come to us in droves to report continuing problems. Many find that their drugs are not covered by their plan, that they cannot afford their co-payments, that they lost better coverage. We believe that an objective appraisal of Part D would lead Congress to redesign this program, starting off by allowing Medicare to offer a drug benefit integrated into Part B that would be comprehensible and reliable.

But allow me to start with eight correctives that would make the existing drug program better able to meet its stated objectives.

AUTOMATICALLY ENROLL ELIGIBLE PEOPLE IN THE LOW INCOME SUBSIDY

> *Beatrice Gigi, an 87 year old resident of Queens, New York, receives a total monthly income of $1,068 from Social Security and from a small pension from her union. She currently needs to fill two prescriptions a month, but has a hard time making ends meet. Her life savings are down to $18,000, too much to qualify for the Extra Help Program, but too little to offer her peace of mind.*

Since the beginning of the debate of the Medicare Modernization Act of 2003 (MMA), there has been widespread, bi-partisan agreement that the number one priority of a Medicare drug benefit is to assist the poorest Americans secure the medication their doctors prescribe. The low income subsidy, popularly called the Extra Help Program, offers the promise of a comprehensive and affordable drug benefit – so long as the patient selects a drug plan that works for her.

One of MRC's key priorities over the past six months has been to enroll as many people in that benefit as humanly possible. With funding from the Starr Foundation and Robin Hood Foundation, among others, we have enlisted hundreds of volunteers to reach out to likely candidates for Extra Help, explain the program to them and whenever possible enroll people on line. We are probably as sophisticated as anyone in conducting this work. We advertise a toll free phone number through AARP, chain drug stores, senior centers and elsewhere. We have public service announcements and look to work cooperatively with drug plans (who gain enhanced payments when we sign up their enrollees in Extra Help). We work with pharmaceutical companies that supply us with contact information for people with low incomes who have been disqualified from their patient assistance programs because of Part D: they are good prospects for Extra Help eligibility. Still, the results are dismal: it routinely takes 33 calls by MRC volunteers and staff to identify a likely candidate for the Extra Help Program.

We can all admire the tenacity of Sisyphus futilely pushing his boulder up the hill. But that does not mean that the *Myth of Sisyphus* should be our model in designing a public program aimed at protecting the lives and health of millions of older Americans. If we are sincere about assisting poor Americans with Medicare have real access to a comprehensive and affordable drug benefit, we know how to do it.

All people with Medicare whose financial data demonstrate eligibility for the low income subsidy should be automatically enrolled in the Extra Help Program. To simplify this, Congress should eliminate the asset test. The Social Security Administration's own figures show that the asset test disqualifies half those who apply for Extra Help. Considerable research – and MRC's on-the-ground experience – shows that the asset test discourages many people from even applying for assistance. But with or without an asset test, federal financial data on income and income generating assets can be used to automatically enroll men and women eligible for the Extra Help Program. Automatic enrollment, with opt-out, works well in Medicare Part B which has a 96 percent enrollment rate.

Congress: eliminate from the Extra Help Program these hoops that many frail elders will not be able to negotiate. Automatic enrollment could make real the promise of affordable medicine for many of the poorest Americans with Medicare.

REQUIRE MEANINGFUL PART D PLAN COMPARISONS

Reasonable public policy would not require people with Medicare to shoot in the dark to pick a drug plan that would work for them. We appreciate efforts like that of Congressman Doggett's daughter, a physician, to assist her grandmother select a drug plan. Secretary Leavitt, according to published reports, made a similar if less successful effort to assist his parents select a drug plan. But Las Vegas-style gambling on one's health care is not what we should be purchasing for our parents, our grandparents and ourselves.

Many callers to MRC's hotlines are among the more sophisticated of consumers. They did what the President and others told them to do. They found help with the internet, they found a plan that said it covered the drugs they now are taking, they found a plan with premiums and deductibles that seemed affordable, and they signed up.

Now they call us in a panic. They never understood that a "covered drug" could come with a $100 per prescription co-payment. They never thought that a "covered drug" would come with trapdoors – requirements that they try other medications first, or that their doctor would have to agree to become a witness in a legal appeal so they could get the "covered drug." Almost no one now hitting the gap in coverage, the infamous donut hole, was told about this by the plans. How many brokers, people earning commissions for each person they enroll, do you think told their customers about the donut hole?

