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# MODERNIZING MEDICARE

## HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

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# MODERNIZING MEDICARE

**THURSDAY, JULY 26, 2001**

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

The subcommittee met, pursuant to notice, at 9:15 a.m., in room 2123, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Barton, Upton, Greenwood, Burr, Whitfield, Ganske, Wilson, Bryant, Buyer, Tauzin (ex officio), Brown, Waxman, Strickland, Barrett, Capps, Towns, Pallone, Eshoo, Wynn, Green, and Dingell (ex officio).

Staff present: Anne Esposito, policy coordinator; Pat Morrisey, majority counsel; Nolty Theriot, legislative clerk; Karen Folk, minority professional staff; and Bridgett Taylor, minority professional staff.

Mr. BILIRAKIS. The hearing will come to order. Good morning. I now call to order this hearing on modernizing Medicare. Today this subcommittee will hear testimony from the Secretary of Health and Human Services Tommy Thompson. We were all excited by the President's announcement of his framework to modernize and strengthen Medicare last week. This framework provides valuable guidelines for us to use in developing legislation to modernize Medicare and its benefit package.

During this Congress, our committee has taken a very active interest in the Medicare program, to say the least. This year alone, we have held eight hearings covering topics such as modernizing the program, adding a prescription drug benefit to Medicare, and making administrative and programmatic changes to improve services and operations.

One of the first things you did, Mr. Secretary, was to change HCFA's name to CMS, Centers for Medicare and Medicaid Services, which I sometimes refer to as CM2S. This name change will help with morale and the look of the Agency, and I know this is only the start of the changes you hope to make.

As I mentioned, this subcommittee has held several hearings this year on ways to modernize the Medicare program and provide an updated benefits package, including a prescription drug benefit. At hearings we have titled Patients First, we received expert testimony on both provider and beneficiary regulatory burdens. We examined the advantages in policy and implications of merging Parts A and B of the program, we discussed innovative ideas and brought

forth new information to lay the groundwork for a prescription drug benefit, and we explored contractor reform issues.

I am very proud of where this committee has come in the past several months. I look forward to working on a bipartisan basis with my colleagues to come together around a plan to strengthen and modernize Medicare. The success of such a plan is also contingent on the support of you, Mr. Secretary, and that of the administration, and that is why I am particularly pleased with the President's principles for modernizing the Medicare program. Like the President, I believe that all seniors should have the option of a subsidized prescription drug benefit as part of Medicare. I also agree that Medicare legislation must ensure the long-term financial viability of the program.

And, finally, I am pleased that both you and the President have agreed to take a closer look at Medicare's regulations and administrative procedures. I am confident that your comprehensive review will identify areas requiring legislative action to streamline and reform the Centers for Medicare and Medicaid Services, formerly HCFA. I was very grateful that the President and the administration have developed a plan to provide some temporary immediate and real relief—and I will underline "temporary immediate"—and real relief to our seniors struggling with high prescription drug costs. I, of course, am referring to the recent announcement that Medicare will endorse drug discount cards. This echoes what I have said for months, that this administration is not one that sits on the sidelines. They will propose and enact solutions now.

I know that this is not the final solution to the problem that our seniors will face in buying their medicines, however, it is a good first temporary step. We hope to continue working with you, Mr. Secretary, and the President, as the details of this plan become more clear in the coming months, and to ensure that no one sector of the drug distribution chain is responsible for the discounts—and we have talked about that.

I am also very pleased that the President has recognized the importance of preventative care—very, very pleased. I have always believed that we should modernize Medicare to ensure proper coverage of preventive care and serious illnesses. It is unfortunate that Medicare coverage of mammograms, prostate cancer screenings, and flu vaccination began only recently. While I am pleased that coverage has been initiated, we can and must do more to ensure that Medicare's coverage of preventative care no longer lags behind that of private health insurance plans.

In closing, I want to again thank you, Mr. Secretary, for your time and effort in joining us today to share the administration's views on the important issue of Medicare reform. I will now recognize the ranking member, Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman, and welcome, Secretary Thompson, it is nice to have you again in front of us. I am concerned about what the President's principles do not say, and I am concerned about what they imply. These principles say the President wants to offer at least some beneficiary subsidized prescription drug coverage. It is not clear whether seniors would need to buy private plans to be eligible for the subsidy, but I will get to that in a moment.

These principles do not say the Federal Government must tackle unjustifiably high prescription drug cost as part of its commitment to Medicare prescription drug coverage. A laissez faire attitude from the administration and from this Congress toward unreasonably high prices and the anti-competitive behavior on the part of the drug industry squanders billions of dollars that could be put toward meaningful prescription drug coverage.

These principles say that Medicare should provide better health insurance options like those available to all Federal employees. They say all beneficiaries in modernized Medicare should have the option of subsidized prescription drug coverage. They say modernized Medicare should provide better coverage for preventive care and serious illness. They say current beneficiaries and those approaching retirement should have the option of keeping traditional plans with no changes. But these principles imply that private health insurance is a better option than traditional Medicare. They imply that the current Medicare plan will not be available to future Medicare beneficiaries. They imply that enhanced benefits and prescription drug coverage would be available to all beneficiaries who opt for a private plan.

I read these principles and then I went back to the Bush-Cheney campaign Website and read one of the President's campaign speeches on "modernizing Medicare." During his campaign, the President was prone to using rhetoric we are all familiar with, "Medicare is a one-size-fits-all program, Medicare beneficiaries deserve more choices."

He was also forthcoming about tying access to subsidized coverage for prescription drugs and other new benefits to private health plans, and about the fact that seniors, not the Federal Government, would pay for the benefit enhancement that would make these plans comparable to the Federal plans, to the FEHBP plans for Federal employees.

In a speech he said that under his plan, during his campaign, Medicare beneficiaries can "choose the basic plan for no cost at all, or can choose to pay a little more for the plan with additional benefits." I would like to think that the President's principles reflect a turnaround in thinking. I would like to think he truly wants to enhance the Medicare benefits package for all enrollees regardless of income, regardless of whether they choose to stay in the fee-for-service plan or enroll in an HMO, but his principles don't add up.

You can't simultaneously increase spending and reduce it. His principles say he wants to do both. He links prescription drug coverage to fundamental changes in Medicare. I think it is safer to go with what his principle imply than what he actually said. Unfortunately, I think it is safer to assume the President is trying to wrap appealing but misleading rhetoric around new benefits and choices in choices around Medicare privatization because it is simply easier to impose privatization on the public that way.

I think it is safe to say that underlying these principles is the desire to see traditional Medicare or as it is portrayed in the President's principles, the government Medicare plan, wither on the vine.

When I go home and talk to my constituents about Medicare, I hear complaints, but they are rarely about traditional Medicare.

They are often, almost always, about the +Choice program. I think it is fair to say that Medicare beneficiaries aren't asking us to make Medicare look more or act more like FEHBP, they certainly, certainly are asking us to make +Choice plans more reliable, but they are not asking for more choices, as many like to say. That is because traditional Medicare offers maximum choice—choice of doctor, choice of hospital, choice of nursing home, choice of all providers. Those are the kinds of choices that actually make a difference to the consumers of health, to our constituents. A choice between 2, or among 3, or among 50 HMOs affords less choice—in spite of what my friends on the other side of the aisle say—affords less choice than traditional Medicare.

My constituents are asking for prescription drug coverage delivered through the Medicare program. They are not asking for private prescription drug plans. They are not asking for a drug card that might save $5—might knock $5 off the $100-plus cost of Prilosec—when most seniors without coverage have incomes below $15,000 a year. Five or ten dollars in savings is not going to cut it.

I wonder if any of my colleagues, Republicans on that side or Democrats on this side, included in their campaigns last year a pledge to privatize Medicare, or even mention a desire to expand a desire to expand the role of private insurers into the Medicare program.

Many of us in our campaigns talked about strengthening Medicare, about preserving Medicare, but few, if any, of us talked about privatizing it. The idea of privatizing Medicare, of turning as much of the program as possible over to the private insurance industry, is an inside-the-Beltway idea being spun this way and that as its proponents in Congress and in the private sector try to sell it to the public. They may not use the word "privatization," but that is what they are doing. The idea of privatizing Medicare did not arise as a response to the needs or the desires of Medicare beneficiaries. People at home are hardly clamoring for privatization of Medicare.

One of the President's principles, Mr. Secretary, is that Medicare should encourage high quality care for all seniors. It is the Nation's most popular public program because it doesn't just encourage high quality health care for all seniors, as you know, it ensures it. Let us work together to build on that commitment by adding prescription drug coverage and other enhancements to the existing program. Let us work together to eliminate waste in spending by combatting fraud and abuse in all forms including outrageously high prescription drug costs. Let us work together to improve the way, as you have begun, the way that CMS functions. But please don't practice "Medi-scare," telling seniors and the next generation that Medicare is in perilous trouble, in need of privatization. Don't ask us to exploit seniors' need for prescription drug coverage and lower out-of-pocket health care costs to lure them into a privatized health care system. They are beneficiaries, their families, and every American who invests in and will someday benefit from Medicare deserves something better than that. Thank you, Mr. Chairman.

Mr. BILIRAKIS. The gentleman's time has expired. The Chair now recognizes the chairman of the full committee, Mr. Tauzin.

Chairman TAUZIN. Thank you, Mr. Chairman, and I particularly want to welcome our friend, the Secretary, to this hearing, and thank him for coming to share with us the administration's views on this most important question that, as you know, was "the" first priority of this Committee when we reorganized this year, and that is improving not only the Medicare system, but also the delivery system of the government agency that manages the system. And I want to thank you for the decisions you have already made, Mr. Secretary, particularly in making sure that when Members of this body representing the people of this country communicate with your CMS agency now, that we are going to get our answers in a reasonable time instead of some 12 months delay, I think, that was formerly the case with CMS, which was, I think, formerly known as "Prince," I think, I am not sure what it was known as before.

But let me tell you when we are really going to be happy on this committee. We are really going to be happy when you and I and the Chairman and this committee completes our reform of CMS so that patients don't have to wait 12 to 18 months to get an appeals case heard by a DLJ. We are going to really be happy when the DLJ is specifically trained to do Medicare appeals instead of just Social Security appeals. We are going to really be happy when seniors and patients don't have to wait 2 years to get approval on new medical technologies that could be saving their lives. We have got some real work to do, and I am so pleased that you are onboard to help us help your agency in accomplishing those kind of reforms because, as we have titled this project, it is Patients First, and when CMS and Medicare remembers its mission of taking care of patients instead of simply piling up data it doesn't even use, in a warehouse somewhere, and not answering phone calls and appeals and approving new technologies in a timely fashion, then I think we will all be able to rest a bit and know that we have done our job. And I want to thank you for committing yourself to this Herculean effort.

Whether we are eligible for Medicare today, or we have family members who are eligible, or we will be eligible in a couple of years—and by the way, you know who you are and I know who I am—we all have a strong interest obviously in addressing challenges facing the program.

You know, we were thinking about 1965 when the program was first commenced, and what things looked like then, and how medical was provided then, and how insurance programs worked then, and we can understand, looking back, why the Medicare program was structured the way it was. But if we were given the task today of creating a Medicare program out of just thin air, just building a new one, no one would build it on the structure and design the way it is currently structured and designed.

No one, for example, would not include a drug benefit in the program, recognizing now that drugs and outpatient service is becoming such a large part of the health maintenance effort for our seniors. No one would divide it into Parts A and B coverage because we know insurance programs don't do that today. Hospital services and physician services are provided together in a common plan. And no one would build it on some sort of monopoly delivery of drug benefits, there would be competitive deliveries and competi-

tive choices available for Americans, just as they are for Members of this body and other Federal employees.

We would probably structure it more like the Federal Employee Benefits Plan, where there are, in fact, choices and competition and seniors would have the benefit that Federal employees have of choosing different options, such as sticking with what they have got or choosing something different that might be better for them.

We would designed this plan totally different this year, and we would design it keeping in mind that the people we are talking about, the patients we are talking about in this case, represent the greatest generation of Americans.

I agree with Rush Limbaugh when he said that, you know, our generation is a bunch of wusses compared to that generation. I mean, these are the people that sacrificed everything to keep the world safe for freedom and democracy. They are the people that knew what it was to be an adult at 18, and we are struggling to find out in our generation, how to become adults at 50 and 60. And these are the patients we are talking about. They are the most—I guess the patients are the people we owe the most to in our country, and yet we have got a Medicare program designed for them on an old, outdated model that doesn't take care of the most important needs today in prescription drug benefits.

We have got a huge challenge in front of us, and I say again, none of us should rest, Mr. Secretary, until we have a new CMS that puts those patients first, that ends some of the unnecessary bureaucracy in this system. I don't care whether it is 60,000 pages or 130,000 pages of instructions to providers, but we ought to simplify that system. We ought to make the rules of the road clear for the providers. We ought to make easy access to appeals available to patients, and new technology approvals on a timely basis, and we ought to make sure the program is structured as good, or better, than the Federal Employees Health Benefits Program, with as many good choices and competition working for seniors as works for the rest of us in this society.

And so I want to thank you for challenging us and challenging the whole country to rethink how we plan for and provide for health care coverage for our seniors, and for working with us to build a better program.

We can differ on the edges of that debate. We can differ on what works better. But I think we all agree that what we have got is in desperate need of repair. And the surveys sent out by our committee to all the stakeholders makes the case. The more people focus on what is wrong with our current program, the more they are asking us to work with you to change it, and the fact that you have come to Washington and committed to help us change it is deeply encouraging, and I thank you for that, sir. I yield back the balance of my time.

[The prepared statement of Hon. W.J. "Billy" Tauzin follows:]

PREPARED STATEMENT OF HON. W.J. "BILLY" TAUZIN, CHAIRMAN, COMMITTEE ON ENERGY AND COMMERCE

Thank you, Mr. Chairman. I am pleased that today we are discussing .9 topic of utmost importance to all Americans—the Medicare Program.

Whether we are eligible for Medicare today, have family members who are eligible, or will be eligible in a couple of years—*you know who you are*—all of us have a strong interest in addressing the current challenges facing the program.

Medicare has provided health care security to millions of Americans, seniors and disabled, since 1965. It has been serving us well, but we now must work to modernize this program—to bring Medicare into the 21st Century—and ensure that it is strengthened financially, for the short and the long term.

The Medicare program simply has not kept up with rapid advances in medical care or innovations in health care delivery. Modem medicine has undergone many changes since President Johnson signed the Medicare program into law over 35 years ago. Yet prescription drug coverage is still not included in Medicare's basic benefit package, although it is a standard feature in private,, employer-sponsored health plans. Most private insurance plans set limits on out-of-pocket expenses-unfortunately, Medicare doesn't.

The Energy and Commerce Committee is committed to modernizing the Medicare program. To date, we have held hearings on several critical issues related to Medicare—all to improve the quality of care seniors receive. We've examined the prospect of merging parts A and B of the Program, contractor reform, and prescription drug benefits. We've also looked at ways to improve the current Center for Medicare and Medicaid Services (formerly HCFA) so that Medicare is administered more with patients in mind.

Clearly, a combination of administrative reforms and legislative changes are necessary to update Medicare's traditional system so that it can effectively meet the needs of the beneficiaries and providers in the years to come.

Today's hearing focuses specifically on the President's framework forstrengthening the Medicare program.

As we'll see, the addition of a prescription drug benefit is a high priority, and for good reason. Almost 400 new drugs have been developed in the past decade to battle diseases like cancer, heart disease, diabetes and arthritis. But Medicare doesn't currently cover outpatient prescription drug coverage. Our "Greatest Generation" relies on Medicare for their health care needs and they don't even have this basic benefit. Clearly, our seniors deserve better.

Advances in medicine have given us the capability to prevent sickness, not just treat it. For this reason, I am also pleased that preventive health care is another component of the President's Medicare principles. The Administration proposal to eliminate co-payments on all preventive procedures will go a long way to give our seniors better protection against serious illnesses.

We need immediate bipartisan solutions to the funding problems facing the Medicare program. We must forge a bipartisan consensus to strengthen Medicare's long-term financial status and to ensure that Medicare benefits remain a reality for seniors for a long time to come.

Mr. Chairman, I thank you again for holding this important hearing, and for directing our attention to the problems in the Medicare program. I welcome the Secretary and thank him for coming here today to answer our many questions about the President's reform agenda.

Mr. BILIRAKIS. I thank the gentleman. Mr. Dingell, for an opening statement.

Mr. DINGELL. Mr. Chairman, thank you. I thank you for convening this hearing on an issue of great importance, and I commend you for your interest in this subject.

Mr. Secretary, welcome, glad to see you here. This is a very important subject that we are inquiring into today, and I look forward to hearing your comments about the President's Principles for Medicare Reform and a Medicare prescription drug benefit. I am indeed pleased that the President has sent us a set of principles. I would note with regret, however, these principles do not provide enough detail to discern much of anything about what seniors can expect if they are enacted into law.

The President has been in office for 6 months now. He has managed to send details on a tax bill, on a faith-based initiative, on an energy policy, but when it comes to seniors we have only vague principles. But some of the things we see and hear in those vague principles I find very troubling, indeed.

I believe there is one principle that we ought to put first, before all others, and that is the wise "first, do no harm." We must make sure that whatever Congress does, we protect the program that has served our seniors so well for many years.

I would note to you that I was in Congress when we passed Medicare because I was one of the authors of it, as was my Dad, and I know what seniors did not have before, and I know what they have now. I know how important passing Medicare was to them. It has gotten a bit out-of-date, but not distressingly so. There are changes which could be made which will make it better, which won't cost much, and I hope we can work together, Mr. Secretary, on those matters.

I would note that this program is enormously popular with our Nation's seniors and, as I have noted, there are gaps in Medicare's benefit package and that seniors' out-of-pocket expenditures for health care services are, indeed, a heavy burden. Seniors are looking to Congress to strengthen and to improve the traditional Medicare program by adding preventive benefits, to which you wisely alluded in your comments today, and also to reduce some cost-sharing requirements, but the overwhelming message that I get from seniors as I talk to them—and I suspect you did this in your days as Governor—is a plea to add a meaningful prescription drug benefit to Medicare, and to do so as soon as possible.

Now, I will say parenthetically, I don't think that seniors are sufficiently unsophisticated to not ask for a drug benefit that is affordable, that is universal, that is guaranteed, and that is a part of our traditional Medicare program. That is really, Mr. Secretary, what they want.

The President has proposed certain temporary administrative actions which he says will help seniors without insurance, with the high cost of prescription drugs. I must confess myself singularly unimpressed with the discount card plan which mimics plans already available to seniors, which they have found largely unworkable and unrewarding, and which, interestingly enough, would have the practical effect of doing several things. First, the cards would hurt the pharmacies, and have achieved already the almost universal opposition of the pharmacies.

Second, they would, in many instances, in fact, increase the cost to seniors of certain prescription pharmaceuticals under that plan.

The third thing they would do is a dead certainty, and that is those cards would benefit, protect and enhance the earnings of pharmaceutical manufacturers, who seem to, if I read the daily financial reports, be doing splendidly.

The President also states that he is committed to enacting a drug benefit for seniors. I hope that he is willing to acknowledge that broader Medicare reforms, which involve many complex and contentious issues, will take longer than seniors should have to wait for a prescription drug benefit.

The enactment of a prescription drug benefit should not be held hostage to a larger reform plan that will take years to develop. And I would note to you, Mr. Secretary, I served on the Medicare Commission, and I listened to some of the talk of some of those people who would reform it and, quite frankly, some of the gray hairs in my balding head come from some of the statements and some of

the plans and some of the goals that were expressed during that time.

The President has also said that he is committed to a prescription drug benefit for all seniors, regardless of whether they are in Medicare+Choice or the fee-for-service plan. Real access means making a drug benefit a part of the traditional Medicare program. If his access refers to private drug-only insurance plans that seniors may purchase, I note that this isn't going to work, and the health insurance industry testified before this very subcommittee last year that this approach simply would not work.

Frankly, Mr. Secretary, seniors may not have much confidence in private insurance plans given the instability that has plagued Medicare+Choice markets in the past few years, and the continuing withdrawal of HMOs from that program.

I think we need to act quickly. I am delighted that you are here, and I hope that we can work together to enact a prescription drug benefit that is affordable, universal, guaranteed, and part of the Medicare program.

Mr. Secretary and my colleagues, the clock is ticking. Thank you, Mr. Chairman.

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

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

Chairman Bilirakis, thank you for convening this hearing on an issue that is of fundamental importance to our nation's seniors, people with disabilities, and generations of Americans who expect that Medicare will be there to care for them in the future. Secretary Thompson, I look forward to hearing your comments about the President's principles for Medicare reform and a Medicare prescription drug benefit.

I am pleased to see that the President has sent us a set of "principles." However, these principles do not provide enough detail to discern much of anything about what seniors can expect. The President has been in office now for six months. He has managed to send details on a tax bill, on a faith-based initiative, on an energy policy -but when it comes to seniors, we only have vague principles.

I have one principle that we should adhere to: first, do no harm. We must make sure that whatever Congress does, we protect the program that has served our seniors so well for so many years. The traditional Medicare program is enormously popular with our nation's seniors. However, there are gaps in Medicare's benefit package, and seniors' out-of-pocket expenditures for health care services are a heavy burden. Seniors are looking to Congress to strengthen and improve the traditional Medicare program by adding preventive benefits and reducing some of the cost-sharing requirements.

But the overwhelming message seniors are sending us is the plea to add a prescription drug benefit to Medicare—and to do that as soon as possible. Seniors are asking for a drug benefit that is affordable, universal, guaranteed, and part of the traditional Medicare program.

The President has proposed certain temporary administrative actions that he says will help seniors without insurance with the high cost of prescription drugs. I must confess to being singularly unimpressed with the discount card plan, which mimics plans already available to seniors, and would hurt pharmacies while protecting pharmaceutical manufacturers.

The President also states that he is committed to enacting a drug benefit for seniors. I hope that he is willing to acknowledge that broader Medicare reforms—which involve many complex and contentious issues—may take longer than seniors should have to wait for a prescription drug benefit. The enactment of a prescription drug benefit should not be held hostage to a larger reform plan that could take years to develop.

The President has also said that he is committed to a prescription drug benefit for all seniors, regardless of whether they are in Medicare+Choice or the fee-for-service plan. Real access means making a drug benefit a part of the traditional Medicare program. If his "access" refers to private, drug-only insurance plans that seniors may purchase, I note that the health insurance industry testified before this

Subcommittee last year that this approach simply would not work. And, frankly, seniors may not have much confidence in private insurance plans, given the instability that has plagued the Medicare+Choice market in the past few years.

We must act quickly to enact a prescription drug benefit that is affordable, universal, guaranteed, and part of the Medicare program.

The clock is ticking.

Mr. BILIRAKIS. I thank the gentleman. Under the rules, the Chair exercises its prerogative to limit the remaining opening statements to 3 minutes, and I ask the cooperation of the members. Mr. Burr is recognized.

Mr. BURR. Thank you, Mr. Chairman. Welcome, Mr. Secretary. As I sat here thinking about this hearing, I could only think of my parents who both participate in the Medicare program, and my mother, who just several years ago had extensive surgery and spent time not only in the hospital, but in skilled nursing, and then eventually participated in the home-care benefit.

The one thing my parents did after that experience was to bring their bill for that event to me and ask me to explain it to them. For any of you that have ever seen a Medicare bill, it is pretty difficult. I found it to be impossible. I turned to the then HCFA, now CMS, and said, "Explain this to me." In some cases, they couldn't do it.

I knew then that we had a system that if it was difficult for me to understand, it had to be impossible for most seniors to understand. My parents are lucky because they carry a supplemental from my dad's former employer. It does cover deductibles and pharmaceuticals, and they are not faced with the problem that many seniors are faced with because many don't have it. Not many are faced with decisions between this and that.

As a Member of Congress, I think we have an obligation to always do what we think is right. We missed a tremendous opportunity last year when this body passed a prescription drug bill that ended up going nowhere. It wasn't what we ultimately all wanted, but it was a great step in the right direction.

I want to commend you, Mr. Secretary, and the President and this administration, because you have clearly communicated the blueprint, the principles of what is the right thing, but you have left it up to this body to fill in the blanks, the specifics.

The only way that we can fail is if we miss this opportunity again, like we did last year, and not have a bill that is enacted into law. We have an opportunity right now to accomplish that. We have an opportunity to clear up the confusion that exists between A and B, by merging it, by making sure that a system that is 30-some-years-old is, in fact, a 21st Century system.

We have an opportunity to package a new set of preventative care benefits into a system that up until this time ignored preventative care because of the cost and couldn't look at a potential savings down the road. We have an opportunity to restructure the copay, the deductible, to make sure that we don't charge seniors the most when they enter the hospital than any other point in the Medicare system, which is wrong. And, most importantly, we have the opportunity for that drug benefit, a drug benefit that takes into account where technology has gone.

Mr. BILIRAKIS. Would the gentleman please finish up?

Mr. BURR. I would be happy to. Mr. Chairman, I am excited about the opportunity. I think even with the differences that we will have on many of these points, America is ready for us to bring this system up to the 21st Century. I thank you and I yield back.

