

THE ADMINISTRATION'S PRESCRIPTION DRUG PROPOSAL

HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON WAYS AND MEANS HOUSE OF REPRESENTATIVES ONE HUNDRED SIXTH CONGRESS SECOND SESSION

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MAY 11, 2000
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**THE ADMINISTRATION'S PRESCRIPTION
DRUG PROPOSAL**

THURSDAY, MAY 11, 2000

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The Subcommittee met, pursuant to call, at 9:31 a.m. in room 1100, Longworth House Office Building, Hon. William M. Thomas, (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE

Contact: (202) 225-3943

May 4, 2000

No. HL-14

Thomas Announces Hearing on Administration's Prescription Drug Proposal

Congressman Bill Thomas (R-CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on the Clinton Administration's prescription drug proposal. The hearing will take place on Thursday, May 11, 2000, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 9:30 a.m.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include representatives from the Administration, the Congressional Budget Office, as well as other interested parties knowledgeable on the structure and financing of a Medicare prescription drug benefit. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Although Medicare currently offers a range of health care benefits, it differs significantly from other Federal health care programs and private sector health insurance in that it does not generally offer its enrollees coverage for outpatient prescription drugs. This is significant given that, on average, seniors currently spend in excess of \$600 annually on prescription drugs. However, in the absence of Medicare prescription drug coverage, beneficiaries have come to rely upon several other sources of prescription drug benefits, such as employer-sponsored retiree health insurance, Medicaid or other State-sponsored health programs, and managed care plans offered through the Medicare+Choice program. In total, recent data indicates that approximately two-thirds of beneficiaries have coverage through these alternate sources, thus leaving more than 10 million beneficiaries without coverage.

In February, the Administration presented a proposal in its budget to provide for a Medicare prescription drug benefit. Seniors would pay a monthly premium to enroll in a new Part D program, in which beneficiaries and the Federal Government would split prescription drug costs up to a certain amount. This new program, administered by the Federal Government, would be accompanied by a proposed budgetary reserve fund for catastrophic drug expenses starting in 2006, allocated only after Congress and the Administration agree on a structure to provide for these costs.

In announcing the hearing, Chairman Thomas stated: "The purpose of this hearing is to examine the President's proposal for providing prescription drug coverage for Medicare beneficiaries. Now that the President's plan has been put into legislative form and analyzed by the Congressional Budget Office, the Subcommittee can better understand the probable implications of the President's approach to this vexing problem."

FOCUS OF THE HEARING:

The hearing will examine the Administration's proposal to provide access to prescription drugs for Medicare beneficiaries and how it will affect the financing of Medicare and its implications for beneficiary care.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit six (6) single-spaced copies of their statement, along with an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, with their name, address, and hearing date noted on a label, by the close of business, Thursday, May 25, 2000, to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, by close of business the day before the hearing.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be submitted on an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, typed in single space and may not exceed a total of 10 pages including attachments. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers where the witness or the designated representative may be reached. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at <http://www.waysandmeans.house.gov>.

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Chairman THOMAS. The Subcommittee will come to order.
Today the Subcommittee will continue its hearings on the important issue of expanding Medicare to provide coverage for outpatient

prescription drugs for Medicare beneficiaries. Today we will examine the President's proposal for addressing this problem. Every Member of this Committee understands the importance of this issue to Medicare beneficiaries.

Increasingly, in today's world medicines are the preferred method of treatment for a variety of ailments. This is particularly true for many chronic conditions that disproportionately impact the Medicare benefit community.

Nevertheless, since its inception in 1965, the Medicare Program has generally excluded coverage of outpatient prescription drugs; however, as care givers turn increasingly to many of today's miracle drugs to manage chronic ailments and new and more-expensive biotech treatments come on the market, the financial pressures grow, caused by the Medicare Program's lack of a drug benefit, and that pressure will only continue to grow.

We have had a number of anecdotal examples of beneficiaries spending down life savings, forced to make difficult choices, and without the kind of protection that we have been discussing on both sides of the aisle, they are more frequently exposed to catastrophic drug costs that can leave them destitute if they buy the drugs or create very difficult life choices, and, probably most insidious of all, practice one of the most negative aspects of current prescription drug medicine, and that is do it piecemeal—start a program and then determine their own regimen based upon finances rather than on medical efficacy.

Seniors need a program of access to prescription drugs. Incidentally, the Medicare Program, as a whole, needs modernization so that we will be able to meet the needs of today's retirees, but also those retiring in the future. This is why, in part, republicans announced last month the outline of a plan to provide prescription drug benefit for Medicare beneficiaries and modernizations.

We have pledged to Speaker Hastert that this Subcommittee will work closely to make sure that legislative language can be taken up by the House late this spring or early this summer.

This, of course, brings us to today. The object of this particular hearing is to better understand and try to lean from the President's proposal.

Recently, there have been important developments on this issue. First, the President's bill has been drafted into legislative language, and this is very helpful. It enables us to examine the details and better understand how the proposal would actually work.

Second, the Congressional Budget Office has updated its score of the proposal, and I believe they actually announce some further refinements here today in testimony, and if that is not the case I certainly hope by making that statement we will try to get them to.

It is really critical, because a lot of these decisions are tied intrinsically to financial implications of the policy, and changes made in the policy sometimes have significant financial implications.

Third, the Congress has passed a budget resolution that set aside \$40 billion over the next 5 years to finance reforms in Medicare and a prescription drug program. This is slightly more than the President's initial program would cost, based upon CBO's last estimate. This level of spending was supported by leaders in both par-

ties, and they were both included in the republican and in the democrat budget resolutions.

Finally, if you watched the video media last night and yesterday morning's paper, you know that the President and the Congressional democrats have already begun to rethink the President's initial proposal.

Yesterday morning, at a press event at the White House, the democrats acknowledged one of the perceived flaws with the President's original plan and expanded on the President's offer of dealing with the catastrophic costs, or a real insurance benefit that protects seniors who encounter serious illness and the possibility of exorbitantly high drug bills through no fault of their own. This is good news. It means that republicans and democrats are moving toward each other on the issue.

Yesterday, the President said he wants to work with the republican leadership in Congress to get a bill passed this year. This is also good news, for if we are going to pass legislation to help seniors and disabled beneficiaries with their drug costs this year, we have got to work together, and ultimately Congress and the President have to agree.

Yesterday, Chairman Archer and I wrote the President a letter to tell him just how seriously we take this issue and how we are committed to working in good faith to get a prescription drug benefit signed into law before Congress adjourns. It is my hope that this hearing will be useful and hopefully instrumental in moving us down the path toward agreement.

Yesterday the President showed he is willing to alter his plan to address legitimate criticisms. I, too, want to approach this process with an open mind.

While those of us on this side of the aisle have agreed on some firm principles that will guide us as we write our bill, we want to learn from the President's effort and build upon his proposal so that the Medicare beneficiaries can get the best Medicare Program possible—a modernized Medicare with prescription drugs.

Chairman THOMAS. With that, I would ask the gentleman from Wisconsin, who I understand is subbing for the gentleman from California, Mr. Stark, if he would have any opening remarks.

Mr. KLECZKA. Thank you, Mr. Chairman.

As Chairman Thomas indicated, Congressman Stark was unable to be here this morning due to a meeting at the White House on the progress the Conference Committee is making on the managed care bill. I suspect that will be a very short meeting.

I am pleased to offer opening remarks for this morning's hearing on one of the most critical issues in senior health care today, a prescription drug benefit.

I thank the chairman for holding this hearing and join him in welcoming our new Mom, Administrator DeParle—Nancy, welcome—Mr. Scanlon and Mr. Crippen to this morning's hearing.

Mr. Chairman, there is truly an urgent need to help Medicare beneficiaries with the cost of prescription drugs. Prescription drugs are used to prevent and treat virtually every major illness. They can accomplish what once could only be done through surgery, with far less pain and far less cost. They can provide treatment where

none existed before, improving the quality and length of life for the patient.

Prescription drugs are essential to quality health care, yet many seniors cannot afford the medical miracles made possible by pharmaceutical drugs.

Some Medicare beneficiaries have employer-based retiree prescription coverage, others private supplemental coverage that exists in drug costs; however, many have no coverage at all.

A study by the Commonwealth Fund found that in 1996 only half of all the Medicare beneficiaries had prescription drug coverage which lasted throughout the entire year. Even for those who do not have year-round coverage, there is no guarantee that this coverage will continue. Employer-sponsored health care has steadily declined over the last decade.

While an estimated 65 percent of large employers offered retiree health care benefits in the eighties, less than 40 percent do so today.

As Pabst Brewery retirees in my district can attest, retiree benefits are not always a stable source of health care coverage. Pabst canceled their benefits in 1996.

The 13 million plus seniors without any prescription drug coverage must pay high out-of-pocket costs for their drugs. To see how much seniors in my district without drug coverage were paying, I had a survey done of the five most frequently prescribed drugs for older Americans. The survey found that seniors were paying an average of 119 percent more for drugs than the drug companies' most favorite customers. In addition, the prices these seniors are paying are 75 percent higher than the prices that Canadian customers pay, and 73 percent higher than the prices that Mexican customers pay.

These costs often exceed what fixed income seniors can afford. Far too many seniors are forced to choose between food and medicine. Adding a voluntary prescription drug benefit to Medicare is essential to ensure these seniors will have affordable access to prescription drugs.

Despite the clear need for such coverage, the pharmaceutical companies are worried that having a drug benefit in Medicare will cut into their profits. To protect their profits, they are running a multi million dollar ad campaign featuring a woman named Flo. Flo is trying to convince seniors that a Medicare drug benefit will limited their drug choices or cause them to lose their current drug coverage, but those scare tactics are not backed up by the facts.

Despite what Flo says, seniors in Medicare deserve the same quality of prescription drug coverage available in most other health plans. They should not be forced to accept second-class health care benefits.

The President has proposed giving seniors without drug coverage affordable access to the medicines they need, while protecting quality drug coverage for those who already have it. The plan uses Medicare's purchasing power to obtain discounts for seniors.

Starting in 2003, seniors who choose to participate would pay a monthly fee of \$25 to participate in a Medicare drug benefit. In return, the program would pay half of their first \$2,000 in drug costs, rising to one-half of \$5,000 in 2009.

In addition, starting in 2006, the President's plan would provide catastrophic coverage to limit the out-of-pocket expenses for seniors with the most exorbitant drug costs.

Again, seniors who do not want or need this coverage do not have to participate in this strictly voluntary Medicare drug program. This plan is not perfect, but it is a good place to start.

Just yesterday, the House democratic caucus unveiled a Medicare drug coverage proposal which builds on the White House plan. The democratic plan would provide drug coverage beginning in 2002 rather than 2003. The democratic plan would implement catastrophic coverage earlier than the President's plan—we would start it in year 2002—and commence to protect all seniors whose drug expenses exceed about \$3,000 per year.

The House budget resolution sets aside \$40 billion, as the chairman indicated, over the next 5 years to create a Medicare prescription drug benefit.

The adjustments to the budget baseline, which will be made this summer, will make more funds available to cover the additional cost of adding essential catastrophic coverage.

In today's hearing we will begin the Committee's discussion on how to meet the prescription drug needs of our Nation's seniors. We have an obligation to bring Medicare into the 21st century by adding a prescription drug benefit.

I am pleased to know that our republican colleagues share our commitment to add a prescription drug coverage to Medicare; however, I was disappointed yesterday, in listening to one of the news reports, where Senator Trent Lott was quoted indicating that he believes that a drug benefit is necessary but probably will not get done until next year.

I would suggest to my colleague, Mr. Thomas and Chairman Archer, not only send a letter to the President urging his participation and negotiations, but maybe we would get Senator Trent Lott to agree to do something this year, also.

The President's plan is an excellent starting point. I look forward to working together on a bipartisan basis to build on this proposal.

Thank you, Mr. Chairman.

Chairman THOMAS. I thank you.

[The opening statement of Mr. Ramstad follows:]

Statement of Hon. Jim Ramstad, a Representative in Congress from the State of Minnesota

Mr. Chairman, thank you for calling this hearing today to review the Administration's prescription drug proposal.

The health system in America is the best in the world. We have the most advanced pharmaceuticals, medical devices and care delivery systems in the world. In Minnesota, hundreds of people from foreigner countries flock to our state to visit the Mayo Clinic and the University of Minnesota/Fairview Hospital for specialized care.

Sadly, however, Medicare has not kept pace with the incredible strides of American medical ingenuity. That's why I have authorized legislation, along with Rep. Thurman, to ensure seniors have access, through Medicare, to new technologies and look forward to similarly working on improving senior access to life-saving and life-enhancing prescription drugs.

I commend the President for devising a plan to give seniors prescription drug coverage. However, as one who has worked tirelessly to improve the bureaucratic morass surrounding the coverage process for medical devices and procedures, I caution everyone to be careful in how we address prescription drug coverage.

Any plan that is not transparent is doomed to implode within its own black-box of decision-making. Anything that is too bureaucratic is doomed to fail under its

highly regulated, in-flexible system of red tape. Any plan that does not rely on competition is doomed to be far too expensive for the system to absorb.

If Members are willing to put politics aside and work in a bipartisan, pragmatic way, we can and will design an effective and efficient ways to use scarce Medicare and surplus dollars to help seniors. Hopefully, at the same time, we can modernize Medicare to reflect the advancements in our health care system, including a targeted prescription drug proposal to cover low-income seniors without displacing the coverage and quality that a majority of enrollees already enjoy.

Mr. Chairman, thanks again for holding this hearing. I look forward to learning more from today's witnesses or now we can best address this critical issue.

Chairman THOMAS. I would ask the administrator, Nancy-Ann DeParle, to please come to the microphone.

My understanding is that the business on the floor will probably begin with six votes at 10 a.m., and I had hoped to perhaps get the administrator's testimony and some questioning in prior to those votes. We are still going to try to do that, but, based upon the extended opening testimony on the part of the gentleman from Wisconsin, that may have consumed the minority's time in answering questions. I hope I can accommodate them to some degree.

As usual, your written testimony will be made a part of the record, and you can address us in any way you see fit. Nice to have you back.

STATEMENT OF HON. NANCY-ANN MIN DEPARLE, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Ms. DEPARLE. Thank you. Mr. Chairman. I will try to be brief.

I appreciate the opportunity to be here to talk about the need for a Medicare prescription drug benefit. This Subcommittee will be a focal point for the debate around this important subject. If it happens, it is going to have to happen in here. There is going to have to be a consensus in here. So it is a privilege to be before you today to provide the administration's perspective.

When Medicare was founded 35 years ago, the great challenge before us was to provide access to the twentieth century miracles of modern hospitals for our seniors. Now we have to put in place a voluntary drug benefit that is affordable and available to all Medicare benefits.

The good news is I am beginning to feel like I am preaching to the converted up here. I know that everyone up here is serious about this, and now we have to figure out how to do that.

Drugs are as important to medicine today as hospital care was when Medicare was created; yet, as many seniors lack drug coverage today as lacked hospital coverage back in 1963.

We all agree that the drug benefit is needed. We don't necessarily agree on all the policy aspects of the design, so I think what we need to do is to begin having some serious discussions of this. There are many design parameters that we can discuss as we move forward to implement a drug benefit. Mr. Chairman, you noted some of them. So did Mr Kleczka.

We look forward to working with you on the details. We are open to your ideas and we are flexible.

There are certain key principals, I think, from the administration's perspective that we don't want to compromise. First, the benefit has to be voluntary and accessible for all beneficiaries.

Second, it has to be affordable for all beneficiaries, as well as for the Medicare Program.

Third, it must have efficient administration integrated into Medicare, but using the private sector to deliver it in a competitive way and give beneficiaries bargaining power in the marketplace. That is why we have suggested that private pharmacy benefit managers administer the new Medicare benefit, as they do right now for private sector health plans.

Fourth, a Medicare prescription drug benefit must provide access to needed medications and provide high-quality care.

Finally, Mr. Chairman—I know you agree with this—we should try to do this in the context of broader Medicare reform.

As I said, we are open to your ideas and we are pleased that we share our policy goal to ensure that every beneficiary has access to voluntary, affordable drug coverage.

Some ideas that have been suggested, though, don't seem to meet the principles that I outlined, and I want to just touch on some of those.

As you said, Mr. Chairman, we have provided the legislative language for our bill to the Congress, and I appreciate your acknowledging the hard work that went into all those details. Now we need to see the details of some of the other proposals, but right now we are concerned that providing direct premium assistance or coverage only for the poor wouldn't meet our principle of ensuring that all beneficiaries who need coverage will be able to afford it.

As you know, drug coverage is not just a problem for the poor, it is a middle class problem, too, and many beneficiaries now find that their drug coverage is not reliable, as former employers drop coverage and Medigap is not available to everyone.

Second, we are concerned that providing a subsidy that is too small or providing no direct premium assistance to beneficiaries would not make the benefit affordable to everyone who needs it.

The independent HCFA actuaries calculate that a subsidy of less than 50 percent for all beneficiaries would leave many unable to afford the coverage. That would mean that those who did choose the coverage would have higher costs, and that would increase premiums for everyone and leave even more people unable to be able to afford the coverage, so that is something that we need to work on.

We are also concerned that a drug-only private insurance model would not meet our principles of providing a Medicare benefit that is accountable and affordable for all Medicare beneficiaries. Here, our concern is that there wouldn't be a guarantee that insurers would offer a comprehensive benefit, that it might be available only where insurers chose to offer it, and that it would have selection problems. Even with stop-loss provisions or other adjustments, we are concerned that enrollment would be dominated by those with the highest costs and, again, that you would get into a spiral with unaffordable premiums.

We need to see the details and we need to sit down and talk seriously about the details and the pros and cons of the various pro-

posals, but I think we all agree that our challenge is something that we all accept, which is to help older Americans and the disabled have access to the 21st century miracles of modern medicine.

I know how serious you are, Mr. Chairman, and the other Members of this Subcommittee, about moving forward on this issue, and I want to tell you that I am serious about it, too. We want to work with you to provide seniors with a voluntary benefit that is available and affordable for all, so let's work together to get it done.

I thank you again for holding this hearing, and I am happy to try to answer your questions.

[The prepared statement follows:]

Statement of Nancy-Ann Min DeParle, Administrator, Health Care Financing Administration

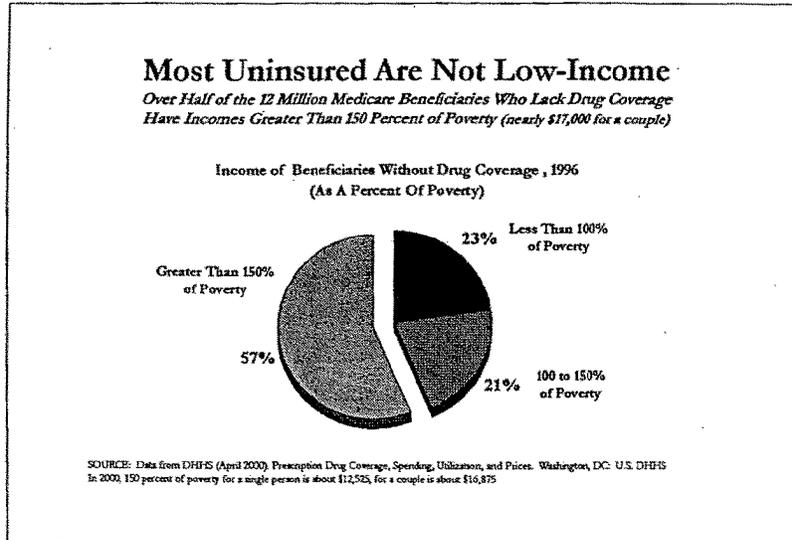
Chairman Thomas, Congressman Stark, distinguished Subcommittee members, thank you for inviting me to discuss the need, and our proposal, to provide prescription drug coverage for Medicare beneficiaries. This Subcommittee will be a focal point of the debate around this important issue and it is a privilege to be before you today to provide the Administration's perspective.

We must act now to ensure that all beneficiaries have an affordable prescription drug benefit option. Pharmaceuticals are as essential to modern medicine today as hospital care was when Medicare was created. And the President believes that we have an extraordinary opportunity to address this shortcoming in the context of additional necessary reforms to the program that make it more effective, modern, and adequately financed.

Lack of prescription drug coverage among senior citizens today is similar to the lack of hospital coverage among senior citizens when Medicare was created. Three out of five beneficiaries lack dependable coverage. Only half of beneficiaries have year-round coverage, and one third has 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, out of the hospital, and living longer lives.

Drug coverage is not just a problem for the poor. More than half of the beneficiaries who lack coverage have incomes above 150 percent of the federal poverty level. Millions more have insurance that is expensive, insufficient, or highly unreliable.

Even those with most types of coverage find it costs more and covers less. Copayments deductible, and premiums are up. And coverage is often disappearing altogether as former employers drop retiree coverage, Medigap is becoming less available and more expensive, and managed care plans have severely limited their benefits. Clearly all beneficiaries need access to an affordable prescription drug coverage option.



KEY PRINCIPLES

The President has identified key principles that a Medicare drug benefit must meet.

- **It should be a voluntary benefit accessible to all beneficiaries.** Medicare beneficiaries in both managed care and the traditional program should be assured of an affordable prescription drug option. Since access is a problem for beneficiaries of all incomes, ages, and areas, we must not limit a Medicare benefit to a targeted group. At the same time, those fortunate enough to have good retiree drug benefits should have the option to keep them.

- **It should be affordable to beneficiaries and the program.** We must ensure that the premiums for the voluntary drug benefit are affordable enough so that all beneficiaries participate. Otherwise, primarily those with high drug costs would enroll and the benefit would become unstable and unaffordable. And beneficiaries must have meaningful protection against excessive out-of-pocket costs.

- **It should be competitive and have efficient administration.** Medicare should adopt the best management approaches used by the private sector. Beneficiaries should have the benefit of market-oriented negotiations.

- **It should ensure access to needed medications and encourage high-quality care.** Beneficiaries should have a defined benefit that assures access to all medically necessary prescription drugs. They must have the assurance of minimum quality standards, including protections against medication errors.

- **It should be done in the context of broader reform.** The drug benefit should be a part of a larger plan to strengthen and modernize Medicare.

The President's plan meets these principles. As part of a broader reform plan to strengthen and modernize Medicare, it adds a long-overdue voluntary prescription drug benefit to Medicare.

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 and employers would be given new financial incentives to encourage the retention of these plans. Premiums will be affordable, beginning at \$26 per month, with extra assistance for those with low-incomes. Medicare would cover half of the prescription drug costs up to \$5,000 when fully phased in, and would provide protection against catastrophic costs. 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 medically necessary drugs prescribed by their physicians and will benefit from the quality assurance programs used by private benefit managers. The President's budget includes the prescription drug benefit as part of a

comprehensive plan to make Medicare more efficient and competitive and extend its solvency.

We have broad consensus that we must act now to establish a Medicare drug benefit. We have an historic opportunity provided by the growing budget surplus. 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 in the context of Medicare reform.

BACKGROUND

Prescription drugs can prevent, treat, and cure more diseases than even before, both prolonging and improving the quality of life. Proper use of prescription drugs should minimize hospital and nursing home stays, and could, in some cases, substitute for more expensive care that is already covered by Medicare.

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 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. We project that this year more than half of Medicare beneficiaries will have prescription drug spending of \$500 or more, and 38 percent will spend more than \$1000. Each year, about 85 of Medicare beneficiaries fill at least one prescription. Yet one-third of beneficiaries have no coverage for drugs at all and, in 1996, half did not have drug coverage for the entire year.

Almost half of beneficiaries without coverage have incomes above 150 percent of poverty (\$12,525 for a single person, \$16,875 for a couple), demonstrating that this not just a low-income problem. All these beneficiaries end up paying more for needed prescriptions because they do not get the discounts commonly offered 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-quarters of rural beneficiaries do not have access to Medicare+Choice plans and the drug coverage that many of these plans provide.

