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EXPANDING AND IMPROVING MEDICARE: PRESCRIPTION DRUGS: AN OREGON PERSPECTIVE

FIELD HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED SEVENTH CONGRESS

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EXPANDING AND IMPROVING MEDICARE: PRESCRIPTION DRUGS: AN OREGON PERSPECTIVE

THURSDAY, AUGUST 15, 2002

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Beaverton, OR

The committee met, pursuant to notice, at 10:34 a.m. in the Beaverton City Council Chambers, 4755 S.W. Griffith, Beaverton, OR, the Hon. Gordon Smith presiding.

OPENING STATEMENT OF SENATOR GORDON SMITH

Senator SMITH. Good morning, ladies and gentlemen. I would like to welcome you all to this special field hearing of the Senate Committee on Aging. It is the purpose of this hearing to explore the Oregon perspective on prescription drugs for seniors, and we are very thankful that each of you has come and have an interest in this.

We are going to hear from two panels today, and they are going to share with us their expertise, and their testimony will become part of the congressional record, as we use this hearing to help try and move along the national debate on prescription drugs in a more productive and informative way.

If time allows, the panelists will also address questions from the audience, and if you would like to pose a question to them or to me, please write it down on one of the cards the staff will provide, and we'll try to get them answered, time permitting.

Please also make sure that your name and address are clearly printed on the cards, because if we run out of time, we will make sure your questions are answered by mail and also make them part of the congressional record. When you fill out your card, please hold it up so that our staff can collect it.

Before we move forward to the first panel of witnesses, I would also like to draw your attention to some of the services that are available to you today at this hearing. Case workers from my staff and also from the staff of my colleague, Senator Wyden, who is not able to be with us this morning, are here to help resolve problems that you may have with Medicare, Social Security, or other government entities.

In addition, experts from the Centers for Medicare and Medicaid, the agency which administers Medicare, are also on hand to help answer questions and resolve problems. Representatives from the

Senior Health Insurance Benefits Assistance Program, or SHIBA, are also here.

On behalf of the committee, I am also pleased to welcome members of the Governor's Commission on Senior Services. We appreciate that you are here.

On behalf of the committee, I would also like to thank all of the other agencies that have sent representatives to today's hearing for the seniors who have turned out for this event today.

They include the Multnomah County Aging and Disability Services, Washington County Aging and Veterans Services, Clackamas County Aging and Disability Services, Oregon Alliance of Senior and Health Services, Oregon Gerontological Association, Elders in Action, RSVP of Washington County, Elsie Stuhr Community Center in Beaverton, the King City Senior Center, Irvington Covenant Center, Oregon Health Sciences University, Social Security Administration, and Medicare Northwest. I think that must cover pretty much everyone in the room.

We're very pleased that you're here, and we want this to be informative to you and helpful to this national debate.

I have a statement that I will include in the record and share with you in part.

I will tell you that prescription drugs for seniors is truly an issue whose time has come. Medical and technological breakthroughs in recent years have made it possible to extend and improve life while controlling illness in ways never thought possible before, even 50 years ago. People are living longer and living better with the help of new treatments and therapies.

But these improvements have come at a price. While Medicare has done much to reduce poverty for Americans over 65, it has not grown and adapted to keep pace with the health expenditures for the 34 million seniors and 5 million disabled younger adults who rely upon the program.

On average, the Americans over age 65 spent an estimated 22 percent of their income for health services and premiums in the year 2000. However, seniors in poor health and without supplemental coverage spent even more, about 44 percent of their incomes on, health care.

In 1965, when Medicare was created, the average senior spent $65 per year on prescription drugs. Wouldn't that be nice? Today, the average senior spends $2,149 each year on prescription drugs, 35 times more.

Well, drug prices are currently the fastest growing segment of national health care spending, and yet more than a quarter of all seniors, many seniors have no source of coverage for their prescriptions. This is a particularly important issue, because Americans over age 65 consume three times more prescription drugs than people under the age of 65. Looking around the room, I probably don't need to tell you this, but virtually all Medicare beneficiaries use prescription drugs on a very regular basis.

One of the purposes of this hearing is to understand prescription drug use among Oregon seniors. I would like to hear from you how many of you use one or more prescription drugs. Can you raise your hand if you are currently taking a prescription drug pretty much all around?

