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SENIORS' ACCESS TO AFFORDABLE PRESCRIPTION DRUGS: MODELS FOR REFORM

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND ENVIRONMENT

OF THE

COMMITTEE ON COMMERCE
HOUSE OF REPRESENTATIVES

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SENIORS' ACCESS TO AFFORDABLE PRESCRIPTION DRUGS: MODELS FOR REFORM

WEDNESDAY, FEBRUARY 16, 2000

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:24 a.m., in room 2322, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Upton, Greenwood, Burr, Bilbray, Ganske, Norwood, Coburn, Lazio, Cubin, Pickering, Bryant, Waxman, Pallone, Deutsch, Stupak, Green, Strickland, DeGette, Barrett, Hall, Eshoo, and Dingell (ex officio).

Staff present: Carrie Gavora, majority professional staff; Tom Giles, majority counsel; John Manthei, majority counsel; Kristi Gillis, legislative clerk; Bridgett Taylor, minority professional staff; and Amy Droskoski, minority professional staff.

Mr. BILIRAKIS. The hearing will come to order. The Chair wishes to announce that, with the exception of the chairman's and ranking member's opening statement, the others will be limited to 3 minutes in the interest of time. We have a long hearing scheduled.

I now call to order this hearing on Seniors' Access to Affordable Prescription Drugs: Models for Reform. Today's hearing will provide an opportunity to delve deeper into the details of specific proposals to expand prescription drug coverage for Medicare beneficiaries. I believe every hearing is an opportunity for members to educate themselves, and the issue of prescription drug coverage certainly merits our time and attention.

However, I feel strongly that we must act soon to advance legislation that can be enacted this year. As I have repeatedly said, I believe no beneficiary should have to choose between filling a prescription and buying groceries. At a minimum, we must take action to help individuals in greatest need today.

As you know, I have introduced a bipartisan plan to improve prescription drug coverage for the poorest and sickest Medicare beneficiaries. The bill is not perfect, and I would not try to force this approach on any other member. After reviewing all of the proposals before us, however, I hope that we can reach a consensus this year on some plan to improve prescription drug coverage for Medicare beneficiaries particularly those in need.

I am proud of the subcommittee's record of success in addressing difficult legislative issues on a bipartisan basis. And, given the

charged political climate and the complexity of the prescription drug debate, the challenge before us is most certainly daunting.

As we seek common ground, I noted with interest a provision in the President's budget proposal to set aside $35 billion in on-budget surplus money over 10 years for a policy that provides protections against catastrophic drug costs. In a similar vein, the bipartisan bill that I have introduced would establish a stop-loss protection for beneficiaries who have high annual drug costs. I hope this is an area where we can find agreement, and I look forward to hearing more about the administration's plans in this regard.

Our first panel of witnesses will describe the perspective of senior citizens in this debate, and it includes a fellow Floridian, Dr. Beatrice Braun. Our second panel includes representatives from the Health Care Financing Administration and the General Accounting office, and our final panel includes several distinguished experts with a diverse range of experience in addressing these issues. I want to welcome each of our witnesses and thank them for taking the time to join us. I look forward to today's hearing and the opportunity to work together to advance legislation to help beneficiaries obtain the medicines they need.

The Chair now recognizes Mr. Waxman.

Mr. WAXMAN. Thank you very much, Mr. Chairman.

This Congress needs to take action to provide prescription drug benefits under Medicare. We need to act to eliminate price discrimination for drugs for our seniors. These two simple actions are long overdue, and I hope today's hearing marks the first real step toward dealing with these needs.

Sherrod Brown, who has been committed to securing a universal prescription drug benefit in Medicare, normally would be here today in his position as ranking member on this subcommittee, but he is in Ohio suffering from injuries from a serious automobile accident. I know we all wish him a speedy and full recovery, and I know he is anxious to be back and help pass prescription drugs legislation out of this committee.

No one would design Medicare today without including a prescription drug benefit. It is as critical to good medical care today as hospital care or physician care was when Medicare was first enacted. The simple fact is that if people can't get the drugs they need, they don't have adequate health care coverage.

We know that over one-third of Medicare beneficiaries have no drug coverage, and nearly 30 percent more have unreliable or very inadequate coverage. That is almost two-thirds that need help. Retiree coverage is shrinking or being eliminated, benefits are increasingly expensive and inadequate, and we know that all the trends show that this situation is only going to get worse.

Further, we know that seniors out there trying to purchase their prescription drugs on their own face tremendous price discrimination. They pay more for their drugs, frequently twice as much or even more for their drugs than the government or other favored customers of the drug companies. They are at the stage of their lives when they have more health problems and chronic illnesses. They need and use drugs more than any other part of the population, and yet they have the hardest time getting coverage, and when they purchase out of pocket, they pay the highest prices.

Medigap coverage is no answer. Any policy with drug coverage becomes an extremely expensive policy. Not only is the drug coverage itself expensive, but the adverse selection that occurs runs up the costs overall. So people pay very high premiums that not uncommonly are barely equivalent to the amount of drug coverage that the policy supposedly provides. In some cases, seniors find they are paying more in increased premiums than the drug coverage is worth.

And this isn't simply a problem for the low income. More than half of current Medicare beneficiaries without drug coverage have incomes above 150 percent of poverty. If you are a widow living on Social Security, if you have several different chronic conditions, if you need prescriptions regularly, you can't afford your drugs. It is that simple.

All this clearly underlines the need for Medicare coverage of prescription drugs for all of the program's beneficiaries. We wouldn't pay for hospital care only for the poor. We shouldn't think of limiting drug coverage in that way, either.

To me, the crisis that faces Medicare today is not its solvency. We know that the Trust Fund is solvent for at least 15 more years. The crisis in Medicare is that it doesn't provide coverage for prescription drugs when that coverage is so obviously needed.

Do we need to work long term to adjust Medicare and its financing so that we are ready to care for the baby boomers? Of course we do. But this is a program that is too vital for too many to take hasty or ill-considered actions that are neither well understood or supported by the public. More fundamental changes are a long term project.

But however we change the program in the future, we know that it will have to provide prescription drugs if it is going to meet the health care needs of our seniors and disabled citizens. It will never be easier or cheaper to do than it is now. Let's get on with providing coverage in the program and ending price discrimination for seniors. I hope our witnesses today will help us take the steps to achieve these goals this year. This Congress could have no better legacy.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. Mr. Greenwood?

Mr. GREENWOOD. Thank you, Mr. Chairman.

As Mr. Waxman has just said, we are in a crisis. We have wasted a lot of time trying to resolve this crisis. There has never been a prescription drug benefit for Medicare. We had an opportunity about a year ago, when the bipartisan Breaux-Thomas Commission made recommendations that would have enabled us to structurally reform Medicare in a way that would have made it quite convenient to add the prescription drug benefit, and unfortunately it was the administration that decided to sink that bipartisan agreement.

So here we are today in a position where, as we know and it has been said, 35 percent at least of America's seniors do not have access to prescription drug benefits at all. And in this day and age, if you don't have access to the new marvels of the pharmaceutical industry and the new marvels of the biological industry, you don't have good health care.

As we look at this problem today, one of the things that we should focus on is illustrated by the first chart, which has just been covered up by the second chart. Now, the first chart indicates that the place we need to focus our attention, obviously, is on the lowest income, the 35 percent of seniors without prescription drug coverage. If you look at the far right, only 5 percent of the wealthiest American retirees, 5 percent of those over $50,000 per year of income are without the benefit, and that escalates as you go, in inverse proportion to income, as you go down to those below $10,000 where you have 37 percent of the seniors without the benefit.

This will get worse. Actually, that is—okay, that will do. This problem is going to get worse for several reasons. No. 1, as we all know, the percentage of those of us who will be above the age of 65 by 2030 will go from 13 percent last year to 20 percent, and the reliance on medication, for a lot of very good reasons and to the benefit of the retirees, will go from 33 percent of the population of retirees using medication of some kind to 51 percent on a regular basis.

Another reason why this crisis will worsen if we don't resolve it soon is because the costs of pharmaceuticals in total are increasing rapidly in comparison to a generally declining Consumer Price Index. If you look at 1993, the average increase in pharmaceuticals was about 8.2 percent that year against a 2 percent CPI. And while the CPI is still 2.7 percent in 1999, the increase, the 1-year increase in the cost of pharmaceuticals total was 18.5 percent, double digits, and that trend is probably going to continue in that direction.

Finally, what is important I think to look at is that simple approaches, oversimplified approaches that would simply try to freeze the prices of pharmaceuticals, won't do the job because the annual increase in the prices of pharmaceutical products on the market is not the culprit. If you look at that chart, they increased 8.4 percent in 1990. In 1998 there was only 3.2 percent. That is the purple portion of those bar graphs on the bottom. So the annual increase in the price of products on the market is relatively de minimis.

What is happening is that the utilization, the volume mix, the likelihood that the retiree is on one or more medications, is increasing, and the new products coming onto the market that have cost a half a billion dollars——

Mr. BILIRAKIS. Would the gentleman finish up?

Mr. GREENWOOD. [continuing] is the major cause of the price, the cost increase. So we should avoid simple approaches to this problem, but we should get on with it, and this side of the aisle is prepared to do that.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

The gentlelady from Colorado.

Ms. DEGETTE. Thank you, Mr. Chairman, and thank you for holding this hearing on Medicare prescription drug coverage.

As we have heard already from my colleagues, our seniors are in crisis over prescription drug issues. Almost two-thirds of them have limited or no coverage whatsoever, and as we just heard, the issue is not just one for coverage but also for addressing rising costs. In fact, the average annual prescription drug costs for seniors are esti-

mated to increase from $942 in 1999 to $2,353 in 2011. For seniors, who often live on a fixed income, they are at considerable risk to such extraordinary cost inflation, and they desperately need a comprehensive Medicare prescription drug benefit.

Some people say we should just build on the current system. However, access to prescription drugs cannot be just based on factors as where you happen to retire, as is so often the case today.

For example, just among the 14 to 15 percent of Medicare beneficiaries that are enrolled in HMOs, some Medicare+Choice HMOs offer comprehensive coverage; others have adopted limited coverage with, as Bruce Vladeck points out, a bewildering variety of formulary restrictions, benefit caps, and other techniques to try to manage their pharmaceutical costs which significantly complicate the process of choice for beneficiaries, and an increasing number of plans are completely dropping drug coverage.

The options for the other 85 percent of Medicare beneficiaries are further complicated by the perverse incentives of prescription drug coverage in inpatient settings but lack of coverage in outpatient settings, interactions with third party coverage and Medicaid.

All of this cries out for adoption of a standard Medicare pharmaceutical benefit that would significantly simplify the choice process. Moreover, with a standard prescription drug benefit, as is the case among private employers, the Medicaid program and the VA, Medicare could for the first time assist seniors with the spiraling costs of prescription drugs by bargaining for volume discounts on their behalf. Without it, according to a study I did of prescription drug prices in my district, seniors are going to pay, at least in the First Congressional District of Colorado, on average 121 percent more for prescription drugs than favored customers like large insurers, HMOs and the VA.

Mr. Chairman, to address both the lack of prescription drug coverage and rapidly rising costs, this Congress has the responsibility to act this year, and I am glad that we all seem to recognize the problem on a bipartisan basis. The devil is always in the details, and I look forward, along with my colleagues, to hearing the testimony that we will hear today.

Thank you, and I yield back.

Mr. BILIRAKIS. I thank the gentlelady.

Dr. Coburn?

Mr. COBURN. Thank you, Mr. Chairman, for holding this hearing. I think there are a couple of things that we need to talk about when it comes to Medicare prescription drugs, and I do have the experience of having my seniors decide over a pill versus a meal, and I also know that about one out of every three prescriptions I write them, they don't fill because they don't have the money to do it.

As we look at this, you know, everybody says we are in surplus, but it is important to keep in mind that the surplus last year, the $1 billion true surplus, came out of the Medicare Part A Trust Fund. The $23 billion that is projected for surplus for this year is coming out of the Medicare Part A Trust Fund. It is excess payments into Medicare. The $22 billion for the year 2001 is coming from the Medicare Part A Trust Fund.

So, as we look at the integrity of the Medicare system, it is important that we understand that the projections that Mr. Waxman gave that it will be fine for 15 years, it is not going to be fine for 15 years, because we are going to spend the money, and the money is going to get spent on other things. So the first thing we need to do, if we are going to establish a drug program for Medicare, is to stop taking Medicare Part A Trust Fund money.

The second thing that I think we need to do is to look at what the real problems are in the drug industry. One of the greatest mistakes this Congress did was give drug companies the right to advertise on television. If you look at the 18.5 percent increase in the cost of drugs for 1999, ask how much that would have been decreased if $5 billion hadn't been spent on television advertising for drugs that are prescription anyway. Last week an associate of mine saw a television ad for an IV antibiotic, on television.

Now, who is paying the price for that? Who is paying for that? Medicare seniors are paying the price because we have decided to allow drug companies to advertise prescription drugs on TV, of which half the doctors, when they get asked to do that, immediately give something other than that because they are so abhorrent that the TV should be telling a patient what they need when they don't give full information on it.

The second thing that I think needs to be looked at is the lack of competition in the drug industry. There is no competition in the drug industry. We like to say there is, but there is not.

No. 3 is the fact that the American consumer is subsidizing drugs in Canada and Mexico, that if you look at the prices and we ignore the NAFTA system for allowing drugs to move across borders, in fact we are subsidizing drugs to a great extent throughout the country.

The fourth thing that I think needs to be looked at is the lack of utilization of appropriate generics, and the failure of the FDA and the administration to approve an increasing number of generic drugs, and the failure of the medical profession to utilize generic drugs in their efforts to try to lower the costs. Real care of patients is determined on whether or not you identify what is wrong with them, give them something that they are going to use, that will in fact impact. If you give somebody a prescription that costs $100 and they can't fill it, you haven't helped them at all.

Mr. BILIRAKIS. Please summarize.

Mr. COBURN. I will. So what should be the things that we look at as we look for prescription drug relief? Prolong the life of Medicare, that is the first thing we ought to do. The second thing we ought to do is make sure whatever we do increases competition. No. 3, the third thing is increase access. And the fourth thing, what can we do to lower costs?

And I thank the chairman.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Burr, to inquire? Do you have an opening statement?

Mr. BURR. Thank you, Mr. Chairman.

So many numbers, so many differences in the numbers. Here is one number that I don't think anybody will dispute: $11,727 is the income of an individual at 150 percent of poverty in the United States of America. The question you have to ask yourself is, how

long will we allow that individual to make a decision as it relates to where that $11,000 is spent, and for us, the safety net, not to provide the drug access and availability for them.

I don't think that the argument in this committee will be over whether there is a need for the Federal Government to be involved. Until Mr. Dingell came in, I could safely say nobody on the committee was here when we passed Medicare into law. But clearly, had drug benefits been part of the standard policy at that time, I think that prescription drugs would have been part of Medicare and should be today.

The GAO will testify shortly that it should be done in conjunction with comprehensive reform of Medicare. You have already heard some members say we don't need to do that now. One of the reasons that we are in this position is that we haven't been bold enough to tackle tough things in the past as it relates to health care, and especially as it relates to seniors' health care.

I personally believe that it is time that they have the best delivery system for health care, and that is not our current Medicare system. But we can add the drug benefit in the right way, a way that makes it comprehensive and universal so that all seniors can have an option of buying in and some seniors being supplied the subsidy, and it fits in the model of where we go for Medicare in the future, then I am all for doing it with this very important first step.

Mr. Chairman, I look forward to the witnesses. I thank them for their testimony in advance. I look forward to this committee producing a product that some in this town say we can't do, and in fact this Congress passing it and this President signing it into law.

I yield back.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Dingell, to inquire?

Mr. DINGELL. Mr. Chairman, thank you. First, I commend you for the hearing today. Second of all, I observe this is a most important subject and one on which we should provide leadership, and again I commend you.

I ask unanimous consent that my full statement be inserted into the record, and I be permitted to summarize.

Mr. BILIRAKIS. Without objection, the opening statement of all members of the panel will be made a part of the record.

Mr. DINGELL. Mr. Chairman, one of the great needs of Medicare, which was originally introduced by my dad, and which I sat in the chair when it was passed, is to see that we give our senior citizens coverage for prescription drugs, because many of them are compelled to go to a doctor, to receive the friendly bedside manner, but not to receive the thing which is absolutely essential to the success of the treatment, and that is prescription pharmaceuticals to address the basic medical need which they confront.

More and more costs are being asserted against them. Medicare beneficiaries have only limited coverage for insurance against the costs of prescription pharmaceuticals, and indeed many of them are suffering significant difficulties, including hard choices between prescription pharmaceuticals which they need and, unfortunately, food, lodging and other things which happen to be equally important to them.

The inclusion of prescription drugs in the Medicare program does not have to wait for system-wide reform. It can be dealt with through incremental change, and if you have observed the difficulties that we always confront when you try to make a massive, sweeping change, the end result is, nothing happens. My suggestion is that we then get down to the business of addressing this problem in a simple, easy change which we can make which will achieve broad support, and which is really not subject to any criticism.

There are two discharge petitions now pending, one on the Allen bill, H.R. 664, and one on the Stark-Dingell bill, H.R. 1495. The Allen bill will provide access to prescription drugs at discounted prices for seniors, making them more affordable. I will note that not infrequently drugs of the same exact chemical prescription or substance are made available to animals at about half the cost to which they are made available to senior citizens. Clearly there is some imbalance here that needs to be addressed, and I would suggest that we can and should do so at an early time. The Stark-Dingell bill would add a universal affordable prescription drug benefit to the Medicare program.

The petitions will seek to have an open rule so that we can full and fair consideration of the bills on the House floor. I prefer to follow, of course, the regular order, and it is for that reason I am delighted, Mr. Chairman, that you are having this hearing, because this enables us then to commence moving forward on both of these pieces of legislation and not to confront the kind of problem that the committee and the Congress confronted when we had to move the Patients' Bill of Rights, which was so ably sponsored by my dear friend, Mr. Norwood, with my modest assistance.

Mr. BILIRAKIS. If you would summarize, please.

Mr. DINGELL. Having made that observation, I look forward to a successful consideration of this matter, a harmonious and bipartisan working together to achieve a solution to a problem which the senior citizens find most troublesome. And I would note simply to the committee, the people want it, the country needs it, it is good for us all to resolve this question, we can do so easily, and I am delighted to see you embarked upon the beginning of this undertaking. And I know that the committee, under your leadership, will move forward, and I look forward to being a modest participant.

[The prepared statement of Hon. John D. Dingell follows:]

PREPARED STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Medicare is one of the most successful social programs of our time. In 1965, when Medicare was created, about half of America's seniors did not have health insurance. Almost 1 in 3 seniors lived in poverty, and were forced to choose between food, rent, or needed care.

Today, as a result of Medicare, seniors can get affordable health care. The poverty rate of the elderly has been cut in half. Americans are living longer and more prosperous lives.

However, since the program's enactment, there have been many advances in medicine. Most notably, prescription medications have been a critically important form of treatment, helping to cure disease, to prevent relapse of illness or injury, and to prevent the onset of disease or disability.

But, most seniors find themselves paying more and more out of pocket for the drugs they need to stay well. Some Medicare beneficiaries have insurance coverage to help with these costs, but this coverage is unstable and declining. Medicare bene-

ficiaries today face problems with drug coverage similar to the health insurance coverage problems faced in 1965. Many are presented with a stark choice between food, rent, or prescription drugs. And of those with coverage, about half are without full-year coverage.

To fulfill the promises made to seniors in 1965, we need to modernize the Medicare benefits package and make prescription drugs an integral part of Medicare. What this means is that prescription drugs should be available to all Medicare beneficiaries through the Medicare program, whether in fee-for-service or managed care. The benefit should be defined so that all Medicare beneficiaries are guaranteed dependable coverage, no matter where they live or how they get their coverage. Additionally, the benefit should be structured to encourage participation, and it should have protections for the low-income beneficiaries. Recognizing the important role that employers play in providing retiree benefits, we should also encourage employers to continue providing these benefits as well.

However, the inclusion of prescription drugs in the Medicare program should not have to wait for system-wide reform. We do need to explore ways that the Medicare program can be modernized and encouraged to work more efficiently, but given the number of people affected by system-wide reform, we should proceed with caution, and certainly accept no proposal that would eliminate the universal guarantee and social insurance nature of the Medicare program. We should be seeking to fulfill the promises made to seniors in 1965, not break them.

We are eager to get down to the business of providing prescription drug coverage in Medicare and making needed medicines more affordable for seniors this year. Today, we Democrats introduced two discharge petitions: one on the Allen Bill, H.R. 664, and one on the Stark-Dingell bill, H.R. 1495. The Allen bill would provide access to prescription drugs at discounted prices for seniors, making them more affordable. The Stark-Dingell bill would add a universal, affordable prescription drug benefit to the Medicare program. These petitions seek to discharge an open rule, so that we can have full and fair consideration of these bills on the House floor. While I prefer to follow regular order, both of these bills were introduced almost a year ago, but we have not seen any action to date. Seniors have already been waiting too long for help.

I am pleased to see that this Committee is exploring the issues surrounding providing prescription drug coverage in Medicare. I look forward to hearing from today's witnesses, and I hope that we will expeditiously proceed to markup on a proposal that would guarantee all Medicare beneficiaries affordable, accessible, and comprehensive coverage of prescription drugs. But if this Committee fails to act, each Member can do his or her part by signing the discharge petitions so that seniors are not kept waiting.

Mr. BILIRAKIS. And I thank the gentleman.

Mr. Bryant?

Mr. BRYANT. Thank you, Mr. Chairman.

Access to prescription drugs for Medicare beneficiaries is probably the most critical issue facing lawmakers this year. The current Medicare benefit package does not cover most prescription drugs, and I have heard from many seniors in my district who struggle to afford their medicines every month.

Today none of us would devise a medical insurance program for seniors that didn't include coverage for prescription drugs, but the current Medicare program was created in 1965, and back then drugs didn't play as vital a role in keeping people healthy. A lot has changed in health care since then. Conditions which used to require hospitalization can now be treated with new medications. These modern medicines help keep people out of the hospital, out of nursing homes, and help people remain active, productive members of society.

Over the past 35 years medicine has changed, but Medicare has not been able to keep up with those innovations because of the way it is designed and its overwhelming complexity. The program continues to be plagued by financial problems. Frankly, we owe beneficiaries a better Medicare, one that can adapt and adjust to changes in the health care system. We should not lose sight of the

long term goal as we work to provide new, affordable options for prescription drug coverage for seniors.

I want all beneficiaries to have access to affordable prescription drugs. I am interested to hear from our witnesses today on how they think they can provide better access. I know someone is here from HCFA to talk about the administration's plan, and I am glad, because I have concerns about that proposal. To be honest, after looking at the President's numbers, I am not sure many seniors will get much of a benefit from his plan.

For example, the average senior without any form of drug coverage is paying approximately $468 in total drug costs annually, according to the latest data from the Medicare current beneficiaries survey from HCFA. Under the administration's plan, a beneficiary would pay $302 a year in premium expenses and half the cost of the prescriptions that they purchase, so $302, plus half of the $465 on average is $234, equals about $536 total that a person would pay under the President's plan. This senior would be paying $68 more under his plan.

I may be crazy here, but I think we can probably do better than that. These are the facts and the figures that we have to look at closely today, and I am confident that we can find a better market-based solution that will help the seniors than the President has suggested so far.

I want to thank the witnesses today in advance who have taken their time to be here, and I look forward to your testimony. Mr. Chairman, I yield back the balance of my time.

Mr. BILIRAKIS. And I thank the gentleman for that.

Mr. Pallone?

Mr. PALLONE. Thank you, Mr. Chairman, and I want to thank you for holding this hearing.

The lack of an affordable prescription drug benefit is, without question, the biggest problem with the Medicare program today. The problem can't be corrected piecemeal by simply devising a plan to cover the poorest seniors. A comprehensive, affordable drug benefit should be available to all seniors regardless of income. Over 50 percent of Medicare beneficiaries without drug coverage are actually middle class seniors.

It is not clear to me whether the Republican leadership is prepared to move away from their previous plan to cover only the one-third of Medicare beneficiaries who lack any prescription drug coverage at all. The Speaker, I understand, has appointed a partisan task force to study this issue, and I hope this is not a mere diversionary tactic to stall any action by this committee to move quickly on a comprehensive drug benefit that includes putting an end to the price discrimination seniors face when purchasing pharmaceuticals.

That price discrimination issue has been well documented by Mr. Waxman and his Government Reform Committee and a number of consumer groups. The Waxman committee report shows that seniors pay almost twice as much for their prescription drugs than do the pharmaceutical industry's most favored customers. Families, U.S.A., to cite just one example from outside the government, found that the prices of the 50 drugs used most frequently by seniors

have risen at approximately two times the rate of inflation over the past 5 years, and four times the rate of inflation over the last year.

When it comes to an examination of who has taken the lead in trying to fix this problem, I think the record is clear. Notwithstanding Chairman Bilirakis' bill, the Republicans have done little on this issue. Democrats, on the other hand, have been on the House floor day after day since the 106th Congress began, pushing for consideration of legislative solutions such as those that have been offered by Congressman Tom Allen and Mr. Waxman and by Congressman Pete Stark and Mr. Dingell. All day today, in fact, Democrats will be signing discharge petitions on both of these bills in an effort to overcome the GOP's opposition to moving this issue forward quickly.

Both the Stark and Allen plans would increase the negotiating power of those seeking to provide a Medicare drug benefit, allowing pharmaceuticals to be purchased at cheaper prices and passing those savings on to all interested seniors. The President's plan also proposes to establish a comprehensive benefit and provide pharmaceuticals to seniors who need them at discounted prices, and I strongly support his proposal. On the other hand, I don't know of any Republican proposals or expressions of support for confronting the issue of pharmaceutical price discrimination.

Mr. Chairman, before closing, I did want to express my view that I do think it is important to bring in the pharmaceutical companies in our efforts to pass the Medicare prescription drug benefit. The willingness of the drug companies to drop their initial opposition to a benefit, and specifically to the President's proposal, is refreshing. I was contacted by some of New Jersey's pharmaceutical executives in particular last month, who expressed their willingness to sit down and help come up with a plan.

In an effort to show bipartisanship and support for a plan that the industry did not oppose, I, along with my colleague from New Jersey, Marge Roukema, sponsored the House version of the SPICE Act last year, and I believe——

Mr. BILIRAKIS. Please summarize.

Mr. PALLONE. [continuing] and I believe that that also can move the prescription drug benefit debate forward.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

Dr. Norwood?

Mr. NORWOOD. Thank you very much, Mr. Chairman.

This is of course a very important hearing, but just on a little lighter note, I want to say to my dear friend John Dingell, who can be described in many wonderful ways, "modest" is probably not one of the words that should be in his vocabulary.

We need to begin this process of matching a real and correct legislative solution to the rhetorical problem that dominates the political arena, and we are not going to get there, my friend Mr. Pallone, by making this a partisan issue, and you know that. My observation is that if you want to be real partisan, that is a certain way of how not to get the job done.

The question is, how do we increase seniors' access to affordable prescription drugs? I would like to begin by noting a very simple truth, a fact: The long term health of the Medicare program is far

from settled. When we first took up Medicare reform at least 5 years ago, bankruptcy was imminent, in fact this year. In 1997 we made some very hard choices in changing the way we reimburse providers, and it did extend the solvency of Medicare 15 years.

In fact, we did go too far, which is why we had to pass a bill making some technical refinements last year, and I am proud we recognized we went too far and made the correction. But we all know the problems in Medicare are far from being solved. I am sure we have all been visited by our hospitals. They are far from comfortable with their Medicare reimbursement, for example.

Medicare needs a long term solution, and we should be spending more talking about ways to make fundamental changes to make Medicare solvent for our children and our grandchildren. Yet, here we are talking about adding a massive, costly new benefit to Medicare.

Now, I am not trying to argue that the cost of prescription drugs for seniors is not a very, very real issue. It is a very real issue for those seniors who have no drug coverage, I can tell you that. The question for me is, should we be trying to create a new drug benefit for all seniors, or should we be trying to find a way to get help in purchasing prescription drugs to those seniors who actually need the help? I like Mr. Perot, but I am not interested in helping him with his drugs, for example.

Mr. Chairman, the President's proposal is unacceptable to me. It is like using a backhoe to weed your garden. When the long term solvency of Medicare is in question, adding $168 billion in a government-run universal benefit just doesn't quite make sense to me. It is like trying to solve the problem of a company going bankrupt, and the solution, the CEO says, is "Let's go see how much more money we can spend. Maybe that will solve the problem." I believe that when we fully examine the consequences of such a proposal, it could have on the pharmaceutical market, for example, and we had better examine that——

Mr. BILIRAKIS. Please summarize.

Mr. NORWOOD. [continuing] particularly in their research, we will probably reject the President's proposal.

Mr. Chairman, I would like to add my remaining remarks to the record, and simply say I would like to associate my final comments with Dr. Coburn. I think he is exactly correct when we talk about the use of generic drugs. That is an important part of the solution. I think he is precisely correct when he said——

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. NORWOOD. [continuing] we made a mistake allowing the drug, the pharmaceutical companies, to advertise on TV, and I hope we will deal with that. And that is all, Mr. Chairman.

[The prepared statement of Hon. Charlie Norwood follows:]

PREPARED STATEMENT OF HON. CHARLIE NORWOOD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Thank you, Mr. Chairman. This is a very important hearing today, because we need to begin the process of matching a real legislative solution to the rhetorical problem that dominates the political arena. How do we increase seniors' access to affordable prescription drugs?

I would like to begin by noting a very simple fact—the long-term health of the Medicare program is far from settled. When we first took up Medicare reform five years ago, bankruptcy was imminent. In 1997, we made some very hard choices in

changing the way we reimburse providers and extended the solvency of Medicare for 15 years. In fact, we probably went too far in some areas—which is why we had to pass a bill making some technical refinements last year.

But we all know the problems in Medicare are far from solved. I am sure we have all been visited by our hospitals. They are far from comfortable with their Medicare reimbursement. Medicare needs a long-term solution, and we should be spending more time talking about ways to make fundamental changes to make Medicare solvent for my children and grandchildren.

Yet here we are talking about adding a massive, costly new benefit to Medicare. I am not trying to argue that the cost of prescription drugs for seniors is not a real issue. It is a very real issue for those seniors who have no drug coverage whatsoever. The question for me is . . . should we be trying to create a new drug benefit for all seniors or should we be trying to find a way to get help in purchasing prescription drugs to those seniors who need help?

Mr. Chairman, the President's proposal is unacceptable. It is like using a backhoe to weed your garden. When the long-term solvency of Medicare is in question, adding a 168 billion dollar, government-run, universal benefit just doesn't make sense. I believe that when we fully examine the consequences such a proposal would have on the pharmaceutical market—particularly in the area of research—we will reject the President's proposal.

Mr. Chairman, I believe we need to focus on the real problem through a targeted approach. We need to be looking at solutions that benefit those who have no drug benefit and need help to afford the cost of prescription drugs. We need to be careful not to do anything that might negatively affect pharmaceutical research. We need to be careful not to do anything that might make the job of long-term Medicare reform more difficult.

If we can find a common ground between us on what is necessary to help seniors in need, we can pass useful legislation. If we are going to turn this into a political football, then we are wasting our time and not doing seniors any good. Mr. Chairman, I look forward to working with you to make a difference for seniors in need.

Mr. BILIRAKIS. The gentleman from Michigan.

Mr. STUPAK. Thank you, Mr. Chairman. I apologize for being a little bit late because I was down in line signing the discharge petitions. I think they are critically important. I think we have to do them. Since 1998 I have been on the Stark-Waxman bill—excuse me, Stark-Dingell bill and the Allen-Waxman bill. And, you know, the discharge petitions just say let's have a full, honest, open debate on this issue. But I am pleased that at least the debate can start here, Mr. Chairman, and I thank you for holding a hearing.

You know, like I said, it has been 2 years, 1998, since we brought forth those bills. In those 2 years, what I have found is, seniors across my district, like the 88-year-old widow up in Sheboygan, Michigan, whose only income is $814 from Social Security. Her monthly prescription drugs are $446. Fifty-four percent of her income goes just to try to pay for her prescription drug coverage. And no matter where I go in my district, from Lawrence to Traverse City to Ironwood, seniors are spending anywhere from 25 percent to 50 percent of their income just for their prescription drugs, and we have examples of letters that go on and on. And then you see reports where, if you are a veterinarian, you get the same medicine for your animal for half the costs that seniors are paying. There is something wrong with it.

So, while we are not trying to politicize the issue, we are certainly going to get the political pressure up here to get this issue before us. A drug benefit is very, very necessary.

I noticed over the break that the drug companies were running these ads about accessibility to drugs. It is not accessibility. It is called affordability. How can you have seniors who have prescription drug coverage pay 50 percent less than a senior who is standing in line at the pharmaceutical companies, I mean at the drug

store, paying half of what they have to pay just because they don't have any kind of drug benefit coverage?

So I think we should move these bills, being the Allen bill and the Stark bill, and I hope we would do it quickly. There is no excuse for it. I think what we should strive for in these hearings is, how can we provide universal prescription drug coverage for everybody, under Medicare or any other kind of program you want to advise, and also to end the drug price discrimination by the pharmaceutical industry, not only amongst our seniors, but when you are dealing with animals and seniors.

And I live on the Canadian border. We can go across to Canada, the same drug, the same everything, half to 60 percent less of what you would pay in the United States, and they are all manufactured here in the United States. No reason for it, Mr. Chairman.

So I look forward to this hearing. Thank you for having it. I yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman.

Dr. Ganske?

Mr. GANSKE. Thank you, Mr. Chairman.

I think it is true that there are some Medicare beneficiaries, for instance widows who exist solely on their Social Security, and out of that Social Security is taken Medicare premiums, and they are faced with the situation where on some months they have to decide between different types of medications that they can have refilled, or even between medications and other essentials of life such as heating and food. So I think there is no question that we should do something, especially to target the neediest of Medicare beneficiaries, in regards to the high cost of prescription drugs.

You know, Mr. Chairman, Congress has dealt with this issue before, and I think it would behoove every Member of Congress, not just this committee, to go back over what Congress did in 1988 and look at this issue. Now, I know there are some members on the panel here who were here at that time, but CRS has a report for Congress on the Medicare Catastrophic Coverage Act of 1988. And I want to just review a little bit of what went on, and so I am going to quote rather liberally from an editorial that was written by Dan Rostenkowski for the January 17 Wall Street Journal, and it goes something like this:

"Given Ronald Reagan's conservative reputation, many people are surprised to hear that he enthusiastically signed the largest Medicare expansion in history. That 1988 legislation limited the costs of hospitalization and partially paid for prescription drugs. The plan was wildly popular and it passed with overwhelming bipartisan support, 328 to 72 in the House."

"Today it is equally surprising to hear that the following year George Bush signed legislation repealing that expansion. The reversal was by far the largest cut in Medicare benefits in history, but the repeal legislation passed the House by a 360 to 66 vote, the most sudden and drastic reversal in my 36 years in Congress," said Mr. Rostenkowski.

He goes on. He says, "The problem was, and still is, a lack of money, the result of senior citizens' reticence to pay more. Debating the wisdom of the Reagan era expansion plan, Senator Alan Simp-

son said at the time, 'It is a social experiment. It's called pay for what you get.'"

Rostenkowski said, "The plan was financed by a premium increase for all Medicare beneficiaries, supplemented by extra payments from more affluent recipients." Rostenkowski says, "In hindsight, we made several mistakes. The first was to break precedent and ask that the group receiving the benefits actually pay for them. The second involved timing. We adopted a principle universally accepted in the private insurance industry: People pay premiums today for benefits they receive tomorrow. Apparently, the voters didn't agree with these market principles."

"Television critics' archives preserve the image of unhappy Chicago senior citizens surrounding my car"—this is Rostenkowski——

Mr. BILIRAKIS. Please sum up, doctor.

Mr. GANSKE. [continuing] "when I visited a decade ago to explain why I thought Medicare expansion was a good deal."

Then if you look at what went on, you will see that the initial projections—and this is from the Washington Post, August 1989, so it is before the provision went into effect—the initial cost estimates for the prescription benefit at that time for this program was $37 billion, but within a few months they had raised it to $42 billion and then $45 billion.

And my point is this, Mr. Chairman. When we look at this problem, we have no idea what a prescription drug benefit is going to cost because we have an explosion of technology going on. We will see genetic——

Mr. BILIRAKIS. I'm sorry to interrupt, but your time has long expired.

Mr. GANSKE. [continuing] drugs that are going to be very expensive. So I think we need to make a decision. If we are going to provide some Federal funds to help those neediest, how do we do that without an open-ended commitment that could bust the bank and bring us back a year from now, a la 1988?

Mr. BILIRAKIS. The gentleman from Florida, Mr. Deutsch.

Mr. DEUTSCH. Thank you, Mr. Chairman. You know what? I have a prepared statement which I would like to submit to the record, but I think it appropriate to respond to what my colleague just mentioned. I think the year which is more appropriate to reflect upon is 1965, and that is when Medicare was created. I think that is a much more appropriate analogy to where we are today.

Thirty-four years ago, health care in American was fundamentally different than it is today. There have been these fundamental changes, and a variety of statistics that we can talk about. The average cost that a senior, the percentage of their income paid out of pocket is actually more today, even with Medicare, which talks about the costs that are outside of Medicare, including the most significant one, which is prescription drug coverage.

You know, I think some of the numbers, and numbers sometimes really do say things that are significant, there are more than 2 million seniors in America that spend over $1,000 a year on medication out of pocket, without reimbursement. Since Medicare, you know, average spending has risen from 11 percent in 1965 to over 18 percent now. It was 11 percent in 1965; it is over 18 percent of their income today.

The reality is, and it is not just the poor, it is at many income levels, that people are making choices. I know many of my colleagues have had hearings in their district and talked to real people. I mean, I would encourage all of my colleagues to talk to their constituents. I mean, all of us sort of claim to, but sometimes I wonder how many of us actually do, actually do and talk to seniors and talk to real people, and what they are faced with on a day-to-day basis in terms of their lives.

The choices that people were making 30 years ago, whether health care or food or to visit their grandchildren one time in 6 months or one time in a year, I mean, those are similar choices people are now making about prescription drugs. Not everyone, obviously, but a significant number of Americans and our constituents.

You know, I think this is clearly an issue whose time has come. Medicare wasn't passed in 1 hour, in 1 day, in one congressional session. It was fought tooth and nail, unfortunately, I think it goes without saying, by—and I don't like to be partisan so I won't be partisan—but by certain Members of Congress for many years. It was successfully fought, by certain interest groups, was successfully fought for years.

But I think at a certain point what happens in the legislative process is it is overdetermined, and I think we are looking at something that in fact is overdetermined. The American people want this. It is appropriate, it is commonsense, it makes sense, it should happen, and you know what, it will happen.

And I hope that there is a bridge that lasts between us, because it is the right thing. I applaud my chairman, my colleague from Florida, for having this hearing and being incredibly concerned and sensitive to this issue. And I urge all of my colleagues on both sides of the aisle to take this opportunity which we as Democrats offer you today, to sign a discharge petition, to sort of put your money where your mouth is and actually get this legislation passed for the American people.

Mr. BILIRAKIS. A vote has been called on the floor. I would love to be able to get the opening statements out of the way before we run over.

Mr. Bilbray, for an opening statement. Hopefully you can cut it down.

Mr. BILBRAY. Thank you, Mr. Chairman.

Mr. Chairman, I know many members of this committee and the full committee get kind of tired of those of us in California saying we do it this way or that way, and I understand that. I have been educated in the ABC's of Washington: Anybody but California. But I think that one of the frustrations we have had out West is that we are so far from Washington, DC, it is hard for our voices to be heard sometimes, even though with 32 million people, the small intimate group.

Today I want to really thank a lady for coming, Mrs. Lewis, who actually works with the osteoporosis group, she is a director in San Diego, and took the time and the effort to fly all the way across this continent to bring a message here. And I don't think she has the only message that we should be listening to, but I think it is one of the opportunities that we have as we address this challenge.

And I want to thank Mrs. Lewis for coming out here and making this effort, because I think she has a message of some of the unique situations and some of the ideas that we have developed in San Diego, in California.

That aside, I think that as we address this issue, it is not as simple as we would like it to appear at first blush. We can talk about why don't we spend more government funds on this, but then do we allow the pharmaceuticals to take advantage of an inflated price because of the huge influx of government money going into this field?

Do we then all at once try to place price controls on and limit profits, which then may affect the commitment, the involvement in the development of new breakthrough drugs, and all at once not only reduce the accessibility to seniors but also the general population? Do we at the same time, when we talk about this issue, do we talk about R&D credits, about encouraging pharmaceuticals to do more research, to create new products that will compete with the ones on the field and break up some of these monopolies we have seen before?

My colleague from Oklahoma points out the issue of advertisement, which is something that we legitimately should talk about.

I think that the biggest thing that I would ask us to consider here is what we do with this issue does just not affect seniors. It affects the entire country, because access to pharmaceutical drugs and the breakthroughs and the miracles that we are seeing coming out of this industry comes at a price.

But it also requires us to take a responsible approach to this, that the abuses of the pharmaceutical industry in this field is the enemy, but the pharmaceutical industry is not the enemy. It is obviously the guiding light of the future. And, as my colleague from Pennsylvania pointed out, there would not be a threat of major increased costs if there wasn't the fact that we are having these breakthrough drugs showing up every day, new breakthroughs.

And so I think that we need to be responsible, and I strongly urge my colleagues to remember that this is not a Democrat or Republican issue, this is not a California or an East Coast issue. This is an American issue that is really leading the rest of the world, and hopefully we can get the facts, find reasons to find answers rather than finding excuses to be against each other, and keep an open mind.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. BILBRAY. Thank you, Mr. Chairman. I yield back.

Mr. BILIRAKIS. Mr. Green, a brief opening statement, please.

Mr. GREEN. Thank you, Mr. Chairman. I will submit my whole opening statement.

Mr. BILIRAKIS. Without objection.

Mr. GREEN. Following my colleague from California, I thought I was the only one that said how we do it in Texas is the way we should do it in the country. My concern is, we don't do it in Texas, and that is why we need to do it here as well as we should.

And I know signing a discharge petition is one way to move the issue forward. I thank you, Mr. Chairman, for this second hearing. And I would hope that whether it is the discharge petitions, the two bills, or some other bill that maybe our subcommittee can put

together, we need to address this issue this Congress. And because of the number of seniors that not only contact me, but from all over the country that talk to their Members, and like my own district does with the people who say they have to forego their prescriptions because they can't afford them. They are using most of their Social Security check to pay for their prescription medications.

And, Mr. Chairman, it is an important issue, because when I can go into my district and show that seniors are paying almost twice as much for prescriptions than other groups that have negotiating power can receive, when they pay over twice as much and my constituents in Houston can drive to Mexico and receive those—it is a 6-hour drive from Houston—and buy the same pharmaceuticals, or that they could go down to their vet and buy those same pharmaceuticals for their animal, it is much cheaper than for humans. So that is why it is important this Congress to address it, and I yield back my time.

[The prepared statement of Hon. Gene Green follows:]

PREPARED STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. Chairman: Thank you for convening this important discussion. I am pleased to have this opportunity to learn more about models for a prescription drug program.

Most of us agree that the lack of prescription drug coverage for our seniors is a real and growing problem.

And it is not just a problem for the poor—it is a problem for middle-income seniors who worked hard their entire lives, paid taxes, contributed to building our great country and are now forced to choose between buying medicine and buying groceries.

I urge those here today—with their charts, numbers and figures, to remember that these percentages are people . . . and these people are in desperate need of prescription drugs.

There are many ideas and options out there for how to put together a drug program. Some support the state-run method . . . others support vouchers . . . others support tax credits.

All these approaches have their pros and cons, and I have no doubt that all are proposed in good faith.

But as we continue this debate, we need to judge each of these proposals by a few important criteria.

Number one: Does the proposal continue Medicare's traditional program structure by covering ALL seniors?

Number two: Does the proposal provide free or reduced-price coverage to low income seniors?

Number Three: Does the proposal ensure that seniors get the same benefits—and access to the same or similar drugs—in all regions and regardless of whether they are in fee-for-service or managed care plans?

Number Four: Does the proposal ensure that the Medicare program continues its legitimate role in ensuring that the prescription drug program is fair and cost-effective?

Number Five: Does the proposal ensure that seniors will have consumer protections and that they will continue to get benefits, even if an insurance company goes out of business?

As we continue the debate on how to model a prescription drug program, I urge my colleagues to consider these five points and to measure all proposals against them. A drug benefit program that only covers a few, or only provides a limited benefit, will be of little or no use to America's seniors.

Only by crafting a full and fair benefit can we meet the needs of our seniors. Anything less is unacceptable.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Lazio.

Mr. LAZIO. Thank you very much, Mr. Chairman. I want to thank you as well for holding the hearing, and it has been a pleasure working with you on this issue, and I want to thank the staff as well.

I guess my quick question is, how much good are we going to do for seniors if our only concern is cost, which is what I think I hear from some members on this panel, and the issue of quality is effectively dismissed?

This past Sunday night ESPN hosted their Espy awards. Usually the show highlights world records, Super Bowls and record-high salaries, but this year they also awarded a 1999 comeback athlete of the year award to Lance Armstrong. He made world headlines last summer with the most stunning comeback ever in the history of sports, his 1999 victory at the Tour de France.

As most of us know, his stunning comeback has less to do with his athletic achievement, since he was the No. 1 ranked cyclist in the world in 1996, but more to do with his amazing victory from cancer. In the fall of 1996 Armstrong was diagnosed with testicular cancer. The cancer spread to his lungs, and he was given about a 20 percent chance of survival. He was 25 years old.

For the next 2 years he aggressively attacked his illness like he did racing bicycles. However, he couldn't do it alone. In his acceptance speech he spoke about how his competitive nature and will to live was not enough. He needed the best therapies and medicines available to him to win this battle with cancer. Without research, he said, he would not have been there to accept the award.

That is true with cancer and diabetes and a whole rift of different diseases that plague both seniors and the rest of the population. Access is the key, and price controls in my opinion are not. Price controls do not allow new breakthrough medicines and lifesaving therapies to reach my constituents.

I just want to take one example, two examples, and briefly, Mr. Chairman. The story of a Long Island senior who wrote me in disgust about the President's plan. She had approximately $500 in drug costs last year. Under the Clinton plan she would have to pay $552.40 for her prescriptions. Well, that doesn't make sense. She is paying $52.40 extra each year to belong to Clinton's plan, and we are supposed to call this a benefit.

I have also received a large amount of constituent mail regarding a new, wonderful, but extremely expensive drug for rheumatoid arthritis. Many people are aware of it. For this $14,000-per-year drug, a senior participating under the Clinton plan would still be paying $12,697 per year, and we are supposed to call this a benefit. I think we can do better.

We know there are market-oriented solutions, at least to alleviate part of the pressure, through PBMs and other mechanisms that will help drive the price down. We know if we get more seniors or all seniors into plans like that, they will be able to take advantage of the same discounted prices and price rebates that seniors participating in Medigap and other insurance that covers prescriptions get. And we also know that if we have a federally mandated price control system in place, that we will not have the kind of breakthrough drugs that people like Lance Armstrong were able to use to triumph over his illness.

Mr. BILIRAKIS. Let's make the vote. The gentleman's time has expired.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Chairman, thank you for holding today's hearing to examine ways in which we might craft a prescription drug benefit for Medicare beneficiaries. I am deeply concerned about the burden borne by many individuals who do not have insurance coverage for prescriptions. No senior citizen should be forced to forego needed medication, take less than the prescribed dose, or go without other necessities in order to afford life-saving medications.

I read and sign all of my mail, and I have seen a dramatic increase over the past several years in the number of Medicare beneficiaries writing to me about the struggle they are having with rising prescription drug costs. These are not form letters I am referring to. They are hand written letters—often with their bills enclosed. We are fortunate in Michigan to have a state prescription drug program, but this covers only low-income individuals with high monthly drug costs. Further, we have no Medicare managed care plans in our district because Medicare's payment rates are too low to attract plans. Thus, my constituents are denied access to coverage through this route. Yet they have paid the same Medicare payroll taxes into the system over the years and pay the same monthly premiums as beneficiaries who do have this choice. This is a matter of fairness, as well, for my constituents.

Because of my keen interest in addressing this issue, I am very glad to be serving with you the House Leadership's prescription drug task force led by our Chairman. Our nation leads the world in the development of new drugs and medical devices that enable us to effectively treat diseases and conditions. But if people cannot afford to buy these drugs, their benefits are lost to many in our population.

I share the task force's goal of and commitment to ensuring that every Medicare beneficiary has access to affordable coverage and has protection from unusually high out-of-pocket costs. I am committed to crafting a plan that is senior friendly—one which avoids the often complex, complicated bureaucracy of the current Medicare program.

Our goal in crafting this plan must also be one of ensuring that our nation continues to lead the world in the development of life-saving new drugs. Over the past decade, we have seen so many breakthroughs in drug therapy, from a new, much more highly effective treatment and perhaps preventive for breast cancer, to antivirals for AIDS and other diseases, to treatments for cystic fibrosis. As we continue to map the gene and understand more fully the link between genes and disease, think of the possibilities. We are perhaps within reach of preventing or curing diabetes, Parkinson's, Alzheimer's, and other debilitating and terrible afflictions. As our population ages, we need to encourage further breakthroughs in the prevention, treatment, and management of chronic, debilitating conditions such as arthritis and osteoporosis, for that is the only real hope of controlling health care costs. Crippling the incentives and resources needed for new drug discovery and development would dash these hopes, leave these promises unfulfilled, and condemn many to suffering and premature death.

The task before us is daunting. It will take all of us, Republicans and Democrats, Ways and Means and Commerce, House and Senate and Administration, working together to pull this off and plug a huge hole in the Medicare program with a common-sense, workable, comprehensive drug benefit. We need to put aside partisanship and short-term political considerations and do what is right for our constituents and for the future of health care in America.

PREPARED STATEMENT OF HON. CLIFF STEARNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Thank you, Chairman Bilirakis, for holding this important hearing. Today's hearing will focus on various proposals for providing prescription drug coverage to seniors who do not have access to affordable coverage.

I believe that we need to figure out how to expand insurance coverage for drugs, not attempt to give the government the ability to fix prices. Price controls never work. All they do is reduce supply or eliminate discounts that are available to some. As a matter of fact, the Omnibus Budget Reconciliation Act of 1990 (OBRA) required drug manufacturers to provide rebates to State Medicaid programs based on

the lowest prices they charged to the purchasers in an effort to lower Medicaid drugs prices.

As Chairman of the VA Subcommittee on Health, this is an issue that I'm very familiar with. In fact, in July 1997 we received testimony from Ms. Bernice Steindardt, of the GAO's Health, Education and Human Services Division, about this mandate. She told the subcommittee that the end result of the 1990 OBRA drug rebate was that many manufacturers raised drug prices (because of the size of the Medicaid market) to minimize the impact of the rebates. That is why we must be cautious in moving in the same direction as a way to provide our seniors with prescription drug coverage.

One of the proposals we will hear about today is legislation to provide lower wholesale prices of drugs for Medicare-affiliated pharmacies. This has the potential of repeating the disastrous effects that were created by OBRA 90. Why is this the case? Because manufacturers would have a strong incentive to raise those "lowest" prices substantially in order to keep from losing their profit margins.

The bottom line is that there is no simple solution to our problem.

By enacting the Medicare Plus Choice program as part of the Balanced Budget Act of 1997, Congress sought to expand Medicare beneficiaries access to prescription drugs by allowing them to join health plans that offer this benefit. Congress' goal in the BBA was to extend to Medicare beneficiaries the same range of choices that exist for working Americans. Choosing between competing health plans offers Medicare beneficiaries greater promise of accessing the drugs they need than will government price controls.

