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THIRD IN SERIES ON MEDICARE REFORM: LAYING THE GROUNDWORK FOR A RX DRUG BENEFIT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

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THIRD IN SERIES ON MEDICARE REFORM: LAYING THE GROUNDWORK FOR A RX DRUG BENEFIT

TUESDAY, MARCH 27, 2001

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

The Subcommittee met, pursuant to notice, at 2:11 p.m., in room 1100 Longworth House Office Building, Hon. Nancy Johnson (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
March 20, 2001
HL–3

CONTACT: (202) 225–3943

Johnson Announces Third Hearing in Series on Medicare Reform: Laying the Groundwork for a Rx Drug Benefit

Congresswoman Nancy L. Johnson (R–CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on the addition of an outpatient prescription drug benefit to the Medicare program. **The hearing will take place on Tuesday, March 27, 2001, in the main Committee hearing room, 1100 Longworth, beginning at 2:00 p.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 beneficiaries as well as experts on prescription drug coverage patterns, elements of benefit design, and the costs of drug coverage. 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:

This hearing will be the third in a series of Subcommittee hearings intended to lay the groundwork for the development of legislation to improve and strengthen the Medicare program—and the first to focus specifically on adding a much needed prescription drug benefit to the program. The first Subcommittee hearing, held on February 28th, gave Members a general overview of the reform debate. Our second hearing, on March 15th, addressed the need to bring regulatory relief while still protecting the program from waste, fraud, and abuse. Subsequent hearings will continue to target various aspects of the Medicare program in need of improvement.

In announcing the hearing, Chairman Johnson stated: "Nobody would design a seniors health program today which does not fully integrate prescription drugs. Adding a prescription drug benefit to an improved and modernized Medicare program is one of the most important tasks this Congress must accomplish this year. It will not be easy—the issues we will confront are extremely complicated. But it must be done. Next week's hearing will help us get started."

FOCUS OF THE HEARING:

This hearing begins the Subcommittee's consideration of the many issues surrounding the development of an outpatient prescription drug benefit within the Medicare program. The first panel will outline existing patterns of prescription drug coverage and spending, and witnesses will help Members begin to identify the many design decisions that will have to be made in structuring a new benefit. The second panel will turn to current and future beneficiaries to hear directly from them what they would like to see in a new drug benefit.

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, Tuesday, April 10, 2001, to Allison Giles, 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.

Chairwoman JOHNSON. The hearing will come to order.

Today's hearing continues the Subcommittee's examination of Medicare modernization. Our first hearing focused on fundamental Medicare reform ideas, and our second hearing addressed Medicare's complexity and the regulatory burden on the providers that served beneficiaries. Last week, we heard from the Medicare trustees that the overall fiscal challenges to the program remained formidable. Today, we will examine the inadequacy of the current benefit package, specifically the absence of outpatient prescription drug coverage.

Every Member of this Committee understands the importance of this issue to Medicare beneficiaries. Increasingly, medicines are the preferred method of treatment for a variety of ailments. This is particularly true for those with chronic diseases that disproportionately affect the Medicare beneficiary. Prescription drugs will only become more important as the biotechnology products currently in the pipeline are approved by the FDA for illnesses such as Alzheimer's, arthritis, cancer, osteoporosis, heart disease and stroke.

Nevertheless, since its inception in 1965, the Medicare Program has generally excluded coverage of outpatient prescription drugs. While more than seven out of 10 beneficiaries do have supplemental prescription coverage, millions of beneficiaries have none, and much of the current supplemental prescription drug coverage such as Medigap remains expensive and inadequate.

Medicare beneficiaries consume more prescription drugs than any other demographic group, yet those without coverage have the least bargaining power and are therefore often paying the highest prices. Further, low-income beneficiaries often have to make unacceptable decisions between taking their medicines and having food on their table. No one would design a seniors' health plan today without fully integrating prescription drugs. The lack of coverage symbolizes just one of the many ways in which the Medicare benefit package has not kept pace with modern medical care.

Today, we will hear testimony from the Congressional Budget Office about its new projections that any prescription drug benefit will cost us one-third more than projected last year. We will also hear CBO's analysis of the critical design elements that drive or constrain costs. Then, we will hear testimony from a researcher at the Health Care Financing Administration that seniors' prescription drug coverage increased from about 65 percent in 1976 to 73 percent in 1998. The research also makes clear that those seniors without coverage tend to consume far fewer drugs than those with coverage: not surprising but very unfortunate.

Additionally, we will hear from Michael Cohen about ideas to reduce prescription drug errors and improve quality, critical aspects of any successful drug benefit. Finally, we will hear from current and future Medicare beneficiaries about the principles they think are important in the design of a prescription drug benefit. We will hear from a beneficiary without coverage, a beneficiary with good retiree coverage who wants to keep it that way, a young person representing the Third Millennium, concerned with the cost and structure of a Medicare benefit, and an advocate representing the National Committee to Preserve Social Security and Medicare.

In short, this hearing will bring us up to speed on the status of prescription drug coverage and the challenges we face to successfully integrate drug coverage into a modernized Medicare program. Last year, our respective political parties toiled on this issue in separate rooms. It is my hope that through this series of hearings and our regular member seminars, we can bridge differences and develop a bipartisan consensus on how to tackle the complex and difficult issue of integrating prescription drugs into Medicare.

Mr. Kleczka.

[The opening statement of Chairwoman Johnson follows:]

Opening Statement of Hon. Nancy L. Johnson, M.C., Connecticut, and Chairman, Subcommittee on Health

Today's hearing continues the Subcommittee's examination of Medicare modernization. Our first hearing focused on fundamental Medicare reform ideas. Our second hearing addressed Medicare's complexity and the regulatory burden on the providers that serve beneficiaries. Last week, we heard from the Medicare Trustees that the fiscal challenges to the program remain formidable.

Today we will examine the inadequacy of the current benefit package—specifically, the absence of an out-patient prescription drug benefit. Every member of this committee understands the importance of this issue to Medicare beneficiaries. Increasingly, medicines are the preferred method of treatment for a variety of ailments. This is particularly true for those with chronic conditions, that disproportionately impact the Medicare beneficiary. Prescription drugs will only become more important, as the biotechnology products currently in the pipeline are approved by the FDA for illnesses such as Alzheimer's, arthritis, cancer, osteoporosis, heart disease and stroke.

Nevertheless, since its inception in 1965, the Medicare program has generally excluded coverage of outpatient prescription drugs. While more than 7 out of 10 beneficiaries do have supplemental prescription drug coverage, millions of beneficiaries do not. And much of the current supplemental prescription drug coverage, such as Medigap, remains expensive and generally inadequate.

Medicare beneficiaries consume more prescription drugs than any other demographic group. Yet those without coverage have the least bargaining power and are therefore often paying the highest prices. Further, low income beneficiaries often have to make unacceptable decisions between taking their medicines and other necessities of life. No one would design a seniors' health program without fully integrating prescription drugs. The lack of coverage symbolizes just one of the many ways Medicare has not kept up with modern health care.

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Then we will hear testimony from a researcher at the Health Care Financing Administration that seniors' prescription drug coverage *increased* from about 65% in 1996 to 73% in 1998. The research also makes clear that those seniors without coverage tend to consume far fewer drugs than those with coverage. Additionally, we will hear from an academic about ideas to reduce prescription drug errors and improve quality, critical aspects of any successful prescription drug benefit.

Finally, we will hear from current and future Medicare beneficiaries about principles they think are important in the design of a prescription drug benefit. We will hear from a beneficiary without coverage, a beneficiary with good retiree coverage who wants to keep it, a young person representing "Third Millennium," concerned with the cost and structure of a Medicare drug benefit, and an advocate representing the National Committee to Preserve Social Security and Medicare.

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Mr. KLECZKA. Thank you, Madam Chair.

Madam Chair and Members, the Ranking Member, Mr. Stark, is running a little late. So on behalf of himself and myself, I would like to deliver the opening statement today.

Madam Chair, thank you for holding today's hearings. This Subcommittee has been given a very important charge: crafting a meaningful prescription drug benefit for our Nation's seniors. And I appreciate the chairwoman's leadership and thoughtful approach to further educate Members on the various policy options. The year

is young, and there is ample opportunity for us to try to find a bipartisan agreement on issues of mutual interest.

Adding prescription drug coverage under Medicare is by far the single most important Medicare reform or modernization proposal under consideration this year. No matter where each of us lives, whether it is in Connecticut, Minnesota, Florida, Washington State or Wisconsin, we have seniors looking to us to modernize the Medicare Program and provide some assistance to help with the escalating costs of life-enhancing and life-saving prescription medications.

Unfortunately, if we are held to the budget before us, we are less likely to succeed. A budget is a statement of priorities, and drug coverage is clearly not a priority of this budget. Right now, our task is to develop a bipartisan prescription drug benefit that will provide adequate, sustainable assistance to senior citizens and disabled persons who depend on Medicare. The bottom line is that the Health Subcommittee should not be held hostage to a budget that shortchanges a Medicare drug benefit.

If it turns out that a package that we believe is necessary to meet the needs of the Medicare beneficiaries doesn't fit within the budget currently before us, then the House will have to prioritize. Does Congress want an adequate prescription drug benefit for the elderly, or does it want to repeal the estate tax? Does Congress want an adequate drug benefit for senior citizens, or does it want a new missile defense system called Star Wars?

The chairwoman is proceeding in the right way. She is holding educational seminars to help our Members focus on the important areas in the prescription drug debate and other issues before the Committee. We have scheduled hearings that will enable us to determine how best to help Medicare beneficiaries with prescription drug costs. However, so far this year, we have yet to see an appropriate drug benefit proposal, and I am not being partisan. I am putting the responsibility on all of us. I think we would be better off reporting no drug benefit than reporting a $105 billion to $153 billion plan that would undoubtably fall so dramatically short of what is needed.

We should develop a meaningful package. If the decision is made not to proceed with it, so be it. But we will have done a real service by developing a package that can work if and when we are willing to dedicate the necessary resources to make it work. We can even specify or suggest routes to obtain the needed resources through taxes, through premiums, through surplus expenditures or through a combination.

In this era of record surpluses, we should be able to move with a real drug benefit, but if we cannot, then we should continue working on mechanisms to lower drug costs through drug reimportation, improved payment policies for the limited drugs Medicare currently covers, patent reform and other proposals to make drugs more affordable in the absence of coverage.

Finally, while I look forward to the testimony from our witnesses, we should not be lulled into a sense of complacency because it appears that many beneficiaries currently have drug coverage. Coverage has declined since the study data were collected in 1998, and recent data from the Commonwealth Fund show that only 50

percent of beneficiaries have some type of coverage throughout a given year. In addition, only the poorest beneficiaries, who are also on Medicaid, have coverage that is comprehensive, affordable and reliable.

That is why it is so important to have a Medicare drug benefit that is universally available. CBO's baselines and estimates should be a wakeup call to President Bush and Congress. Creating a prescription drug benefit will be costly, but we can afford it if we rearrange our priorities. I look forward to working with the chairwoman and our colleagues on the Committee to see if we can do better.

Thank you, Madam Chair.

[The opening statements of Mr. Kleczka and Mr. Ramstad follow:]

Opening Statement of Hon. Gerald D. Kleczka, M.C., Wisconsin

Madam Chair, thank you for holding today's hearing. This Subcommittee has been given a very important charge—crafting a meaningful prescription drug benefit for our nation's seniors—and I appreciate the Chairwoman's leadership and thoughtful approach to further educate Members on various policy options.

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We should develop a meaningful package. If the decision is made not to proceed with it, so be it. But, we will have done a real service by developing a package that can work *if and when* we are willing to dedicate the necessary resources to make it work. We can even specify or suggest routes to obtain the needed resources—through taxes, through premiums, through surplus expenditures, or a combination.

In this era of record surpluses, we should be able to move forward with a real Medicare benefit. But, if we cannot, then we should continue working on mechanisms to lower drug costs through drug reimportation, improved payment policies for the limited drugs Medicare currently covers, patent reform, and other proposals to make drugs more affordable in the absence of coverage.

Finally, while I am looking forward to the testimony from our witnesses, we should not be lulled into a sense of complacency because it appears that many beneficiaries currently have drug coverage.

Coverage has declined since the study data were collected in 1998, and recent data from the Commonwealth Fund show that only 50 percent of beneficiaries have some type of coverage *throughout* a given year. In addition, only the poorest beneficiaries who are also on Medicaid have coverage that is comprehensive, affordable and reliable. That's why it's so important to have a Medicare benefit that is universally available.

CBO's baselines and estimates should be a wake-up call to President Bush and Congress. Creating a prescription drug benefit will be costly, but we can afford it if we rearrange our priorities. I look forward to working with the Chairwoman and our colleagues on the Committee to see if we can do better.

Opening Statement of Hon. Jim Ramstad, M.C., Minnesota

Madam Chairwoman, thank you for calling this important hearing today to review proposals to expand access to prescription drug benefits for seniors.

As founder and co-chair of the House Medical Technology Caucus, I appreciate the incredible advances that the medical technology and pharmaceutical industries have made in recent years to treat and cure many illnesses, diseases and conditions. These advances are truly breathtaking in their scope and will become more and more prevalent as medical science continues to advance.

Unfortunately, the Medicare system penalizes seniors by incorporating these advances too late, if at all.

Congress needs to comprehensively reform Medicare to modernize the program and expand access to critical new technologies and drugs. By acting this year, we can improve health, save lives and save the system money.

The question of course is how to maintain the standard of care enjoyed by America's seniors, improve the system and meet the incredible demographic challenges coming in the very near future. This is not a simple task, and a prescription drug benefit will place new pressure on Medicare as our nation's senior population grows.

Some propose to simply add a prescription drug benefit on top of the current system. I believe we've tinkered too long. We must modernize Medicare to provide these important new benefits and streamline their delivery to seniors.

Since anything worth doing is worth doing well, we must carefully review all of the ideas that have come forward for their strengths and weaknesses, as well as for unintended consequences.

I applaud the work of Chairwoman Johnson in tackling these issues and thank her for holding this hearing today to explore in depth the challenges in adding a prescription drug benefit to Medicare. I look forward to learning more from today's witnesses on how we can best address the critical issue of including prescription drug coverage in Medicare.

Chairwoman JOHNSON. I thank the gentleman, and I would just want to say, because we will have a spirited debate on the budget tomorrow on the floor, that if I didn't believe that a prescription drug bill was a great priority of my leadership, my colleagues and the President, I wouldn't be putting the kind of effort into it that I am. I believe there is very deep commitment on the Republican side as I believe there is on the Democratic side to provide prescription drugs through Medicare, and that is the course I am on and the course that I hope we will be able to complete.

It is now my privilege to welcome Dr. Crippen of the Congressional Budget Office here today and thank you in advance, Dr. Crippen, for your extensive testimony and particularly for your dwelling on the difficult issue of what actually affects the national cost of a national prescription drug program.

STATEMENT OF DAN L. CRIPPEN, PH.D., DIRECTOR, CONGRESSIONAL BUDGET OFFICE

Dr. CRIPPEN. Thank you, Madam Chairman, and Members of the Subcommittee.

I hope today to describe some of the issues affecting the design of a Medicare prescription drug benefit and to give you some notion of what relative changes might do to the cost and the effect of such a benefit. But first, I think I would be remiss if I did not spend at least 30 seconds on the context in which we are having this debate. The annual report released last week by the Medicare Board of Trustees indicates that the Hospital Insurance (HI) trust fund's expenses will exceed its dedicated, noninterest revenues beginning in 2016. We actually believe it will be sooner, as soon as 2011, perhaps.

And that is actually the good news. The bad news is that the retirement of the baby boomers between 2010 and 2020 will almost double Medicare's enrollment, while the number of workers will only increase by 15 percent. The cost per beneficiary will also continue to grow faster than the economy, and as a result, Medicare will consume an ever-increasing share of gross domestic product (GDP).

It is important to keep in mind that Medicare is only one of the Federal programs that transfers resources from the working population to the retired and disabled. This poster, which you have all seen before, illustrates what the near future might look like if we take no action (chart 1). Just these three Federal programs—Medicare, Medicaid, and Social Security—will grow from 7 percent of GDP to 15 percent of GDP by the time the baby-boom generation is finished retiring in 2030, and their spending will constitute nearly three-quarters of Federal spending as we now know it.

And then, there is "worse" news. In recent years, growth in prescription drug spending has far outpaced growth in spending for other types of health care. Even without a Medicare drug benefit, the Congressional Budget Office (CBO) expects prescription drug costs for the elderly to grow at an average annual rate of over 10 percent per person—twice the pace of Medicare's growth and much faster than the growth of the economy—ultimately costing $1.5 trillion over the next 10 years.

In 1997, about one-third of the Medicare population had no prescription drug coverage, but nearly 70 percent had it. The next chart illustrates the distribution of spending for all prescription drugs for Medicare in 1997 (chart 2). The single largest component is out-of-pocket payments at 45 percent, which compares with out-of-pocket costs of about 39 percent for the total population. The second largest source of funding is employer-sponsored retiree health benefits, and the third largest is Medicaid. I should note that State-based programs, which covered 5 percent of the total in 1997, have been growing rapidly in both number and coverage and probably contribute a larger share today.

Madam Chairman, virtually any Medicare drug benefit will move a significant share of this non-Federal, mostly private funding to the Federal budget, reducing and replacing State funding, employer contributions, and other sources of current funding. I have a few examples for the Committee today of the comparative mag-

nitudes of some of the many parameters in a prescription drug benefit. For that purpose, we have constructed a prototypical benefit, a straw man, if you will, as a basis for comparison in making these changes. That base case is not the same as any of the existing proposals that you or we have seen before, and we present numbers for only 1 year, assuming that the benefit in that year is fully phased in.

Conceptually, there are at least 6 steps we must go through in developing the specifications of a proposal for covering the prescription drug costs of Medicare beneficiaries. First, a proposal has to specify the rules for joining the program. Is the program voluntary or mandatory? If voluntary, is it a one-time election? These rules, combined with the attractiveness of the benefit and premium, will determine whether all or only some Medicare beneficiaries participate. For the purposes of our exercise today, we assume that all part B beneficiaries enroll in the drug benefit and cannot disenroll in the future.

Second, the proposal needs to specify what part of drug spending by or on behalf of the participants is excluded from coverage, such as initial deductibles or amounts in excess of a benefit cap. In our base case, there are no exclusions, no deductibles, no benefit cap, and no "hole" in the benefit.

Third, a proposal should specify the share of covered spending that is paid by beneficiaries through cost sharing. Our prototype includes 50 percent coinsurance, up to the catastrophic cap.

Fourth, a proposal should specify the share of benefit payments that will be funded by beneficiaries' premiums and the remainder, which, is paid for by Federal taxpayers in the form of general revenues. The base case today assumes that beneficiaries will pay for 50 percent of the program's benefits.

Fifth, a proposal should specify what, if any, subsidy will be provided to low-income beneficiaries and under what rules. This, as the Committee is aware, is an exceedingly complex area with complicated interactions between Medicaid and any new Medicare drug benefit. Our base case assumes full Federal coverage of premiums and cost sharing for anyone with income of less than 135 percent of the poverty level and some subsidy for the premiums of beneficiaries with income up to 150 percent of the poverty level.

Finally, Madam Chairman, a proposal should specify the rules for administering the benefit, such as the use of pharmacy benefit managers (PBMs); the level and nature of competition, constraints applying to cost controls on beneficiaries, and so on. Our prototype assumes the use of one PBM with some restrictions on cost controls.

Members of the Committee, this series of posters, of which you have copies, is an attempt to depict some of these moving parts in a way we hope is helpful. The first is the base case I have just described (chart 3). As depicted, the beneficiary pays 50 percent of the cost of each prescription filled until his or her cost-sharing expenses reach the stop-loss amount. Note that this cost sharing need not necessarily be paid directly by beneficiaries; it could be paid by third parties.

Above the stop-loss amount, the costs of the benefit are split between beneficiaries, who pay half the cost through premiums, and

Federal taxpayers. In addition, low-income beneficiaries receive subsidies, as I have described. In this case, the total cost to taxpayers is approximately $32 billion—$26 billion for the Medicare benefit and $6 billion for low-income subsidies. Beneficiaries who purchased drugs would pay (or have paid on their behalf by third parties) $57 billion in copayments; premiums from all enrollees, whether or not they filled any prescriptions, would total $26 billion.

The first variation on the base case that we have made is the addition of a $250 deductible (chart 4). As you would expect, that change lowers taxpayers' costs, in this case by $2 billion, and raises beneficiaries' cost exposure by a similar amount. That is Case A, the $250 deductible. Case B takes the base case again and, with no deductible, simply raises the catastrophic ceiling from $4,000 to $6,000 (chart 5). Taxpayers' costs in this case are reduced by about $1 billion from the base case, and beneficiaries' or third parties' costs are increased by a similar amount.

The third variant on the theme here, Case C, again takes the base case and adds a benefit cap of $2,500 in drug spending (chart 6). The cap is well below the catastrophic ceiling of $4,000, creating a hole in the benefit design similar to that in many of the proposals that the Committee considered last year. Again, the taxpayers' share drops, while the beneficiaries' exposure increases.

Our final poster depicts all of the previous changes applied to our prototype benefit: a $250 deductible, a benefit maximum of $2,500, and a $6,000 catastrophic cap (chart 7). Not surprisingly, the changes produce a more dramatic shift from taxpayers to beneficiaries. Perhaps in this case what is more important are the shifts within the two categories. The Federal share includes more low-income subsidies and much less indirect Medicare costs. The total cost exposure for beneficiaries is not only increased in this case by $12 billion but the relative contributions shift: Cost sharing by those who use drugs makes up a bigger share and premiums paid by all Medicare recipients a smaller share. In fact, the shift is so strong that this case has the lowest monthly premium of the four variants we present today.

Madam Chairman, there are more variations on these themes in my written statement, and these themes, or policy levers, cover only the basics. There are a myriad of details that can have significant effects on our estimates. As a result, none of the numbers we show here should be taken too literally. They are meant to be illustrative, to show the relative effects of these options and variations.

Let me conclude by returning to the amount currently spent on outpatient prescription drugs by the elderly—in a content of no Medicare benefit. That amount makes it obvious that it will be costly to provide a generous benefit to all beneficiaries. Either enrollees' costs or taxpayers' costs will be high.

Over the period 2002 to 2011, CBO estimates that about $1.5 trillion will be spent on prescription drugs for the elderly. Thus, a rough cut of a drug benefit that covered 50 percent of current drug spending would suggest a gross cost, before netting out any premiums, of at least $728 billion through 2011. If, instead, all costs above $1,000 a year were covered for all beneficiaries, gross costs through 2011 would be $1.1 trillion. If only costs above $5,000 a

year were covered, gross costs through 2011 would be at least $365 billion.

Madam Chairman, just as we are currently paying for much of our Medicare's benefits for our parents and grandparents through payroll and income taxes, our children and grandchildren will pay for us after we retire. Adding a drug benefit would significantly increase Medicare's costs, and, unless it was financed largely by enrollees, the burden on our children would be even greater.

I look forward to answering your questions.

[The prepared statement of Dr. Crippen follows:]

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

Madam Chairman and Members of the Committee, I am pleased to be here today to discuss some of the major issues affecting the design of an outpatient prescription drug benefit for Medicare beneficiaries. Those design issues present some difficult choices among desirable, but potentially conflicting, objectives and need to be considered in the context of the growing financial pressures facing the Medicare program.

FINANCIAL PRESSURES FACING THE MEDICARE PROGRAM

The growth of Medicare spending has been much slower in the past few years than it has been historically. In fiscal years 1998 through 2001, the Congressional Budget Office (CBO) estimates that benefit payments will grow at an average annual rate of 3.4 percent, compared with 10.0 percent per year over the previous decade.

CBO further estimates that Medicare will spend $237 billion on benefits for 40 million elderly and disabled people in fiscal year 2001. Despite the recent slowdown in spending growth, that amount is almost 25 percent more than Medicare spent five years ago. The program now accounts for about 12 percent of estimated total federal spending, or 2.3 percent of gross domestic product (GDP).

Moreover, CBO is projecting faster Medicare growth over the next decade. We estimate that Medicare spending will more than double—reaching $491 billion—by fiscal year 2011, reflecting an average increase of 7.7 percent per year (see Figure 1). At that rate, Medicare spending in 2011 will constitute 19 percent of the federal budget, assuming that no change occurs in current tax and spending policies. In fact, the program will account for 36 percent of the projected increase in federal spending by the end of the decade.

The Medicare trustees' report that was released last week projects that total Medicare spending will increase substantially in the long run, rising from 2.2 percent of GDP in 2000 to 8.5 percent in 2075. In addition, the difference between projected total Medicare spending and total federal revenues specifically dedicated to the program is expected to grow substantially. Sources of those dedicated revenues include the Medicare payroll tax, the portion of the income taxes on Social Security benefits that is paid to the Hospital Insurance (HI) trust fund (Part A of Medicare), and premiums paid by enrollees for Supplementary Medical Insurance (SMI, or Part B of Medicare). According to the Medicare trustees, the discrepancy between total Medicare expenditures and dedicated revenues will be $64.0 billion in 2001, or 0.6 percent of GDP (see Figure 2). By 2075, that gap is projected to grow to 6.0 percent of GDP. The growing difference between spending and dedicated revenues indicates the Medicare program's increasing dependence on general revenues to pay its bills.

These financial pressures have focused policymakers' attention on restructuring the Medicare program. There are two potentially conflicting considerations:

- First, Medicare spending is expected to grow at a rapid rate, making the program increasingly dependent on general revenues and, ultimately, unsustainable in its present form.
- Second, Medicare does not provide the protection offered by most private insurance, since it lacks a stop-loss provision and coverage for prescription drugs.

PROVIDING MEDICARE BENEFICIARIES WITH COVERAGE FOR PRESCRIPTION DRUGS

Modernizing Medicare's benefit package by adding a prescription drug benefit could close a significant gap in program coverage but only at a sizable cost to the federal government or to enrollees.

Beneficiaries' Current Spending on Prescription Drugs

In recent years, growth in prescription drug spending has far outpaced growth in spending for other types of health care. Those rising expenditures have had a significant impact not only on Medicare beneficiaries but on employers who offer retiree health coverage and on state governments as well.

Between 1990 and 2000, annual spending on prescription drugs in the United States grew at nearly twice the rate as that for total national health expenditures, and it has maintained a double-digit pace since the mid-1990s. For the U.S. population as a whole, three factors explain most of that growth: the introduction of new and costlier drug treatments, broader use of prescription drugs by a larger number of people, and lower cost-sharing requirements by private health plans. Within some therapeutic classes, new brand-name drugs tend to be much costlier than older drug therapies, which has also contributed to growth in spending. Use of prescription drugs has broadened as well, because many new drugs provide better treatment or have fewer side effects than older alternatives and more people are aware of new drug therapies through the "direct to consumer" advertising campaigns of pharmaceutical manufacturers.

Even without a Medicare drug benefit, CBO expects prescription drug costs for Medicare enrollees to grow at a rapid pace over the next decade (see Table 1). At an average annual rate of 10.3 percent per beneficiary, drug costs are expected to rise at nearly twice the pace of combined costs for Medicare's HI and SMI programs, and much faster than growth in the nation's economy. (CBO's estimates of rising drug spending are based on the latest projections for prescription drug costs within the national health accounts.)

CBO's baseline estimate of prescription drug costs for Medicare enrollees is up significantly over last year because of higher projections of the rate of growth in per capita drug costs. Last year's analysis indicated that spending by Medicare enrollees on outpatient drugs not covered by Medicare would total $1.1 trillion over the period 2001 through 2010 (see Table 2). This year, our projection for the same period is $1.3 trillion, or about 18 percent higher.

Our estimate for 2002 through 2011, the current 10-year projection period, is roughly $1.5 trillion—which is about 32 percent higher than last year's projection for 2001 through 2010. The jump results from assuming a higher growth rate and replacing an early low-cost year (2001) with a late high-cost year (2011).

Those changes to CBO's baseline estimate—higher per capita drug spending and the inclusion of a new high-cost year in the projection window—imply that proposals for a prescription drug benefit will have a higher price tag than they did last year. But for any given proposal, the exact magnitude of the difference between CBO's estimate for last year and its estimate for this year will also depend on the bill's specific features.

Existing Coverage

While third-party coverage for prescription drugs has become more generous over time for the population as a whole, that trend is less clear for Medicare beneficiaries. In 1997, nearly one-third of the Medicare population had no prescription drug coverage. On average, Medicare beneficiaries paid about 45 percent of their drug expenditures out of pocket (see Figure 3). By comparison, all people in the United States paid an average of 39 percent of the cost of their prescriptions. Because Medicare beneficiaries are elderly or disabled, they are more likely to have chronic health conditions and use more prescription drugs: nearly 89 percent filled at least one prescription in 1997. Medicare beneficiaries made up 14 percent of the population that year, yet they accounted for about 40 percent of the $75 billion spent on prescription drugs in the United States.

Those factors suggest that growth in drug spending has a larger financial impact on the Medicare population than on other population groups. However, aggregate statistics mask a wide variety of personal circumstances. Nearly 70 percent of beneficiaries obtain drug coverage as part of a plan that supplements Medicare's benefits, but those supplemental plans vary significantly in their generosity.