There may be a few that don't have to, and I am glad for you.

How many of you are taking three or more drugs at this time?

A pretty good number. I am not surprised.

Surveys have shown that seniors with some drug coverage will fill, on average, 22 prescriptions a year, while those without the coverage will fill less than 15.

How many of you spent more than $100 last month on prescription drugs, a show of hands?

There you go.

A new survey just released by the Kaiser Family Foundation and the Commonwealth Fund found that nearly one in four seniors skip doses in medication or do not fill a prescription due to cost. Among lower income seniors, the numbers are much higher. The lack of drug coverage is more than simply a financial burden; it is a serious health risk for seniors.

Going without prescribed medications can lead to serious adverse consequences for the health of seniors. Medications can control chronic conditions and avert acute health conditions if taken as prescribed, and it can keep people out of the hospitals, which is much, much more expensive. If taken incorrectly, seniors' health and quality of life can terribly suffer and lead to much more expensive care.

I have spoken to all seniors around Oregon. If there's an issue on their minds, it is prescription drugs that resonates most clearly. I feel strongly that the loss of one's health should not be the loss of one's home, and I have been working to add prescription drug coverage to the Medicare program, so that all seniors will have access to affordable drugs.

I regret to tell you that, over the last 3 weeks, the Senate worked on this. That is before the August recess. We spent 3 weeks debating and working and amending various prescription drug proposals. As you already know, we did not clear the 60 vote threshold that the Senate imposes for all of these important kinds of issues.

In working with Senator Graham of Florida, my colleague across the aisle, I tried my best to come up with a compromise between the two positions that would provide an affordable benefit to seniors and to government.

But, unfortunately, politics won the day, and I am now working with him to see if we can't modify our proposal to reach another agreement to bring the issue up again in September so that our nation's seniors will not have to wait yet another Congress for the prescription drug benefit that they need and deserve.

Now, in the absence of other members of the Senate committee with us today, I am going to turn to the true experts in this debate by introducing our witnesses. Today we will hear testimony from two panels of witnesses. The first witness, Mr. Bobby Jindal, is the Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services. He has analyzed several prescription drug proposals and can help us understand the history of Medicare and the effects of different bills under consideration. Mr. Jindal is also a former state Medicaid Director from Louisiana.

Mr. Jindal, Oregon welcomes you, and we hope you brought some Cajun cooking and maybe some Zantac after that. So, Bobby, before I turn to you——I would like to welcome Mr. Roy Dancer, a senior

citizen from Oregon. He is a retired and distinguished school teacher. His wife is with him.

How long have you been married?

Mr. DANCER. About 47 years.

Senator SMITH. Well, three more and we're going to have a party. That, folks, is the best success story anybody can issue. We congratulate you.

In addition to being a school teacher, he will share his experience of getting access to prescription drugs since becoming eligible for Medicare.

Mr. Dancer, it is my pleasure to welcome you here, as well, on this first panel.

Bobby, we'll turn first to you.

STATEMENT OF BOBBY JINDAL, ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. JINDAL. Thank you, Senator. I also want to thank you on behalf of the Administration. I was just with the President down in Texas for his economic summit. I want to thank you on behalf of the Administration for your leadership and hard work on this issue. I know you and your staff have worked tirelessly, as has the Administration, on adding a prescription drug benefit to Medicare.

It is an honor to be in front of you today. It's an honor to be here in Oregon, where the weather certainly is cooler than in my home State of Louisiana.

Senator SMITH. You may have trouble selling that to Oregonians. Global warming is in full force right now.

Mr. JINDAL. I do take the opportunity to come to you to talk about this important topic. As I said, the President is down in Texas at his economic summit, and one of the messages that came across loud and clear during the health security panel, the President made it very clear you cannot have economic security without health security.

One of the messages that came across very clearly is that a top priority is that we must make prescription drugs more affordable to seniors. We must add that benefit to the Medicare program.

Across the country and around the world, scientists, doctors, and innovators have developed new technologies and treatments that weren't even imagined in 1965. The private sector has been transformed. When you look at modern insurance today, it would be impossible to provide a comprehensive medical insurance package to the private sector without prescription drug coverage.

During that same time, even though Medicare has provided security for millions of Americans since it was created, it has not kept pace with the changes in the world around it. Today the program is threatened by a system that has failed to deliver health plan options for all seniors and by an outdated benefits package that includes very limited drug coverage.