In 1996, about one-third of Medicare beneficiaries had private sector coverage offered by former employers to retirees. However, this coverage is eroding. The number of firms with 500 or more employees offering retiree health coverage dropped from 40 percent in 1994 to 30 percent in 1998, according to the employee benefits research firm Mercer/Foster Higgins (the numbers for small firms would be even lower).

The true impact of this trend has not yet been realized, because some employers' decision to drop coverage apply 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 available, plans have been raising premiums and copayments for drugs, while lowering caps on drug coverage. In 2000, three-quarters of plans cap benefit payments for brand-name drugs at or below \$1000, and nearly on-third of plans cap this 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 who typically have income below 100 percent of poverty, and the majority of beneficiaries eligible for such coverage—60 percent—are most 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 65-year-old beneficiary for the standardized “I” Medigap plan ranged from \$991 to \$5,943 per year in 1999. And the average premium for the standardized “H” Medigap plan ranges from \$1,174 in Virginia to \$2,577 in Georgia.

Furthermore, Medigap premiums 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 dedicates over half of the on-budget surplus to Medicare and extends the life of Medicare Trust Fund to at least 2030. It also improves access to preventive benefits, enhances and use of private sector purchasing tools, help 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. The hallmark of the Medicare program since its inception has been its social insurance role.

Everyone, regardless of income or health status, gets 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 premiums, with beneficiaries paying an estimated \$26 per month in 2003. The independent HCFA Actuary has concluded that premium assistance below 50 percent would result in adverse selection and thus an affordable and unsustainable benefit.

Premiums will be collected like Medicare Part B premiums, as a deduction from Social Security checks for most beneficiaries who choose to participate. 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 reduced premiums on a sliding scale, based on their income. The Federal government will fully fund States’ Medicaid costs for the beneficiaries between 100 and 150 percent of poverty.

Under the President’s plan, Medicare will pay half of the cost of each prescription, with no deductible. The benefit will cover up to \$2,000 of prescription drugs when coverage begins in 2003, increase up to \$5,000 by 2009, with 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, similar to standard practice in the private sector.

We want to give beneficiaries a fair price that the market can provide without taking any steps toward 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 and patient counseling programs. And their contracts with the government will include incentives to keep costs and utilization low while assuring a fairly negotiated contractual relationship with participating pharmacists.

Similar to the best private health plans in the nation, virtually 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 certifies that the specific drug is medically necessary. Coverage for the handful of drugs that are now covered by Medicare Part B will continue under current rules, but they also may be covered under the new drug benefit once the Part B coverage is exhausted.

The President's plan also strengthens and stabilizes the Medicare+Choice program. Today, most Medicare+Choice plans offer prescription drug coverage using the excess from payments intended to cover basic Medicare benefits. Under the President's proposal, Medicare+Choice plans in all markets will be paid explicitly for providing a drug-benefit—in addition to the payment they receive for current Medicare benefits.

Plans will no longer have to depend on what the rate is in a given area to determine whether they can offer a benefit or how generous it can be. This will eliminate the extreme regional variation in Medicare+Choice drug coverage, in which only 23 percent of rural beneficiaries will access to Medicare+Choice have access to prescription drug coverage, compared to 86 percent of urban beneficiaries.

And beneficiaries will not lose their drug coverage if a plan withdraws from their areas, or if they choose to leave a plan, because they will also be able to get drug coverage in the traditional Medicare program. We estimate that plans will receive \$54 billions over 10 years to pay for the costs of drug coverage.

Administrative Workload

The administrative workload for the drug benefit proposed by the President would be handled largely by the pharmacy benefit managers, who will be responsible for the vast majority of day-to-day functions. The capacity of these benefit managers to process claims instantly has expanded rapidly in recent years, and we have no doubt that this capacity could be readily expanded by 2003 to administer our proposed drug benefit.

There would be no need for the type of coverage determination process in the traditional Medicare program because the pharmacy benefit managers would establish their own formularies, and be required to cover off-formulary drugs whenever determined to be medically necessary.

The federal role primarily would be in conducting a competition for the pharmacy benefit manager contracts, overseeing the contracts, and ensuring a smooth interface with other Medicare programs and data systems.

MEETING BASIC PRINCIPLES

As mentioned previously, a set of key principles guided the development of the President's plan. We are willing to support other proposals that meet these principles:

- Voluntary benefit accessible to all beneficiaries.
- Affordable to beneficiaries and the program.
- Competitive and efficient.

- Ensures 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 provide assistance only to low-income beneficiaries fail to help millions of beneficiaries with no or undependable coverage. Most lacking drug coverage have incomes about 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 strength for the program and is responsible for its overwhelming support among the American people.

Proposals with high premiums due to inadequate government assistance would make the benefit unaffordable to many low and middle-income beneficiaries. 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 that is wide enough to maintain an adequate risk pool.

Proposals that link a drug benefit to a high-option Medicare plan with additional benefits like a stop-loss for out-of-pocket costs for Medicare's basic benefits also are less affordable. Beneficiaries who elect the high option would have to pay not only for drug coverage but also for the other, typically unsubsidized costs of 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 drug coverage 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 provide a guarantee to a dollar amount benefit rather than a defined benefit fail to meet the principles of affordability and competitiveness. 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. Additionally, most health policy experts agree that standardizing health benefits is essential to a competitive system, since it allows for "apples to apples" choices among beneficiaries.

Finally, given the importance and costs of a Medicare drug benefit, both seniors and taxpayers should know what benefit they are buying.

CONCLUSION

The need for a prescription drug benefit in Medicare is clear. There is consensus across the political spectrum that it should be added. The principles on which it should 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.

Chairman THOMAS. Thank you very much.

We do have it in bill form. Unfortunately, after this Subcommittee had announced the time for discussing the President's plan, there have been, I think everyone would agree, significant modifications to the President's plan, so you may not be able to answer these questions, although my assumption is that, in working out the additional details and working with the independent HCFA actuaries, that you scrubbed the additional proposals that the President and the democrats announced.

My concern is that one of the principles that you advocated was the affordability, and the President's initial plan was really not an insurance plan, it was a pre-paid plan, and so you could work the numbers back from the amount of money that you would have. It

is not a criticism. In fact, it is an admiration. It is easier to determine what your obligations are by building a plan that way.

But yesterday the President announced that he was going to deal with a catastrophic—that is, a cost protection program for seniors—that would trigger—and I wasn't clear on the news reports—at \$3,000 or \$4,000. Do we know what the dollar amount is that it triggers at?

Ms. DEPARLE. We haven't made that decision yet.

Chairman THOMAS. You haven't made that decision. If it would trigger at \$3,000, that really would involve more than 20 percent of the beneficiaries who are consuming more than 65 percent of the costs, so my question would be: How is that catastrophic structure paid for? Is it a shared cost with the beneficiaries? Is it 100 percent assumed by the Federal Government? And if it is the former, how much would it be to the beneficiaries? And if it is the latter, how much more does the President's program cost than the one that we have examined that is in legislative form?

Ms. DEPARLE. Well, if I could go back to the principle, again—and you articulated, as well—from our perspective, one of the principles here is that this benefit must be affordable, both for beneficiaries and for the program, and I know you agree with both of those sides of the formula there.

When we initially put our proposal out a year or so ago, Mr. Chairman, we weren't sure that that financing would be sufficient to cover a catastrophic benefit. All of us, from a policy perspective, wanted to do that, but we weren't sure we had the funding to do it.

In this year's budget, because of the good economy and because of the work that we have done together with Medicare and everything else in the Federal budget, we were able to set aside \$35 billion, starting in 2006, I think, to introduce—

Chairman THOMAS. Yes, but it wasn't until 2006, and the legislation only had the dollar amount, so there was no—

Ms. DEPARLE. That is right.

Chairman THOMAS.—structural aspect to it. And, of course, 2006 is some time away. But the announcement yesterday was 2003, so my assumption is you can explain to me the payment structure of the catastrophic portion of the President's plan.

Ms. DEPARLE. No, sir, I cannot, because we still want to sit down with you and have serious discussions about the details of your proposal. You have an interesting catastrophic proposal. The democrats announced one yesterday that they would fund at a higher level. We want to sit down and talk with you.

Now, on the policy issue—

Chairman THOMAS. You cannot say the democrats announced one. The President held the event at the White House, so it is the President's plan, as well. Or are you saying that this is the Congressional democrats' plan and not the President's? I am trying to understand the—

Ms. DEPARLE. Well, in the end it will be everybody's plan, including, I hope yours, but the plan that was announced—

Chairman THOMAS. I am wondering about the beginning. We will work on the end, but right now—

Ms. DEPARLE. There were, I believe—

Chairman THOMAS. Is this part of the President's plan, or is this something that the President held an event at the White House to help the Congressional democrats get exposure?

Ms. DEPARLE. I wasn't there, but I can tell you this: the President is committed to providing catastrophic coverage for beneficiaries and—

Chairman THOMAS. Do you believe it is fair to say, then—

Ms. DEPARLE.—he wants to work with the democrats and with you to do that.

Chairman THOMAS. OK. Do you believe it is fair to say, then, that the prices that have been announced, not just the cost—for example, \$26, as has been cited as the premium cost, but then, of course, you go to the end of the program in 2009 to say that it covers 5,000. Actually, it is 2,000 if the price is going to be \$26. I don't think it is really fair marketing to take the cheapest price up front for the cost of the beneficiaries and then go to the end of the program and talk about what the benefits are going to be, and I would hope that you would agree with that, because if we are going to move forward in a bipartisan way we ought to deal with numbers that have a relationship to each other. So if the premium is \$26, the benefit was going to be 2,000.

Ms. DEPARLE. And it is \$50 when it rises up to 5,000. Yes, sir.

Chairman THOMAS. I understand that. But you never see that in a discussion of the print. You take the cheapest and the best. And I understand the marketing aspect, but—

Ms. DEPARLE. But you are asking me, and I am telling you of course you are right, the premium rises.

Chairman THOMAS. That is all I want to hear.

Then the question is: Do you think it is reasonable to assume that you are now bringing in a catastrophic program in the year 2003 that we should then assume that the beneficiaries' premiums would be higher than was announced under the President's plan that is in legislative form? Would that be a reasonable assumption?

Ms. DEPARLE. No, sir.

Chairman THOMAS. Therefore, the only other—

Ms. DEPARLE. Let me explain why.

Chairman THOMAS.—assumption is government is going to pick up the entire cost of the catastrophic.

Ms. DEPARLE. No. But you are making these as assumptions. There are policy options here. One option is for the government to pick up the entire cost, depending on how you—

Chairman THOMAS. And, therefore, the beneficiaries' premiums would be about what they are, because that would be that part—

Ms. DEPARLE. Yes, sir.

Chairman THOMAS.—of the President's program—

Ms. DEPARLE. Yes, sir.

Chairman THOMAS.—that would remain stable.

Ms. DEPARLE. Yes, sir. And in our original plan in January in the President's budget we said we had allocated \$35 billion. We didn't just pull that number out of the air. We had looked at a number of different ways of doing it. We want to—

Chairman THOMAS. But that didn't start until 2006.

Ms. DEPARLE.—sit down with you. That is right, it didn't.

Chairman THOMAS. Now we have one that starts in 2003 that covers 65 percent of the beneficiaries' costs of prescription drugs. It is right around the corner.

Ms. DEPARLE. But that plan, sir, was the Congressional democrats' plan. We are working with them, but I cannot give you the details of that.

Chairman THOMAS. That is fine. Then it is not—

Ms. DEPARLE. All I am saying is—

Chairman THOMAS.—the President's plan, it is—

Ms. DEPARLE.—you are right. There are two options here. There is a tension between providing a full catastrophic benefit with no additional cost to beneficiaries or providing one where the program's costs, the costs of the Medicare Program, are lower and beneficiaries pay more.

Chairman THOMAS. That is fine. But—

Ms. DEPARLE. We will have to work together on that.

Chairman THOMAS. My concern is that, if we are reaching out across the aisle to try to build a bipartisan agreement, you probably should figure out how you are going to pay for the catastrophic and then be honest about the price to the beneficiaries if, in fact, they are going to share in that cost—since they are going to benefit, it might be reasonable to talk about having them share in it— or admit that the cost of the program is not the cost of the program that has been announced because it could very well double the cost of the program.

Again, it is like saying it is the cheapest price for the premium at the beginning, but telling you the benefits are what it is at the end. That kind of a discussion makes it much more difficult to work in a positive, bipartisan atmosphere. It might almost appear that it is a partisan statement in an attempt to make the plan look better than it is.

Ms. DEPARLE. Mr. Chairman—

Chairman THOMAS. So fundamental honesty is probably going to be one of the best environments for us to move forward, not of the President's plan as written, because that we can, I think, shed some light on.

Ms. DEPARLE. If I could just respond, Mr. Chairman, I agree with you about honesty and making sure that we all know what kind of program we are adopting and that beneficiaries know it. If I didn't believe that, I wouldn't have had our staff work overtime at Christmas drafting the legislative details to get them up here. It would have been much easier for me to just talk on the talking points.

Chairman THOMAS. And I—

Ms. DEPARLE. That is why the details are up here.

Chairman THOMAS. And I have complimented you on that.

Ms. DEPARLE. And I am eager to see the other details.

Chairman THOMAS. I have indicated it is a great help, because all of us are wrestling with this new attempt to deal with an issue, and the President's plan adopts a model, to a certain extent, that tends to be prevalent in the private sector with pharmacy benefit managers.

One of the criticisms you have made of other plans that may, in fact, be hypothetical criticisms just to let people know what you are

concerned about, is the fact that you don't know if the program would be available in various regions if, for example, entities like PBMs wouldn't play in terms of structuring the program.

What is there in the President's plan that guarantees that PBMs would play, would, in fact, agree to carry out the duties that you have assigned them in this plan? Is there any guarantee in the President's plan that PBMs would participate?

Ms. DEPARLE. Well, we believe they would, sir. They—

Chairman THOMAS. No, is there anything—because you have criticized other plans saying you don't know if they would participate. My assumption is that criticism is based upon the fact that the President has, in his plan, a clear structural way in which PBMs would participate in the President's plan. Or are you saying that it is problematic for the President's plan, as well, as to whether PBMs would play?

Ms. DEPARLE. No, I don't think it is, because we have talked to health plans who have administered this way. You have to realize, pharmacy benefit managers provide services, managing pharmacy benefits for over 200 million Americans today.

Chairman THOMAS. No, I understand that—

Ms. DEPARLE. All the health plans—

Chairman THOMAS.—but they do it in a fundamentally different way, and I will have one question like that to—

Ms. DEPARLE. I don't think they are doing it in a fundamentally different way.

Chairman THOMAS. OK. Then, when you read the GAO and the CBO testimony, they both indicate they have real concerns about the President's plan, in terms of the freedom of the PBMs to manage costs. And one of the things that the President's plan doesn't have is a shared risk aspect with the PBMs.

But I am concerned about a more fundamental problem, pointed out primarily in the GAO testimony, which looks at the traditional structure of HCFA and the way in which it manages the Medicare Program, which is it pays after the fact.

One of the real advantages of PBM is almost an instantaneous analysis of drug use and structuring.

If, in fact, the President's plan says that it is a 50/50 shared cost up to \$2,000, and the assumption is it is going to follow the HCFA model in which bills will be paid, the product will be consumed, and at the end of the \$2,000 50/50 it is 100 percent or 100 cents on the dollar out of the pocket of the beneficiary.

How would you propose to reconcile the problem of beneficiaries consuming more drugs than the 50/50 share would allow, but having, in fact, gotten the reduced price? Would beneficiaries be required to pay back after the fact any benefits that they received after that amount, or would the PBMs be responsible, because that is the entity through which the drug program flows? Or would HCFA just eat it because they cannot respond in a timely fashion to payment problems, as indicted by the GAO's testimony?

Ms. DEPARLE. Well, I think I followed you. Let me see if I did. If I understood your question, the way our proposal is designed, beneficiaries would get the benefit of the lower prices that we believe that pharmacy benefit managers will be able to negotiate, even beyond their cap. And the pharmacy benefit managers have

in place systems that are able to track the amount that beneficiaries have gotten. They will know when they hit their cap, and they will know that beyond that they can still get their drugs at the lower price, but they will be paying for it after that.

They do that kind of thing now, and there is no reason to expect they couldn't do it with Medicare, as well.

Chairman THOMAS. So you are assuming that PBMs that currently operate out in the regular world would look very much like the PBMs that would be under the President's program?

Ms. DEPARLE. Yes, sir. I do assume that.

Chairman THOMAS. I think you will find, if you read carefully the Congressional Budget Office testimony and the General Accounting Office testimony, both of them believe that the PBMs under the President's program would be severely hampered in their ability to function as they now function, to the point that they question whether or not you would even recognize them as the current entities.

Of course, we will do some follow-up questions when that panel is available.

Thank you very much. It is very helpful to have someone grapple with the real world relationship of these new entities, because we are going to have to do it, and your willingness to do it over the Christmas vacation ahead of us is a great help in us moving forward.

The gentleman from Wisconsin?

Mr. KLECZKA. Let me again thank the chairman.

Ms. DeParle, I think in your testimony you indicated that the President's plan is a starting point, you are open to suggestions, changes, negotiation, and I think we all admit that probably one of the knottiest problems we are going to have to face in this whole debate is how to provide the catastrophic coverage. And one of the main reasons is that will probably be one of the most expensive.

Now, it has been cited that there are flaws in the President's plan; however, one of those flaws would be addressed in the democratic plan, and that is moving some of these dates up, which I am assuming the administration would agree to.

I am trying to get a better understanding of the republican proposal, and it seems to me that the mainstay would be to provide a subsidy to health care plans that provide drug coverage to seniors, medigap type plans. Is that your understanding also?

Ms. DEPARLE. Yes. It is more of an indirect subsidy through those plans, as I understand it.

Mr. KLECZKA. Versus a voluntary benefit to the Medicare Program?

Ms. DEPARLE. Yes.

Mr. KLECZKA. OK.

Ms. DEPARLE. And versus a direct subsidy, as in our plan and, I guess, the Breaux-Frist plan and some of the others.

Mr. KLECZKA. OK. Let me just ask a general question. We had a situation in my District where a whole bunch of seniors boarded a bus and took a trip to Canada and came back with the medicines they need for the next two to 3 months.

In your research, why is it possible for individuals in Canada and Mexico to buy drugs that much cheaper in those countries versus

our country? And is it the drug companies' contention that if, in fact, we would provide a drug benefit to Medicare or tamper with the pricing, that all research dollars for drug companies would dry up immediately?

Could you respond to those two concerns?

Ms. DEPARLE. Well, as I understand it, the reason why they are able to provide drugs more cheaply, one of the chief reasons is because of the purchasing power that they use on behalf of a number of beneficiaries pulling them together.

We don't want to do price controls. We don't want to tamper with drug prices, either, but we believe that Medicare beneficiaries should get access to these miracles of modern medicine through prescription drugs and that we should do that by using the leverage of the Medicare Program, and that is what our proposal would do.

Mr. KLECZKA. How about the contention that if, in fact, we tamper with the way drugs are sold in this country, that all research dollars are lost forevermore and we will not have these modern miracles occurring any more?

Ms. DEPARLE. Well, I don't believe that that would happen. As I said, we are not talking about imposing price controls or driving all of the research and development dollars out of this, first of all.

Second, remember that the Congress and the American taxpayers fund a lot of the initial research through the National Institutes of Health and other research that this body funds, so I think that there is certainly support in the Congress. No one can have any doubt that this Congress supports research for new biomedical advances, and I don't think anyone up here is interested in something that is going to drive research and development out. I know the President isn't. That is why we tried to use a private sector model to do this.

Mr. KLECZKA. Fine. Thank you very much.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you very much.

The gentleman from Louisiana?

Mr. MCCRERY. Thank you, Mr. Chairman.

Well, since we had some testimony this morning from one of our colleagues on the House democrat plan, and the President seems to—while he has not endorsed it, he is wanting to talk with the House democrats about crafting something. I think it is important to note that the three plans that are out there—the President's plan, the republican plan, and now the House democrats plan—have many similarities.

Ms. DEPARLE. Yes.

Mr. MCCRERY. For example, they are all voluntary. We don't force any senior to choose this new Medicare benefit. We think now that we are all agreed that there should be some stop loss provision to protect against financial ruin for seniors because of drug costs. We all agree that there should be some private sector administration of the program, whether it is a PBM or an insurance company. In our plan, it could be either.

All of the plans provide some subsidy for everybody, all seniors, not just low-income seniors, all seniors. Our plan does. The President's plan does. And now the House democrats' plan does.

We all provide greater subsidies for low-income seniors than we do for any other seniors.

Those are commonalities among the plans. We are not that far apart. The democrats on the House side don't know yet how much theirs will cost, if they do a \$3,000 stop loss. They say they may have to go to \$4,000. We will see. Likewise, we don't yet know the level of stop loss that we can offer for the \$40 billion that we have been given by the budget over the next 5 years.

So, rather than see the media, the press take the bait and try to draw distinctions, say the republican plan is only going to help low-income seniors, I think it would be more constructive if, in our comments to the press, we would make it clear that there are quite a few things in common among all the plans, that we all have common goals, which are to help low-income seniors with the cost of drugs, to help all seniors get a better deal for the cost of their drugs, and to subsidize, to some extent, the cost of drugs to all seniors, and, finally, to prevent financial ruin for seniors because they might have tremendously high drug costs.

If those are our goals and we share those goals, there is no reason why we should not be able to come to an agreement on a proposal. The only thing that is missing, I would say, in the President's plan and the House democrats plan, is choice. In the republican plan, we at least envision there being greater choice for seniors, in terms of choosing a drug plan. The President's plan and the House democrats plan seemed to offer only one choice—voluntary, yes, but only one choice for seniors, because you are only going to have one PBM to service a region. That means only one plan. At least we envision, in the House republican proposal, to have multiple PBMs or insurance companies offering different kinds of drug plans that would have those common elements.

So if we can bring you all along to our way on the choice element, I think we can get this done.

Mr. Chairman, I appreciate your letting me talk a little bit about why we should all be pleased that we are as close as we are.

Chairman THOMAS. I thank the gentleman, because we often stress our differences, and, as the gentleman indicated, there are a lot of commonalities.

Does the gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON. Yes, thanks.

As you realize, the bell is going off and we have a long series of votes, and, so that everyone will have a chance to get a little something on the record, instead of a dialog, Madam Administrator, I am just going to put on the record three very, very serious concerns that I have about the proposals that the President and the democrats have put on the table.

First of all, I know, from our work on our proposal, that at least the executive branch has a pretty good understanding of the extraordinary cost of stop-loss benefits over 3,000, and I would just remind my democratic friends that the President's current proposal is funded by cutting Medicare 72 billion.

Now, there may be cost savings from modernization, but, in your overview, you say some of that 25 billion in savings is going to come from competitive bidding and managed care choice plans. Managed care choice plans in my part of the country are going out

of business because we have done such a poor job of reimbursing them fairly and paying in a timely fashion.

Another source of your funding, 39 billion, comes from extending the BBA provisions. We reversed some of those provisions a little last year. We are going to have to reverse some of those provisions again. We cannot possibly have a home care industry if we cut the reimbursements 15 percent after we go to prospective payments.

So, you know, my hospitals are absolutely in crisis, and I am going to fight with every breath in my body for at least what MedPac has proposed for hospitals. And then we are going to have to defer the 15 percent for home health care providers? Small nursing homes are having a terribly difficult time.

I don't see how we can count on the savings that have been estimated by the executive branch to fund the prescription drug bill to begin with. That is a big problem. Where is the money going to come from and are we going to take it out of the hide of current Medicare providers, many of whom are already on the ropes? That is one issue.

Second, in what was done at the White House yesterday—I will make these shorter—the democrats say that the government is going to negotiate discounted prices, but in another place they say the government will not be allowed to set prices. This is a contradiction of no small significance.

Third, I do not see how, through this benefit administrative process, small pharmacies in the remote towns in my District will be able to participate.

I am very concerned about access, small pharmacies, funding issues, and price setting, and I want that on the record.

Thank you, Mr. Chairman.

Chairman THOMAS. If Members have some questions, I am quite sure that we can engage in the written exchange of questions and answers, as we have done in the past, because we are going to be limited on time.