The bipartisan commission developed a proposal that is worth real discussion. The Breaux-Frist bill (S. 1895) would provide Medicare beneficiaries the same options that most federal employees, including the President and members of congress have. We should allow seniors the opportunity to take advantage of the changes in health care delivery benefiting every privately insured person. I am pleased that we are finally talking about this innovative and free market approach to help senior citizens.

We need to help them gain access to affordable prescriptions through insurance coverage and the truly effective price competition of an active marketplace.

That is why I support the Breaux-Frist bill because it would restructure Medicare, using the Federal Employees Health Benefits Program (FEHBP) as a model. This would ensure that seniors would have access to newer drugs and devices because they would choose the plan they want.

I look forward to hearing distinguished witnesses.

PREPARED STATEMENT OF HON. TOM BLILEY, CHAIRMAN, COMMITTEE ON COMMERCE

I'm pleased that the Subcommittee is holding this hearing today. This is the third hearing this Committee has held on the topic of senior citizens access to prescription drugs.

I've been studying this issue closely for a number of months now and it is a tough one. It is clear that too many seniors have trouble affording their medications. It is equally clear that many seniors have drug coverage today that they like and don't want threatened by anything we do in Congress.

Americans have the best health care in the world. My first goal in helping seniors afford medicine is to preserve what is good about our health system today. We are on the edge of remarkable breakthroughs in new drug therapies to treat and even cure diseases that just ten years ago were considered death sentences. We don't want to do anything to jeopardize this work.

Yet, America's role as the world leader in drug research has its costs. Our challenge is to find ways to make sure seniors have access to needed medication without resorting to price controls or big-government drug purchasing schemes.

Many folks under 65 years old are fortunate to have health insurance to cover most or all of the costs of their prescription drugs. But Medicare does not pay for most prescription drugs for seniors. In my opinion, this shows that if a private insurance company tried to market and sell the Medicare benefit to Americans today, I would bet few would buy it—Medicare does not reflect how modern medicine is practiced and delivered.

This is why I truly want to explore a way to give seniors access to all the private health coverage options available to Americans under the age of 65. Every Member of Congress has this choice. Lets give seniors the same choice.

I want to develop legislation that provides all seniors access to affordable, private drug coverage. I believe we should assist those seniors who cannot afford to purchase this coverage. And I think it is critical that whatever we do, that we protect

not only low-income seniors but those who have very high annual out-of-pocket drug costs.

Whatever is done to help seniors with their drug costs, it must minimize the substitution of private health coverage with government run programs. Our first witness today, Mrs. Rita Lewis, will talk about her own experience. Like millions of other seniors, Rita is worried that Congress will harm her coverage. There has to be a way for us to strike a balance for those who need coverage and those who are already covered.

Again, I want to thank the Chair for holding this hearing and look forward to the witnesses testimony.

PREPARED STATEMENT OF HON. SHERROD BROWN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Should the Medicare program offer prescription drug coverage? What good is insurance if it covers the diagnosis, but not the cure? Of course Medicare should cover prescription drugs.

But why can't we target coverage to just the lowest income seniors? Two reasons.

Medicare works because every American contributes to it and every American benefits from it. A third of all seniors lack drug coverage, millions more are underinsured, employers are dropping their retiree coverage and private health insurers are ratcheting down their prescription drug benefits. This is a broad-based problem.

Whether or not Medicare should cover prescription drugs is not a real question. If you believe this nation benefits from helping seniors live in good health and above poverty, than Medicare should cover prescription drugs.

But it is expensive to cover prescription drugs. Can the U.S. afford it? Yes and no.

We are the wealthiest nation in the world. Our retirees are collectively responsible for our current prosperity. Their security and well-being resonate across families, communities, and ultimately the nation. We can afford to—it is in out best interest to—provide seniors health care coverage that makes sense and that means providing prescription drug coverage.

But we can not afford to waste tax dollars that otherwise could be used to bolster Medicare's long-term solvency. We can not afford to be ripped off. To be fiscally responsible, to best serve the public, we need to pay fair prices for prescription drugs.

So the question is, are current prices fair?, if you define "fair" as meaning "necessary" to finance future research and development.

Maybe prices are fair. Maybe drug companies have no choice but to charge such high prices. I doubt it. Knowing how much drug companies are investing in marketing, knowing what their profit margins are, not to mention their CEO salaries, and knowing any reduction in prices could be largely offset by increase in the volume of sales, I doubt prices need to be this high. But even if drug manufacturers could justify their revenue requirements. How could they justify placing such a disproportionate burden on Americans?

How can they justify charging Americans two and three and four times what they charge individuals in other industrialized countries? Why are prescription drugs more expensive here? Because other countries won't tolerate outrageous prices. We do. We don't negotiate prices. We don't demand that drug manufacturers reduce their prices to reflect the federally funded portion of research and development. And we don't make use of the collective purchasing power of 38 million seniors to demand fairly priced drugs. Instead, we nod our heads when drug manufacturers warn us that any action we take would stifle research and development.

Drug prices can come down in the United States without stifling research and development. Take the case of medical devices. The Medicare program is the largest purchaser of medical devices in the United States. The Medicare program pays discounted prices for medical devices and yet new devices are developed every day. Obviously a fast way to make money is to charge inflated prices for prescription drugs. It works beautifully for a product so important to so many people. That does not make it necessary.

So, what do we do about high prices? The drug industry says the best way to make prescription drugs affordable for seniors is to enroll all 38 million in private health insurance plans. I'm not sure I follow their logic. Look at what is happening in the private insurance market today. Health insurance premium increases are back in the double digits. Insurers blame prescription drug costs. Enrollees in private plans can expect higher co-pays and lower prescription drug caps.

One of the fundamental truths about health insurance is the larger the pool of enrollees, the more stable the premiums and benefits will be. Fragmenting the risk

pool has never been a good idea and it is certainly not a good idea when it comes to such a big ticket item as prescription drugs.

We have other options. I have introduced legislation that would give drug manufacturers a choice. They could either disclose their true costs and work with us to bring prices down, or they could license their patents to generic drug companies and let the free market bring prices down to a more reasonable level. Mr. Allen has introduced legislation that would permit seniors to purchase drugs at discounted prices. Mr. Sanders and Mr. Barry have introduced legislation that would permit us to import drugs when they are priced less expensively in other countries.

So I ask you again. Should Medicare provide prescription drug coverage for seniors? Yes. Will it be expensive? Yes. Is there something we can do to make it less expensive? Yes. Now is the time to stop debating this issue, and do what is right for seniors.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

We've spent a great deal of time this Congress talking about the need to shore up the Medicare program.

Yes, we must ensure the solvency of the program but we must also modernize it.

The key to ensuring that the program covers the best that medical science has to offer is to provide a comprehensive prescription drug benefit.

When Medicare was created in 1965, seniors were more likely to undergo surgery than to use prescription drugs.

Today, prescription drugs are often the preferred, and sometimes the only, method of treatment for many diseases.

In fact, 77% of all seniors take a prescription drug on a regular basis.

And yet, nearly 15 million Medicare beneficiaries have no insurance coverage for prescription drugs whatsoever.

This means that a lot of senior citizens—most of whom are on modest, fixed incomes—are spending a great deal of their monthly incomes on prescription drugs. In fact, 18% of seniors spend over $100 a month on prescriptions.

My senior constituents have told me about being forced to limit the amount they spend on groceries in order to pay for their prescription drugs.

For some seniors, enrolling in Medicare managed care plans has provided them drug coverage. However, 11 million beneficiaries don't have access to any managed care plans.

During the last two years, Medicare managed care plans have withdrawn from many regions, standing thousands of seniors, many of whom only signed up to get drug coverage in the first place.

Today, only 16% of Medicare beneficiaries are enrolled in Medicare HMOs.

Many managed care plans are dropping or severely limiting coverage. A recent Kaiser study found that current drug coverage in Medicare+Choice plans varies greatly and may be in jeopardy altogether as plans face declining profits.

We can't rely solely on the private sector to provide this service. Prescription drugs must be included in the basic Medicare benefits package. And it must be affordable.

When he enacted the Medicare program, President Johnson said, "the benefits of this law are as varied and broad as the marvels of modern medicine itself."

I think we can all agree that the tremendous advances prescription drugs have made in the diagnosis and treatment of every illness from arthritis to Alzheimer's are today's greatest "marvels of modern medicine."

Thirty-nine million seniors are relying on us to make sure they have access to these marvels. Let's not disappoint them.

Thank you, Mr. Chairman. I look forward to hearing from the witnesses.

Mr. BILIRAKIS. I would ask the first panel to come forward, and as soon as I return, we will get started. Thank you.

[Brief recess.]

Mr. BILIRAKIS. I ask Mrs. Rita Lewis and Dr. Beatrice Braun to please come to the table, take their seats. As Mr. Bilbray has already introduced her, Mrs. Rita Lewis is director of the Osteoporosis Support Group of San Diego; and Dr. Beatrice Braun

is a member of the Board of Directors of AARP. Welcome, good ladies. I appreciate very much your being here.

Your written statement that you have already submitted to the committee is already a part of the record. We will give you 5 minutes to hopefully supplement it or complement it, if you will. Mrs. Lewis, please proceed. Take your time, but move that mike close because we certainly want to hear everything you have to say.

STATEMENTS OF RITA H. LEWIS, DIRECTOR, OSTEOPOROSIS SUPPORT GROUP OF SAN DIEGO, CALIFORNIA; AND BEATRICE BRAUN, MEMBER, BOARD OF DIRECTORS, AARP

Mrs. LEWIS. Can you hear me?

Mr. BILIRAKIS. Yes.

Mrs. LEWIS. Good morning. It is a great honor to be here today before the Commerce Committee to share my thoughts about the Medicare program and prescription drugs.

My name is Rita Lewis. I am 80 years old, and I live in San Diego, California. For the past 16 years I have received my Medicare benefits through a private health plan. I am very pleased with the quality of the care I receive from my doctors, nurses, and other health care providers.

As a resident of San Diego, I have a wide variety of plans available to me. I stay with my plan because it works for me, and the doctors and nurses have never let me down. For the $15 a month, I receive top notch care. The 11 medications I take daily have minimal cost.

One of the best features of my plan is that I have so much less paperwork than friends of mine who are in the old Medicare program. They spend hours on the phone trying to sort out their bills. With my plan, it is easy to understand. When I go to my physician, I pay $5, and when I was hospitalized on several occasions, my private plan picked up 100 percent of the costs. This gives me peace of mind.

Now, I would like to take a moment to talk about my own medical condition. When I was in my early 60's, I learned that I had osteoporosis, the bone disease that affects older women and some men. My doctors tried every available medicine to stop my bone loss, but they did not work and I lost over seven inches in height. My condition was so bad that my husband could not give me a hug without breaking one of my ribs, sometimes two.

A new drug was developed to stop the deterioration of my bones. My doctor immediately prescribed this medication and I began to see the effects. The progression of my osteoporosis was stopped, and I have actually had bone mass increases. With the discovery of this new drug, I am now able to walk again every morning, 40 to 45 minutes, at a fast clip now.

In addition to osteoporosis, I have several other medical conditions that are treated with prescription drugs. In total, I take eight medications a day and three calcium pills that amount to 11 pills. These drugs are vital to my health. My plan covers most of the costs for these drugs. My co-pay ranges from $10 to $30 for a 90-day program. I order my prescriptions by telephone or through my mail order program. Some are new brand name drugs, like my

osteoporosis drug, and others are generic. It costs me in the neighborhood of $600 a year for my prescription drugs.

I understand that some Members of Congress would like to add prescription drugs to the Medicare program. I am concerned that a large government approach will be confusing and will cost more. Like my husband Aaron says, "There is no free lunch." While it is important for seniors to have access to prescription drug coverage, I think that plans like mine provide the best solution.

In closing, let me leave you with one final thought. I am 80 years old. I take eight medications a day. I see many doctors and nurses, and I have been in and out of the hospital. My health care plan works for me. I would like more healthy years to enjoy my husband, my children, my grandchildren, and so do a lot of other seniors. Please remember seniors like me when you consider changing Medicare. And thank you.

[The prepared statement of Rita H. Lewis follows:]

PREPARED STATEMENT OF RITA H. LEWIS

Good morning. It is a great honor to be here today before the Commerce Committee to share my thoughts about the Medicare program and prescription drugs.

My name is Rita Lewis. I am 80 years old and I live in San Diego, California. For the past 16 years, I have received my Medicare benefits through a private health plan. I am very pleased with the quality of the care I receive from my doctors, nurses, and other health care providers.

As a resident of San Diego, I have a wide variety of plans available to me. I stay with *my plan*, because it works *for me* and the doctors and nurses have never let me down. For $15 dollars a month, I receive top notch care. The 11 meds I take daily have minimal cost.

One of the best features of my plan is that I have so much less paperwork than my friends who are in the old Medicare program. They spend hours on the phone trying to sort out their bills. With my plan it is easy to understand. When I go to my doctor, I pay $5. And when I was hospitalized on several occasions, my private plan picked up 100 percent of the costs. This gives me peace of mind.

Now, I would like to take a moment to talk about my own medical condition. When I was in my 60s, I learned that I had osteoporosis, the bone disease that affects older women, and some men. My doctors tried every available medicine to stop my bone loss, but they did not work and I lost over *seven* inches in height. My condition was so bad that my husband could not give me a hug without breaking one of my ribs.

A new drug was developed to stop the deterioration of my bones. My doctor immediately prescribed this medication and I began to see the effects. The progression of my osteoporosis was stopped and I have actually had bone mass increases. With the discovery of this new drug, I am now able to walk again on my own and without canes. I keep fit by walking five days a week for 40-45 minutes.

In addition to osteoporosis, I have several other medical conditions that are treated with prescription drugs. In total, I take 8 medications a day and three calcium pills, for a total of 11 pills. These drugs are vital to my health. My plan covers most of the costs for these drugs. My copay ranges from $10 to $30 for a 90-day supply. I order my prescriptions by telephone or through my mail order program. Some are new brand name drugs, like my osteoporosis drug, and others are generic. It costs me about $600 a year for my prescription drugs.

I understand that some Members of Congress would like to add prescription drugs to the Medicare program. I am concerned that a large government approach will be confusing and will cost more. Like my husband Aaron always says, "there is no free lunch." While it is important for seniors to have access to prescription drug coverage, I think that plans, like mine, provide the best solution.

In closing, let me leave you with one final thought. I am 80 years old. I take 8 medications a day. I see many doctors and nurses and I have been in and out of the hospital. My health care plan works for me. I want more healthy years to enjoy my husband, children, and grandchildren and so do other seniors. *Please remember seniors like me when you consider changing Medicare.*

Mr. BILIRAKIS. Thank you very much, Mrs. Lewis.

Dr. Braun, please proceed.

STATEMENT OF BEATRICE BRAUN

Ms. BRAUN. Good morning. I am Bea Braun, from Spring Hill in Florida, and a member of AARP's Board of Directors, and I truly thank you, Mr. Chairman and members, for the opportunity to testify today.

As we all know, since it was enacted Medicare has provided access to affordable health care and has kept many older people out of poverty, but the challenges are very large that we now face. As a retired physician, 50 years out of medical school, I have seen the practice of medicine change dramatically, particularly in the area of prescription drugs. Penicillin was just coming in when I was in medical school.

Simply stated, prescription drug coverage is smart medicine. Yet, while most employer plans include drug coverage, Medicare does not. We are pleased that Congress, the administration and the drug industry recognize that prescription drug coverage must be a part of a strengthened Medicare program. The only question is how to do it.

The AARP believes that a Medicare prescription drug benefit must be available to all and affordable for all beneficiaries, but the benefit should be voluntary so no one has to give up what they already have, as Mrs. Lewis says. And the benefit must be affordable for all beneficiaries, and not just those with low incomes. The benefit needs to assure that it helps middle income beneficiaries handle mounting prescription costs.

Equally important, it needs to ensure enough participation in the benefit to avoid risk selection. One of Medicare's greatest strengths has been its success in pooling the risk of nearly 40 million beneficiaries. This has let Medicare avoid the cherry-picking that exists in the under-65 health insurance market. This broad risk pool must be sustained in order to keep Medicare strong and affordable.

While 65 percent of beneficiaries may have some type of drug coverage, the employer-based retiree coverage is declining rapidly. Medigap coverage is very expensive, and limited in what and who it covers. And managed care coverage has proven unstable. Premiums are going up, and in many cases there have been pull-outs from various counties in the country, including my own.

I am not attempting today to give a full review of the prescription drug proposals before Congress. That will take many more hearings. But as Congress undertakes this effort, I would like to raise the following fundamental questions that need to be answered by any drug proposal:

Will the proposed prescription drug coverage be affordable to beneficiaries, and assure a viable risk pool for the program? These go hand-in-hand. How would insurers be prevented from cherry-picking beneficiaries? How would beneficiaries with very high drug costs be protected? Does the proposed benefit meet the needs of current and future beneficiaries?

AARP is reserving judgment on current proposals until these and other questions about their impact on beneficiaries and the program itself are answered. How to provide Medicare beneficiaries with affordable prescription drugs is a huge challenge. We urge the

Congress, the drug industry and consumers to engage in a serious debate on the merits of the full range of approaches.

The success of any drug benefit proposal, as well as broader changes in Medicare, depend on a clear understanding on the part of the public and policymakers alike of the changes being contemplated. This will require not only extensive dialog but also a thorough analysis of how the proposal would affect current and future beneficiaries. In fact, if legislation is pushed through too quickly, before the effect on beneficiaries is known, AARP would be compelled to alert our members of the dangers in such legislation and why we could not support it.

The AARP is committed to working with Members of Congress on a bipartisan basis to advance the debate over prescription drug coverage and to carefully explore the best options for securing Medicare's future. And I thank you, Mr. Chairman, for giving us the opportunity and for your efforts to examine the high costs of prescription drugs for our older Americans, including me.

[The prepared statement of Beatrice Braun follows:]

PREPARED STATEMENT OF BEATRICE BRAUN, AARP BOARD MEMBER

Mr. Chairman and members of the Committee, I am Beatrice Braun, a member of AARP's Board of Directors. I want to thank you for your interest in the issue of the high cost of prescription drugs and the difficulties older Americans have in paying for needed medications. AARP appreciates this opportunity to share our perspective on the need for a Medicare prescription drug benefit and some of the broader issues involved in reforming the Medicare program.

For over thirty years Medicare has provided older and disabled beneficiaries with dependable, affordable, quality health insurance. I live in Florida, which has one of the largest beneficiary populations in the nation. As a retired physician, I have seen first hand how Medicare has made a difference in the lives of older Americans. Medicare has been instrumental in improving the health and life expectancy of beneficiaries in Florida and across the nation. It has also helped to reduce the number of older persons living in poverty.

Medicare's promise of affordable health care extends beyond the current generation of retirees. Now, more than ever, Americans of all ages are looking to Medicare's guaranteed protections as part of the foundation of their retirement planning. AARP believes that in order for Medicare to remain strong and viable for today's beneficiaries, and for those who will depend on it in the future, we must confront the key challenges facing the program.

Foremost among these challenges is ensuring that Medicare's benefits and its means of delivering care remain dependable even as they are updated to keep pace with the rapid advances in health care. The practice of medicine has changed dramatically since the Medicare program was created. We are now living in a time of amazing breakthroughs in medical technology. Among the most striking are the advances in the area of prescription drugs. Drug therapies that were not available when Medicare began are now commonly used to prevent and treat virtually every major illness. In many cases, new drugs substitute for or allow patients to avoid more expensive therapies such as hospitalization and surgery. In other cases, drugs facilitate treatment or provide treatment where none existed before, improving the quality and length of life for the patient. As a result, prudent reliance on prescription drugs now goes to the very core of good medical practice.

Ironically, while older Americans typically need more medications than younger people, most employer plans include and rely on prescription drug coverage as an essential tool for medical management, but Medicare still does not. Consequently, high prescription drug prices impose significant financial hardship on the millions of Medicare beneficiaries who have inadequate or no insurance coverage for prescription drugs. It is important to remember that beneficiaries without coverage pay top dollar for their prescriptions because they do not benefit from discounts negotiated by third party payers as do most younger persons. AARP believes prescription drug coverage must be part of an improved Medicare program. Simply stated, prescription drug coverage is smart medicine.

The second challenge facing Medicare is our nation's changing demographics. The retirement of the baby boom generation will nearly double the number of Medicare

beneficiaries in the program. Medicare's financing and delivery systems must be capable of serving this enormous influx of beneficiaries whose health care circumstances, needs, and expectations will be similar in some respects to those of today's beneficiaries, but very different in others. Just as important, longer life spans are already causing rapid growth in the very old population. Medicare must be prepared to handle the unique health care needs of a growing number of older Americans who reach 85, or even 100.

To meet these challenges, the program's long-term financial solvency must be secure. AARP supported the Balanced Budget Act of 1997 as a first step towards securing Medicare's long-term solvency. The strong economy we now enjoy and the Medicare Trustees' projection of solvency to the year 2015 are good news. But, this does not mean we can afford to become complacent or that we can delay the debate over how best to strengthen Medicare.

The deliberation over Medicare's future must be ongoing. It will take a sustained effort to update and improve Medicare. Changing a program that millions of Americans depend on for their health care is no small task. There must be a careful and thorough examination of the full range of issues—prescription drugs being only one issue among them—and a similarly careful effort to make sure that policy makers and the public alike understand the trade-offs that will be necessary.

AARP believes that it would be a serious mistake for anyone to hinder debate on reform proposals. By the same token, it would be an error for the Congress to rush to judgment on any reform option before policy makers and the public understood the proposed changes and their anticipated effect on beneficiaries, providers, and on the Medicare program in general. As we all learned over the recent BBA revisions, earlier experiences with the Catastrophic Coverage Act in the late 1980s, and from the health care reform debate of the early 1990s, unless the American public understands the trade-offs they are being asked to make, and the changes that they will face, initial support can erode quickly.

THE NEED FOR A MEDICARE PRESCRIPTION DRUG BENEFIT

AARP is pleased that the Subcommittee has begun to examine the various Medicare prescription drug proposals before the Congress and is developing its own prescription drug benefit plan. The work you are embarking upon is extremely challenging; it is also immensely important to millions of Americans who take prescription medications. It is our hope that today's hearing will help focus attention on the need for an affordable Medicare prescription drug benefit for all beneficiaries, as well as on other Medicare reform issues.

As new prescription drugs are becoming available to treat and even prevent more and more serious conditions and life-threatening illnesses, reliance on these drugs has become especially significant for older Americans. Eighty percent of retirees use a prescription drug every day. While older Americans comprise only 12 percent of the U.S. population, they account for one-third of prescription drug spending. In fact, after premium payments, prescription drugs account for the single largest component of health care out-of-pocket spending, for non-institutionalized Medicare beneficiaries age 65 and older. On average, these beneficiaries spend as much out-of-pocket for prescription drugs (17 percent of total out-of-pocket health care spending) as for physician care, vision services, and medical supplies combined. By contrast, inpatient and outpatient hospital care each accounts for about 3 percent of older beneficiaries' total out-of-pocket health spending.

High use, high drug prices, and inadequate insurance coverage pose serious problems for today's Medicare beneficiaries. A chronic health problem necessitating some of the newest, most expensive prescription drugs can deplete a retiree's financial resources. Some beneficiaries are forced to choose between food and their medications. Others do not refill their prescriptions or take the proper dosage in order to make their prescriptions last longer. A new international health care survey of the elderly by the Commonwealth Fund reports 7 percent of adults age 65 and over did not even fill a prescription due to cost.

Because of Medicare's current lack of prescription drug coverage, many beneficiaries must pay for prescription drugs completely out-of-pocket. While some beneficiaries may have employer-based retiree coverage, or be able to purchase private supplemental coverage that assists with costs, or join a Medicare HMO that offers a prescription drug benefit, these coverage options are inadequate, limited, expensive, and unstable. For instance, a new study by the Commonwealth Fund, reports that many Medicare beneficiaries do not have continuous prescription drug coverage. In 1996, just 53 percent of beneficiaries had prescription drug coverage throughout the year.

Although 65 percent of Medicare beneficiaries have some type of coverage for prescription drugs, this figure can be very misleading. In fact, the majority of Medicare beneficiaries—not just those with low incomes—need drug coverage in Medicare. Why?

First, Medicare beneficiaries' current prescription drug coverage does not protect them from high out-of-pocket expenses. AARP estimates that 25 percent of Medicare beneficiaries spent over $500 out-of-pocket on prescription drugs in 1999, and over half of these beneficiaries had some type of coverage. Forty-two percent of beneficiaries who spent $1,000 or more on their prescription drugs (excluding insurance premiums) had some type of drug coverage. For example, some beneficiaries buy Medigap policies that provide a drug benefit. Two of the three Medigap policies that cover prescription drugs have an annual cap of $1,250 on drug coverage; the third policy has a $3,000 cap. All three Medigap policies that have a prescription drug benefit require the beneficiary to pay 50 percent coinsurance. It is interesting to note that while Medigap drug coverage is quite limited, the premiums on these policies exceed $1,000 a year. Other beneficiaries choose to enroll in Medicare HMOs that offer some prescription drug coverage. Yet, this year 32 percent of Medicare HMOs offering drug coverage have a $500 cap that applies to brand or to brand and generic drugs, and average copays in these plans have increased dramatically from last year—an estimated 21 percent for brands and 8 percent for generics.

Second, current prescription drug coverage available to Medicare beneficiaries is limited. Private Medigap policies may be the only option for obtaining drug coverage for beneficiaries who do not have access to employer coverage or Medicare+Choice plans. Yet, because almost all Medigap policies with drug coverage exclude beneficiaries based on pre-existing conditions once they have passed the first six months of their Medicare eligibility, and because not all three Medigap policies that include prescription drugs are not offered everywhere, many Medicare beneficiaries desiring such coverage cannot obtain it. Additionally, although Medicare HMOs are prohibited by law from underwriting the coverage they offer, such plans are not available in all parts of the country.

Third, current drug coverage options are not stable. For example, beneficiaries who obtain prescription drug coverage from their former employer are finding that coverage to be unstable. Retiree health benefits that include prescription drug coverage are becoming more scarce. While an estimated 60 to 70 percent of large employers offered retiree health coverage during the 1980s, fewer than 40 percent do so today. Of those employers who offer retiree benefits, 28 percent do not offer drug coverage to Medicare eligible retirees.

Further, beneficiaries who have drug coverage through Medicare HMOs cannot depend on having this coverage from year to year as plans can change benefits on an annual basis or even terminate participation in Medicare. For example, this year many beneficiaries in Medicare+Choice plans are living through abrupt changes in their prescription drug coverage that they did not foresee when they enrolled. Some of the most visible of these changes include:

- Increasing premiums—Over the past few years, more and more Medicare+Choice plans are charging premiums for their coverage, and those premiums are climbing. This year 207,000 beneficiaries must pay over $80 per month to enroll in a Medicare HMO. This compares to 1999 when only 50,000 Medicare beneficiaries enrolled in Medicare HMOs had a premium above $80 per month.
- Higher cost-sharing—For the first time this year, all Medicare HMOs that provide prescription drug coverage are charging copays for those prescription drugs, and the average beneficiary copay has increased significantly.
- Decreasing benefit—The annual cap on the typical Medicare+Choice drug benefit has decreased. While in 1999 only 21 percent of Medicare HMOs had an annual cap of $500 or less on their drug benefit, this year 32 percent of plans will have a $500 cap.
- Loss of benefit—This year some Medicare+Choice plans dropped their prescription drug benefit entirely. Although Medicare+Choice has provided beneficiaries with an opportunity for drug coverage, the volatility of the Medicare+Choice market has made that coverage unpredictable and unstable from year to year.

ISSUES SURROUNDING ADDING PRESCRIPTION DRUGS TO MEDICARE

AARP is committed to the creation of a voluntary, affordable Medicare prescription drug benefit that would be available to all beneficiaries, so that they may benefit from longer, healthier lives, fewer invasive medical procedures, and reduced health care costs. We appreciate the Subcommittee's interest in this issue and look forward to working with the Congress and the Administration to assure that a prescription drug benefit that is available and affordable to all Medicare beneficiaries

becomes part of Medicare's defined benefit package. To that end, we have identified principles that we believe are fundamental to the design of a Medicare prescription drug benefit:

- A Medicare prescription drug benefit must be *available* to *all* Medicare beneficiaries. First, the benefit should be *voluntary* so that beneficiaries are able to keep the coverage that they currently have, if they choose to do so. A Medicare prescription drug benefit should not be an incentive for employers to drop or cut back on retiree health coverage. Second, the benefit needs to be *affordable* to assure enough participation and thereby avoid the dangers of risk selection. To this end, the government contribution will need to be sufficient to yield a beneficiary premium that is affordable, and a benefit design that is attractive to beneficiaries. In other words, this is not simply a matter of beneficiary affordability, but equally important, the fiscal viability of the risk pool. Medicare Part B is a model in this regard. The Part B benefit is voluntary on its face, but Medicare's contribution toward the cost of the benefit elicits virtually universal participation.
- Prescription drugs should be a defined benefit and part of a defined benefit package. It is critical that beneficiaries understand what is included in their benefit and that they have dependable and stable prescription drug coverage. In addition, defining the drug benefit would reduce the opportunity for risk selection.
- The benefit must assure beneficiaries have access to medically appropriate and needed drug therapies.
- The benefit must include quality improvement components to reduce medical errors and mismedication and to help reduce overall health care costs.
- The benefit must include meaningful cost-containment mechanisms for both beneficiaries and Medicare. This should include drug-purchasing strategies that enable Medicare beneficiaries and the program to take advantage of the aggregate purchasing power of large numbers of beneficiaries.
- The benefit must provide additional subsidies for low-income beneficiaries to protect them from unaffordable costs and assure that they have access to the benefit.
- The benefit must be financed in a fiscally responsible manner that is both adequate and stable. AARP believes that an appropriate amount of the Federal budget surplus should be used to help finance a prescription drug benefit.
- A new prescription drug benefit should be part of a strong and more effective Medicare program. Prescription drug coverage must be integrated into the program in a manner that strengthens Medicare by improving the program's ability to support modern disease management and prevention strategies. Many of these strategies hold promise to both improve health outcomes and lower program costs.

PRESCRIPTION DRUG PROPOSALS BEFORE THE CONGRESS

The need to modernize the Medicare program to address the lack of prescription drug coverage has become a major issue for the 106th Congress. Several types of proposals for establishing a Medicare prescription drug benefit have been introduced. *At this time, AARP has not taken a position on any of the proposals before Congress. As these plans continue to be refined, we have reserved judgment until further questions can be answered.* We have not attempted in this testimony to undertake an extensive review of all of the prescription drug proposals introduced and the full range of questions that they raise. That essential step will require many more hearings, close review by a range of experts, and careful assessment of the impact of the proposed changes on beneficiaries, plans, providers, and the program itself. However, we have tried to summarize the major types of policy approaches before the Congress and the fundamental questions that must be answered about each.

President Clinton's Proposal

The approach put forward by President Clinton requires Medicare to pay for 50 percent of beneficiaries' prescription drug costs. This Medicare benefit would be available to all beneficiaries, but would be voluntary. Benefit management would be contracted out to private entities, such as pharmacy benefit managers (PBMs). This approach would allow market forces to reduce drug prices for beneficiaries because the contracted third parties could negotiate the same types of discounts from manufacturers and pharmacies for Medicare as they currently negotiate for health plans and HMOs. The government would be distanced from the role of determining prices under this approach. Additional financial assistance would be provided to low-income beneficiaries and financial incentives would be offered to employers to ensure that they retain current retiree health benefits. The Administration has now also

suggested a new catastrophic benefit, although the details have not been spelled out.

While AARP is pleased that the President's proposal includes prescription drug coverage for all beneficiaries, details of his plan are forthcoming and there are still unanswered questions about how a Medicare-based proposal would work. For instance:

- Will this prescription drug coverage be affordable to beneficiaries?
- Are the proposed benefit package and subsidy sufficient to attract a large number of beneficiaries?
- How would the President's new additional benefit to protect those beneficiaries with extremely high drug costs work?

The Kennedy-Stark-Dingell bill takes a similar Medicare-based approach as the President's, but would provide a different and more generous benefit structure. Although the bill's proposed benefit would include a deductible of $200, the beneficiary's coinsurance would be 20 percent rather than 50 percent, as proposed by the President. In addition, the Kennedy-Stark-Dingell bill would include a cap on the benefit of $1700 and stop-loss protection after the beneficiary has $3000 in out-of-pocket prescription drug expenses. This proposal raises the following questions:

- What happens to beneficiaries after they have exceeded the benefit cap but before they are eligible for stop-loss protection?
- Would beneficiaries support this type of benefit structure?
- Does this type of benefit meet the need of most current and future beneficiaries?

The Breaux-Frist Proposal

The approach introduced by Senators Breaux (D-LA) and Frist (R-TN) provides some subsidy to all beneficiaries interested in purchasing prescription drug coverage. Unlike the President's plan, this approach would not create a defined prescription drug benefit; rather, it allows entities, such as insurance companies or health plans, to offer any type of benefit so long as the benefit is equal to a certain actuarial value. Plans would compete by varying their drug benefit design.

AARP is pleased that the Breaux-Frist bill improves upon earlier versions of the proposal in that it would include some form of subsidy for all beneficiaries who choose to purchase a "high option" plan. However, we have several questions that relate to our belief that the benefit must be affordable and avoid risk selection. These questions include:

- Is the prescription drug benefit affordable? Is a 25 percent premium subsidy enough to create a viable risk pool and make the benefit affordable for most beneficiaries?
- How would insurers be prevented from "cherry picking" beneficiaries since the drug benefit would be pegged to an actuarial cost and not to a particular benefit design?
- What will be the effect on quality of care and on beneficiaries or program cost of having a prescription drug that is administered separately rather than as part of the rest of Medicare? Will this lack of integration lead to cost-shifting or poorer quality care?
- Will prescription drug insurance that is offered through private entities be more expensive for beneficiaries and for the Medicare program than a benefit administered by Medicare because Medicare does not have to make a profit, and has lower administrative overhead costs?
- Will high-option stop-loss protection extend to the prescription drug benefit? How would beneficiaries who have very high drug costs be protected?

The Bilirakis Proposal

Another approach, illustrated by Representative Bilirakis' (R-FL) bill, is to create a state-based approach for low-income beneficiaries, while expanding Medicare's benefits to include stop-loss protection so that the program would cover prescription drug costs once a beneficiary's annual out-of-pocket expenses reached a specified threshold. This approach would rely on the states to develop mechanisms for reducing prescription drug costs for low-income beneficiaries. While AARP opposes a Medicare prescription drug benefit for low-income beneficiaries only, the approach of providing low-income drug assistance *outside* of the Medicare program deserves further review. However, a state-based approach with accompanying Medicare stop-loss protection raises the following types of questions:

- How will the state low-income drug assistance program work? Would all states offer a low-income prescription drug program?
- What processes would be established for enrollment and outreach in the state-based low income prescription drug programs?

- Would there be any incentives for Medicare+Choice plans to keep offering a drug benefit or to offer wrap-around coverage?
- Would receipt of Medicare stop-loss protection be conditioned on the purchase of private sector insurance?

The Allen Proposal

Another approach, reflected in Representative Allen's (D-ME) bill, attempts to lower prescription drug prices by limiting the prices that manufacturers could charge beneficiaries. This approach does not involve the creation of a Medicare prescription drug benefit, but rather would lower drug prices by legislatively tying the prices paid by retail pharmacies for drugs sold to Medicare beneficiaries to the best prices paid by the government. Although it does not provide a Medicare benefit, the Allen approach has helped focus attention on the inequity of prescription drug pricing and merits review. However, a prescription drug discount approach raises the following types of questions:

- Will manufacturer discounts be passed on to Medicare beneficiaries?
- Will manufacturers engage in cost-shifting?
- Will a lower return on pharmaceuticals taken by beneficiaries discourage manufacturers from further research and development of drugs mainly used by older Americans?

OPTIONS FOR MEDICARE REFORM

The above policy approaches for dealing with the high cost of prescription drugs illustrate one challenge we face in modernizing Medicare. The President's Medicare reform proposal, the plan introduced in the Senate by Senators Breaux and Frist, and proposals that will likely emerge from the House, provide opportunities for furthering debate about Medicare's future. We urge the Congress to carefully examine the different reform options and begin to answer some of the most critical issues surrounding broad changes to Medicare, including:

- How, and to what extent, would Medicare's long-term solvency be improved?
- Would fee-for-service Medicare remain an affordable option for beneficiaries of all incomes?
- Would all beneficiaries—regardless of the area of the country in which they live—have access to the same set of defined Medicare benefits?
- Would a prescription drug benefit be affordable and available to all beneficiaries?
- Would the level of the government's contribution continue to assure adequate choice for beneficiaries over time, without regard to where they live?
- How would beneficiaries be protected from high out-of-pocket costs?
- Would the entity responsible for administering Medicare be accountable to Congress and to beneficiaries?
- How would Medicare reforms be financed?

KEY PRINCIPLES THAT SHOULD GUIDE BROADER MEDICARE REFORM

As this Committee also examines the broader issue of reforming Medicare, AARP urges you to consider the fundamental principles that, since Medicare's inception, have helped to shape it into such a successful program. We believe strongly that these principles must be the basis of any viable reform option.

Defined Benefits Including Prescription Drugs

All Medicare beneficiaries are now guaranteed a defined set of health care benefits upon which they depend. A specified benefit package that is set in statute is important for a number of reasons. First, it assures that Medicare remains a dependable source of health coverage over time. Second, a defined benefit package serves as an important benchmark upon which the adequacy of the government's contribution toward the cost of care can be measured. Without this kind of benchmark, the government's contribution could diminish over time, thereby eroding Medicare's protection. Third, a benefit package set in statute reduces the potential for adverse selection by providing an appropriate basis for competition among the health plans participating in Medicare. And finally, a defined benefit package provides an element of certainty around which individuals, employers, and state Medicaid programs may plan.

As was laid out earlier in this statement, because prescription drugs are central to the delivery of high quality health care, Medicare should be like most other health insurance plans and include prescription drugs as part of Medicare's defined benefit package offered by all participating plans—including traditional fee-for-service.

Adequate Government Contribution Toward the Cost of the Benefit Package

It is essential that the government's contribution or payment for the Medicare benefit package keep pace over time with the cost of the benefits. Currently, payment for traditional Medicare is roughly tied to the cost of the benefit package. If the government's contribution were tied to an artificial budget target and not connected to the actual cost of the benefit package, there would be a serious risk of both the benefits and government payment diminishing over time. The effect of a flat government payment—regardless of the plan cost—could be sharp year-to-year premium and cost-sharing increases for beneficiaries. It could also mean significant differences in what beneficiaries would have to pay for different Medicare plans.

Out-of-Pocket Protection

Changes in Medicare financing and benefits should protect all beneficiaries from burdensome out-of-pocket costs. Medicare beneficiaries age 65 and over, spent on average, about $2,430—nearly 20 percent of their income—out-of-pocket for health care expenses in 1999, excluding the costs of home care and long-term nursing care. In addition to items and services not covered by Medicare, beneficiaries have significant Medicare cost-sharing obligations: a $100 annual Part B deductible, a $776 Part A hospital deductible, 20 percent coinsurance for most Part B services, a substantially higher coinsurance for hospital outpatient services and mental health care, and significant coinsurance for skilled nursing facility care and very long hospital stays.

AARP believes that Medicare beneficiaries should continue to pay their fair share of the cost of Medicare. However, if cost-sharing were too high or varied across plans, Medicare's protection would not be affordable, and many beneficiaries would be left with coverage options they might consider inadequate or unsatisfactory.

Viable Fee-for-Service

Medicare beneficiaries must continue to have access to a strong and viable fee-for-service option. Managed care is not yet established as a fully satisfactory choice for many beneficiaries. In addition, many beneficiaries live in areas of the country where managed care plans are not available or likely to become available. Without an affordable fee-for-service option, these beneficiaries could end up paying as much or more out-of-pocket for health care coverage that does not meet their needs.

Protecting the Availability and Affordability of Medicare Coverage

Medicare should continue to be available to all older and disabled Americans regardless of their health status or income. Our nation's commitment to a system in which Americans contribute to the program through payroll taxes during their working years and then are entitled to receive the benefits they have earned is the linchpin of public support for Medicare. Denying Medicare coverage to individuals based on income threatens this principle. Similarly, raising the age of Medicare eligibility would have the likely affect of leaving more Americans uninsured. Thus, in the absence of changes that would protect access to affordable coverage, AARP opposes efforts to raise the eligibility age for Medicare. Analogies to Social Security's increasing age of eligibility simply do not apply. Social Security's early retirement benefits—though actuarially reduced—start at age 62, and most retirees today begin to collect benefits at age 62 not at age 65.

Quality of Care

Medicare beneficiaries have come to depend upon quality care in Medicare. Quality standards have been a hallmark of the program and have often served as a model for the private sector. Systematic data collection and analysis, careful quality monitoring, as well as new techniques for promoting quality outcomes, must remain a part of any reformed Medicare system.

Administration of Medicare

Effective administration of the program remains essential. The agency or organization that oversees Medicare must be accountable to Congress and beneficiaries for assuring access, affordability, adequacy of coverage, quality of care, and choice. It must have the tools and the flexibility it needs to improve the program—such as the ability to try new options like competitive bidding or expanding centers of excellence. It must ensure that a level playing field exists across all options; modernize original Medicare fee-for-service so that it remains a viable option for beneficiaries; ensure that all health plans meet rigorous standards; and continue to reduce waste, fraud and abuse in the program.

Financing

Medicare must have a stable source of financing that keeps pace with enrollment and the costs of the program. Ultimately, financing sources will need to be both broadly based and progressive. Additionally, because health care costs are rising faster than productivity, AARP supports using an appropriate portion of the on-budget surplus to secure Medicare's financial health.

CONCLUSION

The Medicare program needs to be ready to meet the unique challenges it faces now and in the future. Foremost among the challenges is ensuring that, even as the program adjusts to ensure its future financial soundness, it must also adjust to keep pace with the rapid advances in medicine. Therefore, AARP believes that an affordable Medicare prescription drug benefit that is part of Medicare's defined benefit package and available to all Medicare beneficiaries is essential to any Medicare reforms.

How to provide Medicare beneficiaries with affordable prescription drugs is a huge challenge. AARP urges all stakeholders—government, industry, and consumers—to engage in a serious debate on the merits of the full range of approaches. The success of any drug benefit proposal as well as broader changes to Medicare depend on a clear understanding—on the part of the public and policy makers alike—of the changes that are being contemplated. This will require not only extensive dialogue, but also a thorough distributional analysis of how the proposed changes would affect the full range of current and future beneficiaries.

If legislation is pushed through too quickly, before there has been a thorough examination of the effect on beneficiaries and the program, and before there is an emerging "public judgment" about the changes, this would be a very serious mistake. In such a circumstance, we would be compelled to alert our members to the dangers in such legislation and why we could not support it.

We thank you for your efforts to examine proposals to establish a prescription drug benefit for Medicare beneficiaries. AARP looks forward to continuing to work with members of this Subcommittee and the Congress to advance the debate over prescription drug coverage, and to carefully explore the best options for securing Medicare's future.

Mr. BILIRAKIS. Thank you, Dr. Braun. Thank you both for your testimony. Of course, Dr. Braun, it is always a pleasure to welcome a fellow Floridian before the subcommittee.

As a Representative of one of the oldest districts in the country and a senior myself, I am particularly sensitive about the struggle many Medicare beneficiaries face in obtaining the medicines they need. I have said repeatedly that our most vulnerable seniors deserve help right now. Dr. Braun, your written statement included a caution that I would summarize as haste sometimes makes waste, and I certainly agree with you.

Over the past couple years, members of the Medicare Commission, administration officials, experts in the private sector, and many Members of Congress have given considerable thought to these issues, but I believe that we must act. I still feel that we must act this year to ensure that no senior citizen is forced to choose between buying groceries and filling a prescription. And, Dr. Braun, you clearly said it is a huge challenge.

My fundamental question to both of you is, yes, we need to reform Medicare, and yes, we need to do it as quickly as we can, but we want to get it right. I ask you, if Congress and the President do not reach an agreement on broader reform to protect and improve Medicare this year, which almost certainly would include prescription drugs, the question is, don't we have a moral obligation to help the poorest and the sickest beneficiaries now, rather than just wait until we can finally get around to reform? And I would ask Mrs. Lewis if you have an opinion——

Mrs. LEWIS. I would totally agree with that.

Mr. BILIRAKIS. Do you have any explanation that you would like to offer in that regard?

Mrs. LEWIS. No, I really don't.

Mr. BILIRAKIS. Dr. Braun?

Ms. BRAUN. Yes, I certainly think we need to help our low-income beneficiaries a great deal, but you and I both realize that middle income beneficiaries actually are having a great deal of trouble also, particularly if they have high drug costs. The median household income, not individual income but household income of those over 65 is $20,000 a year, which I think all of us would have difficulty getting along on. And if they have high drug costs, even though they are middle income, they really have a big problem.

I would hope that we might be able to pass something that would be available for all beneficiaries, that could be affordable, and also that could be voluntary so it doesn't take away from anything that people have, like Mrs. Lewis is very, very fortunate with the coverage that she has. And I certainly realize that we need to work cost containment into the situation, and we also need to work quality into the situation. There are just a lot of principles that we are going to need to follow. And I don't think, while a low income benefit, not in Medicare because Medicare really should be the same for all its beneficiaries, but even outside of Medicare, our ideal, it could be done certainly, as I know the chairman has proposed.

Mr. BILIRAKIS. What we have proposed, of course, is not just the poorest, the low income beneficiaries outside of the scope of Medicare——

Ms. BRAUN. Right, right.

Mr. BILIRAKIS. [continuing] people who are Medicare beneficiaries, but we have also proposed something to help the sickest because of the stop-loss provision. Dr. Braun, in an ideal world, if you could satisfy the quality situations and address the areas that Dr. Coburn and so many others have mentioned, and you had no problems with the finances—and Medicare program certainly has a lot of problems, financially and otherwise—you could do something equally for all beneficiaries, including Ross Perot and so many others in that category. I certainly don't put you in that category——

Ms. BRAUN. No. I wish.

Mr. BILIRAKIS. [continuing] but you are not in the lowest economic strata.

Ms. BRAUN. No, I am not in the lowest.

Mr. BILIRAKIS. Don't we have a moral obligation, if we have a shortage of resources, to help at least the sickest people and the poorest people now, and then hope that eventually we might get to the point where we are able to reach the goal that the AARP and Mr. Waxman and others have mentioned of doing everything equally across the board for all Medicare beneficiaries?

Ms. BRAUN. I really think the need is there for all Medicare beneficiaries. That is the problem.

Mr. BILIRAKIS. For all, equally? An equal need?

Ms. BRAUN. No. Low income would certainly need subsidies, and they do have a tremendous need, and I can understand the chairman's thoughts on that subject, but I really do think there is a need across the board for all beneficiaries. And I think with the

chairman's thoughts, doing it outside certainly is better than trying to do something in Medicare which would only be available for certain people. But I think we have a lot of concerns about what would the States do with this, how many would step up to the plate, and——

Mr. BILIRAKIS. Well, we don't know, but they seem to be moving toward that. I understand that the National Conference of State Legislatures has put that at the top of their agenda.

Well, my time has long expired. Mr. Waxman?

Mr. WAXMAN. Thank you, Mr. Chairman. I am pleased to hear from the two witnesses today.

Dr. Braun, as I understand your testimony, you don't disagree with Mrs. Lewis. If she has good coverage, you want her to stay with her coverage.

Ms. BRAUN. Absolutely.

Mr. WAXMAN. She shouldn't have to be pushed into something else if she doesn't want to.

Ms. BRAUN. Absolutely. I think that is wonderful. As I say, in the county above me all the managed care has pulled out. There isn't any. In my county one has pulled out. Another one which had most of the managed care people went from zero to $93 a month for their premium. So there are real, real problems, and I think our rural areas will never really have managed care, so we do need to think in some other kinds of terms. Let the people who have coverage keep it, but the people that don't have it, we have got to think about.

Mr. WAXMAN. Well, not all managed care plans have coverage.

Ms. BRAUN. They are cutting down on it.

Mr. WAXMAN. But a lot of people don't want to be in managed care, and if they stay in Medicare fee-for-service, which most seniors do, they ought to be able to have some help with the costs of their prescription drugs.

Now, a lot of people are saying that we ought to only help people 150 percent of poverty and below. I guess they are compassionate conservatives because they care about low income people.

Ms. BRAUN. That is good to hear.

Mr. WAXMAN. It is good to hear, sort of surprising in some cases, but it is good to hear. But what is wrong with that? Do we have a problem for people above 150 percent of poverty? After all, just by the way, 150 percent of poverty for a married couple is $17,100.

Ms. BRAUN. That is right.

Mr. WAXMAN. For singles it is $12,750. That sounds pretty low, and I know there are people above that that are having problems with prescription drugs.

Ms. BRAUN. That is very true. That is very true. There are a lot of people having problems with prescription drugs, particularly if they have rather high costs, and that risk needs to be spread. However the program is set up, we need to pull in, make it possible for people to come into the program so that it is worthwhile for the people who don't have problems as well as for the others.

Mr. WAXMAN. If it is going to be voluntary, it has got to be a program that is affordable——

Ms. BRAUN. Right.

Mr. WAXMAN. [continuing] and to be affordable, you have got to bring in lots of people to participate.

Ms. BRAUN. That is right.

Mr. WAXMAN. Could anybody imagine what the reaction would be among your membership in AARP if we said Medicare was only going to be for people 150 percent of poverty and below?

Ms. BRAUN. No. I would hope that that day will never come. Medicare is not a means-tested program. It is an insurance program that people have paid into, even Ross Perot.

Mr. WAXMAN. Even Ross Perot has paid in, and everybody pays into Medicare, and then when they are eligible, they are entitled to it.

Ms. BRAUN. That is right.

Mr. WAXMAN. And if they are entitled to have insurance, insurance ought to cover prescription drugs.

Ms. BRAUN. That is right. I would agree absolutely. In today's medicine it doesn't make any sense not to have prescription drug coverage.

Mr. WAXMAN. What do you think of the argument that we shouldn't provide prescription drugs until we have reformed Medicare? I suppose people could then say that if you haven't reformed Medicare, you shouldn't do that unless you reform the whole health care system. Are we just hearing arguments that will keep us from doing anything?

Ms. BRAUN. That might be true. I do think it would be ideal, if we could do it, to do it within the context of all of Medicare, but I think it may be a situation that we really need to move on and we won't be able. It will take us a while to move on total Medicare reform. I think particularly it would fit better into the whole program because the financing then could be considered for the whole program rather than just for a small program.

Mr. WAXMAN. I have the impression that some of the people that are compassionate conservatives because they want to cover low income people, have more compassion about the pharmaceutical companies, making sure they can charge whatever they want for prescription drugs. If only low income people were covered, and of course we have the very low income now under Medicaid eligible for prescription drug coverage, what will it mean for drug companies? Won't they just continue to be able to discriminate against the elderly and charge them higher prices?

Ms. BRAUN. It would sound so, but certainly no matter what kind of system is set up, it needs to have cost containment and there need to be—some of the cost containment things that are now in the private sector need to be introduced in order to have cost containment across the board. I think that is very necessary.

Mr. WAXMAN. What about this argument that Medicare drug benefits are going to destroy research and development for new drugs, and therefore if we want new drugs, we shouldn't provide elderly people with Medicare coverage for their prescription drug costs?

Ms. BRAUN. We really haven't seen any evidence of that happening in legislation that has come about in the past, and I certainly think we need to be sure that the research is still in place, that they continue. However, research is the lifeline of the pharma-

ceutical companies. It would be hard to think that they wouldn't try to find new drugs because that is where the profit is.