Melanie Kovarick, age 33 from Phoenix, Arizona is disabled because of multiple sclerosis and qualified for Medicare in March. She started researching prescription drug plans early on, but found the process to be more than difficult. She says, "There is a mind-numbing amount of research involved in trying to pick an appropriate plan. I read the entire 2005 Medicare changes book released in November. I read the entire 2006 Medicare options book released in December. Neither had any real details about what would or wouldn't be covered and the most in-depth comparison the whole program did was to determine which county each plan covered. I was referred to the State Health Insurance Program and the Medicare.gov web site and was promised they clearly answer any and all of my questions and help me perfectly plan the best options for my medical coverage.

"The Medicare.gov website was the worst disappointment, actually worse than the books that they published supposedly to educate us on the changes. There are roughly 40 options of different kinds of plans- all significantly different in how they pay and how YOU pay (monthly premiums, co-pays, co-insurance, and restrictions). You can try to use the benefit comparison tool, which only permits you to 'compare' three plans at a time and only provides the most BASIC of information on each plan.

"I keep looking and looking [at plans] but the options get worse and worse the more that I dig into them. These new 'plans' are a fragmented mess with every private company scrambling to get a new piece of this customer bonanza and all the Medicare recipients scrambling to try to catch the carrot dangling in front of them – help with rising prescription costs."

If a majority of the members of Congress continues to support this marketplace experiment, two steps could help: one, Congress should authorize a drug benefit integrated into Medicare to serve as a reliable safe harbor, a genuine choice, for people dissatisfied with the private plans; and two, Congress should force a more finite number of plans into meaningful comparisons that will allow, however imperfectly, some consumers to make a less risky selection.

END MARKETING ABUSES

MRC's experience with frantic callers to our hotline is leading us to the unhappy conclusion that nearly all marketing of Part D plans is misleading, nearly all of it exploitative of the neediest and frailest older Americans. Worst off are people who were contacted by telemarketers, a practice sanctioned by CMS. Caller after caller tell us that they did not know much about the plan they had enrolled in, and that they had been told things that were just not true. Other callers tell us that they did not know that they had signed up for an HMO, not a drug plan, until their doctor presented them with a bill and told them he is out of the HMO's "network." Increasingly, as people fall into the gap in coverage, the infamous "donut hole," they are shocked. Why?

Segundina Diaz is a 66-year-old woman from Queens, New York who has health insurance coverage through Medicare and New York Medicaid. Ms. Diaz met with the MRC counselors at her local senior center because she could not see her doctor with the Medicare Advantage HMO plan that she had signed up with. Her doctor was not in her plan's HMO network. Ms. Diaz told the MRC counselor that a marketing representative from a Healthfirst Medicare Advantage plan told her that she was going to lose her Medicaid coverage if she did not sign with this new plan. A caseworker at the senior center and the doctor's office tried to contact the market representative for days with no success. MRC finally contacted CMS and it authorized a retroactive disenrollment from the HMO.

The design of this privatized drug program creates a single commercial incentive for the drug plans, the brokers they employ, and the marketing firms they retain. The incentive: market share. Even putting aside purposeful fraud by the unscrupulous, deception is an inevitable by-product of this market created by the MMA and CMS.

Have you reviewed marketing material from the drug plans? Have you heard sales pitches at free breakfast meetings? At senior centers? A plan with a low deductible or a low premium will highlight that feature. People will be sold low deductible plans without understanding the other side: restricted formulary, rigid medication utilization tools, excessive costs per prescription. How many members of Congress have seen plan marketing materials – TV ads, brochures radio spots – talk about the gap in coverage? Even CMS is part of the problem. Late last year CMS spent untold public dollars running an insert about Part D in *Parade Magazine*. CMS, supposedly explaining the standard drug benefit, neglected to even mention the donut hole. Shareholders are protected by the Securities Exchange Commission and securities laws. Aren't older Americans entitled to similar protections from the predatory practices of the insurance industry? Deception comes in many forms: omitting material information from drug plan advertising is one that is epidemic in Part D.

Telemarketing of drug plans must be banned, and all marketing materials must be limited to accurate and comprehensive comparisons of standardized plans.

IMPROVE ACCESS TO MENTAL HEALTH DRUGS

Clients continue to flock to MRC seeking help with barriers drug plans are putting in the way of access to antidepressants and antipsychotics, drugs commonly needed by people with mental illnesses. As you know, CMS required plans to cover "all or substantially all" of these medicines, along with drugs in four other critical therapeutic classes. But that requirement is being undermined by other restrictions imposed by plans -- prior authorization, step therapy and quantity limits. Quantity limits in particular are billed as "safety edits," but drug plans (seeking, of course, to maximize profits) generally impose them only on the most expensive drugs. Cost, not safety, is motivating the plans.