Does the gentlewoman from Florida wish to inquire?

Mrs. THURMAN. Mr. Chairman, thank you.

Actually, I want to use my time to allow, since this was supposed to be a hearing to discuss with the administration exactly what the drug proposals were and the differences between them; I would like to give Ms. DeParle an opportunity to respond to Mr. McCrery on some of the issues that were outlined so that we have an idea of what actually are the differences and where we are similar.

Ms. DEPARLE. Thank you. In fact, I was hoping I would have that chance.

On the last point you raised, Mrs. Johnson, about how will pharmacies be allowed to participate, under our plan all qualified pharmacies will have to be allowed to play, and so people can go into your District into the small towns that I have been in with you, and all those pharmacies will be allowed to participate. I am sorry if that detail wasn't clear to you.

Mrs. JOHNSON. If the gentlelady will yield, it is simply easier said than done when you have a regional administrator, but it is the details that we will eventually get into together that are going to answer this.

Ms. DEPARLE. It is, but we spent a considerable amount of time working with plans that have used pharmacy benefit managers, and large plans as well as small plans, and I believe that aspect of it is not problematic.

You also referred to the way that the plan is financed, and I want to talk about that for a minute.

Our plan costs around \$195 billion over 10 years. That includes the \$35 billion that we set aside in the out years to design and work with the Congress on a catastrophic benefit.

The funding for this is partly out of the surplus dollars—\$135 billion of it comes from that, and about \$60 billion comes from savings from things like modernization.

Under the President's plan, there is a model for using Medicare+Choice in a slightly different way than has so far been done to do competitive pricing and bidding to provide the Medicare benefit package.

And yes, we do believe and our actuaries do believe there will be some savings from that, and that, under the new pricing methodology, which is different than the one that you criticized, that there will be more plans available.

I also want to make a point. You raised the concerns that I know you have, and we have talked about them many times about the managed care plans up in Connecticut. I think that shows, as much as anything, that one of the things we have to do is start reimbursing for prescription drugs. You know, that is one of the pricing problems they have right now.

What they get paid for is to provide the traditional Medicare benefit, which does not include prescription drugs, but they know they need to provide prescription drugs and they are trying to do it on the price that we are currently paying them, which doesn't include that cost.

So if we can work together, both of our plans, as Mr. McCrery said, would cover these costs. In our plan, I think about \$54 billion of the dollars I talked about, the 195, would go to managed care plans to cover the prescription drug benefit.

Let's do this. Let's make it available in fee-for-service, too, so all of your constituents would have access to it. I think that is what we need to do.

Mrs. THURMAN. Ms. DeParle, let me ask you one question, though, because Mr. McCrery mentioned the issue of choice was part of our difference.

I have to tell you, when I go home—and I probably have more seniors in my District than most people up here, about 200,000 on Social Security and Medicare. That is not what they are telling me, because they are so aggravated with what has happened to them under HMO managed care, because they keep getting switched around. All of their prescription drug benefits are either being lowered or they are faced with higher premiums, higher deductibles, those kinds of things.

Have you tested anything about what seniors want, what would be the best plan for them and the easiest for them to participate in?

Ms. DEPARLE. We haven't. We haven't asked questions specifically about that. What we have done, though, is, in connection with

our Medicare education program that this Committee has been a big supporter of, is, when we do focus groups about the education, the seniors often talk about other things, just as they do in the townhall meetings that all of you have, and they are continually saying, "We really want prescription drug coverage," so we all know that.

The other thing they do tell us, though, is, at least with respect to managed care, they care a lot more about having a choice of doctors and having their doctor covered than they do about having a choice among a bunch of different plans.

I guess I would say to Mr. McCrery that was the one area where I slightly disagreed with him, as well. I agreed with most of what he said about the commonality, and I appreciate that he is focusing on that, but I do think there is a tension that we have to recognize between this notion of choice and having 300 different plans to choose from, or whatever the ideal would be, and the notion of stability and affordability and accessibility.

The problem is, with insurance, as you all are expert on this and you know, when you have so many choices you introduce adverse selection, risk selection into it, which can drive up the cost both for the beneficiary and the program. There is really a tension there, and we have to recognize it.

I think, you know, I like our plan better because it guarantees access, I believe. I know the chairman doesn't agree with me, but I believe it guarantees access to everyone to an affordable, accessible benefit. I hear Mr. McCrery saying that he values this choice. We need to sit down and talk about that, because I think we just have to recognize there are some differences there and there is a tension.

Chairman THOMAS. I thank the gentlewoman.

We are going to have six votes in a row, the first one having commenced and now getting close to finishing, so the Chair apologizes, but there is no way we are going to keep the administrator to come back. I apologize to the Members if they had questions. You can certainly submit them in writing and she will respond, and I have a hunch this is not the last hearing that we are going to have.

My guess is that we will reconvene at approximately 11:30 a.m.

In a brief response to the gentlewoman from Florida's statement and the administrator's response, I have read recently that there are some lobbyists inside the beltway who are complaining that Members of Congress are looking at issues in which the voters and the beneficiaries find most important and that we have not adopted the various lobbyists or organizational or associational representatives' priorities. I, frankly, am pleased over that, because I thought that was our job. It probably makes their job more difficult, since they cannot control the process, but, working with the administration, with elected representatives, our job should be to modify and change programs to meet the real needs and the felt needs of the people that we represent.

I appreciate the administrator's willingness to come.

As we add additional programs, I would hope that we move forward with legislative language. I am conscious of that commitment to our plan, as well, and I look forward to working with you again.

The Subcommittee stands in recess until approximately 11:30.

[Recess.]

Chairman THOMAS. The Subcommittee will reconvene.

I thank the principals for allowing us to carry out our Constitutional duty.

We have before us now in this panel—and I thought it was appropriate, since we were dealing with the President's legislatively expounded plan, to look first to the administration, itself. I am sorry the time line was such that we could not accommodate all Members with a more-detailed cross question and answer process with the administrator. But, since it is a written plan and our job is to understand how the administration addressed certain concerns that may be more or less common to any plans that are attempting to introduce a prescription drug structure into Medicare, we have on the second panel Dr. Bill Scanlon from the General Accounting Office, who has been a long-time resource for us in understanding and analyzing Medicare-related information. We have Dr. Crippen, head of the Congressional Budget Office, and available if necessary, a lifeline, Mr. Lieberman, if the question becomes too technical. I don't know whether it is phone a friend or polling the audience, but it is a lifeline that will be available to us to get resources available.

With that, I would indicate that any written testimony that you have is made a part of the record, and you can address us in any way you see fit, focused on the President's plan and the ramifications for this Subcommittee in looking at a prescription drug proposal along with modernizations to be added to the Medicare Program.

I guess we will start with Dr. Scanlon and then go to Dr. Crippen.

**STATEMENT OF WILLIAM J. SCANLON, PH.D., DIRECTOR,
HEALTH FINANCING AND PUBLIC HEALTH ISSUES, HEALTH,
EDUCATION AND HUMAN SERVICES DIVISION, U.S. GENERAL
ACCOUNTING OFFICE**

Mr. SCANLON. Thank you very much, Mr. Chairman and Members of the Committee. I am very pleased to be here today to discuss the issues related to adding a prescription drug benefit to Medicare, and, in particular, the President's proposal.

While there is growing consensus that the Medicare Program should incorporate such a benefit to address concerns that beneficiaries who lack access to prescription drug coverage will be able to receive such coverage, as I am sure you will hear from Dr. Crippen, such a benefit would involve considerable cost.

Therefore, the imperative, as well as the challenge, would be to expand access to prescription drugs in the most efficient way possible to minimize the financial consequences for Medicare.

It is particularly important to look to those that have experience with managing a drug benefit. Private insurers and HMOs have adopted a variety of techniques to manage their drug benefits which may be instructive for Medicare, though how to apply these techniques requires careful consideration.

Many third party payers contract with pharmacy benefit managers, or PBMs, to develop and implement these cost control tech-

niques and to perform other tasks related to managing a drug benefit.

PBMs attempt to use the leverage of their large purchasing power to negotiate with drug manufacturers and pharmacies for discounts or rebates on their products and services. They have often used formularies to increase that leverage. With PBMs promising larger shares of the market for the drugs and the pharmacies they select, manufacturers and pharmacies may be likely to compete harder to contract with a PBM by offering more-favorable prices.

Exactly how much of these techniques affect expenditures is uncertain. Data on the size of the rebates under the discounts are proprietary, and how much the techniques have altered utilization is unknown. Estimated savings reported to us and other researchers by insurers and PBMs range from 14 to 31 percent. Several cautions, though, are appropriate.

First, these estimates are self reports from the plans, not built upon data that we or others have analyzed.

Second, they are several years old, and the dynamics and changes within the pharmaceutical market have been considerable.

As you consider the methods to manage a potential Medicare benefit, these private sector techniques offer a useful starting point. At the same time, there are several issues that arise in considering how to adapt them to the unique characteristics of Medicare and its beneficiaries.

Adoption of PBM techniques within traditional fee-for-service Medicare on a nationwide basis could be difficult, given the program's size and the need for transparency in its actions.

Determining whether a drug should be on a formulary typically involves clinical evaluations based on a drug's safety and effectiveness and a negotiated manufacturer's price. Plans and PBMs currently make those determinations privately, something that would not be tolerable for Medicare, which must have transparent policies that are determined openly.

Given the stakes involved in a drug being selected for a Medicare formulary, one could imagine the intensive efforts to scrutinize and influence the selection process. In addition, once the formulary is in place, it may be difficult to steer utilization and limit use of non-formulary drugs, especially in the fee-for-service environment, where it may be hard to influence prescribing practices.

Although contracting with multiple PBMs to manage segments of the drug market could potentially mitigate some of the likely difficulties that Medicare would face in adopting private sector strategies on a national basis, these area PBMs could potentially face some of the same difficulties.

Furthermore, if each PBM had exclusive responsibility for a geographic area, beneficiaries who want certain drugs could be advantaged or disadvantaged merely by the fact that they live in a certain location.

To reduce variation, Medicare could, like some private sector purchasers, specify core benefits or maintain clinical control over formulary decisions; however, without the ability to create and manage a formulary, the ability of a PBM to exact price discounts and control overall costs would be diminished.

If multiple PBMs were to compete in a single area, issues would arise in terms of informing beneficiaries about the differences in their policies, monitoring their marketing and recruitment strategies, and accounting for differences in the health status of beneficiaries using each PBM.

We have seen in our work on Medicare+Choice that trying to take advantage of cost containment strategies involving the benefits of competition also creates an obligation to adequately inform beneficiaries about the options available to them. Our work on Medicare+Choice has demonstrated that it is not an easy task to ensure that beneficiaries are adequately informed about their options.

Regardless of the model that is chosen for managing a drug benefit, attention also needs to be paid to the nuts and bolts of administering the benefits—in other words, paying the claims.

The efforts of PBMs to control expenditures involve a capacity also to scrutinize claims more effectively and quickly than is typical of Medicare today. PBMs provide online, real-time drug utilization reviews to inform pharmacists about potential drug interactions, thereby avoiding some medical errors, as well as whether the prescribed drug is covered in the appropriate formulary and what copayments will apply.

Currently, Medicare does not have such capability. To duplicate the type of capacity PBMs have will likely involve increasing the proportion of Medicare spending devoted to administrative costs. That share today is roughly 2 percent. It is not possible to estimate the administrative cost that will be needed to implement a drug benefit with any precision; however, the number of prescriptions for Medicare beneficiaries could easily approach the current number of claims for all other services combined, or \$900 million annually, suggesting the total administrative cost would be substantial.

I conclude by noting it is important to find the right balance in adapting these private sector techniques that I have discussed for Medicare. It is desirable to take advantage of these practices to provide a drug benefit as efficiently as possible, through the uniqueness of the Medicare Program, particularly its size, the need for transparency, and its importance to beneficiaries, suggests there will be real challenges in applying these techniques.

Thank you very much, Mr. Chairman. I will be happy to answer any questions you or Members of the Subcommittee may have.

Chairman THOMAS. Thank you very much.

The prepared statement follows:]

Statement of William J. Scanlon, Ph.D., Director, Health Financing and Public Health Issues, Health, Education, and Human Services Division, U.S. General Accounting Office

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here as you discuss the President's proposal to extend prescription drug coverage to Medicare beneficiaries. In previous hearings before this and other committees, GAO has addressed considerations for adding a prescription drug benefit to Medicare, given the fiscal imbalance of the Medicare program and the need to implement major reforms to ensure the sustainability of the program. As you know, the President has proposed contracting with private entities to administer a new prescription drug benefit option under Medicare. This is to allow Medicare to benefit from techniques developed for private insurers to control spending and improve the use of prescription drugs. In this context, my remarks will focus first on the factors contributing to the rise in prescription drug spending and the

impact of the rise in spending on Medicare beneficiaries, particularly those without coverage. Next, I will outline the methods private insurers, including those offering Medicare+Choice managed care products to Medicare beneficiaries, have developed to control these rising costs. Finally, I will discuss issues involved in adapting these methods for the Medicare program and its beneficiaries, should an outpatient prescription drug benefit be added to Medicare.

In summary, private insurers, managed care plans, and employers have tried to manage the high and rising costs of prescription drugs by adopting cost and utilization control techniques. In many cases, insurers and managed care plans contract with a pharmacy benefit management company (PBM) to develop and implement these strategies. If a prescription drug benefit were added to the Medicare program, the federal government would face similar cost pressures and would need to employ methods to control spending. The experience gained in the private sector can provide useful insights into options for managing a possible Medicare benefit. However, the unique responsibilities and characteristics of the Medicare program raise a number of issues and introduce questions about applying private sector tools to the traditional Medicare fee-for-service program and the appropriate roles of the Health Care Financing Administration (HCFA) and other entities, such as PBMs, in managing a drug benefit. In adapting these cost and utilization management techniques, it is important to keep in mind that: (1) the size of the Medicare program and the need for transparency in its actions may reduce the effectiveness of some cost control techniques; (2) using private-sector entities to implement a drug benefit introduces concerns related to beneficiary equity and concentrating market power; (3) private-sector management tools require a capacity to process and scrutinize a large number of claims more quickly than is typical of the traditional Medicare program; and (4) strategies involving coverage restrictions impose an obligation to provide beneficiaries with adequate information about the benefit.

RISING DRUG SPENDING ELEVATES BENEFICIARY ACCESS CONCERNS AND THE IMPORTANCE OF COST CONTROLS

Extensive research and development over the past 10 years has led to the introduction of new, more expensive drug therapies—including improvements upon existing drug therapies and drugs that treat diseases more effectively—which have contributed to the increase both in prescription drug use and drug spending. For example, new drug treatments for arthritis and depression have therapeutic advantages over older medications, but they are also more expensive than the drugs they replace. Biotechnological advances and a growing knowledge of the human immune system are significantly shaping the discovery, design, and production of drugs. As a result of these innovations, the importance of prescription drugs to health care delivery has grown.

Rise in Prescription Drug Spending Caused by Many Factors

Prescription drug expenditures have grown significantly in the past 5 years, both in total and as a share of all health care expenditures. From 1993 to 1998, prescription drug spending rose an average of 12.4 percent a year, compared to a 5 percent annual growth rate for overall health care expenditures. Consequently, drug spending comprised a larger share of total health care spending by 1998—rising from 5.6 percent to 7.9 percent. Total drug expenditures have been driven up by both greater use of drugs and the substitution of higher-priced new drugs for lower-priced existing drugs.

Several factors have contributed to rising expenditures—more third-party coverage of drugs, the introduction of new drug therapies, and more aggressive marketing by manufacturers through direct-to-consumer advertising. The increase in prescription drug coverage provided by private insurance is a likely contributor to the rise in utilization because insured consumers are shielded from the direct costs of prescription drugs. In 1988, private health insurers paid almost a third of all prescription drug expenditures. By 1998, that share had risen to more than a half. 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 driving up the volume of drugs used as well as the average price of medications. Advertising pitched to consumers is also a likely contributor to the increased utilization of prescription drugs. Between March 1998 and March 1999, the pharmaceutical industry's spending on advertising grew 16 percent, to \$1.5 billion. A 1999 study found that the 10 drugs most heavily advertised

to consumers in 1998 accounted for about 22 percent of the total increase in drug spending between 1993 and 1998.¹

Medicare Beneficiary Drug Coverage and Utilization

Elderly individuals, with their greater prevalence of chronic conditions, represent a disproportionate share of drug spending. On average, in 1996, Medicare beneficiaries had estimated annual drug spending of about \$674 per person,² compared to an estimated \$156 per person for the nonelderly population.³ A more recent estimate projected that 20 percent of Medicare beneficiaries would have drug costs of \$1,500 or more in 1999, a substantial sum for those lacking some form of insurance to subsidize their drug purchases.⁴ In 1996, beneficiaries who had no drug coverage and were in poor health had estimated mean annual drug expenditures that were \$591 lower than beneficiaries with similar health status who had drug coverage.⁵ This indicates that the lack of prescription drug coverage may cause access problems, particularly for those in poor health.

Although the Medicare benefit package, largely designed in 1965, provides virtually no outpatient drug coverage, more than two-thirds of Medicare beneficiaries had at least some prescription drug coverage in 1996. Almost one-third of beneficiaries had employer-sponsored health coverage, as retirees, that included drug benefits. About 17 percent of Medicare beneficiaries had coverage because they chose to enroll in a Medicare+Choice plan or purchase a Medigap policy with such coverage. About 10 percent of beneficiaries received coverage through Medicaid.

The rising cost of prescription drug benefits has driven employers, insurers, and managed care plans to adopt new approaches that limit total drug coverage or increase enrollees' out-of-pocket costs. 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. In addition, the drug benefits offered by Medicare+Choice plans have become less generous. Many plans restructured their benefits in 2000, increasing enrollees' out-of-pocket costs and limiting their total drug coverage.

PRIVATE-SECTOR TECHNIQUES FOR CONTROLLING DRUG EXPENDITURES

During this recent period of rising prescription drug spending, insurers and HMOs have adopted a variety of techniques to control enrollee utilization and the prices they pay for drugs. Many insurers and HMOs contract with PBMs to develop and implement these cost control techniques and to perform other activities related to managing the drug benefit. Direct negotiations with drug manufacturers yield lower prices through manufacturer rebate agreements. Because rebates generally depend on the volume of the products purchased, employers or HMOs use techniques to concentrate their enrollees' drug purchases to be able to use market power to maximize rebates. This is accomplished through the use of a formulary. Cost-control techniques also extend to the drug distribution network, with emphasis on negotiating reimbursement rates and dispensing fees with pharmacies and encouraging the use of mail-order pharmacies to lower distribution costs. Insurers or PBMs also perform other functions to manage a drug benefit, control spending, and ensure quality of care such as monitoring drug use when the pharmacist is filling the prescription to enable the substitution of lower-priced products or to identify possible adverse drug reactions. They also use claims data to monitor patterns of patient use, physician prescribing practices, and pharmacy dispensing practices.

PBMs originated as claims processors and mail-order or managed care pharmacies. Today, they provide a wide range of services—such as claims processing, for-

¹ 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.

² GAO calculation based on J.A. Poisal and G.S. Chulis, "Medicare Beneficiaries And Drug Coverage," *Health Affairs* (Mar./Apr. 2000), p. 252.

³ 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, 1996-2005" "[http://www.meps.ahrp.gov/nmes/papers/trends/96-05\(c\).pdf](http://www.meps.ahrp.gov/nmes/papers/trends/96-05(c).pdf)" (Aug. 1998), p. 9 (cited Mar. 16, 2000).

⁴ M.E. Gluck, "National Academy of Social Insurance Medicare Brief: A Medicare Prescription Drug Benefit," "<http://www.nasi.org/Medicare.medbr1.htm>" (Apr. 1999), p. 8 (cited Apr. 22, 1999).

⁵ GAO calculation based on J.A. Poisal and G.S. Chulis, "Medicare Beneficiaries And Drug Coverage," *Health Affairs* (Mar./Apr. 2000), p. 252.

mulary management, and pharmacy network development—to HMOs, insurance carriers, Blue Cross Blue Shield plans, plans that cover federal and state employees, and union members. According to the Pharmacy Care Management Association, the PBM industry's trade association, PBMs manage about 1.8 billion prescriptions annually, or about 70 percent of all prescriptions dispensed to ambulatory care patients. According to a recent estimate, PBMs are responsible for managing the drug benefits for about 71 percent of the 194 million people with third party pharmacy coverage.⁶ There are more than 140 PBMs, which range in size, scope, and services provided. Some administer prescription drug benefits nationwide; others focus on serving clients in particular regions of the country.

PBMs and insurers negotiate rebates from drug manufacturers and thus lower the net prices they pay for drugs. According to a 1996 study, manufacturers' rebates averaged 5 to 6 percent of total drug costs.⁷ This average masks what may be considerable variation across products. The negotiated rebate is typically dependent on the purchasing power of the PBM or insurer, the availability of several brand-named drugs in a therapeutic class, and assurances of a particular level of utilization of the product.

Insurers or PBMs employ various strategies to channel drug utilization to products for which they have rebate agreements that are based on market share. Generally, this is done by using a formulary, a list of prescription drugs, grouped by therapeutic class, that a health plan or insurer prefers and may encourage physicians to prescribe and beneficiaries to use. A particular product may be included on the formulary because of its medical value or because of a favorable price negotiated with the manufacturer. The inclusion of a particular drug on a formulary can affect its utilization, which can increase the level of manufacturer discounts or rebates, and lower a drug's net cost.

Formularies are structured and implemented to steer drug choice when therapeutically equivalent options are available. Closed formularies, which restrict insurance coverage to only selected drugs and require enrollees to pay the full cost of nonformulary drugs, may be the most effective in channeling utilization. However, closed formularies have faced resistance from beneficiaries and providers because they can lead to higher enrollee costs or restrict access to certain medicines. As a result, more insurers are moving to incentive-based formularies that offer enrollees lower copayments for the preferred product or generic drugs. The insurer continues to cover drugs that are not on the formulary, but the beneficiary faces a higher copayment. A third type, open formularies, is often referred to as "voluntary" because physicians and beneficiaries may be informed about preferred drugs, but beneficiaries pay no more for using nonformulary drugs. Formularies that provide the strongest financial incentives to beneficiaries to choose one product over another offer more cost control potential. They can be used to steer utilization to lower-priced products, including generics, and concentrate market share to elicit the best prices or largest rebates on particular products. In doing so, however, they may produce dissatisfaction among consumers, who have to pay more out-of-pocket for nonformulary drugs, and physicians, who believe formularies restrict their prescribing practices.

PBMs and private insurers have also targeted drug distribution costs as an area for cost savings. Similar to their negotiations with manufacturers, PBMs negotiate with retail pharmacies to obtain prices that are well below pharmacies' usual price for customers without drug coverage. PBMs attempt to enhance their leverage with retail pharmacies by limiting the size of the pharmacy network. Restricting the number of pharmacies in the network can benefit participating pharmacies by increasing each one's market share, and as a result, make them more willing to provide larger discounts on the prescriptions they fill. Potential savings from this cost-control technique, however, must be balanced with the inconvenience of a limited pharmacy network. PBMs may also operate mail-order pharmacies that allow enrollees to obtain prescriptions by mail. This is a cost-effective way of dispensing drugs, particularly maintenance drugs for chronic health conditions, such as high blood pressure or asthma.