President Bush believes very strongly Medicare must be strengthened and must be improved to meet the needs of the 21st century, to meet the needs of today's seniors. It is vitally important for the Congress and the Administration to work together to fulfill

Medicare's promise of health care security for our nation's seniors and people with disabilities.

To this end, the President is working with Members of Congress, including yourself and other members from both parties, to develop a framework for strengthening and improving Medicare programs.

In July 2001, the President presented a framework that included the following eight principles. First, all seniors should have the option of a subsidized prescription drug benefit as part of a modernized Medicare program. Second, modernized Medicare provides better coverage and preventative care for serious illness.

Third, today's beneficiaries and those approaching retirement should have the option to keep the traditional plan they prefer with no changes. Fourth, Medicare should make available better health insurance options like those available to all Federal employees.

Fifth, Medicare legislation should strengthen the program's long-term financial security. Sixth, the management of Medicare should strengthen and improve care for seniors. Seventh, Medicare's regulations and administrative procedures can be updated and streamlined while instances of fraud and abuse should be reduced. Finally, eighth, Medicare should provide high quality heath care for all seniors.

The President's framework for strengthening Medicare and improving the program for seniors and disabled Americans calls for fair payment options for Medicare beneficiaries. Through their Medicare+Choice plans, a lot of beneficiaries receive more enhanced benefits than are available under traditional Medicare. Enhanced benefits can include prescription drugs. These programs provide better preventative care services and benefits widely available to millions of Americans who are working today.

Frequently, private plans are providing Medicare benefits at a much lower cost as well. Not surprisingly, private plans have long been the preferred choice for over 5 million Medicare beneficiaries.

As you know, Medicare+Choice has been particularly popular with seniors in Oregon, and 28 percent of your beneficiaries have chosen to enroll in the Medicare+Choice plan, compared to 13 percent of the beneficiaries nationwide.

The Portland area, indeed, was one of the first areas to participate in Medicare's managed care program and remains one of the areas where the program is strongest. Six plans serve beneficiaries in Oregon, and four companies are right here in Washington County. In addition, three plans offer coverage for prescription drugs.

In spite of this popularity, however, the future of Medicare+Choice is in question. Since a new payment system was implemented in 1998, hundreds of private plans have left the program or reduced their service areas, adversely affecting coverage for millions of beneficiaries, reversing what had been a upward trend in plan availability and enrollment. Here in Oregon there are 16,000 fewer enrollees now than at the peak enrollment 2 years ago.

The Administration's proposal is to move toward a more secure, equitable, and fair payment system for Medicare+Choice plans. This proposal will modify the current formula to better reflect actual health care cost increases and allocate additional resources to counties that most need them.

This will make it possible for more private plans to remain with Medicare. Proposals to help sustain plan choices in Medicare are supported by both Democrats and Republicans.

The President has also proposed a new system for new types of plans to enter the program to encourage a variety of new plans, like preferred provider organizations, to participate. Even though these are incredibly popular in the under 65 population, there are currently few or no such choices in the Medicare program. Just in the next few days we're rolling out a demonstration program to encourage these types of options to be available to today's seniors.

Another important step in bringing Medicare into the 21st century is we are forming Medigap plans. Two-thirds of seniors rely on individual or employer sponsored supplement plans, and yet Medigap premiums have been rising at an alarming rate.

In the current Medigap structure, all plans offer first dollar wrap-around coverage, and yet there are two problems for these plans. First, they are expensive for beneficiaries; and, second, they do not offer beneficiaries the benefits they want, and create incentives for excess utilization.

According to a recent study by the HSS, it is far easier for beneficiaries to buy foreign travel insurance than to buy prescription drug coverage under Medigap. It is clear most people would prefer drug coverage.

The President, therefore, has proposed adding two new Medigap plans to the existing ten. The new plans would offer prescription drug coverage to protect beneficiaries against catastrophic health care costs and include modern beneficiary cost sharing. For these changes, they are expected to offer a more affordable price than the existing popular Medigap plans.

As you know, since his first days in office, the Secretary of Health and Human Services, Tommy Thompson, has made the prevention of disease one of his top priorities. He has often said, our current medical system waits too long, and it's far more expensive and far less effective to treat disease after the fact.