Mark McConathy, age 44 from Clearwater, Florida, is an engineer with a PhD in computer science. He designed data servers before a stroke left him unable to work. Now, Dr. McConathy takes 16 to 17 medicines a month, for various conditions including diabetes, hypertension and grand mal seizures, and is surviving on a monthly income of $851. For his seizures, Dr. McConathy takes Clonazepam, a drug in the benzodiazepine family that is categorically excluded from coverage under Part D. At $53 a month, Dr. McConathy has had to skip doses of Clonazepam leaving him more prone to grand mal seizures. Dr. McConathy has also had problems getting another mental health drug, Effexor, because his part D plan sponsored by AARP, imposes a quantity limit on it. Left with significantly higher drug expenses under Part D, Dr. McConathy is unable to afford both food and medicines.

One important, and relatively inexpensive, class of drugs – benzodiazepines – is excluded by law from Part D coverage. This exclusion threatens the stability of the drug regimens of many people with mental illness. Most state Medicaid programs continue to provide coverage but many people with low incomes do not qualify for Medicaid, and states are under financial pressure to cut back coverage. In Florida, people who qualify for Medicaid through spend down are finding it difficult to maintain access to these medicines.

Congress should end the exclusion of benzodiazepines from the Part D benefit and ensure adequate coverage of mental health drugs, and should enjoin plans from doing an end run around formulary requirements with utilization management dodges.

ELIMINATE THE "DONUT HOLE"

The donut hole, the gap in coverage that extends from about $2,250 to $5,100 in drug spending will disrupt treatment for needy men and women with Medicare. Our clients are hitting it already, and estimates suggest that some 7 to 10 million people with Medicare are at risk of reaching the coverage gap. Even those enrolled in a plan will be forced to choose between buying medicine, paying the monthly premiums they still owe, and buying other necessities of life. Most impacted are those who fail to qualify for the Extra Help Program, perhaps because a life insurance policy or other savings they rely on for financial security puts them over the limit.

Anthony Sakelarious, of Las Vegas, Nevada, is disabled due to severe degenerative disk disease that runs in his family. He has had two "failed" back operations and is in constant pain. On some days he is able to get to the food store or the pharmacy but he is usually unable to leave his home because he is in such pain. Mr. Sakelarious takes 10 medications – two of which are very expensive and help control the pain.). Without warning, Mr. Sakelarious was just told that he had hit his drug plan's coverage gap and he would have to pay the full cost for his medications. He is over the limit for the Extra Help Program and is anxious about dipping into what is left of his saving to pay for his medications. He was told by his doctors that there is no surgical cure for his back problems and he will need to take medications for the rest of his life. Mr. Sakelarious worries about how he will he be able to pay for his medications in the coverage gap next year, and the years after that – especially since he has learned that the gap will widen with each year.

We understand that the donut hole resulted from the financial constraints imposed on Congress by the White House when it was debating the MMA in 2003. But the decision to hand the drug benefit over to private insurers rather than have Medicare secure lower prices precluded savings that could have been used to fill the coverage gap. Studies show that, if Medicare secured the same prices that the Veterans Administration or other industrialized countries pay, there would be enough money to fill the donut hole. We appreciate that there is much debate, some of it informed, about this assertion. Proof of Medicare's effectiveness as a negotiator is found in the pharmaceutical industry's virulent opposition to allowing Medicare to negotiate drug prices.

We understand why PhARMA will fight this to the death. Why are a majority of the members of Congress afraid to try it?

STANDARDIZE, STREAMLINE PART D EXCEPTIONS AND APPEALS

Parts A and B of Medicare have worked well because they are based on the concept that individuals will have access to care deemed medically necessary by their treating physician. In theory, drugs under Part D are supposed to follow a comparable concept: while Part D consists of a patchwork of plans with various options and limitations on prescriptions, the MMA also includes exceptions and appeals provisions intended to allow individuals to access medically necessary drugs.

We now know from our first hand experience that the current system fails to deliver on this bedrock concept – access to medications that are medically necessary. Over the last several months MRC has helped hundreds of men and women take on the Part D appeals system. Most of our appellate clients had been denied access to medically necessary medications, and almost all were stymied by the Part D appeals process. Here are ways to improve this flawed, consumer hostile system:

- standardize the appeals process and forms;
- streamline the appeals process; and
- provide resources for independent consumer organizations to provide representation to people denied medically necessary medicine.