Mr. WAXMAN. A lot of my Republican colleagues pointed out, and I think they are absolutely right, a lot of that money that the drug companies get goes into marketing. They are doing direct advertising on television, and they have other direct marketing costs. Some of those marketing costs in some companies rival what they are spending on research and development. If they had to cut back, maybe they will cut back on some of the marketing and continue the life flow of new drugs that the research and development would bring.

Ms. BRAUN. Could be.

Mr. WAXMAN. Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Greenwood?

Mr. GREENWOOD. Thank you, Mr. Chairman.

Let me first say to Mrs. Lewis that I am delighted that you can walk at a brisk pace for 45 minutes. That is more than most Members of Congress can do. But it shows us the increased vigor that today's elderly have. My parents are 78 years old, and recently my mother and father and I jumped out of an airplane together, went skydiving.

Mrs. LEWIS. The word is determination.

Mr. GREENWOOD. We come from a crazy family.

I would like to address a question to Dr. Braun. In your testimony, I think that the following is a direct quote. You say, "If legislation is pushed through too quickly, before there has been a thorough examination of the effect on beneficiaries and the program, and before there is an emerging public judgment about the changes, this would be a very serious mistake. In such a circumstance, we would be compelled to alert our members to the dangers in such legislation and why we could not support it."

And I commend you for recommending to the Congress that we take a very deliberative approach to this very, very critical issue. In fact, I think in response to a question you said that we need several more hearings, many more hearings to work this out, and that may be the case.

That being so, there is an effort afoot in the House to discharge from committee consideration the Allen-Waxman bill, which would essentially say to this subcommittee and to the full Commerce Committee and to our counterparts on the Ways and Means Health Subcommittee and their full committee, "Stop thinking about it, stop deliberating, stop bringing witnesses from the AARP or anyone else forward to really hone your judgment on this." Just yank the bill out of committee without consideration, wipe your hands of it, and throw it out on the floor for what I think would be a very politicized vote and not worthy of the greatest deliberative body on earth.

Having said all that, would you then agree that that would be a precipitous thing to do, and meet your test of pushing something through too quickly?

Ms. BRAUN. Well, I am not all that savvy on the politics end of the situation, but I think we certainly stand with our judgment that there does need to be a full debate, and that no debate on any-

thing that is being suggested should be hindered. And we do need a chance to analyze bills and really see what their impact is going to be on beneficiaries, and that is really all I can say about that.

Mr. GREENWOOD. Okay. Let me ask you another question, if I could, Dr. Braun. AARP's second largest source of revenue, next to membership dues, is the sale of Medigap insurance. As you know, in 1990 Congress required that seniors would have to buy down their deductibles and purchase questionable items such as foreign travel insurance before they are allowed to buy prescription drug coverage. Moreover, the drug coverage that is offered has 50 percent co-insurance and low benefit caps.

Do you think Congress ought to consider changing the Medigap law and allowing AARP and others to sell a product that has a better value for seniors? We believe right now that Medigap is a good buy for seniors.

Ms. BRAUN. I think that whole situation needs to be looked into, Congressman, because I think it is questionable. Those Medigap, first of all, not everybody can get them because they are all medically underwritten, so once you get something wrong with you and need the medicine, you can't get them. But even when you have them, they are expensive. They are all capped, they have 50 percent co-payments, and the premiums are very expensive. So they really perhaps are not that good a buy, although some seniors want to feel that kind of security, and so they hold onto them if they can afford them.

Mr. GREENWOOD. Wouldn't you say that that speaks to the need to take a relatively comprehensive look at the structure of Medicare, including Medigap, before we just sort of glom onto a Medicare prescription drug benefit without looking at the foundation of Medicare that would sit below it?

Ms. BRAUN. I think that is one of the problems of doing it separately. It would be much easier to look at the whole situation, and certainly nobody would welcome any more than we do if Congress would find a way that we didn't need Medigap insurance, that there wouldn't be all that much gap, so that people would not need that extra insurance. It does seem kind of strange that seniors have to have one insurance program, and then they have to have another insurance over that to fill in gaps. It doesn't make too much sense.

Mr. GREENWOOD. Thank you very much.

Ms. BRAUN. So it would work out better to do it with the whole program, but on the other hand, perhaps it will be possible to do it without doing the whole program.

Mr. GREENWOOD. It will be possible, but maybe not advisable. Thank you very much for your answer to my question.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Pallone, to inquire?

Mr. PALLONE. Thank you, Mr. Chairman.

I wanted to ask Dr. Braun a couple of questions. I guess my biggest concern here, and I expressed it in my opening statement, is that we will, or at least on the Republican side that they will continue to look to target lower income people and not have a broad-based benefit under Medicare. And you certainly, Dr. Braun, ex-

pressed some of the concerns about that, but I just wanted to dwell if I could on two aspects of that that bother me.

First of all, we know that when we are dealing with any kind of insurance, from the point of view of the finances, the broader the insurance pool, the better off we are. And you, you know, obviously mentioned that, and I guess there are two parts to my question. One is if you would maybe elaborate on that a little more, because I think it is very important that this be a very broad pool.

The other thing, though, is political, and I know you said you are not so much savvy about the politics, but I am going to venture to say as a politician that my concern about just addressing the problem of the lower income is also based on the fact that then what happens is you don't have the political support, if you will, that you have for a broad-based benefit that covers everyone.

In other words, one of the reasons why I think that Medicare is so strong and that any effort to try to cut back or do anything that might damage it, we have such a huge reaction in the public, is because everybody gets coverage. All seniors get coverage under Medicare. And if you start to make it, any aspect of it, just low income based, you lose the political support for Medicare which I think is very important if we are going to continue to have it. And of course AARP is a grand example of that because a lot of your members, you know, they can be poor but a lot of them are even wealthy, I would venture to say.

So I just wanted you to comment on those two aspects, one, the need for a broad insurance pool, and also the political aspect, that we don't want to undermine the support of the public for a program if it becomes need-based, if you would. And you don't have to, but I am just asking you to.

Ms. BRAUN. No, I think as far as the insurance is concerned, any kind of insurance depends on having a very broad risk pool, so you have some people who aren't using and other people who are. We all know we carry fire insurance for our houses, and we hope the houses don't burn down, but there are enough people carrying it so that it is not terribly expensive and they can pay for it when it does burn down.

And we need the same sort of thing with the insurance for prescription drugs. I think it is very important that whatever is done, we don't put a measure in Medicare which is just for low income. I think it is very, very important to keep the original plan of Medicare, which was that it would be a defined benefit and the benefits would be available for everybody who is eligible for Medicare. That is really, really important, I think.

As far as the support, political support for the situation, that may have some value, as you are saying. However, I think the need is so strong in the middle income group that if we simply do the low income, I think you are still, Congress is still going to feel the pressure that people need coverage, and very especially when they don't have any other place to get it.

Mr. PALLONE. You know, you also talked, there was a recent AARP study on seniors' out-of-pocket costs for drugs, and it talked about the problem of access to affordable drugs cutting across all beneficiaries and not just the low income.

Ms. BRAUN. Right.

Mr. PALLONE. Even beneficiaries with current drug coverage are not insulated, as you mentioned, from high out-of-pocket costs. For example, those with Medigap or Medicare+Choice coverage still may pay significantly out of pocket. Could you comment on that?

Ms. BRAUN. Well, there are other out-of-pocket costs where it is not just prescription drugs. That is just a part of it. I think that the largest part actually is the premiums, but there are—anything that is not covered by Medicare, the seniors are going to have to get separately, and glasses and hearing aids, all of those things are not covered and they can be very expensive, so——

Mr. PALLONE. I mean, the point is, we are getting a situation, like with Medicare+Choice, where not only are premiums being charged where they weren't before, but the out-of-pocket costs, you know, co-payments and all those other things are going up.

Ms. BRAUN. Yes. They are capping the drug costs in a lot of cases where they didn't cap them before——

Mr. PALLONE. I think that is why——

Ms. BRAUN. [continuing] and the 50-50 costs for them also adds to the costs.

Mr. PALLONE. Someone told me that there is almost no plan anymore than doesn't provide some premium, you know, that the option of not having premium has almost ceased to exist.

Ms. BRAUN. Yes, almost, that is very true.

Mr. PALLONE. Thank you.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. Thank you. I thank the gentleman.

Dr. Coburn, to inquire?

Mr. COBURN. Thank you.

Mrs. Lewis, thank you so much for sharing your medical history with us. I think it is very important. I have a lot of patients very similar to you, and they are really a joy to be around.

I want to ask you a question. Your osteoporosis is measured by getting a bone densitometry. How often do you get that test?

Mrs. LEWIS. The past several years I have had a bone density scan once a year. However, I had a fall and my pelvic bone fractured not too long ago, and at that time, when I got out of the hospital and recovered up to a certain point, we then had another one, but that was a separate item.

Mr. COBURN. But since you have been on your new medicine, your bone density has not decreased, it has actually increased.

Mrs. LEWIS. It has, minimally——

Mr. COBURN. Minimally.

Mrs. LEWIS. [continuing] but it has increased instead of decreased.

Mr. COBURN. I am making this point, is she has been on an effective medicine that was proven once that it was working, and yet Medicare paid for another bone densitometry study each year. Why? Not medically indicated, just it was done, and it was done because it was out there. Once a patient starts achieving a reversal, if they do, and not all do, and once you have established that fact on a medicine, you don't need to do another test.

My point being, is we need to look at all of Medicare because one of the most abused tests out there today is a bone densitometry test, and it is being done in doctor's offices across the board, and

people are getting charged for it, Medicare is paying for it, and we are taking money out of the Trust Fund to pay for it, and yet it is not necessarily indicated. And so the point is, is there is money going out of Medicare for something that is not necessary, where that money could be directed toward drugs.

I would also raise another point, and that is, Mr. Pallone has sponsored a bill that focuses on subsidizing low income and uses private coverages, the SPICE bill. So, you know, I think it is important that we keep things above board.

I also wanted to make one other point, and I wanted to ask Dr. Braun. My Medicare, I mean my AARP number is DOLCA027, and I happen to be a member of AARP, and the question I would have for you, whatever we do on drugs, who should pay for it?

Ms. BRAUN. I think that has to be——

Mr. COBURN. What is AARP's position on who should pay for that?

Ms. BRAUN. I think it has to be shared, and certainly the beneficiaries need to share in that. I think everybody needs to get together, the providers, the drug manufacturing companies, everybody needs to get together, the government, to figure out how we can do this in a fair kind of way that will make it affordable to all beneficiaries.

Mr. COBURN. Do you think your grandchildren and mine should pay for our drugs tomorrow?

Ms. BRAUN. The ones who are working now? I hope that——

Mr. COBURN. Yes, that they should pay for our drugs tomorrow.

Ms. BRAUN. I hope that they are paying for what they will get eventually. It is being used certainly at the present time, but I really see that as an insurance, and insurance that they are promised health benefits when the time comes that they will retire. Now, goodness knows by that time how much it is going to cost.

Mr. COBURN. Well, let me interrupt you, because the demographics don't support that at all. The demographics do not support that even with the benefits that we have today, that our children can continue to pay the rate at what they are paying and come anywhere close to supporting the baby boom generation, of which I happen to be part of. And so what I would like to know is, what is AARP's position on who should pay the additional cost? There is going to be an additional cost. Everybody agrees to that. Who should pay? Should our children and grandchildren pay for it? Where is the money to come from?

Ms. BRAUN. I think, as I say, I think the present day beneficiaries certainly need to do their fair share with the situation where they can afford to. The low income people can't. I certainly think that the government, we have an on-budget surplus fortunately now——

Mr. COBURN. No, we don't. Now, I made that point in my opening statement. There is no on-budget surplus. Every bit of the money in the surplus for last year, this year and next year comes from excess Medicare payments, every penny. In other words, maybe we ought to think about spending less money on other programs so we can meet the obligations of our seniors. Is that a possible solution?

Ms. BRAUN. That is a very difficult solution, depending on what programs. And I am sure no matter what program you decide, they are going to say you can't.

Mr. COBURN. How about the 110,000 IRS employees?

Ms. BRAUN. What?

Mr. COBURN. How about the 110,000 IRS employees? How about the 100,000 Department of Agriculture employees? Is there any room for us to gain efficiency in the Federal Government so we can move resources to help our seniors with their drugs?

Ms. BRAUN. I would hope maybe there is. I am sure I have no idea whether you need more or less——

Mr. COBURN. I guess one of the things I would like to see is the AARP be a little more imaginative on where the money ought to come from to help our seniors.

I see I am out of time. I want to thank you for your testimony. I did not mean to be combative. I appreciate what you all do.

Mr. BILIRAKIS. Thank you, Dr. Coburn.

Ms. DeGette, to inquire? We will go down the line. The gentleman from Michigan?

Mr. STUPAK. Thank you, Mr. Chairman.

There has been a lot of discussion about the discharge petition, and I don't want that to be left like somehow we are doing this evil process to get this bill to the floor. A discharge petition, and I haven't been here as long as a lot of people, maybe 8 years, has never been successful yet. We have never had 218 people sign it.

Whenever you get close to 200, the majority party, in this case the Republicans, would then bring some type of watered-down bill or something that they would like, and that would be the answer to stem the 218 votes from a discharge petition being successful. So in order to have a fair and open, honest debate, the only place we are going to get a chance is these committees.

And so this discharge petition, after 2 years a lot of us are frustrated. We have been on this process for over 2 years, trying to get this legislation or this issue before the Congress. So while maybe not successful in coming to the floor the way we would like to see it, with a full, honest, fair debate, at least through the discharge process we get the issue out front and you can see we even have a hearing.

So I think the discharge petition and those people who had the courage to sign it are doing the right thing to get this debate moving, because I really can't understand why the drug companies, and it is not the pharmacists but the drug companies, why does a senior who has no drug coverage have to pay twice as much for the same prescription? I think that is unconscionable, I think it is a terrible thing we do, and we have to stop this pricing discrimination by the pharmaceutical companies.

Having said all that, having said all that, doctor, I would like to follow up a question that Mr. Pallone was asking you about the access and out-of-pocket expenses and things like that. Older seniors and sicker seniors are more likely to have higher drug costs. In fact, I think it is like most seniors take 2.4 percent more, 2.4 times more drugs than people under 65. But while certain seniors are more likely to have high drug costs, almost any senior could find themselves with enormous drug bills after an unexpected illness.

This fact points to the need for a Medicare drug benefit that is available to everyone, not just certain groups of senior citizens.

Dr. Braun, judging by what you have told us, it seems that the only way to guarantee security for those in need is to provide a benefit for all beneficiaries, because I believe everyone is getting older, illness can come at any time, requiring expensive drugs, and even with coverage, they have limited coverage, as you have indicated. Would you agree that the best way to proceed is with a universal benefit, be it 55-up or 65-up? Would you agree that the best way to benefit is a universal benefit for all seniors?

Ms. BRAUN. Yes. I think AARP has stated that we really feel that it should be available for all Medicare beneficiaries, but also that it should be voluntary so that people can keep what they have if they want to keep what they have.

Mr. STUPAK. And if it is voluntary, do you have any, have you done any studies or anything that would indicate what percentage of your seniors would participate in a benefit like this?

Ms. BRAUN. I think it is going to depend on how it is set up. That is the problem at the present moment, and that is what we are going to need to look at, why these things need more analysis, because we really need to see what the impact is going to be on the beneficiary, and then we can find out from our members where they stand or how they feel about that.

Mr. STUPAK. And I apologize if this question has been asked before, but the three plans that are floating around right now, the President's proposal, the Stark bill which would make it part of Medicare, and of course the Allen bill which would stop the price discrimination from the pharmaceutical companies, of those three bills, has your organization taken a position on any one of those three?

Ms. BRAUN. No, we haven't taken a position on any of the bills because we really think that they need more analysis. We have questions on each one of the bills that we really need answered, and therefore we are not in a position to take a position at the moment.

Mr. STUPAK. With your organization, have you prioritized this as one of your priorities for this Congress, or have you prioritized the issues?

Ms. BRAUN. We are certainly very hopeful that it will be possible, but it does have to—you know, it does have to be done right, as the chairman said.

Mr. STUPAK. By "have to be done right," does AARP have any kind of a position paper that they would like us to study or look at?

Ms. BRAUN. Well, I think you have the principles that we have set up in the testimony, and those are the things by which we are judging each one and from which we elicit questions that we feel are not answered in the particular bill.

Mr. STUPAK. Other than the testimony, there is no other position paper or anything like that available from AARP?

Ms. BRAUN. Not that I know of, but I will check that out for you.

Mr. STUPAK. Thank you.

Mr. BILIRAKIS. Please summarize, Bart. Your time is up.

Mr. STUPAK. Thank you. I will yield back.

Mr. BILIRAKIS. All right. Thank you.

Mr. Bryant?

Mr. BRYANT. Thank you, Mr. Chairman, and I again thank the panel for its excellent testimony.

What I hearing coming across from the other side of the aisle about this discharge petition, people around Washington that have been here longer than I have, and many on the other side have been here much longer than I have, and I think everybody understands what is going on with the discharge petition. It is a very effective tool to use politically to highlight an issue, and certainly something that was done I am sure very often 5 years ago, before the Republicans took over.

And it can be used effectively, as I said, politically and also to appear legislatively to put emphasis on a point, make a point, I guess, but it has not been a very successful one in bringing bills out of the House. Again, I can only speak for the last 5 years that I have been here, but I am sure there was not much success when the Republicans tried the same tactic when the Democrats were in control for the 40 years or so before that.

So let's just lay that on the table, and I think go back to the idea that this is a very important issue and one that no one, neither side I think really wants to be ramrodded or pushed too quickly into trying to achieve a solution, which we all want to do. Medicare is a very important piece of legislation I think that has been a success, and when we start talking about adding to it, which we all think is necessary here with a drug benefit, we want to do it right. I think the panel agrees, and I am sure everyone in this room agrees to that. So let's don't, in the interest of politics and because this might be a good campaign issue in November to help retake control of Congress or help keep control of Congress, let's don't rush to a judgment, if you will, in this case.

We hear something about price controls. I think some of the legislation that has been offered in effect amounts to price controlling, and I think that most of us here understand that does not work very effectively, and certainly in this environment of prescription drugs has the potential to really chill the research and development. The drug that Mrs. Lewis testified about that has so greatly helped her, that could—no telling how many drugs that are like that out there right now, yet to be discovered or that are in the pipeline of being discovered, that could be affected by such measures as price controls.

But I guess in the end I did want to ask Mrs. Lewis a question about your particular case. You have testified, I think, that your drug bill averages about $600 a year. Do you know how much of that actually comes out of your pocket, or is that what you pay out of your pocket?

Mrs. LEWIS. That is what I pay out of my pocket.

Mr. BRYANT. So your total drug bill is higher than the $600?

Mrs. LEWIS. Yes. There are other things that occur from 1 year to another. That means other prescriptions, but it is not those that I take every week.

Mr. BRYANT. That would be your premium combined with any copayments you have——

Mrs. LEWIS. Right.

Mr. BRYANT. [continuing] that would total about $600?

Mrs. LEWIS. Exactly.

Mr. BRYANT. The insurance company picks up, I guess, a larger portion of your drug, prescription drug bill?

Mrs. LEWIS. Yes, I am sure they do. It is a lot more.

Mr. BRYANT. Well, the reason I was drawn to that $600 figure is because that was very close to the example that I used in my opening statement in alluding to the President's proposal that is on the table.

Mrs. LEWIS. It wasn't taken from there.

Mr. BRYANT. Right. Well, I wanted to graphically use you as another example of that, realizing that the President's bill is not necessarily going to be one to pass out of here, and realizing that it is not mandatory; that, you know, whatever comes out probably is going to be optional.

But whatever comes out, whether it is the President's bill or something else, is going to kind of set the standard, because I think what we see is the private sector will eventually evolve around maybe to where the government would be in this Medicare benefit, and you might have people dropping their coverage for their retirees so they can go to the government program.

So what we pass out of here realistically could set the standard, and I am still concerned about the President's bill where it would cost, on that average of $600 a year, it would actually cost a person more money to be on that program when you add up the premium of about $302 a year, together with a 50 percent co-pay on every prescription drug they buy. And at this point it doesn't seem to have a stop-loss provision. I know he has talked about adding some dollars to this plan, but not really defining yet, to my knowledge, what type of stop-loss or ceiling he would set where you wouldn't have to pay anything beyond that.

But it is an expensive plan, and I think as the American people learn about the President's plan, they are not going to be happy with it. And I still think that we as a Congress can simply do better, and I think that is the purpose of this hearing, is finding out, listening to what you have to say so we can do a better job than that, than his plan.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. BRYANT. And I would yield back.

Mr. BILIRAKIS. Thank you, Mr. Bryant.

Mr. Dingell, to inquire?

Mr. DINGELL. Thank you, Mr. Chairman.

Mrs. Lewis, welcome. Thank you for being here. I am not clear from your statement. Are you for or against having prescription pharmaceuticals covered by Medicare?

Mrs. LEWIS. I think it should, but I don't know where it stops. I don't know what the extent of it would be.

Mr. DINGELL. I see. Now, you haven't told me yet whether you are for or against. You say you think it should be but you don't know where the expense stops. That last part of your statement doesn't mean that you are against covering prescription pharmaceuticals under Medicare, does it?

Mrs. LEWIS. To tell you the truth, I hesitate to give an answer to that because I don't feel I know enough.

Mr. DINGELL. Okay, so you don't know whether you are for or against covering prescription medications in Medicare?

Mrs. LEWIS. Well, I prefer to have Medicare.

Mr. DINGELL. I still don't understand what you are telling me. There are a lot of senior citizens who don't have the kind of plan you have, and who don't have prescription pharmaceuticals covered. Do you think they should have their prescription pharmaceuticals covered or not?

Mrs. LEWIS. I think it should be covered by Medicare.

Mr. DINGELL. Ah, good. Thank you. Now, is your plan a nationwide plan, or is it one which is just peculiar to your area or to your State?

Mrs. LEWIS. It is not throughout the country. It just happens to be something that we have a great many companies like this one.

Mr. DINGELL. In California?

Mrs. LEWIS. Yes.

Mr. DINGELL. And they offer coverage only in California?

Mrs. LEWIS. I don't believe so.

Mr. DINGELL. Is this a plan where the premiums are paid for under Medicare?

Mrs. LEWIS. No.

Mr. DINGELL. So the premiums, then, for the plan that covers you and offers you prescription pharmaceuticals, is not within the—is not covered——

Mrs. LEWIS. It comes out of my Medicare.

Mr. DINGELL. [continuing] or the benefits are not made available because of payments from Medicare. Is that right?

Mrs. LEWIS. Yes, it does.

Mr. DINGELL. I am not quite sure I understand.

Mrs. LEWIS. It does come from Medicare, a certain portion.

Mr. DINGELL. So Medicare pays the premiums for the plan that you have; is that what you are telling us?

Mrs. LEWIS. Yes. My husband explained it in this fashion. Medicare is taking care of a certain portion for individuals. They are paying the insurance companies to give me some——

Mr. DINGELL. How much do you pay in addition to what Medicare pays for the plan that you have?

Mrs. LEWIS. I pay——

Mr. DINGELL. So Medicare pays a part of the premium and you pay a part of the premium?

Mrs. LEWIS. Yes.

Mr. DINGELL. How much do you pay a month?

Mrs. LEWIS. I pay $15 a month.

Mr. DINGELL. In addition to what Medicare——

Mrs. LEWIS. In addition to Medicare.

Mr. DINGELL. Okay. If you didn't have prescription pharmaceuticals covered, you would have a pretty serious problem, wouldn't you?

Mrs. LEWIS. Yes, I certainly would. As it happens, I will admit to you that I don't pay taxes, we don't pay taxes, so you know approximately what our income is.

Mr. DINGELL. So having said that, I am trying to understand, if a senior in another part of the country doesn't have the availability

of a plan of this kind, that senior is in some substantial difficulty, isn't he?

Mrs. LEWIS. My husband is reminding me that prior to being with this company, my drug bills came to about $1,500 a year.

Mr. DINGELL. Well, I am pleased that you have found a way to resolve this.

Mrs. LEWIS. I am very grateful, too.

Mr. DINGELL. Mr. Chairman, I thank you.

Mr. BILIRAKIS. I thank the gentleman.

Let's see. Dr. Ganske?

Mr. GANSKE. Thank you, Mr. Chairman. So many questions, so little time.

Thank you, Ms. Lewis, for being with us. I am over here. Thank you very much for coming.

Mrs. LEWIS. You are very welcome.

Mr. GANSKE. Dr. Braun, I thank you also. I received an interesting letter from a constituent who I will not name, or the FDA may go after him, but he says that he got a prescription from his doctor and the cost was $2.43 per pill. Then he started to look through the internet, and he found the following.

He said, "I can order through Pharmaworld in Geneva, Switzerland, after paying either of two American doctors $70 for a phone consultation, a price of $1.05 per pill. I can order through Canadian pharmacies"—see attached letter—"if I use a doctor certified in Canada, or my doctor can order it on my behalf through his office for 96 cents per pill, plus shipping. I can send $15 to a Texan"—and he encloses a letter—"and get a number at a Mexican pharmacy who will send it without a prescription and it is priced at $52 per 100 pills."

Now, it so happens that when we passed the North American Free Trade Agreement, the one thing that our own government blocks our consumers from getting across the border is prescription drugs, although obviously there are senior citizens who are going through the internet and doing this at 50 percent off. I mean, I hear this from all of my colleagues along the Canadian border and along the Mexican border. We have examples of people just going over and getting their prescription drugs at significant discounts.

Does AARP have a position on whether, if we address this pharmaceutical benefit problem, we should change the law to allow senior citizens to shop across the borders to fill their prescriptions?

Ms. BRAUN. I don't believe that we have. That would only advantage people who lived close enough to the border to be able to go back and forth.

Mr. GANSKE. Not necessarily, because you could live—this gentleman lives in Des Moines, Iowa, right in the middle of the country, and he can do this through the mail.

Ms. BRAUN. Through the net, yes.

Mr. GANSKE. So, has AARP taken a position on that?

Ms. BRAUN. We haven't taken a position. We have some concerns that the FDA has also, to be sure that the packaging and the warnings and the drug was the same in the first place, so there are I think a lot of questions from that point of view, but we haven't taken a position on that one way or the other.

Mr. GANSKE. Is AARP going to take a position on that issue? Are you looking at——

Ms. BRAUN. I don't know. We have certainly discussed it and, like you, we have gotten questions from our constituents or, you know, our members, wanting to——

Mr. GANSKE. Well, I hear this from my constituents all the time, and they are all AARP members.

Ms. BRAUN. And it is a concern, of course. Yes. Of course, the other thing, fortunately lots of seniors are using the net, but there certainly are an awful lot of them that wouldn't know how to go about that at all.

Mr. GANSKE. That is true.

Ms. BRAUN. So this person is very fortunate.

Mr. GANSKE. So this is something AARP is looking at?

Ms. BRAUN. Yes.

Mr. GANSKE. As a recommendation?

Ms. BRAUN. Yes. Our members have asked that we——

Mr. GANSKE. Changing our FDA regulations?

Ms. BRAUN. Yes. Our members have asked that we look at it, and we started to consider it this year, and it is going to be considered.

Mr. GANSKE. Have you received a lot of requests from your members to look at that issue?

Ms. BRAUN. We have. Yes, we have received requests.

Mr. GANSKE. Okay. Now, let me get into the issue of funding. According to a recent CBO report, Congressional Budget Office report, if we followed 1997, the Balanced Budget Act, we would see in the next 10 years roughly about $1 trillion in surplus above and beyond Social Security, and we have said we are going to keep that Social Security account separate. The second assumption was—that is if you keep 1997 BBA and there is no emergency funding. That is about a trillion in surplus.

The second scenario is, if you would just freeze spending at today's level, then you would get about roughly a $600 billion surplus over 10 years. The third scenario from the CBO was that if you increased spending according to a cost-of-living allowance and you factored in average emergency funding, you would have about $300 billion in projected surpluses.

Now, we just passed a bill in Congress that, if it became law, would eat up $182 billion. That is the marriage tax penalty. And we are also very concerned about increasing coverage for the uninsured, for health insurance. So let's just say that we increase, let's take the third scenario. We have got $300 billion——

Mr. BILIRAKIS. Please speed up your question so we can get a quick response to it.

Mr. GANSKE. Okay. We have got $300 billion in surplus, or say $400 billion, and we have got some tax relief in there that eats up half of that. Okay. That leaves us with say $200 billion. We have also got a problem with Medicare as it currently exists in a few years not having enough money.

So my point is this: How much of what is probably a real surplus should we devote to a pharmacy benefit, No. 1, just as a percentage?

Mr. BILIRAKIS. I am sorry, Greg, but you are taking advantage of——

Mr. GANSKE. Excuse me, Mr. Chairman. I will finish this real soon.

And, second, how much of that should go to—how much, what percentage should senior citizens contribute to that pharmacy benefit?

Mr. BILIRAKIS. The gentleman's time has expired. Do you have a quick answer to that, Dr. Braun?

Ms. BRAUN. Yes. I think AARP does support using some of that amount to support Medicare, to support prescription drugs being covered. As to the exact figures, I am——

Mr. GANSKE. Would senior citizens be willing to assume 50 percent of the cost——

Mr. BILIRAKIS. The gentlelady——

Mr. GANSKE. I only want to know about percentage——

Mr. BILIRAKIS. The gentlelady from Colorado is recognized.

Ms. DEGETTE. Thank you, Mr. Chairman.

I would like to talk with you, Dr. Braun, for a couple of minutes about some of the proposals that we have been hearing about to provide drug benefits to seniors through State prescription programs. Are you aware of these types of programs, doctor?

Ms. BRAUN. Yes.

Ms. DEGETTE. Do you know whether they are available in all of the States?

Ms. BRAUN. No. Actually, they are available in very few States, and I think it was something like 14, maybe now up to 17 at this point, but it is certainly not even a majority.

Ms. DEGETTE. Thank you. And something I have been a little bit concerned about is that if we use a block grant type approach, all States may not adopt this benefit right away. For example, Arizona didn't create a Medicaid program until 1985, which was 20 years after the program was authorized by Congress. And I am wondering if you see this as a potential hazard if we go to a State-based scenario?

Ms. BRAUN. Yes, I think we do have that concern. I think the chairman himself has that concern about his own. I won't put words in his mouth.

Ms. DEGETTE. Let me ask another question, which is the GAO study I think we are going to hear about on the drug benefits currently available to seniors, including the State pharmacy benefit programs. GAO found that there is an enormous amount of variability among the State-based programs, and the deductibles in these programs could go from zero to $640. Have you found that to be an issue?

Ms. BRAUN. Yes, that is a major problem, just as it is in Medicaid.

Ms. DEGETTE. And what is AARP's position on block grants in general in the pharmaceutical arena, to States?

Ms. BRAUN. I think that is one way of taking care of the very low income, but certainly not, you know, our preferred way, which would be to be sure that everybody has the benefit.

Ms. DEGETTE. Thank you. Mr. Chairman, I just would like you to indulge me for a moment. I, even though I didn't hear Mrs.

Lewis testify, I read her testimony, and I think it is very useful to have beneficiaries come in and actually talk to us about what is going on.

I was a little dismayed when I heard her tell Mr. Dingell that she and her husband are on a fixed income and don't even have to pay taxes, and I am sure it was very expensive for them to fly here from California and to stay at a hotel and come and testify. I am wondering if, using the chairman's prerogative, we could agree that the committee could find some way to pay their travel expenses here today so they wouldn't have to pay for this?

Mr. BILIRAKIS. Well, I really can't respond to that in a way that you would prefer because, you know, there is precedent. I honestly don't even know what the arrangements were that were made. Staff would know. So we will look into that.

Ms. DEGETTE. If we can help——

Mr. BILIRAKIS. I very much appreciate your concern.

Ms. DEGETTE. [continuing] I would like to help out in any way we can. Thank you, and I will yield back the balance of my time.

Mr. BILIRAKIS. Thank you.

Mr. Bilbray?

Mr. BILBRAY. Thank you, Mr. Chairman.

Doctor, I really appreciate your candor about, you know, where we go from here on this issue, because I think AARP, you know, could take the easy route and say, "Well, just spend more money on this program, don't look at the comprehensive repercussions." And I appreciate the fact that you realize and are willing to stand up and say spending just more money is not always the answer. We need to look at how it affects the whole thing.

Ms. BRAUN. We have children and grandchildren, too.

Mr. BILBRAY. And I really, I just think that, hope that some of us on both sides of the aisle are willing to take that responsibility on in saying it isn't as simple as we would like to say. It is not a 30-second sound bite, even if it is an election year. So I think that we can develop that bipartisan support on this issue following your leadership, and I think that is critical.

Mrs. Lewis, I understand that you have been enrolled in a Medicare health maintenance organization for 16 years.

Mrs. LEWIS. That is correct.

Mr. BILBRAY. Can you tell the committee—and I need to preface this by saying, Mr. Chairman, in my community in San Diego, almost 60 percent of seniors are on some kind of health maintenance program, and so this is at least one community where we have seen the private sector step in and actually provide some great options. At least that is what I hear from my constituents, and I know that isn't available in other places.

But, Mrs. Lewis, can you explain to the committee how you first selected this kind of coverage, first of all?

Mrs. LEWIS. It is kind of a personal message.

Mr. BILBRAY. Yes. Can you tell us how you found out about it? You know, how did this——

Mrs. LEWIS. A neighbor in the area that we lived in at that time told me what this particular company offered, and it sounded too good to be true, but it proved to be true. I can't give you figures.

I have no way of knowing exactly what it may cost them above and beyond what I pay. I don't know. I just know it is very comfortable.

Mr. BILBRAY. So if you were not in a situation where you were talking to your neighbors, where you had that kind of community communication, you may not have ever known about this program?

Mrs. LEWIS. It is possible. I believe that there were articles in the newspaper at that time, but I hadn't read it.

Mr. BILBRAY. Your recommendation, at least that we should be looking at this type of option being made available for all seniors as much as possible——

Mrs. LEWIS. Yes, I do.

Mr. BILBRAY. [continuing] why do you make that recommendation, again?

Mrs. LEWIS. I would make the recommendation because it is the perfect situation for my husband and I. I don't know about other people and how they run their homes and what their income is. It is not any of my business.

Mr. BILBRAY. The ranking member of the full committee pointed out that with this private program, in cooperation with the public support that we give Medicare+, we were looking at, what $45 a month plus $15 of your own money a month for the Medicare+Choice?

Mrs. LEWIS. And $5 a visit to a doctor.

Mr. BILBRAY. $5 to $10 co-pay.

Mrs. LEWIS. Right.

Mr. BILBRAY. And with your limited income, you can maintain that financial participation in the program?

Mrs. LEWIS. We manage it.

Mr. BILBRAY. Okay. Doctor, I know this is a tough one for you because I know that you have to confront your own internal politics of the AARP. We all have our internal politics. Does it really seem like it is impossible for us to make this kind of choice and this type of participation in the choice available to all seniors through either a private or a public program?

Ms. BRAUN. Do you mean making HMOs available all over the country? Is that what you are saying?

Mr. BILBRAY. Not just HMOs, but let's just say this cooperative effort. The Congressman, the doctor was talking about the fact that how much participation would AARP be willing to have the seniors involved, and I think that we maybe here have a prototype to at least look at, that here is seniors with limited income who are participating in a program, and frankly I think to a degree a bit of pride that they are participating in the program. It is not just being given to them. It is not just coming from their grandchildren and children. Is there any possibility that AARP could support at least looking into this strategy and having it, either public or private, having seniors participate at this level?

Mr. BILIRAKIS. A short response, please, Dr. Braun, if you can.

Ms. BRAUN. I still am not quite sure what you are talking about, but I think it is wonderful where it is available, but it is not available in a great many places, and probably never will be in rural areas.

Mr. BILBRAY. Mr. Chairman, my question was, though, if it was available, would you support requiring seniors to participate at this level in the financing formula?

Ms. BRAUN. In the financing formula?

Mr. BILBRAY. Yes.

Ms. BRAUN. Sure.

Mr. BILBRAY. Okay. Thank you very much. I appreciate it. Thank you, doctor.

Mr. BILIRAKIS. Mr. Barrett?

Mr. BARRETT. Thank you, Mr. Chairman, and I do thank you for holding these hearings. I think they are very beneficial.

I feel compelled to address some of the questions or the implicit questions that were posed by several Members who are no longer here, from the other side. And the first one dealt with a question that was posed to Dr. Braun, as to asking you to choose between Medicare coverage prescription drugs or cutting some other government service. It was presented, at least as I heard the question, it was presented that these were the only two options, that you were either going to get this or we are going to have to cut some—if you were going to get this, we were going to have to cut some other service.

I think that we have to put that notion to bed right away because, as Mr. Ganske indicated and others indicated, we have passed legislation conferring tax breaks on married couples, some who suffer a marriage penalty, others like myself who have a marriage bonus. And the decision was made that that was an easy choice to make, that we could have a tax cut for $182 billion that would benefit, a lion's share of those benefits would go to wealthier people.

So I just want to make sure that we understand that we are not just talking here about services versus Medicare benefits, that there is another factor in here, and that is tax cuts and who is going to benefit from those tax cuts. And so if we are going to have an honest debate, I think that that has to be included in that debate.

The other question that was posed or implicit question that was posed, one of my colleagues talked about the price controls. Now, I infer from his statement that he was talking about Tom Allen's bill, and I want to address that head-on because there is absolutely nothing, absolutely nothing in that bill that sets price controls. The prices are set by the pharmaceutical companies in conjunction with the HMOs or the Federal Government, whoever they are bargaining with.

They drive a bargain between themselves and their preferred customers. What the Allen bill does, it says once you pharmaceutical companies, once you have set that price, then you can't discriminate, and for many of us that is a very, very important notion, that seniors—and I don't think that there is anybody in this room that would dispute the fact, and I emphasize the word "fact," that seniors in this country who are not in HMOs, who do not have insurance plans, pay significantly higher amounts for those drugs than anybody else basically in this world, that American seniors are hit harder than anybody else, certainly than anybody in this country.

My concern, as we debate this issue and we move toward a discussion as to whether Medicare should cover prescription drugs, is if we simply take the current pricing mechanism that is out there, the current marketing practices, and plop them from where they are and plop them into Medicare, we have not addressed, we still have not addressed that issue of price discrimination against seniors. All we have done is said, "Well, seniors will still be discriminated against, but rather than coming out of their own pocket, it is going to come out of the government's pocket."

And I think for the pharmaceutical companies that is just fine. If they can continue to have that price differential, they don't care who is paying for it. If it is seniors, fine; if it is the government, that is fine, too. But I get more sympathetic to some of the questions from some of my colleagues who are concerned about the cost of the Medicare program, because I think if we have a plan that simply shifts the current marketing system into Medicare and don't do anything about this price discrimination, that eventually it is going to weaken the system.

The question I have for you, Dr. Braun, is along the lines of the questions that I think again Mr. Ganske was posing. I would like to see the AARP be more aggressive in saying, "We want freedom of choice for our constituents," for your constituents; that if these drugs are being sold in Canada at a lower price, if they are being sold in Switzerland at a lower price, if they are being sold in Mexico at a lower price, well, freedom of choice, everybody loves freedom of choice. If we are talking about how bad it is to put price controls on companies, it is also bad to put purchasing controls on purchasers, and we should take those off as well. Then the free market can just run wild.

So I would ask you to reconsider or to consider more in depth the position that your organization takes, because I think that that will help move this debate forward.

So, having said that, Mr. Chairman, I would yield back the time.

Mr. BILIRAKIS. Thank you very much.

Mr. Lazio, to inquire?

Mr. LAZIO. I am not going to ask any questions. The only point I want to make, and it is partly in response to my colleague, Mr. Barrett, is that if every senior was in a PBM, they would all have the benefit of that leverage or that market leverage. All of them would be able to participate in lower prices. And so there are market mechanisms short of mandates that would help drive prices down and give all seniors the benefits that seniors who have Medigap policies, that they enjoy or that their insurance companies enjoy or that their employers enjoy.

And with that I——

Mr. BARRETT. If the gentleman would yield——

Mr. LAZIO. Yes, I am happy to yield to the gentleman.

Mr. BARRETT. And I understand what you are saying and I agree with it, but I think that almost by definition, the most vulnerable and most isolated seniors are the ones that are least likely to be attracted to those market mechanisms. And just as the chairman was, I think, asking some legitimate questions as to shouldn't we be helping the most infirm and the sickest first, I think that we have to recognize that the very people who are least likely to join

those organizations are the ones that are going to be the most vulnerable ones that the chairman was speaking of.

Mr. LAZIO. Reclaiming my time, we can create a structure, an infrastructure that provides the right incentives so that all seniors can and will and will want to participate in that kind of market-related mechanism. It is just a question of whether we are going to embrace the market system or we are going to look for, in my opinion, look to a mandated approach that will have a good deal of unforeseen consequences for seniors, especially during this time of sort of a wild technological explosion.

I love to talk to kids when they come to Washington, because I say, "I envy you, the things that you will see in your lifetime, the creativity, the innovation, the discovery." I mean, this is the age of biological discovery. I just hope that whatever we do does not hamstring our ability to continue to explore the ends of the envelope when it comes to those biological discoveries.

Mr. PALLONE. Could I ask the gentleman to yield? This goes back, I think it is part of what you were getting at and part of what Mr. Bilbray was getting at, but I was confused when Mr. Bilbray asked Dr. Braun this question or Mrs. Lewis this question about mandates.

Was he suggesting that, when he was asking you, was he asking whether or not you would support mandating, if you will, that every senior pay a certain amount the way Mrs. Lewis is? Or was he actually saying that he thought there should be some sort of mandate that seniors should have to participate in managed care? It wasn't clear to me, and I was just wondering maybe if you would clarify that. Is it your position that you think that every senior should be forced to pay a certain amount, or would you favor that every senior would be able, should have to participate in managed care? I was just confused about the question and maybe how you responded to it.

Mr. LAZIO. Let me just, because I don't have all that much time, and I would be happy to yield if we have time, but it also matters who controls the formulary. If the government controls the formulary, if the government controls what type of pharmaceuticals are going to be available at what cost, we are going to have, in my opinion, some significant distortions to the market that will have impact on discovery and innovation.

So, you know, it is a broader question I think in a sense than just should seniors be in some form of PBM. But——

Mr. GREENWOOD [presiding]. If the gentleman would yield on that——

Mr. LAZIO. [continuing] you know, in other words——

Mr. GREENWOOD. Excuse me. The gentleman has yielded to the temporary Chair. I also would like to comment about some of the rhetoric that is used here.

There is no discrimination against seniors for prescription drug benefits, for prescription drug products. There is an experience that anyone of any age has when they walk into a drug store and buy one product at a time, retail, without benefit of having a plan to pay for them. That is what happens in the retail market, whether you are buying bicycles or drugs.

What we are trying to do is create a system so that seniors get the benefit of group purchasing leverage, so that they can enjoy those kinds of reductions in prices and that we can subsidize the cost of what they do have to pay. But I think we ought to, if we are going to be truly bipartisan and get beyond some of the rhetoric here, we ought to stop this rhetoric as if somebody is discriminating against seniors. We want to get seniors out of the one-by-one retail market and put them in a group plan.

And I will recognize Ms. Eshoo for inquiry.

Ms. ESHOO. Thank you, Mr. Chairman, and thank you to both of the witnesses that make up our first panel.

First I have some observations and then I have a question. I think that what has come from you to the members of this committee today is that a universal system is important. That is what Medicare is as an insurance policy for the seniors of our country, so the issue of should it be for a handful, should it be for this group or should it be for that group, should we segment the market, I think that as far as AARP is concerned you have laid that to rest. You are saying that we need a universal system.

We understand that Medigap insurance policies can be expensive. I know in my own experience in paying for that coverage through AARP for my mother and father, I started out in the mid-eighties at $35 a month for the two of them, and the year that my father died, which was 2 years ago, it had gone up to close to $300-plus for the two of them. That is my own personal experience. I still thought that it was a pretty good buy because we couldn't get it anywhere else.

We know that there has been a reliance on the private insurers, i.e. the health management organizations, the HMOs, that they are not obligated to remain in a geographic area, nor are they obligated to keep up with the promise that they may have first offered to those in order to bring them in to their insurance organization. In the Bay area, the San Francisco Bay area, which is a known area throughout the country, it is an area where the economy, the ground is on fire, we are doing so well. And yet insurance company after insurance company has pulled out of the market, and so what Mrs. Lewis enjoys, many of the seniors that the Bay area delegation represents, they no longer enjoy those benefits because the insurance companies have pulled out of the market.

And with regard to the issue of reforming Medicare before we offer another benefit, I would like to place something else on the table. This is a reform that we are talking about here. This is a very important reform to the system because no one would design a system today without prescription drug coverage. What was a part of the system in 1965, where they had surgical coverage, in-hospital coverage was a must then. Prescription drug coverage is a must today.

I think that once again the people of our country are ahead of our government. They know that this is something that should be a part of this system. In listening to you, Dr. Braun, I want to urge you to take back to the AARP and its respective policy committees, to come back to the Congress with what you see is the best way of structuring this; not whether we should have it, not whether we shouldn't. I think that all of these things, most frankly, all of the

Members, regardless of their party, regardless of where they are, for the most part anyway, in terms of their ideology, we know that we need to provide this.

And to ask AARP to figure out our budget I think is unfair, but I think we do need to look at how the best way this should be constructed, because there is a 500-pound gorilla in the room but no one wants to take a look at it. The pharmaceutical companies do not want HCFA to do the administrating. We know that. I mean, I don't know how many people have said it here, but they don't want that because they are hearing that there will be price controls, and let's put it right out there. There are other models to take a look at. I don't know which way you may go, but I think it might be a worthy exercise for AARP to take a look at it.

The one consistency in all of this is that seniors indeed do use drugs, legally, and that they are increasingly paying more and more out of their pocket for that. Too many are having to make an awful choice between their rent, food, other necessities, on fixed, rather low incomes, and we need to do something about this. So I would ask you to go back to your policy committee and do some examination of which system you think would work better, or the combinations thereof.

Now, my question. Some of the proposals that have been introduced would allow plans to vary the benefits that seniors get. For example, HMOs would be allowed to tailor the drug benefit however they wanted. Some might choose to put high co-payments on certain drugs; others might choose not to cover certain drugs at all. Could you comment, Dr. Braun, on why you think it is so important——

Mr. GREENWOOD. The gentlelady's time has expired.

Ms. ESHOO. And she is going to answer, which has not expired.

Mr. GREENWOOD. No. I'm afraid the gentlelady's time has expired.

Ms. ESHOO. Oh, Mr. Chairman, we are all spending a lot of time here today. I mean, 30 seconds, can I ask the committee for 30 seconds?

Mr. GREENWOOD. Certainly you can ask. We will yield you the additional 30 seconds.

Ms. ESHOO. Thank you.

Could you comment, Dr. Braun, on why you think it is so important to ensure that Medicare provides a defined benefit?

Ms. BRAUN. I think we need the defined benefit so that, if we bring competition into the field, you really need to know what you are competing on. And therefore I think, you know, we do need to have a defined benefit in the program.

Ms. ESHOO. Thank you.

Mr. GREENWOOD. The gentleman, Mr. Strickland, is recognized for inquiry.

Mr. STRICKLAND. Thank you, Mr. Chairman.

I took note of the accurate point that seniors are not discriminated against in a technical sense in drug pricing, but the fact is that more seniors in this country are more likely to be ill and need more medications, and so in a practical sense they are the part of our population that bears the brunt of this price discrimination. It is not only directed toward seniors, but seniors bear a dispropor-

tionate burden for that price discrimination than any other sector of our population, so I think in a practical sense we can say seniors are being discriminated against in the way drugs are priced.

I have heard references to price controls today, and many of my colleagues who tout the world economy I think probably do not recognize the fact that all the other countries have price controls of one sort or another on prescription drugs, so once again it is the American consumer that is bearing the brunt of what we say is necessary in terms of pharmaceutical profits in order to carry out the research to bring new and better, more effective drugs on stream. The fact is that the American consumer is being treated grossly unfairly in the way these drugs are being priced.

And the third thing I would like to say to our honored guests here today is that I represent an area in southern Ohio that is a very poor Appalachian area, and I encounter on a weekly basis seniors who would give everything they have, which may not be very much, to have access to the kind of benefit plan that you described in San Diego. And I am very sorry that I was not here when you gave your testimony. I have read it, and I am anxious to find out how such a generous benefit could be available and still allow whoever is providing it to be financially solvent.

But I want to thank you for being here. I think you both have contributed greatly to our understanding of this problem.

Mr. BARRETT. Would the gentleman yield?

Mr. STRICKLAND. Yes, I would.

Mr. BARRETT. I just want to respond to the chairman on my statement using "discrimination" and make it very clear what I meant. The current marketing system has a much greater discriminatory impact on seniors, who disproprotionately are not covered by health plans that help pay for the cost of prescription drugs. The intent, the stated intent may not be to discriminate against seniors, but because seniors are disproportionately not covered by health care plans, they bear the brunt of this discriminatory marketing system. That is what I meant, and that is what I meant to say.

Mr. GANSKE. Would the gentleman yield?

Mr. PALLONE. Would the gentleman yield?

Mr. STRICKLAND. I yield to the gentleman from New Jersey.

Mr. PALLONE. I just wanted to ask the gentleman to yield the time that he has left.

Dr. Braun, just again so I understand you, when Mr. Bilbray was asking Mrs. Lewis about—or asking you about Mrs. Lewis' plan and saying that he wanted to know whether you would support, you know, everyone being mandated to have something like that, it wasn't clear if he was asking whether or not we should mandate that everyone pay a certain amount per month, like she has a $15 per month co-pay or something, or whether he was asking if everyone should be part of a managed care plan. And you answered affirmatively, and I just wanted to clarify that, AARP's position on that.

Ms. BRAUN. No, I certainly did not see it as mandatory for everybody to join a managed care plan. I think I was responding to the fact that the low costs that Mrs. Lewis has certainly are something

that could be borne by beneficiaries, that that is within a normal range of what could be borne.

Mr. PALLONE. Okay. Thank you.

Mr. GREENWOOD. If I may, if the gentleman would yield 30 seconds to me, the point that I was making, Mr. Barrett, is that I think the word "discrimination" is a poor word to describe the phenomenon of the marketplace.

I cannot go to Detroit, knock on General Motors' door and ask them to sell me a Chevrolet for the same price that a dealer would get the Chevrolet, because I am not buying train loads of them. There is no economy of scale there. So that is what we are confronting in the retail market. It is not discrimination, it is an economic fact of life that we want to overcome. We want to change that economic set of circumstances so seniors do have the purchasing power, virtually wholesale purchasing power, not retail purchasing power.

Mr. BARRETT. If the gentleman would yield again, just for 15 seconds——

Mr. GREENWOOD. Fifteen seconds.

Mr. BARRETT. [continuing] my point is the impact. I think we have to look at the impact, and I stand behind my statement that the impact against seniors is far more discriminatory.

Mr. GREENWOOD. All right. Enough of these semantical battles. The Chair recognizes Mr. Waxman, who wishes to make a unanimous consent request for a submission to the record. Is that correct?

Mr. WAXMAN. Yes, Mr. Chairman. I have two documents from AARP and another one from Leadership Council of Aging Organizations. I would like to have it made part of the record.

[The information referred to follows:]

AARP
January 28, 2000

The Honorable PETE STARK
239 Cannon House office Building
U.S. House of Representatives
Washington, D.C. 20515

DEAR REPRESENTATIVE STARK: I am writing in response to your letter concerning the design of a Medicare prescription drug benefit. Your commitment to prescription drug coverage for Medicare beneficiaries and long-standing leadership on this issue continue to be deeply appreciated.