The claims processing capabilities of PBMs enable them to engage in other activities that may help control overall health care expenditures or improve quality of care. For example, drug utilization review (DUR) programs analyze patterns of drug

⁶Testimony of Jeff Sanders, Senior Vice President, Value Development, PCS Health Systems, Inc., before the Senate Committee on Finance, June 23, 1999. <http://www.senate.gov/finance/6-23san1.htm>

⁷A. Cook, T. Kornfield, and M. Gold, Mathematica Policy Research, Inc. for The Henry J. Kaiser Family Foundation, *The Role of PBMs in Managing Drug Costs: Implications for a Medicare Drug Benefit* (January 2000), p. 20.

use on a real-time basis when a pharmacist is actually filling a prescription. These programs use databases and computer systems that include a patient's entire drug utilization history for all network and mail-order pharmacies. These systems identify instances in which a drug may be inappropriate for a particular patient given a person's medications or age. Most PBMs use system edits specifically tailored to particular types of beneficiaries, such as people who are 65 years of age or older who may have a difficult time tolerating certain medicines. Such interventions can both improve quality of care and prevent additional health care costs by reducing drug interactions or flagging evidence of inappropriate use, such as early refills. DUR can also be conducted retrospectively, usually on a monthly or quarterly basis, to profile physician prescribing practices, pharmacy dispensing practices, or patient utilization. The results of retrospective DUR programs are used to encourage physicians to prescribe less costly therapeutic alternatives or generics, encourage pharmacies to substitute generics or preferred formulary drugs for more expensive non-formulary drugs, and ensure that some patients are not overutilizing prescription medicines.

APPLYING PRIVATE-SECTOR TECHNIQUES TO A DRUG BENEFIT WITHIN MEDICARE

Private-sector entities have attempted to control the growth of prescription drug expenditures while preserving or enhancing the value of drug coverage for their enrollees, often through contracts with PBMs. The President proposes to contract with entities, such as PBMs, to administer a new Medicare prescription drug benefit. This could allow Medicare to use the cost control and quality enhancing techniques developed for private insurers. Yet the unique characteristics of Medicare and its beneficiaries will require careful consideration as private-sector experience influences the design of methods to increase beneficiary access to prescription drug coverage. I would like to discuss four issues that should affect how any Medicare prescription drug program is designed.

- Adaptation of PBM techniques within the traditional fee-for-service Medicare program could be difficult given its size and the need for transparency in its actions.
- Contracting with private-sector entities to administer a drug benefit with cost and utilization controls would raise other challenges.
- The efforts of PBMs to control expenditures involve a capacity to scrutinize claims more effectively and quickly than is typical of Medicare today.
- In the competitive model for Medicare—such as exists today with Medicare+Choice or in the models envisioned in some reform proposals to expand drug coverage—cost containment strategies involving restrictions on coverage through formularies or pharmacy networks impose an obligation to adequately inform beneficiaries about plan policies.

Adding a Drug Benefit to the Traditional Medicare Program Raises Issues About the Feasibility of Applying PBM Techniques

It may be difficult for the traditional fee-for-service Medicare program to design and implement a national drug benefit using private-sector management techniques such as formularies. Traditional Medicare has generally established administrative prices for services such as physician or hospital care and then processed and paid claims with few utilization controls. Adopting some of the techniques used by private plans and insurers to obtain better prices and affect utilization might have the potential for better cost-control. However, adapting those techniques to deal with the unique characteristics and size of the Medicare program raises many questions. Because the traditional Medicare program may be unable to operate with the flexibility that PBMs have in the private sector, it may rely on other pricing strategies to try to exact lower prices from manufacturers.

Having a formulary would enhance Medicare's ability to control costs by enabling it to negotiate significantly discounted prices with manufacturers by promising to deliver a larger market share for a manufacturer's product. Yet, implementing a formulary and other utilization controls could prove difficult for Medicare. Determining whether a drug should be on the formulary and which drugs should be preferred, typically involves clinical evaluations based on a drug's safety and effectiveness, and decisions on whether several drugs are therapeutically equivalent. A pharmacy and therapeutics committee within the health plan or a PBM may make these decisions. Plans and PBMs currently make formulary determinations privately—something that would not be tolerable for Medicare, which must have transparent policies that are determined openly. Given the stakes involved in a drug being selected as preferred on a Medicare formulary, one can imagine the intensive efforts to offer input to and scrutinize the selection process. In addition, once the formulary is in place it may be difficult to steer utilization or withstand pressure to allow access to non-

formulary drugs, especially in the fee-for-service environment, where it may be hard to influence prescribing practices.

If Medicare covered all drugs in a therapeutic class on the same terms, beneficiaries may not be influenced toward particular drugs and thus manufacturers would have no incentive to offer deep discounts. Without a promised share of the Medicare market, manufacturers may determine they could reap greater returns from charging higher prices and concentrating marketing efforts on physicians and consumers to influence prescribing patterns.

If Medicare cannot effectively operate a formulary, it may have to rely instead on administratively determined prices. These could be similar to the manufacturer rebates received by the Medicaid program, which is currently the largest government payer for outpatient prescription drugs, comprising about 17 percent of national expenditures on outpatient drugs. Since the enactment of the Omnibus Budget Reconciliation Act of 1990 (OBRA), drug manufacturers are required to provide rebates to state Medicaid programs on outpatient drugs based on the “lowest” or “best” prices they charged other purchasers. In return for the rebates, state Medicaid programs maintain open formularies that permit reimbursement for all drugs. Although 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 for open formularies, which limits the utilization controls Medicaid programs can use at a time when prescription drug expenditures are increasing rapidly.

Contracting with PBMs to Implement Cost Control Strategies Presents Other Challenges for Medicare

Using PBMs or other similar entities to administer a Medicare drug benefit in geographic areas could potentially mitigate some of the likely difficulties that the program would face in attempting to apply private sector strategies on a national basis. But such an arrangement raises additional questions about how private sector techniques could be applied within Medicare. PBMs could potentially face some of the same difficulties mentioned previously—namely, their usual cost and utilization management tools may be blunted in the Medicare context due to the scrutiny their policies may face. Moreover, the decision to use a single or multiple PBMs for the entire country or one or multiple PBMs per region has the potential to affect the ability of the PBM or PBMs to control the cost of a Medicare drug benefit and to alter the value of the benefit available to different beneficiaries.

A single PBM contractor administering a Medicare drug benefit would likely be subject to the same level of scrutiny as a government entity. Such scrutiny may compromise the flexibility PBMs typically have used to generate savings. An alternative would be to grant flexibility to multiple PBMs that are responsible only for a share of the market. Contracting with multiple PBMs, though, raises other issues. If each PBM had exclusive responsibility for a geographic area, beneficiaries who want certain drugs could be advantaged or disadvantaged merely because they live in a particular area. This kind of geographic variability may be difficult for Medicare to sustain. While it is true that such variability exists in the Medicare+Choice program, individuals enrolled in a Medicare+Choice plan have chosen to enroll and accept the terms of the benefit. For beneficiaries in traditional Medicare, their regional PBM may be their only drug coverage option. To reduce variation, Medicare could, like some private-sector purchasers, specify core benefit characteristics or maintain clinical control over formulary decisions instead of delegating those decisions to the PBMs. However, without the ability to create and manage a formulary, PBMs would have less flexibility to use techniques that have been integral to their efforts to maximize price discounts and control overall costs.

If multiple PBMs operate in each area, beneficiaries would choose one to administer their drug benefit. PBMs would compete for consumers directly, unlike the private-sector where they normally compete for contracts with insurers or other purchasers. With multiple PBMs, issues would arise regarding informing beneficiaries about the differences in each PBM’s policies, monitoring PBMs marketing and recruitment strategies, and accounting for differences in health status of beneficiaries using each PBM. Having more than one PBM in an area may also dilute the market power of each PBM, because they would individually control fewer beneficiaries and need to be concerned about retaining beneficiaries. Having PBMs compete for beneficiaries may create an incentive for the PBM to have less stringent formularies, if all beneficiaries are subject to the same cost-sharing requirements regardless of the PBM they use.

The competitiveness of a bidding process for contracts to administer a Medicare drug benefit would depend, in part, on the size of the region for which PBMs compete. One recent study showed that the PBM industry is competitive, but that it

is dominated by a few large companies.⁸ If a contract were awarded for the entire country or a few large regions, these large companies may have an advantage. Large regional contracts would concentrate Medicare's market power in these few firms, giving them more leverage to negotiate with manufacturers. If PBMs competed for smaller areas, more regional PBMs may bid to provide services in their region. Awarding more contracts that cover fewer beneficiaries may encourage participation by a greater number of PBMs, but may also dilute the overall market power associated with providing a drug benefit to Medicare beneficiaries. It may also be more burdensome to administer more PBM contracts.

Drug Benefit Administrative Functions are Unlike Traditional Medicare Activities

PBMs' ability to administer formulary policy and impose other utilization controls involves a capacity to process and scrutinize claims that is very different from traditional Medicare's handling of claims for other services. For example, PBMs have the ability to provide on-line, real-time drug utilization reviews. These serve a quality- and cost-control function by supplying information to pharmacists regarding such things as whether a drug is appropriate for a person based on his or her age, medical conditions, and other medications, as well as whether the drug is covered on the formulary, and what copayments will apply. Currently, Medicare does not typically manage utilization of services in this fashion. It does not have the capacity to conduct real-time review of most services. Instead, Medicare pays claims after services have been delivered. In the current Medicare program, analysis of utilization patterns for individual services or providers is only possible after all claims have been submitted and assembled. Nevertheless, Medicare's administrative costs historically have been extremely low, averaging about 2 percent of the cost of the services themselves.⁹

Duplicating the type of controls PBMs have exercised over private-sector drug benefits will likely involve devoting a larger share of total expenditures to administration than is currently expended in the traditional Medicare program. The magnitude of the increase is difficult to estimate. Much depends on what services PBMs are asked to provide and how much of the Medicare drug benefit each PBM will administer. Even if the dimensions of the PBM's or contractor's role are specified, estimating the likely costs remains problematic. A Medicare drug benefit will be a large-scale endeavor. The number of prescriptions for Medicare beneficiaries could easily approach the current number of claims for all other services combined or about 900 million annually. It is unclear how much PBMs or others would have to increase current capacity or instead use more of the capacity already built into their information and claims processing systems—a consideration that could significantly affect the administrative costs that may be incurred.

Informed Beneficiary Choices Require Adequate, Comparable Information

Any Medicare benefit that requires beneficiaries to choose among options for prescription drug coverage, for example between competing PBMs or health plans, would require a mechanism to ensure that they had adequate information to select the option that best meets their needs. Yet our previous work on the Medicare+Choice program indicates that it is difficult to provide that kind of information in a timely manner, in a format that is readily comparable. We identified a number of factors that make it difficult for beneficiaries to make an informed choice among Medicare+Choice options. In some cases, detailed information about plans' benefits and out-of-pocket fees is provided only after a beneficiary enrolls in a plan. In other cases, detailed information may be available before enrollment from plan sales agents and member literature, but beneficiaries may find it difficult to compare available options because plans present the information in different formats and use different terms to describe covered benefits. The lack of comparative information can be particularly problematic when evaluating plans' drug benefits, because many design characteristics determine the true value of the drug coverage.

Comparing alternative prescription drug coverage options can be difficult because formulary types and management techniques differ considerably, affecting the benefit. A beneficiary may not be aware of formulary changes until they are at the pharmacy counter. Aggressive formulary management may control spending, but beneficiaries need to be aware of how it may affect their access to a particular medi-

⁸A. Cook, T. Kornfield, and M. Gold, Mathematica Policy Research, Inc., for The Henry J. Kaiser Family Foundation, *The Role of PBMs in Managing Drug Costs: Implications for a Medicare Drug Benefit* (January 2000), p. 41.

⁹*Medicare: HCFA Faces Challenges to Control Improper Payments*, (GAO/T-HEHS-00-74, Mar. 9, 2000).

cine and the prescribing practices of their physicians. Such issues present even greater challenges in the management of a drug benefit for the entire Medicare population.

CONCLUDING OBSERVATIONS

There is growing consensus that Medicare needs to change its benefit structure to include outpatient prescription drug coverage. Yet such an undertaking has substantial consequences for the cost of the program. In fact, one recent study suggests that such an expansion would add between 7.2 and 10 percent annually to Medicare outlays.¹⁰ The structure of such a new benefit—whom it would cover and the extent of its coverage—is an important determinant of the added cost. This is why, in previous hearings, the GAO has emphasized the need to make prescription drugs more affordable to beneficiaries who lack coverage by expanding access to group rates, extending discounts associated with group purchasing, and targeting government subsidies for those most in need. To the extent that this is accomplished through expanding Medicare's benefit package, cost-control methods need to be incorporated into the management of the benefit. The private sector has developed and refined techniques, which have been implemented in some Medicare+Choice plans and private health plans, to control prescription drug costs. Applying these techniques to the larger Medicare population will require adaptations that may diminish their effectiveness.

The challenge in adding prescription drug coverage to the Medicare program will be in designing and implementing drug coverage to minimize the financial implications for Medicare while maximizing the positive effect of such coverage on Medicare beneficiaries. Most importantly, this benefit expansion must be consistent with efforts to ensure the long-run sustainability of Medicare so that the program does not consume an unreasonable share of our productive resources and does not encroach on other public programs or private sector activities. Private sector tools for controlling drug expenditures provide options for controlling drug expenditures. However, how to apply these tools effectively to a Medicare drug benefit presents a number of challenges and requires careful consideration of the nature and magnitude of the Medicare program.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other members of the Subcommittee may have.

GAO CONTACTS AND ACKNOWLEDGEMENTS

For future contacts regarding this testimony, please call William J. Scanlon or Laura A. Dummit at (202) 512-7114. Other individuals who made key contributions to this statement include John C. Hansen, Kathryn Linehan and Myrna Perez.

Chairman THOMAS. Dr. Crippen?

STATEMENT OF DAN L. CRIPPEN, DIRECTOR, CONGRESSIONAL BUDGET OFFICE; ACCOMPANIED BY, STEVE LIEBERMAN, EXECUTIVE ASSOCIATE DIRECTOR, CONGRESSIONAL BUDGET OFFICE

Mr. CRIPPEN. Mr. Chairman, Mr. Stark, with your tolerance, I want to spend just a couple of minutes talking about the current state of the debate, if you will, and then the context in which the President's proposal was made.

I recently listened to a debate in the other body that produced, not surprisingly, a flood of endorsements of pharmaceutical benefits for the elderly, accompanied by the virtually universal arguments that the practice of medicine has changed since 1965, that drugs have become a more important and expensive component of health care, and that therefore we need to modernize Medicare—

¹⁰Gluck, p. 8.

all of which is not unlike the statement made by the administrator this morning.

I did not hear anyone mention, however, the other aspects of medicine that have also changed. For example, both the frequency and duration of hospitalization have decreased dramatically, and as a result, over 50 percent of hospital beds in this country go unused every day. Despite that fact, there are even more in-patient rooms under construction, notably right here in Washington. We may want to address, as we “modernize” Medicare, how our current system underwrites that potentially excess capacity.

Nor did I hear in that debate about how the number of retirees and workers and their demographic profiles have changed since 1965 and how they will change in the next 30 years. Between now and 2030, the number of retirees will grow by some 85 percent, while the number of workers will grow by only 15 percent. And those retirees will live, of course, much longer than they did in 1965.

At the same time, there are claims being made about the current Medicare program—indeed, that the Congress cut it too much in 1997. Those providers who are more politically savvy, of course, say that the Congressional Budget Office (CBO) underestimated the effects of the Balanced Budget Act (BBA) and led you astray. Although we did underestimate future Medicare payments, with the exception of the interim payment system for home health care, we continue to believe the estimates are reasonable.

It is useful to remember what was happening before enactment of the BBA—20 percent annual increases in home health care spending, for example—and to mention the effects of the government’s efforts to reduce abusive and fraudulent payments. CBO’s larger error was in failing to recognize the magnitude of those effects. To argue for restoration of the BBA cuts is, at least in part, to argue to restore the aggressive, if not abusive, billing practices that were frequently found among providers before Columbia/HCA’s practices became headline news.

There are other aspects of the debate thus far that I find curious and interesting. We are told, for example, that the private insurance market will not offer coverage for prescription drugs, that at if it did, most it would only be a system of reimbursement and not true insurance. That seems to me to invite the question, just what are the medigap policies that these same insurers offer if not first-dollar coverage at considerable expense to the taxpayers today?

We estimate, for example, that on the one hand, medigap coverage costs the taxpayers hundreds of dollars per person per year because of the increased utilization it induces. Medigap reform, on the other hand, could save billions of dollars a year. As this Committee well knows, the design of those policies is a matter of government regulation.

Mr. Chairman, my musings are perhaps just that, but one thing I am certain of: we need to analyze the impact of Medicare and any changes to it, not just in today’s economic and fiscal climate but also in that of the future, and not just in the context of today’s retirees and their health care but in the context of the nation’s collective needs.

For example, we currently expect that federal programs for the elderly will increase from 7 percent of gross domestic product (GDP) to 15 percent, as my generation retires. In terms of today's budget, Mr. Chairman, that would mean that about \$600 billion—an amount equal to total discretionary spending today—would have to be cut, raised through new taxes, or borrowed. A drug benefit of any kind will obviously exacerbate that result, pushing spending for retirees near the level of the entire current federal budget.

In the end, it does not matter if these programs have balances in trust funds or dedicated revenue sources. What matters is how much of what our kids produce will we demand that they give us. Let me repeat that, Mr. Chairman, because if there were only one point I might leave you with today, it would surely be that one. What matters is how much the elderly of the future—namely, my generation—will use of the nation's future income, produced by our children, and not the solvency or even the existence of some federal trust fund.

Turning to the President's proposal, Mr. Chairman, our analysis has raised a variety of issues regarding the design of such a benefit—issues that will, of course, apply to many of the other Medicare pharmaceutical proposals as well. The specific features of the proposal determine the cost of the program to federal and state governments and the policy's effectiveness in providing affordable access to prescription drugs for Medicare beneficiaries.

Some of the more important design issues, which are discussed in my submitted testimony, are things like the nature and initial value of the benefit; the effectiveness of pharmacy benefit managers (PBMs) and other forms of potential competition, as my colleague has just testified; program participation; and effects on Medicaid costs.

Ultimately, future costs will depend on how much demand increases—that is, after all, the point of this policy—and how much the price of drugs is increased as well. Offering a new benefit to 39 million people, over 10 million of whom currently have no coverage, will have unforeseen effects of possibly large magnitudes. And even without that new coverage, drugs spending for by the elderly has been increasing at double-digit rates, well in excess of the rate of growth of spending for the Medicare Program, as a whole.

In general, the President would create a voluntary prescription drug benefit, Part D of Medicare, that would begin in 2003 and be fully phased in by 2009. It would pay half of the cost of beneficiaries prescription drugs, up to a specified cap. The insured half of the benefit would be financed equally by premium payments and by general tax revenues.

After taking the cost of premiums into account, enrollees would pay 75 percent of the cost of the benefit, and the government would pay 25 percent, up to the benefit's maximum.

Although the President's budget suggests earmarking \$35 billion from 2006 through 2010 for a possible catastrophic benefit, no policy is specified. Like you, we have seen only press reports of the initiative announced yesterday, and we have no further details. For the moment, our estimate includes neither the earmarked \$35 billion nor the effects of yesterday's proposal.

Having said that, CBO estimates that the provisions of the President's proposal, excluding catastrophic coverage, would add a total of \$160 billion to federal costs through 2010. That estimate is identical to the one the administration gave you this morning.

On a bit of a personal note, Mr. Chairman, the administration's estimate last year for a virtually identical policy was two-thirds that figure, a difference that, at the time, caused the President to publicly disparage our estimates and some of your colleagues to question our motives.

As you can see on the next chart, which is table 3 in my written statement, CBO's total of \$160 billion represents \$134 billion in outlays for Medicare and \$26 billion for Medicaid. States would also face an additional Medicaid cost.

CBO estimates that the monthly premium for Part D would start at \$24 in 2003 and rise at to about \$50 in 2010—again, very much in line with the administration's own estimates.

Let me conclude, Mr. Chairman, by stating what is perhaps obvious by now: providing prescription drug coverage to Medicare beneficiaries is a complex policy challenge. The role and cost of prescription drugs have grown dramatically since the inception of Medicare, as drugs have become a more critical component of modern health care. More than two out of every three Medicare beneficiaries have arranged some form of third-party coverage, leaving 31 percent currently without any drug coverage for prescription drugs.

The enormous variation in comprehensiveness, cost, and financing of existing drug coverage tremendously complicates the challenge of reforming insurance for prescription drugs. Under the President's proposal, for example, 33 percent of participants in the new drug benefit would have expenses for drugs that exceeded the cap in 2003. Even so, the proposed drug benefit would add significantly to federal costs.

The specific details of a proposal matter enormously—the level of coinsurance, existence of a stop-loss provision, splitting how financing is split between beneficiaries and taxpayers, and the nature and degree of subsidies for low-income people and employers.

Mr. Chairman, suffice it to say that Medicare does not exist for the preservation of medical institutions and the well-being of providers but rather to finance health care for our retirees. Nor does it exist in a world of unlimited resources. We have to look at the outcomes and at the effects of the program and the health of the beneficiaries in the context of what we and, ultimately, our children can afford.

Thank you, Mr. Chairman.

[The prepared statement follows:]

Statement of Dan L. Crippen, Ph.D., Director, Congressional Budget Office

Mr. Chairman and Members of the Committee, I am pleased to be here today to discuss the President's proposal for a prescription drug benefit for the Medicare program. That proposal recognizes the public's concern that rising drug costs may be placing a large and growing financial burden on Medicare beneficiaries. About 30 percent of those beneficiaries do not have insurance coverage for prescription drugs, and others have only limited coverage. The President's proposal would provide some benefit for most Medicare beneficiaries but, as currently specified, would provide little financial protection for those who face extremely high spending for prescription drugs.

The proposed prescription drug benefit is part of a broader set of policies for Medicare recommended in the President's budget for 2001. Those policies would expand Medicare eligibility to new populations, reduce payments for certain covered services, introduce innovations from the private sector to fee-for-service Medicare, and convert Medicare+Choice into a competitive defined benefit program.

My testimony today will focus on the prescription drug proposal. As background to that analysis, I will briefly discuss spending by Medicare beneficiaries on prescription drugs and the extent of the insurance coverage for that spending. I will then describe the President's proposal and the Congressional Budget Office's (CBO's) most recent analysis of that plan, including a newly revised estimate of the plan's costs. The new estimate is about \$11 billion higher than the one we reported in April in our analysis of the President's budgetary proposals. My statement will conclude with some observations on several design features that affect the cost and effectiveness of a Medicare prescription drug benefit.

SPENDING AND INSURANCE COVERAGE FOR PRESCRIPTION DRUGS

The majority of Medicare beneficiaries spend some money on prescription drugs in a year, and a significant fraction of those beneficiaries have very high expenses. In 1996, for example, the Health Care Financing Administration (HCFA) estimates that, in total, the average Medicare beneficiary spent more than \$670 for prescription drugs. (That includes both out-of-pocket expenses and any insurance reimbursement.) About 87 percent of beneficiaries had some drug spending; about 7 percent had expenditures of \$2,000 or more (see Figure 1).

Several statistics suggest the significance of prescription drug spending by the Medicare population. Because Medicare beneficiaries are elderly or disabled, they use more prescription drugs than the average person. Medicare beneficiaries constituted about 14 percent of the U.S. population in 1996 but accounted for about 40 percent of the \$62 billion spent in the United States on prescription drugs in that year.

In addition, drug spending by Medicare beneficiaries has grown at a more rapid rate than spending on other health services. Between 1995 and 1996, for example, total drug spending by an average Medicare beneficiary grew by 12.2 percent, whereas federal spending for Medicare benefits (on a per-beneficiary basis) grew by 7.2 percent (see Table 1). Those rates compare with 4.6 percent growth in gross domestic product per capita over the same period.

The Medicare program does not cover most prescription drugs that beneficiaries take on an outpatient basis, and to obtain such coverage, many beneficiaries turn to supplemental coverage.¹ In 1996, according to HCFA data, more than two-thirds of beneficiaries had supplemental insurance that provided some drug benefits (see Table 2). The sources of the coverage vary (see Figure 2). Many Medicare+Choice plans offer drug coverage as a supplement to their overall benefit package. Other sources are employer-sponsored and medigap (individually purchased) plans that include drug coverage. In addition, some beneficiaries are eligible for prescription drug coverage under Medicaid or through other public programs.