Mr. BILIRAKIS. Thank you. Mr. Waxman.

Mr. WAXMAN. Thank you, Mr. Chairman. Mr. Secretary, I am pleased to see you and welcome you to our committee. Mr. Burr says he is excited. I, too, am excited if we can do something constructive. He says you have given us a blueprint. What I am troubled about is I think that blueprint is too sparse in the details for us to know what the administration really is asking from us.

I don't think it is the duty of Congress or this administration to rewrite Medicare as if we are doing it from scratch. Medicare is a program upon which millions of people rely. It is the only program they have for their health care services.

Mr. Tauzin said this is the greatest generation in the history of this country that is relying on Medicare. That is why we shouldn't experiment with them. This should not be an experiment to see whether if we try different ideas, maybe they will work because, if they don't work, we are taking a program that people think is pretty good and doing a lot of harm to those very people who rely on it. That would happen if they can't find private insurance available to them or if they have to come up with more money that they can't afford.

The general statements by the administration I certainly applaud. We are all for more preventive services. We are all for better management. We all want to see a Medicare system that will provide prescription drug coverage. But when you get beyond these broad statements, I still don't know what the details are. I hope you will be able to help us understand those details.

For example, is the administration asking that we have Medicare beneficiaries rely on private insurers to provide them with prescription drug coverage, even though the insurance industry has said they can't handle such a thing, or are we going to have a proposal that will cover everybody in Medicare? When we get to the so-called "modernization" of Medicare, the administration has said current beneficiaries and those approaching retirement should have the option of keeping the traditional plan, but what about everybody else? And are we going to find that the prescription drug option is simply going to be a lever to get beneficiaries to go into something other than traditional Medicare if they don't want to?

This raises serious questions about why the President hasn't been more specific. We really don't know what kind of plan you all favor. It may be because you haven't come to grips with the broad outlines or the details, or it may be that you are simply unwilling to expose your plan to any detailed scrutiny.

We should work together. I want to work together with the administration in this area, but let me just point out, this is not like the Federal Health Insurance plans for the government employees. With Medicare, we are talking about a population that is older and sicker, that don't have the same range of income. The risk pool is certainly not the same. We are talking about people who need to know that they are going to be protected, that they are going to have benefits that will be there to pay for their medical bills. We

ought not to experiment on the greatest generation, leaving them perhaps without the promises that have been made to them. Thank you very much.

[The prepared statement of Hon. Henry A. Waxman follows:]

PREPARED STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Secretary Thompson, I'm pleased to see you here today to elaborate for the Subcommittee on the principles announced by the President for changes in the Medicare program.

In my view, those principles provide little real information on the kind of changes this Administration has in mind. On the one hand, they reflect what we might call universal truths—things that nobody could disagree with:

—we're all for high-quality health care.
—we're all for strengthening the management of the program so that it can provide better care, and for reducing fraud and abuse.
—we're all supportive of preventive care.
—and we all agree that seniors need a subsidized prescription drug benefit as part of a modernized Medicare.

But of course, the devil is in the details. And those are pretty scarce.

It's great to be for better coverage of preventive care, but where is the commitment in the budget to pay for it? Should we assume you want to reduce the coverage of current benefits—or increase the deductible and cost-sharing obligations of the current program—to pay for those preventive services? That might not be such a good deal.

It's also welcome to know that the President endorses a subsidized drug benefit for all seniors. But frankly, it's hard to tell what the Administration has in mind.

Could this mean a plan where Medicare beneficiaries have to rely on private insurers to provide them prescription drug benefit coverage, even though the insurance industry itself said it wouldn't offer such plans? Or has the President decided that kind of limited proposal wouldn't be acceptable? You can't tell from his principles. But it's going to make a big difference to the people who need help.

Then there's the issue of the so-called modernization of Medicare. You say that *current* beneficiaries and those approaching retirement should have the option of keeping the traditional plan. Does that mean that there is no commitment to keeping the traditional plan for others? Is it your intention to let it wither on the vine, to use the phase of one of our former Republican colleagues?

You indicate that Medicare should provide a variety of health insurance options. But is there any commitment to assure that beneficiaries would always have the option to pick traditional Medicare if they want it, and would they have an assurance that they wouldn't be stuck paying higher premiums because the good risks have been siphoned off to private plans?

And for beneficiaries who do chose traditional Medicare—and frankly, I think most of them will, do you intend to assure that they have access to a guaranteed defined set of drug benefits as part of traditional Medicare or not?

There's a lot of important questions here, and unfortunately the President's principles give us—and more importantly, the American people—very little indication of what he really supports.

In fact the only thing you've been *specific* about is the public endorsement of private drug discount cards. And that raises very serious questions about putting a Medicare seal of approval on private cards that may or may not deliver what they promise to people.

The studies my staff have done at the Government Reform Committee indicate that the savings are nowhere near to what the hype has been. In fact, the programs we looked at deliver only a few percentage point savings—less of a discount than you could get without any card—or paying an enrollment fee—at all.

All of this raises in my mind some pretty serious questions about why the President hasn't been more specific about what his plan is. Is it that this Administration really doesn't know what kind of a plan it favors, that it hasn't even come to grips with the broad outline, let alone the details? Or is it simply that you are unwilling to expose your plan to any detailed scrutiny?

I hope today we can begin to understand better what this Administration really intends to do to the Medicare program that 40 million beneficiaries rely on.

I hope we can get some clarity on exactly what the commitment is to provide a specific and guaranteed prescription drug benefit to all Medicare beneficiaries, not

as a lever to force them out of traditional Medicare, but as an improvement which assures that traditional Medicare better meets their health care needs.

I look forward to your answers today, and many more specifics in the future. Thank you.

Mr. BILIRAKIS. Thank the gentleman. Mr. Ganske.

Mr. GANSKE. Thank you for being with us, Mr. Secretary. Last winter I received letters from a lot of constituents in Iowa, who were elderly, their home heating prices were going out of sight because we came up against a natural gas shortage and the spikes were very significant, and some of those letters indicated that people were actually having to make choices between keeping their home heated in the winter, in the middle of an Iowa winter, and actually paying for their prescription drugs. And as my parents are both in Medicare, they have some very significant prescription drug costs, I see their bills. I get letters from constituents.

This committee is working on both of these issues. We are working on an energy policy and we need to address the prescription drug issue.

One of my concerns about a comprehensive prescription drug policy is that it would be very, very expensive. And I represent both a major metropolitan area, Des Moines, but also southwest Iowa with a lot of small town hospitals, and the Medicare reimbursement for those hospitals is a very large percentage of their income. They are already really close to not having enough money to stay open. If a hospital would close in a town like Red Oak or Harlan, that would be terrible in terms of the access to medical care, but it would also potentially be disastrous for the town and for the economic survival of that community.

And so when we look at adding a benefit like prescription drug, we need to also be aware that we are not going to then be shifting funds or make it more difficult to provide other services that are necessary in Medicare, i.e., that if we give a prescription drug benefit, that we are not going to clamp down so tightly on the other services that, for instance, we could end up losing hospitals in small towns. I mean, it would be great to have a better prescription, or "a" prescription drug program for our seniors, but it wouldn't be so great if now they had to drive 125 miles into Des Moines to get to a hospital. So this is a balancing act.

I have proposed that at least in the interim, that we take care of the low-income Medicare beneficiaries and the qualified Medicare beneficiaries up to 175 percent of poverty, and utilize the State Medicaid drug programs, which you are very familiar with, but pay for that from the Federal side so that you are not imposing an additional financial burden on the States. That may be something that we will get a chance to talk about a little later.

Mr. BILIRAKIS. Would the gentleman please finish up.

Mr. GANSKE. Thank you, Mr. Chairman. I do want to say that on June 28 I gave Mr. Scully a copy of a floor speech I gave that had 26 suggestions for Center for Medicare Services reform. He promised me a prompt reply. I still have not received any paper from Mr. Scully on that. And I will provide you with a copy also.

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

Ms. CAPPS. Thank you, Mr. Chairman, for holding this hearing. I think it is very important for the members of the subcommittee

and the Congress as a whole to take a good, hard look at some of the ideas put forward by the President for reforming Medicare. I want to express my appreciation to the President, and to you, Mr. Secretary, for the hard work that undoubtedly went into the framework we are reviewing today, but I am concerned that this framework is very short on details. Certainly, I think we can all agree that there are some places where we would like to make changes and improvements in Medicare. Often we can even agree on what the problems are, but difficulty in reshaping a program like Medicare is almost always in the details and the implementation. For instance, the President cites the need to have a prescription drug benefit for Medicare seniors, but it doesn't say how this should be done.

Would the benefit be under the Medicare program, or would it be contracted out to private organizations? What kind of cost-sharing mechanisms would there be? Is it going to apply to all Medicare beneficiaries, or just some seniors in particularly dire straits.

I think that just about everyone on this dias agrees that there should be a drug benefit, but if there is ever going to be one, we need to answer the questions above. I am frankly disappointed with the one specific proposal this administration has put out on prescription drugs—the discount card plan. This proposal, because it does not permit Medicare to regulate the discounts or have any enforcement role, does nothing to lower the overall cost of prescription drugs. Additionally, it is not clear what kind of savings this card would yield for seniors.

One of the strengths of the Medicare benefit is that the collective buying power of all the seniors in the program could reduce the price of these drugs, but this plan will divide up that group and does not explain how the savings will be achieved or from whom they will be extracted.

I am also concerned about what I see as a desire to rely on the private insurance companies and their example for their reform. The marketplace can and has been a place for a wonderful efficiency, but it can also be ruthless in its drive for profit, and we cannot allow health care decisions for our seniors to be strictly business decisions.

Government works best when it is harnessing the incredible potential of the private sector, but softening some of its harsher edges. Today the House should have been debating the Patient's Bill of Rights to do just this. Sadly, we have put that aside, but we on this subcommittee can at least make sure that our seniors are protected under Medicare from the abuses of the marketplace.

It would be a terrible injustice to our seniors to open Medicare unshielded to the cruelties of the business world. Medicare is a sacred program to many of today's seniors. They count on it, and they should be able to do that in the future. We as a society have made a pledge to them that they will have health care. Prescription drug coverage is part of health care. It is, I would add, a cost-effective often a preventive health care measure that if it is not followed through with and seniors, as many of we know personally, have to choose which of their prescriptions they will take, it can be a less expensive alternative than being admitted to an acute care facility.

So, I look forward to working with you, Mr. Secretary, on this framework and on what you have to say, and I want to hear from you and your panelists. Thank you very much for coming. Yield back.

Mr. BILIRAKIS. I thank the gentlelady. Mr. Buyer.

Mr. BUYER. Thank you, Mr. Chairman. Mr. Secretary, thank you for being here. This is your second appearance before the subcommittee. I would like to applaud the President's principles for moving forward with reform for Medicare, and also applaud not only the President, but your commitment to a viable financially sound program with an added prescription drug benefit.

The President and you, Mr. Secretary, are to be commended for being forthcoming about the shortcomings in Medicare and for seeking to make improvements in the program. Medicare is crucial to the well being of the Nation's 40 million seniors and disabled individuals. It is important that we deal honestly and forthrightly with our seniors and younger generations about the program structure and finances. While Medicare provides payment for vital health care services, it also impacts the health care practices of nearly every doctor, hospital, and skilled nursing facility in the Nation. They often see a side of Medicare that the beneficiaries do not see. Providers of services see regulations and paperwork and the daunting threat that if they inadvertently fall out of line, they could be subject to treble damages.

Reducing the tremendous regulatory burden on providers should ease its administration for the provider and the government alike. It should also ensure that seniors will continue to have access to quality care. This paperwork burden is especially acute for many providers in my rural district. They don't have the access to the technology or the personnel to keep up with the burden, Mr. Secretary. Any efforts that you can take to relieve this burden on the providers, especially those in rural areas, is welcome.

I also noticed in your prepared testimony that you initiated listening sessions around the country for those who deal with the Medicare rules in the real world. I compliment for doing that. I would also be happy to welcome those listening sessions in Indiana, and if you want to come to one of the rural towns and see what that impact is not only in the quality of care, but the impact upon the providers, I welcome you, and please have your staff be in touch with me. I appreciate you being here. Thank you.

Mr. BILIRAKIS. Thank the gentleman. Mr. Towns.

Mr. TOWNS. Thank you very much, Mr. Chairman. Let me thank you, Mr. Secretary, for being here today. I want to thank you for acting on the concerns that I expressed about the advance beneficiary notice during your last appearance before this committee. As a result of your positive action, health agencies will only have to submit the ABN forms once for patients rather than continue submissions every 60 days eliminates a major paperwork burden, and I want to thank you for that.

I want to congratulate you, Mr. Secretary, on implementing these improvements in such a short timeframe. Your actions demonstrate that bureaucracy can be moved in the right direction. I hope to be able to continue to work with you on regulatory reform issues, like due process for home health and hospice agencies.

As we continue our dialog on Medicare reform, let me thank you again for moving so swiftly and, on that note, Mr. Chairman, I yield back. Thank you.

Mr. BILIRAKIS. The Chair thanks the gentleman. Mr. Whitfield.

Mr. WHITFIELD. Thank you, Mr. Chairman, and, Mr. Secretary, we are delighted you are with us today. There has been some discussion this morning about experimenting with Medicare, and I am convinced that there is not any Member of Congress nor anyone in the administration that wants to do a lot of experimenting to the detriment of senior citizens, but we do want to explore new ways to be more effective in delivering better health care to our senior citizens, and I believe that these fundamentals that have been set out are designed to do that.

While we all agree that a prescription drug benefit is vitally important and is probably the most important thing, I know there has been some criticism of the administration about the discount card, and I notice that you, in your testimony, say that the discount card is simply a first step and is not meant to be a substitute for a comprehensive drug benefit, and that is what we are all working toward.

Another way that we can help senior citizens—and I know that this will be addressed as well—is that providers today are quite frustrated as they ask questions of contractors and try to determine answers to and speed up their reimbursement, and many of them are quite confused about that. And I know that trying to streamline the regulations and administrative procedures will help address that problem as well.

I would also just mention one other thing. Lois Capps and I, along with others, have introduced legislation to try to address the shortage in the nursing area and the pharmaceutical area, and hope that you will work with us in that area because that is very important also as we try to address the health problems of senior citizens. I yield back the balance of my time.

Mr. BILIRAKIS. The Chair recognizes Mr. Green for 3 minutes.

Mr. GREEN. Thank you, Mr. Chairman for holding the hearing. Mr. Secretary, welcome again. The entire committee and I appreciate your commitment to addressing our Nation's health needs.

I have reviewed the material from today's hearing. I am confident that, as you already hear from our opening statements, there will be a spirited debate. And I just want to say a few words about the President's proposal on prescription drug savings card.

Under his plan, from the way I see it, Medicare would endorse and promote several privately administered discount cards. And while this program sounds good on the surface, with closer exam it doesn't offer anything that seniors can't do now. In fact, in some ways it could actually limit their sources. Currently, seniors can receive a discount card through AARP, Reader's Digest and other sources. In fact, seniors can buy any of these plans based on their individual prescription drug needs. Under the President's plan, seniors would be limited to one discount card, which bothers me because under the free market system they can purchase all of them if they want because each card may cover only certain types of prescriptions. And as we know, seniors take a variety of prescriptions and they have total coverage. And according to some estimates,

seniors can save more by comparative shopping than they could through a prescription card.

A study by the Government Reform Committee reveals that discount cards result in less than 2 percent cost savings below the average drugstore.com price, and these savings don't even take into account the cost of signing up for the program. The proposal would cost $35 million, which would be really a commercial for these private prescription discount cards and at the taxpayers' expense. And the fact that I am concerned about is that we need a prescription drug benefit, and I appreciate the President saying this is a first step. But even that first step needs to be one that is as effective as we can make it.

The President's proposal does address the need for prescription drug benefit, and there is a lot of good ideas on preventative care and streamlining administrative procedures that you have in your program, and some are controversial, such as the voucher program and other proposals that require a lot of time to work out.

Mr. Chairman, I know we hope to mark up a Medicare reform bill in September, but I have some concerns that it might take much longer than that for the House and the Senate to really work our will. We need a meaningful prescription drug benefit, and we need it as soon as possible. And with that, Mr. Chairman, I yield back my time.

Mr. BILIRAKIS. Mr. Greenwood, for an opening statement.

Mr. GREENWOOD. Good morning, Mr. Secretary, welcome. Yield back.

Mr. BILIRAKIS. Mr. Barrett.

Mr. BARRETT. Thank you, Mr. Chairman. I won't be quite as brief as Mr. Greenwood. Thank you for holding this hearing and, Mr. Secretary, welcome back to the committee, it is nice to see you back here again.

As I listen to the opening statements of my colleagues and reflect on the town hall meetings that I have held on this issue in Wisconsin, I think the one thing that we all agree on is that the older Americans want us to act, and I appreciate the fact that you have come forth with a plan. As Mr. Green and others have indicated, there are some concerns with the plan, but I think the most important thing is that we have begun the dialog in what I think will ultimately be an effective resolution to this problem because both Democrats and Republicans recognize that this is a real-world problem, that people are really affected by this. And it is tough when you sit in a hearing or a town hall meeting and listen to an older person say that they really can't afford to purchase the drugs that they need.

So, I am pleased that you are here. I look forward to hearing your testimony, and because I want us to have an effective resolution as fast as possible, I will yield back the balance of my time.

Mr. BILIRAKIS. Thank the gentleman. Mr. Upton.

Mr. UPTON. Thank you, Mr. Chairman. I, too, just want to welcome the Secretary and look forward to his testimony, and I yield back.

Mr. BILIRAKIS. Mr. Strickland.

Mr. STRICKLAND. Thank you, Mr. Chairman. Mr. Secretary, I want to begin by thanking you. When you were here before, I

shared with you the story about a young woman in my district, Patsy Haines, 31 years old, who need a bone marrow transplant and was unable to secure that from her insurer. You took that to heart. You looked into her situation. You wrote me a long, thoughtful letter, and I shared that with her, and I have shared that with my constituents.

Still, the insurance company did not budge, but I have good news this morning. Her friends and neighbors, as I said, were holding bake sales and community auctions. They were able to raise a threshold amount of money, and I was just informed a few hours ago that the hospital is willing to accept what they have raised as a community to negotiate, and very soon she will receive her transplant and we hope that that will save her life. But I want to thank you for following through and for your obvious concern for her.

I also want to thank you because when you were here before I expressed some frustration with the former HCFA and some doubts as to whether or not the Agency would ever be manageable. My experience in the few months that you have been there has been more positive than in the past. I would like to say that Mr. Scully of your staff and I have worked on a matter with Representative Thurman, and he has been responsive. He has returned phone calls and he has shown concern. So, I want to thank you for that.

You indicated that you were going to the office in Baltimore and spend some time yourself, and I think you invited any of us who may be interested to go along with you. I was unable to do that. If you ever do that in the future, I would be most interested in participating.

In regard to our hearing today, I have read your testimony and I have looked over the principles. I have some concerns about the principle that said today's beneficiaries and those approaching retirement should have the option of keeping the traditional plan with no changes, and I have questions about that. At what age should we be concerned that those of us will find that Medicare won't be around in the traditional sense, and I hope in today's hearing we can get some answers, especially regarding that particular principle. But most of all, I wanted to thank you for your follow-through and your concern. I yield back, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman. Mr. Pallone.

Mr. PALLONE. Thank you, Mr. Chairman, for holding this hearing on the President's Medicare Modernization Principles, and I wanted to thank you also for what you said yesterday at our meeting about wanting to work with both sides, with the Democrats as well.

I think the most important issues that need to be addressed are adding a prescription drug benefit that would cover all seniors who want it, and increasing protections while ensuring that Medicare remains affordable for all beneficiaries. The lack of an affordable prescription drug benefit is without question the biggest problem that Medicare faces today, and I don't think it can be corrected piecemeal by simply devising a plan to cover the poorest seniors, a comprehensive affordable drug benefit should be available to all seniors regardless of income because 50 percent of Medicare beneficiaries without coverage are middle-class seniors. Instead of providing a meaningful benefit through Medicare, it seems—and I say it seems because I hope I hear differently today from the Sec-

retary—but it seems as though President Bush and the Republican leadership are preparing to either provide drug coverage to only low-income beneficiaries or some type of catastrophic coverage, and neither of these will allow beneficiaries to receive a comprehensive affordable guaranteed benefit.

In addition, the drug discount card program proposed by the President is not an interim solution, in my opinion, to providing a comprehensive prescription drug benefit. Many companies already provide these cards at little or no expense. Drug manufacturing companies are not held accountable, while it places the entire burden of any possible savings on hometown pharmacies, and it does not require Medicare to pay even a portion of the Medicare recipient's cost of prescription drugs.

When talking about reforming or modernizing Medicare, a drug discount card or privatization is not helpful, in my opinion, to seniors. We need a comprehensive benefit.

At a time when seniors can barely afford the prescription drugs, Mr. Chairman, I also think it is important to discuss or to ensure that health costs to seniors for basic services do not increase, and this merging of Parts A and B of the program may contribute to a rise in the cost of the Medicare program which would be financially detrimental to seniors nationwide. If both Parts A and B are combined, it seems clear that most seniors would face a higher deductible. The deductible for Part A is $776, but only 15 percent of seniors utilize it. The deductible for Part B is $100, and an overwhelming 85 percent of seniors use it. Combining these two parts and finding a deductible that falls in between A and B I think presents a majority of beneficiaries with a significantly higher deductible, which means that most seniors would have to pay more out-of-pocket before their Medicare benefits kick in.

Again, these are the concerns I have, and I hope that rather than focus on these interim solutions in terms of a drug discount card, we get right to the heart of the matter which is providing a comprehensive benefit for everyone. Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman. Mr. Bryant.

Mr. BRYANT. Thank you, Mr. Chairman. Mr. Secretary, thank you for being here and sitting very patiently while we all go in and out and come back just in time to make our statements and pontifications and so forth. I know this is a regular routine that a Secretary has to undergo, but I appreciate again your willingness to sit and listen to us and to attend this hearing.

I think there are some very good points that are being made by my colleagues and members, and while many of us have to go in and out to other hearings, which I am in the process of doing today, again, I appreciate your patience with us.

Let me very quickly, without taking all of my time, go through a couple of questions because I want, if I could, you to answer these today if you could, and if you don't get it all down and can't, if you could late-file your testimony to these questions, and they are a little bit more narrowly drawn than some of the general comments I have heard being made this morning, and concern the issue of U.S. renal care in this country and reimbursement in that regard.

The first one is that the administration's plan speaks of Medicare contract reform and also encourages innovative programs such as disease management demonstrations. There is no better place for these types of reforms that in the End-Stage Renal Disease, the ESRD program. Would the administration welcome congressional authority to permit CMS to directly contract with the ESRD providers so that dialysis and other health care services could be provided through a disease management model, perhaps even a risk-sharing with CMS in the treatment of these patients? That is the first question.

The second question is, Section 422(c) of BIPA 2000 directed the HHS Secretary to develop a system which adds an expanded number of laboratory test in drugs which are currently separately billable under the program, add these into a bundle of dialysis services reimbursed under the ESRD composite rate. A report on this is due Congress in July of 2002. This new payment system seems to be very consistent with the administration's interest in reducing bureaucratic complexity while improving the quality of care. And my question here is, would the administration commit to meeting the statutory deadline, July 2002, and would it consider sharing any preliminary findings with this subcommittee as soon as such findings become available?

And if you could, when it is appropriate for you to answer and respond to us, if you could do that today, and if you can't do that today, if you could, again, share your answer to us in written form. Thank you, sir, and I would yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman. Ms. Eshoo, for an opening statement.

Ms. ESHOO. Thank you, Mr. Chairman, for having this hearing, and I will submit my full statement for the record. I want to welcome the Secretary. This is your maiden voyage here, and I want to welcome you and wish you well with the responsibilities that you shoulder. I look forward to asking you some questions and, most importantly, is this the best we can do?

I want to work with you on reforms, I think they are very important. I offered legislation last year on prescription drug coverage that was really based on a competitive model with multiple PBMs, so I look forward to working with you because, after all, we are here to work for the American people, and let us see how we can push the edges of the envelope out and get some good things done.

So, thank you, Mr. Chairman, and welcome, Mr. Secretary, and I wish you well in your position because there are a lot of people that are counting on you to make good on the things that haven't been done and I think that we all want to accomplish.

Mr. BILIRAKIS. I thank the gentlelady. Mr. Barton, for an opening statement.

Mr. BARTON. I don't have a formal opening statement, Mr. Chairman, I just want to welcome the Secretary. We have talked by telephone several times, and you have always been very receptive and accommodating, and many of us are supporting Alan Slobodan to be General Counsel at the FDA and your people are working on that. So, we look forward to your testimony, and welcome to the subcommittee.

Mr. BILIRAKIS. The Chair thanks the gentleman. Ms. Wilson, for an opening statement.