Like you, AARP is committed to creating a Medicare prescription drug benefit for all beneficiaries as a high priority in Medicare reform. We believe modernizing Medicare's benefit package to keep up with advances in medicine is a must. Because prescription drugs are central to the delivery of high quality health care, Medicare should be like most other health insurance plans and include prescription drugs as part of Medicare's defined benefit package offered by all participating plans as well as in traditional fee-for-service.

AARP is committed to pursuing the answers to the questions you have raised and to continuing to advance the debate over the best way to assure that a prescription drug benefit that is available and affordable to all Medicare beneficiaries becomes part of Medicare's defined benefit package. We have identified some fundamental principles to guide the development of a Medicare prescription drug benefit:

- A Medicare prescription drug benefit must be **available** to **all** Medicare beneficiaries.
- Prescription drugs should be part of Medicare's defined benefit package. It is critical that beneficiaries understand what is included in their benefit and that they have dependable and stable prescription drug coverage.
- The benefit needs to be affordable to assure enough participation and thereby avoid the dangers of risk selection. To this end, the government contribution

will need to be significant enough to yield a premium that is affordable and attractive and a benefit design that is responsive to beneficiaries' needs. Medicare Part B is a model in this regard. The Part B benefit is voluntary, but Medicare's contribution toward the cost of the benefit elicits virtually universal participation.

- Beneficiaries should be able to keep the coverage that they currently have, if they choose to do so. A Medicare prescription drug benefit should not be an incentive for employers to drop or cut back on retiree health coverage.
- The benefit must assure that beneficiaries have access to needed drug therapies.
- The benefit must include quality improvement components to reduce medical errors and mismedication and to help reduce overall health care costs.
- The benefit must include meaningful cost-containment for both beneficiaries and the Medicare program. This should include drug purchasing strategies that enable Medicare beneficiaries and the program to take advantage of the aggregate purchasing power of Medicare beneficiaries.
- The benefit must provide additional subsidies for low-income beneficiaries to protect them from unaffordable costs and assure that they have access to the benefit.
- The benefit must be financed in a fiscally responsible manner that is both adequate and stable. AARP believes that an appropriate amount of the Federal budget surplus should be used to help finance a prescription drug benefit.
- A new prescription drug benefit should be part of a strong Medicare program. Prescription drug coverage must be integrated into the program in a manner that preserves and strengthens Medicare.

We understand your interest in ranking the importance of the variables involved in designing a drug benefit. At this time, however, AARP is in the process of evaluating what would make sense from a policy perspective as well as the type of benefit that would best meet the needs of current and future beneficiaries. For example, there are strong indications that older Americans want stop-loss coverage, but there are also indications that they want some degree of first dollar protection. Yet, depending on the amount of the corresponding premium, beneficiaries may not be able to afford a comprehensive benefit. More importantly, we are not yet prepared to say what type of drug benefit design the public will support because we do not know what other changes will occur as part of Medicare reform and that their impact will be on beneficiaries.

We believe these principles will help define a Medicare prescription drug benefit that our broad-based membership can support. The task of designing a drug benefit will not be easy, but we look forward to working with you in this effort to carefully explore the best options for a Medicare prescription drug benefit. Please do not hesitate to contact me or have your staff contact Tricia Smith or Mila Becker of our Federal Affairs Department at (202) 434-3770.

Sincerely,

HORACE B. DEETS

LEADERHIP COUNCIL OF AGING ORGANIZATIONS
February 7, 2000

United States House of Representatives
Washington, DC 20515

DEAR REPRESENTATIVE: The undersigned members of the Leadership Council of Aging Organizations (LCAO) look forward to working with the Congress on the creation of a Medicare prescription drug benefit.

As you consider current proposals and draft new prescription drug proposals, we would like you to consider the following issues that are of the highest priority to our organizations and the millions of Americans that we represent.

Benefits

- Medicare should guarantee access to a voluntary prescription drug benefit as a part of its defined benefit package.
- Medicare's prescription drug benefit should provide comprehensive coverage, including the most current, effective, and individually appropriate drug therapies.
- Medicare's contribution toward the cost of the prescription drug benefit must keep pace with the increase in prescription drug costs and not be tied to budgetary caps.
- Adding a Medicare prescription drug benefit must not reduce access to other Medicare benefits.

Coverage

- The Medicare prescription drug benefit should be available to all Medicare eligible older Americans and persons with disabilities, regardless of income or health status.
- The Medicare prescription drug benefit must be voluntary and must provide safeguards against the erosion of current prescription drug coverage provided by others.

Affordability

- The financing of a new Medicare prescription drug benefit should protect all beneficiaries from burdensome out-of-pocket expenses and unaffordable cost sharing, particularly low-income beneficiaries.
- The new benefit must protect individuals from extraordinary expenses for prescription drugs.
- The government subsidy must be sufficient to guard against risk selection and to provide an attractive benefit design.
- Sufficient subsidies should be provided for low-income beneficiaries to ensure that they have access to the benefit.

Administration

- The new prescription drug benefit should be efficiently managed, include appropriate cost-containment, and reflect the purchasing power of the Medicare beneficiary pool.

Quality

- The new Medicare prescription drug benefit must meet rigorous standards for quality of care, including appropriate monitoring and quality assurance activities.
- The Medicare program should work to prevent the overuse, underuse, and misuse of prescription drugs.

We request that you carefully consider the issues presented above as you develop your Medicare prescription drug proposals. We look forward to working with you to ensure that the Medicare program is strengthened by your efforts.

Sincerely,

AARP; AFSCME Retiree Program; Alzheimer's Association; American Association for International Aging; American Association of Homes and Services for the Aging; American Federation of Teachers Program on Retirement and Retirees; American Society of Consultant Pharmacists; Asociacion Nacional Pro Personas Mayores; Association for Gerontology and Human Development in Historically Black Colleges and Universities; Association of Jewish Aging Services; B'nai B'rith Center for Senior Housing and Services; Eldercare America, Inc.; Families, USA; The Gerontological Society of America; Gray Panthers; National Academy of Elder Law Attorneys; National Asian Pacific Center on Aging; National Association of Area Agencies on Aging; National Association of Foster Grandparent Program Directors; National Association of Nutrition and Aging Services Programs; National Association of Retired and Senior Volunteer Program Directors, Inc.; National Association of Senior Companion Project Directors; National Association of State Long-Term Care Ombudsman Programs; National Association of State Units on Aging; National Caucus and Center on Black Aged, Inc.; National Committee to Preserve Social Security and Medicare; National Council of Senior Citizens; National Council on the Aging, Inc.; National Hispanic Council on Aging; National Indian Council on Aging, Inc.; National Osteoporosis Foundation; National Senior Citizen Law Center; Older Women's League.

Mr. GREENWOOD. Without objection, the Chair would enter a request for unanimous consent to submit for the record a CRS report titled, "Discharge Use in the House: Recent Use and Historical Context," which goes to the comments of Mr. Stupak that it is unlikely that discharge resolutions result in legislation. This is a list from CRS as to how frequently that happens. Without objection, so entered.

[The information referred to follows:]

97-856 GOV

CRS Report for Congress

Received through the CRS Web

Discharge Rule in the House: Recent Use in Historical Context

Updated November 29, 1999

Richard S. Beth
Specialist in the Legislative Process
Government and Finance Division

ABSTRACT

This report presents information on any legislative action beyond the committee stage that occurred on any measure on which a discharge petition was filed in the House, 1973-1998. It also provides summary information on House action pursuant to the discharge rule in each Congress since 1931, when that rule first reached essentially its current form. Finally, for each discharge petition from 1993 through 1998, it sets forth the subject and number of signatures obtained. At the end of the 106th Congress, this report will be updated to reflect action in that Congress. For information on the provisions and operation of the discharge rule, see CRS Report 97-552 GOV, *The Discharge Rule in the House: Principal Features and Uses.*

Discharge Rule in the House: Recent Use in Historical Context

Summary

The discharge rule of the House of Representatives affords a way for Members to bring to the floor a measure not reported from committee. Before a motion to discharge may be made, 218 Members must sign a petition for that purpose. This report provides summary data on discharge petitions filed since adoption of the present form of discharge rule in 1931. It also identifies the 25 occasions since 1973 on which a committee report or floor action occurred on a measure against which a petition was filed (or an alternative measure on the same subject).

Since 1973, nine discharge petitions obtained the required signatures. The House discharged the committee four times, but adopted only one of the measures involved (an amendment to the discharge rule itself). The other five measures received floor consideration under procedures other than discharge, and three of these became law. All five measures rejected were proposed constitutional amendments, requiring a two-thirds majority for passage.

Also since 1973, nine other measures on which discharge was attempted received floor consideration under other procedures. Six of these became law. Committees reported a further seven measures on which discharge was attempted.

Over the entire period since 1931, 540 discharge petitions have been filed, of which 46 obtained the required signatures. The House voted for discharge 26 times, and passed 19 of the measures involved. Two of these measures changed House rules. Only two of the remaining 17 became law. Of the 20 completed petitions on which the House did not vote to discharge, five motions were defeated; no action occurred in six cases; and nine measures received floor consideration under other procedures. Seven of these latter nine became law.

Also, since 1931, 32 other measures on which petitions were filed reached the floor under other procedures. All but three passed the House, and 17 received final approval. Overall, either the petition has been completed, or the measure has received floor action under some procedure, in roughly 15% of discharge attempts.

The discharge rule permits the House to bring a measure to the floor either directly or by considering and adopting a special rule for the purpose. Overall since 1931, 23% of discharge petitions have sought to discharge the Committee on Rules from special rules for considering unreported measures. During the most recent decade, however, 52% of petitions have adopted this approach.

Only since the 103rd Congress has the number of Members signing each discharge petition been public information. During that period, three petitions were signed by more Members than the number belonging to the minority party. Sixteen were signed by fewer than this number of Members, but more than 90. Thirteen were signed by 30-70 Members, six by 5-30, and seven by three or fewer.

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Discharge Rule in the House: Recent Use in Historical Context

Introduction

Function of the Discharge Rule

The "discharge rule" of the House of Representatives (now Rule XV, clause 2),[1] provides a means by which a majority of Members may bring to the floor for consideration a measure that has not been reported from committee. To initiate action under this rule, a Member files a discharge petition either (1) on the measure or (2) on a special rule providing that the measure be extracted from committee and considered. If a majority of the membership then signs the petition, it enables the House to entertain, on specified days, a motion that the pertinent committee be discharged from considering the measure (or the special rule). If the House adopts this motion, it then may entertain a motion to consider the measure (or it takes up the special rule for considering the measure). Finally, if the House adopts the motion to consider (or the special rule), the measure comes to the floor for consideration.[2]

The House first adopted the discharge rule in essentially this form in 1931. From then through 1998, discharge petitions were filed on 540 measures. Most of these never led to any floor action. During these years, the House adopted only 26 discharge motions.[3] However, an additional 41 of the measures involved (or alternatives on the same subject) reached the floor through other procedures available under House rules. Some of these floor proceedings may have occurred because the leadership or the pertinent committees were acting in response to the discharge attempts.

Pertinent Features of the Discharge Rule and Their Development

Although the House has had a discharge rule since 1910, it did not adopt the essential features of the present rule until 1931, and many features of earlier discharge

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[1]U.S. Congress, House of Representatives, *Constitution, Jefferson's Manual, and Rules of the House of Representatives, 106th Congress*, H.Doc. 105-358, 105th Cong., 2nd sess., compiled by Charles W. Johnson, Parliamentarian (Washington: GPO, 1999), sec. 892.

[2]The mechanics of the rule are described in more detail in U.S. Library of Congress, Congressional Research Service, *The Discharge Rule in the House: Principal Features and Uses*, by Richard S. Beth, CRS Report 97-552 GOV (Washington: Feb. 18, 1999).

[3]Including unanimous consent requests with equivalent effects.

procedures were not comparable with those of today. For this reason, the data in this report address only the period since 1931.[4]

Elements introduced into the rule in 1931 include the present requirements for filing a discharge petition and the possible outcomes from doing so. The 1931 revisions also established mechanisms (1) to ensure that House will actually be able to consider a measure once a petition is entered, and (2) to prevent dilatory use of the rule.

One of the most significant innovations of the 1931 rule was the establishment of three alternate forms for initiating discharge action. Since 1931, it has been possible to file a discharge petition either:

- directly on an unreported measure;
- on a special rule providing that an unreported measure be extracted from committee and considered; or
- on a special rule for considering a measure already reported from committee, but never called up for floor consideration.

The different implications of these three methods are explained in the next section.

Since 1931, the House has amended the discharge rule four times, on each occasion only in specific features, not in basic structure. One of these amendments took place shortly after adoption of the present form of rule; the others did not occur until the 1990s.

- In 1935, the House increased the number of signatures required on the petition from 145 (one-third of the House) to 218 (one-half of the House);

- In 1991, the House eliminated a provision that had the effect of preventing debate on, or amendment of, a special rule reaching the floor through discharge;

- In 1993, the House provided that the names of signers on discharge petitions from that time forward be available to the public; and

- In 1997, the House prohibited filing a petition to discharge any special rule that would have the effect of permitting nongermane amendments.

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[4]For data on the use of earlier forms of the discharge rule, see tables 2 and 3 in U.S. Library of Congress, Congressional Research Service, *The Discharge Rule in the House of Representatives: Procedure, History, and Statistics*, by Richard S. Beth, archived CRS Report 90-84 GOV (Washington: March 2, 1990), pp. 58-59. Reprinted in U.S. Congress, House Committee on Rules, Subcommittee on Rules of the House, *Discharge Petition Disclosure: H.Res. 134*, hearing, 103rd Cong., 1st sess., Sept. 14, 1993 (Washington: GPO, 1993). See also Richard S. Beth, *Control of the House Floor Agenda: Implications from the Use of the Discharge Rule, 1931-1994*, paper presented at the Annual Meeting of the American Political Science Association, Sept. 1, 1994, pp. 6-8.

Data Presented in This Report

This report presents three kinds of data on the use of the discharge procedure: First, for recent years (1973-1998, 93rd-105th Congresses), the report identifies all measures on which both a discharge petition was filed and any action beyond the committee stage occurred.[5] As a result, the measures identified include those on which action took place pursuant either to the discharge rule or to other procedures.[6] This scope facilitates assessment of the likelihood that a measure on which Members attempt discharge will receive favorable legislative action by any means.

Second, for the entire period from 1931 through 1998 (72nd-105th Congresses), the report provides summary data on the number of discharge petitions filed and their success rates (by several different criteria). For these comprehensive summary data, separate tables cover action under the discharge procedure itself and action under other procedures.

Third, for the 103rd, 104th, and 105th Congresses (1993-1998), the report sets forth the number of signatures received by each discharge petition filed. Prior to the 103rd Congress, the identities of Members signing were disclosed only for discharge petitions that received the required number of signatures. These data are, as a consequence, not available for Congresses before the 103rd.

Recent Discharge Attempts on Measures That Became Available for Floor Action

From 1973 through 1998 (93rd-105th Congresses), 167 discharge petitions were filed. Only four of the measures involved reached the floor through the discharge procedure itself. In 14 of the remaining 163 instances, however, either the measure received floor consideration under other procedures, or an alternate measure on the same subject did so. An additional seven measures were reported from committee (either before or after the discharge petition was filed), but saw no further floor action. Table 1 (beginning on pg. 7) provides information on all 25 of these measures. It includes all cases, during the period considered, in which use of the discharge rule may have had some connection with action on a measure beyond the committee stage.

Each entry in Table 1 identifies the measure by number and notes its subject (proposed constitutional amendments include the notation "AMENDMENT"). The table also notes the committee(s) to which the measure was referred, or from which it was reported. It next shows which of the forms of discharge petition was filed, how many signatures it obtained, and whether it resulted in a discharge motion being offered on the floor. The following two columns provide a synopsis of floor action

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[5]Comparable information for the 72nd through 100th Congresses (1931-1988) appears as Table 11 in Beth, *Discharge Rule: Procedure* (archived CRS Report 90-84), pp. 93-108.

[6]Corresponding measures may have been taken up by subsequent congresses without use of the discharge procedure. This report takes no account of subsequent action of this kind.

on the measure, as well as on related special rules and alternate measures. Finally, the table notes the final status of each measure. Throughout, the table provides the numbers of any related measures and the dates of key actions. The following paragraphs detail the significance and use of each of these items.

Form of Discharge Petition. A discharge petition may be filed to bring to the floor any measure that has remained in committee at least 30 legislative days.[7] A petition may also be filed on a special rule providing that any such measure be extracted from committee and considered, if the special rule has been before the Committee on Rules for at least seven legislative days without being reported. Finally, a petition may be filed on a special rule for considering a measure already reported, if, again, the special rule has been before the Committee on Rules for seven legislative days without action. Table 1 indicates which of these three courses of action was attempted in each case, giving the date the petition was filed and, where applicable, the resolution number of the special rule.[8]

The first two methods of discharge both provide means for securing consideration of a measure on which the committee of referral seems unlikely to act. Of these two methods, the second has the advantage that it permits proponents to draft a special rule that sets appropriate terms for considering and amending the measure. The third method, by contrast, offers the possibility of bringing to the floor a measure that the committee of referral may be willing to see considered, but which the leadership and Committee on Rules seem unlikely to schedule for action.[9]

Number of Signatures. A discharge petition entitles a Member to offer a motion to discharge a committee from a specified measure only after the petition is signed by a majority of the total membership of the House (218 Members). In the 103rd Congress, the House amended the rule to provide that signatures to pending discharge petitions be publicly available. Until then, signatures had been treated as confidential except when the full 218 were obtained. Table 1 notes which petitions obtained the full number of signatures required and, for the 103rd-105th Congresses, the number of signatures obtained by each other petition listed.

Action on Discharge Motion. Once the 218 signatures are obtained, a motion to discharge is entered on a special discharge calendar. Beginning seven legislative days thereafter, the motion may be offered on the second or fourth Monday of each month, except during the last six days of a session. On several occasions during the period examined, after a discharge motion was entered, the House instead accepted a unanimous consent request that the committee be discharged and the measure be considered at a specific time. This report treats the acceptance of such a request as equivalent to the adoption of a discharge motion. When a petition does not obtain

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[7]Normally, each day the House meets is a legislative day. A legislative day begins when the House convenes after an adjournment, and ends when the House next adjourns.

[8]Table 2 shows the frequency with which these different forms of discharge have been used in each Congress since 1931.

[9]The implications of these three methods of discharge are more fully explained in Beth, *Discharge Rule: Features* (CRS Report 97-552).

218 signatures, of course, no discharge motion can be offered on the floor, and no discharge vote can occur.

Floor Action. Table 1 reports action pursuant to the discharge rule itself in one column, and that pursuant to other procedures in a separate column. In either case, the pertinent column notes whether the measure was (1) reported from committee after the petition was filed, (2) taken up on the floor, and (3) passed or rejected. If the measure was considered under the terms of a special rule, the table also records floor action on the rule. For measures not considered in Committee of the Whole, the table identifies the procedure under which consideration took place.

Sometimes, although no floor action takes place on the measure that is the subject of the discharge procedure, floor action does occur on some other measure on the same subject. This action may occur because the committee of referral reports the other measure; the leadership schedules it for floor consideration; or the Committee on Rules reports a special rule for considering it. If discharge is sought on a special rule, another possible action is that the Committee on Rules may report a different special rule, providing for consideration of the same measure or an alternative measure.

Any of these actions may represent an attempt to forestall or preempt consideration of the measure on which the petition was filed, or at least to forestall its consideration under the terms of the original special rule. The table identifies cases in which such actions occurred, noting the numbers of the alternative measures and special rules.[10]

Final Status. A discharge attempt may succeed directly, by bringing a measure to the floor under the discharge rule itself, or indirectly, by bringing it (or another measure on the same subject) to the floor under some other procedure. Yet even when the discharge effort succeeds (in either sense), the measure may still fail to achieve enactment. The House may consider the measure and reject it, or the measure may fail at a later stage of the legislative process. Table 1 notes whether each measure listed became law or (for concurrent or simple resolutions, and for joint resolutions proposing constitutional amendments) otherwise attained final congressional approval. For measures that did not reach final approval, the table notes the last point in the legislative process the measure reached. This information indicates whether a measure failed or succeeded through the discharge effort itself, or because of conditions occurring at other some point in the process.[11]

Timing of Action. Table 1 does not supply a date for every legislative action it lists. It does, however, identify dates on which:

- measures were referred or, where pertinent, reported;
- discharge petitions were filed;

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[10]Table 4 shows how often, since 1931, these kinds of actions through other procedures have occurred on measures subjected to discharge attempts.

[11]Table 3 shows how often, since 1931, discharge attempts have achieved various degrees of success through the discharge procedure itself.

- the required number of signatures was obtained; and
- key floor actions took place.

The rule requires petitions to be filed at least 30 legislative days after the date of referral. The interval between referral and filing may suggest how urgent the measure's supporters felt the matter to be, or how much confidence they had in the committee of referral. Similarly, the interval from filing to obtaining 218 signatures, as well as the number of signatures obtained, may indicate the breadth and intensity of support for a measure.

Finally, the interval between the filing or entering of the discharge petition and floor action on the measure may suggest whether the committee, House leadership, or Committee on Rules was attempting to supersede or forestall action pursuant to the discharge procedure. This information accordingly helps to suggest the effectiveness of the discharge procedure in eliciting responsive action by these organs. Such an effect might be inferred, for example, if, after a discharge petition is entered but before the discharge motion can be offered on the floor, the committee reports the measure or the Committee on Rules reports a special rule.

Table 1. Measures on Which Discharge Petitions Were Filed and Which Became Available for Floor Action, 1973-1998

Measure and Subject	Committee Action	Discharge Attempt		Floor Action[A]		Final Status
		Form	Action	Under Discharge Procedure[B]	Under Other Procedures	
93rd CONGRESS (1973-1974)						
none						
94th CONGRESS (1975-1976)						
H.R. 7590 Audit of Federal Reserve agencies	Reported by Banking, Currency, and Housing 7/10/75	Filed 10/7/95 on H.Res. 746 for reported measure	Signatures not completed			House did not act
H.R. 9725 Strip mining	Reported by Interior and Insular Affairs 3/12/76	Filed 4/7/76 on H.Res. 1107 for reported measure	Signatures not completed			House did not act
95th CONGRESS (1977-1978)						
none						
96TH CONGRESS (1979-1980)						
H.J.Res. 74 School busing AMENDMENT	Referred to Judiciary 1/15/79	Filed 3/21/79 on unreported measure	218 signatures obtained 6/27/79	Measure considered 7/24/79 Measure rejected		House did not act further
H.R. 3567 Soft drink distributor antitrust exemption	Referred to Judiciary 4/10/79	Filed 5/8/80 on unreported measure	218 signatures obtained 5/29/80		Measure reported 6/20/80 Measure considered by suspension of rules Measure passed S. 598 passed in lieu	P.L. 96-308

Measure and Subject	Committee Action	Discharge Attempt		Floor Action[A]		Final Status
		Form	Action	Under Discharge Procedure[B]	Under Other Procedures	
H.R. 3263 Regulatory reform	Referred to Judiciary 3/27/79	Filed 7/2/80 on unreported measure	Signatures not completed		Measure reported 9/25/80	House did not act
97TH CONGRESS (1981-1982)						
H.J.Res. 350 Balanced budget AMENDMENT	Referred to Judiciary 10/29/81	Filed 7/12/82 on H.Res. 450 for unreported measure	218 signatures obtained 9/29/82		Alternate rule reported (H.Res. 604) Alternate rule adopted 10/1/84 Measure considered Measure rejected	House did not act further
98TH CONGRESS (1983-1984)						
H.R. 500 Interest and dividend withholding	Referred to Ways and Means 1/6/83	Filed 3/17/83 on unreported measure	218 signatures obtained 5/4/83		Measure reported 5/13/83 Alternate measure H.R. 2973 reported 5/13/83 Alternate measure considered by suspension of rules Alternate measure passed	P.L. 98-67
H.R. 1510 Immigration	Reported by Judiciary 5/13/83, Agriculture 6/27/83, Energy and Commerce, Education and Labor 6/28/83; Ways and Means discharged by terms of referral 6/27/83	Filed 10/28/83 on H.Res. 338 for reported measure	Signatures not completed		Alternate rule reported 6/8/84 (H.Res. 519) Alternate rule adopted Measure considered Measure passed S. 529 passed in lieu	Conference

Measure and Subject	Committee Action	Discharge Attempt		Floor Action[A]		Final Status
		Form	Action	Under Discharge Procedure[B]	Under Other Procedures	
H.R. 3 Bankruptcy courts	Reported by Judiciary 2/24/83; Appropriations discharged by terms of referral 3/18/83	Filed 11/2/83 on H.Res. 346 for reported measure	Signatures not completed		Alternate rule reported 3/20/84 (H.Res. 465) for consideration of alternate measure (H.R. 5174) Alternate rule adopted 3/21/84 Alternate measure considered Alternate measure passed	P.L. 98-353
H.R. 5345 School religious group meetings	Reported by Education and Labor 4/26/84	Filed 6/21/84 on H.Res. 510 for reported measure	Signatures not completed		Measure considered by suspension of rules 5/15/84 Measure rejected Rule reported (H.Res. 554) for Senate amendment to H.R. 1310, including similar provisions Rule considered 7/24/84 by suspension of the rules Rule adopted Measure considered by suspension of the rules Measure passed	P.L. 98-377
99TH CONGRESS (1985-1986)						
H.R. 945 Gun control	Referred to Judiciary 2/6/85	Filed 10/22/85 on H.Res. 290 for unreported measure	218 signatures obtained 3/13/86		Alternate rule reported 3/19/86 (H.Res. 403) for alternate measure H.R. 4332 Alternate rule adopted 4/9/86 Alternate measure considered Alternate measure adopted S. 49 adopted in lieu	P.L. 99-308
H.R. 20 Savings and loan regulation	Banking, Finance, and Urban Affairs reported 6/18/85	Filed 7/22/86 on H.Res. 480 for reported measure	Signatures not completed			House did not act

Measure and Subject	Committee Action	Discharge Attempt		Floor Action[A]		Final Status
		Form	Action	Under Discharge Procedure[B]	Under Other Procedures	
100TH CONGRESS (1987-1988)						
none						
101st CONGRESS (1989-1990)						
H.J.Res. 350 Flag burning AMENDMENT	Referred to Judiciary 6/29/89	Filed 3/28/90 on H.Res. 350 for unreported measure	Signatures not completed		Alternate rule reported (H.Res. 417) Alternate rule adopted 6/21/90 Measure considered by suspension of rules Measure rejected Alternate measure considered by suspension of rules (H.R. 5091) Alternate measure rejected	House rejected
H.J.Res. 268 Balanced budget AMENDMENT	Referred to Judiciary 5/11/89	Filed 5/24/90 on H.Res. 391 for unreported measure	218 signatures obtained 6/19/90 No discharge vote		Alternate rule reported (H.Res. 434) Alternate rule adopted 7/17/90 Measure considered under one-hour rule Measure rejected	House rejected
102nd CONGRESS (1991-1992)						
H.J.Res. 290 Balanced budget AMENDMENT	Referred to Judiciary 6/26/91	Filed 5/20/92 on H.Res. 450 for unreported measure	218 signatures obtained 5/20/92 Committee discharged by unanimous consent	Rule adopted 6/10/92 Measure considered Measure rejected		House rejected

Measure and Subject	Committee Action	Discharge Attempt		Floor Action[A]		Final Status
		Form	Action	Under Discharge Procedure[B]	Under Other Procedures	
103rd CONGRESS (1993-1994)						
H.Res. 134 Publish discharge motion signatures	Referred to Rules 3/18/93	Filed 5/27/93 on unreported measure	218 signatures obtained 9/8/93 Committee discharged by unanimous consent	Measure considered 9/28/93 Measure agreed to		House adopted
H.R. 1025 Handgun purchases ("Brady bill")	Referred to Judiciary 2/22/93	Filed 10/7/93 on unreported measure	10 signatures		Rule reported 11/9/93 (H.Res. 302) Measure reported 11/10/93 Rule adopted 11/10/93 Measure considered Measure passed	P.L. 103-159
H.J.Res. 103 Balanced budget AMENDMENT	Referred to Judiciary 2/4/93	Filed 2/24/94 on H.Res. 331 for unreported measure	218 signatures obtained 2/24/94 Committee discharged by unanimous consent	Rule adopted 3/16/94 Measure considered Measure rejected		House rejected
H.J.Res. 131 Pearl Harbor remembrance day	Referred to Post Office 3/3/93	Filed 5/25/94 on unreported measure	7 signatures		Measure reported 7/12/94 Measure considered by unanimous consent Measure passed	P.L. 103-308
S. 1458 Aircraft manufacturer liability	Referred to Judiciary, Public Works 3/18/94	Filed 5/26/94 on H.Res. 405 for unreported measure	160 signatures		Measure reported 5/24/94 (Public Works) 6/24/94 (Judiciary) Measure considered by suspension of rules Measure passed	P.L. 103-298

Measure and Subject	Committee Action	Discharge Attempt		Floor Action[A]		Final Status
		Form	Action	Under Discharge Procedure[B]	Under Other Procedures	
104th CONGRESS (1995-1996)						
H.R. 125 Semi-automatic assault weapons	Referred to Judiciary 1/4/95	(1) Filed 3/15/95 on unreported measure	26 signatures			
		(2) Filed 2/23/96 on H.Res. 364 for unreported measure	3 signatures		Alternate rule reported (H.Res. 388) Alternate rule adopted 3/22/96 Measure considered under one-hour rule Measure passed	Senate did not act
H.R. 1710 Terrorism	Referred to Judiciary 5/25/95	Filed 11/7/95 on H.Res. 240 for unreported measure	2 signatures		Measure reported 12/5/95	House did not act
H.R. 1627 Pesticides and food safety	Referred to Agriculture, Commerce 5/12/95	Filed 5/25/96 on H.Res. 443 for unreported measure	41 signatures		Measure reported 6/11/96 (Agriculture) 7/23/96 (Commerce) Measure considered 7/23/96 by suspension of rules Measure passed	P.L. 104-170
H.R. 2275 Endangered Species Act amendments	Referred to Resources, Agriculture 9/7/95	Filed 7/17/96 on H.Res. 466 for unreported measure	51 signatures		Measure reported 9/9/96 (Resources) Agriculture discharged 9/9/96 by terms of referral	House did not act
105TH CONGRESS (1997-1998)						
H.R. 3580 Supplemental appropriations	Reported by Appropriations 3/27/96	Filed 6/25/98 on H.Res. 473 for reported measure	45 signatures			House did not act

Source: U.S. Congress, House of Representatives, *Calendars of the United States House of Representatives and History of Legislation,* Final edition [95th-105th Congresses] (Washington: GPO [various years]). Library of Congress SCORPIO data base on legislation for the 95th through 105th Congresses. Congressional Legislative Information System data base for the 104th and 105th Congresses. Records of discharge petitions and signatures thereto in the Legislative Resource Center of the House of Representatives. The author expresses appreciation to that office for assistance with access to those records, and to Hettie J. Beth for assistance in compiling some of the data reported.

Notes

[A] Floor action on the measure took place in Committee of the Whole unless otherwise indicated.

[B] Including action pursuant to unanimous consent requests with equivalent effect after petition obtained full number of signatures.

Use and Success of the Discharge Procedure

Frequency of Discharge Attempts

The data presented in this section place the events reported by Table 1 in context of the overall experience of the House with discharge attempts. Table 2 shows fluctuations in the overall frequency with which House Members initiated discharge attempts. After the present form of rule was established in 1931, its use remained relatively common throughout the New Deal and World War II periods. In the 1950s and 1960s, during the ascendancy of the "conservative coalition" and the following period of substantial Democratic majorities, the rule was used much less frequently.

The increase in discharge attempts in the 1970s may reflect the search for new means of agenda access by the increasingly assertive Republican minority of the period. A corresponding decline in the 1980s may reflect a developing sense that discharge offered no promising avenue toward that end. Because a successful discharge attempt requires support from a majority of the House, Members may have found the procedure ill-adapted to measures favored chiefly among the minority party. More frequent use of discharge in the 103rd and 104th Congresses appears to have been encouraged by both the 1993 amendment to the rule, making the names of signers public (see previous section), and the change of party control in the House in 1995. It is not yet clear whether these increases will prove enduring.

Use of the Three Forms of Discharge

The 1931 discharge rule was drafted with the idea that the method of discharging the Committee on Rules from a special rule to extract an unreported measure from committee and bring it to the floor would become the normal use of the rule.[12] As Table 2 shows, however, in most Congresses since that time, most Members attempting to use the discharge procedure to bring an unreported measure to the floor appear to have been either unaware of this method of discharge, or not attracted by its potential advantages. Only in three Congresses were discharge petitions against special rules on unreported measures more common than those against unreported measures themselves.

Table 2 also indicates that attempts to discharge special rules for the consideration of reported measures occurred chiefly during the period of the conservative coalition (roughly 1937-1960). During this period, the Committee on Rules recurrently declined to respond to committee and leadership requests to report special rules for considering measures reported by committees. Supporters of these measures sometimes sought to overcome this obstacle by attempting to discharge the Committee on Rules from a special rule for considering the reported measure. The data in Table 2 suggest that, because this situation made Members focus on the possibility of discharge on special rules for reported measures, it may have led them

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[12]Beth, *Control of the Floor Agenda*, pp. 13-14, 20-23.

to overlook that the discharge procedure could also be used on special rules for unreported measures.

Table 2. Discharge Petitions Filed, 1931-1998

Congress and (Years)	Discharge Petitions Filed			
	On Unreported Measures Other than Special Rules	On Special Rules for Considering Unreported Measures	On Special Rules for Considering Reported Measures	Total
72nd (1931-1933)	9	-	3[A]	12
73rd (1933-1934)	28	-	3	31
74th (1935-1936)	25[B]	4	4	33[B]
75th (1937-1938)	20	20	3	43
76th (1939-1940)	21[C]	14	2	37[C]
77th (1941-1942)	11	4	-	15
78th (1943-1944)	14	7	-	21
79th (1945-1946)	28	6	1	35
80th (1947-1948)	15	3	2	20
81st (1949-1950)	24	3	7	34
82nd (1951-1952)	14	-	-	14
83rd (1953-1954)	6	-	4	10
84th (1955-1956)	3	2	1	6
85th (1957-1958)	2	1	4	7
86th (1959-1960)	1	3	3	7
87th (1961-1962)	2	4	-	6
88th (1963-1964)	2	2	1	5
89th (1965-1966)	4	2	-	6
90th (1967-1968)	2	2	-	4
91st (1969-1970)	9	1	2	12
92nd (1971-1972)	13	1	1	15
93rd (1973-1974)	9	1	-	10
94th (1975-1976)	13	-	2	15
95th (1977-1978)	11	-	-	11
96th (1979-1980)	13	1	-	14
97th (1981-1982)	23	1	-	24

Congress and (Years)	Discharge Petitions Filed			
	On Unreported Measures Other than Special Rules	On Special Rules for Considering Unreported Measures	On Special Rules for Considering Reported Measures	Total
98th (1983-1984)	6	4	3	13
99th (1985-1986)	6	3	1	10
100th (1987-1988)	3	2[D]	-	5[D]
101st (1989-1990)	5	3	-	8
102nd (1991-1992)	5	3	-	8
103rd (1993-1994)	14	12	-	26
104th (1995-1996)	2	13	-	15
105th (1997-1998)	4[E]	3	1	8
TOTAL (1931-1998)	367	125	48	540

Source: *House Final Calendars* for the Congresses indicated. Beth, *Discharge Rule: Procedure*, pp. 77-82. Beth, *Control of the House Floor Agenda*, pp. 62-63. Table 1.

[A]Includes one measure reported adversely.

[B]Includes one petition whose type is unknown.

[C]Includes one petition filed and later withdrawn.

[D]One petition was filed on a rule for considering two measures. It is counted as one petition and not two.

[E]Includes one petition to waive a rule to permit introduction and consideration of a bill.

Success of Discharge Attempts

Table 3 indicates the success of discharge petitions at bringing about action through the discharge procedure itself.[13] Only in a few Congresses since 1947 has more than one petition received the full 218 signatures needed for entry on the discharge calendar. On average throughout the entire period, no more than one in ten petitions has been entered.

Getting the measure to the floor. Between 1939 and 1972, when a discharge petition was entered, the motion was almost always offered on the floor and almost always approved. If supporters of a measure could secure 218 signatures, they could be confident that their measure would receive floor consideration through the discharge procedure. Before and after that period, however, entry of a petition did not guarantee that a discharge motion would ever actually be offered on the floor, much less adopted. Instead, the committees of referral, the leadership, and the Committee on Rules commonly used a variety of devices to preempt further proceedings under the discharge rule. In the 1980s and 1990s, these often involved bringing up the measure, or an alternative proposal, under terms of an alternative special rule reported from the Committee on Rules. When this course of action occurs, proponents of the discharge effort succeed in bringing about consideration of legislation on the subject, but not necessarily of their preferred measure, and not on their own terms.

Passing the measure. Even when a measure does come to the floor pursuant to the discharge procedure, it still does not guarantee that the House will agree to the measure. This finding might be thought surprising, for a measure can reach the floor through discharge only if a majority of Members (1) sign the petition, (2) vote for the discharge motion, and also (3) vote for the special rule or consideration of the measure. A measure that can pass these tests would seem to have a manifest capacity to command majority support in the House. Many of the measures reaching the floor through discharge, however, have been proposed constitutional amendments. Recent examples begin with the Equal Rights Amendment in the 91st Congress, and continue through the Balanced Budget Amendment in the 97th and 100th through 103rd Congresses; several appear in Table 1. Such proposals may possess the majority support required for discharge, yet lack the two-thirds support required for their adoption.

Enacting the measure. Finally, only two measures have become law after being considered pursuant to discharge: a federal pay act in the 86th Congress, and the Wages and Hours Act in the 75th (the first minimum wage law). Measures facing sufficient opposition to block their consideration in the House under regular procedures often suffer from strong opposition at other stages of the legislative process as well.

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[13]For the success of discharge petitions at bringing about action through other procedures, see the next section and Table 4.

Table 3. Proceedings Under the House Discharge Rule, 1931-1998

Congress and (Years)	Discharge Petitions Filed	Discharge Motion		Committee Discharged	Underlying Measure[C]	
		Entered[A]	Called up[B]		Passed House	Received Final Approval[D]
72nd (1931-1933)	12	5	5	1	1	-
73rd (1933-1934)	31	6	1	1	1	-
74th (1935-1936)	33	3	2	2	-	-
75th (1937-1938)	43	4	4	3[E]	2	1
76th (1939-1940)	37[E]	2	2	2	2	-
77th (1941-1942)	15	1	1	1	1	-
78th (1943-1944)	21	3	3	3	3	1[F]
79th (1945-1946)	35	3	1	1	1	-
80th (1947-1948)	20	1	1	1	1	-
81st (1949-1950)	34	3[G]	1	1	1	-
82nd (1951-1952)	14	-	-	-	-	-
83rd (1953-1954)	10	1	1	1	1	-
84th (1955-1956)	6	-	-	-	-	-
85th (1957-1958)	7	1	1	1	1	-
86th (1959-1960)	7	1	1	1	1	1
87th (1961-1962)	6	-	-	-	-	-
88th (1963-1964)	5	-	-	-	-	-
89th (1965-1966)	6	1	1	1	1	-
90th (1967-1968)	4	-	-	-	-	-
91st (1969-1970)	12	1	1	1	1	-
92nd (1971-1972)	15	1	1	1	-	-
93rd (1973-1974)	10	-	-	-	-	-
94th (1975-1976)	15	-	-	-	-	-
95th (1977-1978)	11	-	-	-	-	-
96th (1979-1980)	14	2	1	1	-	-
97th (1981-1982)	24	1	-	-	-	-
98th (1983-1984)	13	1	-	-	-	-
99th (1985-1986)	10	1	-	-	-	-
100th (1987-1988)	5[H]	-	-	-	-	-
101st (1989-1990)	8	1	-	-	-	-

Congress and (Years)	Discharge Petitions Filed	Discharge Motion		Committee Discharged	Underlying Measure[C]	
		Entered[A]	Called up[B]		Passed House	Received Final Approval[D]
102nd (1991-1992)	8	1[I]	1[I]	1[I]	-	-
103rd (1993-1994)	26	2[I]	2[I]	2[I]	1	1[F]
104th (1995-1996)	15	-	-	-	-	-
105th (1997-1998)	8	-	-	-	-	-
TOTAL (1931-1998)	540	46	31	26	19	4

Source: *House Final Calendars* for the Congresses indicated. Beth, *Discharge Rule: Procedure*, pp. 74-75. Table 1.

[A]A discharge petition is "entered" on the discharge calendar when it receives the signatures of 218 Members.

[B]A discharge motion may be offered on the floor on any second or fourth Monday falling at least seven legislative days after the discharge petition is entered (as described in the previous note). Usually, each day on which the House convenes is a legislative day.

[C]A discharge petition may be filed to bring to the floor either a substantive measure in committee or a "special rule" from the Committee on Rules providing for House consideration of such a measure that is either in committee or was previously reported. The last two columns of this table reflect action on the underlying substantive measure, not on the special rule, if any, on which discharge was directly sought.

[D]Includes measures that reached the following status: (1) became law, for bills and joint resolutions; (2) submitted to the states for ratification; for joint resolutions proposing constitutional amendments; (3) agreed to by the House, for House resolutions; and (4) finally agreed to by both chambers, for concurrent resolutions.

[E]The Committee on Rules was discharged from a special rule for consideration of one measure, and the measure was then taken up but recommitted. The Committee on Rules was subsequently discharged from a second special rule for considering the measure. This measure is counted twice in this column and those further to the left, but only once in those further to the right.

[F]Resolution changing House rules.

[G]Includes one petition entered with respect to a special rule on a measure and another entered on the same measure directly.

[H]Includes one petition filed on a special rule for considering two measures.

[I]Includes one measure in the 102nd Congress, and two in the 103rd, from which the committee was discharged, and which were brought to the floor, by unanimous consent, after the discharge petition was entered.

Other Forms of Action on Measures Subjected to Discharge Attempts

Action After a Petition Is Entered. The entry of a discharge petition practically guarantees that supporters will have an opportunity to bring the measure to the floor. When action occurs at this point not pursuant to the discharge rule itself, but under other procedures, it presumably represents an attempt by the committee, leadership, or Committee on Rules to recover control of the floor by taking action to preempt the opportunity that the discharge rule itself affords. The left-hand portion of Table 4 shows how frequently measures received floor action under other procedures after a discharge petition received 218 signatures and was entered on the discharge calendar.

From 1951 through 1978, such action never occurred; previously and thereafter, it occurred seldom. Yet every measure that has reached the floor after a discharge petition was entered, but under other procedures, has been passed by the House and gone on to final approval, except proposed constitutional amendments (the Balanced Budget Amendment in the 97th and 101st Congresses). This record of success is substantially more favorable than that for measures considered pursuant to the discharge procedure itself.

Before 1951, when alternative floor action occurred after a petition was entered, it usually meant that the committee of referral would report and call up the measure under usual procedures. After 1978, by contrast, the committee usually did not report the measure; instead, the alternative action usually involved consideration of an alternative special rule or alternative measure on the same subject. Alternative actions of this sort are included in Table 4 when identifiable. Most recently, however, supporters of discharge have not permitted these attempted alternative actions to forestall further proceedings by discharge. Instead, in three of the four cases during the past four Congresses when a petition was entered (including Balanced Budget Amendments in the 102nd and 103rd Congresses; see Table 1), they arranged for the committee to be discharged, and for the measure to be considered, by unanimous consent.

Action When No Petition Is Entered. The right-hand side of Table 4 shows that alternative action has occurred more frequently on measures for which discharge petitions had not achieved the requisite 218 signatures. Approximately half the measures considered under such circumstances proceeded to final approval, a proportion intermediate between that for measures considered pursuant to discharge and that for measures considered under alternate procedures after a petition was entered. Again, action on alternative measures on the same subject, or pursuant to alternative special rules, is included in Table 4 where it could be identified.

Action on measures with petitions pending was especially common before the mid-1960s, then disappeared entirely until the 1980s. The alternative action in these cases may represent attempts by the committee of referral, or the leadership, to preempt a discharge effort that they perceive as likely to succeed. For petitions that attract few signers, however, the force of discharge as a threat is presumably minimal, so that any alternative action may have occurred simply in the normal course of

committee and leadership activity. Some of these discharge efforts may have occurred in part because supporters of the measures underestimated the likelihood of success through normal procedures. For Congresses prior to the 103rd, of course, there is usually no way of knowing definitely whether a petition obtained few or many signatures.

Summary. Overall, between 1931 and 1998, 67 of the 540 measures against which discharge petitions were filed reached the point of consideration in the House either by discharge or under other procedures (and an additional few were reported, though not considered). Some of these measures may have received action for reasons unrelated to the filing of the discharge petition. Supporters of most, however, presumably believed discharge action necessary because the measure was otherwise unlikely to reach the floor, and also believed that attempting discharge would enhance the measure's prospects. The frequency with which measures on which discharge petitions were filed reach the floor by some means, as compared with that for all measures, offers some support for this proposition.

Table 4. Action Under Other Procedures on Measures on Which Discharge Petitions Were Filed, 1931-1988 [A]

Congress and (Years)	Action on Measure After Petition Entered[A]			Action on Measure Without Petition Being Entered[A]		
	Considered	Passed House	Received Final Approval[B]	Considered	Passed House	Received Final Approval[B]
72nd (1931-1933)	-	-	-	1	1	-
73rd (1933-1934)	1	1	1	-	-	-
74th (1935-1936)	-	-	-	3	3	2
75th (1937-1938)	-	-	-	2	1	1
76th (1939-1940)	-	-	-	2	2	1
77th (1941-1942)	-	-	-	-	-	-
78th (1943-1944)	-	-	-	-	-	-
79th (1945-1946)	2	2	2	-	-	-
80th (1947-1948)	-	-	-	1	1	1
81st (1949-1950)	1	1	1	4	3	-
82nd (1951-1952)	-	-	-	1	1	1
83rd (1953-1954)	-	-	-	1	1	1
84th (1955-1956)	-	-	-	1	1	-
85th (1957-1958)	-	-	-	4	4	2*
86th (1959-1960)	-	-	-	1	1	1
87th (1961-1962)	-	-	-	-	-	-
88th (1963-1964)	-	-	-	2	2	1*

Congress and (Years)	Action on Measure After Petition Entered[A]			Action on Measure Without Petition Being Entered[A]		
	Considered	Passed House	Received Final Approval[B]	Considered	Passed House	Received Final Approval[B]
89th (1965-1966)	-	-	-	-	-	-
90th (1967-1968)	-	-	-	-	-	-
91st (1969-1970)	-	-	-	-	-	-
92nd (1971-1972)	-	-	-	-	-	-
93rd (1973-1974)	-	-	-	-	-	-
94th (1975-1976)	-	-	-	-	-	-
95th (1977-1978)	-	-	-	-	-	-
96th (1979-1980)	1	1	1	-	-	-
97th (1981-1982)	1	-	-	-	-	-
98th (1983-1984)	1	1	1	3	3	2
99th (1985-1986)	1	1	1	-	-	-
100th (1987-1988)	-	-	-	-	-	-
101st (1989-1990)	1	-	-	1	-	-
102nd (1991-1992)	-	-	-	-	-	-
103rd (1993-1994)	-	-	-	3	3	3
104th (1995-1996)	-	-	-	2	2	1
105th (1997-1998)	-	-	-	-	-	-
TOTAL (1931-1998)	9	7	7	32	29	17

Source: *House Final Calendars* for the Congresses indicated. Beth, *Discharge Rule: Procedure,* pp. 86-89. Table 1.

[A]Includes action on alternate measures, where identifiable. A discharge petition is "entered" on the discharge calendar when it receives the signatures of 218 Members.

[B]Includes became public law, if a bill or joint resolution; was submitted to the states for ratification, if a constitutional amendment; was agreed to by the House, if a House resolution; and was finally agreed to by both chambers, if a concurrent resolution.

Number of Signatures on Discharge Petitions

Prior to the 103rd Congress (1993-1994), the names of Members signing a discharge petition were treated as confidential unless the full required number of Members signed, in which case the names were (as now) printed in the *Congressional Record*.[14] Pursuant to an amendment to the rule adopted in 1993, names of those signing discharge petitions are printed in the last issue of the *Record* for each week. Also, the names of signers of discharge petitions are available through the Office of the Clerk.[15] The listings in the *Record* identify discharge petitions only by the number of the measure against which they are filed; their subjects are set forth in the index entry for "Discharge" in the *House Calendar*.[16]

Tables 5 through 7 list all the discharge petitions filed in the 103rd through 105th Congresses (respectively). Each petition is identified by (1) its number, (2) the special rule, if any, that it proposes to bring to the floor, and (3) the number and subject of the underlying measure that it proposes ultimately to bring to the floor. These listings enable identification of what subjects have been addressed by discharge attempts during the past three Congresses.

For each Congress, discharge petitions are listed in order of the number of signatures they obtained. These three tables offer a sense of the range of support that discharge petitions may attract. The tables also note the date on which each petition was filed, on the ground that the number of signatures obtained may be affected by how late in the Congress the discharge process was initiated. Where known, certain other circumstances that may have affected the number of signatures obtained are also noted.

Examination of these tables shows that the levels of support discharge petitions obtain have fallen into groupings fairly clearly separated in size. A first grouping includes the three petitions in the 103rd Congress that gained more signatures than the strength of the minority party. Two of these attained the full 218 signatures; the third, on the "A to Z" spending reduction measure, fell short of that level because of an active counter-campaign by the leadership.[17] Petitions that reach this level of support

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[14]On this change in rules, see Subcommittee on Rules of the House, *Discharge Petition Disclosure.*

[15]They may be examined by request at the Legislative Resource Center, Office of the Clerk, B106 Cannon House Office Building. For the current and the immediately previous Congress, they are also posted on the Clerk's web site at:
http://clerkweb.house.gov/lrc/pd/petitions/petitions.htm.

[16]*Calendars of the United States House of Representatives and History of Legislation* is published by the Clerk of the House and distributed to congressional offices each day the House is in session. Its index appears in the first issue published during each week. The contents of this document are cumulative throughout the Congress, so that the final edition for each Congress is a useful compilation of information about its actions.

[17]George Hager, "Appeal of 'A to Z' Puts Leaders in a Precarious Position," *Congressional Quarterly Weekly Report*, vol. 52, June 25, 1994, pp. 1681-1684. George Hager, George,
(continued...)

evidently must draw at least some support from each party, and therefore may be most likely to appear on legislation favored by a bipartisan coalition.

A second grouping of 16 petitions begins with those signed by about as many Members as the minority party commands seats in the chamber. House records do not identify the party of signers, but this level of support suggests a discharge effort that may have been backed by an essentially united minority party. Especially in the 103rd Congress, a series of other petitions exhibited support levels gradually declining from this level to about 100. Many petitions that achieve these levels of support may also be ones favored principally by the minority party, if not unanimously, then at least by a majority thereof.

During the three Congresses covered, only one petition received between 65 and 95 signatures. Thirteen, by contrast, received between 30 and 65 signatures. Whether or not the signers drew principally from a single party in the House, petitions in this grouping cannot be associated with party in the same sense as may some in the previous grouping, inasmuch as their level of support could not constitute a majority of either party. This level of support nevertheless represents a potentially significant segment of the House, so that it may often be appropriate to view these petitions as representing factional discharge efforts.

Of the remaining 15 petitions, eight obtained between seven and 26 signatures, and seven obtained three or fewer. Many of these can perhaps be understood essentially as individualistic discharge efforts. These observations, of course, cannot be taken as ensuring that discharge petitions in future Congresses will display any similar groupings by number of signatures.