Many Medicare beneficiaries have the option of enrolling in Medicare+Choice plans that offer prescription drug coverage. In 1996, nearly 95 percent of Medicare+Choice enrollees were in such plans—typically, the coverage included a cap on the maximum benefit, cost-sharing requirements, and a drug formulary. (A formulary is a list of drugs preferred by the plan's sponsor, in part because of their lower prices.) Faced with tightening financial circumstances in the past two years, however, an unusually large number of health maintenance organizations (HMOs) have dropped out of the Medicare+Choice program, and many of the plans offering prescription drug coverage have pared benefits significantly. One analysis suggests that only about three-quarters of beneficiaries enrolled in Medicare+Choice plans had drug coverage in 1998.

Employer-sponsored insurance is by far the largest source of prescription drug coverage for Medicare beneficiaries. In 1996, more than 11 million Medicare beneficiaries had drug coverage through employer-sponsored plans. But employers often "carve out" drug benefits from their main benefit package, typically subjecting them to more restrictions than are placed on other benefits. Employers and health plans have also turned to pharmacy benefit managers (PBMs), which use formularies, utilization review, selective contracting with pharmacy networks, and other tools to control the use of prescription drugs.

¹ Under Part B, Medicare now pays for a limited list of outpatient drugs, such as intravenous chemotherapy drugs that must be administered under the direction of a physician.

Medicare beneficiaries may also purchase supplemental drug coverage through medigap plans. Such coverage is limited, however: it requires beneficiaries to pay half the cost of their prescription drugs after meeting a \$250 deductible. Benefits are capped at either \$1,250 or \$3,000 annually. Premiums for medigap plans offering drug coverage are generally higher than for other medigap plans. The higher premiums are partly due to adverse selection (more people with greater need for health care—and thus greater costs—enroll in those plans).

Certain low-income Medicare beneficiaries have access to drug coverage through state Medicaid programs. Such beneficiaries include those who have income lower than 100 percent of the poverty level or medical expenses large enough to meet the program's spend-down requirements. (Individuals may be eligible for Medicaid under a state's spend-down requirement if their monthly income less medical expenses is below some maximum.) The assets that those beneficiaries may own are also limited. Medicare beneficiaries who meet those criteria are generally eligible for full Medicaid benefits, including prescription drug coverage. Other low-income people—those designated as qualified Medicare beneficiaries (QMBs) and specified low-income Medicare beneficiaries (SLMBs)—are eligible for subsidies for some Medicare expenses but are not eligible for full Medicaid services or Medicaid drug coverage. In 1996, about 3.9 million Medicare beneficiaries had supplemental drug coverage through Medicaid.

Coverage for prescription drugs is also available through other sources. Several states have instituted special programs to provide drug coverage for the low-income elderly or people with disabilities. And some Medicare beneficiaries are eligible for drug coverage and other benefits through the Department of Veterans Affairs or the Department of Defense.

People who have supplemental drug coverage consume more prescription drugs than those without such coverage but spend less out of pocket. In 1996, for example, Medicare beneficiaries with coverage spent an average of \$769 compared with \$463 for those without coverage, according to HCFA's estimates. Conversely, those with drug coverage spent less out of pocket: in 1996, beneficiaries with coverage averaged \$253 in out-of-pocket spending on prescription drugs (excluding premiums paid to private insurers or HMOs).

THE PRESIDENT'S MEDICARE PRESCRIPTION DRUG PROPOSAL

The President proposes to create a voluntary, outpatient prescription drug benefit under a new Part D of Medicare. That program would begin in 2003 and be fully phased in by 2009. It would pay half of the cost of prescription drugs, up to a specified cap. The insured half of the benefit would be financed equally by premium payments from enrollees and by general tax revenues. After taking cost sharing and premiums into account, enrollees would pay 75 percent of the cost of covered drugs and the government would pay 25 percent, up to the cap.

The proposed benefit would be administered by a private-sector pharmacy benefit manager in each region of the country, selected through competitive bidding. The PBMs that administer Part D would negotiate lower drug prices, on average, than are currently paid by Medicare beneficiaries. Beneficiaries who enrolled in Part D would receive the benefit of those discounted prices on their prescription drug purchases, including drugs they bought after exceeding the benefit cap.

Although the President's budget suggests earmarking \$35 billion from 2006 through 2010 for a possible catastrophic benefit, no policy is specified. Consequently, CBO's analysis does not focus on a catastrophic benefit, and our estimate does not include the \$35 billion earmark.

How the Benefit Would Work

In 2003, all Medicare beneficiaries would have a one-time chance to sign up for the new benefit. In later years, beneficiaries would be permitted to choose the Part D option only when they first became eligible for Medicare. The only exception involves beneficiaries with certain other prescription drug coverage who lose that coverage involuntarily (for example, when a former employer drops drug coverage for all retirees in its health plan).

The new benefit would have no deductible and would generally pay 50 percent of an enrollee's prescription drug costs, up to a maximum benefit of \$1,000 in 2003. That benefit cap would gradually rise to \$2,500 in 2009. Thus, in 2009, a beneficiary who spent \$5,000 or more on prescription drugs would receive the maximum reimbursement of \$2,500. That beneficiary would also pay \$575 in Part D premiums that year. After 2009, the cap would be indexed to annual changes in the consumer price index (CPI). Assuming that the cost of prescription drugs continued to rise more

rapidly than the CPI, the real value of the cap would shrink, thus eroding the benefit.

Certain low-income beneficiaries would receive help with drug-related costs through the Medicaid program. Medicaid would pay both the premiums and the cost-sharing expenses under the Medicare drug benefit for participants who were also fully eligible for Medicaid. For these so-called dual-eligibles, Medicaid would pay all drug costs not paid by Medicare, including expenses above the cap. Medicaid would also pay the premiums and cost-sharing requirements for people who had limited assets and income below the poverty line. In both cases, the federal government would reimburse states for those costs at the usual federal/state matching rate, which averages 57 percent.

Another group of low-income enrollees would also receive assistance with their prescription drug costs. The federal government would pay all of the premiums and coinsurance for Part D enrollees with limited assets and income between 100 percent and 135 percent of the poverty line, and part of the premiums for Part D enrollees with limited assets and income between 135 percent and 150 percent of the poverty line. Eligibility for those subsidies would be determined by state Medicaid agencies, but unlike the assistance provided to dual-eligibles, the federal government would pay 100 percent of these costs. Neither the federal nor state governments would be liable for covering any drug expenses above the Part D cap for low-income beneficiaries who were not fully eligible for Medicaid.

The President's proposal also includes an incentive that is intended to retain employer-sponsored drug coverage for retirees. Medicare would pay employers 67 percent of the premium-subsidy costs it would have incurred if the employers' retirees had enrolled in Part D instead. In addition, enrollees in Medicare's managed care plans would receive their prescription drug coverage through those plans, which for the first time would be paid directly for providing such coverage.

CBO's Cost Estimate

The new Part D provisions would add a total of \$160 billion to federal costs through 2010, CBO estimates. Of that total, \$134 billion represents outlays for Medicare (net of premium receipts), and \$26 billion represents federal outlays for Medicaid (see Table 3). States would also face additional Medicaid costs. CBO estimates that the premium for Part D would start at about \$24 a month in 2003 and rise to about \$50 a month in 2010.

CBO's cost estimate assumes that most people who are enrolled in Part B of Medicare would also enroll in Part D. But the estimate takes into account the fact that some beneficiaries who have employer-sponsored drug coverage for retirees would rather keep that coverage than opt for the new benefit. In addition, CBO assumes that people who are eligible for benefits under Part B but do not actually enroll would also not enroll in Part D. Under those assumptions, nearly 36 million people would sign up for Part D in 2003, representing approximately 88 percent of total Medicare enrollment.

CBO's estimate is about \$11 billion higher than the estimate in our April report, *An Analysis of the President's Budgetary Proposals for Fiscal Year 2001*. Two significant revisions have been made. First, we adjusted the data on spending for prescription drugs to recognize the discount that beneficiaries insured by employer-sponsored plans receive through their PBMs.² Second, we increased our estimate of the cost of the new subsidies for low-income people.

CONSIDERATIONS IN DESIGNING A MEDICARE DRUG BENEFIT

The President's prescription drug proposal has raised a variety of issues regarding the design of such a benefit. The specific features of a drug proposal determine the cost of the program to federal and state governments and the effectiveness of the policy in providing affordable access to pharmaceuticals for Medicare beneficiaries. Some of the important design issues that might be considered in assessing a Medicare drug benefit include:

- *The Nature and Value of the Benefit.* The proposed benefit is limited and does not include stop-loss coverage, which protects beneficiaries against catastrophically high spending on drugs.
- *The Effectiveness of PBMs.* It is uncertain whether PBMs would aggressively use formularies, coinsurance policies, and other methods to limit Medicare costs.

²HCFA will make such a revision in the Medicare Current Beneficiary Survey for 1997. Previously, the survey assumed that beneficiaries in employer-sponsored plans paid the full retail price for prescription drugs.

- *Program Participation.* Employers, who have been buffeted by rising drug costs, are likely to reduce their retiree coverage under a Medicare drug benefit instead of accepting a subsidy to retain their programs. Medigap insurers are also likely to restructure their plans to take advantage of the benefit. In addition, a drug benefit would reduce the incentive that Medicare beneficiaries now have to enroll in managed care plans rather than traditional fee-for-service Medicare.

- *Effects on Medicaid Costs.* The subsidy for low-income Medicare beneficiaries is superimposed on the existing Medicaid structure, which necessarily complicates the new benefit's design and affects the cost of the program to both federal and state governments.

The Nature and Value of the Benefit

Part D is designed to ensure that most enrollees would receive some benefit. However, because of the annual cap, it would not protect enrollees who have chronic conditions and are dependent on prescription drugs from very large out-of-pocket expenses. In 2003, for example, about

Thirty-three percent of participants would have drug expenses that exceeded the \$1,000 cap on Part D benefits. By 2010, about 22 percent of participants would have expenditures exceeding the benefit cap of about \$2,560. If drug costs continued to rise faster than the CPI, an increasing proportion of beneficiaries would have drug costs in excess of the maximum benefit cap after 2010.

Because the benefit cap would limit Medicare's exposure to increases in prescription drug spending, it would also limit the value of the benefit to people who have the highest drug costs. A program that did not provide first-dollar coverage but limited an enrollee's out-of-pocket costs to some annual maximum (or stop-loss amount) would better protect beneficiaries with the highest drug spending. Such a program would make larger payments to fewer people than would a program that capped benefits.

However, a redesigned benefit that protected beneficiaries more fully from catastrophic costs could raise prices for some drugs because enrollees whose expenses exceeded the stop-loss amount would be less price-sensitive. The patent system assigns exclusive marketing rights to the makers of most new drugs for some period after their introduction. Drugs with patent protection must compete with other products offering similar therapeutic effects. But manufacturers of particular drugs that primarily benefit the elderly would have greater flexibility in pricing their products under a Medicare drug benefit with stop-loss protection than they have now. Such a pricing effect is likely to be greater for plans that have more generous catastrophic coverage or lower cost-sharing requirements.

A Medicare prescription drug proposal that led to higher drug prices could impose additional costs on other federal programs that purchase drugs (including Medicaid, the Department of Veterans Affairs, and the Department of Defense). Higher drug prices could also increase the costs of private health insurance, leading to higher premiums. In that case, CBO would estimate somewhat lower federal revenues from income and payroll taxes as a larger portion of employee compensation was paid through nontaxed health benefits rather than through taxable wages.

The Effectiveness of PBMs

As noted earlier, the President proposes to administer the prescription drug benefit through private-sector pharmacy benefit management companies, which private health plans use to negotiate price discounts and control utilization. A single PBM, selected through competitive bidding, would administer the benefit in each region. CBO's cost estimate assumes that those PBMs would reduce costs by about 12.5 percent from the level that an uninsured retail purchaser would pay—smaller savings than PBMs now generate for large, tightly managed health plans. The savings are net of the administrative costs incurred by a PBM in processing prescription claims.

PBMs save money for private-sector health plans in four main ways. First, they negotiate discounts with pharmacies that agree to participate in their networks. Second, they obtain rebates from manufacturers of brand-name drugs in exchange for preferred status on the health plan's formulary. Third, PBMs use mail-order pharmacies, which are often better able than retail pharmacies to save money. Mail-order pharmacies are likely to have lower average operating costs, and they may be more likely to substitute generic or other lower-cost drugs for the ones prescribed. Finally, PBMs establish differential copayment requirements that encourage beneficiaries to select lower-priced options such as generic, preferred formulary, or mail-order drugs. Some PBMs also use management techniques such as on-line utilization review and prior approval to evaluate care and encourage the most cost-effective treatment practices. A PBM can generally negotiate larger rebates if it can

shift more prescription purchases from one product to a competing product in the same therapeutic class.

The President's proposal would constrain the ability of PBMs to use their cost-saving techniques. For example, the proposal calls for dispensing fees to be high enough to ensure broad participation by retail pharmacies. That requirement could limit the discounts that PBMs could negotiate from pharmacies.

Other provisions could hamper the PBMs' ability to negotiate rebates from drug manufacturers. The proposal specifies that beneficiaries would be guaranteed access to off-formulary drugs when medically necessary and coinsurance requirements could not exceed 50 percent. Some private drug plans require enrollees to pay the full difference between the cost of a brand-name drug and its generic equivalent (if one exists) unless the prescribing physician specifically states that the brand-name drug is medically necessary. Such an approach would apparently not be permitted in the Part D program proposed by the Administration.

The President's proposal envisions competitive bidding to select the PBM for each geographic area, but it is unclear what financial risks, if any, the winning PBM would bear. In the absence of financial risk, PBMs might not have a strong incentive to generate savings under the program. Yet, if they were placed at financial risk, PBMs would have to charge higher premiums.

Another issue that needs clarification is how savings would be measured under a Medicare drug benefit. Actual savings could disappear, even though nominal discount and rebate rates were unchanged, if the prices from which discounts and rebates were calculated rose as a result of the new benefit.

Under the President's proposal, a single PBM would administer the benefit in an area. As an alternative, multiple PBMs in the same area could compete for shares of the Medicare market. Such competition might lead to more aggressive cost management, but that outcome is by no means certain. One potential drawback to a multiple-PBM system is that PBMs might keep their prices low by seeking out healthier enrollees with lower drug costs instead of focusing on cost management. In that case, the possible savings to the federal government would be dissipated.

Program Participation

If a Medicare drug benefit was enacted, private insurers would alter the type of drug coverage they offered. CBO's estimate assumes that most people who participate in Part B of Medicare would also participate in Part D. Thus, employer-sponsored plans and medigap insurance would generally offer their enrollees new options for supplemental coverage. Moreover, with a fee-for-service drug benefit in place, managed care plans in the Medicare+Choice program could become less attractive to beneficiaries.

Employers would probably face lower costs for their retiree coverage under the President's proposal. Firms that offered prescription drug coverage with benefits comparable to those under the Part D program would be eligible to receive federal payments equal to 67 percent of the Part D premium subsidy for eligible retirees. That subsidy payment—together with the tax exclusion of their health plan costs—would induce some employers to keep full drug coverage in their retiree health plans rather than eliminating it or wrapping their plans' benefits around the new Part D package. (Under a wraparound plan, Medicare would be the primary payer for prescription drugs; the employer's plan would serve as a supplement.) Few employers would be likely to maintain full drug coverage, however. CBO assumes that about three-quarters of Medicare enrollees who now have drug coverage through a retiree health plan would enroll in Part D.

Part D would offer a more generous drug benefit than standard medigap plans do, and at a lower premium. As a result, the three medigap plans that now offer drug coverage would no longer be competitive. For its estimate, CBO assumed that those plans would be replaced by one that supplemented the coverage offered under Part D by filling in the 50 percent coinsurance "gap."

Another possible effect of a Medicare prescription drug benefit is to reduce the attractiveness of managed care plans, which typically offer prescription drug coverage to their enrollees. That benefit is often cited as an important factor in beneficiaries' choosing managed care over traditional fee-for-service Medicare. Although managed care plans might become somewhat less competitive with enactment of a Medicare drug benefit, the President has proposed other policies that would create new incentives to compete on the basis of price as well as quality through a competitive defined benefit program. However, CBO assumes that offering a drug benefit in the fee-for-service sector would dramatically slow the growth of enrollment in Medicare+Choice. In 2010, for example, CBO projects that enrollment in Medicare+Choice plans would reach 14.1 million under current law but only 11.6 million under the President's proposal.

Effects on Medicaid Costs

The President's proposal would increase Medicaid's costs for drugs and other benefits—substantially in the case of federal costs and less sharply in the case of state costs. Although Medicaid would no longer have to pay all drug costs for Medicare beneficiaries who now receive full Medicaid benefits, those savings would be more than offset by additional Medicaid spending on behalf of other Medicare beneficiaries.

Part D would pay for a portion of the drug costs that Medicaid now pays for Medicare enrollees who are fully eligible for both programs. That expansion of Medicare's role would lower both federal and state Medicaid costs by shifting them to Medicare. But the savings would be partly offset by the Part D premiums that Medicaid would have to pay for those dual-eligibles.

Certain low-income Medicare beneficiaries who are not eligible for full Medicaid benefits would also become eligible for assistance to pay for their Part D premiums and cost sharing. To receive that assistance, however, eligible Medicare beneficiaries would have to enroll at a state welfare office, and not all of them would choose to do so.

The President's proposal would increase Medicaid spending for services not related to the new drug benefit. The availability of a free drug benefit, made possible by enrollment in Medicaid, would attract more Medicare beneficiaries into the Medicaid program. In turn, that increased enrollment would boost spending for other benefits that Medicaid pays for as well as the prescription drug benefit.

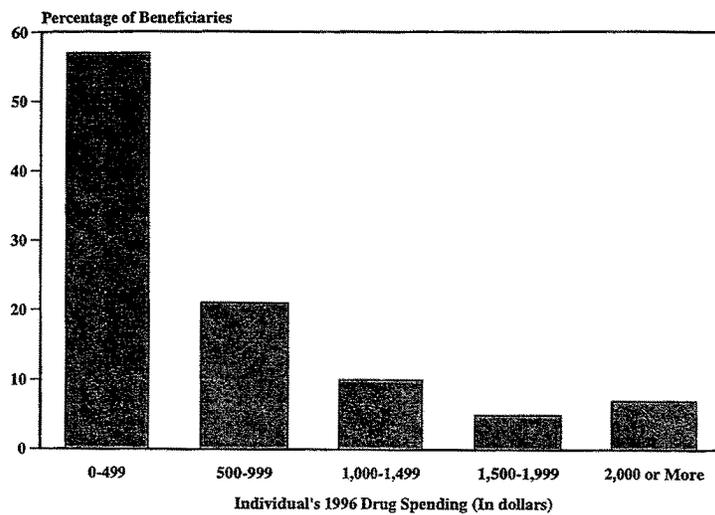
CONCLUSION

The President's prescription drug proposal has both pluses and minuses that must be weighed in assessing its effects. The proposed coverage would provide some assistance to most Medicare enrollees. Because the benefit is capped, however, the proposal would offer little financial protection to beneficiaries with a high level of drug spending. In 2003, for example, about a third of enrollees in the new Part D drug benefit would spend more than the benefit cap for prescription drugs. And the cost of the proposal would be significant. Spending on prescription drugs is the fastest-growing component of health care costs. Even with a capped benefit, the proposal would increase federal outlays substantially.

The specific details of a prescription drug proposal greatly affect the program's costs and value to beneficiaries. The level of coinsurance, the existence of a benefit maximum versus a stop-loss provision, the split in financing between beneficiary premiums and taxpayer subsidies, and the nature and degree of subsidies for low-income beneficiaries and employers all drive the value of the benefit and its costs. The role of the PBMs is equally critical. In attempting to create a competitive environment, the President's drug proposal establishes geographically exclusive PBMs but limits the scope of their activities. As a result, their effectiveness in managing costs is uncertain.

Developing a prescription drug benefit in the Medicare program raises numerous difficult issues. Since the inception of Medicare in 1965, the cost of prescription drugs and their clinical importance have grown dramatically. As drugs became a critical component of modern health care, more than two out of every three Medicare beneficiaries turned to some form of supplemental coverage for their drug expenses. Those arrangements have led to very large variations across beneficiaries in the comprehensiveness, cost, and financing of their prescription drug spending. That variety complicates the task of rationalizing prescription drug coverage and makes developing such a benefit for Medicare a complex policy challenge.

FIGURE 1. DISTRIBUTION OF TOTAL SPENDING FOR PRESCRIPTION DRUGS
BY MEDICARE BENEFICIARIES, CALENDAR YEAR 1996



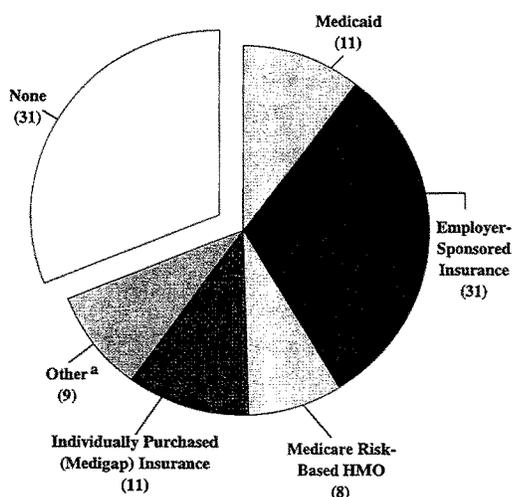
SOURCE: Congressional Budget Office using unpublished data from the Health Care Financing Administration's Medicare Current Beneficiary Survey Cost and Use File, 1996.

Table 1.—Growth of Drug Spending and Medicare Benefits Per Beneficiary, Calendar Years 1995–1996

	Average Spending per Beneficiary (Dollars)		Percentage Change from 1995 to 1996
	1995	1996	
Drug Spending	600	673	12.2
Medicare Benefits	4,953	5,312	7.2
Memorandum:			
Gross Domestic Product per Capita	28,130	29,430	4.6

Source: Congressional Budget Office based on the Health Care Financing Administration's unpublished tabulations of the Medicare Current Beneficiary Survey Cost and Use File, 1995 and 1996.

FIGURE 2. SOURCES OF PRESCRIPTION DRUG COVERAGE FOR MEDICARE BENEFICIARIES (In percent)



SOURCE: Congressional Budget Office based on John A. Poisal and George S. Chulis, "Medicare Beneficiaries and Drug Coverage," *Health Affairs*, vol. 19, no. 2 (March/April 2000), p. 251.

a. Includes Medicare beneficiaries who switched their source of coverage during the year; those eligible for benefits through other public programs such as Department of Veterans Affairs, Department of Defense, or state pharmaceutical assistance for low-income elderly people; and those enrolled in non-risk-based health maintenance organizations (HMOs).

Table 2.—Medicare Beneficiaries, by Type of Supplemental Insurance and Drug-Coverage Status, Calendar Year 1996

Type of Supplemental Insurance	Number of Beneficiaries (Millions)	Number of Beneficiaries with Drug Coverage (Millions)	Percentage of Beneficiaries with Drug Coverage
Medicare Risk-Based HMO	3.2	3.1	95
Medicaid ^a	4.4	3.9	89
Employer-Sponsored Coverage ^b	12.9	11.4	89
Individually Purchased Coverage Only	9.8	3.9	40
All Other Supplemental Coverage ^c	0.7	0.6	81
No Supplemental Coverage	2.9	0	0
Switched Coverage During the Year ^d	3.3	2.7	83
All Medicare Beneficiaries	37.2	25.6	69

Source: Congressional Budget Office based on John A. Poisal and George S. Chulis, "Medicare Beneficiaries and Drug Coverage," *Health Affairs*, vol. 19, no. 2 (March/April 2000), p. 251.

Note: HMO = health maintenance organization.

^a Includes Medicare beneficiaries receiving full Medicaid benefits as well as qualified Medicare beneficiaries and specified low-income Medicare beneficiaries.

^b Includes Medicare beneficiaries with both employer-sponsored and individually purchased supplemental insurance.

^c Includes other public programs such as Department of Veterans Affairs, Department of Defense, and state pharmaceutical assistance programs for low-income elderly people, as well as non-risk-based HMOs (cost and health care prepayment plans).