Ms. WILSON. Thank you, Mr. Chairman. I will forego a formal opening statement as well. I want to welcome the Secretary and look forward to working with him and, as the chairman knows, and other members of the committee, I have worked very hard on the discrimination against rural States and small States in Medicare+Choice, as well as the modernization of the Medicare and Medicare bureaucracy, the HCFA bureaucracy, so that we can focus on care to people rather than on compliance with regulations that sometimes seemingly have no purpose. And as the Secretary also knows, children's mental health is an area of keen interest of mine, and whether it is today or at some other point, I would like to visit with you on the progress being made in that area. Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentlelady. I believe that completes all the opening statements. The written opening statements of all members of the subcommittee are, without objection, made a part of the record.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. BARBARA CUBIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WYOMING

Thank you, Mr. Chairman. I appreciate your efforts in making Medicare reform a top priority of this subcommittee, not just today but during this Congress.

Medicare will touch all of our lives at one point or another, and for obvious reasons. So it is in everyone's best interest to work together to come up with some sound reforms that will improve the program for the long term.

The President's proposal for Medicare reform takes positive steps toward strengthening the program, and I am encouraged by what I have heard so far.

His plan places greater emphasis on preventative care services and the need for prescription drug coverage. Seniors can also keep their existing Medicare coverage without having to make any changes if they don't want to.

I think we are also making some real progress in identifying those problem areas within the program that need our attention, like contractor reform, improving the appeals process, and streamlining what has become a complex bifurcated structure of Part A and Part B services.

I would like to focus my attention on an area of particular importance to rural communities across this country, one that perhaps stands on the periphery of the reform debate, but one that we must address—regulatory relief.

Providers in my home state of Wyoming are quite honestly screaming out with frustration over the constant flood of Medicare regulations coming down the pike—a new regulation every five hours I'm told.

There comes a point when a rural provider with a small practice in tiny town U.S.A. simply cannot keep up with the regulations, not for any fault of their own, but because they do not possess the resources, manpower, or technology to keep up.

By the same token, when Medicare reimburses rural providers at a lower rate that urban providers, it has particularly devastating effects on health care services in rural areas.

I do not profess to fully understand the Medicare reimbursement formula used by Medicare, but what I do know is that Wyoming ranks last among the lower 48 states when it comes to Medicare payments.

Not only that, providers in Wyoming have become so paranoid about the stringent Medicare coding procedures fearing that at any moment they are going to be audited—or worse, charged with fraud and be faced with monetary penalties.

When we add all these things up, we literally force the provider to withdraw from Medicare and do you know who suffers the most in the long run?—our seniors.

As we continue to work through this issue, I hope we all keep in mind that rural America is the very backbone of this country. If we are going to strengthen the Medicare program and allow it to do what it was intended to do—provide medical care to all seniors—then we have got to ensure the survival of rural health care services.

I stand ready to work with this subcommittee and this Administration on any and all ideas related to regulatory relief—as I do in all other areas of Medicare reform.

With that, Mr. Chairman, I yield back the balance of my time.

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PREPARED STATEMENT OF HON. ELIOT L. ENGEL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Chairman, I want to thank you for having this hearing and continuing to examine different ways to improve Medicare for seniors. Let me also thank you Mr. Secretary. I appreciate your efforts in this regard and look forward to working with you on this issue. Today we will examine the President's framework for Medicare reform. I am optimistic that in developing legislation we can work in a bipartisan manner to the benefit of our seniors.

The 89th Congress had the pleasure of designing the Medicare program which has endured numerous changes over the years. However, this Congress is faced with the most significant challenge since Medicare's inception. Not only do we intend to provide a prescription drug benefit but we are also undertaking the enormous challenge of modernizing the Medicare program as a whole. This Congress is saddled with the responsibility of determining what aspects of Medicare have been successful, what aspects have failed, what new services should be included in a modernization package, and how to do that in a fiscally responsible manner. As this and other Committees study different modernization models, we must keep in mind that this is a program designed for the elderly. It must remain affordable, it must maintain a high level of care, and it must allow seniors to live with dignity. To do less would be an injustice to the millions of seniors who rely on Medicare.

In reviewing the President's prescription drug discount plan, I am a bit concerned about his commitment to implementing real drug coverage for all seniors. I have heard talk of providing coverage for low-income individuals along with a catastrophic provision. My concern through all of this is that middle-income seniors will be left out and the promise of coverage will be in the discount card, which clearly is not enough.

While the discount program may be well intentioned, I think it detracts from the real goal of meaningful prescription drug coverage, which should be our focus. In fact, the $300 billion that the President has set aside for a drug benefit is wholly inadequate. It does not allow this Congress to develop a real benefit. The benefit that $300 billion provides will give seniors some relief, but they will be forced to pay a fairly high premium for very little coverage and will still have high out-of-pocket expenses. The President's tax cut further exacerbates this problem by squandering the surplus when it should have been used to provide a real, meaningful prescription drug benefit for seniors. I hope that we will examine alternatives to increase the level of funding for a Medicare drug benefit.

I understand the complex changes that the delivery of health care has endured over the last 36 years and realize that we need to take a good hard look at the Medicare program. Seniors deserve high quality care and if changes are needed we need to make them. I look forward to hearing your testimony, Mr. Secretary, and working with you and the Members of this Committee to develop meaningful legislation that will benefit our seniors.

Mr. BILIRAKIS. The Chair now will recognize the Secretary. Sir, we will set the clock at 10 minutes, but you take as much time as you need to communicate your message to the Congress.

## STATEMENT OF HON. TOMMY G. THOMPSON, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. THOMPSON. Thank you very much, Mr. Chairman, Chairman Bilirakis, Congressman Brown, and all the other members of the committee. Let me just say at the beginning I was very appreciative of the comments that everybody said in the committee, and I would like to just point out that this administration and my office wants to work with each and every one of you. We have a tremendous opportunity to improve Medicare, and if we can set aside our differences and work on the goal of improving Medicare, I think there are enough good ideas out there that everybody can buy into it and accomplish something that the American people really want;

a strengthened Medicare system with a prescription drug benefit for all seniors. I was very heartened and encouraged by hearing everybody's remarks and appreciate that, and that is what I wanted to say up front.

Distinguished subcommittee members, I thank you very much for inviting me to appear before you today. I am very delighted to have this opportunity to discuss President Bush's framework for strengthening the Medicare program so that it can better serve America's seniors and individuals with disabilities.

As you know, the President's plan for improving and strengthening Medicare is based on eight principles, which I will discuss in a moment. These principles reflect ideas developed over many years of work by many people, including a lot of members on this subcommittee, and I thank you for working to ensure that Medicare is better and stronger for all that need it.

President Bush's Medicare principles recognize the need to improve the current benefit package so that it more effectively meets the needs of seniors. The principles also place Medicare on a secure financial footing for future generations. The President is committed to working with Congress on a bipartisan basis to meet these shared goals.

For 36 years, Medicare has been immensely successful, as all of you have pointed out, in helping America's seniors achieve the promise of secure access to needed health care. Yet as medical practice has improved dramatically in the past decades, the Medicare benefit package and delivery system has actually not kept pace. When Medicare was created in 1965, the benefit package was based on the most popular private health insurance packages which were offered at that time. Since then, the health insurance options available to most Americans have changed as the practice of medicine has changed, but Medicare has in many ways remained rooted in the 1960's.

As you all know, one of the most glaring omissions is the lack of prescription drugs in Medicare's benefit package. But even when benefits are covered, Medicare's patchwork benefits leave serious gaps, as all of you have pointed out, as too many seniors discover when they experience serious illnesses. These problems are illustrated not only by prescription drugs, but also by other types of care such as preventive medicine, which I personally believe is one of the biggest failings of America's health care system today. And I would welcome any ideas you would have that would help me improve that system.

Additionally, Medicare's current cost-sharing structure does not include protections for the most vulnerable beneficiaries, those with the highest medical costs. For example, individuals who need hospital care face deductibles of almost $800 for each hospital stay, as well as additional cost-sharing requirements, and our private health insurance programs do not require that $800 cost-sharing deductible each time we go in the hospital. While most private insurance plans also include stop-loss limits to protect against very high out-of-pocket medical expenses, Medicare has no such protections. And even the benefits now available to our seniors are not secure. The oncoming rush of Baby Boom retirees jeopardizes the ability of Medicare to meet its most fundamental obligations.

The President is not content to wait for comprehensive Medicare improvements to strengthen the system, he is taking bold and effective action now so that we will be able to begin the process of improving every aspect of the way Medicare functions.

We have taken immediate action to give all Medicare beneficiaries access to the kind of discounts on drug prices that Americans with private health insurance have available to them.

Now, I know some of you question the need and the use and the quality of the health card, but these discounts are incorporated right now in all the major Medicare drug benefit proposals pending before Congress. People with Medicare could use these cards right now instead of waiting until we implement Medicare, which may be 1, 2, 3 years away; could use these cards when they buy prescriptions to get discounts of up to 25 percent off the retail prices. And I want to point out that we had an information meeting this past Monday, and over 100 individuals representing many companies came and were very enthusiastic about the choices and the opportunity and the chances to drive down drug prices and to be able to negotiate directly with the pharmaceutical companies. The drug discount card is only the first step.

Today I am announcing three other actions that I believe will also significantly enhance the way that we provide health care in America. First, we are now issuing the final Skilled Nursing Facility Prospective Payment System. It includes the Skilled Nursing Facilities, commonly referred to as SNF, provided by swing-bed hospitals. Our plan supports swing-bed hospitals in providing quality care—this is going to help rural areas especially—while still maintaining accurate Medicare payments. I am working to reduce the burden on swing-bed hospitals by pushing back the implementation date of the new rule until July 1, 2002. This is going to give the swing-bed facilities time to prepare for their new role.

We are also reducing the questions from 400 to 100, eight pages that have to be filled out to two pages of rules and regulations, which is a tremendous reduction, 75 percent.

Second, I am announcing that CMS will provide new techniques to assist States in developing and implementing changes to their Medicaid programs. And one of the best ways to improve the waiver process is to be able to enable States to learn from each other so they know what the best waiver ideas are and what is available and what needs to be done.

I did this when I was Chairman of the National Governors Organization starting best practices. I am trying to do the same thing through CMS; put it on the Internet and the Websites so States will know what is out there, what is available. As part of this initiative, CMS will integrate State-to-State learning and information-sharing into the waiver application process through interactive templates on the Internet. State officials and, yes, all Members of Congress, will be able to go online and obtain information on how other States have designed their waivers. State officials will also be able to interact directly with other States that have experience in designing innovative waivers and will be able to work with our staff, CMS staff, on designing approvable waivers.

CMS is also issuing a new guide book that highlights the way States can better help families, especially those with children, who will be able to gain access to and retain Medicaid benefits.

Third, I am announcing several Medicare+Choice improvements—for example, provider credentialling for Medicare+Choice has been taking place every 2 years, adding unneeded regulatory pressure. From now on, it will occur every 3 years.

We are also adding a dose of commonsense to the requirements that we place on providers that participate in Medicare+Choice. For example, CMS will allow new providers to participate once their training is complete or while they are awaiting official credentialling. And we are revising the Medicare+Choice quality improvement requirements to decrease the administrative burden, allow increased flexibility, and reward high performance. For a full list of all these improvements, I have outlined them in my Medicare+Choice program and also in the record.

Improving Medicare+Choice represents the kind of change we need if Medicare is going to be able to meet the needs of nearly 80 million Americans who will be served by this program in 2030. It is also why the President has worked with Members of Congress from both parties to develop a framework to guide legislative program efforts to modernize the Medicare program and to keep the Medicare benefits secure. Let me review them with you now.

First, all seniors—all seniors—should have the option of a subsidized prescription drug benefit as part of modernized medicine and modernized Medicare. About 27 percent of Medicare beneficiaries have no prescription drug insurance and must pay for the drugs entirely out of their own pocket, or go without needed medication. That is unacceptable to you and to the administration, and I hope it will be able to be changed this year under your leadership.

Second, modernized Medicare should provide better coverage for preventive care and serious illness. Preventive care is something we all have to address if we are going to hold down health costs. Medicare's preventive benefits should have zero co-payments and should be excluded from the deductible. Medicare's traditional plan should have a single indexed deductible for Parts A and B, provide cost protection for high-cost illnesses, and take other steps to protect seniors from high expenses.

Third, today's recipient and those approaching retirement should be able to keep the traditional plan with no changes, no higher premiums, no changes in cost-sharing or supplemental coverage, period, and they should have a period of time to switch back to the original plan if they prefer.

Fourth, Medicare should provide better health insurance options like those available to the Federal employees. Plans should be able to compete to provide Medicare's required benefits, and beneficiaries who would choose less costly options should be able to keep most of the savings even if that means that they pay no premiums at all.

Fifth, Medicare legislation should strengthen the program's long-term financial security. Medicare relies primarily on payroll and income taxes to finance its benefits, but the significant increase in retirees means that there will be fewer workers to help sustain the

Medicare program. So, to support good planning for the entire program, Medicare's separate trust funds should be unified to provide a very straightforward and meaningful measure of Medicare's overall financial security that is not vulnerable to accounting gimmicks. Financial security cannot be achieved simply by increasing reliance on unspecified financing sources.

Sixth, the management of Medicare should be streamlined so that Medicare can provide better care for seniors and disabled citizens. For example, we really need contracting reform so that Medicare can use competitive bidding tools to improve quality and reduce costs. A number of recent studies show that this could reduce costs upwards to 25 percent.

Seventh, Medicare's regulations and administrative procedures should be updated and streamlined, and instances of fraud and abuse should be dramatically reduced if we do our job right. Too often, the regulations are complex, variable and inconsistent. They need to change, and I want to tell you, they will.

I am directing CMS to hold listening sessions around the country, much like the town hall type meetings that many of you hold in your districts. And I want to point out that several of you have asked us to come into your districts and hold town hall meetings, Democrats and Republicans alike, and I appreciate that. I don't know if we are going to be able to accommodate all of you, the list is getting quite long, but we will try to get to as many as possible. But we want to gain the input not only from you, but seniors and physicians, administrators and nurses, from everyone involved. Their recommendations will help form the basis of practical commonsense effective regulatory reform.

Finally, Mr. Chairman and members, Medicare should encourage high-quality health care for all seniors. For this administration, there is no more important goal than ensuring that seniors and disabled Americans get the highest quality, and most error-free health care. These are the principles around which the President has committed to building consensus in Congress to strengthen and improve Medicare. The President and I are absolutely committed to working with each of you and the entire Congress to make Medicare stronger and better.

I personally look forward to working with you, with your staff, to realize our mutual goal of improving and transforming this vital program. I thank you very much for giving me this opportunity, and now I look forward to your questions.

[The prepared statement of Hon. Tommy G. Thompson follows:]

PREPARED STATEMENT OF HON. TOMMY G. THOMPSON

Chairman Tauzin, Congressman Dingell, and distinguished Committee members, thank you for inviting me to appear before the Committee today. I am delighted to have the opportunity to discuss President Bush's framework for strengthening and improving the Medicare program so that it can fulfill the promise of providing health care security for America's seniors and people with disabilities in the coming decades. This framework is based upon ideas developed over long years of dedicated work by many people including many Members of this Committee. It recognizes the need to improve the current benefit package so that it better meets the needs of seniors including the addition of a prescription drugs benefit. It also seeks to place the program on a secure financial footing for future generations. The President is committed to working with Congress on a bipartisan basis to meet these shared goals. To this end, he has put forth eight principles that together form the basis of a framework for strengthening the Medicare program. Working together we can

ensure that Medicare keeps it promise not only to today's seniors but also the seniors of tomorrow.

For 36 years, Medicare has been successful in helping America's seniors achieve the promise of secure access to needed health care. Yet as medical practice has improved dramatically in the past decades, the Medicare benefit package and delivery system have not kept pace. When Medicare was created in 1965, the benefit package was based on the most popular private health insurance packages offered at that time. Since then, the health insurance options available to most Americans have changed as the practice of medicine has changed but Medicare has in many ways remained rooted in the 1960s. As you all know, one of the most glaring omissions is the lack of prescription drug coverage in Medicare's benefit package. But even when benefits are covered, Medicare's patchwork benefits leave serious gaps, as too many seniors discover when they experience serious illnesses. These problems are illustrated not only by prescription drugs, but also by other types of care such as preventive medicine.

Additionally, Medicare's current cost sharing structure does not include protections for the most vulnerable beneficiaries —those with the highest medical costs. For example, individuals who need hospital care face deductibles of almost $800 for each hospital stay, as well as additional cost-sharing requirements. While most private health insurance plans include stop-loss limits to provide protection against very high out of pocket medical expenses, Medicare has no such protections. And finally, even the limited benefits now available to our seniors are not secure in the coming decades with the retirement of the Baby Boom generation.

THE PRESIDENT'S FRAMEWORK FOR STREGTHENING MEDICARE

Medicare must be strengthened and improved now if it is to meet the needs of the nearly 80 million Americans who will be beneficiaries of the program by 2030. The President has worked with members of Congress from both parties to develop a framework to guide legislative reform efforts to modernize the Medicare program and to keep Medicare's benefits secure.

We believe that Medicare improvement should be guided by the following set of eight principles:

*1. All seniors should have the option of a subsidized prescription drug benefit as part of modernized Medicare.*

Prescription drugs are an essential part of the health care system for Medicare beneficiaries. One recent study found that while Medicare beneficiaries make up about 14 percent of the population, they accounted for 40 percent of prescription drug spending. Yet, over one-quarter of beneficiaries have no prescription drug insurance and must pay for drugs entirely out of their own pocket or go without necessary medications. Worse, this financial burden falls heaviest on those least able to afford it. Of beneficiaries with incomes below poverty, those with drug coverage filled nearly twice as many prescriptions in 1998 as those beneficiaries without coverage (29 prescriptions compared to 15). A prescription drug benefit will do more than protect beneficiaries from the risk of high prescription drug expenses. Quality private-sector prescription drug benefits also help make prescription drugs more affordable through the use of innovate tools to reduce drug costs. Private insurance plans usually work with pharmacy benefit managers to negotiate volume discounts. They also improve the quality of prescription drug use by working with pharmacists and physicians to provide individualized information on more effective, and lower-cost, drug options. Their computerized support systems can help avoid adverse drug interactions, which are far more common in seniors than in any other part of the population.

Medicare's subsidized drug benefit should protect seniors against high drug expenses and should give seniors with limited means the additional assistance they need. All seniors should have the opportunity to choose among quality private plans. Further, the drug benefit should be implemented in such a way as to encourage the continuation of the effective coverage now available to many seniors through retiree health plans and private health plans. While we must support these continuing options, we should encourage a multiplicity of new choices. The new drug benefit should be available through Medigap plans and as a stand-alone drug plan for seniors who prefer these choices. When Medicare implements the drug benefit, states should not face maintenance of effort requirements for their own drug programs outside of Medicaid.

*2. Modernized Medicare should provide better coverage for preventive care and serious illness.*

Medicare's existing coverage should be improved so that its benefits provide better protection when serious illnesses occur and provide better coverage to help prevent serious illnesses from developing. Medicare has been slow to cover proven treatments for preventing illnesses and saving lives. Coverage often comes long after preventive treatments are widely available in private insurance plans and the cost sharing required to receive these preventive benefits may discourage many from seeking potentially life saving tests. This Congress understands the value of Medicare preventive benefits and crafted important legislation in 2000 to expand preventive benefits for Medicare beneficiaries. Yet gaps remain. For example, colorectal cancer is the second leading cause of cancer death and more than 90 percent of cases occur among individuals over the age of 50. It is also one of the most treatable forms of cancer if it is detected early. However, at the present time, less than 40 percent of colorectal cancer cases are detected early. While Medicare covers colonoscopy for high-risk beneficiaries, the most complete form of screening for this disease, coinsurance requirements may pose a barrier to early detection. Coinsurance for a colonoscopy can range as high as $130 (assuming the beneficiary has already met their Part B deductible). If a beneficiary is at average risk for colorectal cancer, a colonoscopy is covered once every ten years. For an individual at high risk, the procedure is covered once every two years.

Advances in medical technology have made it possible for more seniors to survive illnesses that would have been fatal only a few years ago. Unfortunately, the sickest Medicare beneficiaries are likely to pay the most for their health care costs—exactly the opposite of the way that logical insurance plans should work. For example, Medicare copayments related to serious illnesses such as complex chemotherapy treatments for cancer may exceed 40 or 50 percent. Indeed, the sickest beneficiaries, those who incur over $25,000 in program costs (about 730,000 individuals in the most recent year for which figures are available) averaged more than $5,000 in cost sharing payments alone. This figure does not include items and services such as prescription drugs that are not covered by the program. Beneficiaries within this group include individuals requiring intensive life support following major heart attacks or breast reconstruction surgery following a mastectomy. In general, for patients with multiple hospital outpatient visits and procedures, the costs quickly add up. To protect beneficiaries when they need help the most, private insurance plans generally include "stop-loss" limits. Stop-loss provide guaranteed protection against very high medical expenses. Despite its important coverage gaps, Medicare has no stop-loss protection.

We believe that Medicare's existing coverage should be improved so that its benefits provide better protection when serious illnesses occur and provide better coverage to help prevent serious illnesses. These changes should not reduce the overall value of Medicare's existing benefits. Medicare's preventive benefits should have zero copayments and should be excluded from the deductible; Medicare's traditional plan should have a single indexed deductible for Parts A and B to provide better protection from high expenses for all types of health care; and Medicare should be provide better coverage for serious illnesses, through lower copayments for hospitalizations, better coverage for very long acute hospital stays, simplified cost sharing for skilled nursing facility stays, and true stop-loss protection against very high expenses for Medicare-covered services.

*3. Today's beneficiaries and those approaching retirement should have the option of keeping the traditional plan with no changes.*

Many people in Medicare today, and others, who are approaching retirement, have good supplemental coverage for prescription drugs and other medical expenses. If they wish to continue in the traditional Medicare plan with no changes in their premiums, benefits, or supplemental coverage, they should be able to do so. Beneficiaries who opt for the improved Medicare benefits should be allowed one year to switch back to the original plan.

*4. Medicare should provide better health insurance options, like those available to all Federal employees.*

Medicare beneficiaries do not have access to the same range of choices available to most Americans with private health insurance. The Federal government, many state governments, and most large private employers help their employees get the care that is best suited to their needs by offering them several health care plans, along with useful information to help them choose the best one for their budget and needs. The contrast is most striking here in our Nation's capital. Federal employees and Members of Congress living in the Washington area have twelve different

health plans to choose from, including a variety of fee-for-service plans, and health maintenance organizations (HMOs). But their neighbors with Medicare have only two choices—the traditional fee-for-service plan and a single HMO. This pattern occurs throughout the country. For many beneficiaries, particularly those in rural areas, Medicare offers only one health insurance plan—it is strictly one-size-fits-all. Previous legislation to address this problem, including the establishment of the Medicare+Choice program, has not had the intended effect of providing more reliable health insurance options for all Medicare beneficiaries. Currently, no senior has access to any of the new kinds of private insurance that have become popular with other Americans, such as point of service plans that give beneficiaries the cost savings of networks of providers along with the flexibility of coverage for services from all providers.

Plans should be allowed to bid to provide Medicare's required benefits at a competitive price, and beneficiaries who choose less costly plans should be able to keep most of the savings—so that a beneficiary may pay no premium at all. In areas where a significant share of seniors choose to get their benefits through private plans, the government's share of Medicare costs should eventually reflect the average cost of providing Medicare's required benefits in the private plans as well as the government plan. Low-income seniors should continue to receive more comprehensive support for their premiums and health care costs. Beneficiaries should have access to timely and comparative information on the quality and total cost of all their health care coverage options.

*5. Medicare legislation should strengthen the program's long-term financial security.*

Since 1965, Medicare has provided a guarantee of health care coverage for more than 90 million seniors and people with long-term disabilities. Medicare has made the same promise to millions of Americans who are currently contributing their hard-earned dollars through payroll and income taxes. These Americans are counting on the financial stability and integrity of the Medicare program. But Medicare faces substantial financial challenges in the not-too-distant future. Within the next thirty years, the number of Medicare beneficiaries is expected to nearly double to almost 80 million people. As the number of beneficiaries rises, the payroll taxes of fewer workers will be available to support the program. Rising health care costs will also strain Medicare's resources.

Careful planning is required to ensure that Medicare continues to keep its promises to future generations. We believe that legislation is necessary to improve the program's long-term financial security. To support good planning for the entire program, Medicare's separate trust funds should be merged to provide a straightforward and meaningful measure of Medicare's overall financial security that is not vulnerable to accounting gimmicks. Only by ensuring reliable data and planning ahead can drastic, undesirable changes in Medicare or other Federal programs be avoided.

*6. The management of the government Medicare plan should be strengthened so that it can provide better care for seniors.*

Medicare's traditional plan is falling short in important respects other than its benefits. It has not been able to use competitive approaches to keep its costs down. Its contracting requirements are outdated, making it more difficult to providers and patients to work effectively with a complex claim processing system. And perhaps most importantly, traditional Medicare does not provide integrated services for many seniors who need support for managing their illnesses, particularly in cases of chronic disease.