Traditionally, retiree health plans have provided prescription drug coverage to more seniors than any other source, and their benefits have been relatively generous. In 1997, about one-third of Medicare beneficiaries had supplemental coverage through a current or former employer, and most of those plans provided drug coverage (see Table 3). Although specific benefits vary, it is common to find relatively low deductibles and copayments in employer-sponsored drug plans.

However, because prescription drug spending by elderly retirees has become a significant cost to employers, many have begun to restructure their benefits. For example, a 1997 Hewitt Associates' study for the Kaiser Family Foundation found that among large employers, drug spending for people age 65 or older made up 40 per-

cent to 60 percent of the total cost of their retiree health plans. Average utilization of prescription drugs among elderly retirees was more than double that for active workers. Although relatively few employers in the Hewitt survey have dropped retiree coverage altogether, most have taken steps to control costs, such as tightening eligibility standards, requiring retirees to contribute more toward premiums, placing caps on the amount of benefits that plans will cover, and encouraging elderly beneficiaries to enroll in managed care plans.

Medicare+Choice (M+C) plans are another means by which the elderly and disabled have obtained prescription drug coverage. In 2000, for example, 64 percent of Medicare beneficiaries had access to M+C plans that offered some drug coverage, although a significantly smaller fraction of elderly people signed up for those plans. Many M+C plans have scaled back their drug benefits in response to rising costs and slower growth in Medicare's payment rates. Nearly all such plans have annual caps on drug benefits for enrollees—many at a level of only $500 per year—and a growing share of plans charge a premium for supplemental benefits.

While 26 percent of the Medicare population relied on individually purchased (often medigap) plans as their sole form of supplemental coverage in 1997, less than half of that group had policies that covered prescription drugs. Medigap plans with drug coverage tend to be much less generous than retiree health plans; medigap plans have a deductible of $250, 50 percent coinsurance, and annual benefit limits of either $1,250 or $3,000. Premiums for plans that include drug coverage also tend to be much higher than premiums for other medigap plans, due in part to their tendency to attract enrollees who have higher-than-average health expenses.

Certain low-income Medicare beneficiaries also may be eligible for Medicaid coverage, which generally includes a prescription drug benefit. All state Medicaid programs offer prescription drug coverage (usually involving little or no cost sharing) to people whose income and assets fall below certain thresholds. In addition, as of January 2001, 26 states had authorized (but had not necessarily yet implemented) some type of pharmaceutical assistance program, most of which would provide direct aid for purchases to low-income seniors who did not meet the Medicaid requirements. About 64 percent of the Medicare population lives in those states.

Thus, middle- and higher-income seniors can usually obtain coverage through retiree or M+C plans, while seniors with the lowest income generally have access to state-based drug benefit programs. However, beneficiaries with income between one and two times the poverty level are more likely to be caught in the middle, with income or asset levels that are too high to qualify for state programs and less access than higher-income enrollees to drug coverage through former employers.

Design Choices for a Medicare Drug Benefit

A Medicare drug benefit might address a number of objectives. The most fundamental would be to ensure that all beneficiaries had access to reasonable coverage for outpatient prescription drug costs—but this fundamental notion allows for considerable debate about what that would mean. The various objectives that might be thought desirable in the abstract are often mutually incompatible; as a result, difficult choices must be made. For example, it is not possible to provide a generous drug benefit to all Medicare beneficiaries at low cost—either enrollees' premiums or the government's subsidy costs would be high. If most of the costs were paid by enrollees' premiums to keep federal costs low, some Medicare beneficiaries would be unwilling or unable to participate in the program. If costs were limited by covering only catastrophic expenses, few enrollees would benefit in any given year, possibly reducing support for the program. If, instead, costs were limited by capping the annual benefits paid to each enrollee, the program would fail to protect participants from the impact of catastrophic expenses.

In designing a drug benefit, policymakers must make four fundamental decisions:

- Who may participate?
- How will program costs be financed?
- How comprehensive will coverage be?
- Who will administer the benefit and under what conditions?

Participation.—Although most Medicare enrollees use some prescription drugs, the bulk of such spending is concentrated among a much smaller group. In 1997, about 13 percent of enrollees had expenditures of $2,000 or more, accounting for 45 percent of total drug spending by the Medicare population. Forty-six percent had expenditures of $500 or less, making up about 8 percent of total spending. Most spending is associated with treatment of chronic conditions—such as hypertension, cardiovascular disease, and diabetes. The skewed distribution of spending and the need for people with chronic conditions to stay on drug therapies over the long term makes stand-alone drug coverage particularly susceptible to adverse selection,

where enrollment is concentrated among those who expect to receive more in benefits than they would pay in premiums.

Because of the likelihood of adverse selection, a premium-financed drug benefit offered as a voluntary option for Medicare enrollees must restrict participation in some way. If Medicare beneficiaries were free to enroll in or leave the program at will, only those who expected to gain from the benefit would participate each year. That would drive premiums up, which would further reduce enrollment as enrollees with below-average drug costs dropped out.

Most of the drug benefit proposals developed in 2000 would have provided a voluntary drug option, but they attempted to mitigate the potential for adverse selection by one of two approaches: either they gave enrollees only one opportunity to choose the drug benefit at the time enrollees first became eligible, or they imposed an actuarially fair surcharge on premiums for those who delayed enrollment. Another approach to avoiding the problem of adverse selection would be to couple the drug benefit with Part B of Medicare, so that enrollees could choose either Part B plus a drug benefit or no Part B and no drug benefit. In that case, even if the drug portion of the benefit was not heavily subsidized, the current 75 percent subsidy of Part B benefits would ensure nearly universal participation in the coupled benefit.

Financing.—Program costs could be entirely financed by enrollees' premiums, or some or all of the costs could be paid by the federal government. Given a one-time-only enrollment option, participation rates would be reasonably high, even if the program was largely financed by enrollees' premiums. If enrollees lived long enough, virtually all of them would benefit from drug coverage, and the erosion now occurring in the comprehensive coverage provided by private plans would also spur participation. Further, employer-sponsored health plans would probably require that retirees eligible for a new Medicare drug benefit if their costs under the new program were less than the cost of the drug benefits now provided under Medicaid. However, if a generous drug benefit was fully financed by enrollees, premiums would be high, making the benefit difficult to afford for lower-income beneficiaries ineligible for Medicaid. The drug proposals developed last year all provided full subsidies to low-income people for both cost-sharing and premium expenses, in addition to partially subsidizing premium costs for all other enrollees.

Coverage.—A Medicare drug benefit could be designed to look like the benefit typically provided by employer-sponsored plans. If so, it would be integrated with the rest of the Medicare benefit. Further, it would have low cost-sharing requirements (ranging from 20 percent to 25 percent coinsurance or a copayment per prescription of $10 to $25) and stop-loss protection—a dollar limit above which no cost sharing would be required. Such comprehensive coverage would provide good protection for enrollees, but it would be very costly. Not only would it transfer most of the costs of drugs currently used by enrollees to the Medicare program, but it would also increase utilization among those who now have less generous coverage.

One way to constrain costs and utilization is by limiting coverage—covering only catastrophic costs, for example, or imposing a cap on benefits paid per enrollee each year. If Medicare provided coverage only for catastrophic costs, most enrollees would receive no benefit payments in any given year. Nevertheless, it would be inaccurate to say that those enrollees would receive no benefit, since they would be protected against the possibility of catastrophic expenses—the main function of insurance. Public support for a drug benefit might be stronger, though, if most enrollees could reasonably expect to receive some benefit payments each year.

Alternatively, policymakers could take the other approach to limiting costs: covering a portion of all drug costs but only up to a benefit cap. However, because that approach would not protect those enrollees who were most in need, most of last year's proposals included stop-loss protection. The end result was a benefit unlike anything available in the private sector—a hybrid that had a capped benefit, then a "hole" with no drug coverage, and finally a stop-loss provision, beyond which the program would pay all drug costs (see Figure 4). The larger the range of spending encompassed by the hole, the less costly the program would be—but also the less coverage the benefit would provide.

An approach to limiting costs within the context of a more traditional benefit would be to have a higher initial deductible amount, relatively high cost-sharing requirements, and a high stop-loss threshold. Or the program could provide a more generous benefit similar to those provided by employer-sponsored plans, with federal costs limited by financing most of the program's costs through enrollees' premiums.

Administration.—The way in which a drug benefit is administered can also have a significant effect on how costly it is. All recent proposals have envisioned adopting the now common private-sector approach of using pharmacy benefit managers (PBMs) in each region. Proposals have differed, however, in whether only one or several PBMs would serve a region, in whether the responsible entities would as-

sume any insurance risk, and in the kind of restrictions that would be placed on them.

Private health plans use PBMs to process claims and negotiate price discounts with drug manufacturers and dispensing pharmacies. PBMs also try to steer beneficiaries toward lower-cost drugs, such as generic, preferred formulary, or mail-order drugs. In addition, because of their centralized records for each enrollee's prescriptions, they can help prevent adverse drug interactions. The likelihood that PBMs could effectively constrain costs depends on their having both the authority and the incentive to aggressively use the various cost-control mechanisms at their disposal. In the private sector, PBMs often have considerable leeway in the tools they can use, but they do not assume any insurance risk for the drug benefit. At most, they may be subject to a bonus or a penalty added to their administrative fee, based on how well they meet prespecified goals for their performance.

Some of the proposals developed last year (such as the one developed by the Clinton Administration) adopted the typical private-sector model, with a single PBM selected periodically to serve each region and with all insurance risk borne by Medicare, not the PBM. There are two main concerns about that model: it might prove politically difficult to allow the designated PBMs to use cost-control tools aggressively if enrollees have no choice of provider in each region, and non-risk-bearing PBMs might have too little incentive to use strong tools, even if they were permitted.

Other proposals (such as the Breaux-Frist bills and the House-passed drug bill) adopted a different model, more akin to the risk-based competitive model characteristic of Medicare+Choice plans. Those proposals envisioned multiple risk-bearing entities (such as PBM/insurer partners) that would compete to serve enrollees in each region. Enrollees would have some choice among providers, so that beneficiaries who were willing to accept more-restrictive rules (such as a closed formulary) in return for lower premium costs could do so, while others could select a more expensive provider with fewer restrictions. If the entities bore all of the insurance risk for the drug benefit, they would have strong incentives to use whatever cost-control tools were permitted. However, they would also have strong incentives to try to achieve favorable selection by avoiding enrollees most in need of coverage.

One of the concerns raised about this model was that no entities might be willing to participate if they had to assume the full insurance risk for a stand-alone drug benefit. To mitigate that concern, the proposals included federally provided reinsurance for high-cost enrollees. (Reinsurance means that the federal government shares part or all of the costs of high-cost enrollees.) However, reinsurance would tend to weaken the plans' incentives to control costs. Another concern was that differences among plans in benefit structures or strategies for cost control could result in some plans attracting low-cost enrollees and others attracting more costly enrollees. The risk of that kind of selection would lead plans to raise the cost of the benefit. Moreover, to avoid such risks, plans would, over time, come to offer very similar plan designs.

The Cost of Covering Prescription Drugs for Medicare Enrollees

There are numerous design parameters that must be specified in developing a Medicare prescription drug benefit, and decisions concerning those parameters can greatly affect the benefit's cost to the taxpayer and to the beneficiary. CBO has not finished updating its estimates for several of the proposals developed in the last session of the 106th Congress. We can, however, provide some examples that show how costs would be affected by varying certain aspects of the benefit's design.

The estimates that follow are approximate and subject to change; the cost of a detailed proposal would vary depending on its precise specifications. The estimates are for 2004 only.

Base Case.—For purposes of this testimony, the base case is a benefit that provides coverage for all of the outpatient drug costs of Medicare enrollees (see Table 4). The enrollee would be responsible for coinsurance equal to 50 percent of the cost of prescription drugs up to $8,000 of spending. The new benefit would cover the entire cost of drugs above that amount. Thus, the enrollee would be liable for up to $4,000 in out-of-pocket spending before reaching the stop-loss amount.

To pay for this program, enrollees would be charged a monthly premium designed to cover 50 percent of the cost of the benefit. The federal government would pay for the other 50 percent. We assume that a subsidy of that size would be sufficient to ensure that all enrollees in Medicare Part B would participate in the prescription drug program.

Low-income enrollees would receive a subsidy to enable them to participate in the Medicare drug program. Enrollees with income up to 135 percent of the federal poverty level would receive a full subsidy of premiums and cost-sharing amounts. Those

with income between 135 percent and 150 percent of the poverty level would receive a premium subsidy (on a sliding scale that declined with income) but would be responsible for any cost sharing. States and the federal government would share in those subsidy costs for enrollees with income of less than 100 percent of the poverty level and for those who were dually eligible for Medicare and Medicaid.

The base case also assumes that a single PBM would administer the program in each region, with all insurance risk borne by Medicare. The cases presented in this testimony do not consider the other major alternative for delivering a Medicare drug benefit: instead of a single PBM, the program could be operated through multiple risk-bearing entities who would compete for enrollees. Competing PBM/insurer partners who bore insurance risk would have a strong incentive to use such tools as restrictive formularies and three-tier copayment structures to aggressively manage costs. However, they would also incur certain "load" costs—such as marketing expenses to attract enrollees and a premium for accepting insurance risk—that a single PBM would not. The net impact on program costs would depend on the specific details of the proposal.

The benefit design assumed for the base case would cost the federal government about $31.6 billion in 2004. The Medicare benefit portion of that total is $26.0 billion, and the low-income subsidy (and interactions with the Medicaid program) account for the remaining $5.5 billion (see Table 5). As we will see in comparisons with other cases, a less generous drug benefit would decrease Medicare costs but increase the cost of the low-income subsidy.

In the aggregate, enrollees would pay a total of $26.0 billion in premiums, reflecting a $55.50 monthly premium that they would pay under the base case plan. That total includes premiums that are paid by Medicaid on behalf of low-income enrollees. In addition, enrollees would face about $57 billion in cost sharing for the prescription drugs that they used. Again, that amount includes some cost sharing that would be picked up by supplemental payers, including employer-sponsored insurance and medigap plans. As we will demonstrate below, a less generous benefit would lower premiums but raise the amount of cost sharing paid by enrollees.

Federal costs could be reduced by imposing more cost sharing on enrollees or by varying other aspects of the design. The following discussion of alternative cases examines how the costs imposed on taxpayers and beneficiaries would change if one or more features of the program are varied.

Change Beneficiaries' Cost Sharing.—The overall federal cost of a prescription drug proposal would fall if beneficiaries were responsible for a greater share of program costs. Higher cost sharing would, of course, increase the cost of the low-income subsidy.

Case 1–A is identical to the base case except for a $250 annual deductible. Nearly 89 percent of enrollees have some prescription drug spending during the year and would thus be liable for at least part of the deductible. Including a deductible would lower Medicare costs but raise low-income costs compared with the base case. On balance, the federal cost of the program would fall to $29.6 billion in 2004, and monthly premiums would decline to $50.90. Beneficiaries who had more than $250 in drug spending that year would face higher costs under this option because the added cost of the deductible would be only partly offset by the reduced premium.

An even higher deductible would further reduce program costs. Case 1–B imposes a $500 deductible on the base case, and the federal cost drops to $28.0 billion in 2004. Doubling the deductible amount from Case 1–A does not double savings from the base case, however, because some enrollees who would pay the full $250 deductible would spend less than $500 on drugs in a year and thus would not pay the full amount of the higher deductible.

Lowering the coinsurance rate could alter program costs dramatically. The base case assumes a 50 percent coinsurance rate, while Case 1–C lowers that rate to 25 percent. That adjustment increases the program's net federal cost by one-third, to $42.0 billion in 2004. Medicare's cost would increase to $37.8 billion, while the low-income subsidy would fall to $4.3 billion.

The lower coinsurance would drive premiums upward as program costs rose. Premiums would increase by nearly half, to $80.70 monthly. In the aggregate, beneficiaries would pay about $38 billion in premiums. However, aggregate cost sharing would decline precipitously as well, to just over $30 billion. While all enrollees would face the higher premiums, the lower coinsurance rate would primarily benefit enrollees with significant drug costs.

Raise the Stop-Loss Amount.—The net federal program cost also could be reduced by raising the stop-loss amount, although the additional financial exposure would increase the cost of the low-income subsidy. Under the base case, the stop-loss amount is set at $4,000 paid out of pocket: a beneficiary who had used $8,000 in covered prescription drugs and paid 50 percent coinsurance would not be liable

for any additional costs incurred during the year. (Enrollees who spend more than $8,000 account for about 23 percent of total baseline spending in 2004.)

Case 2–A raises the stop-loss amount to $6,000 in out-of-pocket spending. That higher level is equivalent to total spending by an enrollee of $12,000, which will account for less than 10 percent of total baseline spending in 2004. Under this option, the federal cost of the program would fall to $30.7 billion, a reduction of 3 percent from the base case. The low-income subsidy rises to $5.8 billion compared with the base case. Total premiums fall to about $25 billion, and aggregate cost sharing jumps to almost $60 billion.

Raising the stop-loss amount by an additional $2,000—to $8,000—lowers program costs by less than the previous difference found in Case 2–A. The federal cost for Case 2–B is estimated to be $30.4 billion, or 4 percent lower than the base case.

Cap Benefits.—A third approach would place a limit on drug costs covered under the Medicare benefit. Case 3 would impose such a limit when the enrollee reached $2,500 in total drug spending. That is, the enrollee would receive up to $1,250 in reimbursement for drug expenses before reaching the benefit cap. Such a cap could be absolute, with no additional reimbursement for spending at any level above the cap. However, Case 3 keeps the same stop-loss provision as in the base case, so that the beneficiary faces no cost sharing beyond $8,000 in total charges. That structure leaves a "hole" in covered spending—a range of prescription drug spending for which most enrollees must pay all of their costs. (Individuals with income below 135 percent of the poverty level, whose cost sharing is fully subsidized, would be unaffected by this provision.)

Relative to the base case, the limit on coverage in Case 3 would lower Medicare costs but increase the low-income subsidy. The net federal cost would total approximately $28.1 billion in 2004. The option's benefit cap would also lower premiums to about $22 billion and raise aggregate cost sharing to about $66 billion. The lower premiums simply reflect the less generous benefits under Case 3, compared with the base case.

Combine Features.—The above options were designed to show how varying one parameter of a prescription drug benefit would affect program costs. This section looks at alternatives that combine several changes at the same time.

Case 4–A combines the base case with many of the features described above: a $250 deductible, benefits capped at $1,125 (after the enrollee reaches $2,500 in total drug spending), and stop-loss protection after the beneficiary spends $6,000 out of pocket. The costs of enrollees with income below 135 percent of the poverty level would be fully subsidized inside the benefit "hole."

Such a benefit would be significantly less generous than the base case, but the costs of financing it would be significantly lower as well. In 2004, federal costs would be approximately $23.4 billion, or about one-quarter less than the base case. Likewise, monthly premiums would fall from $55.50 under the base case to $35.20 under Case 4–A. That causes total premiums to drop to $16.5 billion, with a corresponding increase in aggregate cost sharing to $78.9 billion.

Case 4–B is identical to Case 4–A, except that low-income individuals would not be subsidized inside the benefit "hole." CBO estimates that in 2004, federal costs would total $21.4 billion. Nearly all of that savings comes from reductions in the cost of the low-income subsidy. Premiums would drop negligibly compared with Case 4–A.

Case 4–C extends the low-income subsidy to individuals with higher income than in previous cases. Specifically, it includes all of the features of Case 4–A but provides a full subsidy for premiums and cost sharing to enrollees who have income at or below 150 percent of the federal poverty level. Enrollees with income between 150 percent and 175 percent of the poverty level would receive a premium subsidy on a sliding scale. Medicare costs would remain roughly unchanged compared with Case 4–A, but the low-income subsidy would increase to $7.9 billion in 2004.

Increasing the federal subsidy for beneficiary premiums would substantially raise program costs. Case 4–D is identical to Case 4–A except that the federal subsidy is raised to 75 percent of premiums. That change increases Medicare costs by 50 percent compared with Case 4–A but lowers the cost of the low-income subsidy somewhat. The net federal cost would rise to over $30 billion in 2004. The sharp increase in Medicare costs is mirrored by the sharp drop in premiums, which fall from about $16 billion in Case 4–A to about $8 billion in Case 4–D.

Because we have assumed throughout this discussion that the federal subsidy would be at least 50 percent, the increase in Case 4–D does not yield an increase in participation by Medicare enrollees. However, if the federal subsidy declined below 50 percent, CBO assumes that enrollment would decline somewhat.

CONCLUSIONS

While policymakers are well aware of Medicare's long-run financial problems, they also know that its benefit package has deficiencies relative to the benefits typically provided by private-sector insurance plans. One such deficiency is that the program provides only very limited coverage for outpatient prescription drugs—an increasingly important component of modern medical care. But adding a drug benefit would significantly increase Medicare's costs, and unless it was fully financed by enrollees' premiums, it would exacerbate the imbalance between the program's projected spending and its dedicated revenues.

We are extremely unlikely to see a new drug benefit that has no adverse impact on Medicare's long-term financial status. But, as I have discussed today, there are important design features that could be built in to such a benefit to limit federal costs while providing important insurance protection for enrollees. In developing a realistic policy proposal, hard decisions must be made to establish the proper balance among competing objectives.

FIGURE 1. ANNUAL AVERAGE MEDICARE SPENDING GROWTH FOR VARIOUS PERIODS

TABLE 1. CBO'S BASELINE PROJECTIONS OF PRESCRIPTION DRUG SPENDING AND MEDICARE BENEFITS PER ENROLLEE, CALENDAR YEARS 2002-2011

	Spending per Enrollee (Dollars)		Average Annual Percentage Change, 2002-2011
	2002	2011	
Drug Spending[a]	1,989	4,818	10.3
Medicare Benefits[b]	6,512	10,538	5.5
Memorandum:			
Gross Domestic Product per Capita	39,275	56,569	4.1

SOURCE: Congressional Budget Office.

a. Total spending per enrollee on outpatient prescription drugs not currently covered under Medicare, regardless of payer.

b. Medicare benefits per enrollee under the Hospital Insurance and Supplementary Medical Insurance programs.

TABLE 2. COMPARING CBO'S JANUARY 2001 AND MARCH 2000 BASELINE PROJECTIONS OF PRESCRIPTION DRUG SPENDING
(By calendar year, in billions of dollars)

Year	January 2001 Estimates	March 2000 Estimates
2001	71	66
2002	81	74
2003	92	82
2004	104	91
2005	117	101
2006	131	112
2007	148	124
2008	165	137
2009	185	152
2010	205	167
2011	228	n.a.
Total		
2001-2010	1,299	1,105
2002-2011	1,456	n.a.
Memorandum:		
Percentage increase in total spending, January 2001 estimates over March 2000 estimates, for 10 years ending in 2010		17.6

SOURCE: Historical data from the Health Care Financing Administration and projections by the Congressional Budget Office.

FIGURE 2. PROJECTED MEDICARE OUTLAYS AND DEDICATED REVENUES AS A PERCENTAGE OF GDP, CALENDAR YEARS 2000–2075

Percentage increase in total spending, 10 years ending in 2011 (using January 2001 estimates) over 10 years ending in 2010 (using March 2000 estimates)	31.8

SOURCE: Congressional Budget Office.

NOTES: Numbers may not add up to totals because of rounding.
n.a. – not applicable.

TABLE 3. PRESCRIPTION DRUG COVERAGE AMONG MEDICARE ENROLLEES, BY TYPE OF SUPPLEMENTAL COVERAGE, CALENDAR YEAR 1997

	Number of Medicare Enrollees (Thousands)			Percentage of All Enrollees		
	No Drug Coverage	Drug Coverage	Total	No Drug Coverage	Drug Coverage	Total
No Supplemental Coverage	2,941	0	2,941	7.4	0	7.4
Any Medicaid Coverage[a]	1,448	5,449	6,897	3.6	13.7	17.4
Employer-Sponsored Plans	1,671	11,163	12,834	4.2	28.1	32.3
Individually Purchased Policies	5,753	4,532	10,286	14.5	11.4	25.9
Other Public Coverage[b]	0	1,396	1,396	0	3.5	3.5
HMOs Not Elsewhere Classified[c]	678	4,696	5,374	1.7	11.8	13.5
Total	12,491	27,236	39,728	31.4	68.6	100.0

SOURCE: Congressional Budget Office based on data from the 1997 Medicare Current Beneficiary Survey.

NOTES: Some beneficiaries hold several types of coverage at once. The categories in this table are mutually exclusive, and CBO assigned people to groups in the order shown above. The numbers in the table may not add up to totals because of rounding.

HMO = health maintenance organization.

a. Comprises beneficiaries who received any Medicaid benefits during the year, including those eligible for a state's full package of benefits as well as others who received assistance for Medicare premiums or cost sharing through the Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, and Qualifying Individual programs.

b. Beneficiaries who received aid for their drug spending through state-sponsored pharmacy assistance programs for low-income elderly make up 60 percent of this category. The remainder received prescription drug benefits through the Veterans Administration.

c. Primarily HMOs under Medicare+Choice risk contracts.

SOURCE: Board of Trustees, Federal Hospital Insurance Trust Fund (2001).

FIGURE 3. DISTRIBUTION OF DRUG SPENDING FOR MEDICARE ENROLLEES, BY PAYER, 1997

TABLE 4. OPTIONS FOR A PRESCRIPTION DRUG BENEFIT THROUGH MEDICARE IN 2004

Case	Description[a]	Federal Cost (Billions of dollars)	Beneficiaries' Monthly Premium (Dollars)
Base	Federal government pays 50 percent of premiums; no deductible is required; beneficiaries pay 50 percent coinsurance; stop-loss protection is provided after $4,000 in out-of-pocket spending	31.6	55.50
Option 1: Change Beneficiaries' Cost Sharing			
1-A	Require a $250 deductible	29.6	50.90
1-B	Require a $500 deductible	28.0	47.00
1-C	Reduce beneficiaries' coinsurance to 25 percent	42.0	80.70
Option 2: Increase the Stop-Loss Amount			
2-A	Raise the stop-loss amount to $6,000	30.7	53.10
2-B	Raise the stop-loss amount to $8,000	30.4	52.40
Option 3: Cap the Benefit			
3	Cap the benefit after $2,500 in total drug spending; provide stop-loss protection after $4,000 in out-of-pocket spending; subsidize low-income beneficiaries' spending in the "hole"	28.1	47.10
Option 4: Combinations			
4-A	Require a $250 deductible; cap benefits after $2,500 in total drug spending; provide stop-loss protection after $6,000 in out-of-pocket spending; subsidize low-income beneficiaries' spending in the "hole"	23.4	35.20
4-B	Require a $250 deductible; cap benefits after $2,500 in total drug spending; provide stop-loss protection after $6,000 in out-of-pocket spending; provide no subsidies for low-income beneficiaries' spending in the "hole"	21.4	35.00
4-C	Require a $250 deductible; cap benefits after $2,500 in total drug spending; provide stop-loss protection after $6,000 in out-of-pocket spending; subsidize some or all cost sharing in the "hole" for beneficiaries with income at or below 175 percent of the poverty level	24.4	35.20
4-D	Increase the share of premiums paid by the federal government to 75 percent; require a $250 deductible; cap benefits after $2,500 in total drug spending; provide stop-loss protection after $6,000 in out-of-pocket spending; subsidize low-income beneficiaries' spending in the "hole"	30.3	17.60

SOURCE: Congressional Budget Office.

a. The options represent changes relative to the base case. The "hole" is the range of prescription drug spending above the benefit cap and below the stop-loss amount. To "subsidize low-income beneficiaries' spending in the 'hole,'" the federal government and the states would provide aid through one of two approaches: beneficiaries with income at or below 135 percent of the poverty level could receive some or all cost sharing and premium assistance; and beneficiaries with income between 135 percent and 150 percent of the poverty level could receive premium assistance on a sliding scale.

SOURCE: Congressional Budget Office tabulations from the 1997 Medicare Current Beneficiary Survey. Drugs currently covered by Medicare are not included here.

FIGURE 4. POSSIBLE FEATURES OF A PRESCRIPTION DRUG INSURANCE BENEFIT

TABLE 5. APPROXIMATE COST OF ILLUSTRATIVE CASES IN CALENDAR YEAR 2004
(In billions of dollars)

	Federal Cost to Taxpayers			Payments by or for Beneficiaries		
Case[a]	Medicare	Net of Low-Income Subsidies and Medicaid	Total	Medicare Premiums	Cost Sharing	Total
Base	26.0	5.5	31.6	26.0	57.0	83.0
1-A	23.8	5.8	29.6	23.8	61.7	85.5
1-B	22.0	6.0	28.0	22.0	65.8	87.8
1-C	37.8	4.3	42.0	37.8	31.4	69.2
2-A	24.9	5.8	30.7	24.9	59.6	84.5
2-B	24.5	5.9	30.4	24.5	60.4	85.0
3	22.1	6.1	28.1	22.1	66.0	88.1
4-A	16.5	7.0	23.4	16.5	78.9	95.3
4-B	16.4	5.0	21.4	16.4	78.7	95.0
4-C	16.5	7.9	24.4	16.5	79.0	95.5
4-D	24.7	5.6	30.3	8.2	78.9	87.1

SOURCE: Congressional Budget Office.