The Administration is determined to promote prevention of disease by eliminating barriers for beneficiaries. Yet today, beneficiaries who receive screening for osteoporosis, for breast, prostate or colorectal cancer, must first meet the deductible, or pay a 20 percent copay, or both.

Beneficiaries who need diabetes self-management education and training, which is important to maintain control of diabetes in reducing mortality, also face that kind of cost. Under the President's proposal, all these important preventive services will be excluded from the deductible and from co-payments. In other words, we would make free to seniors the type of preventative care that also reduces cost for the program.

In June, the House of Representatives took a step in the right direction by passing a bill calling for these changes. Furthermore, as the Secretary has made clear, we are committed to helping Americans to prevent and reduce disease by encouraging changes in diet and exercise.

These are important elements in our plan to strengthen and improvement the Medicare program. The most pressing challenge remains the lack of drug coverage among seniors. Seventy-seven per-

cent of seniors have some prescription drug coverage today, but 10 million beneficiaries do not.

Forty percent of these beneficiaries earn less than 150 percent of the poverty level. In fact, those beneficiaries that do not have coverage through private insurance are the only Americans today, along with the uninsured, who commonly pay full price for prescription drugs.

Just as you said, beneficiaries without drug coverage spent $617 for drugs out of their own pockets, compared to only $352 for those with coverage. That is simply unacceptable, and the problem must be addressed.

Significant numbers of beneficiaries face unprecedented difficulties in obtaining drugs at a time when drug therapies have become more important than ever in treating and preventing diseases. Recent breakthroughs and those still in the pipeline have and will continue to transform treatment of many terrible diseases.

For example, there are now several new treatments in the pipeline to treat high cholesterol, including drugs designed to interfere with the body's absorption of the cholesterol, and that could actually prevent the conversion of the good into the bad cholesterol, HDL to LDL. But these and other breakthroughs, as exciting as they are, will not help our seniors if they have no means to attain them or afford them.

For this reason, the program needs a drug benefit that will allow such innovations out of the lab and into the medicine cabinet without stifling future innovations. Many in Congress have supported a variety of reform proposals, and yet one of the concerns of the Administration is that, under any of these proposals, it will take at least until 2005 to get a comprehensive drug benefit up and running.

Seniors need help now, and there are steps that can be taken now—for example, low income subsidies and other steps—to help seniors become immediately a part of a larger, overall comprehensive legislation, not as a substitute, but rather as a first step.

Make no mistake. We are committed to strengthening Medicare. We are committed to providing a meaningful prescription drug benefit for all of America's seniors and people with disabilities, and we are also committed to providing assistance immediately.

Last year, the President took the first step when he proposed a creation of a new mandatory endorsed drug card initiative. The house endorsed the plan, and the Administration is hopeful the Senate will, as well.

The drug card is not a drug benefit and it's not a substitute for one. It is, however, an important first step in helping seniors afford the drugs they need today. It is modeled on private health insurance programs where seniors benefit, where they are receiving discounts of 10 to 35 percent.

Under the President's proposal, Medicare endorses private drug cards that meet certain standards, and seniors get information they need to obtain manufacturer discounts and other available pharmacy services.

These plans negotiate discounts and rebates directly from drug companies and pass the savings on to beneficiaries who choose to participate. Beneficiaries could switch cards, and they would not be

charged more than a nominal, annual enrollment fee, to make sure that they get the best discounts, the best prices on drugs, but also get services like drug interaction programs and other services designed to promote preventative care and to reduce medical errors.

The Administration has also proposed immediate support for a comprehensive drug benefit for Medicare beneficiaries up to 150 percent of poverty, or about $18,000 for a family of two.

This program, called the transitional Medicare low income drug assistance program, would expand existing administrative structures operated by the States that already serve the low income and would also allow the States to use the new low income drug card to provide low income assistance for other seniors.

As an incentive, Medicare would pay for 90 percent of the cost of the program to serve the seniors who live in 100 percent to 150 percent of poverty. This policy is projected to expand coverage to 3 million beneficiaries and would also allow the States to use the new low income drug card to provide low income assistance for other seniors.

As an incentive, Medicare would pay for 90 percent of the cost of the program to serve seniors in 100 to 150 percent of poverty. This policy is expected to expand drug coverage to 3 million beneficiaries who don't have drug coverage today.