Contracting reform should be implemented to improve efficiency and performance. Medicare is restricted o using certain insurance companies to process certain types of claims. Other businesses have the experience and capacity to provide these claims processing services but Medicare is prohibited by law from contracting with them. The program also cannot reward or penalize a contractor based on their performance. Medicare also does not have the authority to use competitive bidding tools to improve quality and reduce costs. Enrollees in traditional Medicare frequently require use of medical supplies such as hospital beds, wheelchairs, and oxygen equipment. Prices for these items are set by Medicare and are frequently higher than prices paid by private plans. A number of recent studies indicate that the cost of supplies could be reduced between 15 and 30 percent if Medicare used the same kind of competitive bidding tools that help reduce costs for non-Medicare patients. However, Medicare should not be allowed to create newprice controls and should ensure that seniors continue to have choice of suppliers.

Medicare also needs to reform its medical management tools. Many Medicare beneficiaries are among the sickest and most vulnerable individuals in our society,

often suffering from numerous chronic conditions. Unfortunately, Medicare's traditional approach to paying only for discrete visits and services has denied many seniors the opportunity to take advantage of advances that have been pioneered by integrated health plans in coordinating care for complex conditions and chronic diseases. Private plans have developed disease management programs to improve the quality of care for individuals with specific conditions like heart disease, diabetes, asthma, and gastrointestinal disorders. These programs have the potential to increase quality of care and encourage appropriate health care utilization. While the elderly suffer disproportionately from these conditions, few of them have access to these innovative programs. We believe that beneficiaries who wish to participate in programs such as disease management and coordination of care should be able to do so. We also believe that Medicare's process for covering new technologies should be streamlined.

*7. Medicare's regulations and administrative procedures should be updated and streamlined, while the instances of fraud and abuse should be reduced.*

Medicare's system of regulations and administrative procedures is too complex, too variable and too inconsistent. Needed relief in regulation and oversight, including some bipartisan proposals from members of Congress, should be implemented. This will allow providers to spend more time and effort on patient care and less on paperwork and unexpected and complex rule changes. At the same time, we must continue to assure the integrity of Medicare's trust funds. Medicare's administration should be restructured so that program staff can work more effectively with beneficiaries, health care providers, and health plans.

I have already begun to address the issue of regulatory relief. As I announced last month in Chicago, I am doing a top to bottom review of all Department agencies looking for opportunities to streamline regulations to streamline regulations without increasing costs or compromising quality. We look for regulations that prevent hospitals, physicians and other health care providers from helping people in the most effective way possible. This initiative will determine what rules need to be better explained, what rules need to be streamlined and what rules need to be cut altogether while still providing beneficiaries with high quality care and protecting the interests of taxpayers. To this end, we will listen to the public most affected by the results of our regulations—beneficiaries and providers. I am directing CMS to start holding listening sessions around the country, in the areas where people have to live and work under the rules we develop. I want our people in CMS to hear from local seniors, the disabled, large and small providers, State workers, and the people who deal with Medicare and Medicaid in the real world. I want to get their input so we can run these programs in ways that make sense for real Americans in everyday life. To ensure that CMS responds to these ideas and comments, we will assign a senior level staff person to work with each provider industry. We will also take advantage of the years of expertise developed by the Department's dedicated staff. We will encourage them to think creatively about how we can operate the Medicare program more simply and effectively without increasing costs or compromising quality.

We will do more than listen—we will take action. We are going to use all of this wonderful input, and we are going to improve the way we do business and make Medicare and Medicaid easier for everyone involved with them. This action has already begun. As I announced last week, I am seeking to eliminate unnecessary data that has been demanded of hospitals and skilled nursing facilities in their Medicare Cost Reports. There is a statutory requirement that, for payment, hospitals report their overhead for old capital costs and new capital costs. We will eliminate these reporting requirements for most hospitals as soon as we can after September 30, 2001, when they expire in law. This will shrink the cost report by about 10 percent. This is just the beginning—there will be much more to come.

*8. Medicare should encourage high-quality health care for all seniors.*

For this Administration, there is no more important goal than ensuring that seniors and disabled Americans get the highest quality, error-free health care. Physicians and other health care providers unquestionably share this goal. But currently, there are too many instances where beneficiaries fail to get recommended treatments. There are too many instances where medical errors result in serious consequences for seniors.

The problems of benefit gaps, lack of coverage options, outdated management practices, and excessively complex administrative burdens undoubtedly contribute to these problems. There is also evidence that a range of private sector and public-private initiatives can help providers deliver better and safer care. For example, many hospitals and other health care institutions have launched collaborative efforts to

use information related to quality, giving providers and patients information they can use without increasing data collection burdens on providers.

Medicare should revise its payment system to ensure that quality is rewarded without increasing budgetary costs. Medicare's risk adjustment system for private plans should reward health plans for treating the toughest cases and finding innovative ways to provide care and reduce complications for chronically ill, high cost patients, without creating added paperwork burdens.

TAKING ACTION NOW

In the context of these eight principles, the President is committed to working with Congress to strengthen and improve Medicare. We also intend to begin the reform process administratively—to take advantage of the flexibility that Congress has already provided to us to ease the regulatory burden facing program providers and to provide increased services to beneficiaries. As a first step, we are also taking immediate action to give all Medicare beneficiaries access to the kind of discounts on drug prices that Americans with private health insurance have available to them. These discounts are incorporated in all of the major Medicare drug benefit proposals pending before Congress.

**Medicare RX Discount Card**—While Congress debates Medicare reform and the creation of a prescription drug benefit, Medicare beneficiaries without drug coverage continue to pay the full cost of their medications out-of-pocket. Because beneficiaries without coverage have no source of bargaining power, they also often pay higher retail prices for their prescriptions. Beginning this fall, all Medicare beneficiaries will have access to greater bargaining power. Beneficiaries will be able to choose among Medicare-endorsed Rx discount cards, offered by competing drug discount card programs. These cards will provide a mechanism for beneficiaries to gain access to the tools currently used by private health insurance plans to negotiate lower drugs prices and provide higher-quality pharmaceutical care. Discount cards are currently available in the marketplace through a variety of sources, including pharmacy benefit managers (PBMs), some Medigap insurers, and retail drugstores. Medicare Rx Discount card programs may use formularies, patient education, pharmacy networks, and other commonly used tools to secure deeper discounts for beneficiaries. People with Medicare would be able to use the cards when they buy prescriptions to get discounts of perhaps between 10-25 percent off retail prices.

We are moving to implement this program quickly Beneficiaries will be able to enroll in a program of their choice beginning on or after November 1,2001 with discounts scheduled to take effect no later than January 2002. Discount card programs endorsed by Medicare will conduct marketing and enrollment activities, with support provided by the Centers for Medicare & Medicaid Services (CMS). Enrollment is limited to Medicare beneficiaries and beneficiaries will be permitted to enroll in only one Medicare discount card program at a time.

To receive endorsement by Medicare, Medicare Rx Discount Cards would have to meet a number of qualifications:

- No plan could charge an enrollment fee greater than 25 dollars. This would be a one-time fee to cover enrollment costs. Some plans might not charge any fee.
- No plan could deny enrollment to any beneficiary who wished to participate.
- Plans would have to provide a discount on at least one brand and/or generic prescription drug in each therapeutic class.
- Plans would have to offer a broad national or regional network of retail pharmacies.
- Plans would be required to offer customer service to participating beneficiaries, including a toll-free telephone help line.
- Plans would have to participate in and fund a private consortium. The consortium will comply with all federal and state privacy and consumer laws and regulations and perform numerous administrative functions for the program.
- All discount card applicants that meet the qualifying criteria would be endorsed by Medicare.

We believe this initiative will provide a number of additional benefits for seniors that many of them do not enjoy now:

- First, we believe that providing comparative information to the elderly and disabled about actual drug prices will spur greater competition and lower prices than we see today. Because seniors can switch to a card that offers better pries and services, the discount cards will have strong incentives to get the best possible prices.
- Second, we believe these cards will create market pressures that will allow Medicare beneficiaries to benefit from drug manufacturers; rebates—something most seniors cannot obtain currently in the discount card market now. Combined

with existing retail pharmacy discounts, these rebates will help make prescription drugs more affordable to seniors.

- Third, we believe these competitive pressures will lead to other innovations that improve quality and patient safety—like broader availability of the computer programs to identify adverse drug interactions, and better advice on how seniors can meet their prescription drug needs at a more affordable cost.

To make sure that beneficiaries understand the benefits of this program, CMS will include information about these cards in its extensive education campaign and we expect that the organizations endorsed by Medicare to offer Rx discount cards will conduct their own marketing campaigns. A primary goal of the initiative is to make sure that people with Medicare are fully aware of the program and what it offers. The education campaign will also make clear that the Medicare endorsed Rx discount card is not a Medicare drug benefit.

Regulatory Relief—As you know, I am taking aggressive steps to bring a culture of responsive to all of HHS. As part of this effort, I am taking several steps today that will highlight our commitment to improving our responsiveness to our stakeholders.

SWING-BED HOSPITAL IMPROVEMENTS

An important component to strengthening and improving Medicare for our seniors and disabled individuals is how we treat our providers in Skilled Nursing Facilities. Today, I am happy to announce that we issued the final Skilled Nursing Facility Prospective Payment System (SNF PPS), and it includes the SNF services provided by hospitals with swing beds. I have revised in the initial proposal in several ways that minimize paper work burden and support swing-bed hospitals in providing quality care white still maintaining the accuracy of Medicare payments.

Like all other providers under the SNF-PPS, swing-bed hospitals are require to submit various data to us in order to bill Medicare. Under our initial proposal, swing-bed hospitals would have had to complete the full six-page Minimum Data Set (MDS) that nursing homes complete, as well as other information. After reviewing comments on the proposed rule, I am establishing a unique MDS assessment tool for swing-bed hospitals, reducing the number of pages they have to complete from six to two. This represents a decrease in the number of data elements from approximately 400 to about 100. In addition, CMS will collect only those items it needs to pay these providers and analyze the quality of patient care in their hospitals. This should make these providers' interactions with Medicare simpler and less time-consuming. We are looking at the length and complexity of the MDS for all providers who use it.

I also am taking a number of other steps to reduce burden and provide education and assistance to hospitals with swing beds. I am pushing back the implementation date of this rule, to begin on the latest date permitted by the statue—that is, cost reporting periods starting on or after July 1, 2002. Additionally, CMS will develop and distribute a swing-bed manual that will include instructions on using the new MDS, as well as other information. CMS also is planning a series of training programs to help hospital staff understand how to complete the MDS and transmit materials electronically. In addition, CMS has committed to develop customized software that will be available free of charge to providers. We will establish Help Desks to respond to clinical and technical questions from hospital staff. These initiatives will reduce burden for swing-bed hospitals and make it easier for these providers to interact with Medicare, and for Medicare to pay them the right amount and on time. I am committed to ensuring that we minimize the disruption to swing-bed operations and provide needed support to these providers during the transition period to the SNF PPS.

MEDICAID IMPROVEMENTS

As you probably know, before I came to HHS, I was governor of Wisconsin for 14 years, and I used to have regular discussions with HHS trying to push through our Medicaid State waivers. Well, since I started here at HHS, we've been making sure that waiver applications that come in that are identical to waivers we have already approved for other States receive priority review, and we are looking at other ways to further improve the waiver application process. Today I am announcing that CMS will provide new techniques to assist States in developing and implementing changes to their Medicaid programs. And we are going to take advantage of the Internet to improve the waiver process. I am directing CMS to develop web-based templates for waivers and State plan amendments. These online templates will provide States with a clear, concise way to ensure they are providing all of the informa-

tion the Agency needs for a State to apply for, and operate, a waiver or State plan amendment under Medicaid.

In addition, I want States to be able to learn from each other, so they know which waiver ideas are good ones that we can approve quickly, and which are not. As part of this initiative, CMS will integrate State-to-State learning and information sharing into the waiver application process through interactive templates. State officials will be able to go online and click on resource icons to receive more information on how other States have designed their waivers. They also will be able to interact directly with other States that have experience in designing innovative waivers. They also will be able to work directly with CMS staff for advice to design approvable waivers.

Not only is it important that we make it easier for States to apply for and operate waivers and State plan amendments, and it is important that States know how easy it is to provide Medicaid benefits to the people who need them—especially families with children. Toward this end, CMS is issuing a new guide, "Continuing the Progress: that highlights ways States can accommodate families with children, particularly working families, so they can more easily access and retain their Medicaid benefits. Federal law gives States a lot of flexibility to do this now. CMS's new guide features successful steps some States have taken, so other States might follow their example. For example, successful State practices highlighted in the guide include:

- coordinating Medicaid enrollment with the school lunch program;
- using community-based organizations to reach working parents;
- reaching out to Medicaid-eligible families in the community;
- establishing one-stop shopping for public benefits; and
- making it easier for migrant workers, immigrants, and other families to apply for Medicaid.

Additionally, the guide explains how States can implement Federal policy options that allow families with two working parents to be eligible for Medicaid or that allow children as well as pregnant women to receive on-the-spot Medicaid benefits, through presumptive eligibility. Finally, the guide includes tables with comparable, State-by-State information on the application, enrollment, and renewal processes for children in Medicaid and SCHIP. It is not enough simply to give States ways to help people, we have to help them understand how to accomplish their goals, and we have to help States to share good ideas with one another so that we help as many people as possible.

MEDICARE+CHOICE IMPROVEMENTS

Today I am announcing several initiatives to make the Medicare+Choice program more consistent with the private sector managed care plans and reduce regulatory burden. For example, CMS recently announced in a proposed rule that it plans to reduce the frequency of the Medicare+Choice provider credentialing process to make credentialing requirements consistent with those of States and private accreditation organizations. Previously, provider credentialing for Medicare+Choice had to happen at least every two years. Now, it will be required only once every three years. In addition, we are bringing a dose of common sense to the requirements we place on providers to participate in Medicare+Choice. We want these requirements to mirror those of the States and other credentialing organizations. For example, we will allow for pending Drug Enforcement Administration (DEA) numbers so physicians can provide care even if their DEA number is not yet finalized. In order to align M+C's requirements with those of private accrediting organizations, CMS will allow new physicians and health care practitioners to participate once their training is complete as they await their official credentialing.

Additionally, in response to concerns raised by Medicare+Choice plans, we are committed to thoroughly reexamining the Medicare+Choice Quality Improvement requirements, commonly referred to as Quality Assessment Performance Improvement (QAPI) projects. These changes will decrease administrative burden, as well as allow for increased flexibility and reward high performance. Specifically, in judging whether a plan's quality improvement is successful CMS has moved to an approach that is more consistent with the private sector. Finally, plans demonstrating high performance by meeting or exceeding a quality standard will be excused from participating in the national quality improvement project for that year.

CONCLUSION

While we believe that the Medicare Rx Discount Card is an important first step to provide immediate assistance to Medicare beneficiaries and to improve the program for them, I want to stress again the importance that the importance that the Administration attaches to the need for broader Medicare reform. The discount card

is not intended as a substitute for a comprehensive prescription drug benefit combined with other needed legislative reforms. I am committed to working with you to strengthen and modernize the Medicare program, improve its benefit package, protect its financial future, and increase access to high quality, innovative treatments for our nation's seniors and disabled populations now and in the future. I hope that the eight principles I have outlined here will provide the basis for constructive dialogue to meet these goals that we all share.

Mr. BILIRAKIS. Thank you very much, Mr. Secretary. We will have 5-minute inquiries, but we will have a second round.

Mr. Secretary, I think it was Mr. Pallone who made the comment that we need a comprehensive benefit. I think, for all practical purposes, we all said that we need a comprehensive benefit, and I would like to think by now it is clear that these discount cards are something to cover the time between now, and when a comprehensive plan finally goes into effect. All of the plans that have been discussed up here over the years, the prior administration's plan, the Democratic plan, and the Republican plan, take time to be fully implemented, which leaves beneficiaries without any help. And so, as I understand it—and please correct me if I am wrong—the discount card is a temporary thing intended to cover that particular implementation gap, is that correct?

Mr. THOMPSON. That is absolutely correct. There is 27 percent of the seniors that don't have any coverage right now, and the problem, Mr. Chairman, is these are the individuals that pay the highest cost because they don't have anybody running interference for them. They go into the drugstore and pay the sticker price.

We think with the card and with the full force of the Medicare population, we are going to be able to go to the drug companies and be able to get the discounts there and pass them on to the beneficiaries.

Mr. BILIRAKIS. Can you expand upon that, please, sir? Many of us have talked to your staff—who, frankly, have been very, very cooperative and very helpful. However, we have been hearing from our constituents especially pharmacists, who are concerned that the burden of the discounts will disproportionately fall on them.

Mr. THOMPSON. And I know that is a tremendous concern, and I appreciate their concerns, Mr. Chairman, as you do. The pharmacists are very important people. They are the front lines on health care delivery, and we want to be able to give them as much support as we possibly can.

We think with the size of the Medicare population, that the PBMs will be able to go directly to the pharmaceutical companies and be able to get the discounts there and pass them on to the drugstores, who will then voluntarily enroll and be able to have increased customers coming into their pharmacies. So, we really think it is going to be a win-win situation.

And I know there is some criticism and some concern, and all I can tell you is we are going to work with them and we are going to work with you, and we think this is going to turn out to be truly a win situation, especially for the uninsured seniors who pay the highest price for their prescriptions.

Mr. BILIRAKIS. Did I understand you to say they would go directly to the pharmacists? How about the drug manufacturers?

Mr. THOMPSON. I said directly to the pharmaceutical companies.

Mr. BILIRAKIS. Pharmaceutical companies. I guess I missed that.

Mr. THOMPSON. That is what I said.

Mr. BILIRAKIS. That is really the contemplation, that they would go directly——

Mr. THOMPSON. That is why we are doing this, so that we will have a big enough force to be able to go and negotiate directly with the pharmaceutical companies.

Mr. BILIRAKIS. No portion of that negotiation will take place with the pharmacies, it will all be with the drug manufacturers?

Mr. THOMPSON. That is our intent, Mr. Chairman.

Mr. BILIRAKIS. That is your intent. And will you include safeguards to be sure that there aren't increases in costs, that would then counteract the discount, which means not really a lower price?

Mr. THOMPSON. The beauty of this is that a year from now all the PBMs are going to have to list their drugs, the 100 most common drugs, and the prices that they will be selling them for. And so it is going to be very hard for the companies to increase those prices because seniors will be able to compare with all the PBMs that are going to be enrolled in this program, to be able to make those comparisons. So they are going to have a listing. We think the listing is probably going to have more of an impact than anything else to drive down the cost of prescription drugs for seniors. But as you have said, this is the first step, and I want to make sure that everybody knows that this is just only the first step—to be able to use the full force of the Medicare population hopefully, and we believe properly so, to reduce the amount of the drug prices.

Mr. BILIRAKIS. To what degree has the administration communicated with the PBMs to be sure that they will be willing, available, and there will be enough of them to cover the waterfront?

Mr. THOMPSON. Well, we had the first meeting, and we were absolutely surprised that on Monday of this week we had over 100 individuals representing many different companies, a lot of companies we did not even know about, that came in to get information, and all of them were looking together. Smaller PBMs were looking at joining together into a larger consortium so that they would be able to have a larger force. We think there is going to be, when we put out these specifications, a lot of responses, a lot of bids, and we are fairly confident that there is going to be several—I don't want to pick a number because I don't know—all I know is the enthusiasm for the PBM market has increased much more so than we thought when we first announced it.

Mr. BILIRAKIS. Good to hear. Thank you very much, sir. Mr. Brown.

Mr. THOMPSON. I can tell you the five biggest ones have already said that they are going to bid on them, and several other individuals have indicated they will.

Mr. BROWN. Thank you, Mr. Chairman. One of the President's principles, Secretary Thompson, said that seniors should have the option of prescription drug benefit as part of modernized Medicare. Clarify that, if you would. Does that mean you are planning to create a prescription drug benefit within traditional Medicare, or must seniors join one of the modernized Medicare plans in order to get the prescription drug benefit?

Mr. THOMPSON. Could you say that again? I am sorry.

Mr. BROWN. You had said the prescription drug benefit should—the principle said that seniors should have the option of a drug benefit. As you propose to modernize Medicare with these principles, does that mean that everyone in Medicare, not just those that have taken—that have joined one of the modernized Medicare plans?

Mr. THOMPSON. We want everybody in Medicare to be able to have prescription drug coverage.

Mr. BROWN. So people that stay in traditional Medicare fee-for-service, under your plans, will have an option for prescription drug benefit—will be included with a prescription drug benefit?

Mr. THOMPSON. That is our understanding, that is our position but, of course, this committee and the Ways and Means Committee will be the final determiners of that particular position.

Mr. BROWN. But that is your position?

Mr. THOMPSON. Yes.

Mr. BROWN. Good. I am glad to hear that. Gene Lambrut, former Associate Director of the Office of Administration and Budget, testified sometime ago in our committee, and said that in order to provide Medicare beneficiaries with the same type of prescription drug benefit that Federal employees have—and you have talked—you have and the President has and people on this committee have talked about the positive aspects of FEHBP and all the benefits that it offers.

She said Congress would need to spend $520 billion over 10 years to provide an equal kind of drug benefit. How do we do that? I mean, how can Medicare provide that plan when FEHBP, which you want to model some of this on, has to spend that kind of money? We have, at most, $300 billion available if Congress doesn't spend that even with the tax cut and all. Where are we going to go? How are we going to do this?

Mr. THOMPSON. I don't know what your figures are based upon, Congressman. All I can tell you is that from our preliminary costing out of this, we think that we can do it within the $300 billion set-aside over 10 years to allow this benefit.

Now, I don't know the statistics or the figures that you have, and I haven't compared them to our plan.

Mr. BROWN. And you think you can, even as generous a drug benefit as FEHBP—is that what you are modeling it on, that you can do as generous a drug benefit? I mean, you have talked about the beauties of FEHBP. Can we do a prescription drug benefit as generous as that within your Medicare proposals, regardless of what her estimate of the cost of FEHBP is?

Mr. THOMPSON. Congressman, we didn't make a dollar-for-dollar accounting or comparison of FEHB and the drug benefits and the seven—up to seven plans that they have. We just used that as a model, and these are the principles. We would have to cost-out the prescription drug proposals, like you are going to when you start working on this thing. We think that it is available. We think that we can have a very generous drug benefit for all seniors, but we do not have a comparison of dollars at this point in time.

Mr. BROWN. Well, I am concerned that I hear lots of people—the chairman of the full committee and others—talk about FEHBP and what a good program it is, and we can do a lot of those same things

in Medicare, yet FEHBP offers all kind of preventive benefits and better cost-sharing, limit on catastrophic out-of-pocket expenses, all kinds of other benefits that Medicare doesn't, and yet I just wonder how we are going to pay for this if we are going to model a lot of this on FEHBP.

Let me go back to the cards. You said it is a first step. You want to use the full force of the whole Medicare population in order to extract these discounts, if you will, not just from pharmacists but from the prescription drug manufacturers.

I don't understand today, those companies that do those cards, I would think today would operate under the same principles. Those companies that do those cards want to extract the biggest—they are selling these cards, they are marketing these cards, whether it is Merck Medco, whether it is AARP or anybody else. They want to extract the biggest breaks they can get today. They have access to the whole Medicare population. They have access to the whole population in society. Where does big government come in and get them under your plan to all of a sudden get these discounts up to 25 percent, as you say—it seems pretty high to me—but how do they get the drug manufacturers to do it today—do it in the future, when they are not doing it today? What is the difference?

Mr. THOMPSON. I think the difference, Congressman, is based upon the fact that the Federal Government is going to put the good seal of approval on it. It is going to be very well publicized, and I think the fact that you are going to list a year from now all the 100 drugs from all the pharmaceutical companies that are on that particular PBM, and what they are charging, and so on. And seniors are smart, they are going to make a comparison. And when you have 5, 6, 10, 12 PBMs out there, with the Medicare population having all of those drugs listed and the cost to them, I think that the seniors are going to pick the ones that are going to be the best for them, and the pharmaceutical companies are going to say they want that business. So they are going to drive down their prices because of the cost comparison that is going to be public.

Mr. BROWN. Wouldn't it be a whole lot simpler if rather than seniors getting direct mail and telephone solicitations from all these companies saying, "If you buy these drugs at this price," another one will say, "These drugs are this price," that to do something like have you at HHS negotiate on behalf of 40 million Medicare beneficiaries to get a better price on all drugs, or follow the Canadian model where the Canadian Government, on behalf of 30 million people at a cost of $2 million office in Canada, negotiates prices with prescription drug companies and gets discounts of 50, 60, 70 percent, wouldn't that be simpler to seniors, and a better price only for seniors?

Mr. BILIRAKIS. The gentleman's time has expired. The question, I guess, started before the 5 minutes was up. Maybe a brief response, Mr. Secretary.

Mr. THOMPSON. Congressman, we have the opportunity to do this immediately, that is the beauty of it. We can set it up without any further congressional action, and that is what we are doing. In order to do what you are asking would have to have some congressional authority——

Mr. BROWN. Would you support it?

Mr. THOMPSON. At this point in time? Let us see if this one works.