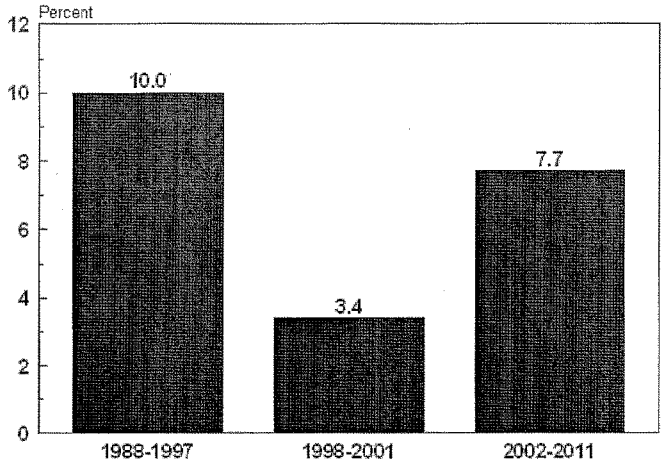
NOTE: Estimates assume that all costs are phased in fully by 2004. Numbers may not add up to totals because of rounding.

a. For descriptions of the illustrative cases, see Table 4.

SOURCE: Congressional Budget Office.

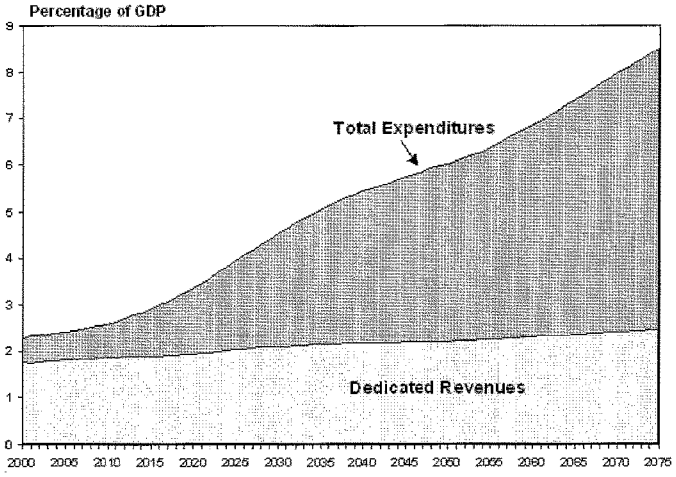
CHARTS PRESENTED AT THE HEARING

FIGURE 1. ANNUAL AVERAGE MEDICARE SPENDING GROWTH FOR VARIOUS PERIODS



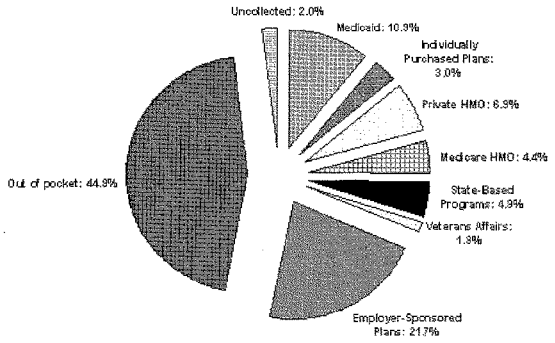
SOURCE: Historical data from the Health Care Financing Administration and projections by the Congressional Budget Office.

FIGURE 2. PROJECTED MEDICARE OUTLAYS AND DEDICATED REVENUES AS A PERCENTAGE OF GDP, CALENDAR YEARS 2000-2075



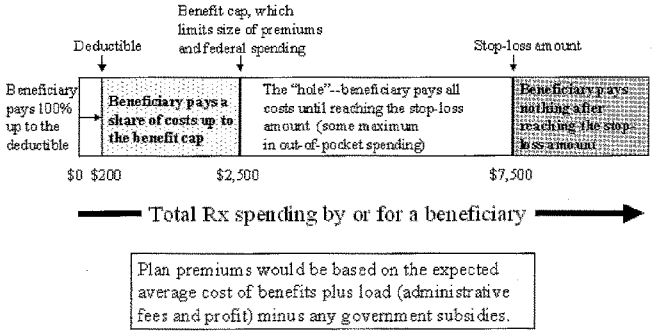
SOURCE: Board of Trustees, Federal Hospital Insurance Trust Fund (2001).

FIGURE 3. DISTRIBUTION OF DRUG SPENDING FOR MEDICARE ENROLLEES, BY PAYER, 1997



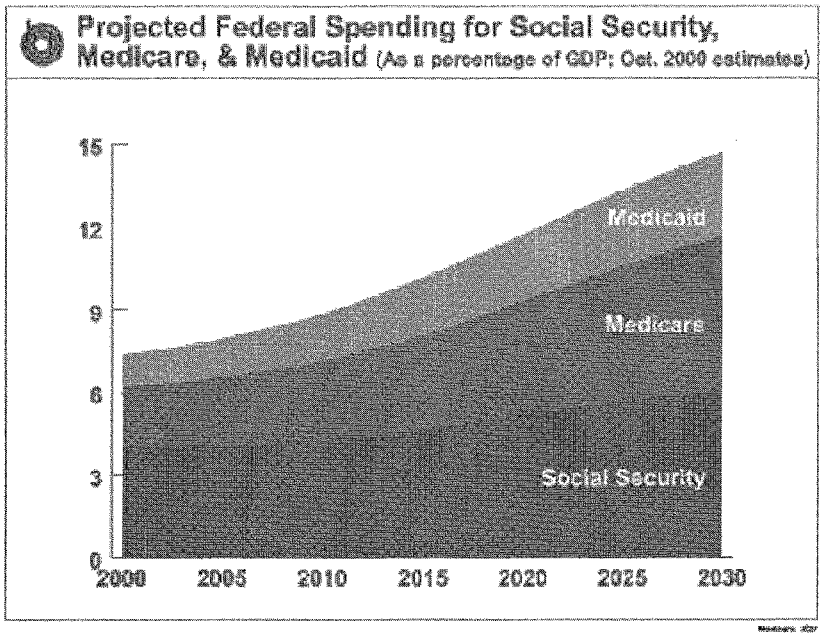
SOURCE: Congressional Budget Office tabulations from the 1997 Medicare Current Beneficiary Survey. Drugs currently covered by Medicare are not included here.

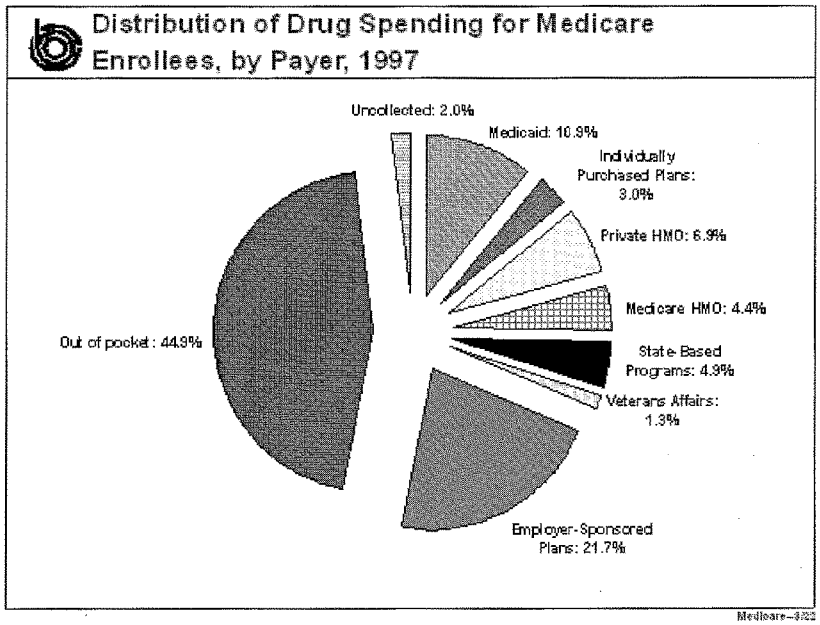
FIGURE 4. POSSIBLE FEATURES OF A PRESCRIPTION DRUG INSURANCE BENEFIT



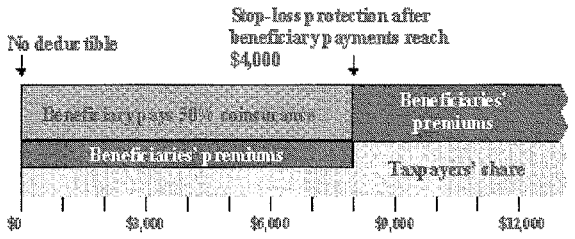
SOURCE: Congressional Budget Office.

CHARTS PRESENTED AT THE HEARING





Base Case



Cost to Federal Taxpayers in 2004: $31.6 billion

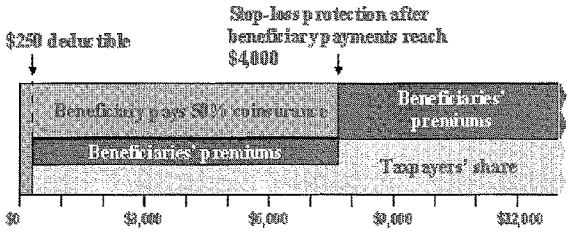
Medicare: $26.0 billion
Low-Income Subsidies/Medicaid: $5.5 billion

Other Payments by/for Beneficiaries: $83.0 billion

Medicare Premiums: $26.0 billion
Cost Sharing: $57.0 billion

Medicare–8/27

Case A



Cost to Federal Taxpayers in 2004: $29.6 billion

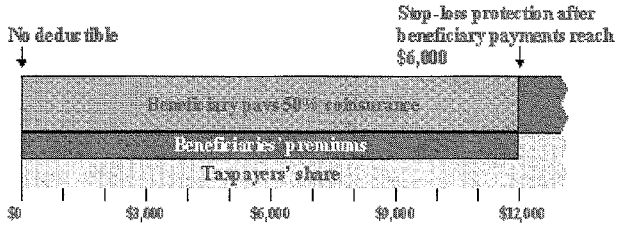
Medicare: $23.8 billion
Low-Income Subsidies/Medicaid: $5.8 billion

Other Payments by/for Beneficiaries: $85.5 billion

Medicare Premiums: $23.8 billion
Cost Sharing: $61.7 billion

Medicare–8/27

Case B



Cost to Federal Taxpayers in 2004: $30.7 billion

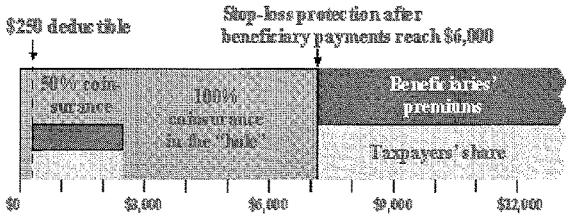
Medicare: $24.9 billion
Low-Income Subsidies/Medicaid: $5.8 billion

Other Payments by/for Beneficiaries: $84.5 billion

Medicare Premiums: $24.9 billion
Cost Sharing: $59.6 billion

Medicare–3/27

Case D



Cost to Federal Taxpayers in 2004: $23.4 billion

Medicare: $16.5 billion
Low-Income Subsidies/Medicaid: $7.0 billion

Other Payments by/for Beneficiaries: $95.3 billion

Medicare Premiums: $16.5 billion
Cost Sharing: $78.9 billion

Medicare–3/27

TABLE 1.—CBO'S BASELINE PROJECTIONS OF PRESCRIPTION DRUG SPENDING AND MEDICARE BENEFITS PER ENROLLEE, CALENDAR YEARS 2002–2011

[In dollars]

	Spending per Enrollee		Average Annual Percentage Change 2002–2011
	2002	2011	
Drug Spending[a]	1,989	4,818	10.3
Medicare Benefits[b]	6,512	10,538	5.5
Memorandum:			
Gross Domestic Product per Capita	39,275	56,569	4.1

[a] Total spending per enrollee on outpatient prescription drugs not currently covered under Medicare, regardless of payer.
[b] Medicare benefits per enrollee under the Hospital Insurance and Supplementary Medical Insurance programs.
Source: Congressional Budget Office.

TABLE 2.—COMPARING CBO'S JANUARY 2001 AND MARCH 2000 BASELINE PROJECTIONS OF PRESCRIPTION DRUG SPENDING

[By calendar year, in billions of dollars]

Year	January 2001 Estimates	March 2000 Estimates
2001	71	66
2002	81	74
2003	92	82
2004	104	91
2005	117	101
2006	131	112
2007	148	124
2008	165	137
2009	185	152
2010	205	167
2011	228	n.a.
Total:		
2001–2010	1,299	1,105
2002–2011	1,456	n.a.
Memorandum:		
Percentage increase in total spending, January 2001 estimates over March 2000 estimates, for 10 years ending in 2010	.....	17.6
Percentage increase in total spending, 10 years ending in 2011 (using January 2001 estimates) over 10 years ending in 2010 (using March 2000 estimates)	.....	31.8

Source: Congressional Budget Office.
Notes: Numbers may not add up to totals because of rounding.
n.a. = not applicable.

TABLE 3.—PRESCRIPTION DRUG COVERAGE AMONG MEDICARE ENROLLEES, BY TYPE OF SUPPLEMENTAL COVERAGE, CALENDAR YEAR 1997

	Number of Medicare Enrollees (Thousands)			Percentage of All Enrollees		
	No Drug Coverage	Drug Coverage	Total	No Drug Coverage	Drug Coverage	Total
No Supplemental Coverage	2,941	0	2,941	7.4	0	7.4
Any Medicaid Coverage[a]	1,448	5,449	6,897	3.6	13.7	17.4
Employer-Sponsored Plans	1,671	11,163	12,834	4.2	28.1	32.3
Individually Purchased Policies	5,753	4,532	10,286	14.5	11.4	25.9
Other Public Coverage[b]	0	1,396	1,396	0	3.5	3.5
HMOs Not Elsewhere Classified[c]	678	4,696	5,374	1.7	11.8	13.5
Total	12,491	27,236	39,728	31.4	68.6	100.0

[a] Comprises beneficiaries who received any Medicaid benefits during the year, including those eligible for a state's full package of benefits as well as others who received assistance for Medicare premiums or cost sharing through the Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, and Qualifying Individual programs.

[b] Beneficiaries who received aid for their drug spending through state-sponsored pharmacy assistance programs for low-income elderly make up 60 percent of this category. The remainder received prescription drug benefits through the Veterans Administration.

[c] Primarily HMOs under Medicare+Choice risk contracts.

Source: Congressional Budget Office based on data from the 1997 Medicare Current Beneficiary Survey.

Notes: Some beneficiaries hold several types of coverage at once. The categories in this table are mutually exclusive, and CBO assigned people to groups in the order shown above. The numbers in the table may not add up to totals because of rounding.

HMO = health maintenance organization.

TABLE 4.—OPTIONS FOR A PRESCRIPTION DRUG BENEFIT THROUGH MEDICARE IN 2004

Case	Description [a]	Federal Cost (Billions of dollars)	Beneficiaries' Monthly Premium (Dollars)
Base	Federal government pays 50 percent of premiums; no deductible is required; beneficiaries pay 50 percent coinsurance; stop-loss protection is provided after $4,000 in out-of-pocket spending.	31.6	55.50
	Option 1: Change Beneficiaries' Cost Sharing		
1–A	Require a $250 deductible	29.6	50.90
1–B	Require a $500 deductible	28.0	47.00
1–C	Reduce beneficiaries' coinsurance to 25 percent	42.0	80.70
	Option 2: Increase the Stop-Loss Amount		
2–A	Raise the stop-loss amount to $6,000	30.7	53.10
2–B	Raise the stop-loss amount to $8,000	30.4	52.40
	Option 3: Cap the Benefit		
3	Cap the benefit after $2,500 in total drug spending; provide stop-loss protection after $4,000 in out-of-pocket spending; subsidize low-income beneficiaries' spending in the ''hole''.	28.1	47.10
	Option 4: Combinations		
4–A	Require a $250 deductible; cap benefits after $2,500 in total drug spending; provide stop-loss protection after $6,000 in out-of-pocket spending; subsidize low-income beneficiaries' spending in the ''hole''.	23.4	35.20
4–B	Require a $250 deductible; cap benefits after $2,500 in total drug spending; provide stop-loss protection after $6,000 in out-of-pocket spending; provide no subsidies for low-income beneficiaries' spending in the ''hole''.	21.4	35.00
4–C	Require a $250 deductible; cap benefits after $2,500 in total drug spending; provide stop-loss protection after $6,000 in out-of-pocket spending; subsidize some or all cost sharing in the ''hole'' for beneficiaries with income at or below 175 percent of the poverty level.	24.4	35.20
4–D	Increase the share of premiums paid by the federal government to 75 percent; require a $250 deductible; cap benefits after $2,500 in total drug spending; provide stop-loss protection after $6,000 in out-of-pocket spending; subsidize low-income beneficiaries' spending in the ''hole''.	30.3	17.60

[a] The options represent changes relative to the base case. The ''hole'' is the range of prescription drug spending above the benefit cap and below the stop-loss amount. To ''subsidize low-income beneficiaries' spending in the 'hole,'" the federal government and the states would provide aid through one of two approaches: beneficiaries with income at or below 135 percent of the poverty level could receive some or all cost sharing and premium assistance; and beneficiaries with income between 135 percent and 150 percent of the poverty level could receive premium assistance on a sliding scale.

Source: Congressional Budget Office.

TABLE 5.—APPROXIMATE COST OF ILLUSTRATIVE CASES IN CALENDAR YEAR 2004

[In billions of dollars]

Case[a]	Federal Cost to Taxpayers			Payments by or for Beneficiaries		
	Medicare	Net of Low-Income Subsidies and Medicaid	Total	Medicare Premiums	Cost Sharing	Total
Base	26.0	5.5	31.6	26.0	57.0	83.0
1–A	23.8	5.8	29.6	23.8	61.7	85.5
1–B	22.0	6.0	28.0	22.0	65.8	87.8
1–C	37.8	4.3	42.0	37.8	31.4	69.2
2–A	24.9	5.8	30.7	24.9	59.6	84.5
2–B	24.5	5.9	30.4	24.5	60.4	85.0
3	22.1	6.1	28.1	22.1	66.0	88.1
4–A	16.5	7.0	23.4	16.5	78.9	95.3
4–B	16.4	5.0	21.4	16.4	78.7	95.0

TABLE 5.—APPROXIMATE COST OF ILLUSTRATIVE CASES IN CALENDAR YEAR 2004—Continued

[In billions of dollars]

Case[a]	Federal Cost to Taxpayers			Payments by or for Beneficiaries		
	Medicare	Net of Low-Income Subsidies and Medicaid	Total	Medicare Premiums	Cost Sharing	Total
4–C	16.5	7.9	24.4	16.5	79.0	95.5
4–D	24.7	5.6	30.3	8.2	78.9	87.1

[a] For descriptions of the illustrative cases, see Table 4.
Source: Congressional Budget Office.
Note: Estimates assume that all costs are phased in fully by 2004. Numbers may not add up to totals because of rounding.

Chairwoman JOHNSON. Thank you, Dr. Crippen.

I just call Members' attention to the last chart which does have the monthly premiums of the cases that you described. I just want to run through some quick things, and then, I want to give everybody a chance to question, so I will try to keep my time limited.

Do your estimates—first of all, does this presentation, particularly where there is a cap, assume that during the hole, so to speak, there is a discount that seniors enjoy? Do you take that into account in your estimate of patient burden?

Dr. CRIPPEN. No, we do not. In one variation, we assume no coverage at all other than the low-income subsidies.

Chairwoman JOHNSON. I see. So if we were to negotiate that, that a PBM would have to provide a discount during that period, that would shift these numbers.

Dr. CRIPPEN. It would shift them slightly, yes.

Chairwoman JOHNSON. Then, in terms of the role of the PBM, you do mention in your written testimony that the costs would shift depending on the powers of the PBM to control costs. How much would they shift, and what would be the key tools?

Dr. CRIPPEN. There are, of course, several tools that PBMs could use, ranging from formularies to discounts. Whether or not the PBM assumes risk is also important. So costs would depend critically on how all of those factors apply—as well as on whether there is more than one PBM. I don't have for you today a range of figures on what would help, but certainly, the more tools that the PBMs are allowed to have, and the fewer the restrictions on things like formularies, the more the discount could be.

Chairwoman JOHNSON. Well, we would certainly need to know that. We would certainly need to know what would be the implications of the PBMs having the right to negotiate formularies, because if you were going to give them that right because it would impact costs, you would certainly want to have more than one PBM. So the issue of whether you have one or more PBMs has to do to some extent with what powers you give them.

Another thought that has come forward is to require that every PBM who participates provide two options, you know, a tight option with a lower premium and a looser option with a higher premium. So actually, if you had two PBMs, you would have four plan choices. So if you could pursue that for us, I would appreciate it.

Then, briefly, do your estimates take into account the reduced hospital and ER usage of having a prescription drug plan? I mean,

over and over again, our community providers tell us and our doctors tell us, everybody tells us, that if they had prescription drugs, they would not end up back in the ER and in the hospital and needing home care and so on. Do you take that into account in your estimates?

Dr. CRIPPEN. We have looked very carefully at that issue and at what evidence is available, and frankly, it is a mixed bag. Most of the studies that suggest there are savings to overall medical expenditures from access to pharmaceuticals are not very compelling, although there are a couple that are more so. But on the other side, there are costs as well, having to do with things like adverse events from prescriptions. So at the moment, we assume no net savings to other parts of Medicare from the implementation of a pharmaceutical benefit.

Chairwoman JOHNSON. OK.

Dr. CRIPPEN. It would save some, but it would also cost some.

Chairwoman JOHNSON. On the issue of errors, of prescription drug errors and interactions, if we put in place a system that reduced errors and reduced the likelihood of adverse interactions, would that help the scoring, and might that help the scoring on this first point too?

Dr. CRIPPEN. It could, in theory. Again, at the moment, given the evidence we have seen, we don't assume that PBMs in and of themselves reduce dramatically the number of adverse events.

Chairwoman JOHNSON. So you would need to know whether—and we would need to know from you—whether or not we adopted some of the recommendations in the National Institutes of Medicine study to reduce errors was if we developed a fairly tight system that we thought would do that?

Dr. CRIPPEN. Yes. The places that seem to show the most promise are hospitals that have implemented very tight systems of control, including integration of the results of lab tests and control of prescriptions. In contrast, PBMs look mainly for drug interactions among different prescriptions. But there is a lot more to it than that; drug interactions are just a small piece of what ultimately you might want to be able to control to avoid adverse outcomes.

Chairwoman JOHNSON. And then, along the same line, if we were able to involve more seniors with chronic illness in disease management plans so that they actually stuck to their regimen more effectively and thereby benefitted from the medications recommended by the physician, would there be any implications of that kind of provision for scoring?

Dr. CRIPPEN. Yes, there should be—again, depending in part on whether the acceptance of such a disease management plan by a beneficiary was voluntary on whether a person got into the plan only after developing the condition, and so on. The acceptance of case management can reduce costs, but how much it reduced them would depend a lot on the rules of the road and how people got in and out.

Chairwoman JOHNSON. And lastly, you did mention this briefly, that a prescription drug benefit in Medicare would have an impact, would have the effect of shifting costs from the State public sector to the Federal public sector. Would you enlarge a little bit on the impact that we might have on the employer sector and if there are

things that we could do to reduce the likelihood that employers would drop their retiree plans.

In the bills that were presented in the last Congress, there was quite a variation in your analysis of the degree to which a public plan would encourage employers to drop their plans. Could you just bring to our attention the factors that would most affect that employer decision?

Dr. CRIPPEN. It would depend a great deal, again, on the details of the plan itself. It varies a lot, as our analysis last year suggested. For example, if the program were constructed, say, like our Case D here, our fourth case, with more beneficiary exposure but a lower premium, it might induce employers to subsidize or pay for the premium for their retirees and then get out of the program altogether. So employers' decisions will depend critically on how the program is constructed and what the beneficiaries are exposed to. We would expect some employers to find ways to shift some of their prescription drug benefit costs, to eliminate their benefit, or change their benefit's structure so that it wraps around the Medicare benefit.

Chairwoman JOHNSON. Thank you, Dr. Crippen. Mr. Stark, and welcome back.

Mr. STARK. Thank you, Madam Chairman.

I apologize, Dr. Crippen, for being late, but let me just see if you can help me out a little bit. A lot of what I am trying to understand here regarding the costs of these various plans I presume depends on adverse selection. And I don't know how big a factor that is in how the estimates change.

Dr. CRIPPEN. In these examples, we haven't included an assumption about adverse selection.

Mr. STARK. OK.

Dr. CRIPPEN. Certainly, it could have an effect.

Mr. STARK. OK. What do you assume the cost of the pharmaceutical drugs is under these estimate? In other words, I guess if you would say the top end of the range were full retail, and the bottom end were I have always been under the assumption that the VA buys at about 50 percent of retail. Where in that range did you assume we would come in, or whatever plan it was, what would be the actual cost to the plan? Did you have an assumption on that?

Dr. CRIPPEN. We made an assumption for today's purposes; it is a combination of price and utilization controls that comes to about 12.5 percent.

Mr. STARK. Off retail?

Dr. CRIPPEN. Yes, but that is 12.5 percent off the gross amount, figured as price times the number of prescriptions.

Mr. STARK. So it is pretty linear? In other words, if you could get down, if you get a third off retail, would the cost drop quite a bit?

Dr. CRIPPEN. Sure.

Mr. STARK. If it is fairly linear and easy to do, could you give us some idea of the estimates for a plan with somewhere between 12 and 35 percent off retail?

Dr. CRIPPEN. Part of the problem, Mr. Stark, is that there are offsetting factors. The more you get the price of a drug down, the more likely you are to increase utilization. So in terms of gross

spending, you may have more drugs out there, which may be part of the——

Mr. STARK. You mean utilization by number of beneficiaries signing up or——

Dr. CRIPPEN. It could be just in the number of prescriptions, which is what we are seeing in the VA, for example. The cost of prescription drugs at the Veterans Administration is going up, not so much because of prices—they have a fairly strict regimen and formulary—but because the same people are getting more prescriptions and using more drugs.

Mr. STARK. I would have no way of knowing what that means. Is that good or bad?

Dr. CRIPPEN. I don't know either. All I am saying is that for purposes of——

Mr. STARK. Arguably, physicians may disagree about what is overutilization and what is underutilization. And I don't know that we have any way of determining that.

Dr. CRIPPEN. We don't. All I am saying is that for costing purposes, you have two main factors that can change. The price may go down, but the number of drugs being used may go up.

Mr. STARK. OK, but it is limited to drugs prescribed by the doctors, I would guess, but I don't know.

Do you have any idea of where the prices might be on any of these plans? If we just made this basically not voluntary, made it like part A: you want Medicare, you have got to be in the drug benefit plan. Would the cost drop substantially?

Dr. CRIPPEN. Not according to what we have assumed here. We assumed, for the purpose of these examples, that the benefit was not voluntary.

Mr. STARK. No, but that is what I meant. What if you assumed that it was not voluntary, that everybody was in?

Dr. CRIPPEN. That is what we assumed.

Mr. STARK. You assumed that?

Dr. CRIPPEN. Yes, we assumed that every Part B beneficiary would enroll in this plan because the subsidies were big enough to entice them.

Mr. STARK. You are figuring there are going to be 40 million whatever people in it? All right. Does the cost go up a lot if you are wrong, I mean, if it is only 50 percent participation because they stay in private plans?

Dr. CRIPPEN. It could. That is where adverse selection could be a major factor—if you had less than 100 percent participation and/or let people move in and out at will.

Mr. STARK. I guess my last question: is this stuff all fairly linear? I mean, I don't want to have you invite us to send you a lot of what ifs, but with your modeling, are what ifs relatively easy using your scales here if we wanted to fine tune? Could we send you a letter and say what if we went to 1,500 instead of 2,000.

Dr. CRIPPEN. Yes, we can certainly analyze many of those variations that we couldn't before, and we would be happy to do that. However, I would not characterize the relationships as linear.

Mr. STARK. OK.

Dr. CRIPPEN. They do change as you move things around.

Mr. STARK. Yes.

Dr. CRIPPEN. Let me give you a stark example, one that is not here. If you used reinsurance, so that you are paying an after-the-fact risk adjustment, the more reinsurance you introduce, the more the benefit looks like the fee-for-service side of Medicare and the less risk the provider has, whether it is a PBM or another provider. Thus, you have some benefit from reinsurance in the first instance, but as you increase that reinsurance, you start losing some of the benefits of requiring providers to bear some of the insurance risk.

In sum, there are continuums here and things that work at cross purposes. Some factors may go up, and some may go down. You cannot just take something and multiply it by the number of years or divide it by something.

Mr. STARK. You have given us a lot to chew on, and I just hope you are leaving the door open for us to come back.

Dr. CRIPPEN. Oh, absolutely.

Mr. STARK. Because I appreciate it, and it will be very helpful. Thank you.