^d Includes Medicare beneficiaries who did not spend 100 percent of their Medicare-eligible months in one insurance category.

Table 3.—CBO'S Estimate of the Cost of the President's Proposal for a Prescription Drug Benefit in Medicare

(By fiscal year, in billions of dollars)

	2003	2004	2005	2006	2007	2008	2009	2010	Total 2003– 2010
Medicare Spending ^a	15	21	26	30	35	38	44	48	257
Part D premium receipts	-8	-11	-13	-15	-17	-19	-22	-24	-129
Subsidy to health plans for retirees	*	1	1	1	1	1	1	1	6
Medicaid Spending	1	2	3	3	4	4	4	5	26
Net Effect on Federal Spending	8	13	17	19	22	24	27	30	160
Memorandum:									
Monthly Part D Premium (Dollars)	24.00	24.80	32.10	33.30	39.90	41.50	47.90	50.70	n.a.

Source: Congressional Budget Office.

Notes: Numbers may not add up exactly to totals because of rounding.

* = less than \$0.5 billion; n.a. = not applicable.

^a Includes administrative costs of \$0.4 billion in 2002.

Chairman THOMAS. I thank both of you.

One of the concerns that I have that we need to get a handle on, if we are going to have an honest and open bipartisan discussion of where we need to go, is some data that I assume to be fairly reliable comparing—again, not trying to argue that one group is under-utilizing health care services or the other group is over-utilizing health care services, but I found it rather interesting, in examining those individuals who did not have medigap, beneficiaries who had an employer's program wrap-around, and those who bought medigap, that there was a clear consumption difference in a hierarchical order of those three categories, and that if someone who doesn't have the augment insurance with the first dollar being required to buy down the deductibles and the copays, it would be obvious that you would get a greater consumption of goods and services if you had an ability to buy down the cost of making those goods and services available.

So maybe the employer's position would be a middle ground, and if that is the case then it might be that below that it would be somewhat under-utilization and above that it might be over-utilization.

My concern is that if we are not moving into a prescription drug program, hopefully having learned from the past, that one of the clear phenomenons will be an increase in utilization of prescription drugs, which I guess is a positive. But what can we do to make sure that that increased utilization is based upon need and not a structural defect that produces, in essence, an over-utilization because we have built in stimuli for over-utilization by virtue of the program that we have put in place?

For example, in the private sector, PBMs have a lot of flexibility to control price—volume sales, formularies, tiered pricing. Is it normal in the private sector for PBMs to share in those savings, or is it built into the managerial structure of the PBMs? My understanding is, according to the administrator, the administration's

PBMs will not be at risk. Is it normal for PBMs in the private sector to share some of the risk, which would encourage them to keep costs down because it would otherwise be out of pocket, or is the President's proposal, which involves PBMs with no risk at all, because my understanding is they get their revenue from the transactions. If there is no risk, more transactions, the more money they get, which I think would be a clear indicator that it might move toward over-utilization.

Mr. SCANLON. Mr. Chairman, In the private sector PBMs do not commonly accept risk for the cost of the drugs. However, their contracts with different third-party payers contain provisions that provide incentives for performance—performance either in terms of obtaining a price discount or performance in terms of controlling utilization.

Those are the devices by which the incentives are there to try and control utilization and offset what might be the reward for the per-payment or the per-prescription kind of payment within the system.

I also would comment on the data that you talked about initially in terms of the relative expenditures of different parties.

In part, I think it also reflects the real concern we should have about the issue of adverse selection—that people who, in the current market, end up with insurance sometimes will be people that know they are going to be needing some sort of coverage, and that in proposals to consider a Medicare benefit we need to think very much about how we can control adverse selection.

In the President's plan, there is a provision that you have a one-time option to enroll, and I think that is important for any plan to consider, because we do not want to create a situation where we have favorable selection.

Chairman THOMAS. And you would agree that the easiest way to deal with that is to make it mandatory?

Mr. SCANLON. Or to subsidize it so it is attractive. part B is not—

Chairman THOMAS. Or make it so attractive that no one would turn it down, like part B at 97 percent voluntary program.

Mr. SCANLON. Right.

Chairman THOMAS. That was supposed to be a 50/50 funded program. It is now a 25/75. So if we would simply give it to them, I guess you could make it voluntary, and if you give it to them it is the same as mandatory.

The point I wanted to make was that there are alternatives dealing with adverse risk selection, but I think, since all the plans are voluntary, those have been dismissed, so we have to pay even more attention to the internal structure of the plan.

Mr. CRIPPEN. Frankly, Mr. Chairman, what I know about the President's bill on this issue I learned from Mr. Scanlon. Clearly, the current structure of PBMs is not one that, in general, requires them to assume financial risk. A couple of companies are now positioning themselves perhaps to be able to do that within the next few months, but there are none at the moment.

Chairman THOMAS. Finally—and I know the President's plan only came out yesterday, but would there be significant cost differences if the catastrophic proposal—which I guess the administration has not completely addressed yet but indicated they had an

interest in working on—of a \$3,000 level, depending upon how you pay for that, either sharing it with the beneficiaries, which would increase the cost to the beneficiaries, or assuming it on government, is that a relatively low level to kick in full-blown protection of dollar amount? And do you have any back-of-the-envelope estimate of what might happen to the cost of the program if you went to the President's current legislatively defined program of a shared cost up to 2,000 and what I would think would be a relatively narrow window of \$1,000 of out-of-pocket, until you have finally wound up with a 100 percent protection of any and all costs above that, which, according to current data I think is about 65 percent of the cost of seniors' drugs today? Any numbers at all, or any inkling or feeling as to what might happen?

I think you would be comfortable with saying it will cost more. I am looking for a little more precision than that.

Mr. CRIPPEN. I think there are too many moving parts at this point. One issue, of course, is what you include in the \$3,000. Do you count all expenses or just out-of-pocket expenses that are not covered by a third party? What you include makes a lot of difference to when the government's coverage would kick in. More important, does the proposal include premium contributions for the benefit? If so, what is the percentage split between Medicare and the beneficiaries? And are the copays covered?

The President's proposal for catastrophic coverage would probably be quite expensive, but that is just looking at data on current drug spending by the elderly. It would be very easy to construct a benefit with a \$3,000 stop-loss amount that could literally double the cost of the underlying program. The details are critical, but just on its face, the benefit would be quite expensive.

Chairman THOMAS. So, in other words, once we have priced the President's program, we have a comfort level—again, because it is not an insurance program, it is a pre-paid benefit program, and you control all of the points, you can control the cost. It probably then would require not a grain of salt but a block of salt to accept any numbers that are currently discussed about a program which takes the President's and adds on to that catastrophic.

I think it is critically important that you people try to get us a number. I know it depends upon all of the points that you indicated, but you are going to have to give us some kind of a range, because I don't think we can move forward in any real fashion if, in fact, your ruminations prove anywhere near close, and that is that this new proposal doubles the cost, which means, instead of roughly \$40 billion over 5 years it is now \$80 billion over five, especially if it has built into it structures that might, in fact, promote utilization beyond the normal utilization increase that would occur, because, from what I have seen of data, the increase of cost of drugs, yes, are tied in part to the increased cost of the drugs, themselves, but the overall cost is the utilization involved and more and more people using the slightly higher-cost drugs.

That can create a snowball effect in which, over a 5-year period, given the incremental cost, could mean also your doubling could be off by 50 percent, and that is what begins to get frightening as we go forward in talking about working out a plan.

The information you provide us will be absolutely critical.

Mr. CRIPPEN. Mr. Chairman, if I might just add to what you have said, the price effect for a catastrophic benefit could be even greater than what has been mentioned here because of what happens once you cross the threshold level. Say you are dealing with a regimen of drugs to treat a chronic illness. If the beneficiary's costs for the drugs are above the catastrophic threshold, the beneficiary has no incentive to change unless there is a big copayment and the drug company has no incentive to keep the cost of the drugs down, particularly if they are drugs whose use is unique to the elderly. So there may be an even stronger price effect with a catastrophic benefit.

Mr. SCANLON. And you set up a structure in which government holds the bag not only on a 50/50 deal through the process, with no one else concerned about keeping costs down, and then a structure which conceivably could be the government holding 100 percent of the bag on the catastrophic. At some point, those bags get pretty heavy.

The gentleman from California?

Mr. STARK. Thank you.

Dr. Scanlon, you point out a lot of the difficulties in implementing or controlling costs. Let me ask you this: We have got, my guess is, 200 million people in America using these pharmaceutical benefit managers, PBMs. Do you think that we should use them if we have a prescription drug benefit in Medicare? And, if we do use them, should we be writing the rules, these lists of items of how they should bid, or should we leave that to the administration?

While they may create some problems, it seems to me that we, those of us who have a Federal benefit—most of us would have some kind of prescription drug benefit manager. I don't know quite how it works. I know I get a copay, and I don't know how the hell they figure it out, but I know we are using PBMs and General Motors uses them.

So would you advise us to use a prescription drug benefit manager? And how much detail would you say we should prescribe in legislation?

Can you get a handle on that?

Mr. SCANLON. Mr. Stark, I think that, in terms of laying out the cautions in our testimony, they are cautions to not have unrealistic expectations about what PBMs can accomplish in terms of administering a Medicare drug benefit. They principally focus on this issue of control of cost. I think that, given I have seen Dr. Crippen's testimony today, there is agreement between the two of us, in terms of this necessary caution regarding what PBMs can accomplish from a cost perspective. That caution is already built into the numbers that CBO is providing you.

The second part of our testimony deals with the fact that PBMs would provide a valuable service in terms of administering a Medicare drug benefit. It is very important to be able to pay claims on a much more realtime basis than we currently do in Medicare, particularly if we are going to have a structure in which an individual's cost-sharing obligation is going to shift, depending upon the amount of drugs that they have used during the course of the year.

The other thing, from the quality perspective, is the role that PBMs potentially play in detecting interactions, which today are a

serious problem for elderly individuals. PBMs can potentially point out other medical factors that should be taken into account, through the type of technology and networks that they have.

Now, the issue, in terms of how prescriptive you are to the Secretary, in terms of a PBM contract, that is one area which is laid out now in very general terms. I am not sure that we could help, in terms of being much more specific. But, during the course of this debate some more specifics may come out. It would be useful to instruct the Secretary along those lines.

At the same time, it is also probably important for you to have expectations that the Secretary is going to have to iterate to the best solution here—that, in terms of trying to negotiate with PBMs, nobody has gone out to the PBMs, themselves, and said, “Are you willing to play in this game and under what terms?”

I think, once this process starts, we may find that the Secretary will come back to you and say, “We need to modify something,” and I think you should feel open to that in the sense that we don’t have experience here so it is hard to lay out the path from the outset.

Mr. STARK. OK. Let me try two things on both of you. These are perceptions that I have, and I wonder how you both would react.

Dan, you brought up the question of Medigap perhaps fostering over-utilization. At least Kaiser in California has done some studies, and I think others have, and I don’t have a congenital objection to copays, but they found that a minimum, almost de minimis amount, like \$5, was enough to deter over-utilization without keeping people from actually getting needed care, so that you didn’t have to get up to 10 percent, just a couple of bucks to make people stop and think.

I wonder if both of you have either a perception that that is a correct understanding of what we could do, in which case it wouldn’t trouble me to use that.

And then my second perception is that—and this is pretty loose, but that the catastrophic benefit would only cover, if we talk about 3,000 out of pocket—that is assuming a 50 percent copay. We are talking about 6,000 in total purchase—that would only clock in for about 2 percent of the beneficiaries.

Now, at that rate, my understanding is we would perhaps be talking about \$5 billion a year, or, in round figures \$25 billion over five.

Now, there have been a variety of numbers suggested, and I am just picking the 3,000—with a 50 percent copay—because it is a perception that I have that that might put us in the ball park of about \$5 billion a year.

Is that close enough for government work, or am I way off?

Mr. CRIPPEN. Yes and no. Or, no and yes.

I think we can be a little more precise here. The information I brought with me has a break at \$5,000 and at \$10,000 but not at \$6,000.

Mr. STARK. OK.

Mr. CRIPPEN. Under a catastrophic Medicare benefit in 2000, beneficiaries who spent more than \$5,000 annually on prescription drugs would spend, on average, \$7,800; beneficiaries with drug spending over \$10,000 annually would average \$14,000. So I would suggest the answer is closer to \$10 than \$5 billion.

Mr. STARK. OK.

Mr. MCCRERY. Will the gentleman yield a minute?

Mr. STARK. Yes. What about the idea that that would affect about 2 percent of the beneficiaries? There's a very flat curve until you get out in the 90th percentiles, and then it jumps way up above \$1,000 or so.

Mr. CRIPPEN. That is probably pretty close.

Mr. STARK. Big percentage of the cost, but a very small—

Mr. CRIPPEN. Is it 40 percent of \$60 billion?

Mr. STARK. Really catastrophic.

Mr. CRIPPEN. Okay. Let's return to the percentage of people covered.

Mr. STARK. Yes.

Mr. CRIPPEN. Among Medicare beneficiaries, 5.3 percent spend more than \$5,000 annually on prescription drugs; 0.9 percent spend more than \$10,000. You said 2 percent spend more than \$6,000; that is clearly in the ballpark.

Mr. STARK. But they probably use up a big chunk of the total cost of the drugs purchased. OK.

Mr. CRIPPEN. My colleague, Steve Lieberman, points out that the number I gave you is probably a little bit low on the amount of total spending. It looks more like \$12 billion to \$15 billion.

Chairman THOMAS. Will the gentleman yield?

Mr. STARK. Sure.

Chairman THOMAS. On his explanation of the catastrophic, which is the first details I have heard, the plan that you outline then is that you take the President's program, which would be a 50 percent match, to produce \$2,000 50/50 coverage, thousand each. Let's leave the premium aside for now. But then at \$2,000 the President's program stops. He proposes in 2006 some catastrophic that would kick in with no details.

Are you indicating that the democrats' plan that they outlined yesterday would then have a catastrophic that would begin picking up once again a 50/50 payment at the 3,000 to get—

Mr. STARK. My understanding, Mr. Chairman—and I will have my staff pull on my coattails here if I am off—is, regardless of what the copay and the—I think the cost sharing is 50/50, and I don't know where that caps out, but the idea was that, after a beneficiary had spent \$3,000 out of pocket, whether that was copay or full pay, that we would pick up from there on all expenses.

Now, I assume that if there was a 50 percent copay up to \$3,000 or \$6,000 in drugs, that is how it would—in other words, if it were a continuous benefit and in the first \$6,000 of purchases you paid 50 percent, you would be 3,000 out of pocket. You can say it one way or the other. And then over that the government would pick up all the balance.

Now, it could be that if you are talking a max of 2,000 in the primary benefit, then there is a chunk of money where the beneficiary would be paying the full price of the drugs without any copay, but, in any event, the numbers that I have heard bandied about would be about 3,000 out-of-pocket, I believe, the copay thing aside, and then we pick up the balance.

It depends on how you estimate the underlying—

Chairman THOMAS. Yes. That is significantly different than has been reported, and I can understand that the reporters would not be able to get that accurate, given the information they had, because I thought we had just invented a new category of catastrophic in which the beneficiary pays 50 percent of the catastrophic cost—

Mr. STARK. No. I didn't mean to imply that.

Chairman THOMAS.—which is not—yes, which is a new and novel idea.

Mr. MCCRERY. If I might jump in?

Chairman THOMAS. Yes.

Mr. STARK. Thank you both.

Mr. MCCRERY. Mr. Stark, if I might jump in, if, in fact, your basic benefit stops at \$2,000, as proposed by the President, then, as I figure it, your catastrophic plan would kick in after \$5,000 of total spending on drugs. Would that be right?

Mr. STARK. Excuse me—first of all, let me just back up a minute, if the gentleman would yield.

Mr. MCCRERY. Sure.

Mr. STARK. We are proposing that it would be 50 percent equal to \$2,000 the first 2 years, then it would go to 3,000, then 4,000, and then 5,000.

Chairman THOMAS. Those are out-of-pocket expenses?

Mr. STARK. No. Those are 50 percent of annual limits. So at the max we would be paying 50 percent of \$5,000, which is \$2,500. Then, in effect, the beneficiary would have to pay the next \$500, or 100 percent of the prescription, and after that the \$3,000 catastrophic would clock in.

Now, you could drop it to \$2,500 to make it seamless, but the cost goes up. You could move that catastrophic up to 4,000—and all I have ever tried to do is keep it easy to explain, both to my colleagues and to my constituents—and make it as seamless as possible.

I am on a bill that says you have got to pay that first couple of hundred out of pocket. We are going to end up, if there is a benefit, trying to make the most convenient benefit out of the dollars we have to spend, and so I think I have explained to you as accurately as I know what the benefit is.

Basically, it pretty much is a 50 percent copay, and then, after you run a couple or three thousand bucks out of pocket, it pays 100 percent.

Mr. MCCRERY. OK. I appreciate the gentleman going to that length to explain. I know you don't have your proposal in concrete, as we don't, and so I appreciate the gentleman letting us know that it is probably not the design of the plan. It is probably not as the press advertised it to be in the initial coverage of the announcement by the democrats that you would have a catastrophic benefit kicking in at \$3,000 of total drug expenditures. That is—

Mr. STARK. No. It does.

Mr. MCCRERY. No.

Mr. STARK. Yes.

Mr. MCCRERY. It is \$3,000 out of pocket.

Mr. STARK. OK. Out of pocket, \$3,000—

Mr. MCCRERY. Which would be about \$5,000—

Mr. STARK. Yes.

Mr. MCCRERY.—of drug expenditures before the catastrophic plan would kick in, and that is a big difference.

Mr. STARK. That is always the way I have explained it.

Mr. MCCRERY. OK. And I appreciate very much the gentleman explaining that.

Chairman THOMAS. And the Chair is also pleased, because, given the new math approach, I am quite sure that the proposal that we have been working on and the proposal that you just announced, if you would use the traditional insurance language of how you begin to pay for and the catastrophic plan kicks in, we are amazingly closer than I thought we were.

Mr. STARK. Mr. Chairman, I will accept no math that I cannot do with my shoes and socks on, so it has to be simple.

Chairman THOMAS. I would say that one of the simpler ways to communicate with others is to use the math that everybody else uses, whether you have your shoes on or not. Once we work that out, I think it is amazing because my assumption is that Dr. Crippen's estimate of doubling the cost was based upon the catastrophic that went into effect at 3,000. Is that correct? So you were somewhat confused.

Let the record show he was nodding his head in a vertical fashion.

Mr. STARK. Yes.

Chairman THOMAS. That was our assumption because that is what everybody told us, so actually that is a positive, and I appreciate that.

Does the gentleman from Louisiana wish to inquire?

Mr. MCCRERY. Thank you, Mr. Chairman.

I will ask this of either of you or both of you, and either can answer.

Both of you have talked about the use of pharmacy benefit managers, PBMs. As we have talked about here today, I think all of us anticipate some usage somehow of these private sector entities to help us with our plans.

In either your written testimony or your explanations orally here today, you have talked about a single PBM administering a Medicare drug benefit would likely be subject to the same level of scrutiny as a government entity, and that such scrutiny may compromise the flexibility that PBMs typically have used in the private sector to generate savings.

Could you elaborate on some of these constraints that could be anticipated and how those would diminish savings that are normally enjoyed by private sector PBMs?

Mr. SCANLON. I think it largely goes to the issue of transparency and the market size or the market leverage that a PBM, either a national one—I wouldn't necessarily envision on the national basis the single PBM, but I would envision that there would be very detailed specification of what the benefit was going to be by the Secretary. That would effectively preclude negotiation on the part of private entities that were going to be contracting or severely limit sort of the negotiation that private entities are going to engage in that had the actual job of administering the plan.

But even if we went down to geographic areas and you consider that all elderly individuals who are the major consumers of drugs are now being bargained for by a single entity, that is incredible power with respect to the pharmacies, it is incredible power with respect to the manufacturers.

Our sense is that the political process, in part, would say this has to be an open negotiation, to a degree, and we need to know what's going on, because anybody that is left out, any pharmacy or any drug that is left out is going to be severely affected.

That, I think, is not going to be conducive to negotiating the same level of discounts that PBMs have been able to do when they do it, in a sense, on a proprietary basis behind closed doors.

Mr. MCCREERY. So if we went from the use of a single PBM to allowing multiple PBMs to compete, would that solve some of those problems?

Mr. SCANLON. I think it solves or ameliorates some of those problems and introduces new ones, because, I think, as you introduce multiple PBMs in a single area, just as we have the model for having multiple Medicare+Choice plans in an area, we need to start to worry about the information that is provided beneficiaries so that they know what they are choosing when they choose a particular PBM. We also need to be concerned about whether or not a PBM has structured a benefit or structured its policies so that it attracts a more favorable group of beneficiaries in terms of better health status.

We need to think about whether and how we would have to risk adjust the payments to PBMs if we have multiple PBMs in an area.

So it is an issue, in terms of both options, that we have challenges that we need to think about how we are going to overcome.

Mr. MCCREERY. And I agree, but if we go with a single PBM it seems to me that the challenges are more clear-cut and that we are less able to overcome those challenges than we are with a multiple PBM arrangement.

One example, in the private sector, in current practice, PBMs negotiate lower prices from pharmaceutical manufacturers by giving preference for a particular drug in a particular therapeutic class on what is called a "formulary." That means that one drug in that therapeutic class would be favored, would be covered, and a competing drug would not be covered, or the formulary drug would be a lower price to the consumer than a non-formulary drug.

But the President's plan, for example, explicitly prohibits formularies. That is an example, I think, of how you talked about, if you have only a single PBM, it would be easier for the government to impose restrictions on it, making it more like a government entity, really, than a private sector entity.

And if you, in fact, prohibit formularies, for example, and you require a 50 percent flat copay, how would pharmaceutical benefit managers negotiate lower prices from pharmaceutical manufacturers?

Mr. SCANLON. Mr. McCrery, I don't think the President's plan precludes a formulary. The President's plan requires that every medically necessary drug be covered. But it also has an option for the entities that are administering the benefit in a particular area

to propose a cost sharing mechanism other than the 50/50 cost sharing mechanism, as long as it is budget neutral.

So one could think of the cost-sharing mechanism somewhat akin to the tiered copayments that we are seeing in the private sector today, where a certain group of drugs have a lower cost sharing for beneficiaries associated with them and other drugs are going to have a higher cost sharing associated with them, and generics and ones that are on the formulary would be the ones that would have the lower copays.

Mr. MCCRERY. OK. So the President's plan then could accommodate some different treatment for different drugs, as long as it was a budget-neutral arrangement?

Mr. SCANLON. Yes, it could.

Mr. MCCRERY. That is interesting. But, even if that were the case, though, if you only had one PBM, it would seem to me to be a less-effective tool than if you had multiple PBMs competing with different drug manufacturers.

Mr. SCANLON. Well, I think if the PBM was unrestrained it actually would have a lot of leverage, in terms of negotiating prices.

Mr. MCCRERY. Sure.

Mr. SCANLON. But I don't think we would allow—

Mr. MCCRERY. That is the very reason we would have to impose restrictions.

Mr. SCANLON. Right. One of the concerns about the size of the Medicare Program is how it can potentially disrupt the market.

Mr. MCCRERY. Right.

Mr. SCANLON. Therefore, you wisely have, on many occasions, put limits on in terms of how Medicare is going to behave in the market.

Mr. MCCRERY. Right. OK.

Mr. STARK. Would the gentleman yield at that point?

Mr. MCCRERY. Sure.

Mr. STARK. This question of the number of PBMs, how many did you envision?

Mr. MCCRERY. More than one.

Mr. STARK. Well, here's an issue that came up—and more than one doesn't trouble me—but if we have 10 million people eligible for this benefit—is that ball park? Dan's nodding his head.

Mr. CRIPPEN. That is the number who are currently uninsured.

Mr. STARK. Yes. And we would pick up more. But if we had 50, you would cut the bargaining power, because, Kaiser, alone, has almost six million people it could bid for.