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[17](...continued)
"Gephardt Pledges Votes on Cuts As 'A to Z' Holds at 204 Signers," *Congressional Quarterly Weekly Report*, vol. 52, July 2, 1994, p. 1773.

Table 5. Discharge Petitions in the 103rd House (1993-1994), by Number of Signatures

Petition Number	Date Filed	Measure Subjected to Discharge: Special Rule (If Any)	Underlying Measure: Number	Underlying Measure: Subject	Final Number of Signatures
2	5/27/93	---	H.Res. 134	Public discharge signatures	218
14	2/24/94	H.Res. 331	H.J.Res. 103	Balanced budget constitutional amendment	218
16	5/4/94	H.Res. 407	H.R. 3266	Spending reductions ("A to Z bill")	204
25	8/3/94	H.Res. 489	H.R. 410	Unfunded mandates	173
13	2/9/94	---	H.Res. 281	Sense of House on child pornography	167
21	5/26/94	H.Res. 405	S. 1458	Aircraft manufacturer liability	160
23	6/29/94	---	H.R. 3875	Protect property against environmental enforcement (wetlands, species)	149
17	5/4/94	H.Res. 368	H.R. 3500	Welfare reform	147
18	5/11/94	H.Res 402	H.R. 300	Social security earnings test	133
11	1/26/94	---	H.Res. 247	Point of order against retroactive taxes	128
1	5/11/93	---	H.R. 493	Line item rescission	127
12	2/9/94	---	H.R. 3261	Internal Revenue Service (IRS) staff liability for litigation awards	116
3	7/1/93	---	H.J.Res. 38	Term limits constitutional amendment	109
10	11/21/93	H.Res. 295	H.R. 2672	Crime	107
19	5/17/94	H.Res. 415	H.R. 830	Judicial review of Regulatory Flexibility Act compliance	102
4	9/23/93	---	H.J.Res. 9	Balanced budget constitutional amendment	97
15	3/24/94	H.Res. 382	H.R. 65	Military disability and retirement	54

Petition Number	Date Filed	Measure Subjected to Discharge: Special Rule (If Any)	Underlying Measure: Number	Underlying Measure: Subject	Final Number of Signatures
5	9/28/93	---	H.Res. 156	Debt limit	53
22	6/22/94	H.Res. 409	H.R. 3835	Advisory referendum on term limits	52
26	8/5/94	H.Res. 472	H.R. 3801	Congressional reform	49
9	10/19/93	---	H.Res. 227	Somalia withdrawal	47
6	10/7/93	---	H.R. 1025	Handgun regulation	10
20	5/25/94	---	H.J.Res. 131	Pearl Harbor remembrance day	7
2	7/12/94	H.Res. 459	H.R. 3266	Spending reductions ("A to Z bill")	2
7	10/14/93	---	H.J.Res. 146	Term limits constitutional amendment	1
8	10/14/93	---	H.Res. 125	House reform	1

SOURCE: See Table 7.

Table 6. Discharge Petitions in the 104th House (1995-1996), by Number of Signatures

Petition Number	Date Filed	Measure Subjected to Discharge: Special Rule (If Any)	Underlying Measure: Number	Underlying Measure: Subject	Final Number of Signatures
8	1/24/96	H.Res. 292	H.R. 2409	Debt limit	173
6	11/17/95	H.Res. 242	H.R. 2261	Lobbying; gift ban	88
2	3/22/95	H.Res. 111	H.R. 807	International Monetary Fund (IMF) assistance to Mexico	55
15	7/17/96	H.Res. 466	H.R. 2275	Endangered species amendments	51
12	3/21/96	H.Res. 373	H.R. 2566	Campaign finance	46
13	6/25/96	H.Res. 443	H.R. 1627	Insecticide, fungicide and rodenticide (FIFRA) amendments; food, drug, and cosmetic amendments	41
1	3/15/95	- - -	H.R. 125	Repeal assault weapon ban	26
9	1/30/96	H.Res. 333	H.R. 2530	Budget balancing	25
4	5/3/95	H.Res. 127	H.Res. 40	Gift ban	23
7	11/9/95	H.Res. 246	H.R. 302	Debt limit	17
14	6/27/96	H.Res. 425	H.R. 2915	Welfare reform	16
11	3/7/96	H.Res. 364	H.R. 125	Repeal assault weapon ban	3
5	11/7/95	H.Res. 240	H.R. 1710	Terrorism	2
10	3/7/96	H.Res. 210	H.R. 464	Repeal assault weapon ban	1
3	4/5/95	- - -	H.R. 920	Repeal Violent Crime Control and Law Enforcement Act of 1994	1

SOURCE: See Table 7.

Table 7. Discharge Petitions in the 105th House (1997-1998), by Number of Signatures

Petition Number	Date Filed	Special Rule (If Any)	Measure Subjected to Discharge: Underlying Measure: Number	Measure Subjected to Discharge: Underlying Measure: Subject	Final Number of signatures
3	10/24/97	H.Res. 259	H.R. 1366	Campaign finance	191[A]
7	7/20/98	H.Res. 486	H.R. 3605	Patients' rights	189[B]
4	6/11/98	- - -	H.R. 306	Genetic discrimination	64
6	6/25/98	H.Res. 473	H.R. 3580	Supplemental appropriations	45
1	9/11/97	- - -	H.Res. 141	Presidents' Day holiday	40
2	10/9/97	- - -	H.R. 1984	Air quality standards moratorium	31
5	6/23/98	H.Res. 467	H.R. 3526	Campaign finance	8
8	9/17/98	- - -	H.R. 836	Filipino military service	1

SOURCE: Records of discharge petitions in the Legislative Resources Center, Office of the Clerk of the House, B106 Cannon House Office Building. Additional information was drawn from the *House Final Calendar* and the Legislative Information System of the U.S. Congress for the Congresses in question.

[A] Sixteen additional Members signed and later withdrew their signatures.

[B] One additional Member signed and later withdrew the signature.

Mr. WAXMAN. It has happened.

Mr. GREENWOOD. It has happened.

We thank the witnesses for your tenacity and your fortitude to stay here for at least 3 hours. We figure that during the 3 hours we listened to you for 40 minutes and you listened to us for 3 hours and 20 minutes, but we thank you for that, and you are excused now, please.

Mr. BILIRAKIS. I join in my gratitude to Mrs. Lewis and Dr. Braun, and would now invite the second panel to come forward finally. May we have order, please?

Ms. Bonnie Washington, director of the Office of Legislation, Health Care Financing Administration, accompanied by Dr. Jack Hoadley, who is director of the Division of Health Financing Policy; and Dr. William J. Scanlon, director of Health Financing and Public Health Issues with the General Accounting Office. Welcome, Ms. Washington and Drs. Hoadley and Scanlon.

Again, your written statement is a part of the record. We are going to set the clock at 5 minutes. You know, we are obviously running behind because we had those two votes and what not. I certainly will not plan to cut you off if you need an extra minute or 2 or 3. So we will start off with Ms. Washington. Please proceed.

STATEMENTS OF BONNIE WASHINGTON, DIRECTOR, OFFICE OF LEGISLATION, HEALTH CARE FINANCING ADMINISTRATION, ACCOMPANIED BY JACK HOADLEY, DIRECTOR, DIVISION OF HEALTH FINANCING POLICY; AND WILLIAM J. SCANLON, DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, GENERAL ACCOUNTING OFFICE

Ms. WASHINGTON. Thank you, Chairman Bilirakis, Congressman Waxman, and other distinguished subcommittee members. Thank you for inviting us here today to discuss the need to provide prescription drug coverage in Medicare.

All beneficiaries need access to an affordable drug benefit. Pharmaceuticals are as essential today as hospital care was when Medicare was created, but too many people are missing out. As many people lack drug coverage today as lacked hospital coverage when Medicare was created. Three out of five Medicare beneficiaries do not have dependable coverage, and only half have coverage the whole year through. One-third of Medicare beneficiaries have no drug coverage at all.

Beneficiaries without coverage are forced to pay full retail prices out of their own pockets because they do not get the generous discounts that are offered to large purchasers. The result is that many beneficiaries go without the medicine they need to keep them healthy and out of the hospital.

Coverage is not just a problem for the poor. More than half of the beneficiaries who don't have coverage for drugs have incomes above 150 percent of poverty. Those with coverage are often finding that it costs more and covers less over time, and for some beneficiaries it is disappearing altogether as employers drop retiree coverage. Clearly, all beneficiaries need access to affordable drug coverage.

The President has identified four key principles that a Medicare drug benefit must meet. First, it must be a voluntary benefit avail-

able to all beneficiaries, because access can be a problem for all kinds of beneficiaries.

The benefit must have competitive and efficient administration, be integrated into the Medicare benefit package, but use the private sector to deliver it.

It must be affordable for both beneficiaries and taxpayers. This means providing enough assistance so almost all beneficiaries participate. Otherwise, mostly those with high drug costs would enroll, and the benefit would become unaffordable and eventually become unsustainable.

Finally, the benefit must ensure access to all medications that physicians deem to be medically necessary, and it also must encourage high quality care with quality standards such as protections against medication errors.

The President's plan meets those principles. It is voluntary, and it is managed by private sector pharmacy benefit managers. It is affordable, with a 50 percent premium subsidy and extra help for low income beneficiaries. And Mrs. Lewis should know that the President's plan guarantees that HMOs like hers will be able to continue to provide the drug coverage that she depends on. Right now, as you know, many HMOs don't, and many that do have been cutting back or raising the premiums for that coverage.

Chairman Bilirakis, we have broad consensus that we must act to establish a Medicare drug benefit that everyone can count on. We have a growing budget surplus and dramatic improvements in Trust Fund solvency. We have a historic opportunity to strengthen and modernize the Medicare program and keep our commitment to meet the medical needs of the elderly and the disabled.

Thank you again for inviting us to be here, and we look forward to continuing to work with this committee on proposals to modernize Medicare. Dr. Hoadley and I would be happy to answer any questions that you have.

[The prepared statement of Bonnie Washington follows:]

PREPARED STATEMENT OF BONNIE WASHINGTON, DIRECTOR, OFFICE OF LEGISLATION, HCFA

Chairman Bilirakis, Congressman Brown, distinguished Subcommittee members, thank you for inviting us to discuss the need, and our proposal, to provide prescription drug coverage for Medicare beneficiaries.

We must act now to ensure that all beneficiaries have an affordable prescription drug benefit. Pharmaceuticals are as essential to modern medicine today as hospital care was when Medicare was created.

Lack of prescription drug coverage among senior citizens and people with disabilities today is similar to the lack of hospital coverage among senior citizens when Medicare was created. Three out of five lack dependable coverage. Only half of beneficiaries have year-round coverage, and one third have no drug coverage at all. They must pay for essential medicines fully out of their own pockets, and are forced to pay full retail prices because they do not get the generous discounts offered to insurers and other large purchasers. The result is that many go without the medicines they need to keep them healthy and out of the hospital.

Drug coverage is not just a problem for the poor. More than half of beneficiaries who lack coverage have incomes above 150 percent of the federal poverty level (above $17,000 for an elderly couple). Even those with most types of coverage find it costs more and covers less. Copayments, deductibles and premiums are up. And coverage is often disappearing altogether as former employers drop retiree coverage and Medigap is not available to everyone. Clearly all beneficiaries need access to affordable prescription drug coverage.

KEY PRINCIPLES

The President has identified four key principles that a Medicare drug benefit must meet.

- **It must be a voluntary benefit accessible to all beneficiaries.** Since access is a problem for beneficiaries of all incomes, ages, and areas, we must not limit a Medicare benefit to a targeted group.
- **It must be affordable to beneficiaries and the program.** We must provide assistance so almost all beneficiaries participate. Otherwise, primarily those with high drug costs would enroll and the benefit would become unaffordable.
- **It must have a competitive and efficient administration.** We must integrate the benefit into Medicare but use the private sector to deliver it.
- **It must ensure access to needed medications and encourage high-quality care.** Beneficiaries must have access to the medications that their physicians deem to be medically necessary, and they must have the assurance of minimum quality standards, including protections against medication errors.

The President's plan meets these principles.

- Beneficiaries will have access to an optional drug benefit through either traditional Medicare or Medicare managed care plans. Those with retiree coverage can keep it.
- Premiums will be affordable, with extra assistance for those with low-incomes.
- There will be no price controls or new bureaucracy; instead, the new benefit will be offered through private pharmacy benefit managers who can efficiently negotiate fair prices. All qualified pharmacies will be allowed to participate.
- Beneficiaries can get all drugs prescribed by their physicians from private benefit managers who meet minimum quality standards.

We have broad consensus that we must act now to establish a drug benefit for Medicare beneficiaries. We have an historic opportunity provided by the growing budget surplus and dramatic improvements in Medicare Trust Fund solvency. We have an obligation to keep our commitment to meet the medical needs of seniors and the disabled. And this can only be done by making a voluntary, affordable, accessible, competitive, efficient, quality drug benefit available to all beneficiaries, as proposed by the President, in the context of Medicare reform.

BACKGROUND

Prescription drugs can prevent, treat, and cure more diseases than ever before, both prolonging and improving the quality of life. Proper use should minimize hospital and nursing home stays, and may help decrease the total cost of care.

Recognizing that prescription drugs are essential to modern medicine, the private sector now includes outpatient drug coverage as a standard benefit in almost all policies. Further, all plans in the Federal Employees Health Benefits Program are required to offer a prescription drug benefit. No one would design Medicare today without including coverage for prescription drugs. Prescription drugs are particularly important for seniors and disabled Americans, who often take several drugs to treat multiple conditions. All across the country, Medicare beneficiaries are suffering physical and financial harm because they lack coverage.

Current coverage for prescription drugs for Medicare beneficiaries is incomplete and unreliable, as shown by data based on the Medicare Current Beneficiary Survey (MCBS). The MCBS is used to gather data on prescription drug coverage and spending. Although that survey only provides information through 1995, we have used additional information that allows us to discuss some disturbing trends since that time.

We project that this year more than half of Medicare beneficiaries will use prescription drugs costing $500 or more, and 38 percent will spend more than $1000. Each year, about 85 percent of Medicare beneficiaries fill at least one prescription. Yet one third of beneficiaries have no coverage for drugs at all. And, in 1996, more than half did not have drug coverage for the entire year.

About half of the beneficiaries without coverage have incomes above 150 percent of poverty, demonstrating that this is not just a low-income problem. All these beneficiaries are forced to pay excessively high costs for needed prescriptions because they do not get the deep discounts offered only to insurers and other large purchasers.

This situation is worse for the 10 million Medicare beneficiaries who live in rural areas. Nearly half of these beneficiaries have absolutely no drug coverage. They have less access to employer-based retiree health insurance because of the job structure in rural areas. And three-quarters of rural beneficiaries do not have access to Medicare+Choice plans and the drug coverage that many of these plans provide.

In 1995, about 30 percent of Medicare beneficiaries had private sector coverage offered by former employers to retirees. And this coverage is eroding. The number of firms with 500 or more employees offering retiree health coverage dropped 40 percent in 1994 to 30 percent in 1998, according to the employee benefits research firm Mercer/Foster Higgins (numbers for small firms would be even lower).

The true impact of this trend has not yet been realized, because some employers' decisions to drop coverage apply only to future retirees. Furthermore, a recent survey prepared for the Kaiser Family Foundation reported that 40 percent of large employers would consider cutting back on prescription drug coverage in the next three to five years. As today's workers retire, the population of Medicare beneficiaries with access to retiree coverage is likely to be well below the levels reported in our surveys.

About one in six Medicare beneficiaries today are enrolled in Medicare+Choice plans, most of which include some drug coverage. Although Medicare+Choice plans are only required to provide the traditional Medicare benefit package, the majority of them also provide prescription drugs, which is one reason why they have been popular with Medicare beneficiaries.

Nearly one-third of all beneficiaries, however, lack a Medicare+Choice option because they live in areas where there are no plans. And where plans are available, they have been raising premiums and copayments for drugs, while lowering caps on drug coverage. In 2000, three quarters of plans cap benefit payments at or below $1000, and nearly one-third of plans cap coverage at $500 or less, even though the majority of Medicare beneficiaries use prescription drugs costing $500 or more each year.

About one in eight Medicare beneficiaries have drug coverage through Medicaid. Eligibility for Medicaid, however, is restricted to beneficiaries under 100% of poverty, and the majority of beneficiaries eligible for such coverage—60 percent—are not enrolled in the program. This enrollment problem persists despite increasing outreach efforts to enroll those who are eligible.

Roughly one in ten Medicare beneficiaries obtain drug coverage from a supplemental Medigap plan. Medigap coverage, however, is expensive and its availability is not guaranteed except right after a beneficiary turns 65.

Costs for these policies are rising rapidly, by 35 percent between 1994 and 1998, according to Consumer Reports, in part because those being covered this way are less healthy than the average beneficiary. The General Accounting Office (GAO) found that almost half of all Medigap insurers implemented substantial increases in 1996 and 1997, with AARP—one of the largest Medigap providers, and the only one offering a community-rated policy covering prescription drugs—increasing rates by 8.5 percent in 1997, 10.9 percent in 1998, and 9.4 percent in 1999.

The GAO also found that Medigap premiums for plans that include drug coverage vary widely, both within and across States. For example, premiums charged to a 65-year-old beneficiary for the standardized "I" Medigap plan ranged from $991 to $5,943 in 1999. And the average premium for the standardized "H" Medigap plan ranges from $1,174 in Virginia to $2,577 in Georgia.

Furthermore, premiums for Medigap coverage can increase with age in most States. In some parts of the country, beneficiaries over age 75 are paying more than $100 per month for a plan with drug coverage over and above the premium for a comparable plan without drug coverage. This occurs despite the fact that the maximum annual payment for drug costs in the "H" and "I" plans is only $1250 per year, barely over $100 a month.

THE PRESIDENT'S PLAN

The President has proposed a comprehensive Medicare reform plan that includes a voluntary, affordable, accessible, competitive, efficient, quality drug benefit that will be available to all beneficiaries. The President's plan also dedicates over half of the on-budget surplus to Medicare and extends the life of the Medicare Trust Fund to at least 2025. It also improves preventive benefits, enhances competition and use of private sector purchasing tools, helps the uninsured near retirement age buy into Medicare, and strengthens program management and accountability.

The President's drug benefit proposal makes coverage available to all beneficiaries, regardless of their incomes. The hallmark of the Medicare program since its inception has been its social insurance role—everyone, regardless of income, is entitled to the same basic package of benefits. This is a significant factor in the unwavering support for the program from the American public and must be preserved. All workers pay taxes to support the Medicare program and therefore all beneficiaries should have access to a new drug benefit.

A universal benefit also helps ensure that enrollment is not dominated by those with high drug costs (adverse selection), which would make the benefit unaffordable and unsustainable. And, as I described earlier, lack of drug coverage is not a low-income problem—beneficiaries of all incomes face barriers.

The benefit is completely voluntary. If beneficiaries have what they think is better coverage, they can keep it. And the President's plan includes assistance for employers offering retiree coverage that is at least as good as the Medicare benefit to encourage them to offer and maintain that coverage. This will help to minimize disruptions in parts of the market that are working effectively, and it is a good deal for beneficiaries, employers, and the Medicare program.

We expect that most beneficiaries will choose this new drug option because of its attractiveness, affordability, and stability.

For beneficiaries who choose to participate, Medicare will pay half of the monthly premium, with beneficiaries paying an estimated $26 per month in 2003. The independent HCFA Actuary has concluded that at least 50 percent of the premium must be subsidized in order to ensure adequate participation. A lesser subsidy would result in adverse selection and thus an unaffordable and unsustainable benefit.

Under the President's plan, Medicare will pay half the cost of each prescription, with no deductible. The benefit will cover up to $2,000 of prescription drugs when coverage begins in 2003, and increase to $5,000 by 2009, with a 50 percent beneficiary coinsurance. After that, the dollar amount of the benefit cap will increase each year to keep up with inflation.

For beneficiaries with higher drug costs, they will continue to receive the discounted prices negotiated by the private benefit managers after they exceed the coverage cap. And, to help beneficiaries with the highest drug costs, we are setting aside a reserve of $35 billion over the next 10 years, with funding beginning in 2006. It will be available so that Congress and the Administration can work in collaboration to design protections for those with the greatest need.

Benefit managers, such as pharmacy benefit manager firms and other eligible companies, will administer the prescription drug benefit for beneficiaries in the traditional Medicare program. These entities will bid competitively for regional contracts to provide the service, and we will review and periodically re-compete those contracts to ensure that there is healthy competition. The drug benefit managers—not the government—will negotiate discounted rates with drug manufacturers, as they do now in the private sector. We want to give beneficiaries a fair price that the market can provide without a statutory fee schedule or price controls.

The drug benefit managers will have to meet access and quality standards, such as implementing aggressive drug utilization review programs. And their contracts with the government will include incentives to keep costs and utilization low.

In general, all therapeutic classes of drugs will be covered. Each drug benefit manager will be allowed to establish a formulary, or list of covered drugs. They will have to cover off-formulary drugs when a physician requests a specific drug that is not on the formulary. Coverage for the handful of drugs that are now covered by Medicare will continue under current rules and will not be included in the new drug benefit package.

And Medicare+Choice plans will benefit from the President's Plan. Beneficiaries enrolled in Medicare+Choice plans will receive this optional coverage through those plans, and the plans will use their existing management tools to negotiate prices and formularies. In some markets today, M+C plans offer prescription drug coverage using the excess from payments intended to cover basic Medicare benefits. Under the President's proposal, M+C plans in all markets will be paid explicitly for providing a drug benefit, so they no longer have to depend on what the rate is in a given area to determine whether they can offer a benefit. We estimate that plans will receive $54 billion over 10 years to pay for the costs of drug coverage.

We will no longer see the extreme regional variation in Medicare+Choice drug coverage. Today, only 23 percent of rural beneficiaries with access to Medicare+Choice have access to prescription drugs, compared to 86 percent of urban beneficiaries. Under the President's plan, both rural and urban beneficiaries will have drug coverage available from all Medicare+Choice plans in their area. And beneficiaries will not lose their drug coverage if a plan withdraws from their area or if they choose to leave a plan.

The President's budget proposes to pay for the drug benefit through a combination of premiums and dedication from the on-budget surplus. Premiums will be collected like Medicare Part B premiums, as a deduction from Social Security checks for most beneficiaries who choose to participate. Beneficiaries pay roughly half of program costs.

Low-income beneficiaries would receive special assistance. States may elect to place those who now receive drug coverage through Medicaid in the Medicare drug

program instead, with Medicaid paying premiums and cost sharing as for other Medicare benefits. We would expand Medicaid eligibility so that all beneficiaries with incomes up to 135 percent of poverty would receive full assistance for their drug premiums and cost sharing. Beneficiaries with incomes between 135 and 150 percent of poverty would pay a partial, sliding-scale premium based on their income. The Federal government will fully fund States' Medicaid costs for the beneficiaries between 100 and 150 percent of poverty.

MEETING BASIC PRINCIPLES

In any proposal to provide a prescription drug benefit for Medicare beneficiaries, it is essential that the key principles identified by the President be met.

- It must be a voluntary benefit accessible to all beneficiaries.
- It must be affordable to beneficiaries and the program.
- It must be competitive and efficient.
- It must ensure access to needed medications and encourage high-quality care.

Unfortunately, some of the proposals to establish a Medicare drug benefit fail to meet one or more of these criteria.

Proposals that cover prescriptions for only some diseases fail to provide access for all beneficiaries who need coverage. The number of conditions for which effective drug treatments are available is growing at an unprecedented pace. All beneficiaries need to know that they will have affordable access to the drugs they need when they need them.

Proposals that provide assistance only to low-income beneficiaries also fail to guarantee access for all beneficiaries. Most lacking drug coverage have incomes above 150 percent of poverty, and it is increasingly difficult for them to afford the medicines they need as drug prices rise faster than inflation. It also is essential that we maintain the principle that all Medicare benefits are equally available to all beneficiaries. This is a pillar of the program's strength and overwhelming support among the American people.

Proposals with a premium subsidy of only 25 percent would make the benefit unaffordable to many low and middle-income beneficiaries unable to shoulder the remaining 75 percent. As a result, the benefit would attract a disproportionate number of enrollees with high drug costs. That would drive up the price of premiums, which would further discourage those with lower incomes or lower drug costs from enrolling, and in the end result in an unsustainable program. As mentioned above, the independent HCFA actuary has concluded that a subsidy of at least 50 percent is essential to attract a range of enrollees wide enough to maintain an adequate risk pool.

Proposals with continuous or annual open enrollment periods would be especially vulnerable to attracting enrollees with high drug costs because beneficiaries could wait until they had substantial drug costs before enrolling. This would exacerbate adverse selection problems caused by an inadequate premium subsidy.

Proposals that link a drug benefit to a high-option Medicare plan with additional benefits like a stop-loss for out-of-pocket costs also make the drug benefit less affordable. Beneficiaries who elect the high option would have to pay not only for drug coverage but also for all the other higher costs of the high option plan that many would not need, want, or be able to afford.

Proposals that fail to establish private sector benefit managers everywhere, and instead merely allow private plans to offer coverage when and where they wish, fail to ensure access for all beneficiaries. The benefit would be available only in regions where Medigap and other private plans step forward to offer it. Medigap insurers have already said they would not find stand-alone drug policies an attractive business proposition and are currently offering drugs less frequently. Medigap plans also have little experience negotiating with drug manufacturers and do not pool the purchasing power of seniors. That could well make the coverage unaffordable for many beneficiaries.

And, finally, proposals that do not include a minimum or specified benefit design cannot ensure access or high-quality care. They would allow insurers offering the coverage to "cherry-pick" by tailoring benefits in a way that would limit the value of the benefit to those with greater prescription drug needs. And they would not ensure that minimal safety protections, such as medication error prevention programs, are in place.

CONCLUSION

The need for a prescription drug benefit in Medicare is clear. The consensus across the political spectrum that it should be added is broad. The principles on

which it must be based are strong. The opportunity is before us. The time to act is now.

I look forward to working with all of you on this critical issue. I thank you for holding this hearing, and I am happy to answer your questions.

Mr. BILIRAKIS. Thank you, Ms. Washington. Dr. Hoadley, would you like to add anything.

Mr. HOADLEY. Not at this point.

Mr. BILIRAKIS. Dr. Scanlon, please proceed, sir.

STATEMENT OF WILLIAM J. SCANLON

Mr. SCANLON. Thank you very much, Mr. Chairman and members of the committee. I am very pleased to be here as you discuss options to increase Medicare beneficiaries' access to prescription drugs.

There has been growing concern about the gap in the Medicare program created by the lack of outpatient prescription drug coverage, a gap which may leave some of Medicare's most vulnerable beneficiaries unable to afford needed drugs or heavily burdened by their cost. While you have heard today much of the statistics that are in our testimony about the lack of coverage for some Medicare beneficiaries and the fragility of coverage from others, I would like to add one fact that I think illustrates some of the tradeoffs that you have heard about in terms of being able to afford drugs or to afford the other necessities of life, a tradeoff that has consequences for one's health potentially.

And that is that having coverage has a significant impact on your access to drugs. Medicare beneficiaries without drug coverage but who are sick tend to buy fewer drugs than their counterparts with drug coverage. Research shows that beneficiaries in poor or fair health, without coverage, spend 30 to 50 percent less on drugs than similar beneficiaries with coverage. And that difference in spending is considerable because, as we have also heard, beneficiaries with coverage are much more likely to be getting discounts on the drugs that they purchase.

Potential remedies to afford greater access to prescription drugs that have been discussed have fallen into two categories. The first involves proposals to subsidize an insurance benefit, either through a publicly operated program or in the form of a drug-only private insurance policy. The second would provide access to the elderly to discounted prices available to other purchasers.

Adding a drug benefit to Medicare, an example obviously of the public sector approach, has probably received the most attention. Therefore, in the rest of my oral remarks I would like to comment on that option, though I would note at the same time that the issue of designing and managing a public drug benefit applies equally if the program is federally managed through Medicare or managed by State government.

A fundamental consideration in developing a Medicare prescription drug benefit would be to make the best use of resources that are available. If you believe that resources are limited, a first step in that regard would be to target those resources to provide the greatest benefit, potentially focusing assistance on lower income beneficiaries who are not eligible for Medicaid or those with larger catastrophic drug expenses.

A second major concern will be how to ensure that the program dollars are spent efficiently and effectively. Accomplishing this will be challenging. Looking at the experience of other third party payers who have pursued different strategies to control their spending, and thinking about how to apply them in a public program, illustrates some of the challenge.

The world in which the insured individuals purchase drugs at retail pharmacies, at retail prices, and then seek reimbursement, is giving way to a world in which third party payers influence which drug is purchased, how much is paid for it, and where it is purchased. Medicaid programs provide an example of one approach to cost control which focuses on seeking discounted prices.

The Medicaid drug rebate program requires drug manufacturers to give State Medicaid programs rebates for outpatient drugs based on the lowest or best prices that they charge other purchasers. While effective in securing the Medicaid programs billions in rebates, the impact of these discounts on the pharmaceutical market needs to be noted. Manufacturers' adjustments of prices and discounts following the introduction of Medicaid rebates meant that other payers faced higher prices.

The Medicaid rebate approach has not included techniques included by other payers to limit spending by exercising controls on utilization. These other payers, including private insurers and Medicare+Choice plans, have sought to manage their drug benefits by attempting to control and channel drug utilization through the use of formularies and cost sharing. These mechanisms not only contribute to controlling use, but they also allow payers to concentrate purchases on selected drugs and thereby use purchasing power to obtain even greater discounts from manufacturers.

Adopting some of these techniques with Medicare might provide the potential for better control of costs. However, how to adapt them to deal with the unique characteristics and enormity of the Medicare program raises many questions.

I would like to end my comments by broadening the discussion a bit. Adding a drug benefit to Medicare is correctly seen as a modernization of the Medicare benefit package and program. But however we feel, you also need to recognize there are other and bigger challenges to modernizing Medicare. That is to make sure it is sufficient and sustainable to serve the needs of the baby boom and future generations of beneficiaries, and that we can satisfy other social needs and preferences.

We are in a period of prosperity. The deficit has evaporated. Surpluses are projected for the next 10 years. The growth of Medicare spending has temporarily abated. But, nevertheless, we face substantial challenges brought about by demographics.

The baby boom generation will add approximately 30 million to Medicare rolls by 2030. While those numbers alone might imply huge increases in spending, the likely improvements in medical service that all will want access to will also create additional pressure.

We have been aware of the financial pressures facing Medicare. However, they have been discussed most often in terms of the solvency of the Hospital Insurance, HI, Trust Fund. We need to broaden our focus. HI Trust Fund solvency is an issue. As the

graphic over there indicates, the fund will be depleted about the year 2014. Indeed, for the majority of the 1990's there were outflows from that fund every year.

The HI Trust Fund, however, is only a part of the picture. It funds Part A. Part B coverage of physicians and other services is almost 40 percent of the program, and it is funded 75 percent out of general revenues. Thus, we need to focus on the full share of our resources that will be needed by Medicare.

As this next graphic shows, Medicare, Medicaid and Social Security will absorb increasing shares of Gross Domestic Product and Federal revenues this century. Indeed, if Federal revenues were to remain at a constant share of GDP, by 2030 these entitlements will be crowding out some discretionary spending like defense or education. By 2050, all discretionary spending would be crowded out, as would some interest on the debt.

This picture means that prudence demands that we focus broadly on Medicare and not just on the absence of prescription drug coverage. We should be making every effort to ensure needed services are purchased efficiently, that the burden of financing is distributed equitably, and that the program remains sustainable and affordable for future generations.

Thank you very much, Mr. Chairman.

[The prepared statement of William J. Scanlon follows:]

PREPARED STATEMENT OF DAVID M. WALKER, COMPTROLLER GENERAL OF THE UNITED STATES

Mr. Chairman and Members of the Subcommittee: I am pleased to be here today as you discuss options for increasing Medicare beneficiaries' access to prescription drugs. There are growing concerns about gaps in the Medicare program, most notably the lack of outpatient prescription drug coverage, which may leave Medicare's most vulnerable beneficiaries with high out-of-pocket costs that they may not be able to afford. In 1996, almost a third of Medicare beneficiaries lacked prescription drug coverage. The remaining two-thirds had at least some drug coverage through other sources—most commonly employer-sponsored health plans. Although the proportion of beneficiaries who had drug coverage rose between 1995 and 1996, recent evidence indicates that this trend of expanding drug coverage is unlikely to continue. Moreover, the burden of prescription drug costs falls most heavily on the Medicare beneficiaries who lack drug coverage or those who have substantial health care needs. In 1999, an estimated 20 percent of Medicare beneficiaries had drug costs of $1,500 or more—a substantial sum for those lacking some form of insurance to subsidize the purchase.

At the same time, however, long-term cost pressures facing the Medicare program are considerable. There appears to be an emerging consensus that substantive financing and programmatic reforms are necessary to put Medicare on a sustainable footing for the future. These fundamental program reforms are vital to reducing the program's growth, which threatens to absorb ever-increasing shares of the nation's budgetary and economic resources. Thus, proposals to help seniors with the costs of prescription drugs should be carefully crafted to avoid further erosion of the projected financial condition of the Medicare program, which, according to its trustees, is already unsustainable in its present form.

On the one hand, you must grapple with the hard choices involved in making the Medicare program sustainable for future generations. On the other, you are faced with the plight of many seniors who cannot afford the medical miracles that may be achieved through access to pharmaceutical advances. Expanding Medicare's benefit package could address the latter. However, a recent study suggests that such an expansion could add between 7.2 and 10 percent annually to Medicare's costs.[1]

[1] M.E. Gluck, *National Academy of Social Insurance Medicare Brief: A Medicare Prescription Drug Benefit* (April 1999), p. 8. http//www.nasi.org/Medicare.medbr1.htm (4/22/99).

Increased spending of that magnitude would only exacerbate the tough choices that will be required to put Medicare on sustainable footing for the future.

You are considering these issues at a historic crossroad. After nearly 30 years of deficits, the combination of hard choices and remarkable economic growth has led to a budget surplus. We appear—at least for the near future—to have slain the deficit dragon. In its most recent projections, the Congressional Budget Office (CBO) shows both unified and on-budget surpluses throughout the next 10 years. While this is good news and even superior to the projections made last year, it does not mean that hard choices are a thing of the past. First, it is important to recognize that by their very nature projections are uncertain. This is especially true today because, as CBO notes, it is too soon to tell whether recent boosts in revenue reflect a major structural change in the economy or a more temporary divergence from historical trends. Indeed, CBO points out that assuming a return to historical trends and slightly faster growth in Medicare would change the on-budget surplus to a growing deficit. This means we should treat surplus predictions with caution. Current projected surpluses could well prove to be fleeting, and thus appropriate caution should be exercised when creating new entitlements that establish permanent claims on future resources.

Moreover, while the size of future surpluses could exceed or fall short of projections, we know that demographic and cost trends will, in the absence of meaningful reform, drive Medicare spending to levels that will prove unsustainable for future generations of taxpayers. Accordingly, we need to view this period of projected prosperity as an opportunity to address the structural imbalances in Medicare, Social Security, and other entitlement programs before the approaching demographic tidal wave makes the imbalances more dramatic and possible solutions more painful.

As the foregoing suggests, the stakes associated with Medicare reform are high for the program itself and for the rest of the federal budget, both now and for future generations. Current policy decisions can help us prepare for the challenges of an aging society in several important ways: (1) reducing public debt to increase national savings and investment, (2) reforming entitlement programs to reduce future claims and free up resources for other competing priorities, and (3) establishing a more sustainable Medicare program that delivers effective and affordable health care to our seniors.

My remarks today will focus on Medicare beneficiaries' access to prescription drugs and the environment in which you consider increasing that access. Two proposals before you, one offered in the President's budget and the other contained in the Breaux-Frist bill,[2] would incorporate Medicare prescription drug coverage in the context of larger Medicare reform. Other proposals that focus only on increasing access to affordable prescription drugs are also being considered. These proposals would either subsidize prescription drug coverage or lower prices faced by beneficiaries without coverage. To put these proposals in context, I will discuss the factors contributing to the growth in prescription drug spending and efforts to control that growth. I will also discuss design and implementation issues to be considered regarding proposals to improve seniors' access to affordable prescription drugs. I then will repeat my message about the Medicare program's current financial condition and its long term sustainability.

But before I turn to the specifics, let me reiterate that although people want unfettered access to health care, and some have needs that are not being met, health care costs compete with other legitimate priorities in the federal budget, and their projected growth threatens to crowd out future generations' flexibility to decide which of these competing priorities will be met. Thus, in making important fiscal decisions for our nation, policymakers need to consider the fundamental differences between wants, needs, and what both individuals and our nation can afford. This concept applies to all major aspects of government, from major weapons system acquisitions to issues affecting domestic programs. It also points to the fiduciary and stewardship responsibility that we all share to ensure the sustainability of Medicare for current and future generations within a broader context of also providing for other important national needs and economic growth. We have an opportunity to use our unprecedented economic wealth and fiscal good fortune to address today's needs but an obligation to do so in a way that improves the prospects for future generations. This generation has a responsibility to future generations to reduce the debt burden they will inherit, to provide a strong foundation for future economic growth, and to ensure that future commitments are both adequate and affordable. Prudence requires making the tough choices today while the economy is healthy and the workforce is relatively large.

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[2] S. 1895, Medicare Preservation and Improvement Act of 1999.

RISING DRUG SPENDING ELEVATES BENEFICIARY ACCESS CONCERNS AND THE IMPORTANCE OF COST-CONTROL EFFORTS

Extensive research and development over the past 10 years have led to new prescription drug therapies and improvements over existing therapies that, in some instances, have replaced other health care interventions. For example, new medications for the treatment of ulcers have virtually eliminated the need for some surgical treatments. As a result of these innovations, the importance of prescription drugs as part of health care has grown. However, the new drug therapies have also contributed to a significant increase in drug spending as a component of health care costs. The Medicare benefit package, largely designed in 1965, provides virtually no coverage. In 1996, almost one third of beneficiaries had employer-sponsored health coverage, as retirees, that included drug benefits. More than 10 percent of beneficiaries received coverage through Medicaid or other public programs. To protect against drug costs, the remainder of Medicare beneficiaries can choose to enroll in a Medicare+Choice plan with drug coverage if one is available in their area or purchase a Medigap policy.[3] The availability, breadth, and price of such coverage is changing as the costs of expanded prescription drug use drives employers, insurers, and managed care plans to adopt new approaches to control the expenditures for this benefit. These approaches, in turn, are reshaping the drug market.

Rise in Prescription Drug Spending

Over the past 5 years, prescription drug expenditures have grown substantially, both in total and as a share of all health care outlays. Prescription drug spending grew an average of 12.4 percent per year from 1993 to 1998, compared with a 5 percent average annual growth rate for health care expenditures overall. (See table 1.) As a result, prescription drugs account for a larger share of total health care spending—rising from 5.6 percent to 7.9 percent in 1998.

Table 1: National Expenditures for Prescription Drugs, 1993-98

Year	Prescription drug expenditures (in billions)	Annual growth in prescription drug expenditures (percent)	Annual growth in all health care expenditures (percent)
1998	$90.6	15.4	5.6
1997	$78.5	14.0	4.7
1996	$68.9	12.9	4.6
1995	$61.0	10.6	4.8
1994	$55.2	9.0	5.5
1993	$50.6	8.7	7.4
Average annual growth between 1993 and 1998		12.4	5.0

Source: Health Care Financing Administration (HCFA), Office of the Actuary.

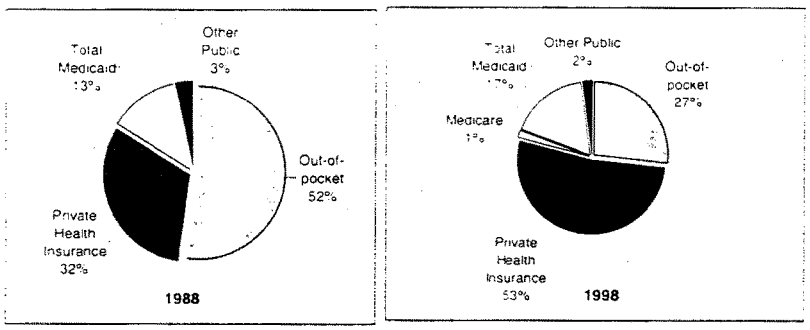
Total drug expenditures have been driven up by both greater utilization of drugs and the substitution of higher-priced new drugs for lower-priced existing drugs. Private insurance coverage for prescription drugs has likely contributed to the rise in spending, because insured consumers are shielded from the direct costs of prescription drugs. In the decade between 1988 and 1998, the share of prescription drug expenditures paid by private health insurers rose from almost a third to more than half. (See fig. 1.) The development of new, more expensive drug therapies—including new drugs that replace old drugs and new drugs that treat disease more effectively—also contributed to the drug spending growth by boosting the volume of drugs used as well as the average price for drugs used. The average number of new drugs entering the market each year rose from 24 at the beginning of the 1990s to 33 now. Similarly, biotechnology advances and a growing knowledge of the human immune system are significantly shaping the discovery, design, and production of drugs. Advertising pitched to consumers has also likely upped the use of prescription drugs. A recent study found that the 10 drugs most heavily advertised directly to consumers in 1998 accounted for about 22 percent of the total increase in drug spending between 1993 and 1998.[4] Between March 1998 and March 1999, industry

[3] As an alternative to traditional Medicare fee-for-service, beneficiaries in Medicare+Choice plans (formerly Medicare risk health maintenance organizations) obtain all their services through a managed care organization and Medicare makes a monthly capitation payment to the plan on their behalf.

[4] Barents Group LLC for the National Institute for Health Care Management Research and Educational Foundation, *Factors Affecting the Growth of Prescription Drug Expenditures* (July 9, 1999);, p. iii.

spending on advertising grew 16 percent to $1.5 billion. All of these factors suggest the need for effective cost control mechanisms to be in place under any option to increase access to prescription drugs.

Figure 1: Comparison of National Outpatient Drug Expenditures, 1988 and 1998



Note: Out-of-pocket expenditures include direct spending by consumers for prescription drugs, such as coinsurance, deductibles, and any amounts not covered by insurance. Out-of-pocket premiums paid by individuals are not counted here.
Source: HCFA, Office of the Actuary.

Note: Out-of-pocket expenditures include direct spending by consumers for prescription drugs, such as coinsurance, deductibles, and any amounts not covered by insurance. Out-of-pocket premiums paid by individuals are not counted here.
Source: HCFA, Office of the Actuary.

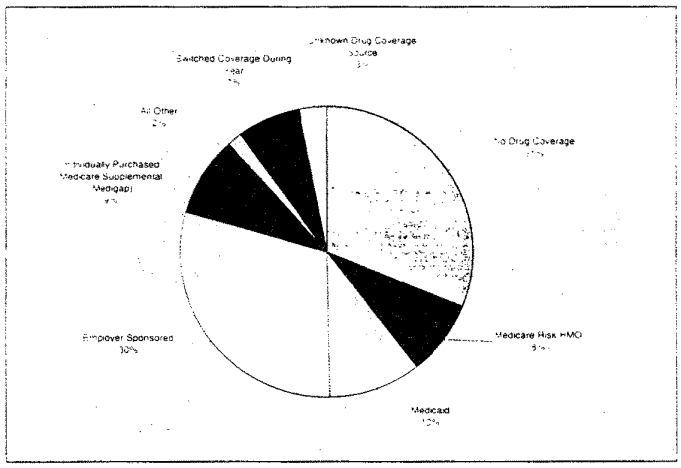
Current Medicare Beneficiary Drug Coverage

Prescription drugs are an important component of medical care for the elderly because of the prevalence of chronic and other health conditions associated with aging. In 1995, Medicare beneficiaries had an average of more than 18 prescriptions filled.[5] This varies substantially across beneficiaries, however, reflecting the range of their needs and also financial considerations such as third-party prescription drug coverage. In 1995, an elderly person's total average annual drug costs were $600[6] compared with a little more than $140 for a non-elderly persons.[7] For some, prescription drug spending was considerably higher—6 percent of Medicare beneficiaries spent $2,000 or more.[8] A recent report had projected that by 1999 an estimated 20 percent of Medicare beneficiaries would have total drug costs of $1,500 or more—a substantial sum for people lacking some form of insurance to subsidize their purchases or for those facing coverage limits. [9]

In 1996, almost a third of Medicare beneficiaries lacked drug coverage altogether. (See fig. 2.) The remaining two-thirds had at least some drug coverage—most commonly through employer-sponsored health plans. The proportion of beneficiaries who had drug coverage rose between 1995 and 1996, owing to increases in those with Medicare HMOs, individually purchased supplemental coverage, and employer-sponsored coverage. However, recent evidence indicates that this trend of expanding drug coverage is unlikely to continue.

[5] M. Davis and others, "Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries," *Health Affairs,* Vol. 18, No. 1 (Jan./Feb. 1999);, p. 237.
[6] M. Davis, p. 239.
[7] Agency for Health Care Policy and Research Center for Cost and Financing Studies, National Medical Expenditure Survey data, *Trends in Personal Health Care Expenditures, Health Insurance, and Payment Sources, Community-Based Population, 1987-1995* (Mar. 1997), p. 10. http://www.meps.ahcpr.gov/nmes/papers/trends/intnet4d.pdf (6/10/99).
[8] J.A. Poisal and others, "Prescription Drug Coverage and Spending for Medicare Beneficiaries," *Health Care Financing Review,* Vol. 20, No. 3 (Spring 1999), p. 20.
[9] M.E. Gluck, p. 2.

Figure 2: Sources of Drug Coverage for Medicare Beneficiaries, 1996



"All Other" includes coverage under non-risk Medicare HMOs, state-based plans, the Department of Defense, and the Department of Veterans Affairs.
Source: HCFA, based on the 1996 Medicare Current Beneficiary Survey.

"All Other" includes coverage under non-risk Medicare HMOs, state-based plans, the Department of Defense, and the Department of Veterans Affairs.
Source: HCFA, based on the 1996 Medicare Current Beneficiary Survey.

Although employer-sponsored health plans provide drug coverage to the largest segment of the Medicare population with coverage, there are signs that this could be eroding. Fewer employers are offering health benefits to retirees eligible for Medicare and those that continue to offer coverage are asking retirees to pay a larger share of costs. The proportion of employers offering health coverage to retirees eligible for Medicare declined from 40 percent in 1993 to 28 percent in 1999. This decline is at least in part due to the rise in the cost of providing this coverage, which grew about 21 percent from 1993 to 1999. At the same time, the proportion of employers asking retirees to pay the full cost of their health coverage increased from 36 percent to 40 percent.

In 1999, 13 percent of Medicare beneficiaries obtained prescription drug coverage through a Medicare+Choice plan, up from 8 percent in 1996. Medicare+Choice plans have found drug coverage to be an attractive benefit that beneficiaries seek out when choosing to enroll in managed care organizations. However, owing to rising drug expenditures and their effect on plan costs, the drug benefits the plans offer are becoming less generous. Many plans restructured drug benefits in 2000, increasing enrollees' out-of-pocket costs and limiting their total drug coverage.

Beneficiaries may purchase Medigap policies that provide drug coverage, although this tends to be expensive, involves significant cost-sharing, and includes annual limits. Standard Medigap drug policies include a $250 deductible, a 50 percent coinsurance requirement, and a $1,250 or $3,000 annual limit. Furthermore, Medigap premiums have been increasing in recent years. In 1999, the annual premium for one type of Medigap policy with a $1,250 annual limit on drug coverage, ranged from approximately $1,000 to $6,000.

All beneficiaries who have full Medicaid benefits [10] receive drug coverage that is subject to few limits and low cost-sharing requirements. For beneficiaries whose incomes are slightly higher than Medicaid standards, 14 states currently offer pharmacy assistance programs that provided drug coverage to approximately 750,000 beneficiaries in 1997. The three largest state programs accounted for 77 percent of all state pharmacy assistance program beneficiaries. [11] Most state pharmacy assistance programs, like Medicaid, have few coverage limitations.

The burden of prescription drug costs falls most heavily on the Medicare beneficiaries who lack drug coverage or who have substantial health care needs. Drug

[10] Certain low-income Medicare beneficiaries are dually eligible for Medicare and Medicaid.
[11] These programs are operated in New Jersey, New York, and Pennsylvania.

coverage is less prevalent among beneficiaries with lower incomes. In 1995, 38 percent of beneficiaries with income below $20,000 were without drug coverage, compared to 30 percent of beneficiaries with higher incomes. Additionally, the 1995 data show that drug coverage is slightly higher among those with poorer self-reported health status. At the same time, however, beneficiaries without drug coverage and in poor health had drug expenditures that were $400 lower than the expenditures of beneficiaries with drug coverage and in poor health. This might indicate access problems for this segment of the population.

Even for beneficiaries who have drug coverage, the extent of the protection it affords varies. The value of a beneficiary's drug benefit is affected by the benefit design, including cost-sharing requirements and benefit limitations. Evidence suggests that premiums are on the rise for employer-sponsored benefits, Medigap policies, and most recently, Medicare+Choice plans. Although reasonable cost sharing serves to make the consumer a more prudent purchaser, copayments, deductibles, and annual coverage limits can reduce the value of drug coverage to the beneficiary. Harder to measure is the effect on beneficiaries of drug benefit restrictions brought about through formularies designed to limit or influence the choice of drugs.

Cost-Control Approaches Are Reshaping the Pharmaceutical Market

During this period of rising prescription drug expenditures, third-party payers have pursued various approaches to control spending. These efforts have initiated a transformation of the pharmaceutical market. Whereas insured individuals formerly purchased drugs at retail prices at pharmacies and then sought reimbursement, now third-party payers influence which drug is purchased, how much is paid for it, and where it is purchased.

A common technique to manage pharmacy care and control costs is to use a formulary. A formulary is a list of prescription drugs, grouped by therapeutic class, that a health plan or insurer prefers and may encourage doctors to prescribe. Decisions about which drugs to include in a formulary are based on the drugs' medical value and price. The inclusion of a drug in a formulary and its cost can affect how frequently it is prescribed and purchased and, therefore, can affect its market share.

Formularies can be open, incentive-based, or closed. Open formularies are often referred to as "voluntary" because enrollees are not penalized if their physicians prescribe nonformulary drugs. Incentive-based formularies generally offer enrollees lower copayments for the preferred formulary or generic drugs. Incentive-based or managed formularies are becoming more popular because they combine flexibility and greater cost-control features than open formularies. A closed formulary limits insurance coverage to the formulary drugs and requires enrollees to pay the full cost of nonformulary drugs prescribed by their physicians.

Another way in which the market has been transformed is through the use of pharmacy benefit managers (PBM) by health plans and insurers to administer and manage prescription drug benefits. PBMs offer a range of services, including prescription claims processing, mail-service pharmacy, formulary development and management, pharmacy network development, generic substitution incentives, and drug utilization review. PBMs also negotiate discounts and rebates on prescription drugs with manufacturers.

EXPANDING ACCESS TO PRESCRIPTION DRUGS INVOLVES DIFFICULT DESIGN DECISIONS

Expanding access to more affordable prescription drugs could involve either subsidizing prescription drug coverage or allowing beneficiaries access to discounted pharmaceutical prices. The design of a drug coverage option, that is, the scope of the benefit, the covered population, and the mechanisms used to contain costs, as well as its implementation will determine the effect of the option on beneficiaries, Medicare or federal spending, and the pharmaceutical market. A new benefit would need to be crafted to balance competing concerns about the sustainability of Medicare, federal obligations, and the hardship faced by some beneficiaries. Similarly, the effect of granting some beneficiaries access to discounted prices will hinge on details such as the price of the drugs after the discount, how discounts are determined and secured, and which beneficiaries are eligible.