Mr. BILIRAKIS. Mr. Burr, to inquire.

Mr. BURR. Thank you, Mr. Chairman. Again, Mr. Secretary, welcome. In the administration's principles, one area that was highlighted was an expansion of services to potentially include preventative care which has been a difficult discussion in the past up here, as it related to Medicare services, that expansion into certain areas of preventative care. What do you expect that would cost participants in co-payments and/or deductibles?

Mr. THOMPSON. We would like to be able to have the preventive coverage not have any deductibles at all. We think the beauty of it is to encourage people to get preventative health and start taking care of themselves personally. We think it will pay many dividends to the taxpayers in the future by driving down health care costs, but also improving the health of the individual. And we think the mammograms and the pap smears and also the PSAs and all of these things are so important. They are in there now, but we need to do more. We need to have a better diet, and more exercise. We have an obese Nation that is getting fatter and exercising less. We have diabetes that is going to be an epidemic if we don't do something about it.

So, if we are not going to face up to the facts that we have this problem confronting us, it seems to us the best way to address this is through preventive health and encourage people to do something about it.

Mr. BURR. Well, I commend the administration for taking the initiative to put it in, and I think that that will have overwhelming support from this committee and from this Congress.

Mr. THOMPSON. Thank you.

Mr. BURR. Mr. Secretary, throughout the BBA, Congress, I think, did a disservice to the long-term care industry. We placed in jeopardy reimbursements. The result of that, with less predictability in their reimbursements, financial markets responded, capital dried up, they were faced with financial ruin in many cases.

The facts are that by 2030, 77 million seniors will potentially be in the market for long-term care needs. We are in a situation that without predictable and fair reimbursements, without some type of action on their workforce numbers, without reassurance to the financial markets, we won't be prepared for this onslaught of seniors with our long-term care facilities.

Are there proposals, or will there be proposals from the administration that specifically address these problems within this industry that I think is vital to our future?

Mr. THOMPSON. I think, Congressman, you really address something that is badly needed in America, and we need, I think, three important concepts, big concepts, if we are going to improve the delivery of health care. One is long-term care. We have really not addressed this as a Nation.

The second one, and probably the most important one, is preventive health which I have already addressed. But the third one is the way we deliver health care in America is just wrong. You know, grocery stores are more technologically advanced than hospitals

and clinics. And we need to put some dollars, somehow, into advancing the technology in the hospitals to reduce down the kind of pharmaceutical mistakes, the kind of mistakes that are costing up to 98,000 individuals to lose their lives.

So, those three principles—and you have addressed two of them—but if we could address those three, we could improve the quality of health care so dramatically in America and we would all be very proud of it. I think we would save a lot of money in the process.

Mr. BURR. Well, you have segued me into my next question, which is, what has been an inability at CMS to see or to have a vision of what was being approved in the way of new technologies at the FDA, and the delay that exists which truly does affect the quality of care for seniors, in our implementation of a code and a reimbursement for those procedures within the Medicare system. Can we expect some changes in that?

Mr. THOMPSON. Mr. Burr, I can guarantee you are going to see changes made there because you have addressed the three most important things that I believe are needed if we are going to really improve the quality of health care. The new technology is out there. If we use the new technology that is available, we could reduce the number of deaths, the number of medical mistakes tremendously in this country, and overall improve the quality of care. So, absolutely, the reimbursement formulas need to be updated and modernized, as well as Medicare. Prevention has to be a part of that, and also the approval of new technology, but also a way to get the new technologies into clinics, into doctors' offices, and into hospitals. It is just, to me, somewhat ridiculous that we still are writing out prescriptions that nobody can understand or read, and then giving the drugs and not have any kind of check on the interaction of different drugs and whether or not the drugs have been given.

Mr. BURR. I thank you.

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

Mr. WAXMAN. Thank you, Mr. Chairman. Mr. Secretary, I would like to get a clear answer on several points. Is the administration committed to maintaining traditional Medicare with its fee-for-service structure and full choice of providers, is it committed to maintaining Medicare as most seniors know it, and are you committed to maintaining it not only for current beneficiaries and people about to retire, but as a permanent part of the program not just for the next 5 or 10 years, but on a continuing basis?

Mr. THOMPSON. I didn't hear the last——

Mr. WAXMAN. Not just for the next 5 or 10 years, but on a continuing basis.

Mr. THOMPSON. Congressman, we believe that if we pass an improved Medicare system, that most seniors will want to go into the improved system. But, if they don't, they should have the opportunity, as you have indicated, to stay in the current fee-for-service system. And I have no difficulty with that, and that is going to be a decision that this Congress will have to make.

Mr. WAXMAN. Then let us get to the really key point, are you committed to assuring that seniors and disabled beneficiaries will not face financial pressures to move out of traditional Medicare if

this is where they want to stay? In other words, will they have to pay relatively higher premium amounts just to stay in the traditional program, or not? And I ask this because, as you know, this is one of the basic criticisms of the so-called Breaux-Frist No. 1 proposal, the good risks go to cheaper plans, the average premiums are used to set the Federal contribution, the portion of traditional Medicare paid by the government falls, and then the beneficiary is left paying more just to stay in the traditional program. Have you rejected that approach?

Mr. THOMPSON. I don't think rejection is the right word because what we have is we didn't start there. We didn't include it, we didn't reject it, it wasn't part of it. We started on our principles off of Breaux-Frist No. 2 where part were being included, but that wasn't where we really ended up. We ended up in a whole new system and principles that we think can be endorsed on a bipartisan basis. And what we are trying to do is—as you know, Part B costs are going to go up. We don't want to put the cost on any segment of the Medicare population. We want to have the fairest system as we possibly can.

Mr. WAXMAN. Well, we want to be fair. If they just want to stay with what they have, what I want to know is, are you committed to assuring the seniors and disabled beneficiaries that the Federal contribution to the premium for traditional Medicare will not be reduced as a portion of the cost for the fee-for-service program from what it is today? In other words, are we going to assure people who choose traditional Medicare that they are not going to face negative financial consequences for making that choice and they are not going to have to pay more just to keep what they have at the present time?

Mr. THOMPSON. Congressman, that is my position, but this Congress is the one that is going to make the final position on that.

Mr. WAXMAN. But your position is to allow people to keep traditional Medicare and not have to pay——

Mr. THOMPSON. It is our position to allow individuals to keep the current——

Mr. WAXMAN. And not to have to pay a financial penalty because they make that choice.

Mr. THOMPSON. That is correct.

Mr. WAXMAN. I appreciate that answer, and I agree with you on that. Let me ask you a quick question.

Mr. THOMPSON. But you also have to understand Part B keeps going up on an annual basis, as you fully well know.

Mr. WAXMAN. On the Medicare cards, these prescription drug discount cards, I have doubts whether you will really get the discounts. My staff did a study showing that people can go ahead and get these cards now, but they can get drugs at an even cheaper price than by using some of the cards. But let us say that we have these cards. I am concerned about the privacy rights for people who enroll in these programs. Independent of the President's plan, there may be a question about whether these discount cards will be covered under privacy regulation. Is it your view that drug discount cards are covered by the recently issued privacy regulations?

Mr. THOMPSON. I haven't taken a position. I haven't studied it. I would presume absolutely.

Mr. WAXMAN. I guess the second question is, the Department has said it will require these Medicare-endorsed programs to comply with HIPPA, but it is not clear what that means. How is the Department going to structure the relationship to ensure that individuals who use these programs are given the protections of the privacy regulations? You may want to get back to me with an answer on this, but I assume you want to make sure that we apply those privacy protections if they go into these private prescription drug cards.

Mr. THOMPSON. I am a full believer that if we pass rules for everybody else, we should comply with them ourselves, Congressman, and absolutely we will.

Mr. WAXMAN. Of course, we pass those rules to apply to ourselves. I want them to apply to everyone else when our seniors are involved and the government is giving its stamp of approval.

Mr. THOMPSON. So do I, Congressman.

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

Mr. WAXMAN. Could we leave the record open for elaboration on——

Mr. THOMPSON. I would be more than happy, if the gentleman wants to submit some questions.

Mr. BILIRAKIS. Is the gentleman expecting a response from the Secretary regarding that question?

Mr. WAXMAN. Yes, and I will write a letter to the Secretary so we can get an exact answer.

Mr. BILIRAKIS. Mr. Barton.

Mr. BARTON. Thank you, Mr. Chairman. Mr. Secretary, I want to go back to Chairman Bilirakis' questions on the prescription drug card for seniors. I watched the President's press conference on that, and within 2 hours my telephone was ringing with retail pharmacists in my district afraid that those discounts were going to come out of their operating margins, which are pretty slim.

Now, I have read all the material that is generally available to the Congress and the public on the prescription drug discount card, and I want to reinforce what Chairman Bilirakis said, and that is I think the committee is all for giving seniors lower drug prices, and a prescription drug card is a way to do that, but the discounts that are generated need to be shared by the manufacturer and the wholesaler, in my opinion, and I would assume in the committee's opinion.

What—I won't say "guarantees"—but what mechanism is built into the program to try to facilitate that the discounts come from the manufacturers and the wholesalers as opposed to at the retail level?

Mr. THOMPSON. Congressman Barton, it is a fact that the current discount card companies have not gotten the discounts from the manufacturers. They have negotiated with the pharmacists, and that is where the pharmacists are very concerned. And that has been a failure of the current cards. And what we think that we are going to be able to do with putting the government supporting this concept, that the discounts are going to have to come from the manufacturer, pharmaceutical company, and that is where the discounts are going to come.

And the second thing that we are going to ensure is the fact that they are going to have to list what the prices are, and I can't imagine a drug company that is going to be looking at these lists are going to want in any way to have one of their drugs at a higher cost than another——

Mr. BARTON. How do we do that?

Mr. THOMPSON. That is the insurance that we have. We don't have any law to give us, you know, any supervisory power to go in and get the discounts ourselves, but we think the marketplace itself is going to accomplish this.

Mr. BARTON. Well, why hasn't it done it already, then?

Mr. THOMPSON. Because they haven't had the power, they haven't had the CMS or——

Mr. BARTON. If we are not going to change the law or an Executive Order or some regulation that somehow encourages these discounts to come from the manufacturers, if the discounts under the current system are coming from the retail pharmacists—and, again, we are not changing anything other than the President is putting out the idea—what makes the President and you think that it is all of a sudden going to come from the manufacturers? I am not being argumentative, I am on your side, but I am fixing to go home to town meetings, and I won't have you by my side to take the arrows when the retail pharmacists show up in droves and say, "You are our Congressman, what are you going to do about this?" And I say, "Well, I talked to Secretary Thompson, he assured me that it is okay," and they say, "Well, that is great, now how do we know"——

Mr. THOMPSON. I don't want to be argumentative either, of course, but I want to point out that this is a concept that is going to allow one card per senior, and is going to increase the purchasing power and the negotiating power, and which each one of these PBMs are going to have to have at least 2 million seniors that are going to be enrolled——

Mr. BARTON. Define the PBM for me. I am more of an energy guy than a health care guy, so what is a PBM?

Mr. THOMPSON. That is these companies that have these discount cards, and they are going to be issuing one card, the Pharmacy Benefit Management——

Mr. BARTON. They are in existence today?

Mr. THOMPSON. They are in existence, and they have indicated at our meeting on Monday that they feel that the discounts will be coming out of the manufacturing companies, and they think that they will be able to—with the sheer force of the negotiating power of the size of the number of people in that group, that they will be able to go to the pharmaceutical companies and demand reductions.

And the third thing, the listing of the prices is going to have, I think, a tremendous impact on lowering the prices from the pharmaceutical manufacturers, and that is—and the drugstores, the pharmacists can enroll or they don't have to. This is a voluntary thing. But the PBMs are going to have to negotiate with the pharmacists in your area so that every senior in a particular area has at least one drugstore that is enrolled.

Mr. BARTON. Now, one of the President's talking papers—Mr. Chairman, could I ask one final question?

Mr. BILIRAKIS. Make it quick, please.

Mr. BARTON. It talks about that the retail pharmacists can organize their own discount program. Is there anything that we need to do in terms of an antitrust exemption to give those pharmacists the ability to do that?

Mr. THOMPSON. I don't think so, but I am not sure.

Mr. BARTON. Thank you.

Mr. BILIRAKIS. Possibly we might ask the Secretary to look into that, it certainly is a good question.

Mr. BARTON. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Ms. Capps.

Ms. CAPPS. Thank you, Secretary Thompson, for the opportunity to have a discussion with you. I am not going to spend time on what you call a very temporary, perhaps stop-gap measure anyway, than what we have been talking about the discount cards. I have serious questions about them partly because of their enforceability and, also, to use that as a segue, the one modernization that I have seen experienced in my district with Medicare to include the possibility of prescription drug coverage has been the Medicare+Choice program, and the new discussion about modernizing Medicare, particularly the Breaux-Frist plan, kind of pushes this in the direction of involving the private sector even more. And I want to have you hear from me about my concerns with the Medicare+Choice market as it is reflected in my very rural district on the Central Coast of California.

We have many complaints from seniors about the plan that have pulled out because it is not cost-effective for them. They can't make the profits that they wanted to. And it is not just my district, but in many areas across the country.

Mr. THOMPSON. All over America.

Ms. CAPPS. So, seniors I represent are very jaundiced about the possibility of modernizing Medicare by enticing more seniors into more plans such as the Federal Government has for its own employees and so forth. That is why I think we are continually saying what about the traditional fee-for-service Medicare plan? That is what seniors really would like to see include prescription drug coverage, the way that would include all of them.

I want to just ask you to comment on the BIFA, the Beneficiary Improvement and Protection Act of 2000, in increased payments to Medicare+Choice organizations by $11 billion over 10 years, hoping that they would get a better return and come back and they would be more involved in the Medicare program.

In addition, we required these plans to put this extra money toward increased benefits or lowering the cost, including more preventive measures, as you and I both support. However, many seniors are even more disappointed as time goes on, with the way these plans have worked out for themselves. And that is why I want you to give me some reassurance and talk to me about how the prescription drug option the President is considering offered by private drug-only insurance companies, how can this be an improvement on what many of us would call a dismal performance so far?

Mr. THOMPSON. Congresswoman Capps, I have got to agree with you that Medicare+Choice has had some real difficulties, and I think a lot of those difficulties have been brought on by us—stiff regulations, unable to get a decent return—and I think it is important for us to direct our attention to see if we can improve it. I think it is important to keep the Medicare+Choice companies in the mix and be able to offer the services.

I think also that if we have more choices and better opportunities, your seniors are going to be able to pick what is the best insurance coverage for them, and we have to make sure it is available. Now, under the FEHB, as you know, every county in America has to be covered by at least the choice up to seven plans.

Now, we think that if we pass something like this, that we will have that kind of choice throughout America, and rural California, as it is in rural Wisconsin, and that is what I think you would like to see happen. I know it is what I would like to see happen. And I can't stand here, or sit here, and tell you that automatically I have a magic wand that is going to do that, but that is what I want to work toward to make that happen.

Ms. CAPPS. Through incentives, because we have added a lot of incentives and it hasn't worked. As I speak to you, one of the remaining companies is considering to withdraw. They have raised their premiums time and time again.

Mr. THOMPSON. I know, they have contacted us.

Ms. CAPPS. Thank you. You see, we have a jaundiced eye toward this as a plan. I haven't seen it work in my district, and seniors who worked hard all their lives, choose Medicare+Choice so that they can get the prescription benefit, that is their major reason for choosing that plan, and then those companies leave because they can't make a profit. You can't make them stay, this is the private sector. Why would we go down this path further?

Mr. THOMPSON. Well, I think we go down this path to make sure that we do cover them with prescription drugs.

Ms. CAPPS. You make them come? You make them stay in my district?

Mr. THOMPSON. Well, I don't know if that is make it, I think that we can certainly set it up so that they want to stay and expand. That is what I think is a much better model than forcing people to stay because they won't do a good job. And so you want the best services for your constituents as I want for your constituents, and I think we have to work together to accomplish that.

Mr. BILIRAKIS. The gentlelady's time has expired. I made the announcement earlier that we would have a second round. I should have also said subject to the Secretary's time schedule, and I understand he has to be gone from here by noon. So, let us all cooperate as much as possible, if we would like to even touch that second round. Mr. Ganske.

Mr. GANSKE. Thank you, Mr. Chairman, and once again welcome, Mr. Secretary. I keep wanting to refer to you as Governor. I am sure there are a few times when you are dealing with some of these contentious issues that you wish that that might still be the case.

Mr. THOMPSON. I hope you don't ask that question, Congressman.

Mr. GANSKE. I won't request a reply to that. Part of the problem that I see with the pharmaceutical benefit manager plans is that I know they are being bought up by the pharmaceutical companies, and I think there is a potential for some real conflict of interest in terms of whether they would then function in a fair way or in a way that could produce any savings.

I want to, though, focus on—I am just curious, how did the State of Wisconsin provide a drug benefit for its Medicaid patients.

Mr. THOMPSON. We added it sometime ago, Congressman.

Mr. GANSKE. What was the mechanism? I mean, did you do it through a managed care plan? Did you just simply provide a card for somebody who qualifies for Medicaid to go to a pharmacy, and then you added everything up and you got your negotiated discount?

Mr. THOMPSON. It was through managed care.

Mr. GANSKE. So that in essence the managed care company that is providing Medicaid for Wisconsin was then doing the negotiations, their negotiations with the pharmaceutical companies.

Mr. THOMPSON. That is correct.

Mr. GANSKE. Now, you already have a mechanism in place for Wisconsin then for your Medicaid beneficiaries, plus you are under that situation getting discounts from the pharmaceutical companies. What would be wrong with extending that benefit to those low-income seniors, the elderly widow who is just above your Medicaid level but still is living off her Social Security primarily, but maybe has a little bit of property so she can't get into Wisconsin Medicaid—what would be wrong with just giving her one of those Wisconsin cards and letting her go to any pharmacy in Wisconsin and participate in the discount that your HMO has already negotiated with the pharmaceutical companies? Wouldn't that be a simple way to give this benefit to those who need it the most, without creating an additional bureaucracy and also having, in effect, a legitimate way to negotiate discounts either through HMOs or through the mechanism that is already there for other Medicaid programs?

Mr. THOMPSON. Congressman, we didn't have that option. We wanted to move, and we wanted to get something up right now, and we felt that it was important for us to do so, and the prescription drug discount was a way in which we could do that, and we set it up. And I want to tell you that the kind of responses that we are getting has been very encouraging for us to believe that this is going to work.

Mr. GANSKE. If Congress, though, would pass a provision like this, it would seem to me it would be relatively easy to implement it. Now, as a former Governor, I would expect that you would hope that if Congress is going to extend this benefit above the poverty line, as defined, that since we would be prescribing that we would also pay for that. In other words, I would suspect that as a former Governor you would probably not want to see a cost-share on that additional coverage. Would I be correct that that would be sort of what most Governors would say?

Mr. THOMPSON. If I was still a Governor, I would absolutely concur.

Mr. GANSKE. But if you were still a Governor, I think that if the Federal Government were offering your State an extension of benefit and paying for it entirely from the Federal side, wouldn't that be a way that you could then be telling your constituents in Wisconsin that we are helping those low-income seniors who aren't quite so poor that they are in Medicaid but are really struggling, and we have a program in place, we are just going to let you participate in that? Wouldn't that be a relatively simple way to handle that?

Mr. BILIRAKIS. The gentleman's time has expired, but please answer the question.

Mr. THOMPSON. That is a simple way and it would provide some benefits, but that requires congressional action, and this program that we were able to put out there did not require congressional action, we could get it up and running, and we think that we will be able to get those discounts to all seniors across America, not only Wisconsin but across America.

Mr. GANSKE. Thank you.

Mr. BILIRAKIS. Mr. Strickland, to inquire.

Mr. STRICKLAND. Mr. Secretary, I have two questions that I think are fairly practical and not particularly theoretical. One of the President's Medicare principles mentions the need to update and streamline Medicare's regulations and administrative procedures. And in your testimony before the Ways and Means Committee, you discussed reducing the regulatory and the administrative burden on providers. However, providers aren't the only ones that face regulatory and administrative burdens. Seniors face these barriers.

This subcommittee has heard many times that participation rates in the Medicare low-income assistance programs, the qualified Medicare beneficiary and the specified low-income Medicare beneficiaries programs, the QMB and the SLMB programs, that the participation is very low. One of the reasons that seniors do not take advantage of these programs is because of the fact that seniors have to go to their local Welfare office and sign up for either of these programs, something that many seniors feel is burdensome and in some cases embarrassing to them.

I believe a much better solution is to allow seniors to enroll in these programs at their local Social Security Office. And so my question is this: Do you support reducing these burdens on seniors, and could you support allowing seniors to enroll in these two programs at their local Social Security Offices rather than at the Welfare office?

Mr. THOMPSON. Let me just say, Congressman, I really applaud you. I thank you for new ideas, and that is what I really enjoy coming in front of a committee like this and finding out that some of the thinking that is going on by you and other members of this committee, and I will take it back. I can't imagine we would be opposed to it. But let me just point out that we are going to put $35 million into a public informational campaign starting in October of this year, for Medicare seniors across America to be able to find out what really is out there and give them the best opportunity to really find out what they need and to explain to them in common terms what Medicare is all about and the programs available. We also are

going to set up a hot-line that is going to be open 24-hours-a-day, 7-days-a-week so that seniors in your congressional district as well as seniors all over America are going to be able to pick up that 1-800 number and call in for information. And we are also going to train librarians in respective areas across America to teach seniors how to use the Internet, to be able to get information and to be able to apply.

Now, you may have the best idea of allowing seniors to go down to the Social Security Office and apply. I can't imagine who would be opposed to that, but I would like to be able to have just a little opportunity to reflect on that and get back to you, but I would think, at first blush, it would very much be endorsed.

Mr. STRICKLAND. Thank you. And I suspect that if you set up that 24-hour hot-line, some of us who are Members of Congress may be using it from time to time to get answer ourselves.

Mr. THOMPSON. It is going to be set up this fall, Congressman.

Mr. STRICKLAND. One other question, Mr. Secretary. Many of us are concerned about traditional Medicare and what the future holds for traditional Medicare. In the Statement of Principles, it indicates that seniors and those near retirement should have the option of keeping the traditional plan with no changes. I am not sure what that means, but it seems to imply that no new benefits will be added to a Medicare fee-for-service system. Is that what is meant by that statement, or am I misinterpreting the intent?

Mr. THOMPSON. Congressman, we have not made a determination. We have not got down to the finite details. We get criticized if we come in with too many details that tell us that we are legislating, and we didn't want to get involved in that. We know that this is a very contentious subject, and we want to work with you, we want to work with the members of this committee to come up with the best program possible.

We put out these principles. We think that the seniors should not be forced into another program. They like the current program. They should have that opportunity to do so. But in regards to increasing the benefits to that, that has got to be a determination by this committee and Congress.

Mr. STRICKLAND. Thank you, and I yield back my time, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman. Mr. Whitfield, to inquire.

Mr. WHITFIELD. Thank you very much. Mr. Secretary, I know that Medicare is divided up into regions. It is my understanding there are ten regions in the U.S., and there are 50 contractors that are either fiscal intermediaries or carriers, and there seems to be a lack of uniformity in decisions made on reimbursement. And, also, there seems to be maybe a lack of the ability to determine which contractor is doing a really good job and which is not. What are your all's suggestions or thoughts on dealing with that issue?

Mr. THOMPSON. Thank you for asking that question, Congressman, because the way it was set up back in 1965, it was set up to such a degree that we are hampered by doing the best job possible because the fiscal intermediaries have got to be nominated by the health care system in that particular State, that particular region, and then it is based upon cost. And we have too many fiscal intermediaries, we have too many carriers. We should be able to

put it out in an RFP, Request for Proposal, to get the best technology, the best contractor to be able to go in and administer it on a more uniform basis, and that is what we would like to do. We can't do that without Congress changing the law and allowing us to have performance contracts and to be able to limit the number of fiscal intermediaries and carriers, and I am asking Congress to give us that. I know it is contentious and controversial, but I think that the time is right to update the contracting out so that we can get the best services and have more uniformity in our decisions.

The second thing we are trying to do is we are going to be setting up not only the town hall meetings, but we are going to be contacting a lot of the carriers, or all the carriers, all the fiscal intermediaries, but a lot of the providers, and finding out from them what is working, what are the best practices out there, which region is doing the best. I am a big believer in taking what is working and adapting that to other areas that are not doing quite as well, and that is what we intend to do.

Mr. WHITFIELD. Well, I am delighted to hear that because I have had a lot of town meetings also with providers, and have met with Regional Directors of HCFA, now CMS, and we have brought in some of these contractors, and it is kind of embarrassing how unresponsive they are to consider basic questions. So, I think that is an area that definitely needs to be addressed, a problem area.

Mr. THOMPSON. You are absolutely correct, and there is no basis for performance—no basis for performance because everything is based upon cost, whatever it costs we pay. What a foolish system.

Mr. WHITFIELD. Right. Well, I am delighted to hear you are going to be pursuing that, and I know many member——

Mr. THOMPSON. Can't do it without your help, though, I have got to have Congress' help on that.