The Part D appeals process is impossible for the average consumer to navigate. Following near universal criticism, the recent move to standardize the coverage determination request form is a welcome, but very small start. Use of these forms by plans is voluntary, and

they are only the first step in a multi-step appeals process. Steps must be taken to standardize the rest of the appeals process. There should be one form and one set of rules for obtaining an exception. That form and those rules should be posted on the CMS website and mailed to all people with Medicare. Obtaining life-saving medications should not be akin to navigating a mine-field.

Eric Lifschitz is a disabled New Yorker with Porphyria, a rare genetic condition. Medicaid had always covered Mr. Lifschitz's medications, including Anzemet and Protonix. Since early March, Mr. Lifschitz has been attempting to obtain medically-necessary quantities of his medications from his plan, First Health Premier. MRC has sent Mr. Lifschitz's case to the CMS regional office, but that office has been unable to help. His case has also been forwarded to the CMS Central office, but we have yet to receive a response. With MRC's help, Mr. Lifschitz filed a quantity limit exception request to First Health Premier on April 17th. Although all relevant time limits have expired, Mr. Lifschitz has not yet heard about whether or not this request has been granted. Due to his condition, Mr. Lifschitz is unable to tolerate alternative doses or medications.

A standardized appeals process must also be a streamlined one. Individuals should receive a formal denial before they leave their pharmacy, complete with plain instructions on how to appeal that denial. After an initial appeal to a Part D plan, individuals would then appeal directly to the Independent Review Entity.

This would cut out an unnecessary and generally futile step. Currently, after being denied a claim at the pharmacy, people with Medicare must ask the plan twice to cover their drug before receiving an independent review. Drugs subject to prior authorization require three requests for coverage at the plan level before an independent review is allowed. Each of these preliminary steps causes delay in violation of mandatory timelines and at considerable risk to the well being of the patient.

Further, for the current process to be meaningful, people with Medicare require assistance in prosecuting appeals. The current system assumes a helpful and willing physician. Do members of this Committee know many doctors who are routinely willing to take on arduous, uncompensated paper work for the sake of their patients? And who is to help patients pursue appeals?

As noted, MRC is listed on plan denial forms as a go-to patient advocate for people denied coverage of medicines prescribed by their doctors.

How much does CMS contribute to this representation?

Nothing.

How much do the drug plans contribute?

Less.

If Congress wants people with Medicare to have access to medically necessary drugs, it must standardize and streamline the Part D appeals process, and provide assistance to individuals with bona fide appeals of a plan's denial of medically necessary medications.

EXTEND THE MAY 15TH DEADLINE

It's difficult to believe that at some point in the next two weeks the Administration will not move to extend the May 15th deadline for enrolling in a Part D plan. From a bureaucratic perspective, we understand that the Administration believes that adding the pressure of a deadline on people will accelerate enrollment. From a humane perspective, adding more stress on people already overwhelmed with the anxiety of this complicated program will only add to more distress and more bad decisions. The May 15 deadline will lock in those bad decisions.

Connie Barron, age 65, lives in Stamford, Connecticut, and works part time as a social security benefits counselor with the STAR program. Prior to Part D, Ms. Barron had a patchwork of prescription drug coverage. She paid for some medicines out of her pocket and relied on free samples from her doctor for her most expensive prescriptions. Ms. Barron knew she wanted to sign up for a Part D plan, and she went about trying to learn more about the plans by looking on the Medicare.gov web site and calling several of the larger plans. Ms. Barron couldn't access the Medicare Plan Finder for help and when she called several of the plans she either couldn't get through or found the customer service representatives to be less than helpful. In the end, Ms. Barron chose her plan, AdvantraRx Premier Plus (at $42.89 a month) because Coventry is based near her childhood home in Pittsburgh, Pennsylvania. When Ms. Barron called Coventry the operators were nice and she felt like she was "getting accurate and complete information." Upon reflection, Ms. Barron chose Coventry's because it felt familiar in a program that "lacks clarity" and is too complex. She hopes she has time to switch.

Although the deputy administrator at CMS has declared publicly that the agency lacks authority to extend the deadline, the Medicare Rights Center has supplied CMS with a legal analysis showing that it is amply empowered to create a special enrollment period that would cover this calendar year. This would allow people not yet enrolled in a drug plan to do so; perhaps more important, it also would allow people in the wrong plan to switch to one that works better for their health care needs. Justifications to create the special enrollment period are not hard to find.

Computer systems problems – blame CMS, blame SSA or blame the plans, they each blame each other – continue to leave people without coverage, enrolled in the wrong plan, or charged the wrong amounts for the plan that they are in. The insurer with the most Part D enrollees and the best brand name startled people with Medicare over the last two weeks by wrongly threatening to cut them off unless they promptly paid already paid premiums.