The relative merits of any approach should be carefully assessed. We suggest that the following five criteria be considered in evaluating any option. (1) Affordability: an option should be evaluated in terms of its effect on public outlays for the long term. (2) Equity: an option should provide equitable access across groups of beneficiaries and be fair to affected providers. (3) Adequacy: an option should provide appropriate beneficiary incentives for prudent utilization, support standard treatment options for beneficiaries, and not impede effective and clinically meaningful innovations. (4) Feasibility: an option should incorporate such administrative essentials as implementation and cost and quality monitoring techniques. (5) Acceptance:

an option should account for the need to educate the beneficiary and provider communities about its costs and the realities of trade-offs required by significant policy changes.

Adding a Medicare Benefit

Expanding Medicare coverage to include prescription drugs would entail numerous benefit design decisions that would affect the cost of this expansion as well as its acceptability. A basic design decision concerns whether financial assistance provided for the benefit would be targeted to those with the greatest need—owing to a lack of existing drug coverage, high drug expenditures, or poverty—or whether the public financial subsidies would be available to all beneficiaries. The President's proposal extends coverage to all beneficiaries, with greater government subsidies for the poor. The Breaux-Frist Medicare reform proposal incorporates optional drug coverage, which is subsidized fully for the poor and partially for others. The generosity of the benefit—the extent of beneficiary copayments, coverage limits, and catastrophic protections—will also be a major factor in assessing the impact of this benefit on the Medicare program. The President's benefit design incorporates 50 percent beneficiary copayments; an annual benefit limit; and a cap on catastrophic drug costs, which is yet to be designed. Under the Breaux-Frist approach, competing health plans could design their own copayment structure, with requirements on the benefit's actuarial value but no provision to limit beneficiary catastrophic drug costs.

Benefit cost-control provisions for the traditional Medicare program may present some of the thorniest drug benefit design decisions. Recent experience provides two general approaches. One would involve the Medicare program obtaining price discounts from manufacturers. Such an arrangement could be modeled after Medicaid's drug rebate program. While the discounts in aggregate would likely be substantial, this approach lacks the flexibility to achieve the greatest control over spending. It could not effectively influence or steer utilization because it does not include incentives that would encourage beneficiaries to make cost-conscious decisions. The second approach would draw from private sector experience in negotiating price discounts from manufacturers in exchange for shifting market share. Some plans and insurers employ PBMs to manage their drug benefits, including claims processing, negotiating with manufacturers, establishing lists of drug products that are preferred because of efficacy or price, and developing beneficiary incentive approaches to control spending and use. Applying these techniques to the entire Medicare program, however, would be difficult because of its size, the need for transparency in its actions, and the imperative for equity for its beneficiaries.

Medicaid Programs Rely on Rebates and Have Limited Utilization Controls

As the largest government payer for prescription drugs, Medicaid drug expenditures account for about 17 percent of the domestic pharmaceutical market. Before the enactment of the Medicaid drug rebate program under the Omnibus Budget Reconciliation Act of 1990 (OBRA), state Medicaid programs paid close to retail prices for outpatient drugs. Other large purchasers, such as HMOs and hospitals, negotiated discounts with manufacturers and paid considerably less.

The rebate program required drug manufacturers to rebate to state Medicaid programs a percentage off of the average price wholesalers pay manufacturers. The rebates were based on a percentage reduction that reflects the lowest or "best" prices the manufacturer charged other purchasers and the volume of purchases by Medicaid recipients. In return for the rebates, state Medicaid programs must cover all drugs manufactured by pharmaceutical companies that entered into rebate agreements with HCFA.[12]

After the rebate program's enactment, a number of market changes affected other purchasers of prescription drugs and the amount of the rebates that Medicaid programs received. Drug manufacturers substantially reduced the price discounts they offered to many large private purchasers, such as HMOs. Therefore, the market quickly adjusted by increasing drug prices to compensate for rebates obtained by the Medicaid program.

Although the states have received billions of dollars in rebates from drug manufacturers since OBRA's enactment, state Medicaid directors have expressed concerns about the rebate program. The principal concern involves OBRA's requirement to provide access to all the drugs of every manufacturer that offers rebates, which limits the utilization controls Medicaid programs can use at a time when prescription drug expenditures are rapidly increasing. Although the programs can require recipients to obtain prior authorization for particular drugs and can impose monthly limits on the number of covered prescriptions, they cannot take advantage of other

[12] OBRA 1990 allowed the states to exclude certain classes of drugs.

techniques, such as incentive-based formularies, to steer recipients to less expensive drugs. The few cost-control strategies available to state Medicaid programs can add to the administrative burden on state Medicaid programs.

Other Payers Employ Various Techniques to Control Expenditures

Other payers, such as private and federal employer health plans and Medicare+Choice plans, have taken a different approach to managing their prescription drug benefits. They typically use beneficiary copayments to control prescription drug use, and they use formularies to both control use and obtain better prices by concentrating purchases on selected drugs. In many cases, these plans and insurers retain a PBM's services to manage their pharmacy benefit and control spending.

Beneficiary cost-sharing plays a central role in attempting to influence drug utilization. Copayments are frequently structured to influence both the choice of drugs and the purchasing arrangements. While formulary restrictions can channel purchases to preferred drugs, closed formularies, which provide reimbursement only for preferred drugs, have generated substantial dissatisfaction among consumers. As a result, many plans link their cost-sharing requirements and formulary lists. The fastest growing trend today is the use of a formulary that covers all drugs but that includes beneficiary cost-sharing that varies for different drugs—typically a smaller copayment for generic drugs, a larger one for preferred drugs, and an even larger one for all other drugs. Reduced copayments have also been used to encourage enrollees using maintenance drugs for chronic conditions to obtain them from particular suppliers, like a mail-order pharmacy.

Plans and insurers have turned to PBMs for assistance in establishing formularies, negotiating prices with manufacturers and pharmacies, processing beneficiaries' claims, and reviewing drug utilization. Because PBMs manage drug benefits for multiple purchasers, they often may have more leverage than individual plans in negotiating prices through their greater purchasing power.

Traditional fee-for-service Medicare has generally established reimbursement rates for services like those provided by physicians and hospitals and then processed and paid claims with few utilization controls. Adopting some of the techniques used by private plans and insurers might help better control costs. However, how to adapt those techniques to the characteristics and size of the Medicare program raises questions.

Negotiated or competitively determined prices would be superior to administered prices only if Medicare could employ some of the utilization controls that come from having a formulary and differential beneficiary cost-sharing. In this manner, Medicare would be able to negotiate significantly discounted prices by promising to deliver a larger market share for a manufacturer's product. Manufacturers would have no incentive to offer a deep discount if all drugs in a therapeutic class were covered on the same terms. Without a promised share of the Medicare market, these manufacturers might reap greater returns from charging higher prices and by concentrating marketing efforts on physicians and consumers to influence prescribing patterns.

Implementing a formulary and other utilization controls could prove difficult for Medicare. Developing a formulary involves determining which drugs are therapeutically equivalent so that several from each class can be included. Plans and PBMs currently make those determinations privately—something that would not be possible for Medicare, which must have transparent policies that are determined openly. Given the stakes involved in selecting drugs, one can imagine the intensive efforts to offer input to and scrutinize the selection process.

Medicare may also find it impossible to delegate this task to one or multiple PBMs. A single PBM contractor would likely be subject to the same level of scrutiny as the program. Such scrutiny could compromise the flexibility PBMs have used to generate savings. An alternative would be to grant flexibility to multiple PBMs that are each responsible only for a share of the market. Contracting with multiple PBMs, though, raises other issues. If each PBM has exclusive responsibility for a geographic area, beneficiaries who need certain drugs could be advantaged or disadvantaged merely because of where they live. If multiple PBMs operated in each area, beneficiaries could choose one to administer their drug benefit. This raises questions about how to inform beneficiaries of the differences in each PBM's policies and whether and how to risk-adjust payments to PBMs for differences in the health status of the beneficiaries using them.

Extending Federal Price Discounts to Beneficiaries

Another option before the Congress would allow Medicare beneficiaries to purchase prescription drugs at the lowest price paid by the federal government. Because of their large purchasing power, federal agencies, such as, the Departments

of Veterans Affairs (VA) and Defense (DOD), have access to prescription drug prices that often are considerably lower than retail prices. Extending these discounts to Medicare beneficiaries, or some groups of beneficiaries, could have a measurable effect on lowering their out-of-pocket spending, although whether this would adequately increase access or raise prices paid by other purchasers that negotiate drug discounts is unknown.

Typically, federal agencies obtain prescription drugs at prices listed in the federal supply schedule (FSS) for pharmaceuticals.[13] FSS prices represent a significant discount off the prices drug manufacturers charge wholesalers.[14] Under the Veterans Health Care Act of 1992, drug manufacturers must make their brand-named drugs available to federal agencies at the FSS price in order to participate in the Medicaid program.[15] The act requires that the FSS price for VA, DOD, the Public Health Service, and the Coast Guard be at least 24 percent below the price that the manufacturers charge wholesalers.[16]

Although most federal prescription drug purchases are made at FSS prices, in some cases, federal agencies are able to purchase drugs at even lower prices. For example, VA has used national contracts awarded on a competitive basis for specific drugs considered therapeutically interchangeable. These contracts enable VA to obtain larger discounts from manufacturers by channeling greater volume to certain pharmaceutical products.

Providing Medicare beneficiaries access to the lowest federal prices could result in important out-of-pocket savings to those without coverage who are paying close to retail prices. However, concerns exist that extending federal discounts to Medicare beneficiaries could lead to price increases to federal agencies and other purchasers since the discount is based on prices determined by manufacturers. Federal efforts to lower Medicaid drug prices demonstrate the potential for this to occur. While it is not possible to predict how federal drug prices would change if Medicare beneficiaries are given access to them, the larger the market that seeks to take advantage of these prices, the greater the economic incentive would be for drug manufacturers to raise federal prices to limit the impact of giving lower prices to more purchasers.

EXPANDING BENEFITS NEEDS TO BE CONSIDERED IN LIGHT OF LARGER MEDICARE FISCAL CONCERNS

The current Medicare program, without improvements, is ill suited to serve future generations of seniors and eligible disabled Americans. On the one hand, the program is fiscally unsustainable in its present form, as the disparity between program expenditures and program revenues is expected to widen dramatically in the coming years. On the other hand, Medicare's benefit package contains gaps in desired coverage, most notably the lack of outpatient prescription drug coverage, compared with private employer coverage. Any option to modernize the benefits runs the risk of exacerbating the fiscal imbalance of the programs. That is why we believe that expansions should be made in the context of overall program reforms that are designed to make the program more sustainable over the long term. Any discussions about expanding beneficiary access to prescription drugs should carefully consider targeting financial help to those most in need and minimizing the substitution of public funds for private funds. Employers that offer drug coverage through a retiree health plan may choose to adapt their health coverage if a Medicare drug benefit is available. A key characteristic of America's voluntary, employer-based system of health insurance is an employer's freedom to modify the conditions of coverage or to terminate benefits.

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[13] The FSS for pharmaceuticals is a price catalog currently containing over 17,000 pharmaceutical products available to federal agencies.

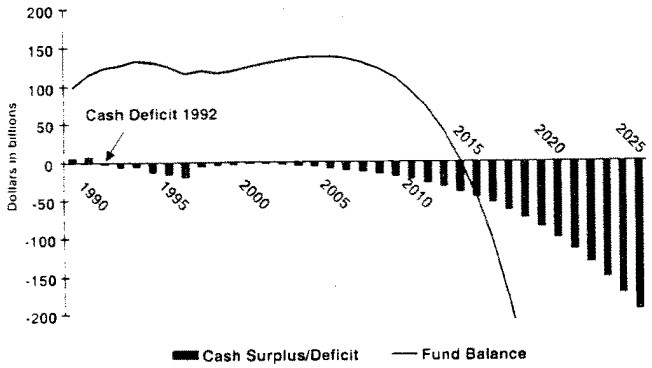
[14] FSS prices are set through negotiations between VA, on behalf of the government, and drug manufacturers and are based on the prices that manufacturers offer their most favored nonfederal customers.

[15] The act covers single-source drugs, innovator multiple-source drugs, insulin, and biological products such as vaccines and antitoxins. The act does not cover noninnovator multiple-source or generic drugs.

[16] The act requires that manufacturers sell drugs covered by the act at no more that 76 percent of the nonfederal average manufacturer's price, a level referred to as the federal ceiling price. The nonfederal average manufacturer's price is the weighted average price of each single form and dosage unit of a drug that is paid by wholesalers in the United States to a manufacturer, taking into account any cash discounts or similar price reductiions. Prices paid by the federal government are excluded from this calculation.

Medicare's Financial Condition

Unlike private trust funds that can set aside money for the future by investing in financial assets, the Medicare Hospital Insurance (HI) Trust Fund—which pays for inpatient hospital stays, skilled nursing care, hospice, and certain home health services—is essentially an accounting device. It allows the government to track the extent to which earmarked payroll taxes cover Medicare's HI outlays. In serving the tracking purpose, the 1999 Trustees' annual report showed that Medicare's HI component has been, on a cash basis, in the red since 1992, and in fiscal year 1998, earmarked payroll taxes covered only 89 percent of HI spending. In the Trustees' report, issued in March 1999, projected continued cash deficits for the HI trust fund. (See fig. 3.)

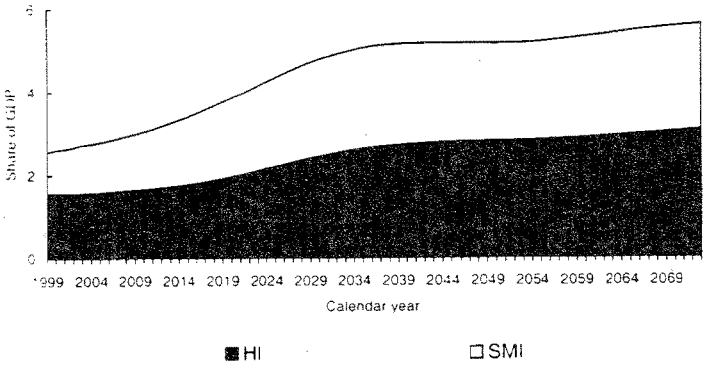


Source: *1999 Annual Report*, Board of Trustees of the Federal Hospital Insurance Trust Fund.

When the program has a cash deficit, as it did from 1992 through 1998, Medicare is a net claimant on the Treasury—a threshold that Social Security is not currently expected to reach until 2014. To finance these cash deficits, Medicare drew on its special issue Treasury securities acquired during the years when the program generates a cash surplus. In essence, for Medicare to "redeem" its securities, the government must raise taxes, cut spending for other programs, or reduce the projected surplus. Outlays for Medicare services covered under Supplementary Medical Insurance (SMI)--physician and outpatient hospital services, diagnostic tests, and certain other medical services and supplies--are already funded largely through general revenues.

Although the Office of Management and Budget (OMB) has recently reported a $12 billion cash surplus for the HI program in fiscal year 1999 due to lower than expected program outlays, the long-term financial outlook for Medicare is expected to deteriorate. Medicare's rolls are expanding and are projected to increase rapidly with the retirement of the baby boomers. Today's elderly make up about 13 percent of the total population; by 2030, they will comprise 20 percent as the baby boom generation ages and the ratio of workers to retirees declines from 3.4 to 1 today to roughly 2 to 1.

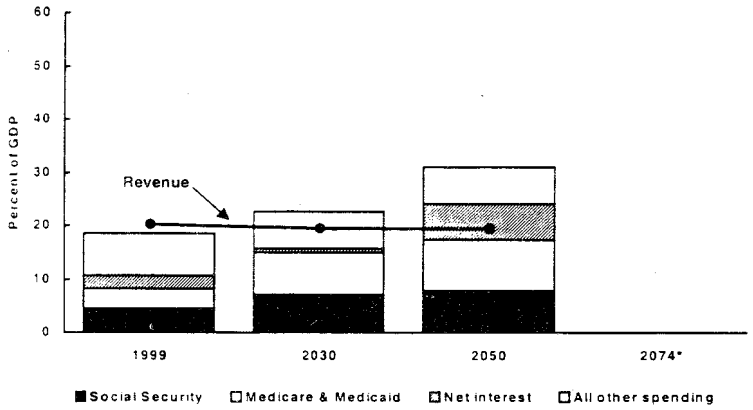
Without meaningful reform, the long-term financial outlook for Medicare is bleak. Together, Medicare's HI and SMI expenditures are expected to increase dramatically, rising from about 12 percent in 1999 to about a quarter of all federal revenues by mid-century. Over the same time frame, Medicare's expenditures are expected to double as a share of the economy, from 2.5 to 5.3 percent, as shown in figure 4.



Source: *1999 Annual Report*, Board of Trustees of the Federal Hospital Insurance Trust Fund and *1999 Annual Report*, Federal Supplementary Insurance Trust Fund.

The progressive absorption of a greater share of the nation's resources for health care, like Social Security, is in part a reflection of the rising share of elderly population, but Medicare growth rates also reflect the escalation of health care costs at rates well exceeding general rates of inflation. Increases in the number and quality of health care services have been fueled by the explosive growth of medical technology. Moreover, the actual costs of health care consumption are not transparent. Third-party payers generally insulate consumers from the cost of health care decisions. In traditional Medicare, for example, the impact of the cost-sharing provisions designed to curb the use of services is muted because about 80 percent of beneficiaries have some form of supplemental health care coverage (such as Medigap insurance) that pays these costs. For these reasons, among others, Medicare represents a much greater and more complex fiscal challenge than even Social Security over the longer term.

When viewed from the perspective of the entire budget and the economy, the growth in Medicare spending will become progressively unsustainable over the longer term. Our updated budget simulations show that to move into the future without making changes in the Social Security, Medicare, and Medicaid programs is to envision a very different role for the federal government. Assuming, for example, that the Congress and the President adhere to the often-stated goal of saving the Social Security surpluses, our long-term model shows a world by 2030 in which Social Security, Medicare, and Medicaid increasingly absorb available revenues within the federal budget. Under this scenario, these programs would absorb more than three-quarters of total federal revenue. (See fig. 5.) Budgetary flexibility would be drastically constrained and little room would be left for programs for national defense, the young, infrastructure, and law enforcement.



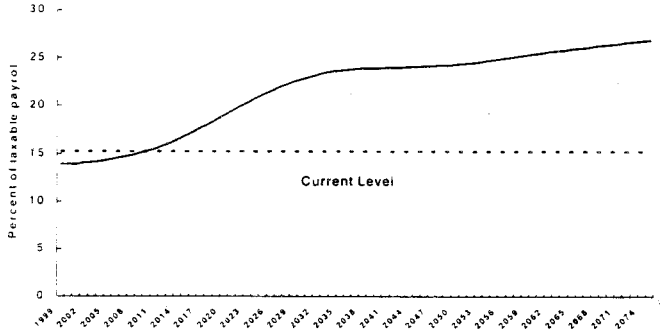
*The "eliminate non-Social Security surpluses" simulation can only be run through 2066 due to the elimination of the capital stock.

Notes:

1. Revenue as a share of GDP during the simulation period is lower than the 1999 level due to unspecified permanent policy actions that reduce revenue and increase spending to eliminate the non-Social Security surpluses.

2. Medicare expenditure projections follow the Trustees' 1999 intermediate assumptions. The projections reflect the current benefit and financing structure.

Source: GAO's January 2000 analysis.



Source: *1999 Annual Report*, Board of Trustees of the Federal Hospital Insurance Trust Fund, and *1999 Annual Report*, Board of Trustees of the Federal Old Age and Survivors Disability Insurance Trust Funds.

While the problems facing the Social Security program are significant, Medicare's challenges are even more daunting. To close Social Security's deficit today would require a 17 percent increase in the payroll tax, whereas the HI payroll tax would have to be raised 50 percent to restore actuarial balance to the HI trust fund. This

analysis, moreover, does not incorporate the financing challenges associated with the SMI and Medicaid programs.

Early action to address the structural imbalances in Medicare is critical. First, ample time is required to phase in the reforms needed to put this program on a more sustainable footing before the baby boomers retire. Second, timely action to bring costs down pays large fiscal dividends for the program and the budget. The high projected growth of Medicare in the coming years means that the earlier the reform begins, the greater the savings will be as a result of the effects of compounding.

The actions necessary to bring about a more sustainable program will no doubt call for some hard choices. Some suggest that the size of the imbalances between Medicare's outlays and payroll tax revenues for the HI program may well justify the need for additional resources. One possible source could be general revenues. Although this may eventually prove necessary, such additional financing should be considered as part of a broader initiative to ensure the program's long-range financial integrity and sustainability.

What concerns us most is that devoting general funds to the HI trust fund may be used to extend HI's solvency without addressing the hard choices needed to make the whole Medicare program more sustainable in economic or budgetary terms. Increasing the HI trust fund balance alone, without underlying program reform, does nothing to make the Medicare program more sustainable—that is, it does not reduce the program's projected share of GDP or the federal budget. From a macroeconomic perspective, the critical question is not how much a trust fund has in assets but whether the government as a whole has the economic capacity to finance all Medicare's promised benefits—both now and in the future. We must keep in mind the unprecedented challenge facing future generations in our aging society. Relieving them of some of the financial burden of today's commitments would help preserve some budgetary flexibility for future generations to make their own choices.

If more fundamental program reforms are not made, we fear that general fund infusions would interfere with the vital signaling function that trust fund mechanisms can have for policymakers about underlying fiscal imbalances in covered programs. The greatest risk is that dedicating general funds to the HI program will reduce the sense of urgency that impending trust fund bankruptcy provides to policymakers by artificially extending the solvency of the HI program. Furthermore, increasing the trust fund's paper solvency does not address cost growth in the SMI portion of Medicare, which is projected to grow even faster than HI in coming decades, assuming no additional SMI benefits.

The issue of the extent to which general funds are an appropriate financing mechanism for the Medicare program would remain important under financing arrangements that differed from those in place in the current HI and SMI structures. For example, under approaches that would combine the two trust funds, a continued need would exist for measures of program sustainability that would signal potential future fiscal imbalance. Such measures might include the percentage of program funding provided by general revenues, the percentage of total federal revenues or gross domestic product devoted to Medicare, or program spending per enrollee. As such measures were developed, questions would need to be asked about the appropriate level of general revenue funding. Regardless of the measure chosen, the real question would be what actions should be taken when and if the chosen cap is reached.

Long-Term Fiscal Policy Choices

Beyond reforming the Medicare program itself, maintaining an overall sustainable fiscal policy and strong economy is vital to enhancing our nation's future capacity to afford paying benefits in the face of an aging society. Decisions on how we use today's surpluses can have wide-ranging impacts on our ability to afford tomorrow's commitments.

As we know, there have been a variety of proposals to use the surpluses for purposes other than debt reduction. Although these proposals have various pros and cons, we need to be mindful of the risk associated with using projected surpluses to finance permanent future claims on the budget, whether they are on the spending or the tax side. Commitments often prove to be permanent, while projected surpluses can be fleeting. For instance, current projections assume full compliance with tight discretionary spending caps. Moreover, relatively small changes in economic assumptions can lead to very large changes in the fiscal outlook, especially when carried out over a decade. In its January 2000 report,[17] CBO compared the actual deficits or surpluses for 1986 through 1999 with the first projection it had produced

[17] *The Economic and Budget Outlook: Fiscal Years 2001-2010* (CBO, Jan. 2000).

5 years before the start of each fiscal year. Excluding the estimated impact of legislation, CBO stated that its errors in projecting the federal surplus or deficit averaged about 2.4 percent of GDP in the fifth year beyond the current year. For example, such a shift in 2005 would mean a potential swing of about $285 billion in the projected surplus for that year.

Although most would not argue for devoting 100 percent of the surplus to debt reduction over the next 10 years, saving a good portion of our surpluses would yield fiscal and economic dividends as the nation faces the challenges of financing an aging society. Our work on the long-term budget outlook illustrates the benefits of maintaining surpluses for debt reduction. Reducing the publicly held debt reduces interest costs, freeing up budgetary resources for other programmatic priorities. For the economy, running surpluses and reducing debt increase national saving and free up resources for private investment. These results, in turn, lead to stronger economic growth and higher incomes over the long term.

Over the last several years, our simulations illustrate the long-term economic consequences flowing from different fiscal policy paths.[18] Our models consistently show that saving all or a major share of projected budget surpluses ultimately leads to demonstrable gains in GDP per capita. Over a 50-year period, GDP per capita is estimated to more than double from present levels by saving all or most of projected surpluses, while incomes would eventually fall if we failed to sustain any of the surplus. Although rising productivity and living standards are always important, they are especially critical for the 21st century, for they will increase the economic capacity of the projected smaller workforce to finance future government programs along with the obligations and commitments for the baby boomers' retirement.

CONCLUDING OBSERVATIONS

Updating the Medicare benefit package may be a necessary part of any realistic reform program to address the legitimate expectations of an aging society for health care, both now and in the future. Expanding access to prescription drugs could ease the significant financial burden some Medicare beneficiaries face because of outpatient drug costs. Such changes, however, need to be considered as part of a broader initiative to address Medicare's current fiscal imbalance and promote the program's longer-term sustainability. Balancing these competing concerns may require the best from government-run programs and private sector efforts to modernize Medicare for the future. Further, the Congress should consider adequate fiscal incentives to control costs and a targeting strategy in connection with any proposal to provide new benefits such as prescription drugs.

The Congress and the President may ultimately decide to include some form of prescription drug coverage as part of Medicare. Given this expectation and the future projected growth of the program, some additional revenue sources may in fact be a necessary component of Medicare reform. However, it is essential that we not take our eye off the ball. The most critical issue facing Medicare is the need to ensure the program's long range financial integrity and sustainability. The 1999 annual reports of the Medicare Trustees project that program costs will continue to grow faster than the rest of the economy. Care must be taken to ensure that any potential expansion of the program be balanced with other programmatic reforms so that we do not worsen Medicare's existing financial imbalances.

Current budget surpluses represent both an opportunity and an obligation. We have an opportunity to use our unprecedented economic wealth and fiscal good fortune to address today's needs but an obligation to do so in a way that improves the prospects for future generations. This generation has a stewardship responsibility to future generations to reduce the debt burden they will inherit, to provide a strong foundation for future economic growth, and to ensure that future commitments are both adequate and affordable. Prudence requires making the tough choices today while the economy is healthy and the workforce is relatively large. National saving pays future dividends over the long term, but only if meaningful reform begins soon. Entitlement reform is best done with considerable lead-time to phase in changes and before the changes that are needed become dramatic and disruptive. The prudent use of the nation's current and projected budget surpluses combined with meaningful Medicare and Social Security program reforms can help achieve both of these goals.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other Subcommittee Members may have.

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[18] *See Budget Issues: Long-Term Fiscal Outlook* (GAO/T-AIMD/OCE-98-83, Feb. 25, 1998) and *Budget Issues: Analysis of Long-Term Fiscal Outlook* (GAO/AIMD/OCE-98-19, Oct. 22, 1997).

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Mr. BILIRAKIS. Thank you, Dr. Scanlon. Thanks to all of you.

Well, Ms. Washington, as you know, I have introduced legislation to establish a protection for beneficiaries who have high annual drug costs, the sickest. Even though we are talking about it being outside of the scope of the Medicare program, at this point in time it would include all Medicare beneficiaries who qualify, so it does hit this universal coverage idea, by the way, which has been mentioned in the past.

The President's budget proposed to set aside $35 billion for that purpose. And maybe this is a little premature, and if it is, certainly I won't press you, but can you elaborate on the administration's specific plans in that regard?

Ms. WASHINGTON. Yes, sir. As you said, we agree that protecting beneficiaries with high out-of-pocket costs is important, and it was one of the areas that we wanted to improve on in the proposal that we submitted last year. We don't have a specific benefit design. We want to work with the Congress to come up with a benefit design that could be affordable for the program and the beneficiaries, to protect them from some of these high out-of-pocket costs. We think that the $35 billion that we set aside will be enough to craft a benefit that offers significant protection. But other than that, we want to work with you on the details.

Mr. BILIRAKIS. Other than that, you have nothing.

Dr. Hoadley, do you have anything to add to that?

Mr. HOADLEY. No.

Mr. BILIRAKIS. Dr. Scanlon, add anything to it?

Mr. SCANLON. Mr. Chairman, we believe very strongly that catastrophic protection is one of the important things to think about——

Mr. BILIRAKIS. We don't use that word. We don't use "catastrophic."

Mr. SCANLON. Sorry. Stop-loss protection. But I would also point out that stop-loss protection for Medicare in general is also an important thing to think about, because of the two glaring omissions from the Medicare benefit package that was enacted in 1965. Outpatient prescription drugs may be one, and beneficiaries' cost-sharing liability, which can be quite high, is the other.

Mr. BILIRAKIS. Well, thanks. Some have suggested that enactment of targeted prescription drug assistance, not just in our plan but any targeted prescription drug assistance, would undermine broader reform to preserve Medicare for the future. You know, a similar "all or nothing" argument was advanced during the debate on health care reform in 1994, and then the end result was what? Well, it was that Americans in need of health insurance were forced to wait 2 years for enactment of legislation to provide portability of insurance and coverage for preexisting conditions.

We must not repeat that mistake, and this is why I feel so very strongly about it. Now, you know, we have seen the charts here,

we have talked about it previously. We all know that Medicare faces a severe financial crisis. The impending bankruptcy of the program, I would think, would be sufficient incentive to make sure that regardless of whether we advance some sort of targeted prescription drug assistance, that it is not going to take away from the need to reform Medicare consistent with all of the discussions that have taken place.

I would like to ask all of you to comment regarding that. You know, I represent such a strong senior citizen area. I am a big supporter of Medicare. And under perfect circumstances, whatever the coverage might be should be universal to all Medicare beneficiaries, but we don't have perfect circumstances. We face the bankruptcy of a program that we have to take into consideration as far as spending is concerned.

You know, I just have trouble quite understanding this business of "all or nothing" when in fact there are people out there who are hurting right now who can be helped in the meantime, until we can get to the point of reforming the system, which is going to take a while, and in this political year many people feel that we are probably not going to be able to get around to it. I hope that they are wrong.

So, Ms. Washington, again it is a policy issue, and I don't know whether it is something you want to address.

Ms. WASHINGTON. Well, I think that we agree. The President agrees that the problem really has two parts. It is modernizing the benefit package with prescription drugs, and it is ensuring that the solvency of the program continues in the long run. And the President, as you know, has proposed a plan that addresses both circumstances.

I think there are particular problems for prescription drugs for the low-income, but I believe we could work together to enact a universal drug benefit this year. As you know, over half of the beneficiaries who don't have coverage do have incomes over $150,000, and I think that part of the success of Medicare is the fact that it is available to everyone. So I think you can work together to design——

Mr. BILIRAKIS. About half of those who don't have—forgive me for interrupting—who don't have coverage have incomes of over $150,000?

Ms. WASHINGTON. Sorry. I misspoke. 150 percent of poverty, which is about $17,000 for a couple. I got 150 and then I got sidetracked.

Mr. BILIRAKIS. You had the figure right, at least, right?

Ms. WASHINGTON. But I think we can work together to do a universal benefit this year, affordable to both the beneficiaries and the program.

Mr. BILIRAKIS. Don't we wish that were truly the case, though?

Dr. Scanlon, my time has expired, but if you have anything——

Mr. SCANLON. But Chairman, I am afraid I can't offer you much advice on this decision. I think as the role of the analyst, what we can do is provide you the elements of the bigger picture. And I recognize that sometimes incremental approaches are easier to accomplish in the short term, but keeping the focus on the bigger picture and knowing how the incremental strategy will build to be able to

deal with that broader question I think is very important. There is no debate that resources are a portion of this question, and it is your decision as to how those can be used best.

Mr. BILIRAKIS. Well, thank you for all the help that we always get from GAO.

Mr. Waxman?

Mr. WAXMAN. Thank you very much, Mr. Chairman.

Ms. Washington, just so we understand how severe this problem is of prescription drugs for the elderly, as I understand it, only about half the beneficiaries have coverage throughout the year. Is that an accurate statement?

Ms. WASHINGTON. That is right.

Mr. WAXMAN. And that coverage is not dependable. Employers are cutting back. Managed care plans are cutting back if not eliminating drug coverage. And then the Medigap policies are very, very costly. Some people just can't afford a Medigap policy.

Ms. WASHINGTON. Right. That is true.

Mr. WAXMAN. Since the administration testified last year on this issue in September, I believe you have gotten some new information about what is happening in managed care plans with respect to the drug coverage they offer. Are managed care drug benefits expanding or shrinking?

Ms. WASHINGTON. Unfortunately, Congressman Waxman, managed care drug benefits are shrinking. This year, 70 percent of the plans are capping their drug benefit at or below $1,000 for the year, and of those, one-third of total plans cap benefits at $500 or lower. This last figure has increased by 50 percent from the previous year, 1999.

Mr. WAXMAN. So we have large numbers of seniors without prescription drug coverage or with undependable coverage. It seems to me that we are in the same situation with regard to drug coverage that we were in 1965 with respect to hospitalization coverage, which drove government to enact the Medicare program, primarily to cover hospital care because seniors just couldn't afford it and didn't have it available to them. Is that an accurate statement?

Ms. WASHINGTON. That is right, sir. Approximately 50 percent of people in 1963 had access to hospital insurance, and that is about where we are with Medicare drug coverage today.

Mr. WAXMAN. Now, Dr. Scanlon, in 1963, 1964 and then 1965, the Congress could have said there is a bigger picture, and therefore we shouldn't solve this problem until we deal with the bigger picture. That could have kept the Congress from doing anything, couldn't it? That is just sort of a rhetorical question.

Mr. SCANLON. I can't give you the details. I know. I can't give you the details of the bigger picture then, but I think that our picture now is quite different than it was in 1965. Medicare has absorbed a much larger share of our economy than it did in 1965, and I think that in 1965 we would have certainly included drug coverage if we had recognized the role that drugs were going to play in medical care.

But the reality was that medical care was so different then, and that was in part how we approached Medicare. I think over time we have refined Medicare dramatically to reflect the fact that med-

ical science and the delivery of medical care has changed quite a bit.

Mr. WAXMAN. You would think, then, an insurance program for seniors in this country ought to have prescription drugs?

Mr. SCANLON. If we were designing an insurance program today, it should have prescription drug coverage. Virtually the entire elderly population uses some drugs. Those that are going to end up with catastrophically high drug costs are a smaller segment and you don't necessarily have the ability to plan for that or have the ability to save for that. That's why having insurance is an extremely positive benefit for beneficiaries.

Mr. WAXMAN. We could have taken that approach with Medicare in 1965 and said, well, just cover catastrophic costs for hospitalization and doctor expenses, and let people figure if they can come up with the money before they get that coverage triggered in, couldn't we?

Mr. SCANLON. I am not saying that we should have only a catastrophic drug benefit. I think because of catastrophic costs, a drug benefit is extremely important. Having a drug benefit that begins at a lower level is also important to prevent the exacerbation of conditions, so that you do not incur other kinds of higher expenses. I think it is also important, though, that there be a sharing of the burden of this benefit.

Mr. WAXMAN. Well, we want to share the burden, so we want to get as many people covered as possible in any kind of voluntary prescription drug government program, wouldn't we? You would agree that if we are going to do it, we should do it for all Medicare beneficiaries, not just the 150 percent of poverty level?

Mr. SCANLON. I think that the decision as to whether you do it for all Medicare beneficiaries is one that you have to base on resources, and this use versus other uses of those resources, and that I think is a decision we can't make at GAO for you.

Mr. WAXMAN. I have seen articles with headlines that say "GAO Says Don't Provide A Prescription Drug Coverage Under Medicare Until All Of Medicare Is Modernized." Is that a recommendation or just a reporter's interpretation of what your statements have been?

Mr. SCANLON. I think those are reporters' interpretations out of context, because the GAO position has been that we should think about modernizing the Medicare program in its totality. Prescription drug coverage is one aspect of it. Stop-loss coverage is another. Making the purchases of all services more efficient is a third. And I think those are the major principles of GAO's position on this.

Mr. WAXMAN. So we have lots of tradeoffs, but ultimately it is up to the elected officials to make the public policy calls. We are not going to solve all the world's problems at once, so we have to decide what is the most severe one facing us, and the most severe one facing the elderly in this country, I believe, is the lack of coverage, not the crisis that may be in 2014 or 2030. That is my opinion.

Mr. GREENWOOD [presiding]. I think the gentleman's time has expired. The Chair recognizes himself for 5 minutes.

Ms. Washington, in his State of the Union address, the President recognized a senior citizen in the gallery whose name was Pat Brown and cited him as an example, and noted that he had an an-

nual prescription drug cost of $4,200 and he had no drug coverage. Could you, in order to illustrate the President's proposal, tell us how her—excuse me—Mrs. Brown would be helped by the President's proposal.

Ms. WASHINGTON. Yes, sir. The President's proposal offers prescription drug coverage up to a limit each year, and the premium for beneficiaries is subsidized by the government at 50 percent and the beneficiary pays the other 50 percent. Drugs are covered up to a limit of $2,000 in the first year and $5,000 when fully phased in.

And so, Mrs. Brown would receive assistance. She would pay the monthly premium, which in 2003 would be $26 a month. And then, she would receive her drugs at a discount that would be offered by the pharmacy benefit manager, or the HMO that she belongs to, and she would pay up to a 50 percent co-pay for the cost of the drugs that she receives each year.

Mr. GREENWOOD. Let me see if our math is the same here. According to my math, she would pay, in 2003 she would pay $3,500 out of her pocket under the Clinton plan, of the $4,200, because the government's contribution is capped at $1,000. She would be paying approximately $300 in premiums, plus one-half of the $2,000 maximum benefit, or $2,200, and therefore her uncovered drug spending would be $3,500. Do we have different mathematicians working for us here?

Ms. WASHINGTON. Well, I think there are two points. The first point is that if she is uninsured now or she participates in a Medigap plan, she is not realizing the benefits of the discounts that the pharmacy benefit managers can give her. So, her costs would hopefully be lower with drug coverage. I think when the benefit is fully phased in at $5,000, she would receive more help than she would in the first year.

Mr. GREENWOOD. If she lives that long, and we hope she does.

Mr. WAXMAN. Without a drug program, she might not.

Mr. GREENWOOD. Right, right. Well, without a good drug program she might not, that is the problem. And of course I think this goes to one of the essential dilemmas here, is with finite resources do we want to make sure that we cover more of her costs and focus this on the lower end of the socioeconomic scale, or provide a relatively thin coverage, at least for the first several years, to everyone. That is a basic philosophical consideration for us.

You mentioned the fact that you hadn't, I think it was in response to a question, that the President and the administration hadn't developed a benefits package, and that you intended to work with the Congress, you hoped to work with Congress on that. In fact, it is my understanding that, A, we have no legislative language from the White House at all with regard to the President's proposal; and, B, I am not aware, and I am one of the guys supposedly writing this legislation, I am not aware of any overtures from the administration to work with the Congress.

And let me say to you that it is my fervent hope that what we end up doing is having a package on the President's desk that we have negotiated with the administration, that we all can feel good about, Republicans and Democrats, and get signed into law this year. But to do that I think we are going to—time is obviously very limited—we are going to have to see language from the administra-

tion, some very concrete and detailed language. We are really going to have to establish a dialog here, where representatives of the administration and representatives of the Congress, both chambers, both sides of the aisle, are working toward that common goal, because we won't get it otherwise.

Could you comment on that?

Ms. WASHINGTON. Yes, sir. Back in July, we released a very detailed plan of the President's proposal that was about 40 pages long. We are working on legislative language now, and I can certainly get back to you about what the plans are for that. But we would be happy to sit down and work with this committee, like we have in the past, to discuss the issues and see what we can do.

Mr. GREENWOOD. Well, I will personally take you up on that because I believe that that is a dialog that has to begin sooner rather than later, and I have been around here long enough to know that when it happens later, it usually is too late and we end up with a veto or we end up with stalemate and a lot of political finger-pointing, and I think we ought to avoid that.

I see no other members—oh, Dr. Ganske is recognized for 5 minutes.

Mr. GANSKE. I want to get back to the macro level here. I appreciate your testimony.

It looks to me like today Medicare expansion of benefits is even more difficult than it was in 1988, 1989, and here is why. We have, I think, a very firm bipartisan commitment to protect Social Security. That makes deficit spending for new programs very difficult.

Second, how do you expand coverage for some when others have no coverage at all, i.e., the uninsured, the totally uninsured?

And, third, as Mr. Scanlon's first chart points out, we are getting closer and closer to Medicare insolvency, and so what should our priorities be? Should our first priority be to protect the current program? Or should it be to expand the current program and then push that insolvency date closer?

Now, the President's plan recommends spending roughly $170 billion over 10 years, I think, $168.5 billion or something like that. Senator Breaux's plan talks about $70 billion. Earlier today I talked about how much this surplus really could be.

And now that I have got the CBO paper in front of me, you know, if you look at the projections for spending just to keep up with inflation, not counting emergency spending, then you get about $830 billion in surplus over 10 years. So knock off about another $200 billion for emergency spending, and then knock off about another $100 billion for a bipartisan commitment for increased spending on defense. I hear that all the time from both sides of the aisle, from the President. So you could knock off about, you know, another $300 billion just for that. So now you are down to about $500 billion over 10 years.

Okay. What I am saying is this: I am terribly frustrated by this process, because we don't know, A, how much a real prescription benefit is going to cost, because we don't know what new drugs are coming along, and the President's plan is open-ended. You are talking about 50 percent of expenses but we don't know what the expenses are. I mean, it could be a lot more than what we are projecting.

And we don't know, because we don't have a budget at this point in time, how much we are projecting for being able to cover, say, the uninsured. If we did nothing more than make an effort to get those who already qualify for Federal programs into the programs, that is an additional significant cost, much less an expansion.

And so, you know, I guess I would like your comments on this. How can we justify this, proposing these programs, without a context of a budget that we have agreed on in a bipartisan fashion? Mr. Scanlon?

Mr. SCANLON. Dr. Ganske, I think in part we need to go and look at that bigger picture again, and it is not just the issue of this financing picture but it is the issue of the operation of the Medicare program. Because I think that in both the President's proposal and in the Breaux-Frist bill and in the work of the commission, we were talking about not only modernizing this program in terms of adding a drug benefit and stop-loss coverage but also trying to make it more efficient, and hope that we would get savings there that would both be able to cover the cost of some of these benefits as well as to make it more sustainable for the future.

Now, there is a big "if" there. I don't think that we have the experience or the analysis yet to feel comfortable that we are going to be able to do this, but I would agree with everything that you said in terms of the dilemma we have in the tradeoffs. There are significant needs besides drug coverage for Medicare beneficiaries, such as the needs of the uninsured, and what is done about those while one is thinking about drug coverage is a major issue.

But I am afraid that what we can try to do is provide you the information on the relative effects of different approaches to this, but when it comes down to having to make a choice between the two, I don't have any advice on that.

Mr. GANSKE. Ms. Washington, let me just go back over these three points that I made.

First, do you agree that there is a bipartisan commitment to protect Social Security that makes deficit spending for new programs very difficulty?

Mr. GREENWOOD. Please be brief when you respond, since the gentleman's time has expired.

Ms. WASHINGTON. Dr. Ganske, I can't really comment on the overall budget structure of the administration.

Mr. GANSKE. The administration doesn't want to see deficit spending.

Ms. WASHINGTON. That is correct.

Mr. GANSKE. Okay. And the administration has a real commitment to providing coverage to those who don't have any insurance, right?

Ms. WASHINGTON. Right. That is correct. We have a proposal——

Mr. GANSKE. And the administration has a real commitment to making sure that Medicare stays solvent?

Ms. WASHINGTON. Yes, sir.

Mr. GREENWOOD. The gentleman's time has expired.

Mr. GANSKE. Mr. Chairman, I would ask for an additional minute, unanimous consent.

Mr. GREENWOOD. A quick minute.

Mr. GANSKE. Hey, there is only three of us. I am sorry. Mr. Burr is down here.

Mr. Scanlon, we are talking about, you know, trying to do basically a number of things in our budget. We are talking about tax cuts, we are talking about an expansion of coverage for the uninsured, we are talking about prescription drugs and expansion of benefits in Medicare, and there are a number of other priorities. Can you make a suggestion for me? How can we even begin to look at what we should be fashioning for some type of drug benefit for those who truly need it, without knowing how much money we have to spend, how much money is available?

Mr. SCANLON. I think we can begin by trying to help you in terms of understanding what the implications of different levels of resources going into this would be, and how those resources, different levels of resources, could be targeted, and some of the potential consequences of that targeting. But beyond that I don't know how to guide you, because I do—I mean, I understand your dilemma completely, which is that the list of potential uses of both existing revenues and future surpluses is quite long and clearly will go well beyond the money that is available.

Mr. GANSKE. Thank you.

Thank you, Mr. Chairman.

Mr. GREENWOOD. The gentleman, Mr. Strickland, is recognized for 5 minutes for inquiry.

Mr. STRICKLAND. Thank you. I would like to address this to Ms. Washington.

You mentioned in your testimony that a Medicare benefit needs to be universal to avoid adverse risk selection problems, and the question I have is, what are the risk selection problems that could occur in a drug benefit that is targeted only toward certain beneficiaries such as low income seniors?

Ms. WASHINGTON. Well, risk selection happens when you are targeting the benefit only to a certain group or you are making it unaffordable for others to join the program. What happens is, when you can't share the risk among the maximum amount of beneficiaries possible, the cost keeps going up and the relatively healthy people will find that it is not affordable to them, and that cycle spirals out of control, so at a certain point the benefit isn't really sustainable because no one can afford it.

Mr. STRICKLAND. And that gets to the second part of my question, and that is the level of subsidy that would have to be available to make benefits affordable to low income folks. And looking at the President's plan, I guess the major concern that I have about it is, is the benefit attractive enough to attract sufficient numbers of voluntary participants to keep this adverse selection process from occurring? And I assume the administration has considered that, but it seems to me that the benefit package is minimal at best, and there are seniors that would find it inadequate and consequently find it not all that appealing to voluntarily participate. Is that a concern?

Ms. WASHINGTON. Well, what we tried to do in designing the benefit is to make it attractive enough so that most beneficiaries would participate, and we set the subsidy level at 50 percent in order to achieve that, but at the same time trying to make it affordable for

the program. We have a series of protections for the lowest income beneficiaries, so that people under 135 percent of poverty have their premiums and cost-sharing covered, and then people between 135 and 150 percent of poverty receive assistance on a sliding scale.

The addition of the stop-loss protection that we talked about earlier would really serve to make the benefit more attractive to those people with the highest out-of-pocket costs, and that was a concern that we had last year, that is the reason why we added that.

Mr. STRICKLAND. One of the groups that is opposed to the administration's initiative has communicated with a number of my constituents, and one of the things they charge is that it will not be voluntary. They don't do that exactly. They are very careful in the words they use and how they use those words, but they make reference to the fact that the administration has indicated that approximately 80 percent of Medicare beneficiaries will choose to participate, and they take that estimate as an indication that this program will not be voluntary.

Can you tell me where you came up or how you came up with the estimate that approximately 80 percent of Medicare-eligible folks would choose to participate?

Ms. WASHINGTON. When we were designing the benefit, we consulted with our actuaries about the size of the subsidy and the generosity of the benefit package, and what, in their opinion, would cause the benefit to be attractive so that almost all beneficiaries would participate. That is how we settled on the 50 percent subsidy.

Eighty percent of the beneficiaries are expected to participate because we have subsidies for employers to continue to offer their private coverage. So, we do think that, as a result of the subsidies, employers would take the incentive and continue to offer their private retiree coverage for those people who have it.

Mr. STRICKLAND. So the 80 percent estimate is not based upon any coercion on the part of this program, but it is based on the assumption—and I guess that assumption is arrived at through some scientific methodology—that 80 percent would choose to participate either because they have no coverage currently, or the coverage they have is inadequate, or the coverage they have is becoming so expensive they can't keep it, or they are afraid their HMO will drop coverage, as many HMOs are doing. Is that a fair assessment of the estimate?

Ms. WASHINGTON. Yes, that is correct, sir.

Mr. STRICKLAND. Thank you.

No more questions, Mr. Chairman.

Mr. GREENWOOD. The gentleman, Mr. Burr, is recognized for 5 minutes for inquiry.

Mr. BURR. Thank you, Mr. Chairman. I apologize to the witnesses for this schedule today.

Ms. Washington, let me see if I just understood you correctly. Based upon the President's proposal in blueprint form, it is estimated that 80 percent of seniors would choose the drug option that the President has proposed?

Ms. WASHINGTON. That is correct.

Mr. BURR. Well, let me run you through a chart. Tell me if I am wrong. Based upon the 2002 phase-in, the partial phase-in, at $1,000 per beneficiary of drug spending, I see a value to the individual who participated of $197.60, and an out-of-pocket cost of $802.40. Who was it that looked at that and said 80 percent of the seniors would see value in that?

Ms. WASHINGTON. Well, there are a couple of reasons why we would see value in the benefit. First of all, the figures you are citing are the first year, and the benefit would——

Mr. BURR. Well, let me cite 2008. At $1,000, it has a "value of the President's plan" benefit, a negative $134, and the out-of-pocket cost, $1,034 for the beneficiary. It actually gets worse.

Ms. WASHINGTON. Well, if you look at the costs of drug coverage for the average beneficiary and you project those forward to when the benefit starts, we do predict that the average beneficiary, while the benefit isn't free and we do require a 50 percent subsidy and 50 percent premium and 50 percent co-pays, there would be value to the beneficiary from the benefit, both in terms of coverage and in terms of——

Mr. BURR. Now, you are subsidizing some income level for the premium costs, correct, under this plan?

Ms. WASHINGTON. For low income beneficiaries?

Mr. BURR. Yes, ma'am.

Ms. WASHINGTON. Right.

Mr. BURR. At what percentage of poverty would you subsidize their premium costs?

Ms. WASHINGTON. Beneficiaries under 135 percent of poverty would see full coverage for premiums and co-pays, and beneficiaries from 135 to 150 percent of poverty would see premium assistance based on a sliding scale.

Mr. BURR. Now, of the individuals that were in that 135 and below, you are paying 100 percent of their premium?

Ms. WASHINGTON. That is right.

Mr. BURR. Then are they on a 50-50 share for every drug they buy then, or are you paying 100 percent of their drugs.

Ms. WASHINGTON. We would also pick up the co-pay for those beneficiaries.

Mr. BURR. You would also pick up the 50 percent co-pay. Now, above the 135, they are partially responsible for their premium, or you are going to subsidize their premium?

Ms. WASHINGTON. They are partially responsible for it. We would partially subsidize their premium.

Mr. BURR. And how about the co-pay, the 50 percent?

Ms. WASHINGTON. No, they would——

Mr. BURR. They would pick up the 50 percent?

Ms. WASHINGTON. For that population, I think they would pick up the co-pay.

Mr. BURR. Okay, so now you have picked up $302, and they are going to pay 50 cents of every dollar that they spend. Now, at what point does the partial subsidy of the premium stop, what income, what poverty level?

Ms. WASHINGTON. That is at 150 percent of poverty.

Mr. BURR. So at 150 percent, the individual is responsible for their premium and their co-pay?

Ms. WASHINGTON. Right.

Mr. BURR. Okay. Now, so these numbers would be accurate for somebody at 150 percent of poverty or above, where of $1,000 worth of drug spending, the actual value of the plan is a negative $134. Let me remind you what 150 percent of poverty is. Mr. Waxman and I disagree. I have it at $11,727 on an annual basis. We are going to tell those people, we are going to offer them a product, that if they have $1,000 worth of drug costs in a year, they are going to pay $1,100 bucks for, and somebody has computed 80 percent of the seniors are going to buy into this?

Ms. WASHINGTON. Well, you have to look at the quality of the coverage that most beneficiaries have now. A third of the beneficiaries have no——

Mr. BURR. Clearly, under this scenario, they could pay for it and they would come out better.