Mr. WHITFIELD. [continuing] many members look forward to working with you on that. I yield back my time.

Mr. BILIRAKIS. I thank the gentleman so much. Ms. Eshoo, to inquire.

Ms. ESHOO. Thank you, Mr. Chairman, and thank you once again, Mr. Secretary, for being here today so that we can start this conversation with you. Let me just make a couple of quick observations. On this discount card, we all like discounts, you know, and I think maybe the older we get, the more we look forward to them. It is a tradition, I guess, to be a senior and get a discount. But I do have to say, look, anything that we can do to ease the burden, how can anyone be against that? But I think that some sand has been thrown in the gears here, and that is by the pharmacists. You have got some problems, you have a bumpy start on this thing. I don't know how it was put together. I don't know who was in the room to have it explained to, but it seems to me that some of the major players were maybe left out, and some of the more obvious people, because you have heard members from both sides of the aisle talk about this. So, I don't know how you get the genie back in the bottle, but you have got a bumpy start on this card business.

I think that anyone that markets wants lists, and so I think it is going to be up to you to satisfy and answer this issue on privacy because, if I were in the drug business, I would want the list of names of everybody in the country so you can keep marketing to

them. So, I don't know how you are going to satisfy that, but that is up to you to do. You are offering this, I think, because it is quick, it is early, it speaks to some things that can be done and not be done legislatively. So, really, the burden, so to speak, is on you, but I do think some sand has been thrown in the gears by the very people that you need to do business with or have a conversation with, and that is just an observation. I think we agree that it is a bumpy start, and you are going to have to repave the road on this thing.

Mr. THOMPSON. If I could just make a quick comment, it is not as bumpy as you would think.

Ms. ESHOO. Well, I don't know, I am just reading the paper, and it is not so good.

Mr. THOMPSON. The response has been quite overwhelmingly in favor.

Ms. ESHOO. Really? By whom?

Mr. THOMPSON. People.

Ms. ESHOO. People?

Mr. THOMPSON. PBMs, companies that want to get involved. Over 100 people came out to a meeting. We expected maybe ten or 15. A hundred people came to the meeting in Baltimore.

Ms. ESHOO. Well, I would expect—and I have a lot of friends in the PBM community because I have worked with them—of course they would support this. I mean, it is their business. But pharmacists are in the pharmaceutical business, dispensing it. I am an observer. I am sitting on this side observing and reading. I am not trying to be harsh on you, I am just saying that I think it is off to a bumpy start, and I think there are members on both sides that would.

Now, we have got cards, I have just commented on that. Reforming Medicare. Everybody is for it until you get close to it, and then it starts falling apart. My sense is that—well, first of all, let me ask you this question. It started out with cards. You have talked about reform, every administration does, or the previous one, that is since I came in, and now the new administration, and we all acknowledge that there should be prescription drug coverage added.

Are you going to take on reform first and then prescription drug coverage? Are you going to do it all together? I know that you have put principles out there for Medicare. Are you going to add any meat to the bone? Which comes first? I mean, in many ways, it is a chicken-and-egg thing, you know, and I think that it is just far too important to get these next steps really bollixed up early on with the administration.

I saw opportunities with the previous administration, most frankly, squandered because of the way some things were handled. That is why I am saying bumpy start on one. Now are you going to do reform first and then prescription drug?

Mr. THOMPSON. We want to do it all together.

Ms. ESHOO. You want to do it all together.

Mr. THOMPSON. You know, you make a very good analogy because what we want to do is we want to work with you. You have got some wonderful ideas on both sides of the aisle, and if we do it properly, we can come up with a comprehensive package that is going to strengthen Medicare, add benefits including the drug benefit, and do the job up right, and that is one of the reasons we

wanted to come up with the principles early, so that we could start fleshing them out, start talking to you and finding out, you know, your ideas on how we might be able to incorporate your ideas as well as other ideas to make this program more workable.

We are very fearful that if we just do the prescription drugs, nobody will have the courage or the intestinal fortitude to stick in there to do the rest of the hard lifting to get the job done. With prescription drugs as part of it, we think we can get the whole thing done at the same time.

Mr. GREENWOOD [presiding]. The gentlelady's time has expired.

Ms. ESHOO. May I ask for just 30 more seconds, unanimous consent?

Mr. GREENWOOD. Without objection.

Ms. ESHOO. Thank you, Mr. Chairman. Mr. Secretary, the district that I represent has one of the most distinguished medical centers in it, Stanford Medical Center. And when you read in the newspapers that the President of Stanford University is saying—and I pray, I don't think it will come to that—but that they could be forced to sell. Something is wrong with our reimbursement system. So, what I want to say to you in these reforms, that if, in fact—I mean, you have got to have the intestinal fortitude as well to say "This is what it is going to cost." It is going to cost something to do these things. And it seems to me that is what people are afraid to go near.

If you think there is some little sand in the gears with this card business, I mean, you ain't seen nothing yet. So, I encourage you to have the intestinal fortitude within the administration, to come forward and say, "You know what, if we are going to do this, it is going to cost something, and these are the cost factors as well," because in order to reform—I know we can save on some sides, but we are going to have to invest on the other. So, I will work with you on that, but we have got a lot of things to fix, we really do.

Mr. GREENWOOD. The time of the gentlelady has expired.

Mr. THOMPSON. I have the intestinal fortitude, and I appreciate that, and I want to work with you as well.

Ms. ESHOO. Thank you.

Mr. GREENWOOD. Mr. Pallone.

Mr. PALLONE. Thank you, Mr. Secretary. I want to talk about and return to the discussion on Medicare+Choice. I think that the work that you are doing, and your staff is doing, and the President is doing on modernizing Medicare is first-rate. I am looking forward to it. I think we are going to have better options for seniors in the future.

A lot of where we are looking in all of this is modeled after Medicare+Choice, building on the Medicare+Choice concept. As we all know and as you have acknowledged in your comments this morning, the Medicare+Choice program, which started out gangbusters—no premiums, prescription benefits, other benefits—was very popular with seniors and, as we all know, for a number of reasons, one of them micromanagement, poor regulatory processes over at the old HCFA, and an irrational system for paying plans based on an AAPCC and then raising it by small amounts. Rather than keeping up with inflation, it has deteriorated.

Now, the people who we want to move most rapidly into our new and improved, modernized Medicare are probably those people who have demonstrated in the past the willingness to leave traditional fee-for-service and move into something that offers them more opportunity.

I am very worried that the very people who will be looking forward to make that first step are going to have a bitter taste in their mouths having taken the Medicare+Choice step and then been disappointed. So, for that reason, I think it is critical that in the immediate future—I am talking about the calendar year coming upon us—we do what is necessary to get Medicare+Choice back up-to-snuff so that we can, indeed, build on it. That means changing the way CMS does its business, but it also means money. We are going to have to pay these plans if you want them to stay in Congresswoman Capps' district. You are going to have to pay them enough.

My question is, is this administration committed in this appropriation cycle, between now and the fall, to put the dollars into Medicare+Choice so that it does return as a viable option, so seniors will see that we don't disappoint them when they leave traditional Medicare fee-for-service?

Mr. THOMPSON. I think we have to. It seems to me that the Medicare+Choice program has got a lot of support, but it is one of reimbursement and being able to stay in business, and we want this opportunity for our seniors to be able to have those kind of choices. And I want it in my home State, and I know you want it in yours, and several other States—the Congresswoman from California has just indicated that there is a company there that is contemplating whether or not they are going to be able to stay in, and that is true across America, and that is because they are losing money.

Mr. PALLONE. And we have intentionally moved forward the date by which the Medicare+Choice plans have to delineate what their benefits will be in the coming calendar year, and what their premiums will be, so that we can catch up to the process here, but we can't be into late fall without some certainty as to how we are going to pay these companies, or they will have to retrench further and compound the existing problem.

Mr. THOMPSON. Really, it is going to be up to Congress to do it, but I hope that Congress does. I support it, and I hope that we can get the job done this year.

Mr. PALLONE. We will push for it, and we are going to need your support.

Mr. THOMPSON. And I hope, Congressman, we can get this done in the context of overall reform. I mean, there are so many pieces out there.

Mr. PALLONE. Well, the problem is we may or may not get this plan of ours signed into law in the next couple of months, and we know we have got some heavy lifting here.

Let me quickly go to another issue that I think is similar in that it is an issue. While we don't have prescription drug benefit for most pharmaceuticals today, Medicare does pay for a lot of them—they tend to be the infused drugs, chemotherapy, et cetera—this issue of average wholesale price. You and I have talked about it a

little bit in my office. We have got a problem here. We are spending almost $2 billion a year more than we should be spending for these drugs because of an absurd and irrational payment system. Seniors are ending up paying 20 percent co-pay for prices that are 5 and 10 times what the doctor is actually paying for those drugs.

Do you have folks over there in your shop looking hard at how we can fix this AWP issue and redesign it so that we take care of the oncologist, we take care of the other specialists, and pay a fair price but not an absurdly inflated prices for these drugs?

Mr. THOMPSON. I want to tell you, Congressman, we have the CMS staff working on so many different problems, this is one of many that we are looking at. We can't address them all, but we are trying to systematically go through them and come up with solutions. As you know, we have moved mountains already, on waivers and changing the name and reducing rules and regulations, and we are going to continue doing that throughout my term. I made it a point and I have told everybody out there that I abhor the status quo, and it is time to move forward and make some changes and to find ways to say "yes" instead of trying to find ways to say "no."

Mr. PALLONE. Thank you.

Mr. GREENWOOD. I think what we are going to have to do here is we are going to have to recess for about——

Mr. PALLONE. Mr. Chairman, I have already voted, so I wouldn't mind——

Mr. GREENWOOD. The problem is that there is no Republican to take the Chair, and I don't trust you that this committee for——

Mr. PALLONE. I can't say I blame you for your point of view.

Mr. GREENWOOD. So we will recess for 5 to 10 minutes until the chairman returns.

[Brief recess]

Mr. BILIRAKIS. Mr. Waxman, 2 minutes.

Mr. WAXMAN. Thank you very much, Mr. Chairman. Mr. Secretary, I want to talk some more about this prescription drug plan. My question is whether we are going to give seniors quality private sector—in your Ways and Means testimony, you said we were going to give seniors private sector insurance prescription drug coverage. I want to know exactly what private sector prescription drug benefits means because I assume that means private drug-only insurance plans. I am interested in your explanation as to why you chose this model of providing drug benefits to seniors, given the reaction of the Health Insurance Association of America last year when Chip Kahn, who was representing them at the time, said that a stand-alone drug-only insurance policy simply wouldn't work in the real world in practice, and he said that there were so many hurdles that they didn't think the insurance companies would offer these plans. Is that what you are looking at for a drug policy for seniors under Medicare?

Mr. THOMPSON. Congressman, we think that it will work, and I know that there are the skeptics out there that have indicated that it would not, but we don't know how else you could do it and really make it work. I know Senator Gramm's bill has got PBMs doing it, and we certainly would look at that, but we think that the private sector is the best way to go.

Mr. WAXMAN. It is interesting because you compare what you would like to see for Medicare to what we have for Federal Health Insurance Benefit policies. They don't have stand-alone insurance coverage for prescription drugs, it is part of the plan, and the same is true for major corporations.

Mr. THOMPSON. But, Congressman, that is what I thought I said. I am sorry. We do want it to be included as part of the package.

Mr. WAXMAN. So you are not talking about buying private health insurance coverage for stand-alone prescription drug benefits?

Mr. THOMPSON. No.

Mr. WAXMAN. You are talking about making it part of the Medicare itself.

Mr. THOMPSON. Right.

Mr. WAXMAN. Thank you.

Mr. BILIRAKIS. I thank the gentleman. Mr. Secretary, just very quickly, you know, we have heard concerns and, frankly, we all have some concerns on the merging of Parts A and B. Now, I know that this is sort of a work-in-progress and I am not sure whether the administration has come up with a dollar figure as far as the merged deductible is concerned, but could you go into that, and then I think what we will probably excuse you at that point.

Mr. THOMPSON. The President and I feel very strongly that if we are going to have a real strengthened Medicare program, you have to be really fair and straightforward and not allow for shifting of one to another and having different co-pays for Part A versus Part B. We think of a unified system.

If we are going to go into this and strengthen Medicare, which I hope that we do, we should be able to combine Part A and Part B, and then be able to have a unified Medicare system, which everybody thinks we do have. And it is only, you know, people that really understand the system that know that we have two different entities that are set up, and when you put them together there is a deficit of about $643 million, and Part A was going to have a deficit in a couple of years until Congress moved the home health from Part A to Part B, and we think that brings itself to—you know, allows for a lot of financial gimmicks, and we feel that it is much more straightforward to combine them, have one co-pay, and be able also to have one in which you wouldn't be able to shift one program when it is going broke, to another program, and that is why we are doing it.

Mr. BILIRAKIS. How would you respond to the concern that only a small percentage of beneficiaries meet the high Part A deductible amount, but more are able to meet the limited Part B level and a new higher combined deductible could adversely affect these beneficiaries.

Mr. THOMPSON. Well, we think that we can develop a system that is going to allow for a real equitable contribution that is fair, and it is going to have to go through this committee, but we think overall the—the overall, the objective, is to strengthen Medicare, and we think we can strengthen it by combining Parts A and B, and we don't think we will accomplish the financial security of the system by maintaining two separate systems.

Mr. BILIRAKIS. Have you determined a deductible figure?

Mr. THOMPSON. No, we have not.

Mr. BILIRAKIS. You have not.

Mr. THOMPSON. We have not.

Mr. BILIRAKIS. Anything you wanted to inquire regarding that point?

Mr. WAXMAN. Well, I was going to ask exactly that question, you haven't decided how much.

Mr. THOMPSON. No, we have not.

Mr. WAXMAN. Because that is going to be a big increase for a lot of people because they don't pay the deductible regularly for Part A unless they use inpatient services, so now they are going to have to pay a lot more money with a combined deductible.

Mr. THOMPSON. We don't think so. We think we can structure a plan that would not increase it very much at all, Congressman.

Mr. WAXMAN. Mr. Chairman, may I ask unanimous consent to put a report into the record on the problems with the prescription drug discount cards, prepared by my staff on the Government Reform Committee?

Mr. BILIRAKIS. I don't see any reason why not. Without objection, that will be the case.

[The information follows.]

# Problems With Prescription Drug Cards

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**Prepared for**
**Rep. Henry A. Waxman**

**Minority Staff**
**Special Investigations Division**
**Committee on Government Reform**
**U.S. House of Representatives**

**July 12, 2001**

## I. Introduction

President Bush has proposed a plan to offer prescription drug discount cards to older Americans. The President's plan is apparently based on similar programs currently offered by private companies and pharmacy benefit managers. These private plans typically charge an annual membership fee. In return, the cardholder is promised deep discounts off the price of prescription drugs at participating pharmacies. Some cards promise savings of over 50%.[1]

This report by the Special Investigations Division of the minority staff of the House Government Reform Committee for Rep. Henry A. Waxman analyzes the actual discounts provided by five private drug card programs. This analysis indicates that many drug card programs offer little, if any, savings.

## II. Methodology

The analysis examined the price of a one-month prescription for the five highest selling drugs for seniors. These drugs are Prilosec, Prevacid, Celebrex, Lipitor, and Zocor.[2] It first obtained the prices of these drugs from five private drug card programs. These programs are the Merck-Medco/Readers Digest YourRx Plan; the Express Scripts Cash Card Plan; the Member Health Network Plan; the Prescription Benefits Plan; and the ProCare Plan.

To determine if the private drug card programs offer seniors any price advantages, the analysis then compared the prices available under the private drug card programs with some of the better prices currently available to seniors through other sources. As a proxy for these prices, the analysis used the prices available through Drugstore.com. Drugstore.com is a national seller of prescription drugs. Drugs can be ordered over the internet or by phone, and refills can be picked up at Rite Aid. Drugstore.com prices are generally lower than prices at local pharmacies,

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[1]Some discount cards claim the following savings: "save up to 40% on brand drugs" (Merck-Medco/Readers Digest); "save 10% to 50%" (ProCare Benefit Card); "savings of up to 70% off retail prices" (ABC-RX/MemberHealth); "savings on generic medications can be as high as 90% off the retail price" (Prescription Benefits); and "our members have already saved over $80 million dollars on their prescription drugs" (People's Prescription Plan).

[2]Prilosec is an ulcer and heartburn medication manufactured by Astra/Merck. Prevacid is an ulcer and heartburn medication manufactured by TAP Pharmaceuticals. Celebrex is an arthritis medication manufactured by Pharmacia and Upjohn. Zocor is a cholesterol-reducing medication manufactured by Merck. Lipitor is a cholesterol medication manufactured by Pfizer. The prices used in this analysis are the the prices for a one month supply of each of these drugs in a common dosage. These quantities are: Prilosec, 20 mg, 30 capsules; Prevacid, 30 mg, 30 tabs; Celebrex, 200 mg, 30 tabs; Lipitor, 10 mg, 30 tab; Zocor, 5, mg, 60 tabs.

but are comparable to prices at large discount chains such as Costco and Kmart.[3]

## III. Findings

### A. Prescription Drug Discount Cards Offer Minimal Discounts for Seniors

Under the five private drug card programs, the average price of a basket consisting of a one-month prescription of each of the five highest-selling drugs for seniors would be $426.08. In comparison, the same drugs from Drugstore.com would cost only $433.23 -- a difference of less than 2% compared to the average discount drug card price. Table 1.

**Table 1: Prescription Drug Discount Cards Offer Minimal Discounts for Seniors**

| Drug | Drugstore.com Price | Average Discount Card Price | Drug Discount Card Price | | | | |
|---|---|---|---|---|---|---|---|
| | | | Merck-Medco/ Readers Digest | Express Scripts | Member Health Network | Prescrip. Benefits | ProCare |
| Prilosec | $108.04 | $109.33 | $104.21 | $112.82 | $112.82 | $110.00 | $106.80 |
| Prevacid | $110.31 | $108.43 | $111.66 | $111.66 | $111.66 | $106.00 | $101.19 |
| Celebrex | $69.46 | $67.38 | $68.69 | $68.89 | $68.89 | $68.00 | $62.44 |
| Lipitor | $54.61 | $51.70 | $50.35 | $50.35 | $50.35 | $55.00 | $52.47 |
| Zocor | $90.81 | $89.23 | $86.64 | $86.64 | $86.64 | $97.00 | N/A |
| **Market Basket Cost** | **$433.23** | **$426.08** | **$421.55** | **$430.36** | **$430.36** | **$436.00** | -- |

This comparison of the cost of drugs under the drug discount card programs and at Drugstore.com does not take into account the effect of the annual membership fee that the discount drug card programs charge. These fees can be substantial, ranging up to $69.95 per year.[4] If the costs of the annual membership fees are taken into account, the small price advantages of the discount drug card programs disappear. In fact, some programs will be more expensive for many consumers than the prices at Drugstore.com.

News reports have highlighted the Merck-Medco/Readers Digest plan as one example of a plan on which President Bush's program will be modeled. The Special Investigations Division

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[3]Kmart will match Drugstore.com prices. Telephone survey conducted by Special Investigations Division, Minority Staff, Committee on Government Reform (July 2001). *See also* Consumer Reports, *Relief for the Rx Blues* (Oct. 1999).

[4]The annual fees are $10.00 for the Member Health Network Plan, $25.00 for the Merck-Medco/Readers Digest YourRx Plan, $48.00 for the Prescription Benefits Plan, and $69.95 for the ProCare Plan.

analysis shows, however, that this plan does not provide significant discounts for the five highest selling drugs for seniors. Prevacid, an ulcer medication, is the second highest-selling drug for seniors in the United States. A one-month supply of this drug is available through Drugstore.com for $110.31. A senior who uses the Merck-Medco/Readers Digest discount card to buy this drug at a pharmacy would pay a higher price, $111.66.

For a market basket of the five drugs, the Merck-Medco/Readers Digest price is $421.55, a 2.7% savings over Drugstore.com. Annual median spending by seniors on drugs is $1,027 per person.[5] Under the Merck-Medco/Readers Digest plan, a typical senior who saved 2.7% on drug purchases would save only $27.69 per year. After taking into account the annual $25 fee that the Merck-Medco/Readers Digest plan charges, this is a total savings of just $2.69 annually.[6]

A major reason why these card programs offer so little savings is because they only reduce costs at one point in the distribution chain -- at the pharmacy level. The card programs generally do nothing to lower the price that pharmaceutical manufacturers can charge for their products. In fact, it is estimated that the pharmacy's cost of obtaining medication represents 78% of the average prescription price.[7]

Another problem is that most current discount card programs offer savings based on a percentage discount (typically 10% to 13%) off a drug's average wholesale price (AWP) and include a drug dispensing fee for the pharmacy (typically $2 to $4). Very few consumers ever pay AWP, which is like a car's sticker price. In fact, consumers typically pay retail prices at drug stores that are below AWP.

### B. Prescription Drug Discount Plans Have Been Implicated in Fraudulent Schemes and Have Been Banned in Some States

Because of the potentially deceptive nature of prescription card discount plans, several states have begun to regulate the marketing and sales of the cards. For example, in August 1998, the Iowa Attorney General's office issued a consumer advisory that warned the public of the potentially misleading claims made by some discount card programs. The consumer advisory states that "some health discount cards promise more than they can deliver, some are worthless, and some are outright frauds." The advisory also states: "The cards may cost hundreds of dollars per year, and some companies promise much more than they deliver. For example,

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[5]CBO, *January 2001 Baseline Projections* (2001).

[6]This analysis assumes that seniors using the Merck-Medco/Readers Digest plan purchase their drugs through the plan at participating pharmacies. If a senior purchased drugs through mail order, a senior could realize modest savings (less than 10%).

[7]Letter from American Pharmaceutical Association, *et al.*, to Sen. Chuck Hagel (Apr. 23, 2001).

companies have promised that the cards could be used for discounts up to 40% at certain pharmacies -- but, after paying for a card, consumers discover that their pharmacy doesn't accept it."[8] This advisory did not address any of the discount drug card plans examined in this analysis.

In response to the problems with the discount drug card programs, several states, including Arkansas, Georgia, Idaho, Kansas, and South Carolina have enacted laws strictly regulating the sales and marketing of these cards.[9] Other states, like California and Washington, have prohibited discount drug card companies from operating in their states unless they are licensed as insurance companies. In 1999, California regulators sent cease-and-desist letters to 46 companies, claiming that some misled consumers about the extent of discounts and the providers who would grant them.[10]

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[8]Iowa Attorney General Consumer Advisory (Aug. 1998) (available at http://www.state.ia.us/government/ag/healdisc.htm)

[9]*Caveat Doctor! Medical Discount Cards Could Burn You*, Medical Economics (Feb. 19, 2001); S.C. Code 37-17-10.

[10]*Obstacles Greet Discount Drug Plan*, USA Today (Apr. 20, 2000).

Mr. BILIRAKIS. All right. Mr. Secretary, you are always so very gracious, and we appreciate your willingness to work with us. I don't know whether you have anything else you would like to say, but I am about to just adjourn the hearing.

Mr. THOMPSON. I would like to, for the record, say that if anyone wants to submit questions, we would be more than happy to answer them.

Mr. BILIRAKIS. Yes. Well, as per usual, that is always the case. Mr. Pallone.

Mr. PALLONE. Thank you, Mr. Secretary. As you know, in the previous Congress the Republican leadership put up what I call an insurance-only drug plan—in other words, basically the idea of giving money to the insurance companies to provide insurance just for prescription drugs for seniors, and I was very critical of that. I didn't think it would work.

We had an example in Nevada where the State of Nevada did something similar and it didn't work and, of course, a lot of the insurance companies testified before this committee and said that they didn't see any of these policies actually being available, regardless of what the government intentions were. And I just was hoping that you are not going to go down that route, in other words, that that isn't one of the things that the administration is looking at in terms of a prescription drug benefit because I don't really see it as something that could work or that would provide any kind of comprehensive coverage, and I just wanted you to comment on that, if you would.

Mr. THOMPSON. Congressman, a similar question was asked by Congressman Waxman. We would like to be able to include it in the Medicare benefits, but we also are going to have options, and individual options that would have a stand-alone drug prescription, and it is going to be a private mechanism, but it is also going to be a public one. And so we think there is a combination and a lot of different choices that individuals will be able to have, and we think the seniors are smart enough—I know they are—to be able to pick and choose what is best for them.

Mr. PALLONE. So that is one of the options that you would consider.

Mr. THOMPSON. It is one of the options that we would consider.

Mr. PALLONE. Thank you.

Mr. BILIRAKIS. I thank the gentleman. The hearing is adjourned, and I know that you are available for any questions. Thank you so much, sir.

[Whereupon, at 11:55 a.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

PREPARED STATEMENT OF ADVANCED MEDICAL TECHNOLOGY ASSOCIATION

AdvaMed represents over 800 of the world's leading medical technology innovators and manufacturers of medical devices, diagnostic products and medical information systems. Our members are devoted to helping patients lead longer, healthier and more productive lives through the development of new lifesaving and life-enhancing technologies. AdvaMed is pleased to present this testimony on behalf of our member companies and the patients they serve.