Would the gentleman feel comfortable that, while we want more than one PBM, we ought to not have so many as to dilute their bargaining power?

Mr. MCCRERY. I think that would—I think the market would take care of that, but I understand the gentleman's point.

Mr. STARK. Yes. You have got to give them enough business—

Mr. MCCRERY. Sure.

Mr. STARK.—to have the bargaining power.

Mr. MCCRERY. Yes.

Chairman THOMAS. And, just coincidentally, I am going to yield to the gentlewoman from Florida. I assume she was aware of the President's program in which, in essence, in a budget-neutral way,

certain diseases would be privileged over others based upon a formulary that was required to be budget neutral, but in which certain drugs could be purchased at a relatively cheaper price than other drugs.

Is that a correct assessment of what you said about the mechanism—

Mr. SCANLON. Well, I—

Chairman THOMAS.—for formularies under the President's plan?

Mr. SCANLON. That would be an issue that would have to be addressed by the Secretary in terms of accepting a formulary proposal. If a formulary were not to include drugs from every therapeutic class, then in the private sector today most third party payers and most employers would reject it. So the issue would be, would the Secretary also reject a formulary that didn't have a drug in every therapeutic class.

Chairman THOMAS. You could have a drug in every therapeutic group, but you said that the President's plan would allow an adjustment in a budget neutral way of buying down the cost of particular drugs within that structure.

Mr. SCANLON. But I don't think it would—

Chairman THOMAS. Which means, based on the particular drugs that are cheaper, particular diseases would be privileged over others on the cost of the drugs to treat them.

Mr. SCANLON. It would be a question of whether there were drugs within the therapeutic class that were only for certain diseases and others for other diseases, because I think that you could structure it in a way that no disease was favored, but there would be an effort to try to steer drug utilization to favored drugs.

Chairman THOMAS. I think what it fundamentally does is underscore the fact that there is no single best path; that there are a number of choices that are going to have to be made where there are virtually tradeoffs on every option. Unfortunately, that is too much like the real world, and we are going to have to engage in that as we make decisions.

You might get a bargaining price between PBMs in a negotiated way, and you also could get a bargain price in a negotiated way with a single PBM, except the role of the government would be a bit more significant in that latter, or the President's proposal, which means that the ability to influence through the governmental structure might be greater in the latter structure rather than the former.

People who were able to get that manipulation would see it as a positive. Those who didn't would see it as a negative.

The gentlewoman from Florida?

Mrs. THURMAN. Dr. Crippen, in all of this let me ask you a question, then. Which would you score as getting the most savings? Multiple? One?

Mr. CRIPPEN. It depends on the restrictions that go with them, as my colleague, Mr. Scanlon, said in his testimony. You can think of PBMs as a surrogate for competition and what that can do. Currently, PBMs perform two of three potential roles. One is price discounting. On the one hand, if there are restrictions on their purchasing power or what they have to bid on, for example, their ability to achieve price discounts may be limited. On the other hand,

PBMs might be able to achieve large discounts because of the number of people who would participate in a Medicare drug program. So it is not clear what the PBMs overall effect on price discounting would be.

The PBMs' second role involves utilization. PBMs do not control utilization, but they do monitor it. They will encourage you to use generic instead of name brand drugs, for example, but they will also monitor the drugs you take to prevent harmful drug interactions.

A third potential role that PBMs do not often play but that may have the best chance of providing both savings and, more important, better outcomes for patients case or disease management. That would be most effective in cases in which we know that a certain protocol works best for a specific disease. Generally, drug protocols for people with chronic diseases have high total costs, or they can have, and those costs will probably increase as more new drugs enter the market. So the potential case management for PBMs to do is there, but it has not yet been realized.

Whether it would be better to have one or five PBMs in a region is not clear. That really depends on the limitations placed on their activities, as Mr. Scanlon said. If you had a dozen PBMs, for example, but said, effectively, "You cannot have formularies, you cannot negotiate discounted prices, you cannot do these other things," the larger number would not matter.

Mrs. THURMAN. OK. You need to help me through this a little bit then, because in your testimony you talked about Medicare beneficiaries with coverage spend an average of \$769. Now, those beneficiaries generally would be under the plan you have just described that would give them the best disease management, correct?

Mr. CRIPPEN. Not necessarily.

Mrs. THURMAN. Isn't that what's happening today? I mean, that is, most of our seniors are under a managed care plan of some sort that goes out and supposedly is doing disease risk management and those kinds of things, correct?

Mr. CRIPPEN. There is some of that being done for Medicare beneficiaries who are in the Medicare+Choice plans. Also, the number of those plans is dropping. Although it depends on the kind of plan they are in.

Mrs. THURMAN. Right.

Mr. CRIPPEN. PBMs is shorthand for having a pharmaceutical manager and most of those arrangements are not in managed care. Most PBMs operate in the private sector, serving the non-Medicare population. But in theory, the managed care setting would be the most likely to provide a case management or disease management approach, which should include pharmaceuticals.

Mrs. THURMAN. In any of yours, Dr. Crippen—and I know that we don't score this, but, even in the usage part of prescription drugs, can you look at all as to—because, I mean, risk disease, all of the kinds of things you just said—is there any savings to Medicare in the long term of having a prescription drug benefit for seniors?

Mr. CRIPPEN. The evidence, Mrs. Thurman, is mixed. For some specific conditions—after heart attacks, for example—the appropriate use of drugs could save you money, but we know of only a

few such conditions and there is evidence on both sides of the question. Some of it says you can save money, a lot of it says you cannot. So for the purpose of estimating costs, we do not assume that there are any savings, per se, for expanding prescription drug—

Mrs. THURMAN. But yet, if you talk to medical folks who say that the senior out there that cannot afford the prescribed drug comes in more often than the person who can continue their drug coverage or their prescription drugs as they were prescribed, so it would seem to me that there would be some savings, if not a lot of savings, in at least the hospital side of it.

Mr. SCANLON. I think you might want to insert the word “net” in front of “savings” here, because I think the issue is that there are savings from particular drugs, substituting for both surgical procedures and hospitalizations, but there are also additional drug expenditures to deal with conditions that wouldn’t have been managed well before, and those that overwhelm those savings.

Mrs. THURMAN. Let me ask a couple more questions here quickly.

I, quite frankly, don’t know that the private sector has done a very good job in negotiating discounted prices with drug companies. I don’t know with PBMs or whomever. I mean, we have seen a raise in drug prices 18, 20, 30 percent.

Are we seeing those same increases in say, for example, the Federal health employees increases, or are we getting a better savings through what we do already the Federal health plan?

Mr. CRIPPEN. Do we know? I would assume it is about the same.

Mrs. THURMAN. Evidently, GAO did a study that said we were getting about a 20 to 27 percent savings, I think, back in 1999 on FEHBP, as versus what is happening today in the private of about—we are actually going up about 18.3 percent.

Mr. SCANLON. Mrs. Thurman, actually that study is a little older than 1999.

Mrs. THURMAN. OK.

Mr. SCANLON. We may have used the information again. There is an important caveat to the information that I mentioned in my oral statement: The information is self-reported by PBMs and the plans, and it is not something that we were able to verify. But, this is the range of savings that they have reported.

The issue is, though, that, while they may have accomplished those savings, they may not have influenced strongly the rate of growth, so that once you get the 14 percent out or the 20 percent out, that the rate of growth continues the same for these plans as it does for other sectors of the pharmacy market.

I think FEHBP is very much like other private insurance, in the sense that we are contracting with insurance companies and they are turning around and contracting with PBMs, who may be serving General Motors, who may be serving Xerox, or any other private sector organization, and negotiating with the same manufacturers and the same pharmacies for the discounts.

So I think they are not necessarily doing any better. There are no techniques that I know of that they have that nobody else uses.

Mrs. THURMAN. Would you say that is the same thing as with the VA?

Mr. SCANLON. Well, the VA, I think, is in a different situation, in part because, one, it has some sort of legislative clout, in terms

of being able to gain a certain level of prices, and, second, it is a major bulk purchaser, and it is its own dispenser.

Mrs. THURMAN. Would Medicare be that same—

Mr. SCANLON. Medicare is going to have to operate in the retail market, to a great extent. We are going to have to anticipate that beneficiaries are going to be able to go to local pharmacies and get their drugs, as opposed to how the VA dispenses, so I think that is a distinction that the VA has that Medicare may not have.

Medicare is also so much bigger. It is also going to influence how it behaves and how we are going to tolerate it, how it behaves sort of in the pharmacy market.

Chairman THOMAS. I thank the gentlewoman for her line of questioning, because it is exactly these kinds of questions that we have to explore.

One of that confusing points, I think, that we have to begin to show a bit more discipline on as we discuss this is the price of drugs versus the expenditure to pay for the drugs, because we continually talk about the price of drugs going up. As a matter of fact, between now and 2005 we are going to see a significant number of brand names kick over into the generic category, and the price of the drugs will go down, but the expenditures for drugs are going to go up because of the increased utilization, especially if we put in a program. So, as we go through this discussion, that is one line of reasoning that we have to keep straight.

The other one—and her question about the number of PBMs is a good one, but I want to underscore the answer that she received, and that is, if you are really going to talk about cost containment or competition, which is another way of saying cost containment, the key to that is the freedom of the PBM to do what it thinks it needs to do, rather than the number of PBMs.

If you have one PBM and you say you are only going to have one, but you let them do whatever they want to do to control the cost, that can be very effective. If you limited them significantly as to what they could do, you could have 50 of them in competition with each other but you are not going to get a significant reduction because they are not able to do the very aggressive cost containment procedures that the private sector is currently engaged in. In fact, we have seen recent reports where some employers, because of their willingness to allow the aggressive cost containment of PBMs, are, in fact, not having to increase their cost to the consumer because of the internal savings.

Now, that is not an ongoing ability. You get some time line control on that.

Is that a fair way to assess what was said: That it is not the number of PBMs; it is the degree of freedom to allow for aggressive cost containment that would be the key to saving some money in that particular aspect of the program?

Mr. CRIPPEN. And the incentives you give the PBMs to achieve savings.

Chairman THOMAS. The other side of the coin.

Mr. CRIPPEN. Yes.

Chairman THOMAS. Any response to that?

[No response.]

Chairman THOMAS. But, see, the problem then goes back to Dr. Scanlon's concerns, because in the private sector, of course, you have the ability to do that, and there are a lot of things that go on which produce a cheaper price, like tough negotiating on volume or a tradeoff on one drug versus another for increased utilization for a particular drug versus another in the marketplace. It would be very difficult for Medicare PBMs, no matter how much the arm length would be, because those kinds of transactions are probably going to have to be a bit more transparent.

So I go back to my original point. There are going to be a ton of tradeoffs here that don't allow us to use a direct analogy to the private sector, but, to a certain extent, we are going to have to talk about the traditional way in which the Health Care Financing Administration has dealt with medical pricing, payment, and oversight, versus if we really want to try to get an effective prescription drug program, the traditional HCFA management techniques are probably least useful in this particular area of any that they have moved into, and we are going to have to examine that aspect fairly closely.

Mrs. THURMAN. Mr. Chairman, it would seem to me, when you have like we have with 39 million people, or however many people are out there, you are still in the best position as a negotiator because you have that many people to share this risk over, with one benefit.

Chairman THOMAS. But you don't, and that is where—unless you are going to drive out the single—see that pie chart up there? The single-largest segment of seniors who are Medicare beneficiaries are currently getting their drug coverage from their employer's insurance, and some of it is much richer.

One of the interesting parts about the President's plan was that it didn't have a whole lot of impact because most people who have employer plans shrugged their shoulders and said the President cannot compete.

To the degree we make it attractive, those employers are not mandatorily required to offer the program. That is why, in the President's program, you incentivize people by paying them to stay in the program, so it really isn't 39 million lives.

Now, there are some things that we could do, for example, on sharing the high-risk portion of beneficiaries that would keep employers in, if we created a pool that covered all Medicare beneficiaries, whether they got the insurance from employers or not. That would utilize the larger number.

But, again, we are going to have to look at subsets of that as we deal with people who have no benefit whatsoever today, people who would be moving from Medicaid, which might have a variety of programs available in States, coming to a more-uniform Federal program, as the President envisions a shift over, with some degree of cost maintenance as we move through—people getting off of medigap because they are paying \$2,100 for an H program and not getting much prescriptions, and they got into it because that was one of the only ways they could get prescriptions in the first place, and now they are getting a much better program.

We talk about this as though it is purely additive and moving into a whole new area. There are a lot of high points on the topog-

raphy that, when we flood the plain, are still going to be there, and we are going to have to deal with them.

Mrs. THURMAN. That is true, but we are already starting to see Medicare choices and those people drop out of areas and drop out of plans because of the high increase in cost of—

Chairman THOMAS. But remember—

Mrs. THURMAN. Wait a minute. Can I finish?

Chairman THOMAS. OK.

Mrs. THURMAN. And so you are also going to start seeing that hit that 31 percent at some point.

I will just tell you what happened yesterday. I had my insurance agents in to talk to me. They told me that they do a group policy insurance right now for a small company. They are going to increase the cost, alone, to that company for their premiums by \$100,000, and the only thing that is driving that is prescription drugs. But, just as importantly, as they are doing that, they are dropping benefits off of their insurance because they cannot continue to pay for everything.

So maybe this is the issue: Whether it is in this debate or whatever debate we have on prescription drugs, at some point we are going to have to get a handle on what is happening in this country, as compared to what is happening in other parts of the world.

You know, I look at Mrs. Johnson over there, who is hitting up against Canada. You go to Texas, and you have got Mexico. You have got Maine passing legislation. You have got Florida passing legislation.

Mrs. JOHNSON. I am sorry.

Mrs. THURMAN. We have got problems.

Chairman THOMAS. She has a time limit.

One quick response. Medicare+Choice is currently paying for drugs out of what would otherwise be the profit amount returned to HCFA. It is not a benefit, as we are defining, so that you will not get the cost squeeze on the prescription drug portion of the Medicare+Choice program. It would be a dollar additive program to the basic benefits package, an entirely different universe of price support and structure, so any analogy to current practice of Medicare+Choice without a prescription drug benefit versus what would happen if you added it simply is not relevant to the discussion of how, in fact, people will react and prices will be structured.

The gentlewoman from Connecticut.

Mrs. JOHNSON. I would just like to say, I think if we think that negotiation is going to solve the Medicare prescription drug cost problem, we are kidding ourselves. The hospitals are part of a nationwide buying group, and their drug costs went up—my local hospital's drug cost went up 40 percent in a single year.

Now, they are getting rock bottom prices. I don't know that we can do better. That is one of the things I want to look at with you, although not at this moment, but I want us to look at what makes us think that government would get any lower prices than some of the very big purchasers, nationwide purchasing groups out there.

But that is only one aspect. The big problem is the explosion of the number of drugs and the complexity of their structure.

But what I want to ask you is—and, Dr. Crippen, you got on this, because I am very afraid that we will legislate to the past in this bill. We have to legislate for the future.

You mentioned disease management. One of my concerns about this whole approach of a beneficiaries manager is that I don't—one of the problems we have had with pharmaceutical managers is that they manage the pharmaceuticals. They are not managing the health.

There has developed in my District, and there are now across the country the embryonic kinds of companies that manage, under the doctor's direction, health. And so, if you want to lower drug cost, you have to stick to the regiment. You have to exercise and you have to lose weight, if that is what your doctor has prescribed as your heart regiment.

I don't think that any benefit manager is going to be able to keep up on this industry that is developing, because it is holistic. It is much more complicated. You have to do it with the doctor involved.

I think one regional benefit manager is going to keep us focused on price negotiations. That is not enough. That is not the future.

So even multiple benefit managers—one of the reason I am interested in multiple insurers is because insurers, because of their broader experience in workman's company and disability law and a lot of areas where they are looking more holistically at managing health care for long-term recovery or managing chronic illness, they are more likely to be able to pair with this kind of disease management entity that is developing in our society.

But if we lock in benefit managers—which, frankly, we have had a lot of trouble with, in my experience—we are legislating to the past using the tools of the past, and the real savings is going to be how do we hook high-cost drugs with other health initiatives to improve health at an affordable cost.

So would you comment on that, on how we keep that in the mix and whether competing insurers might not be a more powerful tool than competing benefit managers.

Mr. CRIPPEN. Let me say two things. First as Mrs. Thurman noted, the Medicare+Choice plans provide the closest thing we may currently have to a disease management application. In contrast, the fee-for-service sector has no incentives and no design that would give you the holistic approach you are talking about.

But perhaps the ideal world—in the case of pharmaceutical management, at least—would be one in which the pharmaceutical managers were at risk or were paired with an insurance company to create some incentive to manage the entire disease in a protocol. And so, if a PBM was put at risk or tied to an insurance company—

Mrs. JOHNSON. So an insurance company in a competitive environment could use this issue of disease management and, you know, you would get a lower premium if you agree that, if you had a chronic disease, you would enter this kind of program, and, working with benefit managers and chronic disease management companies, the insurer could offer than a variety of packages. Some people only want fee-for-service. They don't want to have anything to do with anyone telling them when, what, or anything about the rest of their lives, so they pay a higher premium.

The last thing I just want to put on the record is I am very concerned, Mr. Crippen, that in your estimates you have assumed that 75 percent of those who now get coverage through their employers will move to this plan, because people who are getting benefit coverage through their employers—GM, some of the big guys—are getting better coverage.

Why did you make the assumption that they would move to the public program, which is going to be fraught with difficulty, if the past is any indicator?

Mr. CRIPPEN. We assumed they would move because the general subsidy to the program from the taxpayers would give them an incentive to move. That does not mean, however—

Mrs. JOHNSON. Will that incentivize their employers to incentivize them to move?

Mr. CRIPPEN. Sure. But we are assuming at the moment—although I am not sure it is a valid assumption—that all of these insurers would have continued their current level of benefits through wraparound provisions. So they would take the basic.

Mrs. JOHNSON. I see.

Mr. CRIPPEN.—program—the President's proposal, for example—but would then add to it with wraparound provisions.

Mrs. JOHNSON. That makes sense. Thank you very much.

I am sorry. I have to leave.

Chairman THOMAS. One second, if you can, this business of insurance companies, we are talking about risk. We are talking about a national program. And there are entities which re-insure. It seems to me that there is a dollar amount that you can place on the assumption of risk and that you don't need insurance companies, as we know them, in terms of management of the program if PBMs, disease management structures, or a new entity that evolves in offering the prescription drug management program, not matter how complete it might be on the regimen involved, would be willing to play a role that we invented with the National Association of Insurance Commissioners with the provider-sponsored organizations in which you can assess risk. Risk would have a price that would be passed through to the re-insurance and the government would pay the price for that shared risk.

And so you can utilize this management structure on a risk assumption basis, as well, which is simply identifying the cost of passing it through.

So if an insurance company said, "We aren't going to play in this business," that doesn't mean that we couldn't create entities at the Federal level that would serve us very usefully in helping to produce a more-aggressive managed program.

Is that a fair statement?

Mr. CRIPPEN. I think so. What I was trying to imply, in response to Mrs. Johnson, was that PBMs currently do not assume any risk and probably do not have a capital structure that would support them in doing that directly, whereas insurance companies—

Chairman THOMAS. Of course.

Mr. CRIPPEN.—historically have done exactly that and have the necessary capital. There may well be other entities that would evolve or could be formed, but again, to be optimal, they would

have to assume risk and have a capital basis to back up that assumption.

Mrs. JOHNSON. But could the PBMs perform the role that is envisioned for them in the democrat's proposal without assuming risk?

Mr. CRIPPEN. Yes, they could entirely.

Mrs. JOHNSON. What would be their motivation to control cost?

Mr. CRIPPEN. Whatever incentives the Secretary specifies, as I understand it.

Mr. SCANLON. As it is currently structured, the PBMs would not be at risk and the incentives are not specified, but the Secretary has the discretion to create incentives for the PBMs to control cost.

Mrs. JOHNSON. It would be very helpful if—and maybe your testimony does this. I didn't get through all of it—but to have some better understanding of what incentives might create what economic effect, because, particularly if there is one entity, the likelihood that we will allow them the right to provide the incentives that would be most cost effective is, frankly, very small, in my estimation, one of the reasons why Medicare is in such deep there.

Thank you very much for your thoughts. I look forward to working with you as we try to work through these problems. I appreciate the quality of your work and of your testimony.

Chairman THOMAS. Thank you.

Through no fault of his own, the gentleman from Maryland is no longer a Member of this Subcommittee; however, we are pleased to have him with us. But, before I recognize him, I just want to make one more point.

Coming from a single-payer State, he might better understand this phenomenon of the fact that, in using hospitals as an example of tough negotiators, you do have to keep in mind that that negotiation occurs under a reimbursement structure in which there may not be as much incentive as you might think for very tough negotiations under an administered price structure, and that, when you talk about the price of drugs, comparing two aggressive negotiators probably isn't the most meaningful comparison; it is looking at those seniors, who are the last bastion of retail payers of drugs, and what the cost would be through a negotiated arrangement, allowing them to get the benefits of group purchasing.

A recent study by Lewin said that perhaps those costs could be reduced by 30 to 39 percent, which is fairly comparable to the Canadian price, if you had aggressive, privately managed group purchasing structures.

So ultimately we have to look the what the current price of drugs are to seniors, versus what the price would be if we brought many of these benefits.

Once again, turn that facet a slightly different way and looking at it from a different perspective.

The gentleman from Maryland.

Mr. CARDIN. Thank you, Mr. Chairman.

Just one observation about Maryland. Maryland, of course, has negotiated rates for our hospitals by government. It is a government entity that negotiates the rates. We think that we are going to do even better than the Federal Government is doing, so, therefore, we have built an incentive now in our rate structure to give our hospitals a little bit more money, assuming that we are going

to outdo the Federal Government on how you achieve cost savings within the hospitals.

What I am interested in finding out is, in doing any of your estimates, have you assumed that the prescription drug proposal that the President has recommended would have, in and of itself, any impact on the number of Medicare beneficiaries that choose to go into Medicare+Choice HMO?

Mr. CRIPPEN. Under the President's proposal, we assume that fewer people would go into HMOs.

Mr. CARDIN. I assume that reduction would be based upon the assumption that people are going into HMOs or prescription drug coverage, and now they can get prescription drug coverage through a new part of Medicare, they no longer need to go into an HMO.

Mr. CRIPPEN. Right.

Mr. CARDIN. I assume that is the basis of that assumption.

Let me challenge that for a moment, if I might. And no one can really crystal ball, with any degree of certainty, what is going to happen, but one of the things that we have found, since we changed the reimbursement structure for Medicare+Choice, is that HMOs are having to charge significant premiums for seniors to join. They impose caps on their prescription drug benefits. They have done all these things in an effort to have a cost-effective program, because they are not reimbursed within their government payment for a prescription drug benefit.

But if the President's plan were to become law—and one of the major differences—and Mr. McCrery did not point this out when he was questioning the administrator, but one of the major differences between the President's proposal and the republican proposal is that, because the President puts it into the core plan, all private health care plans must include at least the benefit that is in the President's proposal, so that tomorrow, if this were law, the HMO would have to offer at least this benefit, but they would be reimbursed for it under their contract.

Chairman THOMAS. I tell the gentleman that there is no difference in our plan in requiring that, as well.

Mr. CARDIN. In other words, all the HMOs would also have to provide—

Chairman THOMAS. Yes.

Mr. CARDIN. I didn't know that. I appreciate that clarification. I thought that it was—so you have built it in also that all HMOs would have to cover the benefit.

Chairman THOMAS. Yes. We are currently grappling with the fact that Medicare+Choice—we do not allow certain disease-identified folk to go into the Medicare+Choice, but you certainly wouldn't want to create an option on a basic addition to the program like prescription drugs, and we are trying to deal with both of those problems at the same time.

You would have a full spectrum of choice to all folks who are covered by Medicare.

Mr. CARDIN. So the republican proposal then does put the prescription drug benefit within the core benefit of Medicare, but the only way that a senior can get it is either by joining a Medicare+Choice or participating in a private prescription drug plan? Is that—

Chairman THOMAS. Yes. And one of the reasons we wanted to do that was because, from the Medicare Commission experience, everyone told us that the best way to deliver a new prescription drug program would be in an integrated medical setting, and the closest thing we have to an integrated medical setting today is the Medicare+Choice program, so we would want to incentivize that.