Mr. SCANLON. Mr. Burr, if I could add, I think that we need to really think about this as an insurance plan, and the issue is that if I knew with certainty that I was going to have $1,000 worth of coverage, then maybe I wouldn't buy this insurance plan. But if I have a different situation, which is that the only way I can get into this insurance plan which is subsidized at 50 percent is to opt for coverage now, and to be able to maintain that coverage for the future, and it is always 50 percent subsidized, I may do that.

The example I think that we need to look to is Part B, where the participation rate is well above 90 percent, and it is something where you have to opt into Part B when you first become eligible for Medicare.

Mr. BURR. Or you——

Mr. SCANLON. You don't wait until you discover what your health care costs are going to be.

Mr. BURR. Let me ask you, from a GAO perspective, if we were to design a drug benefit that was open universally to all seniors, and there was value at the high end, let's say for a minute that the cost of the low end and the cost of the high end were the same, have you eliminated the adverse selection risk of the low end because you have got seniors to buy in on the high end?

Mr. SCANLON. I think you have eliminated some of the adverse selection risk. I think the two biggest things that eliminate the adverse selection risk are the subsidy, which makes this of value to more people, and the fact that if you only have limited open enrollment periods, that people are going to sign up not knowing what the future is going to hold——

Mr. BURR. So more mandatory than voluntary, is what you——

Mr. SCANLON. Well, not mandatory. It is voluntary, but you are not——

Mr. BURR. But creating a penalty is a form of a mandatory suggestion. Let me just ask you, because I know we are going to run out——

Mr. GREENWOOD. The gentleman's time has expired.

Mr. BURR. A last question, if I could. Could both of you just comment on your impression of the commission's report, which was premium support as it relates to Medicare, and in that they had a drug benefit, but would you just comment on whether HCFA is supportive and thinks that that model would work, and whether

GAO has looked at it and whether they think that model would work.

Ms. Washington?

Ms. WASHINGTON. When the commission reported out its plan, the President expressed some serious concerns about the model. We have proposed our own plan, that includes injecting competition into the program and adding a prescription drug benefit, that we think would provide the right incentives to choose lower cost plans without increasing fee-for-service premiums for people who would like to stay in that program.

Mr. BURR. But that is not the President's drug plan here.

Ms. WASHINGTON. No. The President's drug plan is included as part of his comprehensive reform proposal.

Mr. BURR. This proposal that is on the table now.

Ms. WASHINGTON. The one we are talking about today.

Mr. BURR. Dr. Scanlon?

Mr. SCANLON. Mr. Burr, we are in the process of looking at both the premium support model and the President's plan, and the Comptroller General, David Walker, is going to be testifying on the 24th about the analysis that we have done, so I would defer until that date.

Mr. BURR. I will wait anxiously for that.

Mr. GREENWOOD. The gentleman's time has expired.

We thank the panel for your forbearance and for your excellent testimony.

We are going to call up the third panel, call up Ms. Lisa Alecxih, vice president of The Lewin Group; Dr. Bruce Vladeck, senior vice president of policy, Mount Sinai NYU Health; Mr. Don Moran, president, The Moran Company; Ms. Carol McCall, executive vice president, Managed Care and Clinical Informatics; and Dr. Don Young, chief operating officer.

For the benefit of the next panel and the members and the audience, I understand that Dr. Vladeck has a time constraint. We would ask, without objection, that Dr. Vladeck have the opportunity to provide his testimony, and then we will break for the vote and come back for the testimony of the others.

STATEMENTS OF BRUCE C. VLADECK, DIRECTOR, INSTITUTE FOR MEDICARE PRACTICE, MOUNT SINAI SCHOOL OF MEDICINE, AND SENIOR VICE PRESIDENT FOR POLICY, MOUNT SINAI NYU HEALTH; LISA MARIE B. ALECXIH, VICE PRESIDENT, THE LEWIN GROUP; DONALD W. MORAN, PRESIDENT, THE MORAN COMPANY; CAROL J. McCALL, EXECUTIVE VICE PRESIDENT, MANAGED CARE, ALLSCRIPTS; AND DONALD YOUNG, CHIEF OPERATING OFFICER AND MEDICAL DIRECTOR, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. VLADECK. Thank you very much, Mr. Chairman. I said in my written statement a number of very sincere things about my appreciation for the courtesy and kindness this committee always showed me, and once again I am grateful for it. When I appeared before you more regularly, I made a number of commitments to my family about I would no longer be missing important events, and that has created my schedule problem today, and I appreciate your indulgence.

Consistent with that, I will summarize very, very briefly my testimony by making one general observation and then just five points that I think are germane to some of the discussion today.

The general observation I would make is actually triggered in my mind by a comment that is part of Mr. Scanlon's written testimony, to the effect that over the last 5 years the 5-year projections of the Congressional Budget Office of GDP have been off by an average of 2.5 percent. I think some of the rhetoric that we got used to 5 years ago about the long term prospects of Medicare and the Medicare Trust Fund is simply no longer accurate. We haven't caught up with what the economy has done in the last three or 4 years, in the models used not only by CBO but by the administration estimators as well, and I think some of the talk about impending bankruptcy and so forth of the Trust Fund is simply no longer accurate.

That is probably a discussion for another day, however, and specific to a drug benefit, let me just make five points very quickly.

The first point, Mr. Greenwood, I believe the technical economic term is "price discrimination against retail customers," but your point is general. It is not targeted at seniors. Nonetheless, if you look at who pays what for prescription drugs in the United States, then the half of seniors who today are paying retail prices for prescription drugs are not only paying more than their fellow Americans who participate in plans, but they are in effect subsidizing more affluent people all over the world who are paying lower drug prices with the same availability, in Western Europe, for example, and that obviously has to be part of the solution to the drug issue that emerges from this process.

Second, if you look at what has happened to Medicare+Choice since the enactment of the Balanced Budget Act, I am increasingly convinced that it would be of enormous benefit to the continued growth of enrollment in captitated plans in the Medicare program to have a universal benefit that was available to everyone in the fee-for-service program. What we are finding, what the GAO and HCFA have reported is that HMOs, both because they believe it is necessary to managed care and because it is necessary to compete in the market, continue to offer drug benefits even though they have had to scale them back very dramatically, but that the cost increases they have experienced because of pharmaceuticals have had an adverse effect on their profitability and have contributed significantly to their departure from the program over the last several years.

If you had the same benefit structure in both fee-for-service and managed care, which was by the way not recommended by the nonreport of the Bipartisan Commission, then in fact the plans could compete on efficiency and customer service and quality and not be at risk for needing to attract beneficiaries by offering a benefit that the plans themselves can no longer afford to provide.

Third, I know it is very popular in this city, I have been guilty of it myself, to talk about the virtues of targeting from an analytic point of view: Let's get the money where it is most needed, let's just make a benefit available to those who most need it.

There has been a lot of discussion already today, I won't repeat, about problems of adverse selection in drug insurance plans, but I would also suggest to you that we have a lot of experience with ef-

forts to target benefits to subsets of the Medicare population or to other folks, with which this committee is very familiar. As of today, barely half of the folks who are eligible for the QMB and SLMB program are enrolled in them.

The problem with targeting is that it is very difficult to make it work, and it often fails to work. The difference in participating rates between, say, the QMB and SLMB program, or in Medicaid enrollment levels when it was tied automatically to an entitlement for cash assistance, as opposed to say enrollment levels in the CHIP program, suggests that you can expend a lot of money on administrative overhead and still reach only a fraction of the people you are ostensibly targeting; and that it is very difficult in a means-tested program to get to all the potential eligibles without enormous, enormous expenditures.

So the problem with targeting is that it is great if you hit your target, but we mostly don't, and that is—we have a lot of experience in that regard, and it raises real questions, particularly with a drug benefit.

I do think the analogy with Part B, though, is highly relevant on the issue of folks who currently have coverage that might be superior to that as part of any plan that was adopted. As Part B now exists, people have a one-time election when they first become eligible. If they have an employer-provided benefit, the election is postponed until the date at which they lose the employer-provided coverage. If they elect after the initial enrollment period, they can still get the benefit, but they have to pay an actuarially determined penalty that reflects their potential risk effect on the actuarial pool from their delayed enrollment. It is a process that has been working very effectively for 30-some-odd years, and there is no reason why it couldn't be adopted again.

The last thing I will say is that we had a lot of experience, as the chairman knows, on the Bipartisan Commission on the whole issue of just what a defined benefit is, and the world in which every employer and every PBM and every HMO has their own formulary and their own generic substitution policies and so forth. I think none of us want to be in the position where Medicare offers one set of benefits in one part of the country and another set of benefits in another part of the country.

And, therefore, while I think it is very valuable to use the expertise of the private sector and private insurance plans in administering a drug benefit, I think important coverage issues which have to do with whether someone can get the same benefit in San Diego that they get in Maine can't be left to a highly decentralized process. I am not suggesting the executive branch should make those decisions unilaterally. There are a lot of mechanisms to get the wisdom and participation of the industry and the scientific community and consumers. But the notion that you would permit too much flexibility in just what the benefit meant from one part of the country to another, I think would be very dangerous and politically very risky over time.

I see my red light is already on. I know you have been very indulgent already. I thank you for the opportunity.

[The prepared statement of Bruce C. Vladeck follows:]

PREPARED STATEMENT OF BRUCE C. VLADECK, DIRECTOR, INSTITUTE FOR MEDICARE PRACTICE, PROFESSOR OF HEALTH POLICY AND GERIATRICS, MOUNT SINAI SCHOOL OF MEDICINE

Mr. Chairman, Mr. Dingell, Mr. Waxman, members of the Committee, it's a great personal as well as professional privilege to have the opportunity to appear before you today. In the two and a half years since I left the government, there's not very much that I've missed, but I was always treated with great courtesy and interest by members of this Committee of both parties, and so I'm pleased to have the opportunity to appear before you again. Professionally, it's especially nice to be able to discuss Medicare reform in an environment in which we can appropriately focus on reforming the program by improving its benefit structure and its services to its beneficiaries, rather than having to focus most of our energies on reducing expenditures. I must emphasize for the record, in addition, that I am appearing before you today as a private citizen, and that the views I will be expressing are my own, and not necessarily those of Mount Sinai NYU Health, the Mount Sinai School of Medicine, or any other organization.

The combined effects of the Balanced Budget Act of 1997, on which we worked so hard together, improved program administration, and—perhaps most importantly—the continued performance of the nation's economy at a level far above the expectations of any of the official forecasters have dramatically altered Medicare's short and long-term financial prospects. At the moment, it appears that program expenditures are growing less rapidly than program revenues, and the projected date of insolvency of the Hospital Insurance Trust Fund, which has already been extended fourteen years since the BBA was enacted, will undoubtedly be estimated to occur still further in the future when this year's Report of the Trustees is released. Moreover, the federal government's budget surplus is so large that we now have the opportunity to infuse literally tens of billions of dollars into the Trust Funds, as a significant down payment on the resources we will need to provide benefits as us baby boomers reach eligibility age over the next thirty years. Still lagging behind these changes, however, is the conventional wisdom about Medicare's long-run prospects: the last several years should have made it clear that the doom and gloom projections of the 1980s and early 1990s were grounded in shortsighted and ultimately inaccurate conceptions of the prospects for the American economy. Medicare today is in better financial health than it has been in some time, so we must concentrate on improving the health of its beneficiaries.

Whatever one's view about the long-term economic prospects may be, it is clear that, in the short run, the most important agenda for Medicare reform is the program's archaic and inadequate benefit structure. I applaud this Committee for turning its attention to the most visible aspect of that inadequacy: the absence of coverage for outpatient prescription drugs within the basic Medicare benefit package. I hope that your deliberations today will be part of a process that produces enactment of a comprehensive prescription drug benefit before this year is out. In my remarks, I would like to make a few general observations about the problems in affording prescription drugs for Medicare beneficiaries, then identify four components that I think are essential in any new prescription benefit. I will conclude with some general observations about containing program costs.

The Need for a Prescription Drug Benefit

I will not belabor what everyone already knows. Prescription drugs are an increasingly important part of modern medical practice, with recently-introduced pharmaceuticals holding the prospect for significant improvements in health and reductions in mortality, especially for the elderly. In conjunction with the increased importance of prescription drugs have come rapid increases in both their prices and utilization. Increasing numbers of Medicare beneficiaries are experiencing difficulty in affording the drugs their doctors prescribe for them; the response to affordability problems of forgoing prescriptions, or taking less than recommended doses, is increasingly reported, as are instances in which elderly patients are hospitalized or receive other, expensive treatments for problems caused by their inability to afford prescriptions. As a proportion of total income, Medicare beneficiaries now spend almost as much on out-of-pocket prescription drugs as the average non-elderly family spends on all out-of-pocket medical expenses. But I would like to emphasize three aspects of this problem that generally receive somewhat less attention.

First, the way in which the prescription drug market has evolved means that roughly 20 million Medicare beneficiaries (those without any prescription drug coverage, those with coverage through individual Medigap policies, and some of those with employer-provided policies) are essentially the only large group of insured Americans paying retail list prices for their prescriptions. As other purchasers, such

as private insurers or hospital group purchasing organizations, seek ever-larger discounts from manufacturers or wholesalers, increased costs are passed on to that part of the population most dependent on prescription drugs, and least able to afford them. Given the price differentials in prescription drugs between the United States and other industrialized countries, that means, in effect, that those 20 million Medicare beneficiaries are subsidizing prescription costs for younger and more affluent people throughout the Western world. Any Medicare drug benefit that fails to remedy this unfairness will be inadequate and excessively expensive.

Second, prescription drug coverage offered on a voluntary basis is especially vulnerable to adverse risk selection. The results are apparent both in the market for those Medigap plans that cover prescriptions and in the experience of state-financed prescription plans for low-income Medicare beneficiaries. While all older people are at risk for high prescription costs, a significant fraction of Medicare beneficiaries with the greatest need for prescription drugs require expensive maintenance doses for chronic conditions. As the prices of drugs and insurance both increase, insurance premiums are thus a good buy for only a diminishing fraction of beneficiaries with the highest costs, thus further driving up premiums in a classic insurance-selection "death spiral."

Third, and perhaps least obviously, I personally believe that guaranteed prescription drug benefits for all Medicare beneficiaries may be essential to the long-run prospects of Medicare+Choice plans. Since the enactment of the Balanced Budget Act, most managed care plans participating in Medicare have apparently concluded that offering some kind of prescription benefit is essential both to their ability to attract enrollees and to their ability to effectively manage their care. Yet simultaneously, increases in prescription drug costs are having a significantly adverse effect on the profitability of plans, causing many of them to reduce or discontinue their participation in Medicare. Inclusion of a prescription drug benefit in the basic Medicare benefit package would permit us to determine payment for fee-for-service and Medicare+Choice on the same basis, move forward with more sophisticated risk adjustment, and make relative efficiency and customer satisfaction the basis for competition between plans and "traditional" Medicare. At the same time, in response to the pressures of rapidly-rising drug costs, Medicare+Choice plans have adopted a bewildering variety of formulary restrictions, benefit caps, and other techniques to try to manage their pharmaceutical costs, most of which are perfectly reasonable in themselves, but which significantly complicate the process of choice for beneficiaries. Adoption of a standard Medicare pharmaceutical benefit would significantly simplify the choice process.

Essential Components of a Medicare Prescription Benefit

• *1. UNIVERSALITY:* First, any Medicare prescription drug benefit should be universal—that is, it should, at a minimum, be available to all beneficiaries in conjunction with their initial Medicare enrollment, and for all current beneficiaries when the new benefit first becomes available. There are at least three reasons for this. The problem of adverse selection in any more limited drug-only insurance program has already been noted. The way to prevent or combat it is to combine universal availability of the benefit, enrollment procedures that are easy but available only under specified conditions, and subsidy levels adequate to insure that the benefit is a good deal even for those beneficiaries who do not anticipate high drug utilization. Further, as members of this Committee well know, our experience with the Qualified Medicare Beneficiary and Supplemental Low-Income Medicare Beneficiary programs demonstrate that efforts to enroll Medicare beneficiaries on an ad hoc basis for needed additional benefits are likely to be cumbersome and ineffective—and likely to fail to reach a large fraction of those most in need. Policy wonks love to expound on the virtues of "targeting" benefits to some subset of the population with particular needs. That's a fine idea in theory, but actual programs too often misfire. And we always run the risk of spending as much money on administration and outreach as we save by delimiting the pool of eligibles. Most fundamentally, the universality of Medicare as a social insurance program is one of its greatest operational as well as political strengths. Beneficiaries know that they have contributed to the program throughout their working lives, and continue to contribute in retirement. To deny an additional benefit to a contributor who fails by some slim margin to meet some arbitrary cutoff or eligibility standard is neither fair nor practical.

I know that many participants in the policy process have expressed concern that a universal Medicare drug benefit might actually prove to be an inferior or more expensive alternative for many of the 30% or so of current beneficiaries who have prescription drug coverage through an employment-related retirement benefit, and I see no reason why beneficiaries shouldn't be permitted to opt out of a new drug benefit, just as they all have the option of declining Part B coverage. Indeed, it

makes sense to extend the Part B analogy still further: beneficiaries should have an initial election period to accept or decline prescription coverage; if they decline because they are covered by an employment-related plan, they should be permitted a new election period should that plan be discontinued; otherwise, delayed election should result in an actuarially-increased premium.

• *2. ADEQUACY:* It would be a tragedy for this or any other Congress to struggle to enact a prescription drug benefit for Medicare beneficiaries that turned out to be inadequate to beneficiaries' needs. It's essential that any prescription benefit be designed and administered in a fiscally prudent way, but it's also essential that the benefit be worthy of its name. That means that it must provide at least some assistance for the great majority of beneficiaries with prescription expenses of as little as several hundred dollars a year—since such "little" amounts, if unexpected and unbudgeted, can have large impacts for people scraping by on fixed incomes—while providing more comprehensive protection against catastrophic expenses. In fact, for Medicare beneficiaries the problem of affording prescription drugs is really three problems in one. To borrow from medical terminology, there are beneficiaries with sudden, acute drug expenses, beneficiaries with significant chronic expenses, and beneficiaries confronted with total financial disaster as a result of prescription drug expenses. A new drug benefit must address all three types of problems.

• *3. UNIFORMITY:* One of the cardinal principles of Medicare is that it provides the same benefits everywhere throughout this diverse and heterogeneous country. One of the lessons many of us learned in the deliberations of the National Bipartisan Commission on the Future of Medicare is just how complex maintaining and insuring a defined benefit can be. This problem is especially important in the context of a prescription drug benefit, since in response to cost pressures, insurers, employers, and health plans have developed an extraordinary array of techniques for limiting formularies, encouraging or requiring certain substitution practices, or delaying coverage for newly-introduced products. But to permit too much variation or decentralization in this kind of decision-making for a Medicare drug benefit would create the very real risk of situations in which beneficiaries living in different parts of the country with identical medical conditions and identical physician decisions about optimal care would receive significantly different benefits. Medicare beneficiaries who need transplants are eligible for them under the same conditions and limitations whether they're in Seattle or Miami. They should be able to get the same drugs, when prescribed by their doctors.

Precisely because administration of a drug benefit is complex and affected by rapidly changing scientific and market conditions, the Congress probably would not want to legislate the details of a drug benefit with the degree of specificity necessary for administration. Rules for generic substitution for brand-name drugs should probably vary from one drug category to another, for example, and vary over time as well, as products enter and leave the market. It's probably desirable, therefore, to construct some kind of broadly-based of advisory structure or process to assist the Congress and the Executive Branch in making such decisions. This would permit an effective combination of broad-based participation by stakeholders in programmatic policy with efficient implementation of those policies. But there must be such a process—open, participatory, and explicit—if beneficiaries in different parts of the country are to be treated equitably.

• *4. ADMINISTRABILITY:* Providing an adequate Medicare drug benefit in a fiscally prudent manner is a significant challenge in itself; it would be unwise to exacerbate that difficulty by imposing a separate, complex, administrative structure on a single benefit. Given the economies of scale available from existing electronic billing and remittance technologies for pharmaceuticals, and the demonstrated quality advantages of utilizing automated prospective utilization review software, it should be possible to maintain the level of exceedingly low administrative costs that now prevails for other Medicare fee-for-service benefits by building on existing private-sector capabilities for benefits administration. At the same time, however, it would be wasteful and foolish to create new enrollment, premium collection, or beneficiary communications processes when the current ones work so unobtrusively and so inexpensively.

Containing Costs of a Prescription Drug Benefit in Medicare

Even at this relatively prosperous juncture in the nation's and Medicare's economic history, it is obviously essential to take every possible step to ensure that a Medicare prescription drug benefit is implemented as economically as possible. Prescription drugs *are* expensive; that's why a drug benefit is needed in the first place, and a new benefit will be expensive. But it's critical that it not be any more expensive than is absolutely necessary.

There are essentially three dimensions to a strategy of controlling the cost of a prescription benefit. The first is to require some degree of beneficiary cost-sharing for first-dollar expenditures, as all the legislative proposals now before the Congress do. The second, as discussed above, is to employ the most effective available utilization management techniques on a uniform and equitable basis. But as I mentioned at the outset of this statement, it is also necessary to recognize that the pricing of prescription drugs for most Americans is already determined not by some reproducible, abstract, formula, but through a continuing process of multidimensional marketplace relationships. Some method must be found to arrive at prices in a Medicare drug benefit that are equitable to taxpayers, beneficiaries, retailers, and manufacturers alike.

The most economical approach, from the perspective of taxpayers and beneficiaries, would be to simply let the federal government negotiate prices directly with manufacturers, but I understand the uneasiness with which many analysts and commentators, not to mention the pharmaceutical industry itself, views this option. There have thus emerged all sorts of proposals to delegate the price-negotiation process to private intermediaries of one sort or another, through contracting with pharmacy benefits management firms or other entities with experience in negotiation of pharmaceutical prices. To the extent that such negotiations are indeed on pricing, *within the context of nationally-uniform policies on coverage, substitution, and formularies, if any,* I suspect that's a reasonable approach, although I would be apprehensive about any sort of fixed-price arrangement that provided the intermediaries with too great a financial incentive to maximize profitability at the expense of beneficiary coverage or convenience.

To make such a system work, over time, would require the availability of cost, price, and use data to both Congress and the Executive Branch that should be easy for private firms already in the business to provide, but that is not now generally available within the pharmaceutical industry. The old Progressive maxim that sunlight is the best disinfectant when the expenditure of public funds is involved should apply here with particular relevance, and should be central to any administrative arrangements the Congress adopts.

Conclusions

In summary, I would urge the Congress to move expeditiously to enact a prescription drug benefit for Medicare beneficiaries that is universal, adequate in coverage, uniform throughout the United States, and simple to administer. Doing so will be expensive, but there are ways to insure that costs are minimized aggressively, and failing to act will make certain that thousands of this nation's most vulnerable seniors are unable to obtain the medications they need to maintain or restore their health—or forced to obtain them by foregoing other, essential expenditures. This problem will only get worse over time. The sooner the Congress acts, the sooner all Medicare beneficiaries will be relieved of the anxiety of being unable to afford medications they know can benefit them.

It has been, again, an honor and a privilege to have the opportunity to appear before you today. I'd be happy to try to respond to any questions you might have.

Thank you very much.

Mr. GREENWOOD. Thank you, Dr. Vladeck. I must ask the indulgence of the rest of the panel, and they have been waiting all day. We have just 5 minutes left in this vote. I am informed that there will 10 minutes of debate followed by another vote, so we will be at least 20 minutes and perhaps 25 minutes until we return.

Dr. Vladeck, we would love to ask you questions, but if your schedule doesn't permit that, we will understand.

Mr. WAXMAN. Mr. Chairman, may we leave the record open and ask him some questions in writing?

Mr. VLADECK. If you have written questions and would like me to respond to them, I will do so right away.

Mr. GREENWOOD. Certainly. Without objection. So this hearing will recess until 2:20.

[Brief recess.]

Mr. BILIRAKIS. Okay. I think we all have been introduced, have we not? Ms. Alecxih, is that correct?

Ms. ALECXIH. That is right.

Mr. BILIRAKIS. Vice President of The Lewin Group. Please proceed. Your opening statement, your written statements, of course, are made a part of the record.

STATEMENT OF LISA MARIE B. ALECXIH

Ms. ALECXIH. Basically, I was asked to discuss issues of fact, primarily in terms of coverage, prescription drug coverage among Medicare beneficiaries, and I guess the key points to be made are that nearly 70 percent of Medicare beneficiaries have some prescription drug coverage. It was mentioned earlier that there is some portion of those that don't have the entire period of the year, but a fairly large proportion, most of those with coverage obtained it from employer-sponsored plans, and nearly equal percentages get it from Medicaid, Medicare HMOs, Medigap, and some similar percentage switch what their source of coverage is during the year.

Those with Medicare HMO coverage and employer-sponsored coverage are most likely to have prescription drug coverage. I said groups of those with Medicare HMO coverage, about 94 percent of them have prescription drug coverage, and those with employer-sponsored coverage, about 89 percent of those have it. And those with Medigap are least likely to have coverage, about 42 percent.

These are all data based on the Medicare Beneficiary Search or Survey, which is a nationally representative survey of Medicare beneficiaries. That 42 percent for Medigap enrollees is probably high. Country-wide, the National Association of Insurance Commissioners data, where it does report policyholders by the type of policy, say standardized Medigap plans, and that is only 15 to 20 percent of those have by that measure an H,I, or a J plan for prescription drugs they chose. So it is not clear whether Medicare is accurate or not.

The level of prescription drug benefits that is provided by these different sources of coverage varies. Medicaid and employer-sponsored tend to have the most generous benefits with low co-pays, and on the employer-sponsored side there are low deductibles, either an out-of-pocket limit or a lifetime limit, where Medigap has a fairly high co-pay requirement with a $250 deductible in their co-pay and plan limits of $1.250 or $3,000.

Each of them limit access to that coverage in some way. Employer-sponsored, obviously you have to have worked for an employer that offers this retiree coverage. That is generally larger employers. Medicaid, you have to be low income; Medigap, beyond the 6-month enrollment period when you become Part B eligible, there are almost always health status questions that you have to pass in order to be able to gain that coverage. And Medicare HMO, you are trading off freedom of choice among providers, and there is some geographic variation in the types and the level of benefit that is offered.

Among the 31 percent of Medicare beneficiaries without prescription drug coverage, if you look at the sheer numbers, most of them are younger and have higher incomes. But if you look at the proportion within a group, the oldest old are least likely to have prescription drug coverage, and those actually in the middle and moderate income groups are the least likely to have prescription drug coverage.

And if you look at the trend in prescription drug coverage over the 1992 to 1996 period, it has increased pretty dramatically based on the MCBS data. It has gone from 54 percent to 69 percent, but it is unclear whether or not this will continue into the future or actually decline, because of payment changes to Medicare HMOs and whether or not those plans will be able to continue to offer drug benefits. We do know that they have limited the level of drug benefits between 1999 and 2000, but not really in terms of the percent of plans offering benefits. It is about the same. And also the role of employer-sponsored coverage in the future, particularly for future retirees. Current retirees look pretty safe. It is the ones who in a decade it is not clear what that source will—what role that will play among the Medicare beneficiaries.

[The prepared statement of Lisa Marie B. Alecxih follows:]

PREPARED STATEMENT OF LISA MARIA B. ALECXIH, VICE PRESIDENT, THE LEWIN GROUP

I am going to discuss what we currently know about coverage and spending for outpatient prescription drugs among Medicare beneficiaries. Most of the data presented are from the 1996 Medicare Current Beneficiary Survey (MCBS). This survey provides the most comprehensive information about the characteristics and health care use and spending among a representative sample of Medicare beneficiaries. In addition to the MCBS: some of the Medicare HMO data were obtained from the HCFA-sponsored medicare.gov website which includes Medicare Compare, a database of relevant benefit coverage and levels for each Medicare HMO; some of the employer-sponsored health plan data were obtained from the 1997 Bureau of Labor Statistics (BLS) Employee Benefits Survey for Medium and Large Establishments found at bls.gov; and some of the private, individually purchased Medicare Supplemental insurance information (Medigap) were based on tabulations of National Association for Insurance Commissioners (NAIC) experience reporting forms for 1998.

Exhibit 1 shows that approximately 69 percent of the 37.3 million Medicare beneficiaries in 1996 had prescription drug coverage at some point during the year.

Because Medicare generally does not cover outpatient prescription drugs, Medicare beneficiaries that most of those with coverage obtain it from a former employer. Medigap, Medicaid and Medicare HMOs accounted for between 12 and 15 percent each of those with prescription who did have coverage obtained it from a variety of private and public sources. *Exhibit 2* indicates drug coverage. Individuals who changed their primary supplemental insurance choice at some point during the year (switched sources) also constituted 12 percent of those with prescription drug coverage. A small percentage (two percent) reported relying on other public sources, such as the Veterans Administration and state-sponsored programs.

Within supplemental insurance group, those enrolled in Medicare HMOs had the highest percentage with prescription drug coverage, followed by employer-sponsored (see *Exhibit 3*). Not all individuals with Medicaid coverage had drug coverage because many receive assistance with Medicare Part B premiums and copayments through the Medicaid Buy-In programs (QMB, SLMB and QI), but do not qualify for the full range of benefits offered by a state. Those purchasing Medigap coverage were the least likely to have prescription drug coverage. The estimate of the percent of Medigap purchasers with prescription drug coverage may be overstated. Data from the National Association of Insurance Commissioners indicate that between 15 and 20 percent of those with Medigap standardized plans purchase those with drug coverage (H, I, and J).

The level of prescription drug benefits varies among the sources of coverage:

- Employer—Slightly over one-half of employer-sponsored plans in medium and large establishments have their prescription drug benefits subject to the major medical limits of the plan. According to BLS data, in 1997, the average deductible was $268, the average annual out-of-pocket expense limit was $1,578, and the average lifetime maximum was $1.1 million. Among plans that had specific copayments for prescription drugs, these were generally $10 or less.
- Medigap—Among the ten standardized plans, H, I and J offer prescription drug coverage with a $250 deductible, 50 percent coinsurance, and plan limits of $1,250 or $3,000.

- Medicare HMO (Medicare+Choice)—Most Medicare+Choice plans have plan limits of $2,000 or less and copayments that vary for generic and brand drugs, but are generally $10 to $25. Although most plans have limits, more beneficiaries actually enroll in plans with no limits or more generous limits than $2,000.
- Medicaid—Medicare beneficiaries who qualify for full Medicaid benefits generally have unlimited coverage for prescription drugs. Some states use formularies, while others require nominal copayments.

Each of the primary existing sources of prescription drug coverage limit access to coverage, either through employment requirements, underwriting or eligibility criteria.

- Employer—Individuals must have worked for a generally large employer that provides retiree coverage in order to have access to this coverage source.
- Medigap—After the six month initial open enrollment period for Part B, insurers check health status prior to issuing policies (underwrite), which means those most in need of prescription drug coverage would not be able to obtain it. In addition, the premiums for these policies can be expensive.
- Medicare HMO—Individuals choosing to enroll in Medicare HMOs trade-off choice of providers for extra benefits. Also, due to Medicare payment policies, there availability of prescription drug coverage without an extra premium and level of benefits vary geographically.
- Medicaid—This program is restricted to low income beneficiaries.

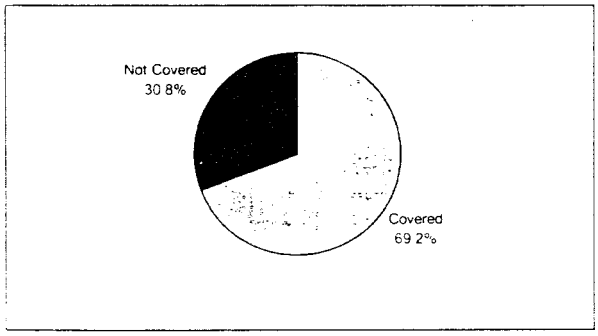
Among those without prescription drug coverage, these individuals tend to be younger and have higher income (see *Exhibit 4 and 5*). The younger elderly constitute a large percentage because they make up the largest group of Medicare beneficiaries. However, the oldest old actually have a higher rate of individuals without prescription drug coverage (see *Exhibit 6*). The same is true among the income groups, where more individual without coverage have higher income levels, but the rate of those without coverage is highest among those with lower incomes.

Medicare beneficiaries who do not have prescription drug coverage spend less on average for their total prescription drug bill, but pay more out-of-pocket (see *Exhibit 7*). These individuals spend less primarily because they lack coverage.

Between 1992 and 1996, the percentage of Medicare beneficiaries with prescription drug coverage increased from 54 percent to 69 percent (see *Exhibit 8*). Much of the increase was the result of increased enrollment in Medicare HMOs. Part of the increase appears to be due to increasing rates of coverage within the primary sources of coverage, which may be the result of individuals seeking out coverage in response to rising prescription drug costs.

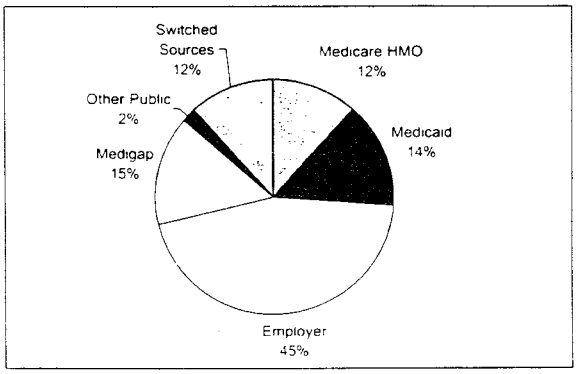
In the future, coverage rates may be less likely to increase because: 1) Medicare HMOs may need to respond to further payment restrictions that may limit their ability to offer zero premium drug coverage and limit their appeal to beneficiaries; and 2) employers are cutting back on health benefits for future retirees.

Exhibit 1
Outpatient Prescription Drug Coverage Among Medicare Beneficiaries, 1996



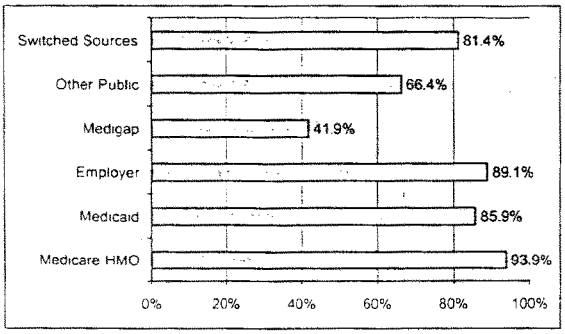
Source: The Lewin Group tabulations of the 1996 Medicare Current Beneficiary Survey (MCBS)

Exhibit 2
Sources of Outpatient Prescription Drug Coverage Among Medicare Beneficiaries, 1996



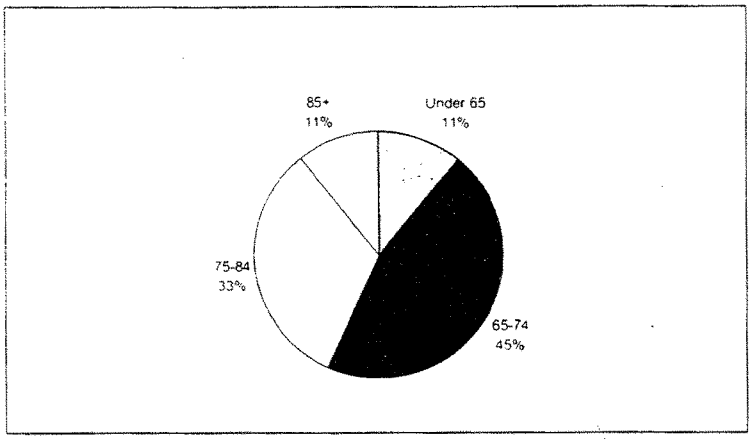
Source: The Lewin Group tabulations of the 1996 Medicare Current Beneficiary Survey (MCBS).

Exhibit 3
Percentage of Individuals by Primary Supplemental Plan Source With Prescription Drug Coverage Among Medicare Beneficiaries, 1996



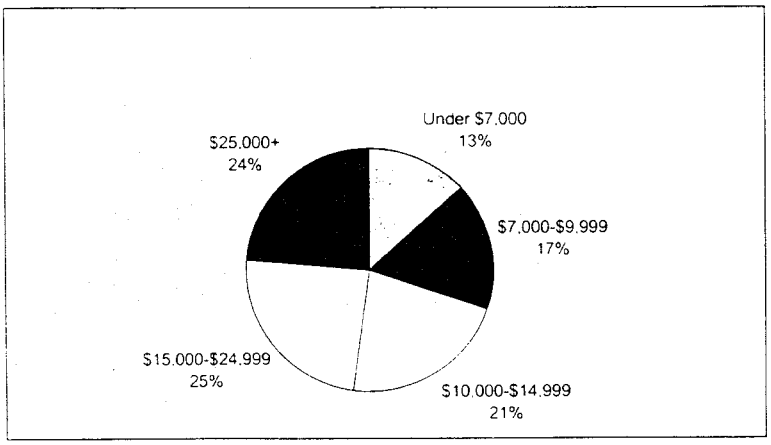
Source: The Lewin Group tabulations of the 1996 Medicare Current Beneficiary Survey (MCBS).

Exhibit 4
Medicare Beneficiaries Without Prescription Drug Coverage By Age, 1996



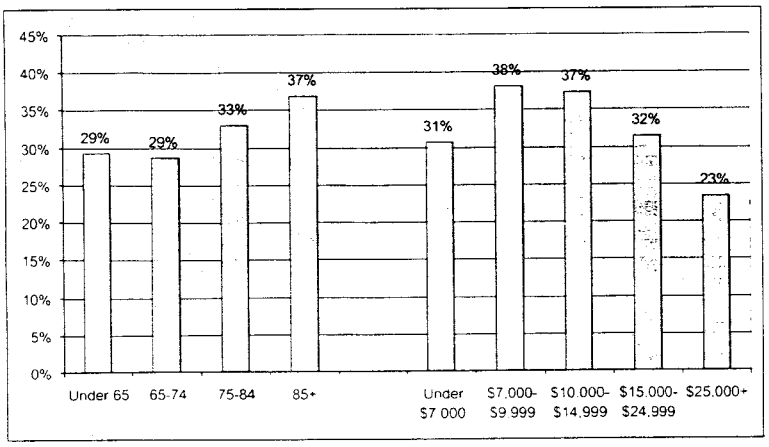
Source: The Lewin Group tabulations of the 1996 Medicare Current Beneficiary Survey (MCBS).

Exhibit 5
Medicare Beneficiaries Without Prescription Drug Coverage By Income Group, 1996



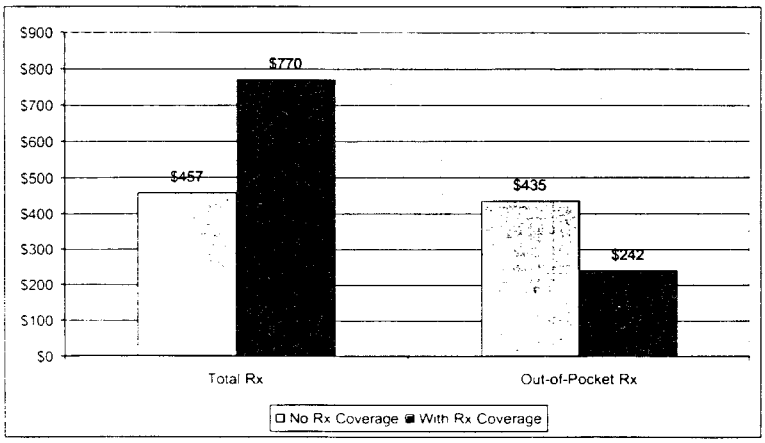
Source: The Lewin Group tabulations of the 1996 Medicare Current Beneficiary Survey (MCBS)

Exhibit 6
Percent of Medicare Beneficiaries Without Prescription Drug Coverage
By Selected Characteristics, 1996



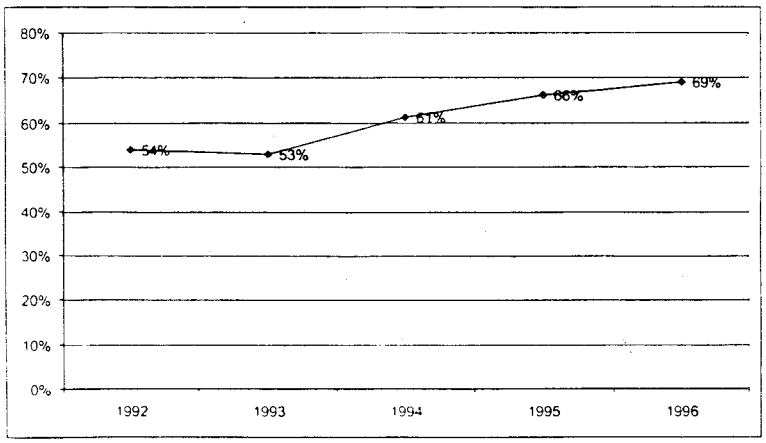
Source: The Lewin Group tabulations of the 1996 Medicare Current Beneficiary Survey (MCBS)

Exhibit 7
Average Total and Out-of-Pocket Prescription Drug Spending Among Medicare Beneficiaries With and Without Drug Coverage, 1996



Source: The Lewin Group tabulations of the 1996 Medicare Current Beneficiary Survey (MCBS)

Exhibit 8
Average Total and Out-of-Pocket Prescription Drug Spending Among Medicare Beneficiaries With and Without Drug Coverage, 1996



Source: The Lewin Group tabulations of the 1996 Medicare Current Beneficiary Survey (MCBS)

Mr. BILIRAKIS. Let's see. Mr. Moran? I skipped over to you. I have you all listed in my notes in a different order.

STATEMENT OF DONALD W. MORAN

Mr. MORAN. Thank you, Mr. Chairman. It is a pleasure to have an opportunity to appear before you all today. Mr. Ganske, a pleasure, as well.

My assignment today, as I understand it, is to concentrate on some of the technical design issues involved in building a Medicare drug benefit, with a particular attempt to address the question of whether or not it is technically feasible and affordable to put stop-loss coverage in as part of the package. And so I just wanted to briefly set the stage for that, summarize 5 or 6 points that I think we have learned about that in looking at it in some depth over the last year or so, and then be available with the rest of the panel to answer whatever questions you have.

The stop-loss issue arises because of the intersection between two forces that you have had ably described before you this morning. On the one hand there is a growing concern about the cost of prescription drug benefits, which means that even those who have them are beginning to see an increasing application of coverage limits placed on those policies.

At the same time we have also seen, I think less fully discussed this morning, some sharp uptake which soon become a tidal wave of very high cost new therapeutic products coming onto the market. In the past we have considered a high drug cost to be products that had an annual cost in the range of $1,000 or $2,000. We are about to enter an era where $5,000, $10,000, $15,000 and $20,000 products that offer major new therapeutic advantages at a substantial price tag will be rolling into the system, and one of the things that you engage in the stop-loss debate is the extent to which even people of middle and upper incomes will have the coverage adequate to cover those kind of expenditures.

So it is in that context, Mr. Chairman, that there has been natural concern from a number of quarters. As a result, in our work over the last year and a half we have made a concentrated effort to look into the technical design issues, and I think we can summarize very succinctly what we think the major issues are.

First, the cost of putting stop-loss into a benefit package ranges from pennies a day to large quantities of money, depending on exactly where you set it. I think it is fair to say that if you were to concentrate a stop-loss benefit focused on the very highest cost drugs and the upper end of the distribution, it might be surprisingly affordable, and that in fact the total number of Medicare beneficiaries who today probably have expenditures in excess of $5,000 or $10,000, say, would add up to a de minimis pile of money from the perspective of the Trust Funds as a whole.

Conversely, if you bring that down well into the—distribution of actual drug expenditures say down to the level of $1,000, then obviously a stop-loss benefit gets very expensive quite quickly and gets progressively more expensive over time. So part of the art of this is understanding what your policy objective is, which target population you really want to go after, and then fashioning a benefit that does that.

Second, I think it is important to say that the cost of a stop-loss benefit is highly sensitive to the quality of the front end coverage that people have. By front end coverage I mean the basic coverage that people have for after dollar deductible and whatever co-payments to cover the first $1,000 or $2,000 of pharmaceutical expenditures. It is fair to say that the better that coverage is, the less quickly people will reach whatever stop-loss limit is in application, and the less they will be spending in excess of that. So the more you marry stop-loss coverage with high quality front end coverage, the more affordable it is likely to be.

A third point which I think is a corollary of that, Mr. Chairman, is that you have to be very careful in your evaluation of proposals that call for just catastrophic-only types of benefits. The reason is, depending on where you might set the stop-loss limit on such a benefit, that such a benefit would have the potential to induce people to drop their existing coverage in favor of that limit. And so you have to be very careful to make sure that either you marry a stop-loss provision to a front end coverage package, or else place the catastrophic threshold high enough so it is not an inducement for people to drop.

Fourth, and I think this is echoed in a couple of the things a variety of people said throughout the day today, integrating administration of a stop-loss benefit with whatever the front end benefit is is very important. To have a situation where beneficiaries would have to be saving up receipts in shoeboxes on one hand, to trundle across town to plunk down to prove eligibility for another benefit, strikes most people in the industry as sort of antediluvian at this point. What you really want is integrated benefits administration from front to back, with stop-loss coverage provided by whoever the front end insurer is.

Fifth, and this has been referenced a number of times by folks during the course of the day today, is that in a voluntary market obviously the character of participation is going to matter in terms of whether not you have significant selection effects, though I would say that, again, if you were targeting a stop-loss benefit higher up into the cost distribution, you would have much less of a selection problem.

Finally, seeing my red light and being ready to summarize, I think I will hit my sixth point, just to say that I think the one thing we all understand about a drug benefit that would focus the benefit on a high cost case or the highest cost cases, it will subject whatever drug expenditures make up that pot of money to substantial scrutiny, and it is going to be very important to understanding that if you go in the direction of a stop-loss benefit, to have a policy that satisfies your policy objectives, to make sure that you can fit that in some way that all parties will consider to be meaningful and real.

Thank you very much.

[The prepared statement of Donald W. Moran follows:]

PREPARED STATEMENT OF DONALD W. MORAN, PRESIDENT, THE MORAN COMPANY

Mr. Chairman: I am Donald W. Moran, President of The Moran Company, a multi-disciplinary health care research and consulting firm based in Fairfax, Virginia. While my firm provides services to businesses and associations with an interest in the matters that are the subject of your hearings, my purpose in appearing

before the Subcommittee today is not to advocate any particular position on the question of whether and how a prescription drug benefit might be added to the Medicare program. Rather, I have been requested to address some of the important program design questions with which this Subcommittee must wrestle in order to arrive at a workable design. I will focus particularly on the issue of whether so-called "stop loss" coverage represents a feasible and affordable option in any drug benefit design the Subcommittee might consider.

The issue of stop loss coverage arises in this debate because of the increasingly high cost of many important pharmaceutical and biologic therapies that are now emerging as a result of rapid innovation in the industry. While these products represent important improvements to the health care system's ability to treat—and even cure—disease, the intensive research and development costs of producing them means that they come to market at substantial price tags.

It is important to understand that the cost to patients is not simply the result of the high unit prices some of these products bear. Since the benefit of many of these products flows from their ability to help physician and their patients manage chronic disease over a sustained period of time, an equally important determinant of the cost to patients is the cumulative cost of maintaining patients on these therapies. Annual maintenance costs in the thousands of dollars—or even tens of thousands of dollars—are becoming increasingly common. This trend raises natural questions about Medicare beneficiaries' ability to access these drugs at an affordable cost.

As pharmaceutical therapy becomes an increasingly important part of the health care system, we can expect a continued rise in the cost of providing benefits for prescription drugs relative to the cost of other health benefits. Although we can expect offsetting benefits from this shift in therapeutic emphasis down the road, the immediate impact is a sharp rise in the trend rate of growth for pharmaceutical expenditures under health benefits programs that cover drugs. Companies that provide drug benefits to both the working aged population and the elderly are responding to this rising trend in various. One increasingly common response, which this Subcommittee has undoubtedly observed in its oversight of the Medicare + Choice program, is a growing trend toward annual benefit limits on coverage for prescription drugs.

Annual benefits limit, viewed from the vantage point of the health benefits market, have some desirable features. Since the great majority of health plan beneficiaries have annual expenditures less than the limits, imposing these caps allows insurers to provide essentially full benefits to the great majority of beneficiaries, at a price far lower than would be possible if the cost of the small number of highest cost users were included. The imposition of caps also partially isolates the insurance pool from the upward trend in drug costs. Imposing caps, however, has the unfortunate side effect of exposing a limited number of the highest prescription drug users to the full cost of the medications they need.

Given these realities, the question arises whether a Medicare prescription benefit should provide "stop loss" protection for beneficiaries. As the term is commonly used, "stop loss" refers to a benefit design under which the beneficiary's out-of-pocket exposure for covered benefits is capped at a pre-specified level, after which the benefits program provides full benefits with no further coinsurance. This benefit design is, of course, the *mirror image* of an annual benefit limitation.

Because of the skewed character of the distribution of drug benefits risk, the cost of providing such a benefit is acutely sensitive to where the "stop loss limit" is set relative to that underlying distribution—both initially, and over time. Using the most recent Medicare Current Beneficiary Survey data available from HCFA—which is our only comprehensive source of information about drug spending and coverage among Medicare beneficiaries—my colleagues and I have conducted a detailed exploration of the fiscal and design implications of providing stop loss coverage for Medicare beneficiaries under various proposals now pending before the Congress. While we would be pleased to share our detailed findings on various points with the Committee at some later time, let me summarize the key lessons we have learned from this analysis:

First, the cost of providing stop loss coverage directed at the highest-cost patients is surprisingly affordable. A policy directed at covering the limited number of Medicare beneficiaries whose annual spending on drugs exceeds, say, $10,000, would amount to less than $50 million today, nationwide. As we come down the consumption scale toward lower levels, however, the costs begin to add up. By the time we get down to the level of, say, $1,000, the current cost of providing stop loss coverage could rise to over $10 billion annually.

Second, the cost of stop loss coverage is highly sensitive to the quality of the "front end" coverage Medicare beneficiaries have. By "front end" coverage, I mean

their present private drug coverage, through either a retiree benefits program or Medigap. This conclusion is a logical one, since the better that front end coverage is, the longer it takes for a beneficiary to exceed whatever out-of-pocket spending cap is provided by the stop loss coverage—and the less spending there is to cover once they reach it.

Third, for the reason just cited, the Subcommittee should be careful in its evaluation of proposals for "catastrophic only" drug benefits proposals. While benefits plans structured in this way may seem attractive for other policy reasons, they may have the effect of encouraging beneficiaries to drop their existing private coverage, converting the stop loss benefit into a high deductible unlimited coverage policy that would start paying benefits much faster than it would if their private coverage had been maintained.

Fourth, there are some important advantages to integrating administration of a "stop loss" benefit with whatever "front end" coverage beneficiaries elect. Unitary administration would sharply reduce the administrative hassle of keeping track of spending by the beneficiary, and would ensure continuity of application of whatever benefits management techniques were employed by the primary insurer.

Fifth, the cost of a stop loss benefit to the beneficiary in a voluntary market for private coverage will depend on the extent of participation, since a voluntary market may experience some degree of adverse selection. If low users were to disproportionately opt out of the system, the *per beneficiary* cost of providing stop loss would rise. It may be useful to note in passing, however, that the *total* cost of providing stop loss coverage through a private voluntary market would not be increased by adverse selection.

Sixth, and finally, it is important to point out that a stop loss benefit, by its very nature, will invite scrutiny of the cost of the high end pharmaceutical products that would comprise the bulk of the spending under such a benefit program. Those concerned, as I am, about the motive toward price controls embedded in any Government-financed drug benefit program will want to evaluate this issue carefully. It would, I believe, be very important to craft a program with a regulatory and financing structure that insulated decision-making about product coverage and pricing from political control.