Dr. CRIPPEN. Part of what we are trying to do is to show you how we do these estimates so that you have some understanding of our methods. These things are not black boxes; you might not agree with all of our assumptions, and we can talk about that.

Mr. STARK. No, it isn't that. It is just that having fussed with this off and on over 10 years, I have never found universal agreement that we should have a big copay or a big deductible or have the catastrophic level at a low rate or a high rate. Everybody kind of wants to—has their own assumption of what would be most useful to a beneficiary, and I include myself because I am not sure, but this will give us a lot to stew on. Thank you. Thank you, Madam Chair.

Chairwoman JOHNSON. I would note that this only deals with a few variables, and as Dr. Crippen has pointed out, then the Committee would have to discuss what level of participation this would incentivize, because that has a big—so it is a bigger picture, but if we begin with the building blocks, I think we will all be able to be better architects. Mr. McCrery.

Mr. MCCRERY. Thank you.

Dr. Crippen, Mr. Stark asked you if we only had 50 percent participation, the cost would go up, and you said yes. Do you mean per capita costs would go up?

Dr. CRIPPEN. Yes.

Mr. MCCRERY. You don't mean overall program costs.

Dr. CRIPPEN. No, that would not be likely, no; I meant——

Mr. MCCRERY. In fact, if we had fewer seniors participating, the overall program costs would likely be smaller than you have predicted.

Dr. CRIPPEN. Yes, depending on what you were covering for that number of people. If, for example, the benefit had a low catastrophic, or stop-lose, amount and somehow you had adverse selection operating, you could spend a lot of money per capita on those beneficiaries. But, you are absolutely right: I did not mean to say that total program costs would go up but that the cost per beneficiary would.

Mr. MCCRERY. So if we could figure out a way to get a benefit through Medicare that would not supplant all of the coverage that

is out there in the private sector already, we would substantially reduce the program costs compared to what you have predicted in your testimony.

Dr. CRIPPEN. Yes, certainly you would.

Mr. MCCRERY. In your testimony and in another response to Mr. Stark, you said that these predictions are based on only using one PBM per region, and you said that the use of a PBM is likely to result in a 12 and a half percent discount from retail, let us say. Last year, when we were debating prescription drugs, you testified that if we use multiple PBMs per region, we would get a discount of about 25 percent. But your testimony today equivocates a little bit on that. In fact, in my quick reading of it, you seem to say that you don't know whether multiple PBMs would in fact result in a bigger discount. What is the status of your thinking today?

Dr. CRIPPEN. There are two points I would make. First, what we said last year was in the context of a specific proposal, and it may be possible to get back to that kind of a discount depending on the details of the proposal. But the point we would make here today is that in general, more PBMs—that is, more competition—offer the prospect of saving more in a gross sense, through the discount.

There are, however, offsetting factors that we need to be aware of and think about when we look at a proposal. Those offsetting factors are things such as marketing costs. If you have competition, there will be some marketing. And how much will the risk premium be? If you have more than one PBM, and you require them to bear some risk, we assume that the PBMs would demand a risk premium that would reduce the net discount somewhat.

These are some of the other factors that we look at in addition to the number of PBMs. The size of the discount that we estimated last year was in the context of a very specific proposal.

Mr. MCCRERY. And in the context of that specific proposal, you haven't changed your estimate of the savings of multiple PBMs versus a single PBM.

Dr. CRIPPEN. We haven't, reestimated that proposal under our new baseline.

Mr. MCCRERY. So at least last year, in the context of that specific proposal, your best estimate was that multiple PBMs would save twice as much in terms of getting a discount on the price of drugs as the single PBM.

Dr. CRIPPEN. Yes, last year, in the context of that proposal, we did estimate that.

Mr. MCCRERY. So I take it, then, that regardless of what some may read in your testimony today that you are not here today to pooh-pooh, if you will, the use of multiple PBMs per region; you are simply saying that you would have to see a specific proposal in order to specifically estimate what savings there might be, what greater savings there might be with the use of multiple PBMs.

Dr. CRIPPEN. Yes, that is absolutely right. For this prototype case, we just assumed one PBM. Assuming more than one would change the assumptions we applied to all of these alternatives.

Mr. MCCRERY. And on your colorful chart that was up, you cut it off at 2030, and you were here the other day, and I asked you if you extended this chart out to the 75-year actuarial window that

the trustees look at, this would actually get a lot higher, wouldn't it?

Dr. CRIPPEN. It would go higher—not as dramatically, of course, in the next——

Mr. MCCRERY. Social Security would level off.

Dr. CRIPPEN. Yes.

Mr. MCCRERY. But Medicare and Medicaid keep rising.

Dr. CRIPPEN. Keep going up.

Mr. MCCRERY. And I believe you testified that by 2030, these program costs, these three program costs, could account for as much as 75 percent of the budget of the United States.

Dr. CRIPPEN. Yes, as we now know it.

Mr. MCCRERY. Yes, and if you were to carry this out, again, to 2075, I believe you testified last time that these program costs could account for as much as 100 percent of the budget of the United States.

Dr. CRIPPEN. Yes, using roughly what we are spending today——

Mr. MCCRERY. Right.

Dr. CRIPPEN. Or 20 percent of GDP.

Mr. MCCRERY. If we continue to spend about 19 percent of GDP——

Dr. CRIPPEN. Yes.

Mr. MCCRERY. That would account for 100 percent of the budget.

And finally, just one quick question. It appears that based on the figures you have given us, total Medicare spending over the next 10 years if we added a prescription drug benefit that is about $365 billion or so, which you estimated the cost would be, that we would increase total program spending by about 30 percent if we added the prescription drug benefit.

Dr. CRIPPEN. I am trying to remember what the 10-year——

Mr. MCCRERY. You said $1.3 trillion was the 10-year cost, I believe.

Dr. CRIPPEN. That $1.3 trillion figure is the estimated 8-year cost of a pharmaceutical benefit.

Mr. MCCRERY. No, no, no; OK.

Dr. CRIPPEN. CBO projects a 10-year cost for Medicare, I am told, of $3.6 trillion.

Mr. MCCRERY. OK; and 10-year cost?

Dr. CRIPPEN. So $360 billion would be 10 percent.

Mr. MCCRERY. OK; thank you.

Chairwoman JOHNSON. Mr. Kleczka.

Mr. KLECZKA. Thank you, Madam Chairman.

Dr. Crippen, could you repeat for me a statement you made in your opening remarks? It was right at the beginning. I cannot find it in your printed remarks. It was to the effect of Medicare being the only program and transferring something to retirees or seniors. Could you just reread that?

Dr. CRIPPEN. I think that this may be what you are looking for: "It is important to keep in mind that Medicare is only one of the Federal programs that transfer resources from the working population to the retired and disabled."

Mr. KLECZKA. OK; what is the significance of that statement? Because we, as the Federal government, also transfer resources for the poor when we provide for Medicaid. We also transfer resources

to only students when we provide Pell grants and other educational aids. Are you being critical on that point, or are you just stating a fact?

Dr. CRIPPEN. No, I am trying to state a fact, Mr. Kleczka. Retiree programs are somewhat unique; that is, we are taking resources from the current working population and transferring them to the retired and disabled people who are not working.

Mr. KLECZKA. Well, we do that with tax revenues every day and in every annual budget here.

Dr. CRIPPEN. But in these retirement program, we have made long-term commitments over at least the next 75 years, and they involve intergenerational transfers of very large magnitudes.

Mr. KLECZKA. OK.

Dr. CRIPPEN. The point I am trying to make is that when you and I retire, we are going to have a significant impact on what our kids are able to afford for themselves and to provide in support for us. That is why these programs are unique in that we are going to go from 7 percent of GDP——

Mr. KLECZKA. Well, I heard that same statement last week by another speaker before the Committee. It might have been the full Committee, and I cannot recall if it was the Secretary of the Treasury, but it seems to be some kind of a theme going on here that we have to be careful of these programs that spend money for our seniors and our retirees, but other Federal expenditures are OK, and I just—I am saying, you know, as a nation, we try to take care of all of our individuals, all of our people. And some are retirees; some are poor; some are students; some are military, you know, manufacturers, you know. That is what makes up the entire budget.

So being that this is the second time I heard it in such a short period, I was getting a little concerned.

I have before us a copy of a chart from the Budget Committee, and it shows the House Budget Resolution. Now, we are talking about modernizing Medicare. The Committee is involved in trying to put together a drug benefit. You presented four options that we can, you know, just look at to see what the cost might be, and they range from $29 billion to $31 billion per year, and costed over 10 years that is, you know, almost $300 billion for a modest drug benefit which covers half the drug costs for $55 per month premiums.

Let me ask you, Dr. Crippen, if you look at the pie chart, we have a contingency reserve in the budget that will be coming up on the House floor for debate today and vote tomorrow, and there is a contingency reserve made up of three components, two of which are Medicare-related. One is a contingency for Medicare of $240 billion and another one a Medicare modernization of $153 billion, which I assume is earmarked to be the drug benefit.

Now, clearly, that is less than half of any proposal you have shared with the Committee today. Is it your opinion that that amount of money would still provide a pretty slim benefit package?

Dr. CRIPPEN. There are at least two points to be made. First, you can't just multiply these numbers by any given number of years. There are only eight policy years.

Mr. KLECZKA. Right, but in the ball park, you know.

Dr. CRIPPEN. Second, we don't know—and maybe the Committee has more information than we do, which is entirely possible—but we don't know what that $153 billion is in the resolution. It could be a prescription drug benefit. It could be a net benefit—that is, a savings somewhere netted out with something else. So we can't tell. But the relationship is certainly true: starting with $1.5 trillion, roughly, in estimated spending for a drug benefit, that $153 billion would cover about 10 percent of total Medicare spending if you were going to provide a uniform benefit to every beneficiary.

On the other hand, if you were going to provide a benefit to the 12 million beneficiaries who currently appear to have no prescription drug coverage, it could cover up to 40 percent of their annual spending on average.

Mr. KLECZKA. So the concern I have, first of all, it is my understanding that that is the drug benefit that is going to be provided for in this budget bill, and Mr. McDermott and I serve on the Budget Committee, and that was my impression. Maybe Mr. McCrery differs with that. But the problem I have with that is we are taking those dollars out of Medicare hospitalization revenues. Now, the trustee was before the Committee last week indicating the Medicare Hospitalization Trust Fund will be solvent through approximately the year 2029. But, now, if Congress keeps dipping into those revenues and not only taking money out of the hospital portion, which is not drugs—I didn't say drugs; I said hospital—but if we take it out of the hospital revenues, that is less for hospital coverage, and if we take another $240 million out of the Hospital Trust Fund for modernization, that is less for the hospital benefit.

And so, we are going to come to a day here in Congress where all of a sudden, there will be very little money left in the hospital benefit, and we are going to tell our seniors that money is gone. Well, if you rob Peter to pay Paul time after time, yes, the money is going to be gone. And so, we are just setting ourselves up for a real fall in this budget that is coming up on the House floor shortly by taking those dollars out for purposes other than what the workers of the country intended them to be used for when they were deducted from the paychecks. Thank you, Madam Chair.

Chairwoman JOHNSON. Before I recognize Mr. Crane, I just want to remind the Members and the public that is watching that in Clinton's last budget, he cut Medicare deeply. In a number of bills he brought up, he cut Medicare more to get money to pay for other things. It is up to us in the end to determine what we are going to spend the tax dollars of the nation on, and in the budget fund that is over and above the 4 percent of spending that is included in the baseline, that is an assumption that every year, spending will go up 4 percent, and that is more than inflation, we think, in most years.

In that fund, there is money outside of the Hospital Trust Fund that I am assured can be used for prescription drugs. But our job is to try to design a prescription drug benefit that is adequate for our seniors but takes into account what Dr. Crippen commented on at the beginning of his testimony. There are three large programs that transfer resources from working people to people over 65, and if we aren't careful, the majority of the Federal budget will be a generational transfer which would make it very hard for our kids

to fund public education, environmental enforcement, roads and bridges and all of those things.

So, I mean, in the end, we are going to work together to construct a cost-effective but beneficiary-friendly prescription drug bill, and while that is not going to be clearly evidenced in the budget we are going to debate, because we don't have a plan yet, we are going to be able to fund the plan we think is responsible. There may be differences amongst us as to what is responsible emanating from our decision as to what that generational transfer can and should be, but here today, the purpose of this hearing is to get a better understanding of how we could construct a benefit that would be both good for beneficiaries and fiscally responsible in the light of the burden our children are going to carry for retirees in the future, which will be larger than the burden that we carry for current retirees; larger than the burden that any generation in the history of our country has ever carried for retirees.

So that budget debate tomorrow is there for all of us to participate in, but I am very pleased, Dr. Crippen, that you brought such specific knowledge of the building blocks to us, and I hope to have a very fruitful discussion. Mr. Crane.

Mr. CRANE. Thank you, Madam Chairman.

Dr. Crippen, some lawmakers believe that the Medicare trustees' projection of 4 more years of Medicare solvency is a sign that we should not address fundamental reforms to the Medicare program but rather focus on adding additional benefits to the program like a prescription drug benefit.

In your opinion, if the Congress were to simply add on a prescription drug benefit to the existing program, how would that change the outlook of the program?

Dr. CRIPPEN. Mr. Crane, as I have testified before this Committee and others, the trust fund accounting mechanism performs only the very narrow purpose of looking at one program. In this case, it is only part of Medicare; it is not even just one program. And so the fact that the trust fund's solvency date has been extended doesn't give me any comfort whatsoever. For example, you could do anything you wanted with the surplus or the budget for next year. You could spend all $5.6 trillion in surpluses over the next 10 years. You could cut taxes by $5.6 trillion, and it would not change the trustees' report one iota. The solvency date would stay the same.

But the rest of the budget would change, and, potentially, the impact of those actions on the economy would change, depending on what you are doing with that money. So the actuarial extension doesn't give me much comfort.

Moreover, adding a prescription drug benefit on top of current spending—on top of the picture that I showed initially of Medicare and other retirement programs going to 15 percent of GDP—would mean that those programs were going to be more than 15 percent of GDP. That may be entirely possible, doable, appropriate, but to me, the real measure is, what percentage of the economy that our kids are generating, that they are earning, are we going to force them to give us? Adding a prescription drug benefit to this 15-percent picture will just make it worse.

Mr. CRANE. I am concerned about the increase in the CBO's recent study that found annual pharmaceutical spending for seniors will likely rise from $1,989 in 2002 to $4,818 in 2011, a 30 percent higher than previous estimate. Given the uncertainty about and the recent surge in drug estimates or prices, rather, how confident can we be about future projections relating to the cost of Medicare prescription drug benefits?

Dr. CRIPPEN. Well, about as confident as we can be about other things. In this case, the price increases that we adopted came from the Health Care Financing Administration (HCFA) actuaries, so we are in accord with what they are doing on their national surveys. Their estimates are thought to be fairly good; however, the projections have gone up more than expected.

The other piece of why our estimates over the 10-year projection period are going up is that, just as in the case of the surplus totals, we have substituted a more expensive year, 2011, for a less expensive year, 2001. So in total, about half of the change we made over last year's estimate is due to just switching those years, moving the projection forward by one year. The other half is due to increased cost trends that the HCFA actuaries believe have shown up in the last 12 to 18 months.

So it is a combination. Regarding your question of how confident are we, these estimates are probably better than most because a number of agencies look at them and outside reviewers do a lot of work with them. And they have gone up significantly just in 1 year.

Mr. CRANE. Thank you, Dr. Crippen, and I yield back the balance of my time.

Chairwoman JOHNSON. Thank you. Dr. McDermott.

Mr. MCDERMOTT. Thank you, Madam Chair.

Dr. Crippen, on page 10 of your testimony, it says to pay for this program, enrollees will be charged a monthly premium designed to cover 50 percent of the cost of the benefit. The Federal government would pay the other 50 percent. I assume that you stand by those. But then, I go to page 21, and I look at these illustrative cases. The base case, it looks like the cost to the Federal taxpayer on the base case is $31.6 billion, and the payments for the beneficiaries are $83 billion. I am having a little bit of trouble meshing, because it does not seem like 31 is half of 83. It seems like it is about a third by the Federal Government and two-thirds by the patients. Could you help me out here?

Dr. CRIPPEN. I will try. If you can go to the chart on the base case, which I think you have up there, it will help show——

Mr. MCDERMOTT. Is there a number on that one? Or which one of your many——

Dr. CRIPPEN. It says base case.

Mr. MCDERMOTT. Ah, yes, base case.

Dr. CRIPPEN. The base case.

Mr. MCDERMOTT. OK.

Dr. CRIPPEN. The chart shows how much the beneficiaries pay in this case and, over what terms, and what the taxpayers' share is. At the bottom, it summarizes the same numbers you have cited from the table on page 21 of my statement.

Mr. MCDERMOTT. So basically, the patients are paying two-thirds of the cost of it, and one-third comes from the Federal Government rather than 50–50.

Dr. CRIPPEN. In this case, yes; I mean, in total. What we were talking about, though—the part that you cited earlier—was premiums.

Mr. MCDERMOTT. Yes.

Dr. CRIPPEN. And here, as you see, Medicare premiums——

Mr. MCDERMOTT. I don't want old people to get confused with the difference between the cost and the premium.

Dr. CRIPPEN. Right.

Mr. MCDERMOTT. Because the premium is one part of what they are paying, but then, they are going to have to pay this 50 percent on top of that.

Dr. CRIPPEN. Yes. The difference I tried to emphasize in my statement is that the premiums are paid by everybody in the program. More than 39 million people will be paying the premiums, whether or not they fill a prescription. The cost-sharing piece, which changes between these variations, is what people who actually use the drugs will face. In the first instance—the base case—they pay 50 percent of the value of the drugs they are buying. So that is the difference, and it is a distinction that is important: the elderly will be paying $83 billion in our base case, $26 billion of it through premiums and the rest through cost sharing.

Mr. MCDERMOTT. And the thing that I found probably the most amazing here was that you assume that everybody will enroll.

Dr. CRIPPEN. We do.

Mr. MCDERMOTT. So in spite of all this stuff we have been hearing around here about people who already have coverage under their retirement plans, or they have got a Medigap policy or whatever, you think they are all going to drop their coverage and jump into this Federal program.

Dr. CRIPPEN. We think that the 50 percent coinsurance and 50 percent subsidy and premium is enough to induce everybody who is in part B to enroll in the drug program. But that doesn't mean that they will necessarily drop other coverage. They may drop Medigap, or new type of Medigap policies may be formed. Again, the cost sharing part of this doesn't mean that beneficiaries pay it themselves. They can insure against it, or their employer could pay it. In many cases, Medicaid or the States will pay it, or Medicaid will pay premiums. So there are third parties involved in paying this money, too. It is not strictly from beneficiaries.

Mr. MCDERMOTT. So what you are saying is you think it is generous enough that everybody is going to want to get in to get the Federal piece——

Dr. CRIPPEN. Yes.

Mr. MCDERMOTT. Of whatever they can.

Dr. CRIPPEN. Exactly.

Mr. MCDERMOTT. OK; now, I want to come back with something that Mr. Kleczka was pushing on. That is the whole question of how much money is in the budget that we are going to vote on in an hour or two or five on the floor. My remembrance of the proposal put forward by the Republicans last year was that it was cost out by CBO at $159 billion; is that correct?

Dr. CRIPPEN. I don't remember exactly, but that sounds about right, yes.

Mr. MCDERMOTT. OK; and the President, in his campaign, said we are going to put $153 billion in for the drug benefit, right?

Dr. CRIPPEN. Yes—I am sorry; I shouldn't say that so quickly. I don't know what the $153 billion is. I mean, is it just a drug benefit? Is it something else? We don't have anything to tell us in the President's budget blueprint, in anything we have gotten from the Office of Management and Budget (OMB). We don't know.

Mr. MCDERMOTT. So you are saying that the Congress is flying blind at this point.

Dr. CRIPPEN. The $153 billion could be a net number. It could be anything as far as we know.

Mr. MCDERMOTT. I think you are confirming what all of us believe, which is that nobody in the House knows what they are doing on this budget, because the President hasn't said. But the $153 billion has been told to us as the amount for the drug benefit.

Dr. CRIPPEN. OK.

Mr. MCDERMOTT. But my understanding is that the recosting of the Republican plan from last year now puts it up over $200 billion.

Dr. CRIPPEN. We haven't reestimated.

Mr. MCDERMOTT. Nobody has recosted it?

Dr. CRIPPEN. No. Presumably, it is going to be more, but I don't know how much more.

Mr. MCDERMOTT. Boy, it is going to be interesting over there on the floor to hear the argument, won't it be? Everybody will talk like they know what they are talking about, and no one will know, because CBO doesn't know.

Dr. CRIPPEN. We don't know what you are talking about. You might know, but we don't know.

Mr. MCDERMOTT. Well, I know you would never question a Member certainly, but what we are going to hear over there is a lot of wind. None of it is based on any facts that anybody really knows.

Chairwoman JOHNSON. Mr. Johnson.

Mr. JOHNSON of Texas. Thank you, Madam Chairman.

Let us talk about some facts that somebody knows; what do you think? According to your testimony, the average beneficiary spends about $1,989 on prescription drugs in 2002, and the median is about $1,163. HCFA says the average beneficiary spends $550 on drugs in 1997. Do you agree with their analysis, first, and how can the spending go up so much in just 5 years?

Dr. CRIPPEN. There are two factors in the analysis that account for the difference, and your two questions address them. First, we think that the spending per capita is a little higher than HCFA thinks it is because there are two elements that HCFA has not taken into account. One is the institutionalized population—that is, anyone who might be in a nursing home or in the hospital for an extended stay. Prescription drug use by those elderly people is not included in the HCFA numbers.

Mr. JOHNSON of Texas. Why are they not?

Dr. CRIPPEN. Up until now, their analysts have not included the institutionalized population. They are going to. We have not seen their new baseline for this year.

Mr. JOHNSON of Texas. That says HCFA is never up-to-date.

Dr. CRIPPEN. I would not say that of my friends at HCFA, but we have included them at population for the last couple of years, and I think they will this year. We have not seen their baseline. So that is part of why the base on which HCFA is figuring per capita spending is smaller. The second is that there is pretty good evidence——

Mr. JOHNSON of Texas. Well, could I interrupt you just a moment? Do we have good data on those institutionalized patients?

Dr. CRIPPEN. We have some data that we consider to be fairly good, and so we make the adjustment. We do adjust up, but I think it is about 25 percent of the total—I am sorry, it is 5 percent of the total. So we add 5 percent to the total for the institutionalized population.

Mr. JOHNSON of Texas. OK.

Dr. CRIPPEN. The second factor, which I think is 25 percent, is underreporting. We believe that the survey from which HCFA develops its numbers has a fair amount of underreporting. People aren't telling HCFA what they are spending, or if they are, they're doing it inaccurately. And so we add a certain amount for that underreporting. HCFA does some of that as well. Last year, its analysts added 15 percent; we added 25.

So for those reasons, some of HCFA's base numbers are lower. But there has also been tremendous growth in spending in the past few years. I mean, if spending grows at a rate of 8 percent to 10 percent a year, it does not take long to double it, as you well know.

Mr. JOHNSON of Texas. Why do people underreport?

Dr. CRIPPEN. In many cases, they don't remember what they spend. I wouldn't—if someone asked me what I spent on drugs last year, I wouldn't know exactly. So there seems to be a bias in the survey toward reporting less drug spending than actually occurs.

Mr. JOHNSON of Texas. Some people deduct it from their income tax.

Dr. CRIPPEN. I am sure they know what it is.

Mr. JOHNSON of Texas. That is right.

As you know, the current fee-for-service programs and any willing provider program, if we perpetuated that structure in a prescription drug program and prohibited the use of restrictive formularies and selected contracting with pharmacies, what impact would that have on our ability to control costs? And additionally, what are the incentives to control costs if we let the government provide 100 percent of the risk?

Dr. CRIPPEN. To answer your last question first, we think that having the PBMs share some risk will give them incentives to help control costs.

Mr. JOHNSON of Texas. Right.

Dr. CRIPPEN. So in our estimate, we give some credit for that. However, as I said a little bit earlier, there is a limit to how much of that you can do without adverse consequences as well. But if PBMs bore some risk, there would be some additional control of costs.

In terms of other controls, the more the Congress says you cannot have a formulary or you, cannot use these other cost-control mechanisms that are now common tools then the less cost control

we think the program can have and the more expensive it will be. Is that responsive to your first question?

Mr. JOHNSON of Texas. Yes; thank you very much.

Dr. CRIPPEN. OK.

Mr. JOHNSON of Texas. One other question if I might, Madam Chairman. The cost of prescription drugs is defined within a fairly wide margin. Nobody really knows what it is. Do you think we can do it for the amount that is set aside in the budget?

Dr. CRIPPEN. That depends, Mr. Johnson, on a number of things and is part of the conversation we have been having with Mr. McDermott as well. If you target the drug benefit toward a very specific population, then $150 billion can buy a lot of drugs. If you give a uniform universal benefit, it is about 10 percent of what everybody spends in total. So you could do a drug benefit of substantial size for a small number of people at that rate. But I would also stress again that I don't know—and I don't know if anybody does—exactly what the $153 billion in the President's budget blueprint is. It could be a net number, with a prescription drug benefit, for example, that costs $300 billion minus savings from Medicare reform of $150 billion. We don't know what the number represents, so it is kind of hard for us to say what it will do or will not do. I can tell you roughly what $150 billion would do, but I don't know what that number represents.

Mr. JOHNSON of Texas. Well, if we don't know the actual costs, we also can surmise that we can do it for that number.

Dr. CRIPPEN. Yes.

Mr. JOHNSON of Texas. Thank you very much. Thank you, Madam Chairman.

Chairwoman JOHNSON. Representative Thurman.

Mrs. THURMAN. Thank you, Madam Chairman.

Dr. Crippen, let me—so, then, you would have to agree that none of the plans that you have run A through D would fit under the $153 billion.

Dr. CRIPPEN. Probably not.

Mrs. THURMAN. I know that number keeps showing up.

Dr. CRIPPEN. The dollar amount in our examples are 1-year numbers, and you can't just assume that you can multiply them by eight to see the long-term policy implications or anything else. We constructed these cases to look only at 1-year costs, because there are numerous details that we have not made assumptions about. My purpose today was not to show you exactly what a drug benefit would cost but rather to give you relative scenarios, to show what would change if you changed deductibles or catastrophic coverage or other factors and how those changes would affect the cost to beneficiaries and taxpayers.

So my attempt today was not to——

Mrs. THURMAN. OK.

Dr. CRIPPEN. Estimate what the cost of a reasonable drug benefit might be. In fact, we are trying very hard not to say that these illustrations are proposals.

Mrs. THURMAN. And I don't blame you, because I know that we have got the Senate stuff that says——

Dr. CRIPPEN. Right.

Mrs. THURMAN. One-hundred and fifty-three billion dollars would give us a very narrow or not much of a drug benefit at all.

So let me ask you, though, because as you know, there is a lot of conversation up here about how we are going to change Medicare, potentially change Medicare and modernize or redo. In looking at any of these numbers, have you all done any comparisons to—and let us take one that certainly we are involved with the Medicare choice programs, specifically looking at what the copayment and then also what the beneficiary would pay in a premium.

Have you looked at anything comparable in the private sector or something that we do in the Medicare choice just to get an idea of kind of what we are looking at here?

Dr. CRIPPEN. Do you mean, as to how people behave?

Mrs. THURMAN. Well, not behave but just in the cost part of it, because, I mean, we know we have specifically a Medicare choice program. We recognize today that first of all, some of us are very unhappy with the Medicare choice program because they move in and out, but one of the reasons people sign up for it is a prescription drug benefit. And if the success part of this program is based on potentially 100 percent of Medicare beneficiaries signing up, you know, you have to have an incentive for why they would want to come over here, and we are seeing a lot of changes in that market. There used to be zero premium. Now, there is—actually, I have seen it go up as far as $179 in premium but not with the benefit in itself. Have you done a comparison on that in particular?

Dr. CRIPPEN. We haven't. We are aware of some of the developments you are talking about: the enrollment flattening out, in fact, probably declining; the number of withdrawals by plans; and the fact that the drug benefits are either getting thinner—less generous—or the premiums are going up. We have not done a thorough comparison across Medicare+Choice plans to know exactly how they are developing, but we have the same kinds of both anecdotal and underlying evidence that you do about the changes.

Mrs. THURMAN. It would seem to me that would be something we would want to look at, because if we are going to look at a Medicare benefit, we need to figure out——

Dr. CRIPPEN. Right.

Mrs. THURMAN. How we best do this.

Dr. CRIPPEN. Part of the problem with doing that—and I think we have talked about this before in this setting—is that there is a very substantial lag in the data that are collected. You see us using data from 1997, for example, or maybe even 1998, but those are the newest ones we have. Much of the M-plus-C developments that we are all talking about here have taken place since 1997 or 1998. So it is a little hard to get as current an analysis as you would like in order to make good decisions.