Mr. CARDIN. Well then I think we are getting closer, Mr. Chairman. I really do think we are getting closer. I didn't realize that you had included in your core benefits the Medicare. If it is included in the core benefit of Medicare—the point I was going to raise, and the reason why I disagree, I think it would be an intuitive conclusion that you don't have to go into an HMO to get the prescription drugs, you could go in—there would be less people going into an HMO—is that now the HMOs are protected in the reimbursement structure, and they can now offer an HMO plan that doesn't charge separate premium, that doesn't have the risk factors associated with a prescription drug benefit because it is already covered, in part, on the reimbursements they are receiving, and in our experience we have seen a reduction of HMO interest in the senior market.

It would seem to me if we put it in the core benefit we are going to have an increased interest of private HMOs into the senior market because of the reimbursement structure.

So what has happened in my own State of Maryland, where we have gone from eight HMO carriers under Medicare+Choice, to now four, which will become three next year—at least no more than three next year—with none now that will not be charging a supplemental premium, and 14 counties that don't offer any coverage at all, it seems to me we have a much better chance, under the President's proposal, to be able to have more private interest in an HMO than we would otherwise.

I just invite your observations to those thoughts.

Mr. CRIPPEN. Certainly. If reimbursement to Medicare+Choice plans increased through this additional prescription benefit proposal, that would allow the plans to charge lower premiums or provide better benefits. That could encourage more beneficiaries to choose the HMO option. However, on balance, CBO estimates that Medicare+Choice enrollment would decline under the President's full Medicare reform proposal, which includes other payment reductions and changes in addition to a drug benefit.

But, part of the story is also that we are looking now at flat or declining growth, just as you suggested. It is certainly happening in Maryland. And so that might help reduce those trends, but it may not necessarily reverse them.

Mr. CARDIN. And let me just make one more observation, if I might, and that is, on the private, employer-based prescription drug benefits that are currently out there, mostly as wrap-around to what Medicare is providing, it seems to me a similar argument was probably made on Medicare part B, that, since the government provided Medicare part B, there would be no need for supplemental, employer-sponsored insurance to cover other benefits.

I think a similar argument would occur with prescription drugs. Yes, we are now covering, under the basic benefit of prescription drug plan, but it gives private insurance, employer-sponsored, an

opportunity to have a more fiscally viable wrap-around plan that may provide a much more generous prescription drug plan than they currently provide, because, again, the government is now covering a significant part of the cost through subsidy.

Mr. CRIPPEN. Sure. Again, if you give the employers more money, there is at least some prospect that they will split it with their employees, which would mean better benefits.

Mr. CARDIN. So the final observation that I would have is that, by providing within the core benefit of Medicare a prescription drug benefit, it seems to me that every one of those Medicare beneficiaries, whether it is a person who has no benefits today, a person who has an employer-sponsored plan versus an HMO, a person in medigap, a person with other, all are going to benefit by Medicare having prescription drug within their core benefit, as recommended by the President.

Mr. CRIPPEN. That is a possibility. Again, we have made no assumption at this point about what employers are going to do, other than that we are quite certain that many of them will take advantage of the program. Some observers argue that one of the reasons employers have provided insurance coverage to their retirees is to give them a drug benefit that is not provided by Medicare. If the Congress enacted a Medicare drug benefit, employers might drop their supplemental coverage, altogether.

Mr. CARDIN. But they would run into political problems. If their supplemental protection was stronger than what is in the basic core program, they would run into a political problem trying to reduce below what they currently are providing.

Mr. CRIPPEN. Possibly.

Mr. CARDIN. It is possible they will not increase it and take advantage of the savings, themselves. I doubt if they would—if they were going to reduce it, they would reduce it now.

Thank you, Mr. Chairman, for your patience.

Chairman THOMAS. Any additional final bites of the apple?

[No response.]

Chairman THOMAS. I want to thank you very much. Obviously, we are looking forward to your continued, over time, analysis of additional permutations.

My goal will be, in a cooperative way, to try to pulse the material to you so that we can do it in a timely fashion and have hearings in which the data has been available so that we will deal with less conjecture and more certainty in beginning to ferret out the choices that might be in front of us.

Thank you very much. Once again, both of you and your support structures have performed an invaluable service for the House, and I thank you for that.

The Subcommittee stands adjourned.

[Whereupon, at 12:59 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of American College of Physicians-American Society of Internal Medicine

Summary

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM) is the largest medical specialty society in the country, representing over 115,000 physicians of internal medicine and medical students. ACP-ASIM's members provide the majority of medical care to adults in America, including Medicare

beneficiaries, and are therefore in a unique position to evaluate the need for and the appropriate structure of any proposed Medicare prescription drug benefit.

ACP-ASIM strongly supports enactment this session of legislation to provide a prescription drug benefit with sustainable financing, with the highest priority going to help low-income beneficiaries. Such legislation must include key consumer protections, particularly if the benefit is to be restricted by a formulary administered by pharmacy benefit managers (PBMs). Patients' access to beneficial drugs must not be hindered by restrictive formularies—or other managed care controls—that are imposed by PBMs solely to reduce costs, without regard to safety, effectiveness, or ease of administration. Physicians should have the option of prescribing drugs that are not on the formulary without cumbersome prior authorization requirements. Beneficiaries should be informed of the impact of the formulary on both co-payments and access to prescription drugs. Also, they should be promptly notified of changes in the formulary. PBMs or others defining a formulary should be required to consult with physicians on the drugs that are included in the formulary.

Background

Prescription drugs are an essential tool for treating and preventing many acute and chronic conditions. In 1965, when Medicare was first established, pharmaceutical therapies were not as commonly available as they are now, and outpatient prescription drugs were not nearly as important a component of health care. Today, however, they are a primary form of medical care and often substitute for more costly therapies, such as hospitalization and surgery.

Pharmaceuticals are the fastest-growing component of national health expenditures. In 2000, national drug spending increased by an estimated 11% compared with 7% for physician services and 6% for hospital care. Since 1990, national spending for prescription drugs has tripled. By 2008, that figure is expected to more than double from an estimated \$112 billion today to \$243 billion. (Source: HCFA, Office of the Actuary).

The growing importance and increased use of prescription drugs have had a disproportionate impact on the elderly, who use prescription drugs more extensively than the general population because of high rates of chronic illness. Although the elderly represent only about 12 percent of the population, they account for over a third of spending on prescription drugs. It is estimated that 80 percent of Medicare beneficiaries use pharmaceuticals on a regular basis. Having drug coverage is a significant factor affecting whether Medicare beneficiaries fill their prescriptions. Lack of or limited drug coverage can expose beneficiaries to high out-of-pocket costs that may result in under-utilization of prescribed medications and adverse health outcomes.

In response to the increase in utilization and costs of prescription drugs, managed care organizations have turned to cost-control techniques, such as the use of formularies and PBMs. In fact, PBMs currently manage an estimated 71% of the volume of prescription drugs dispensed through retail pharmacies that are covered by private third-party payers. Several bills pending in Congress, including the Administration's proposal, would use PBMs to administer a Medicare drug benefit and give PBMs the authority to determine which drugs would be available to patients under such a benefit. PBMs are private companies that contract with health plans to limit the costs of prescription drugs by managing drug utilization and obtaining discounts from retail pharmacies and manufacturers. Formularies—lists of approved drugs that physicians are permitted to prescribe—are typically used by PBMs to limit access to expensive drugs.

ACP-ASIM Concerns with PBMs

As physicians, the members of ACP-ASIM know that the lack of prescription drug coverage can significantly reduce patient compliance with prescribed drug therapies. However, our members also recognize that the cost of prescription drugs is escalating at a rate far greater than health care spending generally and that legislation must work to create and maintain a careful balance between the need for a prescription drug benefit and the cost of such a benefit. It is critical, however, that cost not be the primary factor in structuring any prescription drug benefit program.

Physicians constantly are forced to strike a balance between ensuring that their patients receive medication that is medically necessary and minimizing their patient's out-of-pocket costs. Formularies and/or PBMs that limit beneficiaries' coverage, either in terms of increased copayments or deductibles, or by restricting the availability of certain medications, increase the likelihood that patients will not be able to comply with their physicians' recommended regimens. Moreover, patients with serious illnesses requiring more costly medications may be particularly at risk if PBMs are allowed to restrict coverage to only the cheapest drugs. If drugs are prescribed that are not listed in the formulary, patients may be penalized with higher out-of-pocket costs (increased copayments or deductibles). PBMs also monitor the

number and types of drugs that physicians prescribe to their patients. Physicians who prescribe more costly drugs may be pressured to give their patients less expensive—but potentially less effective—alternatives. All of these circumstances may result in adverse health outcomes.

PBMs need to consult with physicians on the drugs that are included in a formulary. They need to educate patients about how their prescription drug benefit works, what the impact will be on their out-of-pocket costs if they need a drug that is not on the formulary, and how to obtain approval for a drug that is not on the formulary list. Physicians should be able to prescribe beneficial “off-formulary” drugs to their patients, when supported by clinical evidence on effectiveness, without cumbersome prior authorization requirements. Beneficiaries and their physicians need to be promptly notified when formularies are changed or discontinued.

ACP-ASIM believes it is critical that any authorizing legislation on a Medicare prescription drug benefit includes sufficient oversight of how PBMs operate. As private companies, PBMs can exert a great deal of influence over which drugs will be available to Medicare beneficiaries, without any accountability to the public for their decisions. The PBM industry makes their pricing decisions without public scrutiny, oversight or regulation. The PBM industry is highly concentrated, with the top three PBMs—Merck-Medco Managed Care, PCS Health Systems, and Express Scripts—together managing approximately 45 percent of prescriptions dispensed through retail pharmacies that are covered by private third-party payers. A Medicare drug benefit administered by PBMs needs to protect against potential conflicts of interest that can arise when a PBM is owned by a drug manufacturer, or has close ties to a drug manufacturer. ACP-ASIM supports the disclosure of any financial relationships between PBM companies, pharmacists and pharmaceutical manufacturers to patients and physicians.

PBMs are coming under increasing scrutiny. The National Association of Insurance Commissioners is currently considering whether to recommend legislation to regulate the industry. Pending lawsuits contend that some pharmacy benefit managers have violated their duty to act in the best interest of patients. The U.S. Department of Justice is investigating possible illegal kickbacks at the two largest PBMs. ACP-ASIM believes that Congress should proceed cautiously in placing too much control of a Medicare prescription drug benefit program in the hands of pharmacy benefit managers. *Cost-effective* rather than cost-control practices recognize the patient’s well-being as primary and promote quality patient care. Patients should have access to effective treatment rather than the least expensive therapy. **A prescription drug benefit will be a hollow promise to beneficiaries if it allows PBMs to deny them access to beneficial drugs principally on the basis of cost.**

(A list of ACP-ASIM’s recommended consumer protection principles is attached.)

American College of Physicians-American Society of Internal Medicine Consumer Protection Principles for Medicare Prescription Drug Legislation

1. A method of pricing Medicare payments for prescription drugs should be included that will balance the need to restrain the cost of the benefit with the need to create financial incentives for manufacturers to continue to develop new products. Rigid price controls that will discourage innovation should be rejected.

2. The use of formularies should not be mandated. If a formulary is instituted, by a PBM or otherwise, decisions on which drugs should be included and evaluation of physician prescribing patterns should be based on effectiveness, safety, and ease of administration, rather than just costs.

3. Physicians should have the option of prescribing drugs that are not on the formulary (based on objective data to support a justifiable, medically indicated cause) without cumbersome prior authorization requirements.

4. Beneficiaries should have access to comprehensive, accurate and understandable educational and informational material about their prescription drug benefits; such material should include information on how the formulary functions and the impact of the formulary on co-payments and/or deductible requirements, and access to prescription drugs.

5. Beneficiaries and their physicians should be promptly notified (at least ninety days notice) when formularies are changed or discontinued.

6. PBMs or others defining a formulary should be required to consult with physicians on the drugs that are included in the formulary. Formularies should be approved on a regional basis by a professionally qualified body that includes practicing physicians using that formulary.

7. Any request by a benefit manager to alter medication regimes should occur only when such requests are based on objective data supported by peer-reviewed medical

literature and which undergo review and approval of associated managed care organizations/managed behavioral health organizations' pharmacy and therapeutic committees.

8. Physicians should continue to be able to prescribe covered drugs for accepted off-label uses.

9. The prescription drug benefit should not require an expansion of prescribing privileges for non-physician health professionals beyond what can be supported based on their level of training.

10. Issues of generic and therapeutic substitution under the Medicare program should be addressed through the development of a national system that would allow physicians who permit generic substitution to: designate substitution by only "A" rated generic drugs; require any prescription medication crossing state lines, such as those as part of a prescription filled by an out-of-state pharmacy, to use only "A" rated generic drugs if a brand name is not required by the prescribing physician; and require a national uniform policy regarding a phrase that can be used to denote the need for a brand name drug.

11. PBMs should be required, with a patient's consent, to provide treating physicians with all available information about the patient's medication history.

12. PBMs should be required to disclose to beneficiaries and their physicians any financial relationships among the benefit manager, pharmacists and pharmaceutical managers.

Statement of Jacqueline Shannon, President, National Alliance for the Mentally Ill

Chairman Thomas, Representative Stark and members of the Ways and Means Subcommittee on Health, I am Jacqueline Shannon of San Angelo, Texas, President of the National Alliance for the Mentally Ill (NAMI). I am pleased today to offer NAMI's views on proposals now before the Congress to expand the Medicare program to cover the costs of outpatient prescription drugs. In addition to serving as NAMI's President, I am also the mother of Greg Shannon. Greg was diagnosed with schizophrenia in 1985. For the past 15 years, Greg and our entire family have struggled with his illness. Like so many of NAMI 210,000 consumer and family members, I am grateful that the Finance Committee is now poised to fill what has been the most significant gap in the Medicare program since its inception 35 years ago—outpatient prescription drug coverage.

NAMI is extremely pleased that this critical issue is gaining significant bipartisan attention in Congress this year. As President Clinton observed in his State of the Union address on January 27, no one doubts that if the Medicare program were enacted today outpatient prescription drug coverage would be included as part of the basic benefits package. As the Committee has heard from many witnesses on this issue, prescription medications played a relatively minor role in medical care back in 1965 when Congress passed, and President Johnson signed into law, Title XVIII of the Social Security Act. Today, advances in science and treatment have yielded new medications that have become our frontline of attack on major illnesses.

This is certainly the case with serious brain disorders, probably more so than any other class of diseases. Back in 1965, someone diagnosed with a serious brain disorder such as schizophrenia or bipolar disorder (manic-depression) was likely to end up spending much of their adult life in a public psychiatric hospital being treated with medications such as haldol and thorazine that were only marginally effective in treating symptoms and had serious, debilitating side effects. For many consumers, these side effects were as challenging as the symptoms of the illness itself and have been directly related to the problems many have faced in consistently adhering to treatment. Fortunately, advances in science in the last two decades, especially in the development of a new generation of atypical antipsychotic medications for schizophrenia and selective serotonin reuptake inhibitors (SSRIs) for depression, have made it possible for many consumers to achieve a level of recovery never dreamed of decades ago. It is NAMI's view that these new treatments—made possible in large part through the bipartisan effort in Congress to increase federal funding for brain research—are central to higher functioning and recovery.

TWWIIA and its Role in Recovery from Severe Mental Illness

Mr. Chairman at the outset I would like to thank you and all members of the Subcommittee who came together on a bipartisan basis last year to pass the Ticket to Work and Work Incentives Improvement Act. This new law addresses head-on

so many of the outdated and unfair eligibility rules in the SSDI, SSI, Medicare and Medicaid programs that forced beneficiaries to choose between a job and health care coverage. During debate over this legislation last year, and since its enactment, we heard from so many consumers and families who told of their frustrations at seeing genuine recovery from severe mental illness fall short because they were forced to quit a job or cut back their hours, not because of their illness, but because of fear of losing health coverage.

While TWWIIA was a tremendous bipartisan accomplishment, it is a first step. Perhaps the most important next step that Congress can take to help people with mental illness, and all severe disabilities, go to work is to add an outpatient prescription drug benefit to Medicare. NAMI agrees that the 4.5 years of added Medicare eligibility for SSDI beneficiaries included in TWWIIA will be critical in helping people to stay on the job longer. However, for too many people with severe disabilities on SSDI, this extended period of health care coverage comes with a benefit package that is inadequate. Moreover, the most overwhelming gap in the Medicare benefit package is coverage for outpatient prescription drugs.

The Interests of Non-Elderly SSDI Beneficiaries Must Be Part of This Debate

NAMI recognizes that so many of the interests that come before this Subcommittee to offer their views on the issue of Medicare prescription drug coverage speak only to “coverage for seniors.” While this characterization of the issue may offer political simplicity, we believe that it excludes the population of Social Security recipients who need coverage for prescription drugs the most—non-elderly people with disabilities who are SSDI beneficiaries. Furthermore, NAMI would argue that it is non-elderly SSDI beneficiaries with severe mental illnesses who most need outpatient drug coverage. While some SSDI beneficiaries may need only coverage for acute care to achieve recovery and work, individuals with severe mental illnesses simply must have coverage for medications in order to even consider employment as an option.

Currently, there are 1.3 million non-elderly disabled Americans on SSDI. Of this population, nearly 400,000 became eligible through a “mental disorder” under Social Security’s medically determinable eligibility standards. While this figure is not nearly the size of the number of our nation’s growing elderly population, it does represent an important population in the Medicare debate. First, people with severe mental illnesses come on to the cash benefit rolls earlier than any other disability category. The typical onset of an illness such as schizophrenia is late adolescence or early adulthood. Young adults with the most severe, disabling symptoms are likely to qualify for benefits within a year or so. Many depend on benefits for a large part of their adult life. By contrast, individuals who use SSDI as an early retirement program for injuries or chronic disabilities related to lifetime of manual labor stay on cash benefits for a brief period before moving into Social Security’s main retirement program. Thus, the long-term fiscal implications of SSDI beneficiaries with severe mental illness go beyond their numbers.

Second, the lack of an outpatient prescription drug benefit in Medicare has important consequences for state Medicaid programs. While Title XIX is not under the jurisdiction of this Subcommittee, NAMI recognizes that any new Medicare prescription drug benefit is certain to have profound consequences on both beneficiaries and the States. Under the current system, many SSDI beneficiaries with severe mental illnesses are forced to spend down their assets and go into poverty to establish eligibility for Medicaid to get drug coverage. Once on Medicaid, these individuals must stay poor to keep their Medicaid coverage. Persons who are dual eligible for SSI and SSDI face similar concerns, as do so-called “disabled adult children,” who must move onto SSDI when their parents retire. This system also prevents many families from providing even the most modest forms of financial assistance to their sons, daughters and siblings with severe disabilities, out of fear of jeopardizing Medicaid eligibility. The TWWIIA will be a tremendous help to many consumers and families in this arena, but more needs to be done to ensure that people do not have to become poor, and stay poor for their entire adult life, just to access prescription drug coverage.

What Does NAMI Want to See in a Medicare Outpatient Prescription Drug Benefit?

1. Congress should ensure that any prescription drug program offered as part of, or as a supplement to, Medicare be made available to non-elderly SSDI beneficiaries under the same terms and conditions as those for seniors. Although election-year politics may make it tempting to focus on the nation’s growing elderly population, we are adamantly opposed to any program that would discriminate against non-el-

derly people with disabilities who are eligible for Title II benefits by establishing a program that either limits their eligibility or establishes terms or conditions that do not apply to seniors. Managed care plans such as Medicare Plus Choice and “prescription drug only” plans should be required to offer enrollment to non-elderly SSDI beneficiaries under the same rules and conditions as those for seniors.

2. Prescription drug coverage under Medicare should be accompanied by the enactment of parity for mental illness benefits. Currently, the Medicare co-payment for Part B outpatient services is 20 percent. This co-payment does not apply to mental illness treatment, however, which is only covered at a rate of 50 percent. There is also currently a 190-day lifetime limit for inpatient psychiatric hospital treatment. Furthermore, only office-based therapy and partial-hospitalization mental health services are allowed under Medicare’s current coverage—no assertive community treatment or psychiatric rehabilitation is covered. NAMI urges that Congress use this historic opportunity to address a prescription drug benefit that also addresses the discrimination in Medicare’s existing mental illness benefits. Neither the proposals put forward by the Bipartisan Commission on the Future of Medicare nor the Clinton Administration addresses this basic unfairness within Medicare.

3. To the maximum extent possible, NAMI believes that a Medicare outpatient prescription drug benefit should be a national program benefit that is standardized throughout the country. The depth and scope of coverage for medications should not be dependent on where you live. While NAMI is not opposed to a State role in any program, there should be national standards that ensure reasonable similarities in coverage across the nation.

4. Coverage should be adequate to finance the most expensive drugs for the treatment of serious and persistent mental illness. NAMI is concerned that the President’s Medicare prescription drug proposal, as well as several competing plans in Congress, has a principal objective of providing a tangible benefit to a large number of people, rather than helping a small number of Medicare beneficiaries with high drug expenses. For example, in the President’s plan there is no limit on how much an individual would have to pay out-of-pocket for medications. Likewise, the benefit would begin immediately, regardless of an individual’s expenses. While such limitations may serve to keep premiums low so that large numbers of healthy Medicare beneficiaries will sign up for a voluntary program, these restrictions are likely to impose significant burdens on people with chronic and severe illnesses who rely on medications as their principal form of treatment. An examination of the costs of several key psychiatric medications indicates that, while many Medicare beneficiaries might be helped in meeting the high costs associated with their drugs, substantial gaps in coverage would likely persist under proposals such as the President’s. Average annual costs for major psychiatric medications include: Clozaril (\$6,200), Paxil (\$711), Prozac (\$808), Risperidone (\$2,800), zoloft (\$852), and Zyprexa (\$3,000). It is important to note that most people living with severe mental illnesses such as schizophrenia and bipolar disorder are prescribed several medications (including drugs to treat side effects) rather than a single drug.

5. Medicare prescription drug formulary policies should not interfere with access to the newest and most effective medications for serious brain disorders such as schizophrenia and bipolar disorder. Medications for mental illnesses differ from one another—either in their effectiveness in treating specific symptoms or disorders, or in their side effects. There is solid evidence that newer medications offer advantages over conventional medications in either effectiveness or side effects. For example, most treatment guidelines now recommend newer antipsychotic medications as the drugs of first choice because they can be more effective in treating symptoms in some individuals and because their side effects may cause fewer short-term and long-term problems—and in particular, fewer cases of tardive dyskinesia, an irreversible and potentially disabling movement disorder.

However, some health plans (including many that now are a part of Medicare through the Medicare Plus Choice program) place restrictions on access to medications. Sometimes these policies may be appropriate to avoid the inappropriate use of drugs or to encourage the use of generic equivalents. But often the limitations are designed primarily to discourage the use of more expensive medications. Limitations may take the form of a restricted formulary, in which only certain medications are covered by the plan, or a “fail-first” policy, requiring failed treatment with older, less expensive medications before allowing treatment with newer medications. NAMI supports efforts to ensure that Medicare (and all health plans participating in the program such as Medicare Plus Choice) offer access to all effective and medically appropriate medications. If Medicare (or a participating health plan) uses a formulary, exceptions from the formulary limitation must be allowed when a non-formulary alternative is medically indicated. Moreover, procedures should be established whereby beneficiaries can appeal a decision to prescribe a specific medication.

Finally, Medicare (and participating plans) should not be allowed to require beneficiaries to switch from medications that have been effective for them.

Conclusion

On behalf of NAMI's consumer and family membership, thank you for the opportunity to offer our views on this critically important issue. NAMI looks forward to working with this Subcommittee and the entire Congress to ensure that the Medicare program is modernized and preserved for generations to come and that it meets the needs of one of America's most vulnerable populations, people with serious, persistent mental illnesses.