Mr. Chairman, thank you for the opportunity to appear before the Subcommittee this morning to share the results of our work in this area. I would welcome the opportunity to answer whatever questions you or your members may have.

Mr. BILIRAKIS. Thank you, sir.

Ms. McCall?

STATEMENT OF CAROL J. McCALL

Ms. MCCALL. Good afternoon. I would like to thank the chairman and the other remaining members of the subcommittee for bearing with us. I am very thankful for the opportunity to be here.

My name is Carol McCall, and I am very recently the new executive vice president of managed care for Allscripts, but prior to this role, which again is very recent, as recently as last Friday I was vice president of pharmacy management for Humana, which is a managed care organization that provides pharmacy coverage for approximately 450,000 seniors through a Medicare+Choice program.

I am a fellow of the Society of Actuaries and a member of the American Academy of Actuaries, and I also serve as a member of the Academy's Medicare Reform Task Force that is studying a number of issues involving proposed changes to Medicare. Among these changes under study by the Academy are the issues associated with adding a prescription drug benefit to the current Medicare coverage. I would like to note that although I am a member of the American Academy of Actuaries' Medicare Reform Task Force, I am testifying today in my private capacity and not on behalf of the Academy, whose analysis will discuss these issues in more depth.

I would like to outline some of the issues that should be considered when designing a prescription drug benefit provided through insurance mechanisms. However, I would like to first emphasize one very important factor, which is that prescription drug coverage should not be added to Medicare in the absence of overall reform to the financing structure of the Medicare program.

As you are aware, the trustees of the Medicare Trust Funds have indicated that expenditures from the HI Trust Fund, Medicare Part A, are expected to equal income into the fund as early as 2006, and costs are projected to exceed income after that point. In fact, if income earned from interest on the assets in the Trust Fund is excluded, the fund currently pays out more in claims than it receives from payroll taxes and premiums paid by beneficiaries.

The Medicare Part B fund, which is financed primarily by general tax revenues, faces increasing financial pressure due to rising health care costs and a growing population of beneficiaries over the next decade. So adding a prescription drug benefit to either of these programs right now will only exacerbate the financial problems confronting Medicare, without the consideration of more broad reform.

Specifically to the drug benefit itself, there are certain considerations that should be kept in mind when designing a prescription drug benefit, and there are two broad categories that I am going to touch on briefly and then we can, if there are any questions, we can talk about those: First, the category of benefit design in particular; and then, second, overall program design and issues.

First, with respect to benefit design, is what drugs will be covered, and is it intended that all drugs will be covered by a plan or only those prescriptions most utilized by seniors? Will so-called lifestyle drugs be covered? And who will determine which prescriptions are included or excluded from coverage? To what extent will experimental treatments be provided? Each of these issues can have a major impact on the cost of the benefit.

And second is how will the benefit be managed? Most plans offering a drug benefit use some sort of utilization and cost containment mechanisms, and these mechanisms are designed to make sure the drugs prescribed are appropriate for the particular medical condition of the patient. One consideration in providing a drug benefit through Medicare is the extent to which utilization management will be allowed both in the Medicare fee-for-service and in Medicare+Choice health plans on an ongoing basis.

Third, the question of how will beneficiary cost-sharing be structured. A very important part of a health benefit design is how much and the manner in which participants are asked to pay a portion of out-of-pocket costs. If seniors pay for a portion of the cost, they are more likely to compare competing drug therapies, including any generic prescription drug options that are available. In addition, designing benefits where costs are shared, say through coinsurance, can impact the pricing strategies of pharmaceutical companies to the advantage of seniors.

Fourth in benefit design is to consider what extent drug formularies will be permitted. Formularies are one mechanism that PBMs, insurance companies and managed care plans use to contain the cost of prescription drugs. There are a number of different ways

in which formularies can be used, but all of them involve creating a list of preferred medicines whose costs are less than their therapeutic equivalents. The question is, will this mechanism for containing cost be allowed? And, if so, what is the method for choosing which drugs are going to be on a formulary? And can different plans have different formularies?

For overall program design, it is important to consider to what extent will private health plans be involved in the program. As we have just heard, currently prescription drug coverage is available for seniors through employers who offer retiree coverage, to those who enroll in one of the Medicare supplement plans offering such benefits, and for those members of a Medicare+Choice health plan that provides drug benefits. You will need to consider the impact of the Medicare drug benefit on these programs.

For example, will Medicare+Choice health plans be required to offer a benefit, for it is now an option. If a drug benefit is offered through Medicare, how will the Medicare supplement insurance plans currently providing drug benefits be treated? Will pharmacy benefit management companies, or PBMs, be used by Medicare to help administer a drug benefit for the beneficiaries? And what would be the role of PBM companies in this process? Would they serve only as administrators, or would they take some of the risk for their role they play in containing costs?

It is important that we understand these dynamics and the answers to these questions, as it will impact overall program cost and quality.

Finally, in closing, I would like to return to something I said at the start, which is, if Medicare is the vehicle chosen to provide prescription drug coverage for seniors, then Congress must act on the overall financial issues facing the Medicare program. It may be necessary to cut benefits, raise premiums, or increase contributions from the Federal budget in order to maintain the solvency of the Medicare Trust Funds. Adding an additional and potentially costly benefit to Medicare will place a further strain on the Medicare program. Congress should not let this opportunity pass without a serious discussion on how to deal with the long range financial solvency of Medicare.

Thank you.

[The prepared statement of Carol J. McCall follows:]

PREPARED STATEMENT OF CAROL J. MCCALL, EXECUTIVE VICE PRESIDENT, MANAGED CARE, ALLSCRIPTS

Good morning Chairman Bilirakis and members of the Subcommittee. My name is Carol McCall and I am the Executive Vice President, Managed Care for Allscripts. Prior to this role, I served as Vice President, Pharmacy Management for Humana, Inc., a managed care organization that provides pharmacy coverage for approximately 450,000 seniors through the Medicare+Choice program. I am a fellow of the Society of Actuaries and a member of the American Academy of Actuaries. I also serve as a member of the Academy's Medicare Reform Task Force that is studying a number of issues involving proposed changes to Medicare. Among these changes under study is adding a prescription drug benefit to the current Medicare coverage. I appreciate the opportunity to appear before you today to testify regarding ways to provide seniors with coverage for prescription drugs. I would like to note that although I am a member of the American Academy of Actuaries' Medicare Reform Task Force, I am testifying today in my private capacity and not on behalf of the Academy.

Prescription drug costs represent a significant part of health care expenses, and those costs have been rapidly rising over the past few years. The cost of prescription drugs can have a major impact on seniors, many of whom are on fixed incomes. Since Medicare is the primary source of health insurance coverage for seniors (almost 98 percent of the population in this country age 65 years or older is covered by Medicare), one possible approach to this issue is to expand the current Medicare coverage to include some level of payment for prescription drugs.

I would like to outline some of the issues that should be considered when designing a prescription drug benefit provided through an insurance mechanism. However, I would first like to emphasize one very important factor—*prescription drug coverage should not be added to Medicare in the absence of overall reform to the financing structure of the Medicare program.* As you are aware, the Trustees of the Medicare trust funds have indicated that expenditures from the Federal Hospital Insurance (HI) Trust Fund (Medicare Part A) are expected to equal income into the fund as early as 2006, and costs are projected to exceed income after that point. In fact, if income earned from interest on the assets in the HI trust fund is excluded, the fund currently pays out more in claims that it receives from payroll taxes and premiums paid by beneficiaries. The Supplementary Medical Insurance Trust Fund (Medicare Part B), which is financed primarily by general tax revenues, faces increasing financial pressure due to rising health care costs and a growing population of beneficiaries over the next decade. Adding a prescription drug benefit to either of these programs will only exacerbate the financial problems confronting Medicare.

There are a number of health insurance plans today that provide prescription drug coverage for their members. There are practical considerations that should be kept in mind when designing a prescription drug benefit:

- *Is providing a prescription drug benefit through Medicare the best option?*—Many of the current proposals start with the assumption that the drug benefit will be delivered to seniors through Medicare. Is this the most cost-effective way to help seniors meet their medical needs? Do other options exist—such as tax credits or using private insurance—that would work?
- *How will a Medicare prescription drug benefit impact other existing programs?*—It is also important to evaluate the impact of a Medicare prescription drug benefit on other payers for medical care for seniors. Currently, three Medicare Supplement insurance plans pay for drug coverage. In addition, some employers offer retiree health benefits that include prescription drug coverage and there are a limited number of Medicare+Choice health plans with a prescription drug benefit. You need to consider how a Medicare drug benefit will impact those programs.
- *What drugs will be covered?*—Is it intended that all drugs will be covered by the plan or only those prescriptions most utilized by seniors? Will so-called "life style" drugs be covered, and who gets to determine which prescriptions are included or excluded from coverage? To what extent will experimental treatments be provided? Each of these issues can have a major impact on the cost of the benefit.
- *How will the benefit be managed?* Most plans offering a drug benefit try to impose some form of utilization controls. These utilization management strategies are designed to make sure the drugs prescribed are appropriate for the particular medical condition of the patient. One consideration in providing a drug benefit through Medicare is the extent to which utilization management will be allowed both in the Medicare fee-for-service (FFS) program and in Medicare+Choice health plans.
- *To what extent will private health plans be involved in the program?*—Currently, prescription drug coverage is available for seniors who enroll in one of the Medicare Supplement plans offering such benefits and for those members of a Medicare+Choice health plan that provides drug benefits. Will Medicare+Choice health plans be required to offer the benefit (it is now an option)? If a drug benefit is offered through Medicare, how will the three Medicare Supplement insurance plans currently providing drug benefits be treated? Will pharmacy benefit management companies (PBMs) be used by Medicare FFS to help administer the prescription drug benefit for their beneficiaries? What would be the role of pharmacy benefit management companies in this process? Would they serve as the administrators of the program or will they take some of the risk for their role they play in containing costs?
- *Will any of the cost of providing the prescription drug coverage be subsidized?*—There is some concern that Medicare beneficiaries below a certain level of income will not be able to afford a prescription drug benefit that is supported by premium payments and/or co-payments and deductibles. What will be the level

of government subsidy for those enrollees and who will qualify for that support? How will Medicaid eligible seniors be covered?

- *How will co-payments or deductibles be structured?*—If you have to pay for something, you will generally take more notice of how much it costs. One important part of a health benefits design is how much participants are required to pay "out-of-pocket." If seniors pay for a portion of the cost, they may be more likely to compare competing drug therapies, including any generic prescription drug options.
- *To what extent will drug formularies be permitted?*—Formularies are one mechanism that PBMs, insurance companies and managed care plans use to contain the cost of prescription drugs. There are a number of different ways in which formularies can be used, but all of them involve creating a list of preferred medicines whose costs are less than their therapeutic equivalents. Will this mechanism for containing costs be allowed? If so, what will be the methods for choosing which drugs are on a formulary? Can different options and plans for providing coverage have different formularies?

I would like to return to something I said at the start of my testimony regarding this issue. If Medicare is the vehicle chosen to provide prescription drug coverage for seniors, then Congress must act on the overall financial issues facing the Medicare program. It may be necessary to cut benefits, raise premiums or increase the contributions from the federal budget in order to maintain the solvency of the Medicare trust funds. Adding an additional (and potentially costly) benefit to Medicare will place a further strain on the Medicare program. Congress should not let this opportunity pass without a serious discussion on how to deal with the long-range financial solvency of Medicare.

Mr. BILIRAKIS. Thank you very much, Ms. McCall.

Dr. Young?

STATEMENT OF DONALD YOUNG

Mr. YOUNG. Thank you, Mr. Chairman. The Health Insurance Association of America shares the concerns of many of you in Congress, calling for measures to help seniors better afford prescription drugs. We stand ready to work with Members of Congress of both parties and with the administration to help make senior prescription drug coverage a reality for all of our Nation's seniors.

We believe something can and should be done in the near term to help seniors, but short-term solutions should not disrupt current private coverage that seniors depend upon or impede more fundamental Medicare restructuring and reform in the future. Some of the proposals that have been offered would do much more harm than good.

Proposals that seek to provide coverage through stand-alone, drug-only insurance policies simply would not work in practice. Their proponents have ignored the realities of the insurance market and based their supporting analyses on unrealistic assumptions. Designing a theoretical drug coverage model does not guarantee that private insurers will develop that product or that beneficiaries would purchase it.

Some of the problems include high market entry costs; difficulty in pricing premiums for a volatile and continuing, ever cost escalating benefit; adverse selection, since drug use is frequently predictable; and significant regulatory hurdles at the Federal and State levels.

I want to stress also that high deductible products are not a solution. The experience is clear that this is not an approach that is popular with seniors. Since these are not likely to be accepted by seniors, they are not likely to be offered by insurers.

Similarly, attempting to assure coverage by mandating that private Medigap plans provide enhanced coverage for pharmaceuticals

would result in unsustainable premium increases and reduced coverage. Our analysis indicates that Medigap premiums would jump by anywhere from 50 to 100 percent as a result of this type of mandate. Remember, Medigap drug coverage plans are available now, but only 13 percent of those choosing Medigap enroll in such plans, largely due to their added expense.

In conclusion, any new policy proposal must be carefully examined to ensure that unintended consequences do not erode the private coverage options that beneficiaries rely on today to meet their health care needs. Survey after survey shows that beneficiaries are overwhelmingly satisfied with their Medigap coverage. As you consider options to help seniors with ever-escalating drug costs, don't destroy the product they rely on for peace of mind and financial protection. There are other workable solutions.

Thank you.

[The prepared statement of Donald Young follows:]

PREPARED STATEMENT OF DONALD YOUNG, CHIEF OPERATING OFFICER AND MEDICAL DIRECTOR, HEALTH INSURANCE ASSOCIATION OF AMERICA

INTRODUCTION

Mr. Chairman, distinguished members of the Subcommittee, I am Dr. Donald Young, Chief Operating Officer and Medical Director of the Health Insurance Association of America (HIAA). Prior to joining HIAA, I served for 14 years as Executive Director of the Prospective Payment Assessment Commission (PROPAC) where I was responsible for research, analysis, and the development of recommendations to the Congress and the Secretary of Health and Human Services on a wide range of Medicare policies. I also have served as Deputy Director of the Policy Bureau at the Health Care Financing Administration and as Medical Director for the American Lung Association. I began my career as a practicing physician in California.

I am very pleased to be here today to speak with you about how best to increase access to affordable prescription drugs for our nation's seniors.

SENIORS SHOULD HAVE EXPANDED ACCESS TO NEEDED PHARMACEUTICALS

As we all know, pharmaceuticals have become a critical component of modern medicine. Prescription drugs play a crucial role in improving the lives and health of many patients, and new research breakthroughs in the coming years are likely to bring even greater improvements. With older Americans becoming an ever-increasing percentage of the overall United States population, the need for more medicines for this sector of the population is becoming equally urgent. There is continuing emphasis on new pharmaceuticals to treat diseases typically associated with aging. Over 600 new medicines to treat or prevent heart disease, stroke, cancer, and other debilitating diseases are currently under development. Medicines that already are available have played a central role in helping to cut death rates for chronic and acute conditions, allowing patients to lead longer, healthier lives. For example, over the past three decades, the death rate from atherosclerosis has declined 74 percent and deaths from ischemic heart disease have declined 62 percent, both due to the advent of beta blockers and ACE inhibitors. During this same period, death rates resulting from emphysema dropped 57 percent due to new treatments involving anti-inflammatories and bronchodilators.

These advances have not come without their price. Rapid cost increases are putting prescription drugs out of reach for many of our nation's seniors. Because of both increased utilization and cost, prescription drug spending has outpaced all other major categories of health spending over the past few years. For example, while hospital and physician services expenditures increased between 3 percent and 5 percent annually from 1995 through 1999, prescription drug expenditures have increased at triple the rate, averaging between 10 and 14 percent. According to projections by the Health Care Financing Administration, prescription drug spending will grow at nearly 10 percent a year until 2008, almost double the rate of spending on hospital and physician services.

About two-thirds of seniors have some type of insurance coverage for pharmaceuticals—either through employer-sponsored retiree health plans, private Medicare+Choice plans, Medicaid or, in limited instances, individual Medicare Sup-

plemental (Medigap) policies. But this coverage may be limited, and it is likely to decline over time as cost pressures mount for employers, insurers, and individual consumers. For example, recent surveys indicate that employers are contemplating several changes for their retiree health care plans over the next several years, including increasing premiums and cost-sharing (81 percent of respondents to a 1999 Hewitt Associates survey sponsored by the Kaiser Family Foundation) and cutting back on prescription drug coverage (40 percent).

Also, unrealistically low government payments to Medicare+Choice plans is having the effect of reducing drug coverage for many seniors enrolled in these plans.

Increases in per capita payments on behalf of beneficiaries enrolled in Medicare+Choice plans from 1997 to 2003 are projected to be less than half of the expected increases during the same period for those individuals in the Medicare fee-for-service program. In fact, the President's Fiscal Year 2000 budget included projected five-year medical cost increases of 27 percent for the original Medicare fee-for-service program and 50 percent increases for the Federal Employee Health Benefit Program, while Medicare+Choice payment increases during the same period will be held to less than 10 percent in many counties.

In addition, most seniors live on fixed incomes and their purchasing power will continue to erode over time as drug expenditures increase more rapidly than their real income. In terms of current dollars, seniors' income has increased very little over the past ten years. From 1989 to 1998, the median income of households with a family head 65 years of age or older increased from $20,719 to $21, 589. This represents an increase in real income of less than 5 percent over the entire decade.

HIAA shares the concerns of many public voices today calling for measures to help seniors better afford prescription drugs. We stand ready to work with members of Congress from both parties, and with the Administration, to help make prescription drug coverage a reality for all of our nation's seniors.

While we all know that seniors need help, some of the proposals under consideration would fall short of the goal. In addition, the possible effects of any new policy proposal must be carefully examined to ensure that unintended consequences do not erode the private coverage options that beneficiaries rely on today to meet their health care needs. In fact, we are extremely troubled that some of the proposals before Congress would do just that.

Some of the proposals we have examined that rely on "stand-alone" drug-only insurance policies simply would not work in practice; their proponents have, quite simply, promoted a fiction by ignoring the realities of the insurance market and basing their supporting analyses on unrealistic assumptions. Others have proposed to assure seniors drug coverage by mandating that private health plans—either Medigap or Medicare+Choice, or both—provide enhanced coverage for pharmaceuticals. While this option has the virtue of being virtually cost-free from a federal budgetary standpoint, it would be far from inexpensive for seniors who, according to our estimates, would experience premium increases for Medigap products of between 50 and 100 percent. It also would result in many seniors dropping the supplemental coverage they depend upon, creating a whole new set of political problems.

My concern about these two policy options can be summed up in two statements:

- First, designing a theoretical drug coverage model through legislative language does not guarantee that private insurers will develop that product in the market.
- Second, if coverage that consumers cannot afford is mandated, the result will be unsustainable premium increases, limited choice, and reduced coverage.

It is simply not good policy (or politics) for Congress, as well intentioned as it may be, to enact legislation that will result in seniors not being able to purchase today's extremely popular and very successful Medigap coverage.

HIAA HAS DEVELOPED A SOLUTION TO HELP ALL SENIORS

Before I elaborate on these concerns, let me first make clear that HIAA believes strongly that the status quo is unacceptable. Last year, HIAA's Board of Directors approved a three-pronged proposal developed by our member companies that would help all seniors. The HIAA program would: (1) help lower-income seniors through drug assistance programs; (2) provide a tax credit to help offset out-of-pocket drug costs for all other seniors; and (3) ensure fair payments to private Medicare+Choice plans that are struggling to provide prescription drug coverage for seniors despite unrealistically low government payments that will not keep pace with medical inflation and the projected increases in drug costs. I will not discuss the details of HIAA's proposal today. We have shared our plan with all members of Congress and we would be happy to discuss it with you in more detail at any time, or to respond to questions about it following my formal testimony. Let me just say that the HIAA

proposal represents an immediate and workable step that will provide meaningful relief for all seniors, while avoiding the disruption and confusion for beneficiaries that surely would result were Congress to make changes in seniors' private benefit options before addressing needed changes in the underlying Medicare program.

My testimony today will focus primarily on the reasons why we believe that relying entirely on private insurance models as a way to provide drug coverage to seniors is unsound—particularly without significantly restructuring Medicare. First, I will outline HIAA's concerns with stand-alone "drug-only" insurance plans for seniors. I will then elaborate on why we so strongly oppose drug coverage mandates on private insurance products.

WHY A "DRUG-ONLY" BENEFIT IS AN EMPTY PROMISE FOR SENIORS

Some have proposed that most seniors' drug coverage needs could be met by authorizing the creation of several new private insurance coverage options. Theoretically, these "drug-only" policies would be offered either as stand-alone policies, or sold in conjunction with existing Medigap coverage.

Developing a legislative prototype based on a set of theoretical constructs does not guarantee that the market will respond by creating a private insurance product. Creating a new form of insurance is not easy. As with any new product, start-up efforts are costly and time-consuming. Adding to the difficulty is that such insurance policies would have to meet existing (and possibly new) state and federal requirements before they could be sold. Thus, before making its entry into the marketplace, a "drug-only" policy would have to clear a multitude of economic and regulatory hurdles. Our members have told us that it is unlikely to do so.

Economic Barriers and Adverse Selection Problems

Insurance carriers attempting to bring this type of product to market would face many barriers, including the costs of development, marketing, and administration. Premiums for the policy would have to reflect these costs. Adding to these administrative expenses is the inherent difficulty of developing a sustainable premium structure for a benefit that is so widely used and for which costs are rising so dramatically.

Volatility in pharmaceutical cost trends also will make a stand-alone "drug-only" policy difficult to price. While there has been relative stability in the rate of increase of hospital and physician costs during the past two decades, pharmaceutical costs have been more difficult to predict. In March 1999, for example, HCFA estimated that prescription drug expenditures would reach $171 billion by 2007. Just six months later, in September, HCFA was forced to revise these projections and now predicts that prescription drug spending will reach $223 billion by 2007, a 30 percent increase over the previous estimate. Since the Administration first offered its Medicare drug benefit proposal just last year, it has had to revise cost estimates for the program upward by more than 30 percent due largely to greater-than-expected increases in the costs of prescription drugs.

For many reasons, "drug-only" policies would be very expensive to administer. Adding to the economic liabilities of these policies, therefore, are the expense margin limitations insurance carriers must meet under OBRA "90, which are likely to be too small to support separate administration of drug benefits.

The most difficult factor driving up premiums, however, will be "adverse selection." Adverse selection occurs because those who expect to receive the most in benefits from the policy will purchase it immediately, while those who expect to have few claims will forgo purchasing it. When people with low drug costs choose not to enroll in coverage while those with high costs do enroll, insurance carriers are forced to charge higher premiums to all policyholders. The more opportunities there are for enrollment, the greater the risk of adverse selection.

Adverse selection would be a very real problem for this type of product. Projections indicate that one-third of seniors (even if all had coverage for outpatient prescription drugs) will have drug costs under $250 in the year 2000, with the average cost estimated at $68. These seniors are unlikely to purchase *any* type of private drug coverage, given that the additional premium for such a policy would be at least 10 times higher than their average annual drug costs. Of the two-thirds who might buy the coverage, many would be doing little more than dollar trading. Some may actually end up much worse off: a person with $500 of drug expenses could have premium, deductible, and coinsurance costs equal to over 200 percent of the actual costs of drugs. Consequently, many seniors are not likely to purchase the product, resulting in further premium increases for those that do.

Limiting the sale of these policies to the first six months of Medicare eligibility would help in theory only, given legislators' demonstrated proclivity to expand on "guaranteed issue." The Clinton Administration's Medicare drug coverage proposal

seeks to avoid adverse selection by limiting enrollment in a government-provided drug coverage plan to the first six months when beneficiaries initially become eligible for Medicare. While this type of rule theoretically helps, the concept seldom works in practice because legislators and regulators expand guaranteed issue opportunities over time in response to political pressure. For example, the "first time" guaranteed issue rule originally in place for Medigap policies has been greatly expanded over time—both through new federal rules in the Balanced Budget Act of 1997 (BBA) and through state law expansions.

Regulatory Hurdles

Even if such insurance policies were economically feasible, they would face significant regulatory barriers. The National Association of Insurance Commissioners (NAIC) would likely have to develop standards for the new policies; state regulators would have to approve the products before they could be sold, as well as scrutinize their initial rates and any proposed rate increases. Even relatively straightforward product changes based on proven design formulas can take several years to progress from the design stage through the regulatory approval process and, finally, to market.

Because insurers would be required to renew coverage for all policyholders (as they are required to do with Medigap products), policies could not be cancelled if new alternatives were authorized by subsequent legislation or regulations. This would exacerbate adverse selection problems for these plans, since people with the greatest drug needs would retain them while others may seek out less costly alternatives. It also would dampen interest in offering the product in the first place, as insurers would be locked into offering these policies once they were issued.

Guaranteed renewability also would exacerbate pricing problems for these "drug-only" products. While many in Congress have said that they oppose government price controls for pharmaceuticals, private insurers offering "drug-only" coverage are sure to face premium price restrictions on their products at the state level (all states have adopted either rate bands, modified community rating, or full community rating for Medigap as well as medical insurance coverage options available to non-seniors). Even when proposed premium increases are consistent with state law parameters, state regulators are likely to be resistant to the magnitude of increase it would likely take to sustain a "drug-only" insurance policy as drug prices grow over time.

If the NAIC did standardize these policies, as some have proposed, it could impose unworkable limitations on insurers. If insurance carriers were prevented from adjusting co-payments and deductibles as drug costs continue to skyrocket, effective cost management would not be possible without significant premium increases over time. On the other hand, allowing needed flexibility would destroy the standardization of Medigap that Congress and the NAIC have worked so hard to achieve during the past decade.

High-Deductible Options Introduce Additional Practical Limitations

Various suggestions have been made to render these policies economically viable. One suggestion that flies in the face of historical reality is to design the policies with very high deductibles—a feature that has never been popular with seniors. Comprehensive high-deductible Medicare+Choice medical savings account plans authorized under the Balanced Budget Act of 1997 (BBA) are not available because no company believes it can develop sufficient market size to make it worth the effort. It is also notable that no carrier has attempted to develop or market the two higher deductible Medigap policies authorized under the BBA, largely out of the knowledge that this product would not be attractive to a large enough block of seniors to make it viable. The $1,500 deductible in those BBA Medigap policies is considerably lower than some of the deductible levels proposed by advocates of the new drug-only policies.

In short, a "drug-only" policy is an empty promise: it sounds good but it cannot succeed in the real world.

A MEDIGAP DRUG MANDATE ALSO IS A BAD IDEA

Another bad idea is mandating drug coverage for Medicare supplemental insurance. (More than 20 million Medicare beneficiaries have such coverage, with 9 million policies purchased individually and 11 million through the group market.)

HIAA is strongly opposed to proposals that would require Medicare supplemental insurance or Medicare+Choice plans to cover the costs of outpatient prescription drugs without the addition of prescription drug coverage as a Medicare covered benefit. The growing cost of pharmaceuticals would force plans with mandated drug coverage to raise premiums or enrollee cost-sharing or reduce other benefits, all of

which would be counterproductive as seniors dropped their supplemental or Medicare+Choice coverage. Mandated drug coverage also could lead to overly-restrictive government restrictions on private plans, such as prohibitions on the use of formularies or mandating certain levels of coinsurance.

Today's Medigap marketplace is convenient and flexible, offering many choices to seniors. Of the 10 standard Medigap policies (A through J) sold, three (H, I, and J) provide varying levels of coverage for outpatient prescription drugs. Only a relatively small number of seniors (about four million) are willing to pay the additional premiums.

Several studies show that adding a drug benefit to Medigap plans that currently do not include such coverage would increase premiums dramatically. Seniors who today have chosen to purchase Medigap policies that do not provide a drug benefit would end up paying $600 more a year (assuming a $250 deductible for the policy), according to HIAA estimates.

And if Congress were to require more comprehensive drug coverage, those premiums could double. According to a May 1999 study by HIAA and the Blue Cross Blue Shield Association, requiring that all Medigap plans include coverage for outpatient prescription drugs would raise Medigap premiums by roughly $1,200 per year, an increase of over 100 percent.

Premium increases of 50 to 100 percent would result in many seniors dropping their Medigap coverage, leaving them without protection against the high out-of-pocket costs of the hospital and physician services not covered by Medicare. Moreover, increases of this magnitude would discourage employers (who are also purchasers of supplemental coverage) from offering such a benefit at all.

It is doubtful, then, that requiring all Medigap policies to include a drug benefit would be popular with seniors—who would experience diminished choice of policies, higher prices, and in some cases, loss of coverage.

CONCLUSION

The plight of seniors who are struggling to make ends meet and are finding it difficult to pay for medicine is very real. But the immediacy of the problem should not lead to short-term fixes that would do much more harm than good. We believe Congress should step back and examine a broad range of proposals—such as financial support for low-income seniors, tax credits, and fair payments to Medicare+Choice plans, most of which offer drug benefits. We believe there are workable solutions that can meet the needs of our seniors without undermining the coverage they currently rely upon. HIAA stands ready to work with the members of this Subcommittee, and all in Congress and the Administration, to ensure that all seniors to have access to affordable prescription drugs.

Mr. BILIRAKIS. Thank you, Dr. Young.

Ms. Alecxih, you heard the comments by Dr. Young, his most recent comments regarding Medigap insurance. Do you agree with them?

Ms. ALECXIH. In terms of "don't mess with Medigap"?

Mr. BILIRAKIS. In terms of the numbers of seniors or beneficiaries who have Medigap and the reasons why they don't carry the drug——

Ms. ALECXIH. I don't think there is any direct evidence of reasons why they don't carry it. I do know after the 6-month open enrollment period, that there are only like two companies in the Blue Cross-Blue Shield selected States that don't use health status as a screen for whether or not you can gain that coverage at a future time, you know, after your open enrollment. So I don't know if it is just a choice based on premium or if it might also be not being able to gain access because they are underwritten out.

Mr. BILIRAKIS. All right. Now, Dr. Young mentioned, of course, the expense involved to seniors in terms of a Medigap policy which would include drug coverage. Notwithstanding that, if all Medigap insurance policies included drug coverage or if all seniors who have Medigap were to use the Medigap policies that include drug coverage, how many more, in terms of percentage, seniors now not

covered by prescription drug coverage would be covered, would you say?

Ms. ALECXIH. Well, I think you have an issue——

Mr. BILIRAKIS. How much does that close that gap, in other words, of 20, 30 percent, whatever it is?

Ms. ALECXIH. About 15—well, about 30 percent of people who have supplemental coverage get it from Medigap, and probably about 20 percent of those then have drug coverage, and that is—you said 13 percent.

Mr. BILIRAKIS. We get 13 percent.

Ms. ALECXIH. You get 13 percent. MCBS gets 42 percent. So pick a number in the middle for now. So if you say 20 percent of 30 percent, you have got somewhere in the neighborhood of 6 percent, but that is assuming all of them keep the coverage.

Mr. BILIRAKIS. So if all of them, if all of the Medigap policy holders had policies, Medigap policies that offer prescription drug insurance, you would raise that 69 to 70 percent figure of seniors who have prescription drug coverage by, what, 6 percent, another 6 percent? Is that what we are saying?

Ms. ALECXIH. Probably, yes, 76, 77, assuming that everybody who has Medigap continues to have a Medigap policy and that you haven't priced them out of the market.

Mr. BILIRAKIS. Yes. Right, right.

Dr. Young, in your written statement you indicated, and I am just quoting from that written statement, that stand-along, drug-only insurance policies simply would not work in practice, and that their proponents have promoted a fiction by ignoring the realities of the insurance market, and of course you expanded upon this here orally a moment ago. But expand upon that, will you? Explain your reasoning, why you feel that that is the case.

Mr. YOUNG. If you move to an added benefit, drug benefit, you are going to increase the cost, and the people that look at that and say, "Does that cost more than what my drugs cost out of pocket?" and a substantial share are going to say yes. Why should I buy that? That is more costly to me than my drugs are costly.

Mr. BILIRAKIS. Then what you are saying is that prescription drug only coverage would not work?

Mr. YOUNG. That is correct. That is absolutely correct.

Mr. BILIRAKIS. Are we saying that the insurance companies would not offer those policies, they would not be available, or they would be available but be too expensive to be used?

Mr. YOUNG. It is entirely possible that there would be a small number of companies that would offer them, and it is possible that there would be a small number of beneficiaries that would buy them, but the only people that would buy them are in the high income category group, so that it is not a solution that has any practical value across the great majority of the Medicare population.

Mr. BILIRAKIS. Disagreements? Ms. McCall? Or agreements, whatever? Do you have any feeling on that.

Ms. MCCALL. To add to a couple of comments, I think some things to consider, there was a lot of good discussion this morning about the ultimate goal that we want to achieve and how quickly we could do things and how perhaps it may need to be phased. But if the ultimate goal is to integrate a coverage or a set of coverages

for hospital, physician and ultimately pharmacy coverage, that moving toward a stand-alone perhaps is not a step in that direction, No. 1; and would that in fact be a universal access type program?

Point No. 2, there may be some unintended consequences. When you have a more integrated approach with pharmacy and medical, there are medical directors who will tell you that it is very, very important to pay for particular drugs that could be very high in cost, and yet what you gain, you gain for not only quality of care but for cost somewhere else in the care equation. So how companies offering drug-only coverage would approach utilization management, it would be fundamentally different in some respects, and you would have to be careful with that.

Mr. BILIRAKIS. Well, my time is up. Mr. Moran, if you have something real quick.

Mr. MORAN. I just wanted to comment briefly, perhaps, while agreeing with everyone that comprehensive coverage is obviously a superior vehicle to deliver these drug benefits, for all the reasons we have just described, I have a slightly different view, though I reach some of the same places that Don does on the individual coverage. Perhaps we could come back to that in another question, if that is timely from your perspective.

Mr. BILIRAKIS. Ms. Alecxih, do you have anything to add to that?

Ms. ALECXIH. No, thank you.

Mr. BILIRAKIS. Thank you. Mr. Waxman?

Mr. WAXMAN. Well, that is an interesting point that you have all seemed to concur in, that stand-alone policies for drugs only doesn't appear to be a viable way for us to go to cover people. Does anybody disagree with that, on this panel? Mr. Moran?

Mr. MORAN. Yes, Mr. Waxman. While not completely disagreeing with it, from the standpoint that clearly I join my colleagues in suggesting that comprehensive coverage is superior as a mechanism for delivering a drug benefit, for all the reasons we have described, if comprehensive reform is not in the offing, and the question is not whether or not you are going to go forward with an interim benefit but what form of interim benefit you are going to go forward with, then the analytical framework might shift a little bit and you might get a slightly different answer from some of us than the one you have gotten up until now.

Mr. MORAN. Well, give me an example of a benefit that would be limited so that it might induce insurers to want to cover prescription drugs?

Mr. MORAN. Let me offer you, without trying to speak for Don and his industry, a couple of insights. One is that in a purely voluntary market where no one received any degree of financial support for participation, you would have more concern about that than you would in a market where, as many people are discussing in a variety of proposals, a substantial number of people, without regard to their drug health risk, who are going to be offered a fairly substantial degree of subsidies to participate. To the extent that is in fact the case, you could have a viable private market wrapped around that degree of participation without too heavy concerns about the kind of selection effects that people are worried about.

I think a second area of concern is that if there are expedients that could dampen the risk faced by insurers through a variety of mechanisms, public or private, that might also have a mitigating effect.

And, at the end of the day, I think you have to understand that the context of some of the insurance industry's concern is not just what Washington will do but how a freestanding drug benefit would play out vis-a-vis the existing State regulatory structures, because, as you recall, Medigap policies are now price regulated in virtually every State in the country at the individual market level. And if I were an insurer valuating a private market, I might be very concerned that I could go into a Federal scheme that seemed to be well balanced and reasonable, and then get stuck with totally unrealistic price regulation at the State level going forward.

So there is a lot of work to do to get to a workable policy, and I don't mean to pretend that it is simple, but I am not—I am trying to maybe offer you an existing proof that it is perhaps not impossible.

Mr. WAXMAN. It sounds like, and I want to hear Dr. Young's view, but it sounds like you are saying if it is heavily subsidized, maybe someone will offer it, if you relieved them of regulatory responsibility at the State level and limited the benefit.

Mr. YOUNG. Thank you, sir. That is a very good summary.

Mr. MORAN. I would probably go, having been invited to talk to you about the wonders of stop-loss, I would probably have to advocate that in this context, as well. I think you could offer a benefit in the private market context focused on the highest market cost drugs without worry about severe selection effect.

Mr. WAXMAN. How would you get any kind of cost containment under this kind of a scheme? Any of you have any ideas of that?

Mr. YOUNG. In terms of the current Medigap market, while there is not a lot of people in it, there is the ability to get price discounts. The Medigap carriers that do write this and the people that do buy it are pointed toward places where they can buy, mail order houses, other sites, so they get some price discounts. They don't have the care management piece but they do have the pricing discounts.

Mr. WAXMAN. Is that our most efficient way to get the price discounts and to integrate a prescription drug benefit with the other health care needs? Ms. McCall, you spoke to that point a bit.

Ms. MCCALL. I apologize. Is which way the most efficient way?

Mr. WAXMAN. Well, if you get a Medigap policy that covers prescriptions, which is heavily subsidized but has a limited prescription benefit, now it is going to pay for some drugs, and I asked whether there can be cost containment. In Dr. Young's view, he thinks that there could be cost containment because they are a larger purchaser, but are we really going to get the benefit of the maximum cost containment that we could get in a reasonable fashion, and integrate the benefit with other health care services?

Ms. MCCALL. It would be more difficult in that type of design. I will go back to what my colleagues stated in discussions about stop-loss. You can have very high stop-loss, but you have to look at what——

Mr. WAXMAN. I wasn't talking about stop-loss. I was just talking about the benefit itself.

Ms. MCCALL. Correct.

Mr. WAXMAN. Because the fact of the matter is, of all the demographic groups, seniors are charged the highest for prescription drugs, and this is true because so many seniors don't benefit from being a large purchaser with the ability to get discounts on drugs. So I don't think the experience has been, Dr. Young has argued there is some contrary evidence, but I don't think it has been true that under the Medigap plans you get a large amount of discounted drugs. I think most of the time you purchase drugs at retail prices and the Medigap policy pays for it. Do you think the Medigap approach is going to be a way to get leverage?

Ms. MCCALL. I believe that we can get cost containment through lower prices through that mechanism. I have much less experience with Medigap. However, the limited Medigap business that Humana had, we were able to obtain the on-line adjudication and the discounts for the enrollees that we did have in our Medigap policies, so I believe that those mechanisms could be used to obtain the type of cost containment you are talking about.

Mr. MORAN. I guess if I might, Mr. Waxman, just supplement that slightly, it really depends, to be direct about answering your question, on what your standard of efficiency is. If your standard of efficiency is the lowest unit prices for a particular class of drugs, then it really depends on the benefit design. I mean, the challenges, most of the benefit designs we have seen brought forward in this debate are really not insurance; they are just a form of installment financing for whatever purchases people were going to make anyway.

Mr. WAXMAN. There is not much cost containment in that.

Mr. MORAN. No. Well, certainly heavy front end dollar benefit structures capped at $500 or $1,000 or something like that have actuary values very close to $500 or $1,000. I mean, people are basically buying a sure way of paying for that throughout the year. If that is your policy, then you can argue whether price controls are more efficient than competing private markets, that kind of stuff, but that doesn't give you a lot of policy traction.

If, on the other hand, your policy is insurance, then trying to create a market that stimulates an environment where people can get coverage, and I think a private market could actually be a fairly efficient way of bringing about fairly higher end catastrophic—well, I guess we weren't supposed to say the "c" word, were we, Mr. Chairman?

Mr. WAXMAN. If catastrophic coverage were the goal.

Mr. MORAN. If that were the primary essence of where you were going, then a private market could be very efficient at bringing you that.

Mr. WAXMAN. I see my time is up.

Mr. BILIRAKIS. Dr. Ganske?

Mr. GANSKE. Well, Mr. Chairman, I just have to keep going back to lessons that Congress should have learned from 1988 on this. Mr. Burr had a series of questions for the previous panel, and I think this panel was in the room at the time, and it was basically along the lines that under the administration's plan, for instance,

which still costs about $170 billion, a sizable percentage of the beneficiaries would end up paying more rather than less in their current situation, because maybe they don't need that much in terms of a pharmacy benefit.

This in fact is what happened in 1988. That wasn't a voluntary program. That was across the board. And so if you look at the surveys from that time, you found that the senior citizens were about evenly split. About 50 percent thought that that catastrophic plan was good, and about 50 percent were vehemently against it because it raised their premiums, and they also had some means testing in there, the same thing that, you know, the administration is proposing.

And it goes back to what Mr. Rostenkowski said was, tongue in cheek, a mistake that they made when Congress designed that program at that time. He said we adopted a principle universally accepted in the private insurance industry: People pay premiums today for benefits they may receive tomorrow. But the fact is, if you have a voluntary program and if somebody looks at it and says, "You know, I don't need that much right now. I don't think I'll get into paying more premiums right now. I'll just wait until I get a little sicker and I need higher premiums," then you have distorted that risk pool significantly.

So it looks to me like, you know, the administration is trying to get around the problem that they had in 1988 by saying, "Well, now we are just going to be voluntary," but then they come up with this 80 percent participation that I just can't see with the way the numbers are. And it gets us back to, well, if you put enough Federal dollars into this benefit so that the seniors have to pay almost nothing for this, and you are now just talking about a $10 premium increase, well, then, yes, then you may be able to get enough participation, and of course the seniors would love that. But that is why the Clinton administration didn't design it that way, because they have already, under the way they have done it, come up with about a $170 billion plan.

Now, is my analysis correct?

Mr. YOUNG. Your analysis, from the point of view of drug-only Medigap, is exactly on the mark. That is our point exactly. That is why a drug-only insurance, private insurance solution is not a solution at all. It is not going to work. You are right on the mark.

Mr. MORAN. At the risk of sounding like a broken record, I guess I would say that the critique there is not so much the label you put on it but the fact that once again the policy you are characterizing is one that is very heavily oriented, with very heavy front end benefits, with very low caps. In an environment where you are doing that, all you are doing is taking money out of people's pockets and then handing it back to them in some different fashion than what they collected it, and of course you can find a whole variety of circumstances under which some people get more, some people get less, in often seemingly random fashion, without making any sense of it.

Mr. GANSKE. Correct me if I am wrong. We have got several actuaries on this panel, and everyone is well versed in what is going on, but it looks to me like, you know, we have seen some significant HMO premium increases, not in Medicare but across the board.

Isn't a large percentage of that related to the significantly escalating pharmacy benefit cost?

Mr. YOUNG. Absolutely. Drug, pharmacy costs are by far the fastest growing component, 16 percent and in some cases even more a year, and becoming a substantial part of the overall funding.

Mr. GANSKE. And, Mr. Moran, I think you alluded to the fact that we have got some drugs coming on line here that could be hugely expensive. I mean, we are talking about gene therapies. We are talking about, I believe that we will see in my lifetime a type of protein breakdown inhibitor that could affect the ends of the chromosomes, which would be an anti-aging type of medication. Now, you know, a drug company will have the patent for that. I think that that is going to be very, very expensive. That could bump you right into that catastrophic limit, even if it is very high, if you start out with something at $6,000, $7,000. Is that not right?

Mr. MORAN. I think the point I was trying to make earlier is that it depends on what your policy concern is. If your policy concern is in fact about making certain that all Medicare beneficiaries have access to the highest cost products as they become available on the market, to the extent they are therapeutically indicated, then you have to go in the direction of a stop-loss type of policy because no other type of policy is going to get you there.

Indeed, perhaps the analogy that might resonate is that, let's suppose that within 3 years we announced that some biotechnology company had discovered a cure for Type I diabetes that constituted a 6-months course of a biological that cost $75,000 a year to manufacture. How long would this subcommittee be able to avoid hearings on that subject, and what would you do with it, if it came about?

Mr. GANSKE. There you go.

Mr. MORAN. You would either have a stop-loss policy already in place as a policy response to that eventuality, or you would be authorizing that program in the coming months, in the same way that you have authorized programs for the treatment of end stage renal disease and other areas where there were definitive, kind of "nail it" treatments brought forward, regardless of the price.

So, I mean, to me that is the challenge in all of these issues, is on the one hand we can say that we are dealing with this from the context of the existing structure of drug benefit programs and we know what to do, but the policy challenge is right over the horizon looking at us.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. GANSKE. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Mr. Barrett?

Mr. BARRETT. Thank you, Mr. Chairman. I apologize for not being here for the testimony, so my questions might not particularly be on the mark or might seem naive, but the first comment and question I have is, one of the parts of the debate that we hear, one of the points we hear with regard to trying to control the cost of prescription drugs is, whether it is with a market type of approach, or some would argue that it is price controls, is it would inhibit innovation, it would inhibit any type of explorations.

Do you find that the current laws with regard to Medicare, because Medicare obviously covers virtually everything except pre-

scription drugs, have they in any way inhibited research or innovation in other areas of health care? And just go down the line, just to get your opinion on that.

Mr. YOUNG. That would be a very difficult question to answer definitively, as that is a cause and an effect. I don't have any information that says that there is evidence that you have impeded innovation. I think you can argue in a number of cases that Medicare's payment policies have in fact provided fuel that has fostered some innovation, by putting more money in the health care system overall, but I am not sure how anyone would ever draw the conclusion with any degree of certainty that you are asking.

Ms. ALECXIH. I think the set-asides within Medicare and the hospital PPS payment system for teaching hospitals, in and of itself, encourages innovation because that is where a lot of that stuff is going to occur on the medical procedure side. And so I don't—that is all I would have to offer on that point.

Mr. MORAN. I mean, in the intermediate and the longer term it is possible to take all kinds of different views about this. I guess my thinking on this is colored heavily by the fact that if you look out across the existing landscape, a lot of the really cutting edge stuff is being done now by smaller biotech companies rather than by large pharma companies, and virtually all of those are that the point—they are in a premarketing stage. They basically have no revenues, and they are 100 percent dependent on venture capital in order to finance the next 6 to 9 months of operation.

And I guess a concern I have is at some point, if you were to come forward with a serious prospect that there might be some active price intervention from Congress' standpoint, the venture capital would dry up for a large chunk of that, and if venture capital dries up for a large chunk of it, they don't make it through the year.

Mr. BARRETT. But have you seen any evidence of venture capital drying up for any other segment of the health care industry?

Mr. MORAN. I think you would have a difficult time financing any subacute fields this month, frankly. Yes, venture capital dries up in every area of health care where it turns out not to be a good idea on a retrospective basis. And so, I mean, that is the challenge in all of this.

Mr. BARRETT. Ms. McCall?

Ms. MCCALL. I guess to add onto what Mr. Moran has just said, I have had the opportunity to negotiate with a number of manufacturers and have had to pay a lot of attention to formulary design, and I understand the challenges that pharma faces in terms of—not that I always like them, but I understand the challenges they face in terms of how long they have for a drug to be on market.

Mr. BARRETT. That is no my question.

Ms. MCCALL. I understand.

Mr. BARRETT. My question is other areas of health care. I understand the argument that it is tabu, that we should never, ever mention any type of government intervention with——

Ms. MCCALL. Sure. I do believe——

Mr. BARRETT. [continuing] with prescriptions, but it blows my mind when I see the commercials that say do you want government involved in your health care, and I am thinking the only part—

talking to seniors, the only part that government is not involved in is prescription drugs, and everybody is happy with everything but that. So I am wondering what evidence there is that somehow government has screwed up innovation in other areas of health care because government is involved.

Ms. MCCALL. The only evidence that I would see, and I don't think it is screwed up, is again in the subacute area where the issue is one of financing. Are we trying to actually finance something below the cost that it takes to deliver something? Once you reach that point and everybody recognizes it, there will not be an injection of capital into those areas.

But I also believe that what is happening in the drug development area is so unlike what is happening in other areas of technological development, that it is at least different in degree, if not different in kind, in the types of development taking place.

Mr. BARRETT. Have any of you looked at the Tom Allen bill? I know that it is something that—and I was frankly a little disappointed when I looked at the committee memorandum and the different models for reform. It listed—I didn't see any mention at all of the Tom Allen bill, and I am just interested in your comments on that bill.

Mr. MORAN. The superficial policy is what it is. It states an intention to try to go toward what amounts to a unitary pricing structure or a voluntary—I mean, the challenge, whether or not you believe that as a matter of policy is a matter of taste, in my judgment. The question really is as to the administrative workability of it, and I guess my experience in these kind of things is, you won't know until you try it, and once you have tried it, you will find it is a lot more complex than you think it is.

Mr. YOUNG. The information that was presented by Mr. Greenwood I think showed price versus other factors driving up costs, and that price was a component but there were multiple other factors that were driving up drug spending costs, including utilization, mix of services, and things that were used. And so I think you have to be careful if you are focusing only on price, No. 1. And, No. 2, we have had a number of experiments in this country on price controls, and they generally have not worked well.

Mr. BARRETT. I am sorry. Do you believe that the Allen bill is price controls, I guess was my question.

Mr. YOUNG. Okay. Then we get into a matter of semantics. I don't know what kinds of words you want to use, but you are interfering with an exchange or you are intruding into an economic exchange, whether you want to talk about it as price controls or how you do it.

And we do know, as one of the witnesses mentioned earlier, that the Medicaid system, whether you call that price controls, led to a change in the market. There is an action and a reaction to it. So I think you need to be very careful when you start getting involved in market transactions and rules and regulations.

Mr. BARRETT. One final question, just as a follow-up to that. I am of the belief that under the current system, that older people pay more because disproportionately they are not covered by health care plans. And Ms. McCall made reference earlier to unintended consequences. I guess my first question is, do you agree with my

factual assertion that older people by and large are paying more? And, second, is that an intended consequence or an unintended consequence?

Mr. BILIRAKIS. Brief responses, please.

Mr. YOUNG. It is a consequence of younger people tending to have insurance, and they buy insurance through the workplace and they are in some form of pharmacy benefit management, drug pricing. So they are getting a discount, and the seniors, the evidence seems to be overall, are paying more than those who are getting a discount through a large group.

Mr. BARRETT. So, is that an intended consequence or an unintended consequence of the current system?

Mr. YOUNG. No, I think that is an unintended consequence. I think the consequence was to give those who are negotiating in plans, and the plans moved forward, to get the discounts.

Mr. BARRETT. Okay. And I would yield back. My only, if I may——

Mr. BILIRAKIS. You are well past your 5 minutes.

Mr. BARRETT. The fear of moving into these new systems is that there is unintended consequences. My point is, under the current system, as you have said, Dr. Young, there is an unintended consequence that I think hurts older people. And I would yield back the balance of my time.

Mr. YOUNG. If I could just add to it, there is a residual, and maybe we are getting into semantics about an unintended consequence or a residual effect. The fact that the seniors are playing may be a residual effect and not an unintended consequence.

Mr. BILIRAKIS. Dr. Ganske, did you have anything further, another minute or 2? You are more than welcome.

Mr. GANSKE. No, thank you.

Mr. BILIRAKIS. I have shocked you, haven't I?

Well, you have waited for so very long, and we certainly appreciate it. By now, some of you have done this before and you know what it is like being on that third panel, which is always a terrible panel to be on. But we appreciate it so much.

Now, there may be and quite often are questions from the members of the subcommittee staffs to you in writing, and I know you don't mind receiving those and responding to them, if you would. If there isn't anything further to come before this subcommittee, we will go ahead and adjourn and release you, and thank you again.

[Whereupon, at 3:19 p.m., the subcommittee was adjourned.]