As noted, high-pressure marketers have steered people with Medicare into drug plans that do not cover their drugs and into HMOs that do not cover their doctors.

And no one, not even the strongest proponents of the drug program's design, anticipated that 40, 50 or even 60 plans would join the gold rush in most states leaving consumers bewildered and ripe for exploitation.

According to a *Washington Post* poll 71 percent of people polled support extending the enrollment deadline. According to a Kaiser Family Foundation poll, 45 percent of older adults say they do not know about the deadline. Fairness requires Congress to extend the deadline if the Administration refuses to exercise its power to do so.

DELAY THE ENROLLMENT PENALTY

Like the May 15th deadline, the prospect of a late enrollment penalty creates needless anxiety among people with Medicare already frustrated by a confusing choice of plans. The late enrollment penalty accrues during the months people with Medicare are locked out of drug coverage after May 15 and will rise each year as the average drug plan premium rises. With all the problems and confusion associated with the roll-out of the Part D benefit, it is inevitable that some people with Medicare will miss the enrollment deadline. Congress should step in and waive the late penalty for 2006.

People with Medicare below 135 percent of the federal poverty line pay only 20 percent of the late penalty for a limited period of time—literally just a few cents each month and less than the co-payments they are now struggling to pay. But for this vulnerable group, just the existence of a late penalty could discourage enrollment in the benefit. The administrative cost of collecting this penalty is not worth the revenue it generates. Congress should waive the late penalty for all low-income people with Medicare.

ENACT A MEDICARE DRUG BENEFIT

Gloria Tuttle, 78, and her husband Russ, 80, of Graham, Washington, have relied on Patient Assistance Programs for their 13 medications for chronic respiratory, cardiac and acid reflux conditions. These charity programs are a lifeline for Gloria and Russ who have a combined income of less than $22,000 a year and cannot afford to spend hundreds of dollars every month on health care. The Tuttle's were informed that their Patient Assistance Programs would cut them off after May 15, so they sought out help. They consulted with SHIBA, Washington State's state health insurance assistance program, and learned that the cheapest plan for them would charge them $30 for name-brand prescriptions and $7 for generics with a $51 a month premium.

The Tuttle's went straight to their doctor to switch as many of their prescriptions to generics as they could. With the changes, under the cheapest Part D plan, the Tuttle's co-payments would be nearly $300 a month for all their medications, and an additional $102 for the monthly premiums. When you add in their Medigap supplemental insurance premium, the total is far more than they could afford. So, the Tuttle's looked to government assistance programs for help. Unfortunately with a combined income of $22,000, the Tuttle's make too much money to qualify for the Extra Help low-income subsidy program. But if they divorced, as single people they would each be under the income limit, $14,700 a year, to qualify for Extra Help. The Tuttle's are seriously contemplating getting a divorce just to afford their medicines.

"I will not give up until I have tried everything I can – we have faith that the Lord will provide that help in some form and take care of our needs – and so we wait and pray," said Mrs. Tuttle.

These eight reforms would be helpful, because we believe in the principle that anything that helps a single person is a worthy reform. But, even with these reforms the drug benefit will continue to waste billions of dollars that could better be used to deliver a reliable and comprehensive drug benefit to people with Medicare *through the Medicare program.*

Americans need affordable prescription drug coverage that meets our changing health care needs, a program that cover the drugs we need today – and the drugs we will need tomorrow. Medicare provides a cost effective and largely affordable safety net, reliably

allowing older and disabled Americans the peace of mind, the security of knowing that medically necessary and reasonable health care services will be covered. There is a human cost to abandoning that Medicare design for the coverage of prescription drugs.

To provide a benefit as good as we can afford with finite dollars, we think the lessons of Part D – objectively evaluated – teach that the Congress should enact:

- A drug benefit administered directly by Medicare, without the waste and restrictions that come with private health insurers as commercial, profit seeking middleman;
- Negotiated drug prices that keep costs down; and
- One comprehensible, reliable and secure drug benefit that adapts to the needs of the American people now and in the future.

Health security, not a health care lottery, is what people with Medicare require. People in good faith may still believe, even after the evidence of 2006, that the new cottage industry of for profit middlemen hawking incomprehensible drug benefit packages is the way to go. We do not think so. But we are content to allow those plans to continue, so long as these middlemen face a real market. Let the for-profit insurers compete with a Medicare drug benefit, one that fights for lower prices, and keeps administrative costs low and profiteering non-existent.

Honest supporters of a market approach cannot fear competition, not even from Medicare. There is nothing to fear but a better deal for people with Medicare and a fairer deal for the American taxpayer.