Mrs. THURMAN. Let us go back a little bit to the PBMs, because those obviously have a big effect on what the cost or not cost. Can you review for me the various private sector mechanisms that the pharmacy benefit providers used to contain the prescription drug cost? And what I am most concerned about is, you know, we give them the opportunity to go in and negotiate, which would be the competitive part of this, but are there any things that we do to

make sure that this cost savings is given back to the beneficiary so that they could actually see a reduction in their cost?

Dr. CRIPPEN. To answer the last question first, we assume that if you have multiple PBMs, a good portion of whatever they save goes back to beneficiaries because of competition. Regarding the first part of your question—what are some of the things that we assume PBMs do to cut costs and that therefore have an effect on our estimates—we consider such factors as the level and nature of the competition, whether there is one or more PBMs and how they compete; constraints on the cost controls that they can institute—if the PBM is told, you cannot do certain things, that will make a difference in how much they can save for themselves and for beneficiaries; rules for establishing formularies; and conditions for determining pharmacy networks. Those are some of the things that we look at to say whether or not PBMs have effective cost-control tools.

Mrs. THURMAN. But even in using multiple, I mean, you have looked at the administrative costs when you use a lot more that you are spending a lot more on administrative——

Dr. CRIPPEN. Yes.

Mrs. THURMAN. And/or marketing that where some of the savings that you actually would hope to retain and use to subsidize or lower the cost would not necessarily be there.

Dr. CRIPPEN. There are two offsetting factors that we look at. One is marketing costs, and another is risk. Because there is more risk to the prover in a multiple-PBM setting, we consider the amount that the PBMs need to compensate them for the risk they are undertaking. So there are offsetting costs.

Mrs. THURMAN. Thank you.

Chairwoman JOHNSON. And thank you, Representative Thurman, and thank you very much, Dr. Crippen. There are lots more questions I am sure we will have for you as we get into weighing these things as a group, and we appreciate your testimony today.

I am going to call the next two panels together so that Members will have at least the chance to hear the testimony of each of our last six guests, and as you are coming forward, John Poisal, who will start, is from the Office of Strategic Planning at the Health Care Financing Administration. He is a long-time employee of HCFA with a great depth of knowledge in this area, and we are pleased to have him.

Michael Cohen, who is president of the Institute for Safe Medication Practices; Helen Frederick of Crownsville, Maryland; Lore Wilkinson of Durham, North Carolina—we appreciate how far you have come, Lore, and also, Helen, your participation; Max Richtman, the executive vice-president of the National Committee to Preserve Social Security and Medicare; and Maya MacGuineas, the national board Member from the Third Millennium, who has come down from New York, and we thank you for being here with us.

Let us start with John Poisal.

STATEMENT OF JOHN A. POISAL, STATISTICIAN, OFFICE OF STRATEGIC PLANNING, HEALTH CARE FINANCING ADMINISTRATION

Mr. POISAL. Good afternoon. Good afternoon, Chairman Johnson, Congressman Stark, distinguished Subcommittee members. Thank you today for inviting me to discuss my analysis of data on prescription drug use and spending patterns of Medicare beneficiaries recently published in Health Affairs, entitled Growing Differences Between Medicare Beneficiaries With and Without Drug Coverage.

This research, as presented in the article, is based on data collected by the Health Care Financing Administration through the Medicare Current Beneficiary Survey (or the MCBS) from 1998 as well as survey data collected in previous years. The MCBS is an ongoing survey of a representative sample of the entire Medicare population. One of the strengths of the MCBS is that it collects information about what Medicare does and does not cover, which would include prescription drugs. My research focuses on historical prescription drug coverage, utilization and spending.

The research resulted in two main findings regarding drug coverage among the Medicare population. First, the proportion of Medicare beneficiaries with prescription drug coverage at some point in the year did not change between 1997 and 1998, after having increased annually over a number of years. Second, the differences in the levels of use of prescription drugs and total spending on prescription drugs in 1998 widened between beneficiaries with drug coverage and those without drug coverage.

Since 1992, the first year of the MCBS, the data have shown that the prescription drug coverage rate for Medicare beneficiaries has risen steadily. In 1998, however, coverage levels remained flat. In 1998, we estimate 73 percent of noninstitutionalized Medicare beneficiaries had drug coverage at some point during the year. On the other hand, slightly more than 27 percent of beneficiaries, or about 10 million, had no drug coverage whatsoever. These findings are identical to what was found in the 1997 survey data.

Although a fairly high proportion of Medicare beneficiaries had some type of supplemental prescription drug coverage in the 1990s, a month-by-month analysis of the data revealed that this coverage was far from stable. The trends in use and spending for beneficiaries with and without prescription drug coverage differed for the first time in 1998. The data showed that beneficiaries without coverage purchased fewer medications than the year before, while their expenditures were nearly identical. By contrast, beneficiaries with coverage in 1998 continued their previous trend of increases in utilization of drugs and in total expenditures. Their drug purchases increased by 9 percent, and their total expenditures increased by 14 percent.

Also, the gaps in utilization and expenditures between the two populations increased from a difference of five prescriptions in 1997 to a difference of eight prescriptions in 1998. Their total expenditure gap also increased from a difference of $330 in 1997 to a difference of $453 in 1998. The data also show, in the aggregate that utilization and total expenditures for all levels of income were higher for beneficiaries with drug coverage than for those without such coverage.

The differences in both utilization and total expenditures were particularly notable in certain subgroups. For example, the differences for beneficiaries with and without coverage were greatest for the disabled population under age 65. Beneficiaries without drug coverage in that age group used less than half as many prescriptions, and their total expenditures were only one-third as high when compared to disabled beneficiaries with drug coverage.

In addition, there were large differences in utilization and spending between those with and without drug coverage for beneficiaries below the poverty line. The gap in utilization between the two groups was nearly 14 prescriptions in 1998. Moreover, differences in total expenditures for beneficiaries with and without coverage and who had five or more chronic conditions increased by about 70 percent and increased by approximately 30 percent for all other beneficiaries with chronic conditions. Utilization differences between these groups of beneficiaries also increased in 1998.

Clearly, prescription drugs continue to play an increasingly important role in the health care of Medicare beneficiaries. Having prescription drug coverage makes a difference in beneficiary drug use and spending, particularly for low-income seniors and those with many chronic health problems.

Thank you again for the opportunity to testify today, and I will be happy to answer any questions you have.

[The prepared statement of Mr. Poisal follows:]

Statement of John A. Poisal, Statistician, Office of Strategic Planning, Health Care Financing Administration

Chairman Johnson, Congressman Stark, distinguished Committee members, thank you for inviting me here today to discuss an analysis of data on prescription drug use and spending patterns of Medicare beneficiaries recently published in Health Affairs, "Growing Differences Between Medicare Beneficiaries With and Without Drug Coverage Volume 20, Number 2. Prescription drugs provide a vital tool for our nation's young and old in treating both chronic and acute medical conditions. In 1998, total spending for prescription drugs in the United States totaled $91 billion, more than double the total 10 years ago.

The research, as presented in the article, is based on data collected by the Health Care Financing Administration through the Medicare Current Beneficiary Survey (MCBS) from 1998, as well as survey data collected in prior years. The MCBS is an ongoing survey of a representative sample of the entire Medicare population. Survey respondents are interviewed every four months and are asked to record their drug purchases and save their medicine containers to assist them in recalling their drug purchases.

The research resulted in two main findings regarding drug coverage among the Medicare beneficiary population. First, the proportion of Medicare beneficiaries with prescription drug coverage at some point in the year did not change between 1997 and 1998, after having increased annually over a number of years. Second, the differences in the levels of use of prescription drugs and total spending on prescription drugs, in 1998, widened between beneficiaries with drug coverage and those without.

PRESCRIPTION DRUG COVERAGE

Since Medicare currently provides very limited coverage of outpatient prescription drugs, Medicare beneficiaries obtain coverage from a variety of sources. For example, many beneficiaries receive coverage through Medigap plans, their employer-sponsored retiree insurance plan, as well as through enrollment in Medicare HMOs, the Medicaid program, or State-sponsored prescription drug assistance programs. The MCBS collects information on the number of Medicare beneficiaries with prescription drug coverage and the sources of that coverage.

Since 1992, the first year of the MCBS, the data have shown that the prescription drug coverage rate for Medicare beneficiaries has risen steadily. From 1995 to 1997, the level of estimated drug coverage increased, but in 1998 coverage levels remained

flat. As indicated in Chart 1, in 1998, 73 percent of non-institutionalized Medicare beneficiaries had drug coverage at some point during the year. On the other hand, slightly more than 27 percent of beneficiaries, about 10 million, had no drug coverage whatsoever. These findings are identical to what was found in the 1997 survey data.

The increase in the proportion of beneficiaries with drug coverage in the mid-1990s appears to most likely be a result of increased beneficiary enrollment in Medicare HMOs offering an additional drug benefit (Chart 2). During the mid-to late 1990s, Medicare HMO enrollment was growing at about 30 percent annually. The provision of drug benefits by Medicare HMOs during this period, as well as the increase in beneficiary enrollment resulted in more than 15 percent of all Medicare beneficiaries receiving drug coverage from a Medicare HMO in 1998, an increase of 2 percent since 1997, and of 7 percent since 1995.

Although a fairly high proportion of Medicare beneficiaries had some type of supplemental prescription drug coverage in the 1990s, a month-by-month analysis of the data revealed that this coverage was far from stable. For instance, only 46 percent of beneficiaries were covered for all 24 months of 1995 and 1996. In 1997, only 54 percent of beneficiaries had drug coverage for the entire year, and 27 percent had no coverage at any time (Chart 3)

PRESCRIPTION DRUG USE AND SPENDING

The trends in use and spending for beneficiaries with and without prescription drug coverage differed for the first time in 1998. The 1998 data showed that beneficiaries without drug coverage purchased fewer medications than they purchased the year before, filling an average of 16.7 prescriptions, a 2.4 percent decline from 1997. At the same time, those same beneficiaries spent an average of about $550 on their prescription purchases, nearly identical to their expenditures the previous year.

Beneficiaries with coverage continued the trend of increases in both utilization and total expenditures. They purchased a little more than 24 prescriptions per person, up 9 percent from 1997, and total expenditures, including out-of-pocket and payments from drug insurance coverage, increased 14 percent, totaling $999. The gap in utilization between the two populations grew from an average difference of 5 prescriptions in 1997 to 8 in 1998. The difference in total expenditures between the two populations also increased from about $330 in 1997 to $453 in 1998. In addition, the survey data have been consistent in demonstrating gaps in utilization between beneficiaries in both populations for almost every demographic category including age, race, health status, and income.

These differences in utilization and expenditures were particularly notable in certain sub-groups. The differences were greatest for disabled beneficiaries under age 65, a group that has a high level of drug use. Disabled beneficiaries under age 65 without drug coverage used less than one-half as many prescriptions (16 prescriptions), as disabled beneficiaries with coverage used (33 prescriptions). In addition, total drug expenditures for disabled beneficiaries without drug coverage were only one-third as high ($493) in per capita spending as disabled beneficiaries with drug coverage ($1483).

Utilization differences between beneficiaries, with or without drug coverage, with varying levels of chronic conditions also increased in 1998, by approximately two prescriptions per beneficiary. For example, the utilization gap between beneficiaries, with or without coverage, who had five or more chronic conditions, grew from eight prescriptions in 1997 to 10.8 in 1998. Differences in total expenditures for beneficiaries with and without drug coverage also increased by about 70 percent for beneficiaries with five or more chronic conditions and by approximately 30 percent for all other beneficiaries with chronic conditions.

In 1998, total drug expenditures for beneficiaries in poor health with drug coverage were $910 higher than total expenditures for beneficiaries in poor health without drug coverage. This represented a 30 percent increase over the 1997 difference of $695. Average drug expenditures for beneficiaries in excellent health were $250 higher for those with coverage than for beneficiaries with identical self-reported health status who were without coverage. In 1997, the difference in expenditures between these two groups was $203.

Utilization and total expenditures, for all levels of income, were higher for beneficiaries with drug coverage than for those without such coverage. Differences in utilization and total expenditures were greatest between beneficiaries with and without drug coverage below the poverty line and reached a difference of almost 14 prescriptions per beneficiary in 1998.

Beneficiaries without drug coverage spent more out-of-pocket, than those with coverage, but continued to receive fewer medications. Beneficiaries without drug

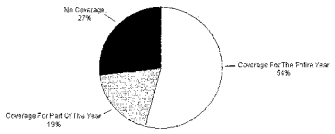
coverage had to pay an average of $546 out-of-pocket in 1998, compared to $325 for beneficiaries with coverage. In other words, beneficiaries without drug coverage paid an average of $33 per prescription compared to $13 for beneficiaries with drug coverage (Chart 4). For beneficiaries without drug coverage, out-of-pocket expenditures, which are equal to their total expenditures, were virtually unchanged from 1997 to 1998, while out-of-pocket and total expenditures for beneficiaries with drug coverage increased by almost 18 percent. Moreover, beneficiaries with drug coverage paid a slightly larger portion of their total drug expenditures (33 percent) in 1998 than they did in 1997 (31 percent). Beneficiaries in Medicare HMOs with drug coverage and those enrolled in individually purchased supplemental plans experienced the greatest out-of-pocket cost increases between 1997 and 1998.

CONCLUSION

Prescription drugs continue to play an increasingly important role in the health care of Medicare beneficiaries. The research presented in the *Health Affairs* article demonstrates that beneficiaries with drug coverage used more drugs and had higher total expenditures than beneficiaries without coverage, and the gap in expenditures and utilization between those with and without coverage increased. Clearly, having prescription drug coverage makes a difference in beneficiary drug use and spending, particularly for low-income seniors and those with many chronic health problems.

CHART 3 – Prescription Drug Coverage Rates Among Medicare Beneficiaries*, 1997

In 1997, 40% of Medicare beneficiaries had either no drug coverage or drug coverage for only part of the year

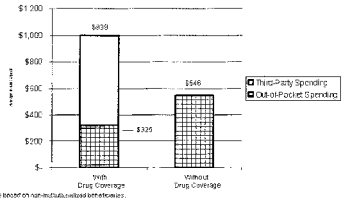


*Data are based on non-institutionalized beneficiaries continuously enrolled in 1997.

Source: HCFA/Office of Strategic Planning. Data are from the Medicare Current Beneficiary Survey.

Department of Health and Human Services

CHART 4
Total Average Drug Spending for Medicare Beneficiaries*
With and Without Drug Coverage, 1998



*Data are based on non-institutionalized beneficiaries.

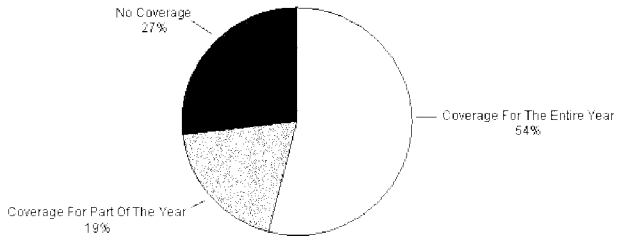
Note: Data have not been adjusted for any possible underreporting by beneficiaries.

Source: HCFA Office of Strategic Planning. Data are from the Medicare Current Beneficiary Survey.

Department of Health and Human Services

CHART 3 -- Prescription Drug Coverage Rates Among Medicare Beneficiaries*, 1997

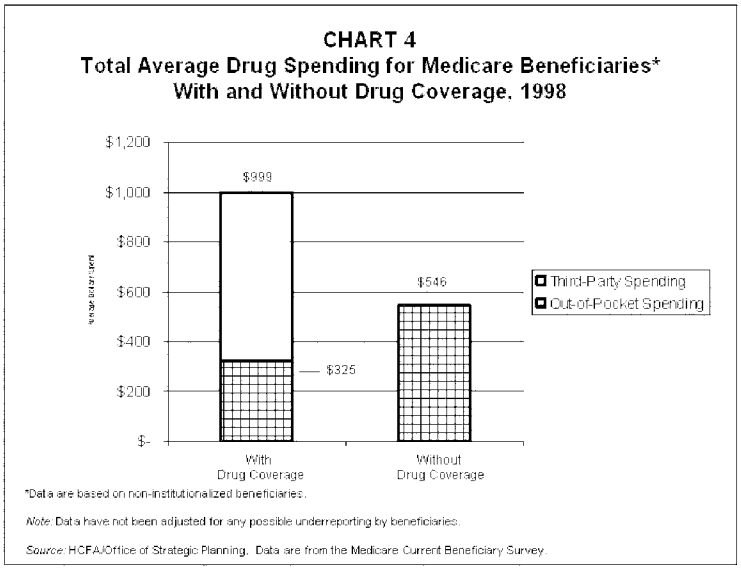
In 1997, 46% of Medicare beneficiaries had either no drug coverage or drug coverage for only part of the year.



*Data are based on non-institutionalized beneficiaries continuously enrolled in 1997.

Source: HCFA/Office of Strategic Planning. Data are from the Medicare Current Beneficiary Survey.

Department of Health and Human Services



Department of Health and Human Services

Chairwoman JOHNSON. Thank you very much for your testimony.

Mr. COHEN. We will come back for questions when everyone is—Mr. Cohen.

STATEMENT OF MICHAEL R. COHEN, PRESIDENT, INSTITUTE FOR SAFE MEDICATION PRACTICES, HUNTINGDON VALLEY, PA

Mr. COHEN. Good afternoon, Madam Chairman.

I represent a nonprofit organization called the Institute for Safe Medication Practices. It is independent, and it is composed of physicians, nurses, pharmacists and consumers, and our focus has been on medication safety for many years. We work with the United States Pharmacopeia's medication error reporting program and also with the Food and Drug Administration's Medwatch program data to review reported errors from practitioners and make recommendations for prevention. This is published widely, and all the hospitals get our material; a number of journals and newsletters.

We think that the proposed legislation is important to drive medication safety, or it can be, at least. And so, we really appreciate having the opportunity to speak today. To a large extent, payers such as Medicare bear some responsibility for medication errors if they don't support basic quality issues and safety requirements. It has to be more than just dispensing accurately. It also has to be looking at the drug therapy and monitoring it and making sure that it is important for the patients. I think that is critical.

So we have identified three areas to think about that we believe are appropriate for legislation related to this prescription drug benefit: continuous quality improvement activities to enhance safety in our nation's pharmacies and other practice sites; largely, that is not done now; better clinical utilization of community pharmacists and the beneficiaries themselves and expanded use of effective technology, the computerized prescribing, barcoded drug administration, and so forth.

We know what to do to prevent medication errors. There is loads of research out there. People, out of altruism, the practitioners, the doctors, nurses, pharmacists are willing to come forward and give us the story about errors that they have made and tell us how they have prevented future events.

And we have found that they are repetitive in nature. What happens in California happens in Connecticut and Massachusetts and everywhere else. And I think it is time that we put a stop to this. One of the things I think that we could really use help with here would be the idea of legislation that requires, as a condition of participation, that pharmacies would perform continuous quality improvement. So far, this is only done in three States that we know of where it is required, where the pharmacist and the pharmacy teams and anybody that dispenses medication, frankly, would seek out information about errors and then apply this information and the expert recommendations to make sure that they don't happen again rather than waiting for another incident to take place. We think that that is critical.

And we have publications that provide this information. I think it should also involve the PBMs and the payers. I think some of the policies that are out there cause some serious problems: lots of interruptions. We talked about the formulary considerations before. It is a mess out there trying to keep things straight about who is getting reimbursed for what, and the pharmacists spend a lot of time with that right now.

Importantly, I think if we are going to do this, the information has to be protected from discovery in a lawsuit. I think that is critical, and the legislation that we have seen so far in the three States that I mentioned have moved in this direction. I also want to tell you that we believe that each provider should do, on an annual basis, a self-assessment. We actually prepared a self-assessment along with the American Hospital Association last year which has 200 characteristics of a safe medication system for hospitals, and currently, along with the American Pharmaceutical Association and National Association of Chain Drug Stores, although we prepared it independently, they are helping to support it, and we have developed a similar project for community pharmacies where they can actually find areas of weakness where they need to focus.

And I think that is something also that can drive quality improvement projects. So I think that is another thing that ought to be required in this legislation.

As far as utilization of pharmacists, it bothers me tremendously that we are wasting a tremendous quality resource in the community pharmacists. Right now, they are frequently tied up with the dispensing activities, the technical activities, but where they could be monitoring drug therapy, they could be, for example, looking at new drugs that patients are on, trying to identify side effects and adverse reactions quickly, even looking at drugs that might otherwise come off the market and making recommendations for improvement.

They could be doing reviews of a patient's drug regimens. We have seen this in the long-term care industry, for example. The pharmacists there, the consultant pharmacists, have done a tremendous job, and research has shown a decrease in cost of $3.6 billion in the long-term care field, and improvements in outcome in patients in long-term care are 43 percent. This same thing could be required for Medicare beneficiaries, and I really don't think there is a reason that we should not look into this activity at least.

We have about 80,000 certified technicians. We have automated technology that is going to help. We have pharmacists now who are graduating at the doctoral level. I believe, we believe, that they can cut down on the number of drugs that are being provided. I think they can really help to reduce the possibility of errors with this drug regimen review.

I also think that another important area that we should be involved with is the technology. We are at the cusp of using devices like this to reduce ambiguity: the look-alike names, for example; the sound-alike names. I would think that there ought to be some incentive in the bill for physicians that actually use computerized prescribing, because it cuts down on the possibility of medication errors. And I think most important, it allows communication of patient information. We don't have that right now in the pharmacy.

We don't know when a patient has renal impairment, kidney disease, for example, and a drug dose might have to be changed. We don't even know for sure what drugs they are on, because right now, the beneficiaries may go to several different pharmacies to get their medication. With devices like this, I think we can pull all that together and reduce the possibility of patient harm and also reduce some of the costs that you are concerned about.

Thank you.

[The prepared statement of Mr. Cohen follows:]

Statement of Michael R. Cohen, President, Institute for Safe Medication Practices, Huntingdon Valley, PA

Good afternoon. Madame Chairman and Members of the Committee, thank you for the opportunity to speak with you this afternoon about important health care quality issues related to the design of a prescription drug benefit program for Medicare beneficiaries. I am Michael R. Cohen, a pharmacist and president of the Institute for Safe Medication Practices (ISMP). ISMP is an independent, nonprofit organization that works closely with practitioners, regulatory agencies, health care institutions, professional organizations and the pharmaceutical industry to provide education about adverse drug events and their prevention. A board of trustees representing the health care community at large governs this interdisciplinary effort by nurses, pharmacists, physicians and health care consumers. Our primary focus has been on proper and safe use of medications. We have a long history of learning about medication errors from health care practitioners and consumers who voluntarily report medication errors and hazardous conditions through a national reporting program operated by the United States Pharmacopeia. All reports are shared directly with the US Food and Drug Administration, Office of Post-marketing Drug Risk Assessment. Dialog with FDA is ongoing when reports relate to drug nomenclature issues (proprietary and nonproprietary names), or pharmaceutical labeling, packaging and medical device design.

Information about medication errors, other adverse drug events, and recommendations for prevention are shared with the medical community through our web site (www.ismp.org); ongoing columns in 16 professional journals that reach nurses, nurse practitioners, pharmacists, physicians, and physician assistants; and a biweekly publication, *ISMP Medication Safety Alert!* that reaches all US hospitals. Currently, we are preparing to launch a similar newsletter for chain and independent community pharmacies. In addition, we reach regulatory authorities and pharmaceutical manufacturers internationally through regular publications in international journals and newsletters. Information from ISMP has been used to effect thousands of improvements in professional practice and commercial drug labeling, packaging and nomenclature. The organization has gained the trust and respect of practitioners and senior officials in health care throughout the nation.

Recommendations to Reduce Error and Improve the Quality of Medication Use

Medications are a blessing, but humans must safely prescribe, prepare, dispense, and administer these drugs. Yet humans are fallible, and as clearly articulated in the recent reports by the Institute of Medicine (IOM), errors and other adverse events occur and cause unbearable human and financial cost. Medication use has been further complicated by the large number of new drugs and technologies introduced every year, an increasing elderly population with chronic and acute conditions requiring complex treatment strategies, and the proliferation of over-the-counter products. In light of this fact, much can and should be done to enhance medication safety.

The current prescription drug benefit legislation is a strong and appropriate vehicle to drive medication safety. Payers bear responsibility for medication errors when they occur because of insufficient support of basic services and lack of quality/safety requirements. As purchasers of pharmacy services through mail and community pharmacies, payers—including Medicare—should require providers to comply with standards most likely to enhance medication safety. They should offer their beneficiaries some assurance of safe pharmaceutical care, which includes important monitoring of the appropriateness of drug therapy and its effects, not just accurate dispensing.

ISMP has identified several focal points that would be most appropriate for legislation related to prescription drug benefits:

- Continuous quality improvement activities to enhance safety in our nation's pharmacies;
- Better clinical utilization of community pharmacists and pharmacy beneficiaries; and
- Expanded use of effective technology.

Achieving and maintaining standards related to these focal points will likely require resources that are not currently available. Thus, legislation must also include changes in the current reimbursement systems to properly support any required safety enhancements.

Continuous Quality Improvement

Data from the USP–ISMP Medication Error Reporting Program reveals that medication-related problems are repetitive in nature. An incident of misuse in one setting is likely to repeat itself in another. Most importantly, the system changes necessary to prevent errors are similar and a growing body of literature is available to guide these efforts. Tragically, too many organizations and individual providers do not believe similar incidents could happen to them. They fail to use information about errors occurring elsewhere as a roadmap for improvement in their own organization or practice. It is not until a serious error hits home that aggressive prevention efforts are implemented. With so much evidence-based information about error prevention at hand, there is little excuse for reacting to errors after they happen instead of preventing them. We need Congress to help shorten the interval between the lessons taught by errors and the widespread corrective action to prevent future errors.

The development and implementation of continuous quality improvement (CQI) efforts should be the highest priority in all pharmacies. Such efforts must be aimed specifically at preventing well-known and repetitive categories of prescribing and dispensing errors, which erode patient confidence in our health care system. For example, in order to participate in the prescription drug benefit program, pharmacies should be required to seek out medication safety information and use it proactively to prevent medication errors. At the same time, safety issues recognized internally and reported by patients must be documented and analyzed, and a process must be established to determine the best strategies to prevent future problems and ensure its implementation. An annual survey to assess consumer perceptions of the quality of pharmaceutical products and professional services might also be required to supply additional information upon which to base improvement strategies.

Informational tools like our ISMP Medication Safety Alert! publication, or ISMP's Quarterly Action Agenda, which is a readily available list of medication problems compiled from our nation's reporting programs, can be a backbone of any CQI effort. The very purpose of the USP–ISMP Medication Error Reporting Program—indeed the purpose of any type of safety reporting program and the expert recommendations that stem from it—is to guide the implementation of quality improvement initiatives by practitioners and organizations. If this is not accomplished, the value of any medical safety-reporting program is diminished. Thus, appropriate funding is needed to ensure that information flowing from error reporting programs are efficiently transformed into learning programs to prevent future errors. Research-based information, anecdotal reports of adverse events, reports from the Joint Commission on Accreditation of Healthcare Organization's Sentinel Event Newsletter, and information from other sources are also instrumental in this effort. ISMP is prepared to assist the Secretary of Health and Human Services, as well as the nation's professional licensing boards, health departments, accreditation agencies, regulatory authorities, and individual organizations in using such informational tools to develop effective CQI strategies that can successfully stop repetitive medical errors.

Practice sites should also be required to conduct self-assessments to help prioritize improvement projects at least annually. In a cooperative project with the American Hospital Association (AHA), ISMP recently developed and distributed the ISMP Medication Safety Self-Assessment to virtually all US hospitals. This weighted self-assessment instrument provides a list of nearly 200 effective medication error reduction strategies in the general hospital setting. Nearly 1,500 hospitals participated fully in the project, which resulted in a large national database of hospital efforts to improve patient safety with medications. This database will allow health care providers to identify areas of weakness and focus improvement activities upon system elements and characteristics that are known to be effective for preventing patient harm. We will also be able to track improvement efforts in the nation's hospitals over time by repeating the process at a later date.

While 1,500 hospitals completed the assessment and sent data to ISMP, there are approximately 6,000 acute care hospitals in the US. Through 1,000 follow-up telephone calls to a randomized list of hospitals, we learned that many more hospitals

would have participated had it not been for advice given them by a national risk management organization to seek legal counsel before returning data to us. This letter instilled a renewed fear of discoverability in a future lawsuit, which had a chilling effect on the ability of hospitals to participate in this extremely valuable project. Unless the basic problem—discoverability of information used in quality improvement projects like this one—is addressed by Congress, we will continue to lose valuable opportunities to address costly (both human and financial) patient safety issues. Records of quality improvement activities must be afforded protection under available state peer review or other protective statutes and thus protected from discovery during civil litigation. It should be noted that Governor Gray Davis of California signed legislation last August to require quality improvement activities following written policies and procedures in the state's pharmacies. A process must be in place to detect and analyze medication errors. Importantly, information that is part of the proceedings and records of review are protected from discovery. Texas and Florida also have quality improvement requirements that include the above protective provisions and several other states are now considering them. This should be a nationwide standard.

Recently, the American Pharmaceutical Association Foundation and the National Association of Chain Drug Stores agreed to fund ISMP to independently develop and implement a similar self-assessment tool for the nation's community pharmacies (chain, independent as well as hospital and clinic ambulatory care pharmacies).