Combined with the low income assistance, the drug card, the Administration is also doing something today, while Congress continues to deliberate the comprehensive legislation, called Pharmacy Plus. This is a program that allows States to provide a drug card for Medicare beneficiaries up to 200 percent of poverty. We've already approved Pharmacy Plus for over 800,000 people in five States and received other applications from an additional five States.

I would like to close by saying the President is committed to working with Congress to enact legislation consistent with his principles. By strengthening and improving Medicare and putting prescription drug benefits in place, we can keep the promises we made to seniors and disabled Americans today and for those who will rely on Medicare tomorrow.

The Administration and Congress must take this opportunity to take important steps to strengthen and improve the program. Seniors should have a program to provide better benefits, better value both for them and for the government, a program that is fiscally sound, does not cause disruption to but that strengthens the coverage they currently have and continues the rapid pace of medical innovation which will bring tomorrow's cures to America's seniors.

On June 28, the U.S. House passed the Medicare Modernization and Prescription Drug Act of 2002, H.R. 4954, a good step toward making Medicare a better prescription drug program for all seniors. The Senate now has an opportunity to follow the house's example. We believe by working together, seniors can have a Medicare program that fulfills the promise of secure and vibrant retirement.

Senator Smith, I will close where I started. Again, I came to Portland directly from Texas, from the President's economic summit, where time and time again the President heard from real Americans like you're doing today, senior Americans saying that we must make prescription drugs more affordable.

I will also close again by thanking you for your leadership. The Secretary and the President send their personal regards, and they want to tell you again how much they appreciate the hard work you're doing to make the Medicare drug benefit a real part of the program.

[The prepared statement of Mr. Jindal follows:]

Statement Of The Hon. Bobby Jindal,

Assistant Secretary For Planning and Evaluation,
U.S. Department of Health and Human Services

Testimony Before:

The Special Committee On Aging of the United States Senate

Field Hearing on Expanding and Improving Medicare Prescription Drugs—
an Oregon Perspective

August 15, 2002
Beaverton, Oregon
City Council Chambers

Thank you for inviting me to Beaverton, Oregon to discuss expanding and improving Medicare prescription drug coverage. I am Bobby Jindal, Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services in Washington, D.C.

Since 1965, Medicare has provided security for millions of Americans. Across the country and around the world, scientists, doctors, and other innovators and practitioners of modern medicine have developed new technologies and treatments that were unimaginable in 1965. Yet, despite significant advances in modern medicine, Medicare has not kept pace with these changes. Today the program is threatened by limited financial protection against high medical costs; a traditional plan that often fails to deliver responsive services to beneficiaries or ensure high-quality care; a system that has failed to deliver health plan options for all seniors; and an outdated benefits package. President Bush believes that it is vitally important for Congress and the Administration to work together to strengthen and improve the Medicare program to fulfill Medicare's promise of health care security for our Nation's seniors and people with disabilities.

Today, 77 percent of Medicare beneficiaries have prescription drug coverage through a variety of methods. These include: enrolling in a plan offered by their current or former employer; enrolling in a Medicare+Choice plan; purchasing a Medigap policy; qualifying for coverage offered by a Federal program, such as the Veteran's Administration; or enrolling in their state's Medicaid or free-standing prescription drug program. Despite these many sources of coverage, too many seniors do not have prescription drug coverage, and these seniors—particularly low-income seniors—need coverage now. Medicare beneficiaries without drug coverage in 1999 reported spending an average of $617 per year out of their own pockets for prescription drugs, compared with $352 for

those with coverage. Moreover, those beneficiaries with low incomes, high drug spending, or both often face daunting difficulty.

A key problem is that a significant number of Medicare beneficiaries face unprecedented hurdles in obtaining prescription drugs at a time when drug therapies have become more important than ever in treating and preventing disease. Recent breakthroughs and those still in the pipeline have, and will continue to, transform treatment of many terrible diseases. For example, recently developed treatment approaches for heart attacks and strokes have reduced the morbidity and improved the mortality in patients experiencing these events. Likewise, several new treatments are in the pipeline to treat high cholesterol including drugs designed to interfere with intestinal absorption of cholesterol and vaccines that prevent the conversion of HDL (high-density lipoprotein) to LDL (low-density lipoprotein) cholesterol. For an estimated 4 million Americans with Alzheimer's disease, there are anti-oxidants and anti-inflammatory agents that are being tested for effectiveness in treating the disease, along with a drug that increases signaling between nerve cells. However, these and other breakthroughs will not help Medicare beneficiaries if they have no means to obtain them. For this reason, the Medicare program needs a drug benefit that will allow such innovations to move out of the lab and into the medicine cabinet, without stifling future innovations.