AdvaMed applauds President Bush's Principles for Medicare Reform, released on July 12, 2001, which emphasize the importance of encouraging high-quality health care for all seniors, better coverage of preventive care and treatments for serious illnesses, increased patient access to the most modern health care options and im-

proved management of the program. Medical technologies are key in helping to realize these goals.

*Medicare should encourage high-quality health care for all seniors, including better coverage for preventive care and serious illnesses.*

The rapid pace of innovation for diagnosing, treating and curing diseases and illnesses continues to drive the high quality of health care available to Americans. However, according to the President, "Medicare takes way too long to authorize new treatments. We must act now to ensure that the next generation of medical technology is readily available to America's seniors."

The President's statement underscores the importance of reducing the current delays of 15 months to five years in Medicare patients' access to new technologies. By keeping pace with advances in medical technology, Medicare can improve patients' quality of care and put Medicare on solid financial ground.

The Administration can make substantial progress in reducing Medicare delays by:

- Properly implementing key technology access reforms in the Benefits Improvement and Protection Act of 2000, including provisions calling for temporary, transitional payments for new technologies in both the inpatient and outpatient settings.
- Creating a Medicare Office of Technology and Innovation to improve the Centers for Medicare and Medicaid Services' (CMS) accountability, openness and coordination in making timely decisions.
- Establishing decision deadlines to improve accountability. For technologies subject to a national coverage decision, CMS should take a total of 6-12 months to set coverage, coding and payment policy and make the technology available to patients.
- Maintaining and strengthening the local Medicare coverage process as an important channel for early patient access to new technologies. CMS should support local decision making processes to ensure the continuation of timely, flexible access to new technology. A wide range of local contractors should continue to work with public stakeholders in creating new medical policies and assign local codes as needed.

*Medicare should provide better health insurance options, and the management of the government Medicare plan should be strengthened so that it can provide better care for seniors.*

AdvaMed strongly supports reduced bureaucracy and streamlining, but we are concerned that contractor consolidation could impair local coverage decision-making for critical new therapies. AdvaMed emphasizes the continued importance of local decision making to help ensure the prompt and appropriate use of new technologies.

AdvaMed also supports broader reforms to the Medicare program to give consumers the ability to choose among a range of competing health plans, as well as the traditional Medicare program. We believe it will be critical to ensure a minimum number of competing health plans in each geographic area, so consumers who are empowered to choose among competing health plans will make sure they have access to the high-quality, innovative medical technologies and procedures they need.

However, implementation of the President's plan should not expand Medicare purchasing authority prematurely. AdvaMed firmly believes in the benefits of market-based competition for providing patients with choices for the most current, high quality health care but the way this important change is implemented will have profound effects on its success. It will be crucial not to implement expanded purchasing authority for the Medicare fee-for-service program before a sufficient number of competing private plans are available in all major geographic areas.

*Conclusion*

AdvaMed believes that these reforms, and other important changes related to prescription drugs, will help provide Medicare beneficiaries with the modern, state-of-the art care that they deserve, within a framework of market-based, competitive health plans. At the same time, the President's plan would address the solvency of the Medicare trust fund—an essential part of any reform proposal.

The President's proposal provides great opportunities for seniors to benefit from the unprecedented advances in innovation happening in health care today. We look forward to working with this Committee, the Congress and the Administration on ways to improve the quality of care available to seniors through Medicare and foster the delivery of innovative therapies for patients.

**STATEMENT**
**on**

# Bush Administration's Principles to Strengthen and Modernize Medicare

**Committee on Commerce**
**Subcommittee on Health**
**United States House of Representatives**
**Washington, D.C.**

**Thursday, July 26, 2001**

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Mr. Chairman and Members of the Subcommittee. The National Association of Chain Drug Stores (NACDS) appreciates the opportunity to submit this statement for the record regarding our perspectives on the Bush Administration's principles for Medicare reform. NACDS membership consists of over 180 retail chain community pharmacy companies that employ over 100,000 pharmacists. The chain community pharmacy industry is comprised of more 33,000 retail community pharmacies, including 20,000 traditional chain drug stores, 7,800 supermarket pharmacies and 5,300 mass merchant pharmacies. Chain operated community retail pharmacies fill nearly 63% of the more than 3 billion prescriptions dispensed annually in the U.S.

NACDS has reviewed the President's Medicare Reform Principles and believes that they are broad enough to be realistic, and indeed, even supportable goals for Medicare reform. However, as the community pharmacy industry has learned over this past few weeks, the specific "details" are important regarding how these principles will impact Medicare beneficiaries. Therefore, it is difficult to make any final judgement about how these principles will impact our industry and beneficiaries.

For example, the principles talk about better "prescription drug benefit coverage" and better "coverage for preventative care and serious illness for seniors". We do not see how these principles could be realized through a prescription drug discount card program. Indeed, this program seems to defy these principles. We strongly object to this program, which was recently announced by the Administration. In fact, NACDS and the National Community Pharmacists Association (NCPA) are seeking to enjoin the Department of Health and Human Services from moving forward with this program because of the economic harm that it will inflict on community pharmacy, and the false promise that it represents for our nation's Medicare beneficiaries in reducing the cost of medications. We have attached to this statement a copy of the complaint that NACDS and NCPA filed on Tuesday, July 17th. Found on the NACDS web site at http://www.nacds.org/user-documents/DiscountCardLawsuit.pdf. In addition, we filed a motion for preliminary injunction to stop this program on Thursday, July 26th, 2001.

In an effort to promote real reform of the Medicare program and the establishment of a true, comprehensive pharmacy benefit for seniors, we have developed our own principles with seven other national pharmacy organizations (see attached).[1] We intend to use these principles to evaluate our support for the various Medicare pharmacy benefit proposals that have been introduced and may be marked up by this Committee. We appreciate the opportunity to submit this statement for the record and look forward to working with the Administration and the Congress in developing a reformed Medicare program.

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

| | |
|---|---|
| NATIONAL ASSOCIATION<br>OF CHAIN DRUG STORES<br>413 North Lee Street<br>Alexandria, VA 22314,<br><br>and<br><br>NATIONAL COMMUNITY<br>PHARMACISTS ASSOCIATION<br>205 Daingerfield Road<br>Alexandria, VA 22314<br><br>Plaintiffs,<br><br>v.<br><br>THE HONORABLE<br>TOMMY G. THOMPSON,<br>in his official capacity as<br>SECRETARY, UNITED STATES<br>DEPARTMENT OF HEALTH AND<br>HUMAN SERVICES<br>200 Independence Avenue, SW<br>Washington, DC 20201,<br><br>and<br><br>THOMAS A. SCULLY,<br>in his official capacity as<br>ADMINISTRATOR,<br>CENTERS FOR MEDICARE<br>& MEDICAID SERVICES<br>200 Independence Avenue, SW<br>Washington, DC 20201<br><br>Defendants. | CASE NUMBER 1:01CV01554<br>JUDGE: Paul L. Friedman<br>DECK TYPE: Administrative Agency Review<br>DATE STAMP: 07/17/2001<br><br>Civil Action No. _____ |

**COMPLAINT FOR DECLARATORY, INJUNCTIVE AND OTHER RELIEF**

Plaintiffs, National Association of Chain Drug Stores ("NACDS") and National Community Pharmacists Association ("NCPA"), for their complaint against defendants the Honorable Tommy G. Thompson, Secretary (the "Secretary") of the United States Department of Health and Human Services ("HHS"), and Thomas A. Scully, Administrator (the "Administrator") of the Centers for Medicare & Medicaid Services ("CMS"), assert as follows:

## INTRODUCTION

1. This complaint concerns clandestine and unlawful action by HHS and CMS in devising and implementing a program that would create new and substantial federal involvement in the private prescription drug marketplace for Medicare beneficiaries in the United States. Over the past several months, representatives of these agencies met secretly with representatives of a small group of the nation's largest and most profitable pharmacy benefits managers ("PBMs"). (PBMs are private entities that contract with health plans or plan sponsors to provide the claims processing and administrative services involved in the operation of prescription drug programs.) These PBMs – Merck-Medco Managed Care, L.L.C., Express Scripts, Inc., Caremark, Inc., Wellpoint Health Networks, Inc., and AdvancePCS – control approximately 80% of the PBM market, and up to 90% of the mail-order pharmacy business. The result of those closed-door, back-room meetings is the Medicare Rx Drug Card Program (the "Card Program") announced on July 12, 2001. Under the Card Program, Medicare will "endorse" prescription drug discount cards issued by PBMs and perhaps others, so long as the companies satisfy certain requirements. The defendants will spend taxpayer money to market the PBMs' private discount cards to Medicare beneficiaries. The PBMs will form a "consortium" to share pricing information, pass judgment on their competitors' marketing materials, and restrict Medicare beneficiaries from owning more than one Medicare-endorsed discount card. The

PBMs will profit by: charging Medicare beneficiaries enrollment fees; extracting price discounts from pharmacies and rebates from manufacturers that need not be shared with Medicare beneficiaries; and steering beneficiaries to mail-order pharmacies owned by the PBMs. The Card Program represents a new and unprecedented interference by government in the private marketplace for prescription drug discount cards for Medicare beneficiaries. Nevertheless, HHS and CMS created it in secret meetings without any authority from Congress and failed to follow even the basic procedural requirements of the Administrative Procedure Act. The resulting unlawful Card Program will cause substantial harm to plaintiffs, their members, and Medicare beneficiaries.

2. The Card Program scheme was developed by HHS and CMS officials as a result of secret meetings they held with a small group of the largest PBMs in the country. These meetings were held over a period of several months prior to President George W. Bush's high-profile Rose Garden announcement of the Card Program on July 12, 2001, which was attended by the small group of PBMs. At these secret meetings, the participants developed the standards for participation in the Card Program, all of which are designed to benefit substantially the large PBMs to the exclusion of other potential participants in the Program. Plaintiffs, their members and senior citizens, all of whom will be directly affected by the Card Program, were purposefully excluded by defendants from attending these meetings.

3. Following these clandestine meetings and the President's announcement, CMS published the Notice of Application for the Card Program in the Federal Register on July 16, 2001 (as placed on display in the Federal Register offices). As outlined in the Notice, a number of standards are set out for participation in the Card Program, none of which relates to the amount of the discount or the actual benefit, if any, afforded Medicare beneficiaries. On the

contrary, the standards will actually limit the ability of beneficiaries to receive discounts by restricting their ability to choose more than one discount card in the marketplace.

4. Neither HHS nor CMS will provide funding for any discounts received by Medicare beneficiaries under the Card Program. Instead, members of NACDS and NCPA, as well as other private entities, would be coerced into funding the discounts to be provided by this federally endorsed and regulated initiative.

5. In establishing and implementing the Card Program, HHS has violated federal law by exceeding the statutory authority granted to it by the Social Security Act; failing to comply with the procedural requirements of the Administrative Procedure Act; adopting regulatory standards that are arbitrary, capricious, and an abuse of discretion; failing to comply with the requirements of the Federal Advisory Committee Act; and unlawfully delegating regulatory authority under the Card Program to a group of private, self-interested card issuers. Plaintiffs NACDS and NCPA ask the Court to declare the Card Program unlawful and to enjoin defendants from taking any action to implement the Program.

## JURISDICTION AND VENUE

6. This Court has subject matter jurisdiction under 28 U.S.C. § 1331 because this case arises under the laws of the United States. This suit is brought pursuant to the Administrative Procedure Act, 5 U.S.C. § 701-706.

7. Venue is proper in this Court pursuant to 28 U.S.C. § 1391(e) because one or more of the defendants resides in this judicial district and a substantial part of the events giving rise to plaintiffs' claims occurred in this judicial district.

**PARTIES**

8. Plaintiff NACDS is an association organized and existing under the laws of the Commonwealth of Virginia. Founded in 1933 and based in Alexandria, Virginia, NACDS membership consists of over 180 retail community pharmacy companies. Collectively, community pharmacy companies comprise the largest component of pharmacy practice with over 100,000 pharmacists. The community pharmacy industry is comprised of more than 20,000 traditional chain drug stores, 7,800 supermarket pharmacies and 5,300 mass merchant pharmacies.

9. NACDS's members operate over 33,000 retail community pharmacies with annual sales totaling over $400 billion. Chain-operated community retail pharmacies fill nearly 63% of the more than three billion prescriptions dispensed annually in the United States.

10. NACDS represents the views and values of the country's leading community retail pharmacies. NACDS is committed to, inter alia, advancing the interests of its member organizations with respect to issues relating to federal and state health policy issues, including issues respecting federal health care programs, such as Medicare and Medicaid. Moreover, NACDS advocates the views of its members during congressional and administrative deliberations of policies and issues affecting retail community pharmacies.

11. NACDS brings this suit on behalf of its members. NACDS members will be injured individually by the Secretary's adoption of the Card Program, and CMS's review, approval and endorsement of discount prescription cards under the Card Program. Neither the claims asserted nor the relief demanded necessitates participation of individual NACDS members for the fair and just adjudication of this lawsuit.

12. NCPA is an association organized under the laws of the Commonwealth of Virginia, with its principal offices in Alexandria, Virginia. Founded in 1898 as the National

Association of Retail Druggists, NCPA represents the pharmacist owners and managers, and 60,000 employee pharmacists of 25,000 independent community pharmacies across the United States, including independently owned chains and franchises.

13. The nation's independent community pharmacists are small business entrepreneurs and multifaceted health care providers who represent a vital part of the United States' health care delivery system. NCPA represents the professional and proprietary interests of independent community pharmacists and promotes and defends those interests, including those pertaining to state and federal health care programs.

14. NCPA brings this suit on behalf of its members. NCPA members will be injured individually by the Secretary's adoption of the Card Program, and CMS's review, approval and endorsement of discount prescription cards under the Card Program. Neither the claims asserted nor the relief demanded necessitates participation of individual NCPA members for the fair and just adjudication of this lawsuit.

15. Together, NACDS and NCPA represent virtually all retail community pharmacies in the United States.

16. Defendant Tommy G. Thompson, the Secretary of HHS, is responsible for the Card Program, and is also charged with implementing provisions of Title XVIII of the Social Security Act, as amended, 42 U.S.C. § 1395 et seq. (the "Medicare Program"). The Secretary administers the Medicare Program and will administer the Card Program through the Administrator of CMS. The Secretary is sued in his official capacity only.

17. Defendant Thomas A. Scully is the Administrator of CMS. He is sued in his official capacity only.

## BACKGROUND

### The Medicare Act

18. Title XVIII of the Social Security Act establishes a comprehensive program of health insurance benefits, commonly known as Medicare, for individuals aged 65 and older, as well as for certain others who come within its terms, including persons with disabilities and persons with end stage renal disease. 42 U.S.C. §§ 1395-1395ggg; 42 U.S.C. § 426-1(a); 42 U.S.C. § 426(a).

19. The Medicare Program is administered by CMS.

20. In broad terms, Part A of the Medicare Program (the hospital insurance program) covers care provided by institutional health care providers, including inpatient hospital care, skilled nursing facility care, hospice care, and home health care. 42 U.S.C. §§ 1395c-1395i-5.

21. Part B (the supplementary medical insurance program) pays for various medical services not covered by Part A, including physician services to individual patients, certain hospital outpatient services, home health and outpatient ambulatory services, speech and physical therapy, rehabilitation, and other diagnostic care. 42 U.S.C. §§ 1395j-1395w-4.

22. Medicare does not pay for prescription drug coverage (other than inpatient prescription drugs and a limited number of enumerated drugs provided in other than an inpatient setting). 42 U.S.C. § 1395y; 42 C.F.R. § 411.15.

23. At the inception of the Medicare Program, and in subsequent amendments thereto, Congress has acknowledged the complexity of the Program and the need for a wide range of expertise and resources in meeting the needs of Medicare beneficiaries. Accordingly, on numerous occasions, Congress has expressly authorized the Secretary to work with the private sector to provide covered benefits to beneficiaries.

24. For example, under Part A, Congress explicitly authorized the Secretary to enter into agreements with private organizations (commonly known as fiscal intermediaries) for the determination of payments due under Part A and for making such payments. 42 U.S.C. § 1395h. The statute provides express authority for these agreements and establishes guidance for the Secretary as to the nature and content of the agreements. Id.

25. Similarly, under Part B, Congress authorized the Secretary to enter into contracts with organizations known as carriers to perform certain functions necessary to administer Part B benefits. 42 U.S.C. § 1395u. The statute details what responsibilities may be delegated to the carrier and what provisions the contract must contain, including continued accountability to the Secretary. Id.

26. Under the Medicare+Choice program, or Part C of Medicare, Congress authorized qualified managed care organizations to provide an alternative system for delivering health care services to Medicare beneficiaries. Here again, Congress, through the Medicare Act, has provided the Secretary with the necessary authority to contract with these private organizations. See 42 U.S.C. § 1395w-21 et seq.

27. In the Health Insurance Portability and Accountability Act of 1996, Congress created the Medicare Integrity Program (MIP), which was designed to review the processing and payment of claims under the Medicare Program. See 42 U.S.C. § 1395ddd. Congress expressly granted the Secretary broad contracting authority to use private entities to carry out the activities of the program. It also imposed requirements on the Secretary, explicitly limiting the types of entities that the Secretary could contract with to perform MIP functions. Id.

28. The Medicare Act also regulates Medicare supplement insurance policies, commonly known as Medigap policies, by instructing a private association, the National

Association of Insurance Commissioners, to adopt model standards which then, in turn, are adopted by the states as regulations. 42 U.S.C. § 1395ss. These Medigap policies, which do not require the expenditure of Medicare monies, provide coverage exclusively to Medicare beneficiaries for expenses not covered by Medicare.

29. Further, the Medicare Act contains examples of Congress bestowing specific contracting authority on the Secretary. One such authority, 42 U.S.C. § 1320c, establishes standards and processes that the Secretary must follow in contracting with private individuals and entities to review the quality of medical care provided to Medicare beneficiaries.

30. Significantly, where Congress has allowed private individuals or organizations to serve a quasi-regulatory purpose, it has done so expressly in the Medicare Act. Under the Medicare Program, provider entities are required to meet certain conditions of participation in order to participate in the program. Congress has expressly granted to private accreditation organizations "deeming authority," under which these organizations' accreditation of providers satisfies the conditions of participation. 42 U.S.C. § 1395bb.

Medicare Rx Discount Card Program

31. On July 12, 2001, President George W. Bush announced the Medicare Rx Discount Card Program. The Secretary and Administrator have responsibility for overseeing implementation and administration of the Card Program. Under the Card Program, Medicare beneficiaries would be permitted to choose only one of several Medicare-endorsed prescription drug discount cards, which would be offered by private entities whose discount cards have been reviewed and approved by CMS. By having CMS endorse certain private cards over others, HHS intends to grant these preferred market participants a competitive advantage vis-à-vis other discount card issuers who lack endorsed cards.

32. On or about July 16, 2001, HHS published a Notice of Application in the Federal Register requesting that by August 27, 2001 all interested parties submit applications to participate in the Card Program. In the Notice, HHS stated that in order for a private entity to participate in the Card Program and for that entity's program to be endorsed by Medicare, certain requirements must be met.

33. Specifically, participation in the Card Program would be limited to entities that meet a number of restrictive standards, which were devised by HHS in conjunction with a small committee of large, private PBMs (the "Committee"). The Committee consisted of five PBMs, Merck-Medco Managed Care, L.L.C., Express Scripts, Inc., Caremark, Inc., Wellpoint Health Networks, Inc., and AdvancePCS, which control 80% of the PBM market.

34. The HHS standards would exclude from participation in the Card Program all entities other than those that: (1) have been in the discount drug card or PBM business for five years; (2) currently have either two million covered lives if a national organization, or one million if a regional entity; and (3) can meet certain solvency requirements. Any entity seeking to participate in the Card Program also must demonstrate the financial means to commit unspecified funds to a private consortium that will be delegated authority to regulate the Card Program.

35. Additionally, to receive Medicare's endorsement, a discount card issuer must, inter alia, charge no enrollment fee, or, at most, an enrollment fee not to exceed $25. The issuer of the card also must: (1) agree to enroll all Medicare beneficiaries seeking to participate in the program; (2) provide a discount on at least one brand and/or generic prescription drug in each therapeutic class; (3) offer a comprehensive national or regional network of retail pharmacies,

with additional mail-order or Internet service at the sponsor's option; and (4) provide a specified measure of "customer service" to beneficiaries.

36. None of these standards bears any rational relation to the amount of the discount or the actual benefit, if any, afforded Medicare beneficiaries. In fact, the standards actually restrict beneficiaries' access to discounts by preventing beneficiaries from holding more than one endorsed card.

37. Only discount card issuers meeting these requirements, imposed by HHS as a result of secret consultations with the Committee, will be endorsed by Medicare, and only those issuers will be permitted to use the Medicare name in marketing to beneficiaries. The Secretary has acknowledged that Medicare's name recognition is so strong that it is unlikely to be duplicated in the private market. Endorsed issuers will also reap the benefits of CMS's substantial promotional efforts on their behalf. In addition, endorsed issuers will be permitted to market additional health care services to enrolled Medicare beneficiaries. It is highly unusual if not unprecedented for the government to endorse a private company or product. In the absence of statutory authority, the Medicare name, which seniors have relied on and trusted for over thirty-five years, should not be utilized by private companies to exploit for their private monetary benefit.

**Clandestine Meetings to Develop the Card Program**

38. As noted above, HHS relied on the Committee, whose members collectively comprise over 80% of the PBM market, to meet secretly and develop the illegal Card Program and its regulatory standards. Based on discussions with HHS and White House officials, NACDS has learned that the Committee's discussions were purposely kept secret from the public

and other interested parties, including NACDS, NCPA, their members, drug manufacturers, and Medicare beneficiaries that will be disadvantaged by the Card Program.

39. While HHS states that entities other than PBMs would be eligible to participate in the Card Program, HHS met privately only with the Committee and its small group of PBM members, and not with pharmacies and beneficiaries who could have offered input on the establishment of the Card Program's requirements. Thus, rather than meet with a representative group of the interested parties that would be directly affected by the Card Program, HHS met secretly with a handful of PBMs that ultimately will benefit the most, and perhaps exclusively, from the Card Program that they helped develop.

40. HHS also sought to insulate itself from public review of the Card Program by failing to publicly solicit comment on the Card Program. Had HHS done so, interested parties of all types, including plaintiffs, consumers and state attorneys general, who have conducted numerous investigations of PBMs, could have provided valuable input to the agency.

**Harm to Medicare Beneficiaries**

41. Under the Card Program, all Medicare beneficiaries would be permitted to enroll to receive a Medicare-endorsed drug discount card, with enrollment being limited exclusively to Medicare beneficiaries. However, Medicare beneficiaries would be prohibited from enrolling in more than one Medicare-endorsed card at a time, and would be allowed to change from one card to another only once every six months. Medicare-endorsed issuers would be permitted by CMS to charge a one-time enrollment fee of up to $25 to cover initial enrollment activities.

42. There are currently a number of drug discount cards available in the private marketplace. Discount cards of many varieties are offered in the marketplace not only by PBMs, but also by numerous chain drug stores. Presently, there are no restrictions on the number of

such discount cards that an individual may utilize. Thus, the enrollment restrictions imposed by HHS will reduce beneficiary choice of the discount cards that best suit each beneficiary's individual needs.

43. Numerous studies indicate that a substantial portion of Medicare beneficiaries use prescription drugs incorrectly. Promotion of mail-order pharmacies by the Card Program will likely lead to even greater misuse and waste of medications, which will result in increased costs to the Medicare Program since beneficiaries who receive their drugs by mail-order, rather than through direct contact with a pharmacist, are even less likely to receive the necessary counseling that community pharmacists provide. Beneficiaries will be harmed by reduced interaction with their trusted local pharmacists.

44. There is substantial evidence that prescription drug discount cards do not pass savings along to the patients who enroll in such programs. Specifically, a July 12, 2001 Congressional report concluded that the savings realized under five private discount drug card programs, including some programs sponsored by members of the Committee, were minimal or nonexistent. These savings are negligible, inter alia, because the discount card issuers extract rebates from pharmaceutical manufacturers, which are not passed on to consumers, and, indeed, often result in steering beneficiaries to higher cost drugs. Several states, including Arkansas, Georgia, Idaho, Iowa, Kansas, South Carolina, South Dakota, California, and Washington, have enacted laws or issued policy statements regulating discount cards. In Iowa, the Attorney General's office has issued an advisory warning consumers that some discount card programs offer illusory benefits. Further, under the now defunct Washington State-sponsored prescription drug discount card program (called "AWARDS"), which was similar to the Card Program, one senior without insurance coverage for prescription drugs signed up for the AWARDS card only

to discover that the diabetes drug he once bought for $18.99 without insurance now cost him $28.63 with the AWARDS card.