Quality improvement requirements should involve all participants in pharmaceutical care, including claims processors and pharmacy benefit managers. Unfortunately, payment policies actually contribute to error. Underpayment of pharmacists, lack of standards for claims processing, numerous interruptions, and phone calls for prescription reimbursement adjudication and pre-approval have resulted in less time available for drug monitoring and patient education activities. An example is requiring pharmacists to dispense drugs at a dose higher than prescribed and making patients split the tablets—an error-prone process—to decrease the cost of a prescription medication. For example, the manufacturer may similarly price an 80 mg, 40 mg, 20 mg, and 10 mg tablet. Although the physician may prescribe 20 mg tablets to be taken four times a day, the pharmacist is required to dispense the 80 mg tablet and tell the patient to take ¼ tablet four times a day. Some patients may become confused and take the full tablet or inaccurately split the tablet. In many cases, to assure that the patient takes the medication properly, a pharmacist will actually break the tablets into one-quarter size. However, the split tablets may begin to crumble in the prescription vial, leading to inaccurate doses.

I would also underscore the need for Congress to oversee providers and payer activities and that participants agree, as a condition of participation, to periodic visits from appropriate authorities to review documentation of quality improvement activities. Currently, little or no oversight exists from standards organizations such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Medicare Peer Review Organizations, state professional boards, departments of health, etc. Without oversight, the private sector has not solved problems associated with safe medication use.

Surely, continuous quality improvement activities are better for the health care provider and public since it offers the potential for reducing the number of prescription errors. A new study released in the American Pharmaceutical Association's (APhA) March/April Journal of the American Pharmaceutical Association (JAPhA) has updated an analysis of prescription drug use problems in the United States. It estimates that drug misuse costs the economy more than $177 billion each year. The estimated number of patient deaths has increased from 198,000 in 1995 to 218,000 in 2000. Clearly, we must have required quality improvement activities to reduce this unnecessary burden. In the legislation, the Secretary of Human Health and Services should be directed to form a task force to examine these and other suggestions to formulate quality improvement requirements that would accompany the prescription drug benefit program. Funding for these activities must be assured.

Improved utilization of pharmacists and pharmacy beneficiaries

The value of medications used appropriately is immense. But, if pharmaceutical care involves reimbursement for only dispensing activities, the drug safety problem will only worsen. Worse, we are overlooking one of the nation's most valuable allies in assuring proper drug use. A trip to the local pharmacy often provides clear evidence that many pharmacy graduates, now educated at the doctoral level with advanced clinical training, are sorely underutilized in the fight against costly adverse drug events. Instead of performing clinical functions for which they are well trained—overseeing a competent technical dispensing staff, screening new prescriptions for safety concerns, educating patients on proper drug use, monitoring patients

for side effects—many are tied instead to dispensing activities, managing pharmacy benefit plans and drug inventories, and performing clerical tasks. Further, with improving technologies (robotics, bar coding of pharmaceuticals and computerized prescriptions) and increasing numbers of certified pharmacy technicians (over 80,000 currently), more of the pharmacist's time will be available for clinical functions.

The Institute of Medicine (IOM) Committee on the Quality of Health Care in America, in their most recent report, *Crossing the Quality Chasm: A New Health System for the 21st Century* IOM urges a strong national commitment to improve health care across six broad dimensions of quality: safety, effectiveness, responsiveness to patients, timeliness, efficiency, and equity. The authors suggest that the current health care system is failing to provide safe, high-quality care consistently to all Americans because it is poorly designed and relies on outdated systems. The report envisions a revamped system which is centered on patient needs and preferences, encourages teamwork among health care providers, and makes greater use of evidence-based approaches to care and information technology. The IOM Committee members recognized that, if organizations are expected to change the processes of care, broader environmental changes are also needed. Importantly, examination of current payment methods (e.g., fee for service, capitation, etc.) to remove barriers to innovation and quality, and testing of options to better align payment methods with quality goals. Realigning the payment to recognize pharmacist clinical services fits right into that idea.

To prevent adverse drug reactions, we need better ways to detect problems early. Pharmacists can serve well in this role, also. They could manage the risk of existing technologies by aggressively monitoring the effects of new drugs on the market and identifying the need for special monitoring to prevent serious adverse events. Thus, pharmacists could safely monitor new and useful drugs that might otherwise be removed from the market because they are being prescribed inappropriately. With the new prescription drug benefit program, strong consideration should be given to reimbursing pharmacists for time spent monitoring patients closely to detect and report anticipated or previously unrecognized problems to the FDA. This would result in earlier detection of medication-related problems and their timely resolution.

Further, we should learn from the valuable experience of the HCFA-required drug regimen review process in long term care, which has saved billions of dollars in prescription drug benefits while also protecting residents from preventable adverse drug events. A comprehensive, on site, drug regimen review is conducted initially upon a patient's admission to a facility and reassessed monthly. As part of drug regimen review, the pharmacist evaluates appropriateness and safety of medication orders and verifies documentation. The pharmacist investigates possible adverse drug reactions in residents who exhibit various identified disorders. A current written diagnosis or identified need and relevant diagnostic data must support medication orders. As needed (PRN) medication orders must include specific written indications for use. Medications selected must be consistent with patients' care plans and shall have a favorable benefit-to-cost ratio reflecting consideration of medical history, the significance of any past drug reactions, and cost. When problems arise, the pharmacist makes recommendations (including identification of the concern, specific means to correct the situation and a determination of how and when improvement will be measured) to appropriate personnel. Consultant pharmacist-conducted drug regimen review improves optimal therapeutic outcomes by 43% and saves $3.6 billion annually in costs from avoided medication-related problems. (Bootman JL, Harrison DL, Cox E: The health care costs of drug-related morbidity and mortality in nursing facilities. Arch Int Med 1997; 157:1531–36. The recommendations must be addressed as a condition of participation.

In the ambulatory care setting, beneficiaries themselves should be required to undergo at least a quarterly review of their prescription and over-the-counter medication regimen by a pharmacist. Similar to the above functions, the requirement would establish that presently prescribed drugs are necessary, that possible adverse effects are identified and reported to the patient's primary care provider, that the beneficiary is aware of proper storage requirements, dosing schedules, side effects, and so on. Pharmacists would be paid to monitor patients closely to detect problems with new drugs or for suspected problems. Not only would this improve care and vastly reduce the nearly $200 billion dollar cost of adverse drug events, it would also eliminate the cost of unneeded medications that patients may still be receiving! The savings to Americans would be enormous. We believe that the legislation should not move forward without a provision for this drug monitoring review with logistics determined by the Secretary.

Another important component is improving patient understanding of their important role in safe medication use and error prevention. About 25% of medication errors reported to our program and FDA's MedWatch program stem from confusion

between proprietary and nonproprietary names. An educated patient or caregiver can be a crucial last check on the safety of any medication. For example, if patients are aware of the name and purpose of their medication, they are better able to recognize if a pharmacist misread the prescription and dispenses a different medication for an unexpected purpose. Legislation should require that the medication's purpose and full instructions be written on each new prescription so that pharmacists can educate patients properly and prevent errors if the purpose and prescribed drug do not match. Listed indications for the drug will also help patients and pharmacists ensure that their interpretation of the prescription is consistent with the prescriber's intent.

Regrettably, the requirement for patient counseling in OBRA 90 legislation is vastly underutilized. Few patients take advantage of the pharmacist's offer to counsel. Instead, they rush the pharmacist to fill a prescription and may not read accompanying drug information material that could prevent adverse events. The new legislation must address the issue by insisting that patients and caregivers have full explanations of new medications while in the doctor's office or pharmacy.

Further, legislation should facilitate health care practitioners' access to crucial information about the patient. Harvard researchers (Leape LL et al. Systems analysis of adverse drug events. JAMA 1995; 274:35–43) showed that over 40% of adverse drug events can be tied to insufficient information about the patient or drug at the time of prescribing, dispensing and administration of medications. The most recent IOM report notes that clinicians operate in silos without the benefit of complete information about the patient's conditions, medical history, treatment received in other settings, or medications prescribed by other clinicians. The report encourages cooperation among clinicians to exchange appropriate information and coordinate care.

Indeed, the same researchers (Leape LL et al. Pharmacist participation on physician rounds and adverse drug events in the intensive care unit. JAMA 1999;282:267–270) showed that pharmacists could prevent 66% of adverse drug events if given access to clinical information to screen and adjust doses and suggest other interventions when clinical indicated.

For example, if a physician fails to adjust the dose of a potentially toxic medication that is excreted through the kidneys in a patient with poor renal function, costly hospitalization, dialysis, transplant, or death may result. While renal function and other important clinical information may be residing in hospital or physician office records, it is often inaccessible to community pharmacists. But with better access to clinical information such as laboratory data, chronic diseases, organ function, allergies, and weight, the pharmacist can screen drug orders appropriately and prevent untold numbers of errors, injuries, and associated costs. The use of web sites or "smart cards" where patients could voluntarily maintain confidential clinical information accessible to their health care practitioners could significantly improve access to information.

Improved use of technology

Health care remains relatively untouched by information technology that has transformed so many other aspects of society. Patient information, including medication prescriptions, is still dispersed on paper, poorly organized, often illegible, and difficult to retrieve. Yet, research shows (Bates DW et al. Effect of computerized physician order entry and a team intervention on prevention of serious medication errors. *JAMA* 1998;280:1311–16) that over half of all medication errors can be prevented through computerization physician order entry (CPOE). An ISMP survey (*ISMP Medication Safety Alert!* February 10, 1999—www.ismp.org) of our nation's computer systems shows that fewer than 13% of US hospitals even have the capability for CPOE. Even fewer ambulatory care physicians are using electronic prescribing technology (estimated to be under 5%). Nevertheless, our survey shows that most in-use prescribing software today does not alert users to errors in an accurate and efficient manner. System vendors and organizations must jointly accept responsibility for designing and implementing systems that offer clinical support to providers and warn about potentially unsafe prescriptions.

Most of the technology software problems stem from the lack of interface and compatibility standards to allow stand alone systems to be fully integrated with each other to ensure that appropriate patient and drug information is available to providers. For example, standards are needed to ensure that any physician can send a prescription to any pharmacy electronically. This eliminates the risk of misinterpreting a handwritten prescription while increasing the detection of potential adverse drug events. We also need to address regulatory and legal barriers that prevent use of electronic prescribing. For example, in many states, verified electronic signatures are not acceptable, thus prescribers must physically sign each prescrip-

tion. Further, incentives should be provided to reward health care practitioners and organizations that adopt technology known to reduce medication errors, such as electronic prescribing and bar code technology.

Bar coding technology can greatly enhance the accuracy of drug dispensing and administration. Although the use of such technology is expanding in ambulatory care pharmacies, mainly through robotics, the pharmaceutical industry must join in this effort by assuring that all drug packages have a standardized, readable bar code or other machine-readable code.

Chairwoman JOHNSON. Thanks very much, Mr. Cohen. Helen Frederick, from Maryland.

STATEMENT OF HELEN FREDERICK, CROWNSVILLE, MD

Ms. FREDERICK. Good afternoon. My name is Helen Frederick.

Chairwoman JOHNSON. Excuse me, Ms. Frederick. Could you pull the microphone down a little bit, the top of the microphone down there? That is good. There.

Ms. FREDERICK. Good afternoon. My name is Helen Frederick. I am very happy to be here today, and I am really glad to hear that Congress is trying to make Medicare better for senior citizens. I would like to tell you a little about my own situation, because I think there are many other people on Medicare just like me who need some help.

I live in Crownsville, Maryland, a small town outside of Baltimore. I am 80 years old, and I have Medicare along with a supplemental policy, United Methodist American. My supplemental policy does a good job of paying for many of the things that Medicare doesn't pay for, but it doesn't pay for prescription drugs. Not all insurance companies of Medicare supplement policies cover prescription drugs, and my insurance company is one of those. The cost of a supplement policy that would have covered my prescriptions would have cost quite a bit more. I couldn't afford it, since I am living on a fixed income.

I am very lucky that I have a home that my husband and I bought. It is paid for now, so I don't have to pay rent, because otherwise, I probably wouldn't be able to pay for the cost of my supplemental policy. Most of the other senior citizens I know also don't have coverage for their prescriptions, but I know a few who have prescription drug coverage through their supplementary policies or through their former employers.

I have diabetes, heart trouble, glaucoma, arthritis, high blood pressure. My medications together cost about $400 a month. And one of my medications by itself costs $109 a month. It is a big part of my total monthly income. And sometimes, I have to skimp on groceries to afford my medication.

I am happy that the prescription drugs I take helped me all these years, but it seems like each year, the costs get higher and higher; that I need to take more medicine. I would like to go to work to help pay for these medications, but my doctor says no, no, I can't.

In the area where I live, there aren't any Medicare HMOs available, so I don't have the option to get on that type of plan. I would like to be able to stay with the doctor I go to now anyway, since I have several different medical problems, and they know my med-

ical history. But I know that some people like HMOs and that they are able to get some of their drugs covered in those plans. I think everyone should be able to choose the plan that is best for them.

I do wonder why we haven't changed Medicare in all these years, since there are so many advances in medical treatments and in medicines. The policies young people have seem to cover most services all on one policy, including prescriptions. I have been on Medicare for 15 years, and it hasn't changed much at all. The hospital deductible has increased, of course, but the outpatient deductible has been $100 as long as I can remember. I don't exactly understand why Medicare is divided into two parts, and it is hard to believe that a health insurance for everybody today would not cover prescriptions as expensive as they are. But since I know that my own prescriptions are so expensive, I wonder how the Government could pay all that cost for everyone. It seems like it would have to be paid for from somewhere.

I don't have a solution to offer today, but I hope that whatever Congress does, it will look at the whole Medicare program and try to bring it up to date. I also hope that people will have choices so that we all don't have to have the exact same type of coverage or all go to the same doctors. Even though I really like to have help with my prescriptions right now, but I worry about how people will be covered in the future and what options my grandson will have when he gets old, and I hope when we do get coverage for prescription drugs, we will, though, think about how it will be paid for, because we need a benefit that will be around for the future.

Thank you for inviting me today. May God bless all who have a voice in planning for our future health.

[The prepared statement of Ms. Frederick follows:]

Statement of Helen Frederick, Crownsville, MD

Good afternoon. My name is Helen Frederick. I'm very happy to be here today, and I'm really glad to hear that Congress is trying to make Medicare better for senior citizens. I'd like to tell you a little bit about my own situation, because I think there are many other people on Medicare just like me who need some help.

I live in Crownsville, Maryland. Crownsville is a small community just outside of Baltimore. I'm 80 years old, and have Medicare along with a supplemental policy with United American. My supplemental policy does a good job of paying for many of the things that Medicare doesn't pay for, but it doesn't pay for prescription drugs. Not all insurance companies offer Medicare supplement policies that cover prescription drugs, and my insurance company is one of those. The cost of a supplemental policy that would have covered my prescriptions would have cost quite a bit more, and I couldn't afford it since I am living on a fixed income. I am very lucky that the home my husband and I bought is paid for now so that I don't have to pay rent, because otherwise I probably wouldn't be able to pay for the cost of my supplemental policy.

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I have diabetes, heart trouble, glaucoma, and arthritis. My medicines together cost about $400 a month, and one of the medicines by itself costs $109. $400 a month is a big part of my total monthly income, and sometimes I have to skimp on groceries to afford my prescriptions. I'm happy that the prescription drugs I take have helped me all of these years, but it seems like each year the costs get higher and higher and that I need to take more medicines. I'd like to go to work to help pay for these medicines, but my doctor says I just can't.

In the area where I live, there aren't any Medicare HMOs available, so I don't have the option to get on that type of plan. I would like to be able to stay with the doctors I go to now anyway since I have several different medical problems and they know my medical history. But I know that some people like HMOs and that they

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Thank you for inviting me today.

Chairwoman JOHNSON. Thank you very much, Ms. Frederick. Mrs. Wilkinson.

Ms. FREDERICK. You are welcome.

STATEMENT OF LORE WILKINSON, DURHAM, NC

Mrs. WILKINSON. Good afternoon. It is a great honor to be here today before the Committee on Ways and Means to share my thoughts about the Medicare program and prescription drugs.

My name is Lore Wilkinson, and I am 70 years young, and I live in Durham, North Carolina. I live a very active lifestyle. I teach a computer class at a magnet school, and I tutor second graders. In addition to that, I walk three miles every day in order to stay healthy.

I am a firm believer in the importance of wellness and preventive care. To that end, I also take some prescription medicines on a daily basis. Because of osteoarthritis and a hypertensive condition in my eyes, I take three doses of medications daily. These medications keep me active and therefore keep me well. One of the reasons I appreciate my private retiree plan coverage is because I have a range of options. Recently, retirees of the company I worked for learned that we would have the option of enrolling in an HMO coverage or choosing one of the other employer-sponsored plan options available to us.

I am enrolling in the HMO coverage because it will continue coverage of my prescription drug needs, and the doctors I see participate in this particular HMO. I made this decision after I learned that the medicines I take were included in their approved list, because not all are. I used the information my employer gave me to comparison shop and found a plan that best suited my medical and financial needs.

I am here today because it is very important to me to have those choices, and I appreciate having an employer-sponsored coverage. I am concerned that if the government decides to offer a one-size-fits-all Government-run plan, I and millions of others will no longer

be able to make these choices about their coverage. I do not want a government plan to disrupt my ability to choose a private coverage that best meets my needs.

The even more important issue I would like to raise is the possibility that employers will not continue offering coverage if a government-run plan is adopted. If employers see that the Government will finance coverage for retirees, I am positive that employers would make business decisions to stop offering health care coverage to retirees. The result for many seniors like me would be to lose our choices of coverage and face increased costs and hassles in a government-run program.

I agree that it is important for seniors to have access to prescription drug coverage, but I also think it is very important that it is structured in such a manner that employers will continue to maintain coverage for the millions of retirees who are happy with their employer-sponsored plans. Such plans were, in essence, computed into retirees' compensation, and we were told that every year.

Earlier, I referenced some medical conditions which I am currently taking medications to manage. I would like to share with you a little bit of background about one experience I had relating to another condition. Last year, at a long-overdue physical after 10 years as I was recovering from a hip fracture, my physician pointed out to me that I was measuring one and a half inches shorter than what I had always been. The recommendation was that I needed to have a bone density test done to determine the severity of my condition.

After obtaining the results, the doctor was able to recommend calcium pills which helped me to regain my strength and maintain my exercise and community service commitments. Yet, Part B Medicare run by the Government initially denied my claim for the bone density measurement, and it took me 3 months of fighting with Medicare representatives to finally get reimbursed for my test, even after a diagnosis of being three-tenths of a percent away from having osteoporosis. I know I am one of the lucky ones to have been able to resolve the claim in only 3 months.

There are two problems with this situation. One is that the inefficiency and bureaucracy of the government-administered program makes obtaining health care services a daunting task for many seniors and actually more expensive for the Government to administer. I have no problem asking questions, and I am well-informed and a careful consumer. I have learned how to ask questions and shop around to find the right solution for my needs. Those skills were developed because I have options and have not been forced into a large Government program.

The second problem is something I also ask you to keep in mind as you begin your important work on modernizing Medicare. I would like to take this opportunity today to emphasize the importance of preventive medicine and wellness. If I only had the government-run Medicare plan, some of the medical conditions I have had would not have been treated at all until it was a debilitating condition warranting an inpatient hospital stay and/or surgery.

Yet there are so many new treatments available which help seniors to achieve wellness, remain active in our communities, enriching other lives, and help us to get more out of lives ourselves. I

know how fortunate I am to have a good employer-sponsored coverage which affords me the choice of private coverage that best meets my needs, but I do worry that a big new Government program plan could eliminate those choices for me and millions of others like me.

I ask you to keep my experience in mind as you begin crafting your proposal to improve access for all seniors to the prescription drug coverage. Thank you.

[The prepared statement of Mrs. Wilkinson follows:]

Statement of Lore Wilkinson, Durham, NC

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

My name is Lore Wilkinson. I am 70 years old and I live in Durham, North Carolina. I live a very active lifestyle, volunteering in various community service projects and I also walk 3 miles every day. I am a firm believer in the importance of wellness and preventive care. To that end, I also take some prescription medicines on a daily basis. Because of arthritis and a hypertensive condition, I take 3 doses of medication daily. These medications keep me active and therefore keep me well.

One of the reasons I appreciate my private retiree plan coverage is because I have a range of options. Recently, retirees of the company I worked for learned that we would have the option of enrolling in HMO coverage or choosing one of the other employer-sponsored plan options available to us. I am enrolling in the HMO coverage because it will continue coverage for my prescription drug needs and the doctors I see participate in this HMO. After some research, I learned that the medicines I take were included on their approved list. I used the information my employer gave me to comparison shop and found a plan that best suited my needs.

I am here today because it is important to me to have those choices and I appreciate having employer-sponsored coverage. I am concerned that if the government decides to offer a "one size fits all" government-run plan, I will not be able to make choices about my coverage. I do not want a government plan to disrupt my ability to choose private coverage that best meets my needs.

The even more important issue I would like to raise is the possibility that employers will not continue offering coverage if a government-run plan is adopted. If employers see that the government will finance coverage for retirees, I am sure employers would make business decisions to stop offering health care coverage to retirees. The result for many seniors like me would be to lose our choices of coverage and face increased costs and hassles in a new government-run program. I agree that it is important for seniors to have access to prescription drug coverage. But, I think it is very important that it is structured so that employers will continue to maintain coverage for the millions of retirees who are happy with their employer-sponsored plans. Such plans were, in essence, computed into retirees' compensation.

Earlier, I referenced some medical conditions which I am currently taking medications to manage. I would like to share with you a little bit of background about one experience I had relating to another condition. Last year, at an examination as I was recovering from a hip fracture, my physician pointed out to me that I was measuring at one and a half inches shorter than what had always been my height. Her recommendation was that I needed to have a bone mass measurement done to determine the severity of my condition. After obtaining the results, my doctor was able to recommend calcium pills which helped me to regain my strength and maintain my exercise and community service commitments. Yet, Part B Medicare, run by the government, initially denied the claim for the bone density measurement and it took me three months of fighting with Medicare representatives to finally get reimbursement for my test. I know I am one of the lucky ones to have been able to resolve the claim in only three months.

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I have no problem asking questions. I am a well-informed and careful consumer. I have learned how to ask questions and shop around to find the right solution for me. Those skills were developed because I have options and have not been forced into a large government program.

The second problem is something I also ask you to keep in mind as you begin your important work on modernizing Medicare. I want to take this opportunity today to

emphasize the importance of preventive medicine and wellness. If I only had the government-run Medicare plan, some of the medical conditions I have had in retirement would have been treated by doing nothing about it until it was a debilitating condition warranting an inpatient hospital stay and surgery. Yet, there are so many new treatments available which help seniors to achieve wellness, remain active in our communities and help us to get more out of life.

I know how fortunate I am to have good employer-sponsored coverage which affords me the choice of private coverage that best meets my needs. But, I do worry that a big, new government plan could eliminate those choices for me. I ask you to keep my experience in mind as you begin crafting your proposal to improve access for all seniors to prescription drug coverage.

Chairwoman JOHNSON. Thank you very much, Mrs. Wilkinson. Mr. Richtman

STATEMENT OF MAX RICHTMAN, EXECUTIVE VICE PRESIDENT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Mr. RICHTMAN. Good afternoon, Madam Chairwoman and Members of the Subcommittee. I am Max Richtman, executive vice president of the National Committee to Preserve Social Security and Medicare. The National Committee is also currently chairing the Leadership Council of Aging Organizations, and as you know, that is a coalition of 46 national nonprofit organizations dedicated to the concerns of aging America.

Although Americans have been enjoying a period of economic prosperity, we have not yet addressed one of the most dire health needs of seniors today, and that is access to affordable prescription drugs. A CNN-Gallup-USA Today poll conducted earlier this year ranked 13 possible priorities for the new administration's use of the Federal surplus dollars. Strengthening Social Security, helping seniors pay for prescription drugs and ensuring the long-term strength of Medicare all ranked among the top five priorities, while cutting Federal income taxes ranked second to last.

President Bush has said repeatedly that a large part of the budget surplus is the people's money and should be returned to the people. We believe that a fair way to return part of this surplus to the people would be in the form of a universal voluntary and affordable prescription drug benefit as part of the Medicare Program for all seniors. This polling reflects the views of our Members as well. Medicare solvency and access to prescription drug benefits remain two of our top priorities.

In February of last year, the National Committee to Preserve Social Security and Medicare joined the Leadership Council of Aging Organizations in developing a set of principles for a Medicare prescription drug benefit which I have attached to my testimony. These principles continue to guide our efforts in this Congress. Essentially, we believe that seniors deserve a prescription drug benefit that is comprehensive in coverage; affordable and regularly adjusted to account for inflation; voluntary but guaranteed to all who want it regardless of income or health status and available as part of the Medicare Program, including traditional fee-for-service Medicare.

We are concerned about various proposals that do not meet our basic standards and principles. We are concerned about proposals to pay for the prescription drug benefit by using Medicare Part A Trust Fund moneys. This would have a major impact on the solvency of the existing trust funds which finances benefits under the current law. Some premium support proposals suggest that private managed-care organizations offer seniors drug coverage. However, access to Medicare managed care has already proven to be unreliable.

Following the Balanced Budget Act of 1997, many seniors enrolled in managed care plans, in large part for the prescription drug coverage. As of January of this year, nearly a million people, one out of every six Medicare plus choice enrollees, were dropped from their managed care plus choice plans. More and more managed care plans are deciding not to participate in Medicare, abruptly dropping seniors, particularly those in rural and hard-to-serve areas.

The dramatic increase in Medigap premiums that include prescription drugs is clear evidence that the private sector cannot provide adequate access to prescription drug coverage for a reasonable cost.

Another concern of the National Committee and the Leadership Council is that managed care plans, as they have historically done, could participate in favorable risk selection by offering Medicare beneficiaries low-cost, low-coverage plans that will attract younger, healthier seniors, leaving the sickest and oldest unable to afford the more generous plans. As you know, the President's blueprint budget provides $153 billion for Medicare reform, including $48 billion for a prescription drug plan called Immediate Helping Hand.

The Immediate Helping Hand proposal will only reach the lowest-income seniors through State-based plans. Even the National Governors' Association has said that it does not want the Federal Government to impose the responsibility of prescription drug plans on States. The 23 States that already provide such assistance reach, on average, about one-fourth of those in need. The National Committee and the Leadership Council agree that these plans do not meet our principles.

Most premium support models being considered cannot guarantee affordability for all seniors, and the President's proposal is far from universal in coverage. About one-half of seniors who lack prescription coverage today have incomes above 175 percent of poverty.

I am going to skip my example because I am running out of time, but let me just finish by saying it is unclear exactly how much it would cost to provide a prescription drug benefit. We heard today from the CBO that it could cost nearly $1.5 trillion over the next 10 years. The National Committee and the Leadership Council estimates that a meaningful, comprehensive benefit to match what seniors truly need and expect would require a 10-year commitment of about twice what the President's Medicare reform proposal calls for. Precise numbers are not available, but it is obvious that there could be cost savings from the overall system due to the dramatic decrease in costs for treatment and hospitalization as a result of

patients' ability to comply with their physician's prescribed drug regimes.

The Leadership Council and the National Committee asks the Congress—this Subcommittee, this Committee and the Congress—to pass a prescription drug bill that makes drugs affordable; that it is included in the basic Medicare package; is universal and includes a broad spectrum of financing elements including beneficiary contributions and general revenue contributions and, very importantly, utilizes Medicare's size to achieve volume price discounts for beneficiaries.

Thank you very much.

[The prepared statement of Mr. Richtman follows:]

Statement of Max Richtman, Executive Vice President, National Committee to Preserve Social Security and Medicare

Good Morning, Madam Chair and distinguished Members of the Committee. I am Max Richtman, Executive Vice President of the National Committee to Preserve Social Security and Medicare, a grassroots education and advocacy organization with several millions of members and supporters around the country. The National Committee is currently chairing the Leadership Council of Aging Organizations, a coalition of forty-six national, non-profit organizations dedicated to the concerns of an aging America.

Although Americans have been enjoying a period of economic prosperity, we have not yet addressed one of the most dire health needs of seniors today, access to affordable prescription drugs. In the year 2000, eight out of ten Medicare beneficiaries reported using prescription drugs on a daily basis, with the average senior taking four prescriptions daily and filling an average of 28 prescriptions a year. Because people are living longer, they are experiencing more chronic conditions than ever before. According to HCFA, 73 percent of women and 65 percent of men who are Medicare beneficiaries have two or more chronic conditions, which are more likely to require prescription drug treatments. The high cost of prescription drug prices, which continues to rise, creates an additional burden for the majority of seniors who are on low, fixed incomes. The SPRY Foundation, a research and education arm of the National Committee, predicted that seniors spend approximately three times as much on out-of-pocket expenses as the under 65 population, due substantially to the fact that just over one-third of the beneficiaries (12 million seniors) have no drug coverage, with access for the remaining two-thirds either declining, or becoming more costly, or both. In the year 2000, the average expenditure for prescription drugs for a senior was $1,205, with an average of $590 as their out-of-pocket expense. Drug costs for seniors are also expected to double by 2008, partly due to the rising cost of development of breakthrough drugs and the increased cost of advertising to consumers. In 1996, overall drug spending has increased from $30 billion in 1996 to $50 billion in the year 2000. Escalating drug costs and increased prescription drug use are not just problems for our senior population. It also is becoming a burden for the younger generations, who must help support their parents, as well as their own families.

A CNN/Gallup/USA Today Poll conducted earlier this year ranked thirteen possible priorities for the new administration's use of federal surplus dollars. Strengthening Social Security, helping seniors pay for prescription drugs, and ensuring the long term strength of Medicare all ranked among the top five priorities while cutting federal income taxes ranked second to the last. President Bush has said repeatedly that a large part of the budget surplus is the people's money and should be returned to the people. A fair way to return part of this surplus to the people would be in the form of a universal, voluntary and affordable prescription drug benefit as a part of the Medicare program for all seniors. This polling reflects the views of our members as well. Medicare solvency and access to prescription drug benefits remain two of our top priorities.

In February 2000, the National Committee to Preserve Social Security and Medicare joined the Leadership Council of Aging Organizations in developing a set of principles for a Medicare Prescription Drug Benefit, which I have attached to my testimony. These principles continue to guide our effort in the 107th Congress. Essentially, we believe that seniors deserve a prescription drug benefit that is comprehensive in coverage, affordable and regularly adjusted to account for inflation, voluntary but guaranteed to all who want it regardless of income or health status

and available as part of the Medicare program including traditional fee-for-service Medicare. We are concerned about various proposals that do not meet our basic standards and principles. We are also concerned about proposals to pay for the prescription drug benefit by using Medicare Part A trust fund monies. This would have a major impact on the solvency of the existing trust fund, which finances benefits under the current law.

Some premium support proposals suggest that private managed care organizations offer seniors drug coverage. However, access to Medicare managed care has already proven to be unreliable. Following the Balanced Budget Act of 1997, many seniors enrolled in managed care plans, in large part for the prescription drug coverage. This year, about one million beneficiaries in these plans have been dropped from their managed care Plus Choice plans. More and more managed care plans are deciding not to participate in Medicare, abruptly dropping seniors, particularly those in rural and hard-to-serve areas. The dramatic increase in Medigap premiums that include prescription drugs is clear evidence that the private sector cannot provide adequate access to prescription drug coverage for a reasonable cost.

Another concern of the National Committee and Leadership Council is that managed care plans, as they have historically done, could participate in favorable risk selection by offering Medicare beneficiaries low-cost, low coverage plans that will attract younger, healthier seniors, leaving the sickest and oldest unable to afford the more generous plans.

As you know, President Bush's Blueprint Budget provides $153 billion over 10 years for Medicare reform, including $48 billion for a prescription drug plan called Immediate Helping Hand. The Immediate Helping Hand Proposal will only reach the lowest income seniors through state-based plans. The bipartisan National Governors Association has said that they do not want the federal government to impose the responsibility of prescription drug plans on the states. The twenty-three states that already provide such assistance reach, on average, only about one-fourth of those in need. The National Committee and the Leadership Council agree that these plans do not meet our principles. Most premium support models being considered cannot guarantee affordability for all seniors and the Bush proposal is far from universal in coverage. About one-half of seniors who lack prescription coverage today have incomes above 175 percent of poverty. Ms. Sylvia Kessler, an 81-year-old National Committee member from Florida, is an excellent example of a middle-income senior who does not qualify for her state based prescription drug plan because she is above the income level required. She also would not be eligible for Immediate Helping Hand because she is over 175% of the poverty rate. Ms Kessler testified in February of this year before the House Energy and Commerce Committee's Subcommittee on Health, as a middle-income senior who can barely afford her nine prescriptions for heart disease and high cholesterol. Because her prescriptions cost $2,300 per year (over 10 percent of her annual income), Ms. Kessler must work two part-time jobs at the local Board of Elections and a flea market in order to make ends meet.

Last week, the Chairman of the Senate Finance Committee said that President Bush's $153 billion would not be enough to offer drug benefits to all 39 million elderly and disabled on Medicare. Exactly how much is required to provide a drug benefit has been debated, but CBO recently estimated that spending on prescription drugs for Medicare beneficiaries would cost nearly $1.5 trillion from 2002 to 2011. The National Committee and Leadership Council estimates that a meaningful, comprehensive benefit to match what seniors truly need and expect would require a 10 year commitment of more than twice President Bush's Medicare reform amount for the drug benefit alone. Obviously, this endeavor would be expensive. Although precise numbers are not available, it is obvious that there would be cost savings for the overall system due to the dramatic decrease in costs for treatment and hospitalization as a result of patients' ability to comply with their physician's prescribed drug regimes.

The Leadership Council and the National Committee calls on members of this body to pass a prescription drug bill that makes drugs affordable, includes drugs in the basic Medicare package, and is universal. It should include a broad spectrum of financing elements including beneficiary contributions and general revenue contributions and utilize Medicare's size to achieve volume price discounts for beneficiaries. Thank you for your time.

LEADERSHIP COUNCIL OF AGING ORGANIZATIONS

LCAO principles for a Medicare prescription drug benefit

In February 2000, the Leadership Council of Aging Organizations (LCAO) forwarded a set of principles to the Congress and the Administration outlining the crit-

ical issues that must be addressed in any Medicare prescription drug benefit that will gain LCAO support. The LCAO continues to support these principles as essential elements that must be incorporated into any major legislation to expand seniors' access to outpatient prescription drugs. Below are the highlights of the LCAO principles:

Benefits

Medicare should guarantee access to a voluntary prescription drug benefit as a part of its defined benefit package.

Medicare's prescription drug benefit should provide comprehensive coverage, including the most current, effective, and individually appropriate drug therapies.

Medicare's contribution toward the cost of the prescription drug benefit must keep pace with the increase in prescription drug costs and must not be tied to budgetary caps.

Adding a Medicare benefit must not reduce access to other Medicare benefits.

Coverage

The Medicare prescription drug benefit should be available to all Medicare eligible older Americans and persons with disabilities, regardless of income or health status.

The Medicare prescription drug benefit must be voluntary and provide safeguards against erosion of current prescription drug coverage provided by others.

Affordability

The financing of a new Medicare prescription drug benefit should protect all beneficiaries from burdensome out-of-pocket expenses and unaffordable cost sharing, particularly low-income beneficiaries.

The new benefit must protect individuals from extraordinary expenses for prescription drugs.

The government subsidy must be sufficient to guard against risk selection and to provide an attractive benefit design.

Sufficient subsidies should be provided for low-income beneficiaries to ensure that they have access to the benefit.

Administration

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

Quality

The new Medicare prescription drug benefit must meet rigorous standards for quality of care, including appropriate monitoring and quality assurance activities.

The Medicare program should work to prevent the overuse, underuse, and misuse of prescription drugs.

Chairwoman JOHNSON. Thank you, Mr. Richtman. Ms. MacGuineas.

STATEMENT OF MAYA MacGUINEAS, NATIONAL BOARD MEMBER, THIRD MILLENNIUM, NEW YORK, NY

Ms. MACGUINEAS. Good afternoon, Madam Chairwoman and Members of the Subcommittee. My name is Maya MacGuineas, and I am a board member of Third Millennium, a national, nonpartisan organization founded by young adults to help offer solutions to long-term problems facing the country. Professionally, I am a fellow at a think tank here in Washington, D.C., the New America Foundation, where I work on fiscal policy issues, primarily the budget, taxes and entitlements.

Thank you for including us in the discussion today about whether or not to include a prescription drug program in Medicare. We are honored to be here and appreciate that you have chosen to include the voices of young adults in this discussion.

Madam Chairwoman, Members of my generation think that a prescription drug benefit should be included in Medicare, but we believe that if one is created, it should be targeted toward poor and low-income seniors. When ranking their preferences for spending initiatives, my peers put education, health care for the uninsured and reforming Social Security all before providing a new prescription drug benefit. As the trustees reiterated last week, Medicare faces tremendous funding pressures that will materialize before anyone in my generation reaches retirement age.

The recent news paints a startling picture: we are now talking about an astounding difference between benefits and payroll taxes and premiums of $333 trillion over the next 75 years, and on its current course, by 2075, Medicare will consume more than 8 percent of GDP. That number may not seem relevant to many of us here today, but to our children and grandchildren, it certainly will be.

The momentum to add a prescription drug program to Medicare has accelerated rapidly, and there is indeed good reason to consider this new benefit. Nonetheless, we believe that the certainty that something should be done should not replace contemplation of how to do it right. The structure of any new benefit will have tremendous budgetary consequences for decades to come. And this is nothing the Subcommittee doesn't already know, but what you may not know are the specifics about how my generation feel about creating a new prescription drug benefit, and I would like to share with you the results of a just-released national survey Third Millennium commissioned from the bipartisan polling team of Democratic Jeffrey Pollock and Republican Frank Luntz.

My peers clearly support a prescription drug benefit for seniors, but the level of support dropped dramatically as the would-be recipient's income increases. For example, more than four out of five of my peers would support a prescription drug benefit for seniors with household incomes of $20,000 or less. Three out of five would support a benefit for seniors with household incomes of $40,000 or less.

Above that $40,000 level, however, support drops off considerably, and only one-third would give the benefit to seniors with household incomes of $60,000 or more, and merely one out of five would support it for those with incomes of $100,000.

And let me put this another way: while most of my generation is more than willing to help a low-income elderly widow in Connecticut's Sixth District or California's Thirteenth, 82 percent of my contemporaries say it is unfair to give prescription drug benefits to Ross Perot or Larry King. Young adults feel similarly when it comes to catastrophic coverage. Thirty-five percent of them would support the program to cover annual, out-of-pocket expenses of over $6,000, though 61 percent would not. However, if the program were targeted toward seniors with low to moderate incomes, support is overwhelming, with an 87 to 12 percent margin.

Now, we know that there are millions of middle to high income seniors who would like a new prescription drug benefit, and indeed, there are members of both parties who want to provide one. My question is this: is it fair to ask low-wage workers in each of your districts who themselves can barely afford health care and pre-

scription drugs and many of whom who have no health insurance whatsoever to subsidize the drug benefits of those who want a handout but don't, in fact, need one?

And it is worth noting that many seniors are, in fact, far wealthier than their incomes imply. Americans over 65 have an 80 percent homeownership rate, twice that of adults under 35 years old. More to the point, 80 percent of these older homeowners own their houses outright, carrying no mortgage, while only 24 percent of those under 65 are in that enviable position.

Looking more broadly at total assets, our elderly families between ages 65 and 74 have median assets of $147,000, the highest of any age group. For all age groups, median assets are $72,000. For those under 35, they are just $9,000. Third Millennium is very excited about the kinds of innovations that we are seeing in the field of medical technology, and as time marches on, Medicare will be looking toward some of these new programs and technologies to incorporate into the program. But Third Millennium believes that the cost of these advances cannot be borne entirely by younger generations, who already face a tremendous financing burden.

We are currently on a budgetary path where Social Security and Medicare and Medicaid will consume more than three-quarters of the Federal revenues in the budget by 2030, and somewhere—it looks like in the late 2040s—there will be nothing left to pay for other programs besides these three programs. Oftentimes, this discussion is painted as a battle between young and old, and that blurs the point. This should be a discussion about who among us, of all ages, receives the benefits and who among us, of all ages, pays.

Madam Chairwoman, what I would like most to stress today is this: adding a prescription drug benefit to the Medicare Program must be part of a more comprehensive reform to strengthen the Medicare Program. When a program is facing a long-term financing shortfall, expanding benefits is not reform. There are many options: raising the eligibility age, means-testing premiums and boosting national savings, that will help keep Medicare in balance.

We should also rely on increased premiums, deductibles and copayments rather than just higher payroll taxes or general revenue transfers. A new benefit should be targeted only toward those who both need and cannot afford them on their own. Two-thirds of seniors do currently have prescription drug coverage. The answer is not, then, to provide a massive new universal benefit. We must acknowledge that adding prescription drug benefits may be a desirable thing to do, but at the same time, it will affect the cost of other reforms. Therefore, the issue of prescription drugs and Medicare reform are inseparable and we hope will be treated accordingly.

Once again, I thank you for inviting Third Millennium to appear before you today. I hope I have helped to shed some light on how many in my generation hope the discussion will proceed. Thank you.

[The prepared statement of Ms. MacGuineas follows:]

Statement of Maya MacGuineas, National Board Member, Third Millennium, New York, NY

Good afternoon, Madam Chairwoman, and members of the Subcommittee. My name is Maya MacGuineas and I am a board member of Third Millennium, a national non-partisan organization founded by young adults offering solutions to long-term problems facing the United States. Professionally, I am a fellow at the New America Foundation, a non-partisan think tank here in Washington, where I study fiscal policy issues, in particular those related to taxes, the budget and entitlement programs.

Thank you for including us in the discussion today about whether to include a prescription drug benefit in Medicare. We are honored to be here and appreciate that you have chosen to include young adults in this discussion.

Madam Chairwoman, members of my generation think that a prescription drug benefit should be included in Medicare, but believe that if one is created, the benefit should be targeted toward poor and lower income seniors. Furthermore, among various new spending options Congress might consider, a drug benefit is a much lower priority than improving education, providing health insurance for the uninsured, and fixing the Social Security system. Given the choice, my peers, young Democrats, Republicans and Independents alike, would not rush to subsidize prescription drugs.

As the Trustees reiterated on March 19th, Medicare faces tremendous funding pressures that will materialize before anyone in my generation reaches retirement age. The recent news paints a startling picture. We are now talking about an astounding difference between benefits and payroll taxes and premiums of $333 trillion over the next 75 years. That's one-third of a quadrillion dollars!

Throughout its history, Medicare has grown more rapidly than the economy and its growth is expected to accelerate with the retirement of the Baby Boom generation and increasing health care costs, leading to mounting expenses and an-ever expanding share of our nation's resources needed to fund the program. On its current course, by 2075, Medicare will consume more than 8% of GDP. That number may not seem relevant to some of us here today, but to our children and grandchildren, it certainly will be.

The momentum to add a prescription drug program to Medicare has accelerated rapidly and there are indeed good reasons to consider this new benefit, not the least of which is the many seniors who need but cannot afford necessary medications. Nonetheless, we believe that the certainty that "something should be done" must not replace thoughtful contemplation of how to do it right.

First, we believe the issue should not be looked at in a vacuum, but rather in the context of the entire Medicare program. To expand the program without regard to the costs—both today's and tomorrow's—and without addressing the current funding and structural problems plaguing Medicare will only exacerbate the looming financing crisis. And the costs we are talking about are not insignificant. A new prescription drug benefit could easily eat up all of Medicare's surpluses over the next decade and more. This is not a responsible way to prepare for the tremendous costs we know are just around the corner.

This is nothing the subcommittee doesn't already know. But what you may not know are the specifics about how younger generations feel about creating a new prescription drug benefit. I would like to share with you today the results of a just-released national survey Third Millennium commissioned from the bipartisan polling team of Democrat Jefrey Pollock and Republican Frank Luntz. I have submitted the results in their entirety with my written testimony. After randomly interviewing 500 young adults between the ages of 18 and 34, our poll found the following:

My peers clearly support a prescription drug benefit for seniors, but that level of support drops dramatically as the would-be recipient's income increases. For example, more than four out of five of my peers would support a prescription drug benefit in Medicare for seniors with household incomes of $20,000 or less. Three out of five would support a prescription drug benefit in Medicare for seniors with household incomes of $40,000.

Above that $40,000 level, though, support drops off considerably. Only one-third would give this benefit to seniors with household incomes of $60,000, and a mere one out of five would support it for those with incomes of $100,000.

Let me put it another way: While most of my generation is more than willing to help a low-income elderly widow in Connecticut's 6th District or California's 13th, 83% of my contemporaries say it is unfair to give a prescription drug benefit to Hugh Hefner, Ross Perot, or Larry King.

The subject of recipient income arises again when younger adults are asked whether wealthy seniors should have their prescription bills subsidized if their out-of-pocket expenses are more than $6,000 annually. While 35% would support such

a subsidy, 61% would not. However, when the exact same question is asked about seniors with low to moderate incomes, supporters overwhelm opponents by an 87% to 12% margin.

My generation's message to Congress is clear: If you want our political support, you need to means-test a new prescription drug benefit. We cannot afford to provide a massive new entitlement for those who don't need it.

We know there are millions of middle-to-high income seniors who would like a new prescription drug benefit. Indeed, there are members of both parties who want to provide one. And my question is this: Is it fair to ask low wage workers in each of your districts, who themselves can barely afford prescription drugs and some of whom have no health insurance at all, to subsidize the drug benefits of those who want a handout but don't need one? Beyond that, is it wise? Two-thirds of retirees currently have prescription drug benefits. If the government introduces a universal program, many current corporate retirement programs are likely to drop that component of their coverage. Couldn't one argue that Uncle Sam's assuming this responsibility would be a form of corporate welfare?

It is worth noting that many seniors are in fact far wealthier than their incomes imply. Retirees are one of the best-off segments of the population, wealthier, in fact, than any previous generation. This in large part is due to the high home ownership rates of older Americans; as many of you know, one's home is the most valuable asset for most families.

The Census Bureau found Americans over 65 have an 80% home ownership rate, twice that of adults under 35. More to the point, according to AARP, 80% of these older homeowners own their homes outright, carrying no mortgage, while only 24% of those under 65 are in that enviable position. Looking more broadly at total assets, the Census Bureau found elderly families between ages 65 and 74 have median assets of $147,000, the highest of any age group. For all age groups, median assets are $72,000; for those under 35, they are just $9,000.

Furthermore, Medicare has been and remains a very generous program. Current retirees are expected to receive two to four times as much as they paid in, according to economist Eugene Steuerle of the Urban Institute. Because of the intergenerational nature of the program, each new expansion provides a windfall for recipients who gain access to new benefits they didn't support during their working years. Now this is not entirely surprising; as time marches on, so too do medical innovations. We are grateful for the many new life-saving and enhancing medicines that have been brought to market over the past decades.

But Third Millennium believes that the costs of these advances cannot be borne entirely by younger generations, who already face a tremendous financing burden. As the GAO recently reported, we are currently on a budgetary path where Social Security, Medicare, and Medicaid will consume more than three-quarters of total federal revenues by 2030. Somewhere in the 2040s, there will be nothing left for any other government spending. The Medicare Trustees contend that just to bring Medicare Part A back into line, program income will have to be increased by 60%.

Oftentimes this discussion is painted as a battle between young and old. That blurs the point. This should be a discussion about who among us—of all ages—receives the benefits, and who among us—of all ages—pays for them.

Therefore, we must target a new benefit only to those who have no other options and who cannot afford prescription drugs on their own. And we must spread those cost among those who can afford them—of all ages. Additionally, we think there is a good argument for providing some type of catastrophic benefit coverage for those who have inordinately high drug costs. But again, we think this should only be done with need and costs in mind.

Madam Chairwoman, what I would most like to stress today is this: Adding a prescription drug benefit to the Medicare program must be part of more comprehensive reforms to strengthen the Medicare program. Since we know that Medicare will face a significant funding shortfall, to ignore this reality while expanding the obligations of the program is not a responsible approach to mending what ails the system. Rather, I fear it will add to the cynicism many young people feel about government and whether the programs they pay for today will be available to them tomorrow.

Indeed, our survey found that nearly half (43%) of people 18–34 think that the TV soap opera "General Hospital" will outlast the Medicare system!

When a program is facing a long-term financing shortfall, expanding benefits is not reform. There are many options—raising the eligibility age, means-testing premiums, relying more on managed care for seniors, and boosting national savings—that will help keep Medicare in balance. We should also rely on increased premiums, deductibles and co-payments rather than just higher payroll taxes or general revenue transfers.

We must acknowledge that adding a prescription drug benefit may be a desirable thing to do, but at the same time it will affect the cost of other reforms. Therefore, the issue of prescription drugs and Medicare reform are inseparable and we hope, will be treated accordingly.

Once again, I thank you for inviting Third Millennium to appear before you today to discuss this very important topic. I hope I have helped to shed some light on where many in our generation hope the discussion will go. I look forward to your questions.

MEDICARE/PRESCRIPTION DRUGS PHONE SURVEY OF 500 AMERICANS AGES 18–34, MARCH 2001

Hello. This is ____ of ____, a national research firm. We are calling people across the nation to get their views on important national issues. Your views will help shape the issues being debated in Congress. This will only take about eight minutes. **(DO NOT PAUSE)**

(1) First, I need to find someone in your household that is between 18 and 34 years old. What is your age, please? **(If not qualified, ask for someone else in the Household who is. Otherwise, terminate)**

26% 18–24
29% 25–29
45% 30–34
—Over 34 **(Terminate)**
—Under 18 **(Terminate)**
—Don't know/refused (terminate) (don't read)

The following set of questions deal with Medicare, the Federal government program that provides health insurance for Americans age 65 and older, regardless of their income. As you may or may not know, Medicare covers hospital costs, and seniors pay a small premium to help cover doctor costs, but Medicare does not cover most prescription drugs. About two-thirds of all seniors, however, have prescription drug insurance through other sources, such as retiree benefits or private insurance.

(2) Congress is currently debating whether to add a prescription drug benefit to Medicare.* * *

Some Members of Congress want to provide prescription drug coverage **To All** seniors regardless of income, at an estimated cost of roughly **98** billion dollars over four years. * * *

Other Members of Congress want to provide prescription drug coverage to only lower income seniors at an estimated cost of roughly **48** billion dollars over four years. * * *

Which type of prescription drug plan do you think Congress should create? (READ ALL ANSWERS—ROTATE)

38% a 98 billion dollar drug benefit for all seniors—regardless of income; or
48% a 48 billion dollar drug benefit only for seniors with lower incomes; or
4% the country cannot afford to offer seniors a drug benefit of any type; or
10% don't know/refused **(Don't read)**

Would you strongly support, somewhat support, somewhat oppose or strongly oppose allocating tax dollars to pay for prescription drugs for seniors with household incomes of

(3) $16,000 per year?

48% strongly support
38% somewhat support
4% somewhat oppose
6% strongly oppose
3% don't know/refused **(Don't read)**

(Rotate top to bottom or bottom to top questions #4–#7)

(4) And what is your response if they had an annual income of $20,000 per year?

47% strongly support
37% somewhat support
7% somewhat oppose
5% strongly oppose
5% don't know/refused **(Don't read)**

(5) And what if they had an annual income of $40,000 per year?

20% strongly support
41% somewhat support
21% somewhat oppose
14% strongly oppose

4% don't know/refused **(Don't read)**

(6) And what if they had an annual income of $60,000 a year?

9% strongly support
26% somewhat support
28% somewhat oppose
34% strongly oppose
4% don't know/refused **(Don't read)**

(7) And what if they had an annual income of $100,000 a year?

6% strongly support
14% somewhat support
18% somewhat oppose
61% strongly oppose
2% don't know/refused **(Don't read)**

(8a) **(Split sample)** And would you [**Read responses**] providing tax dollars to **wealthy seniors** whose out-of-pocket prescription drug bills are more than $6,000 per year?

11% strongly support
4% somewhat support
29% somewhat oppose
32% strongly oppose
5% don't know/refused **(Don't read)**

(8b) **(Split sample)** And would you **[Read responses]** providing tax dollars to **seniors with low to moderate incomes** whose out-of-pocket prescription drug bills are more than $6,000 per year?

55% strongly support
32% somewhat support
6% somewhat oppose
5% strongly oppose
1% don't know/refused **(Don't read)**

Now, according to official government projections, the Medicare system will begin paying out more in benefits than it will receive in taxes well before most of the Baby Boom generation is retired. Knowing this, I'd like to ask whether you support or oppose the following proposals for reforming Medicare.

(9) Currently, Medicare pays doctors and hospitals directly for covered benefits received by seniors. One reform proposal would instead provide **each beneficiary** with a fixed amount of money each year to buy coverage from the private insurance plan of his or her choice. Seniors could stay in the existing Medicare system if they preferred. Is this something you would * * *?

23% strongly support
52% somewhat support
12% somewhat oppose
8% strongly oppose
2% no opinion **(Don't read)**
2% don't know/refused **(Don't read)**

(10a) **(Split sample)** Currently, individuals become eligible for Medicare at age 65. **[One proposal is to gradually raise the Medicare eligibility age to 70 over the next 20 years. Is this something you would * * *?]**

10% strongly support
13% somewhat support
24% somewhat oppose
52% strongly oppose
1% no opinion **(Don't read)**
—Don't know/refused **(Don't read)**

(10b) **(Split sample)** Currently, individuals become eligible for Medicare at age 65. **[One proposal would gradually raise the Medicare eligibility age to 67 to mirror the Social Security eligibility age increases that are already required by law. Is this something you would * * *?]**

14% strongly support
26% somewhat support
27% somewhat oppose
28% strongly oppose
2% no opinion **(Don't read)**
2% don't know/refused **(Don't read)**

(11) Currently, all seniors pay the same amount of money for Medicare coverage, regardless of their income. One proposal would tie the amount of money seniors pay for Medicare to their household income, so wealthier retirees would pay more and lower income seniors would pay less. Is this something you * * *

49% strongly support

29% somewhat support
9% somewhat oppose
11% strongly oppose
1% no opinion **(Don't read)**
1% don't know/refused **(Don't read)**

(12) Today, workers and their employers pay a combined 2.9 percent of their wages for a Medicare payroll tax. In the future, it is projected that this tax will no longer generate enough money to cover the cost of Medicare benefits for everyone who will need them. One proposal is to increase this payroll tax rate on workers to fund Medicare for the future. Is this something you would * * *?

15% strongly support
40% somewhat support
19% somewhat oppose
23% strongly oppose
1% no opinion **(Don't read)**
2% don't know/refused **(Don't read)**

(13) Currently, only a small percentage of senior citizens get their health care through managed care plans, such as HMOs. Would you **[Read responses]** offering seniors financial incentives to enroll in managed care plans in order to slow the growth of Medicare, as long as they could choose another plan later if they were dissatisfied in any way?

31% strongly support
48% somewhat support
9% somewhat oppose
8% strongly oppose
3% no opinion **(Don't read)**
2% don't know/refused **(Don't read)**

(14a) **(Split sample)** Currently, 36% of all federal spending goes to programs for the elderly, mainly for Social Security and Medicare. Do you think spending just over one-third of the federal budget on the elderly is: **(Read and rotate top to bottom or bottom to top)**

16% too high
55% just right
21% not high enough
7% don't know/refused **(Don't read)**

(14b) **(Split sample)** Currently, 36% of all federal spending goes to programs for the elderly, mainly for Social Security and Medicare. **[Thinking about all of the programs the Federal government needs to spend money on,]** do you think spending just over one-third of the federal budget on the elderly is: **(Read and rotate top to bottom or bottom to top)**

20% too high
48% just right
21% not high enough
11% don't know/refused **(Don't read)**

(15) And what do you believe should be the proper ratio of government spending in the federal budget on seniors as compared to children? **(Read and rotate top to bottom or bottom to top)**

3% $8 spent for seniors, for every $1 spent for children
9% $4 spent for seniors, for every $1 spent for children
38% $1 spent for seniors, for every $1 spent for children
31% $1 spent for seniors for every $4 spent for children
9% $1 spent for seniors for every $8 spent for children
9% don't know/refused **(Don't read)**

(16a) **(Split sample)** By most estimates, **[adding a prescription drug benefit to Medicare for all seniors would cost roughly 98 billion dollars over the next four years].** With that in mind, which of the following should be the most important funding priority? **(Rotate)**

9% paying down the national debt
19% Strengthening Social Security
34% Increasing spending on education
11% Adding a prescription drug benefit to medicare
22% Providing health care for the uninsured
5% Don't know/refused **(don't read)**

(16b) **(Split sample)** By most estimates, **[adding a prescription drug benefit to Medicare for low or modest income seniors would cost roughly 48 billion dollars over the next four years].** With that in mind, which of the following should be the most important funding priority? **(Rotate)**

12% Paying down the national debt

13% Strengthening Social Security
34% Increasing spending on education
8% Adding a prescription drug benefit to medicare
25% Providing health care for the uninsured
8% Don't know/refused **(Don't read)**

Now, please take the next two questions seriously:

(17) Considering that they both started in the mid-1960s, which do you think will last longer, the Medicare system or the TV soap opera "General Hospital"? **(Rotate Answers)**

43% General Hospital
52% Medicare
5% Don't know/refused **(Don't read)**

(18) In general, do you think it would be fair or unfair for taxpayers to pay for part of the cost of prescription drugs for very wealthy elderly people who might use them, such as Hugh Hefner, Larry King or Ross Perot?

14% Fair
83% Unfair
3% Don't Know/Refused **(Don't read)**

Now a few final questions for demographic purposes only——

(19) In terms of family status, are you:

6% Single with children
30% Single without children
2% Divorced with children
1% Divorced without children
42% Married with children
16% Married without children
2% Other **(Don't read)**

(20) Do you have health insurance of any kind?