**Limited Participation in the Card Program**

45. The restrictive requirements imposed by HHS will limit participation in the Card Program to a small number of large players in the PBM marketplace. All of the PBMs that were invited to participate in the Committee that designed the Card Program with HHS can satisfy the standards for endorsement, and, according to the Secretary, all have indicated their willingness to participate in the Card Program. Indeed, the Secretary has publicly acknowledged that HHS has already made "deals" with each member of the Committee to participate in the Card Program.

46. Competitors of these large PBMs, many of which are NACDS or NCPA members, will be unable to meet the requirements imposed by HHS for participation in the Card Program. Although numerous companies, including many chain drug stores and some independent pharmacies, currently issue prescription drug discount cards to substantial numbers of seniors, they will not be able to meet the arbitrary requirement that Medicare-endorsed regional card issuers cover one million lives or that endorsed national issuers cover two million lives. Similarly, new market entrants and entities that have provided pharmacy benefit management services for less than five years would be precluded from participating by virtue of the five-year requirement developed by HHS and the Committee.

47. Because the overly restrictive and unnecessary standards developed by HHS and the Committee would preclude participation by many of NACDS's and NCPA's members, the Card Program would create an unfair competitive advantage for the Committee members since these organizations would have Medicare's imprimatur as endorsed discount card issuers. Because HHS's unlawful Card Program favors these other entities, NACDS's and NCPA's retail

pharmacy members will experience significant erosion of already narrow profit margins on drugs and, perhaps more significantly, lose a substantial portion of their customer base to Medicare-endorsed mail-order pharmacies.

48. The Secretary has publicly acknowledged that the Card Program will result in reduced margins for retail pharmacies. According to the Secretary, discounts will be paid for by "lost profits to the pharmaceutical companies as well as to the drugstores."

**CMS's Regulation of the Card Program and Associated Expenditures**

49. While private entities would sponsor prescription drug discount cards under the Card Program, the Secretary, through CMS and the Administrator, initially will be actively engaged in administering the new program. Specifically, CMS will review applications from private sponsors to assess whether the cards they propose satisfy the standards and requirements discussed above. Upon a finding that the issuer meets these standards, CMS will certify the program as a Medicare-endorsed program, thereby permitting the issuer to market its card as being preferred by the Medicare Program over other non-endorsed cards. CMS claims it will conduct a review of participating issuers annually to ensure continued compliance with the requirements established for Medicare-endorsed cards.

50. In addition, CMS intends to contract with an outside entity to develop guidelines for the review of marketing materials proposed by the participating discount card issuers to ensure that such materials convey accurate information. According to the Secretary, this initiative will require funding by the federal government.

51. CMS will have a significant role in disseminating information about Medicare-endorsed private discount cards to Medicare beneficiaries. CMS will provide such information on its www.medicare.gov website, its "1-800-MEDICARE" information hotline, and through

other mediums. Moreover, CMS will actively promote and market issuers that have secured Medicare's endorsement, including referring callers to "1-800-MEDICARE" to private, Medicare-endorsed issuers' enrollment centers. The Secretary has indicated that the funding for such educational and promotion activities will come from the agency's $35 million Medicare beneficiary education campaign.

**Role of the Consortium**

52. Qualified applicants will be required to participate in and fund a private consortium of all Medicare-endorsed discount card issuers (the "Consortium"). By November 1, 2001, the Consortium is required to implement a system to ensure that Medicare beneficiaries are enrolled in only one Medicare-endorsed discount card at a time.

53. After the initial year of the Card Program, CMS will delegate authority previously reserved for CMS to the Consortium, including the authority to disseminate comparative information about the Consortium members' programs. As part of this requirement, the Consortium will publish information on endorsed issuers' specific drug prices, formularies and networks both in hard copy and on the Consortium's website.

54. Beginning on September 1, 2002, the Consortium will be required to review marketing materials used by Medicare-endorsed discount card issuers to ensure that they convey accurate information, and that these issuers are delivering the services promised. According to HHS, CMS will continue to be active in the Consortium's activities, but its only role will be to confer endorsement on issuers that meet the Card Program's requirements.

**Harm to Plaintiffs and their Members**

55. Plaintiffs and their member pharmacies will be significantly harmed by the Card Program described herein. This harm includes, but is not limited to, the following:

(a) The Card Program limits participation to entities that meet certain arbitrary standards, e.g., entities must have been in business for five years and have at least one million covered lives, regardless of their ability to provide meaningful discounts to seniors. These standards arbitrarily and capriciously prevent both plaintiffs and certain of their member organizations, which are otherwise able to provide meaningful discounts to seniors, from participating in the Card Program, causing irreparable harm to them.

(b) The scheme created under the Card Program will cause financial harm to the members of NACDS and NCPA, which operate pharmacies throughout the United States. The Card Program will enfranchise a small group of large PBMs, which, acting with the imprimatur of HHS and CMS, will enjoy substantial market power. If the Card Program works as HHS and CMS intend, these large PBMs will then be in a position to affect prices charged by pharmacies, by denying them their customer base of Medicare beneficiaries unless the pharmacies agree to the prices prescribed by the PBMs under the Card Program. The already thin profit margins of plaintiffs' member pharmacies (which average 1-2 %) will be further eroded and some smaller pharmacies will no longer be able to continue in business.

(c) The Card Program will cause further financial harm to NACDS and NCPA members by its preference for PBMs which offer mail-order pharmacy services (of which the Committee controls almost 90% of the market). By eliminating a customer's visit to a pharmacy, mail-order services eliminate both the individual service that a pharmacist can provide to a customer and the opportunities that pharmacies have to sell non-pharmacy items to customers in their stores. These latter sales are often the only way a pharmacy can stay profitable, as there are no profit margins on some prescription drugs.

**COUNT I (Against All Defendants)**

**The Secretary's Actions Violate the Administrative Procedure Act by Exceeding the Authority Granted by the Social Security Act**

56. Paragraphs 1-55 are incorporated by reference herein.

57. The Secretary, through the Administrator, has established a program targeted exclusively at individuals who are eligible to receive benefits under Title XVIII of the Social Security Act. Under the Card Program, the Secretary has imposed requirements on private entities seeking to participate in this Medicare-related initiative. An entity's applications for participation in the Card Program will be reviewed by CMS, and if approved, will earn the entity Medicare's endorsement as a preferred discount card issuer. Moreover, CMS will review and approve these private entities' marketing materials, and actively market endorsed issuers to Medicare beneficiaries through its existing Medicare information dissemination infrastructure.

58. By regulating in this manner, the Secretary has exceeded and will exceed the statutory authority granted to him by Congress in the Social Security Act. Nowhere does the Act explicitly or implicitly authorize the Secretary to create the Card Program, regulate private entities under the rubric of Title XVIII authority, or use funding appropriated to HHS and CMS to fulfill the purposes of a program not authorized by Title XVIII. Significantly, in the Notice of Application and other pronouncements regarding the Card Program, the Secretary has not cited any legal basis for his actions.

59. In addition, as discussed above, the Secretary has enlisted private entities to administer the Card Program, which involves federal funding and a class of enrollees recognized specifically under the Medicare Act. As described above, on occasion, Congress has authorized the use of private entities to provide services to beneficiaries or otherwise assist in the administration of the Medicare Program. In each such instance, it has done so pursuant to

express statutory authority and has prescribed parameters for the Secretary's interaction with and reliance on the private sector. Here, no such congressional authorization or parameters exist. Accordingly, the Secretary has exceeded the statutory authority granted to him by establishing and implementing the Card Program.

60. Moreover, the Secretary's Card Program is inconsistent with the purposes of the Medicare Program. Congress created the Medicare Program in 1965 to provide health insurance to elderly and certain disabled Americans. Here, the Secretary has foisted responsibility for such assistance on the backs of community pharmacies, without statutory authorization to do so. Indeed, the vast majority of the drugs that will be available under the Card Program are not covered benefits under Title XVIII.

61. Creation and administration of the Card Program requires the expenditure of federal funds. Congress has appropriated funds to CMS to carry out its statutory directives under the Medicare Act; no such funding has been appropriated to develop or implement the Card Program. The use of such appropriated funds is unlawful insofar as such funds are used to implement any aspect of the Card Program.

62. For the reasons described above, the Secretary's conduct is contrary to law.

63. The Secretary's implementation of this illegal Card Program has caused and will continue to cause substantial, imminent, and irreparable injury to NACDS's and NCPA's members unless the Card Program is declared unlawful and the defendants are permanently enjoined from implementing the Program.

**COUNT II (Against All Defendants)**

**The Card Program Was Adopted in Violation of the Rulemaking Requirements of the Administrative Procedure Act**

64. Paragraphs 1 through 63 are incorporated by reference herein.

65. The rulemaking provisions of the Administrative Procedure Act, 5 U.S.C. § 553(b), provide that:

> General notice of proposed rule making **shall** be published in the Federal Register. . . . The notice shall include -
>
> (1) a statement of the time, place and nature of public rule making proceedings;
>
> (2) reference to the legal authority under which the rule is proposed; and
>
> (3) either the terms or substance of the proposed rule or a description of the subjects and issues involved.

(Emphasis supplied).

66. Section 553(c) further requires an agency to:

> give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation . . . [and to] incorporate in the rules adopted a concise general statement of their basis and purpose.

67. The Card Program established by HHS in July 2001 clearly fits within the APA's definition of a substantive rule. As such, it may not be adopted without observance of the APA's notice and comment requirements.

68. The defendants failed to observe the notice and comment requirements in adopting the Card Program. Thus, the Card Program is illegal.

69. As set forth in the documents released by the HHS on July 12, 2001, the Notice of Application of July 16, 2001, and the documents cited therein, HHS and CMS have created a program with binding norms for the affected parties, including but not limited to, the following:

First, Medicare beneficiaries will be limited to enrolling in one discount card program;

Second, the right of Medicare beneficiaries to switch from one program to another will be limited to twice per year on specified dates;

Third, discount card issuers will be required to meet specific standards, including:

- Having been in the business for five years, thus barring the participation of any new entrants;
- Having at least one or two million covered lives currently (depending on whether it is a regional or national card);
- Publishing prices;
- Having a call center,
- Having discounts on at least one brand-name and/or one generic drug in each therapeutic class; and

Fourth, a discount card issuer must agree to fund a consortium to, among other things, review marketing materials (presumably for compliance with some not-yet-developed standards).

70. The individual and cumulative effect of these requirements is to create a systematic and binding scheme to regulate prescription drug discount cards that can be endorsed for Medicare beneficiaries. In short, they create substantive rules for participation in a new government program. The fact that HHS intends to use a so-called private consortium to enforce them (after the first year) does not detract from their status as rules created and endorsed by HHS and CMS.

71. Regardless of the wisdom of, or authority for, creating the Card Program, HHS has acted illegally in failing to observe the notice and comment procedures of 5 U.S.C. § 553. The APA notice and comment procedures serve three important functions: (1) they give the

public an opportunity to both participate in the regulatory process and to receive meaningful feedback from the regulating agency through the solicitation and review of comments; (2) they enable the agency to educate itself on all issues before promulgating rules that will affect those parties that are regulated; and (3) they create a record for judicial review.

72. By adopting a substantive program without providing the public an opportunity to participate (indeed, by selectively permitting a small group of interested persons to participate in secret), HHS has frustrated each of these three important public goals. By denying Medicare beneficiaries and prescription drug providers an opportunity to comment in advance of adoption of the Card Program, all affected parties (except for the privileged few that were invited to participate) have been denied their statutory right to participate in the rulemaking process. At the same time, HHS has forfeited the opportunity to improve the Program by learning from the affected parties. Also, there is no record of the secret meetings for the Court to review.

73. Accordingly, HHS's Card Program must be declared illegal for having been adopted in violation of the procedural protections afforded by the APA. 5 U.S.C. § 706(2)(D).

74. The Secretary's implementation of this illegal Card Program has caused and will continue to cause substantial, imminent, and irreparable injury to NACDS's and NCPA's members unless the Card Program is declared unlawful and the defendants are permanently enjoined from implementing the Program.

**COUNT III (Against All Defendants)**

**The Card Program Violates the Administrative Procedure Act Because It Is Arbitrary, Capricious, an Abuse of Discretion, and Otherwise Not in Accordance with Law**

75. Paragraphs 1 – 74 are incorporated by reference herein.

76. Assuming arguendo that the Court finds that the Secretary had statutory authority to create and implement the Card Program, and that he was not required to follow the rule-making requirements of the APA, the requirements established under the Card Program are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). Indeed, these standards appear to have been designed for the express purpose of promoting the business interests of the Committee members, to the exclusion of other potential participants in the Card Program. Remarkably, none of these standards bears any relation to the ostensible purpose of the Secretary's initiative – i.e., to afford discounted drug prices to Medicare beneficiaries. Because the standards have nothing to do with which cards provide the best discounts, and actually limit access to discounts, they are arbitrary and capricious.

77. Under the requirements developed jointly by the Committee and the Secretary, only applicants that cover at least two million lives if serving as a national organization, or one million if participating as a regional organization, are permitted to participate in the Card Program. This unduly restrictive specification, which clearly is not necessary to assure that participants in the program are qualified to serve the beneficiaries, severely limits competition. There is no reasonable basis to conclude that organizations covering fewer lives, such as 500,000, would be ill-suited to participate in the Card Program.

78. In addition, the requirement that entities must be in business for five years to be eligible to participate in the Card Program is unreasonable, arbitrary, and capricious. The Secretary has asserted no reasonable basis for excluding issuers that otherwise satisfy all other requirements of the Program, including financial stability, but have been in business for fewer that five years.

79. Many of the standards set forth in the Notice of Application fail to identify the specific criteria for obtaining CMS's endorsement. To illustrate, the Notice requires that applicants demonstrate financial soundness, but does not specify the nature of the required showing. The Secretary's abject failure to delineate clear standards for qualification under the Card Program is plainly arbitrary and capricious.

80. Further, the Secretary has delegated significant regulatory authority under the Card Program to the Consortium of private participants that receive Medicare endorsement. Such a delegation of regulatory oversight authority to the very entities that are to be regulated is a clear abuse of discretion that runs afoul of the APA's requirements.

81. Accordingly, the Secretary's standards are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A).

82. The Secretary's establishment of the Card Program, which violates the APA, has caused and will continue to cause substantial, imminent, and irreparable injury to NACDS's and NCPA's members unless the Card Program is enjoined and declared invalid, and plaintiffs are provided such other relief as the Court deems necessary.

**COUNT IV (Against All Defendants)**

**The Card Program Was Formulated by a Secret Committee in Violation of the Federal Advisory Committee Act**

83. Paragraphs 1 – 82 are incorporated by reference herein.

84. The Federal Advisory Committee Act, 5 U.S.C. app. 2 § 1 *et seq.*, requires that federal officials, in creating an advisory committee,

a. set forth a clearly defined purpose for the advisory committee (5 U.S.C app. 2 § 5(b)(1));

b. require the membership of the advisory committee to be fairly balanced in terms of the points of view represented (5 U.S.C. app. 2 § 5(b)(2));

c. assure that the advice and recommendations of the committee will not be inappropriately influenced by the appointing authority (5 U.S.C. app. 2 § 5(b)(3));

d. provide for the duration of the committee and the publication of reports and materials (5 U.S.C. app. 2 § 5(b)(4));

85. The Federal Advisory Committee Act further requires:

a. that meetings of committees be open to the public (5 U.S.C. app. 2 § 10(a)(1));

b. public notice to insure that all interested persons are notified of meetings (5 U.S.C. app. 2 § 10(a)(2));

c. that interested persons be permitted to attend, appear before, or file statements with any advisory committee (5 U.S.C. app. 2 § 10(a)(3));

d. that detailed minutes be kept and documents be made available for public inspection (5 U.S.C. app. 2 §§ 10(b)-(c), 11).

86. Defendants Thompson and Scully repeatedly violated the Act by establishing and utilizing a body of advisors, the Committee, to provide advice on the establishment of the Program. That body continues to exist as the consortium of PBMs that have made a "deal" will receive HHS endorsement and will administer the Program under HHS supervision.

87. According to defendant Scully, the Committee participated in the drafting of the standards for endorsement under the Program.

88. Members of the Committee individually and collectively met secretly and repeatedly for several months leading up to the July 2001 announcement of the Card Program to advise the Secretary and Administrator regarding the Program.

89. On information and belief, the membership of the Committee consists of a small group of PBMs. No representative of community pharmacies, drug manufacturers, or of affected seniors, who will be affected greatly by this Program, is a member of the Committee.

90. The members of this Committee will be members of the government-supervised, Medicare-endorsed Consortium consisting of organizations that will offer benefits under the Program. The Consortium will operate as a quasi-public body overseeing the delivery of benefits under a federal program with federal oversight. The Committee, operated as an advisory committee, established and utilized to advise on the construction of the Program; will be the main participants in the Program; and will run the Program with federal endorsement and oversight.

91. The Committee was established without specific authorization by statute or by the President or as a matter of formal record by defendants.

92. Establishment of the Committee was not accompanied by timely notice in the Federal Register.

93. Committee meetings were held in secret, restricting access by members of the public and other interested parties.

94. Meeting transcripts, agendas, minutes, and other documents pertaining to the Committee's activities have not been made available to the public.

95. Composition of the Committee was not fairly balanced in terms of the points of view represented.

96. Under the Card Program, the Committee will continue to operate as the Consortium engaged in the delivery of prescription drugs, organized and operating under the direction of CMS and HHS.

97. The establishment and utilization of the Committee by defendants, and the Committee's conduct of its meetings in secret, without disclosure, and without fair composition violate the Federal Advisory Committee Act, 5 U.S.C. app. 2 § 1 *et seq.* (2001), and has caused, and will continue to cause, substantial, imminent and irreparable injury to plaintiffs and their members unless the Committee is enjoined and declared invalid.

**COUNT V (Against All Defendants)**

**The Card Program Violates the Administrative Procedure Act Because the Secretary Lacks Statutory Authority to Delegate Executive Authority to the Committee and the Consortium**

98. Paragraphs 1—97 are incorporated by reference herein.

99. The Secretary, through the Administrator, has established a Card Program targeted exclusively at beneficiaries who are eligible to receive benefits under Title XVIII of the Social Security Act. The Secretary, together with the Committee, has adopted rigid requirements for the Card Program and has delegated substantial authority for the administration of the Card Program to the Consortium, a private entity without any statutory authority.

100. The Consortium has substantial regulatory and oversight authority under the Card Program, as set forth in the documents released by HHS on July 12, 2001, the Notice of July 16, 2001, and the documents cited therein.

101. The regulatory and oversight authority of the Consortium includes:

First, the Consortium has the authority to operate a system to verify that beneficiaries are not enrolled in more than one Medicare-endorsed discount drug program;

Second, the Consortium has the authority to review marketing materials used by each Card Program issuer; and

Third, the Consortium has the authority to determine and assess fees on Medicare-endorsed card issuers.

102. The individual and cumulative effect of the Consortium's regulatory and oversight authority under the Card Program is to create a scheme whereby a loose affiliation of private entities will have substantial regulatory and oversight authority over the Card Program from which they gain to benefit. Such self dealing is an impermissible conflict of interest.

103. Nowhere does the Social Security Act or other legislative authority explicitly or implicitly authorize the Secretary to delegate regulatory or oversight authority to the Consortium for the purposes set forth in the Card Program or for any other purpose.

104. Although Congress occasionally has authorized the use of private entities to provide services to beneficiaries or otherwise assist in the administration of the Medicare Program, in each instance it has enacted statutory authority and prescribed parameters for the Secretary's interaction with and reliance on the private sector.

105. Accordingly, HHS's Card Program must be declared illegal for having been adopted in excess of statutory authority.

106. The unlawful delegation of authority by the Secretary has caused, and will continue to cause, substantial, imminent and irreparable injury to plaintiffs and their members.

## PRAYER FOR RELIEF

107. WHEREFORE, plaintiffs pray that this Court: (1) declare the Medicare Rx Discount Card Program to be illegal; (2) preliminarily and permanently enjoin the Secretary and the Administrator from implementing the Card Program, including enjoining the acceptance and

review of applications pursuant to the July 16, 2001 Notice of Application; and (3) provide such other relief as the Court deems appropriate.

DATED: July 17, 2001

Respectfully submitted,

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# "Pharmacy Benefits All" Coalition

## A Unified Agenda for American Pharmacy - June 2001

American College of Clinical Pharmacy (ACCP)
American Pharmaceutical Association (APhA)
American Society of Consultant Pharmacists (ASCP)
American Society of Health-System Pharmacists (ASHP)
Food Marketing Institute (FMI)
National Association of Chain Drug Stores (NACDS)
National Community Pharmacists Association (NCPA)
National Council of State Pharmacy Association Executives (NCSPAE)

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As policymakers discuss a comprehensive outpatient pharmacy benefit for seniors, the "Pharmacy Benefits All" Coalition encourages Congress and the Bush Administration to carefully consider the views of the nation's pharmacists and pharmacies – one of our nation's largest, most accessible, and consistently most trusted group of health professionals.

**Pharmacy Organizations: Who We Represent**

Our organizations represent the spectrum of American pharmacy practice – independent and chain community pharmacists and pharmacies; hospital and health-system pharmacists; clinical pharmacists in academic health centers, medical group practices, and clinics; pharmacists practicing in managed care organizations; consultant pharmacists in long-term and senior care facilities; home health care pharmacists; and virtually every other type of pharmacist and setting where patient care and medication use occur. We are unified in our core beliefs concerning the development of an outpatient pharmacy benefit for seniors.

**Outpatient Pharmacy Benefit For Seniors: What We Believe**

- ***Seniors Should Have Access to a "Pharmacy Benefit" – Not Just a "Drug Benefit"***

We believe that seniors should have access to a comprehensive pharmacy benefit. This includes coverage for the most appropriate medication for the senior, as well as the professional services of pharmacists and pharmacies that assure effective outcomes from medication use.

Pharmacists can work together with the patient and their physicians to help assure that medications are clinically appropriate and cost effective. As a result, preventable drug-related problems, such as side effects and drug interactions, can be avoided. For these reasons, we believe that seniors should have access to a "pharmacy benefit," not simply a "drug benefit." In addition to providing the medication, a meaningful pharmacy benefit would include important components such as collaborative medication therapy management (MTM) services for seniors with chronic medical conditions, refill reminders, extended pharmacist counseling, and outcomes monitoring and evaluation.

Some proposals do not meet these important tests. For example, "prescription drug discount card" programs do not provide adequate pharmacy coverage for seniors, and represent price controls on pharmacies, which are private-sector businesses. Moreover, simply providing coverage for medications is only part of the answer to assuring that seniors have access to a comprehensive pharmacy benefit. Medications are safe and effective only when they are used appropriately. Inappropriate medication use leads to hospitalizations, emergency room visits, and other unnecessary medical costs for which Medicare is already paying a substantial price.

Seniors recognize that pharmacists are the most qualified health professional to provide this level of care and service. Seniors should have the choice of and access to the pharmacist and pharmacy that best meet their specific health care needs.

- ***An Outpatient Pharmacy Benefit Should Pay Pharmacists and Pharmacies for the Services that Meet the Special Needs of the Senior Population.***

Any outpatient pharmacy benefit must recognize that the nation's pharmacists and pharmacies are the individuals and entities that actually provide the medications and professional services that are essential to assure that medications are optimally used.

Payment to pharmacists and pharmacies for providing these products and services must recognize the important health care needs of the senior population, including such services as medication compliance packaging, prescription compounding, and patient education and counseling. Payments should be reasonable and adequate to cover the professional, administrative, and business costs of providing these products and services – as well as a reasonable return on investment – in all pharmacy practice settings in which the care and services are provided.

- ***Pharmacists and Pharmacies Should Deliver Care to Seniors under the Outpatient Pharmacy Benefit.***

Most of the senior outpatient pharmacy proposals introduced to date turn the administration, management, and delivery of services over to "private sector" entities sometimes referred to as prescription benefits managers (PBMs). For example, under several existing proposals, PBM's are charged with "managing care," "developing drug formularies," "increasing generic drug use," "negotiating discounts with pharmaceutical manufacturers", "placing price controls on pharmacies," and "providing medication therapy management programs to seniors."

PBMs can and do have an important role in performing many of the administrative tasks associated with providing the pharmacy benefit to seniors. We believe that the nature and scope of "patient care and cost management" tasks that these proposals would assign to PBMs needs further thorough discussion. Pharmacists and pharmacies are the real "private sector" providers of care and service to patients. Pharmacists and pharmacies provide services and work with patients at their point of care to help assure appropriate medication use and accurate dispensing. Senior citizens will ultimately rely on pharmacists and pharmacies to achieve the outcomes we all seek for a successful outpatient pharmacy benefit.

**What We Pledge**

Our organizations are jointly committed, prepared, and able to work with the 107th Congress, the Bush Administration, the pharmaceutical industry, HCFA, physician organizations, senior advocacy groups, and other interested parties to help design an outpatient pharmacy benefit for seniors that improves medication use, helps control overall health care costs, and enhances the quality of life.

An outpatient pharmacy benefit for seniors will be the single most substantial and important addition to the program since its inception 35 years ago. We must assure that any new program established provides the most cost effective pharmacy benefit to seniors and the Medicare program. Seniors, taxpayers, and the public at large deserve nothing less than our best effort.

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