90% Yes
9% No
1% Don't know/refused **(Don't read)**

(21) In the 2000 Presidential election, did you vote for George Bush, Al Gore, someone else, or did you not vote? If you were not registered to vote, just say so.

35% Bush
29% Gore
6% Someone else
20% Did not vote
7% Not registered
4% Don't know/refused **(Don't read)**

(22) Do you generally consider yourself to be a Republican, a Democrat or an Independent?

29% Democrat
31% Republican
34% Independent
6% Don't know/refused **(Don't read)**

(23) And what is the final level of formal education you completed?

4% Less than high school
21% High school graduate
28% Some college or technical school
34% Four-year college graduate
12% A post-graduate degree of some kind
1% Don't know/refused **(Don't read)**

(24) Region (From sample)

24% Northeast
22% South
31% Industrial midwest
16% Midwest/west
6% Pacific

(25) Gender **(By voice; do not ask)**

48% Male
52% Female

Methodology: Using the traditional random digit dial technique, a nationwide sample of 500 adults aged 18 to 34 was surveyed by telephone from March 6–7, 2001 by the Republican polling firm The Luntz Research Companies and the Democratic polling firm Global Strategy Group. The margin of error for telephone surveys of this type is ± 4.5≠.

Chairwoman JOHNSON. Well, thank you very much, Ms. MacGuineas, and it is extremely important that your generation be a part of this discussion, and I was pleased that Ms. Frederick did note in her testimony that she is concerned about what her grandson's options will be, and certainly, we want him to have the opportunity to educate his children; to own a home and to do those things as well as to discharge his responsibilities to those over 65 with compassion and dignity.

I also want to mention, Mrs. Wilkinson, that it is just frustrating to sit here. First of all, I am very interested that so many of you spoke about choice. I just want you to know how hard sometimes it is to provide benefits through Medicare, and that is one reason why choice is so important. We did actually deal with this issue of bone density testing in 1997, and that you should have had such a hard time getting payment for it so many years later is just one small evidence of the difficulty we face in distributing benefits from Washington.

But for all three of you, your testimony was eloquent, and to have your voices here at this table has been very important for us, and I thank you for being here today.

Mr. Cohen, I did want to ask you—let us see; I am sorry; I guess it was Mr. Poisal—no, it was Mr. Cohen on the——

Mr. COHEN. We will do it together.

Chairwoman JOHNSON. Coverage. And you may actually both be interested in addressing this.

This issue of utilization and coverage, it is only common sense that if you have coverage and help in paying for prescription drugs that you can then buy the drugs that you need. On the other hand, with the amount of advertising now that is commonly associated with the drug industry, is there any evidence, either from the experience of pharmacists or from your research, Mr. Poisal, is there any evidence that some of this utilization is actually not good for your health or doesn't improve your health? And should we be cognizant of that as we develop a prescription drug benefit so we get the advantages of being able to afford the medicines you need without the disadvantages to both the senior and the taxpayer of drugs that you don't need?

Mr. COHEN. Well, I do have a concern about that, as a matter of fact. I remember when FDA first approved the prescription drug advertising, for example. I had hoped that it was going to be more education than marketing, and I think that has not been proven to be the case. For example, I certainly would agree with advertising to consumers for a new vaccine that they should get, like a pneumococcal vaccine, for example, to prevent pneumonia. That is important but not what I am seeing. And I think it does drive the prescription drug use. I do know just yesterday, I saw that the Food and Drug Administration was about to conduct a survey of both physicians and consumers to try to gauge the impact, so I think that is something that the agency is looking into right now.

Mr. JOHNSON of Texas. Thank you.

Mr. Poisal.

Mr. POISAL. The Medicare Current Beneficiary Survey does, in fact, demonstrate what you have indicated, and that is that people with prescription drug coverage do indeed use more prescription drugs than those who do not. Our research, looking from 1997 into 1998, saw that the discrepancy between the two populations grew from five prescriptions on average per beneficiary to eight prescriptions on average.

Unfortunately, the Medicare beneficiary does not capture health outcomes, so it is difficult to ascertain the effect on a beneficiary's health by virtue of, you know, taking medications or not getting medications. The survey is not designed for that type of analysis.

Chairwoman JOHNSON. Mr. Cohen.

Mr. COHEN. Yes; may I just make one more comment? I think that you should be concerned about the number of drugs that patients take. We know that as the number of individual agents that they consume go up, the number of adverse reactions and drug interactions also go up exponentially. So it is a very serious issue. And that is exactly why I was talking about this need to have somebody, on a regular basis, looking at the medication regimens and trying to discontinue unnecessary drugs.

Chairwoman JOHNSON. I do think it is very important. You could even be taking aspirin regularly, and that could be undercutting other things that you are doing.

Mr. Richtman, you mentioned voluntariness twice in your testimony. I don't know whether either of the bills that were proposed last session that had broad backing would meet your definition of voluntary. One of the bills allowed you a one-time option to sign up, and then, you could not sign up again. The one that went to the floor allowed you a one-time option, but if you wanted to sign up again, then, you could do so, but you lost community rating. You got to be health-rated, so your premiums were going to be higher.

Now, if you did move from an employer-provided plan, you could sign up, or if you moved from Medigap, you could sign up, but you couldn't just wait until you needed it and then sign up. So I just wonder whether that definition of voluntary, which I consider terribly narrow but I see no way around, frankly, because otherwise, people will wait until they need it, and furthermore, we will have a terrible problem of selectivity and so on. So whether that definition of voluntariness does meet your——

Mr. RICHTMAN. Well, I don't think we mean to take that definition to an extreme. I think the way Medicare Part B works and the way people are able to enroll in that, we would consider that voluntary.

Chairwoman JOHNSON. OK; well, I think that is as far as I am concerned——

Mr. RICHTMAN. And I think that is a fair definition.

Chairwoman JOHNSON. What I call mandatory voluntary, because you get all or nothing, and nobody in their right mind could not take it. But if that is satisfactory, that is what I wanted to know. Mr. Stark.

Mr. STARK. Well, I want to thank all of the panel very much for their contribution, and your organizations' interest for the seniors, we appreciate it, us seniors.

Ms. MacGuineas, your organization's concern I think is important, too. In reading through your questionnaire, it appears that a large majority of your group, which I think this was in the 18-to-34-year-olds, voted, and you split it pretty evenly, but I think 70 percent voted, which is about three times as high as your age group in general. So you, some way or another, in this poll were able to find those very disproportionate share. Do you know why? Did you look for people who voted in the survey?

Ms. MACGUINEAS. Oh, no, absolutely not. We interviewed a random, selected population, and those were people who were willing to respond.

Mr. STARK. You managed to come out pretty evenly on Republican and Democrat and all of those things.

Ms. MACGUINEAS. Right.

Mr. STARK. But you are way off the scale as voters, which is good.

Ms. MACGUINEAS. Yes, if only we did vote 70 percent.

Mr. STARK. I wish that were representative of your age group. First, I would take quarrel with you on the issue of home ownership, which is a wash. We decided that on a bipartisan basis in the Reagan administration when we basically gave home ownership as a way to qualify for SSI and other things. The theory that most seniors have their home paid for, as you indicated in your statistics, and at that point, they may be paying $150 a month in taxes for a $147,000 or a $100,000 house on average. If you made them sell the house, their rent would immediately go up to $600 a month, and they would pretty much go out the same door that they came in.

The statistics are right but we encourage you at a young age to buy a home, get a mortgage, and pay it off. Then, you can live in that home. But you are not getting rich on it. I mean, it is an asset which does you no good. You have to pay the taxes; you have to paint the house. And if you were not there, you would be paying rent. And so, the idea that the seniors have a lot of money because they own homes, I don't think washes.

And I think we would all agree. Over 90 percent of the seniors have less than $50,000 in income, and that is just what your respondents said. They would strongly support—61 percent of them would support a drug benefit for those under $40,000, right? And then, at $60,000, you drop to 35 percent, so one could assume that the majority of the people polled, if you had split it at the $50,000 level, would support this drug benefit, and that would be for over 90 percent of the seniors.

So your survey is right on target. I am further elated to find that you think that 36 percent of all Federal spending going to programs for the elderly is either just right, 48 percent, or not high enough, 21 percent, which is good. I mean, that is generous of your respondents, more generous, perhaps, than I would think people would suggest if they talk about a disparity between the generations. And I think that you are right on opposition to the idea of increasing the eligibility age. Seventy-six percent of your group said they did not support, either strongly opposed or somewhat opposed, raising eligibility for Medicare to 70 and 55 percent said they opposed even raising it to 67. They are correct.

The one area that I think there was some question is the issue of encouraging people to join HMOs. Do you think that the people taking this poll had a reason to suspect that HMOs save money?

Ms. MACGUINEAS. Can I answer all of your questions or just the last one?

Mr. STARK. None of the rest were questions. I was just complimenting your group on their perspicuity. But now, I am wondering: do you suppose they were aware that managed care really costs Medicare money? So that for everybody who joins a managed care plan, the evidence is that Medicare loses money.

Ms. MACGUINEAS. Right; I think what we have seen is that 17 percent of people are members of HMO programs, and 17 percent of the costs still go to HMOs. I have also seen that part of the problem is that the competition hasn't been complete yet; that there are ways to restructure some of the competitive forces, hopefully, so that HMOs could be more efficient.

Mr. STARK. But there is no evidence that——

Ms. MACGUINEAS. I am not sure whether that is true or not.

In answer to your question, I would imagine most people taking this poll wouldn't know those details. This is a very complicated topic and program, as both of you brought up, and so, I don't think they would.

Mr. STARK. Well, it says here, "would you enroll in managed care plans in order to slow the growth of Medicare"? I mean, that was your question. And I think that was kind of assuming, don't you, that it would save money. That is how I read the question, and I think that was a little tilted. Other than that, I thought your poll was right on, and I thought your group was doing the responsible thing. You are to be commended.

Ms. MACGUINEAS. Thank you. I am glad you thought we were——

Mr. STARK. I hope you will go back now and explain to them that managed care costs us money, and we should find better ways——

Ms. MACGUINEAS. Well, we will try to follow up with more polls.

Mr. STARK. Great.

Ms. MACGUINEAS. One of the questions I just wanted to draw to your attention also, though, was after it talks about how much of the Federal budget should be spent on the elderly, which I think you said you commended, the highest proportion of people who were interviewed thought that the budget should be split basically one-to-one, so we spend one dollar on the elderly for every one dollar we spend on children.

As you all well know, that is not the case right now. We spend $7 on the elderly for every $1 we spend on the children, and there actually was extreme support in our poll for increasing the amount we spend on children to at least as much as we spend on the elderly.

Mr. STARK. But even more said you should spend between $4 and $8, $1 for every $4, $1 for every $8.

Ms. MACGUINEAS. I think that is right. There is even a stronger preference to spend more on children. That is where a lot of people think we should be making investments.

Mr. STARK. And which just goes to show that my kids are more interested in their grandchildren—in my grandchildren than they

are in my grandchildren's grandparent. That makes sense. Thank you.

Ms. MACGUINEAS. Thank you.

Mr. MCCRERY [presiding]. Thank you, Mr. Stark. Mr. Poisal.

Mr. POISAL. Yes, sir?

Mr. MCCRERY. You said that—or in your testimony, you noted that seniors with prescription drug coverage tended to use more prescriptions each year than those without such coverage.

Mr. POISAL. That is correct.

Mr. MCCRERY. Did your review attempt to compare differences in health status or outcomes between those two groups?

Mr. POISAL. We did for health status. As I mentioned earlier, the MCBS is designed to track health care utilization and expenditures, and it is not, in fact, designed to follow outcomes, to evaluate outcomes of beneficiaries' health. However, that said, we do ask when we interview our beneficiaries every 4 months, we go through and interview about 4,000 bennies in their homes every 4 months, three times a year. We do ask them to self-report their health status.

And indeed, when you control for health status—that is to say, regardless of whatever health status you are in—beneficiaries with prescription drug coverage have higher utilization and have higher total expenditures for their prescription drugs than do beneficiaries in that same health status without drug coverage.

Mr. MCCRERY. Can you draw any conclusions from that data as to the outcomes?

Mr. POISAL. Again, the MCBS isn't designed to evaluate outcomes. So I am afraid I can't answer that question.

Mr. MCCRERY. Did your study attempt to analyze whether the presence of coverage led to inappropriate utilization, for example, seniors getting unnecessary prescriptions or maybe a branded product rather than a generic product?

Mr. POISAL. Well, we capture all of the utilization that beneficiaries have; that is to say, whether they had a brand name or a generic-named drug. The analysis that would look at whether or not these particular prescriptions would be considered inappropriate was beyond the scope of the research that we did.

Mr. MCCRERY. Did your study attempt to identify whether the differences between those with coverage and those without coverage stemmed from the fact that those with coverage may have been sicker and therefore had a greater likelihood of purchasing coverage for drugs in the first place?

Mr. POISAL. What we know from looking at our data is that the health status mix for the covered population and the non-covered population, that mix is essentially the same across both of those populations. However, the covered population is slightly more likely to have slightly more chronic conditions than the non-covered population. So, you know, again, self-reported health status is essentially the same, but when you examine chronic condition counts, they are slightly more likely to have slightly more chronic conditions than the non-covered.

Mr. MCCRERY. Thank you. Mr. Kleczka.

Mr. KLECZKA. We have had this discussion before about people with drug coverage taking more drugs than people without drug

coverage, and as I think about that, it is also true that people with cars drive more than people without cars. And so, what I am trying to get at is people—and I found this in my district—people without drug coverage go without. In fact, I talked to a gentleman from my district who retired. He is 58 years old; his wife is 62. They have no supplemental. She just gets her Medicare; he has no coverage. He has hypertension and some other ailments, and I said, well, do you take drugs for this? He said I do not; I cannot afford it.

So that is why we are getting the phenomenon that if you don't have drug coverage, you are not going to use as much drugs, because in that class, people aren't buying them because they can't afford them. That is number one. The other thing that strikes me is when we talk about Medicare and Social Security and spending money on the seniors, my friends, this is called a generational transfer. But every and any other program the Federal Government spends money on is called an authorization and an appropriation and an expenditure.

So now, we are getting into some nomenclature that is a little scary, because if you are gray, and the Federal Government spends money on you, it is a generational transfer, as if we are stealing it from someone. But if you are student going to school, and we are putting millions and billions of dollars into Pell grants and student guaranteed loans, that is an expenditure. And if we are going to go on and spend billions of dollars for Star Wars and give all these billions of dollars to defense contractors, that is an expenditure.

Do you see what I am getting at? There are two different standards for expending the Federal receipts, and if you happen to be old and gray, it is a generational transfer. And this is just popping up this year. We are going to hear more and more about it, OK? This is the second hearing that I have been at where this has been used. And I know, Mrs. Wilkinson, you are ready to answer me, but I am going to ask one question, and then, I will ask you to answer me or respond to me.

Max, you couldn't see the chart I had up, but the reason is because I had taken it to the House floor to use it in the budget debate that is coming up at 5:00. But in this House budget chart, the House Budget Resolution that we are going to be debating, it is very evident that there are plans to spend HI, Hospital Trust Fund, revenues on things other than hospital care for seniors, and on this chart, $240 billion is called Medicare Contingency Reserve, whatever that is. And then, there is another chunk, $153 billion, for Medicare modernization. And I suspect that is where the drug benefit is going to come out of, because it is similar to the amount that has been recommended by the President under this new welfare drug proposal.

What is your group's view of using Hospital Trust Fund dollars for something other than hospital costs?

Mr. RICHTMAN. Well, Congressman, as I pointed out in my testimony, we are concerned about the way the Part A Medicare Trust Fund is designated in the budget and using it——

Mr. KLECZKA. In the law; OK.

Mr. RICHTMAN. And using it in the way you describe would obviously affect the solvency of the Medicare Part A Trust Fund, and we have made that very clear in the statement today and in press

conferences that we have held in the last couple of weeks on Capitol Hill both on behalf of the organization that I represent and the Leadership Council of Aging Organizations.

Mr. KLECZKA. Thank you.

And Mrs. Wilkinson, could you respond to my perplexion here of this new nomenclature: for you, anytime I vote for a dollar, it is a generational transfer, and when I vote for somebody, for a dollar for another group around here, it is just an expenditure. What is going on here?

Mrs. WILKINSON. Well, when we were raising children, we were paying the school taxes, and the people before we were raising children paid for school taxes, and after your children graduate, you are still paying for school taxes. So it is a continuum. So I don't consider it a generational transfer, because we keep helping each other. We are a community of human beings, and we have to keep helping each other.

And my reason for being here is just to implore you as you wrestle with this difficult problem not to break the two-thirds that work in order to fix the one-third that doesn't work.

Mr. KLECZKA. Thank you very much.

Chairwoman JOHNSON [presiding]. Representative Thurman.

Mrs. THURMAN. Thank you, Madam Chairman.

Just to follow along with Mr. Kleczka here on the using Part A, they are not the only ones who are concerned about it. I mean, we have got the American Hospital Association; Association of American Medical Colleges; the Catholic Health Association; Federation of American Hospitals. So, I guess it seems to be kind of cutting across all lines here as to the solvency and the issues of not using those dollars.

Mrs. Wilkinson, I need to ask a question because in September 1999, IBM actually was getting ready to—a new, controversial, new pension plan, and they came to their Congresspeople, and we raised questions about it, and they backed off, and things went forward, and you are getting a great pension now. Well, I mean, at least you are getting what you were told you were going to get, because some of those things—but that is not my point, okay? My point is, and what I am asking you is because in your testimony, you had said the retirees of the company I worked for learned that we would have the option of enrolling in HMO coverage or choosing one of the other employer-sponsored plan options.

You decided to enroll in the HMO coverage because it would continue coverage for your prescription drug needs, so I am assuming, then, the others did not.

Mrs. WILKINSON. No.

Mrs. THURMAN. OK.

Mrs. WILKINSON. That is not correct.

Mrs. THURMAN. OK.

Mrs. WILKINSON. I did not want to run over my time.

Mrs. THURMAN. OK.

Mrs. WILKINSON. I had actually six options.

Mrs. THURMAN. OK.

Mrs. WILKINSON. One was to continue with the plan that I had, which was part of my, quote, compensation up to this year, but starting this year, I was supposed to pay for it.

Mrs. THURMAN. So the benefit changes, so you went into the HMO because you could get the same coverage as that particular option.

Mrs. WILKINSON. I had four choices where I could pay varying amounts.

Mrs. THURMAN. But it did change.

Mrs. WILKINSON. Yes, definitely, it changed in January 2001.

Mrs. THURMAN. OK; so that was an issue for you when you were looking at it. The other thing——

Mrs. WILKINSON. But the one other point that I wanted to make is that fortunately, we can make a choice every year. So if this plan does not work for me this year, I can switch in December to another plan.

Mrs. THURMAN. OK; and then, you also have this insurance through your company, but Part B Medicare actually, which is run by the Government, in fact, did pay for your bone density. It was not your company that paid for that.

Mrs. WILKINSON. When you turn 65, Medicare becomes your primary, and you are required to pay for Part B, or you have no company insurance.

Mrs. THURMAN. OK.

Ms. MacGuineas, I need to ask you a question, because one of the things that was interesting about the survey and certainly one that would skew my feelings about any of the coverage that I had or was looking at for somebody else, 90 percent of the participants in your survey specifically have insurance, correct? I mean, that is what the survey said, which, of course, is not necessarily what we see in some of the other parts of it.

If you wouldn't mind, because we are sitting here talking about prescription drugs, could you tell us about your coverage right now?

Ms. MACGUINEAS. My personal coverage?

Mrs. THURMAN. Do you have insurance, and do you have a prescription drug?

Ms. MACGUINEAS. That is sort of personal, but I will tell you. I do have insurance, but I had a preexisting condition, so it was very difficult for me to get insurance. So I pay for my own insurance. It is rather costly, and I don't have prescription drug coverage.

Mrs. THURMAN. OK.

Ms. MACGUINEAS. So——

Mrs. THURMAN. And do you know about any of these other participants? I mean, did you all look at any of what they have? What I am trying to get at—of the coverage that they might have. Do they have HMO coverage? Did they——

Ms. MACGUINEAS. I don't believe our survey looked at the details of their coverage. We were limited both with resources and time for how many questions we could ask them.

Mrs. THURMAN. Mr. Richtman, let me ask you a question, because when I go to my district, and I have a large senior population who has had a very uncomfortable relationship with Medicare choice programs pulling in, pulling out; in any surveys that you have done, has there been any conversation about seniors who participate in Medicare or who have been in Medicare choice and are now back into Medicare? Do you feel that—or questions that have

been asked to them—that they would prefer to have a Medicare prescription drug program as versus all of these other things that are going on in their lives and why?

Mr. RICHTMAN. Well, we have not focused on that specific question in surveys, but we, as you know, conduct a lot of town meetings all over the country with our Members, and that issue comes up every time. Medicare is a known entity and is a trusted entity, and the way our Membership looks at Medicare is that it has worked well and that it makes sense to add—whether you call it a Part D or some other designation—a prescription drug benefit, and I know there is a lot of talk around Washington, around the country, about this big surplus. Whose money is it, who do you trust with this money, and that is apparently the way the issue is—some are trying to frame the issue that way: "who do you trust"?

For us, the issue is really a question of priorities. There is this large surplus, and what are the priorities that we should really be looking at in dealing with the surplus?

Mrs. THURMAN. But do you get the impression because they have had to do premiums before in Medigap or whatever that they would be willing to help pay for this cost if the benefit was——

Mr. RICHTMAN. Absolutely.

Mrs. THURMAN. Provided through Medicare?

Mr. RICHTMAN. Absolutely, and during the Clinton administration's proposal that was floated during the last year, year and a half, some of the numbers were—starting at $25 a month and going up over, I think, 4 or 5 years to $44 a month. There was no rebellion at the meetings we were involved in with those numbers, as long as there was some consideration of a cap for catastrophic, out-of-pocket costs. That kind of a ball park figure was talked about.

Chairwoman JOHNSON. Thank you. Just to close off, Mr. Richtman, are you aware that Title 18 of the Social Security Act is the section of the law that makes Medicare an entitlement?

Mr. RICHTMAN. I am sorry; say that again, please?

Chairwoman JOHNSON. That Title 18 of the Social Security Act is the section of the law that creates the entitlement of Medicare?

Mr. RICHTMAN. I take your word for it.

Chairwoman JOHNSON. Are you aware that both the bills from both parties last year amended Title 18?

Mr. RICHTMAN. Yes.

Chairwoman JOHNSON. Was it accurate, then, to say that the House-passed prescription drug bill rejected a drug benefit in Medicare?

Mr. RICHTMAN. Well, we didn't think it was—the way it was going to be administered, the way we interpreted——

Chairwoman JOHNSON. I understand that. But please, as we move forward in this debate, you see what a challenging debate it is. You see how important it is that we provide prescription drugs. You see how important it is that we provide it in such a way that we don't make seniors sicker instead of better. You see that it is important that we provide it in a way that young people have a burden that they can bear in the future. You see that it is impor-

tant that we provide it in a way that the benefits actually get to the senior.

So I hope that your organization, which has had quite an honorable history in a number of debates, would try to make sure that your participation in this debate is a little more accurate and a little more constructive. There should be no doubt in anyone's mind who heard the Congressional Budget Office at the beginning of the debate that this is going to be expensive and a challenging endeavor, and we really have to all work together.

The hearing is adjourned.

[Whereupon, at 4:30 p.m., the hearing was adjourned.]

[Submission for the record follows:]

Statement of the American Society of Health-System Pharmacists, Bethesda, MD

The American Society of Health-System Pharmacists (ASHP) is writing to commend the chairwoman and members of the subcommittee for holding the March 27, 2001 hearing on Medicare reform and allowing the subcommittee to hear from a broad spectrum of interested parties. The hearing provided valuable information on devising a drug benefit that will meet the needs of all seniors and enhance their quality of care. ASHP hopes that the committee will continue to hear from interested parties, such as pharmacists, who will play a critical role in achieving this goal. We stand ready to provide any requested information.

ASHP strongly supports efforts to add a drug benefit and to reform the overall Medicare program. We take this opportunity to share with the subcommittee the pharmacists' role in devising a rational and cost-effective benefit. ASHP is the 30,000-member national professional association that represents pharmacists who practice in hospitals, long-term care facilities, home care, hospice, health maintenance organizations, and other components of health care systems.

ASHP believes it is the role of the pharmacist to help patients make the best use of their medicines. The first step in this process is of course to ensure that beneficiaries have access to the prescribed dosage at the prescribed time; to ensure that beneficiaries are not splitting pills or skipping doses in order to make their supplies last. A true drug benefit, rather than mere price reductions, will go a long way towards achieving this goal.

Increasing access to pharmaceutical products however, is only part of the challenge. Assuring appropriate outcomes, preventing adverse effects and medication errors, and enhancing patient understanding and involvement in their drug therapy are equally important components of a successful Medicare outpatient pharmacy benefit. Simply increasing access, without taking this other piece into consideration, will not assure the safe and effective use of medications and could actually result in increased medication-related errors. This is particularly true for seniors who see several doctors or take multiple medications.

Pharmacists are the health professional uniquely trained and committed to assuring appropriate drug therapy regimens. Working in a true collaborative relationship with patients and the prescribing physician, pharmacists are the best ally for ensuring that medications are being used in a clinically appropriate, cost-effective manner, free from preventable side effects, drug interactions, and other medication-related problems.

As the November 1999 Institute of Medicine report, "To Err is Human: Building a Safer Health System" points out: "Because of the immense variety and complexity of medications now available, it is impossible for nurses and doctors to keep up with all of the information required for safe medication use. The pharmacist has become an essential resource * * * thus access to his or her expertise must be possible at all times."

Currently, the expertise and value that pharmacists bring to patient care is not widely accessible through Medicare. This is because pharmacists are the only primary health care professional not recognized under the Medicare program as health care providers. As a result, pharmacists are not eligible to bill Medicare for the services they provide to beneficiaries.

This lack of recognition for pharmacists is consistent with the lack of coverage for pharmaceuticals. Thirty-six years ago, when the Medicare program was established, both pharmacists and prescription drugs were a miniscule part of health care. Since then times have changed. Drug therapy has become the preferred method of treat-

ment for most illnesses. According to a recent ASHP consumer survey, approximately half of the senior population is now taking 5 or more medications each day. At the same time, the pharmacist's traditional role of ensuring accurate, safe medication compounding and dispensing has evolved into a more comprehensive set of clinical, consultative, and educational services.

Medicare must update its policy to be consistent with current health care practice. The new IOM report, "Crossing the Quality Chasm: A New Health System for the 21st Century," recognizes that financial barriers embodied in both public and private payers payment methods create significant obstacles to high-quality health care. The report states: "[e]ven among health professionals motivated to provide the best care possible, the structure of payment incentives may not facilitate the actions needed to systematically improve the quality of care, and may even prevent such actions." Our members have increasingly reported this to be true for pharmacists. Health systems often, even when acknowledging the pharmacists specialized expertise, cannot afford to fully utilize the pharmacists' services since they are non-revenue generating. This is especially contrary to modern practice in the Veterans Health Administration and the Indian Health Service where pharmacists are explicitly recognized as clinical specialists and are providing these services on a broad basis. But again, are not eligible to bill Medicare for the services they provide. Moreover, thirty states have authorized pharmacists to provide these patient care services in collaboration with physicians. Most other states are in the process of doing so.

Research has overwhelmingly demonstrated that quality improvement measures, such as the improved coordination and preventive care that results from pharmacists' drug therapy management services, can translate into dollar savings. This is true for Medicare since it is already paying for the increased hospitalizations, emergency room and physician office visits, as well as nursing home admissions, that result from medication-related complications. According to a 1995 study published in Archives of Internal Medicine, drug-related morbidity and mortality in the ambulatory setting alone cost the nation $76.6 billion annually.[1] An updated analysis, projected this number to have more than doubled in the last 6 years to $177 billion annually.[2] According to the 1995 study, the addition of pharmacists' collaborative drug therapy management services would reduce negative therapeutic outcomes by 53–63% and avoid $45.6 billion in direct health care costs.[3]

A key provision therefore to achieving a comprehensive drug benefit and obtaining even incremental reform to Medicare is the formal recognition of pharmacists as providers under the Social Security Act. This recognition will ensure that the drug "benefit" is beneficial to both Medicare beneficiaries (improving quality of care) and the Medicare system as a whole (improving quality of care and enhancing the efficient use of limited Medicare dollars).

ASHP appreciates this opportunity to present its views to the Subcommittee and looks forward to a continuing dialog on this important health issue. ASHP, in conjunction with the American College of Clinical Pharmacy (ACCP), has established the Pharmacy Provider Coalition to improve patient outcomes through collaborative drug therapy management. Do not hesitate to call either organization as you continue your deliberations and develop meaningful, bipartisan legislation. We look forward to assisting you in this significant undertaking.

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[1] Johnson and Bootman. Drug-Related Morbidity and Mortality. Archives of Internal Medicine. 1995; 155:1949–1956.

[2] Ernest & Grizzle. Drug-Related Morbidity and Mortality: Updating the Cost-of-Illness Model. Journal of the American Pharmaceutical Association 2001; 41: 192–199.

[3] Johnson and Bootman. Supra. FN1.