STRENGTHENING AND IMPROVING MEDICARE

The Medicare program provides health care coverage for nearly 40 million beneficiaries. Established in 1965 to address the national problem of health care for the elderly, the program was later expanded in 1972 to include citizens with disabilities. Since Medicare's inception, the private health insurance market has continued to make dramatic advancements to update coverage and improve health outcomes, while Medicare has often lagged behind. The President believes very strongly that the 1965 model of Medicare must be strengthened to meet the needs of 21st century seniors. By working together, the Administration and the Congress can take the action necessary to strengthen the Medicare system and update its outdated benefits package.

To this end, the President worked with members of Congress from both parties to develop a framework for strengthening and improving the Medicare program. In July 2001, the President presented that framework which includes the following eight principles:

- All seniors should have the option of a subsidized prescription drug benefit as part of modernized Medicare. Medicare's subsidized drug benefit should protect seniors against high drug expenses and should give seniors with limited means the additional assistance they need. The drug benefit should give all seniors the opportunity to choose among plans that use some or all of the tools widely used in private drug plans to lower drug costs and improve quality of care. It should support and encourage the continuation of the effective prescription drug coverage now available to many seniors through retiree plans and private health

insurance plans. In addition, the new drug benefit should also be available through Medigap plans and as a stand-alone drug plan for seniors who prefer these choices.

- Modernized Medicare should provide better coverage for preventive care and serious illness. Medicare's coverage should be improved so that it provides better protection when serious illnesses occur and better coverage to help prevent these illnesses in the first place – like having zero co-payments on Medicare's preventive benefits while still encouraging prudent use of services and beneficiary involvement in health care decisions. Because they will encourage better use of preventive care and other services, better Medicare benefits will also help seniors and the Medicare program get the best value from the new drug benefit.

- Today's beneficiaries and those approaching retirement should have the option of keeping the traditional plan with no changes. No one should be forced to accept significant changes they are not prepared for. While a modernized Medicare program will be attractive to many current beneficiaries, the choice will allow them to move from the existing program to the modernized one.

- Medicare should make available better health insurance options, like those available to all Federal employees. For too long, Medicare has been a "one size fits all" program. Seniors rely on the options offered by private health plans—such as prescription drug coverage and disease management programs. Protecting these options requires increasing payments to plans in areas where payments have not kept pace with rising health care costs.

- Medicare legislation should strengthen the program's long-term financial security. The Administration wants to work with Congress this year to enact this long-overdue legislation. There is a range of views regarding how much new spending needs to be allocated for this purpose. However, without strong measures to make the program more efficient being incorporated along with new benefits, all of Medicare's benefits will become less secure.

- The management of Medicare should be strengthened so that it can provide better care for seniors. The Administration is currently doing what it can, but it needs legislation to proceed with such steps as competitive bidding so that Medicare and its beneficiaries can get better value for the items it buys, while ensuring high quality.

- Medicare's regulations and administrative procedures should be updated and streamlined, while instances of fraud and abuse should be reduced. Here too the Administration has moved aggressively but needs help from Congress to enact the regulatory reforms and simplifications needed to reduce burdens on patients and providers.

- Medicare should encourage high-quality health care for all seniors. Recent reports from the Institute of Medicine and others have made clear the widespread opportunities for improving patient care that exist – which are likely to benefit seniors more because they use more care. These studies have also shown that these problems are not the result of malfeasance, and made it clear that the environment for medical practice must encourages systematic and continuous improvements in care, not endless and costly litigation. Seniors and those with disabilities deserve high-quality care, and Medicare should help them get it through improved information on quality.

These principles highlight that a strengthened, improved, and modernized Medicare program should come hand-in-hand with a comprehensive prescription drug benefit. These steps will help seniors not only by providing a meaningful drug benefit, but also by allowing them to spend their prescription drug dollars more effectively and avoid unnecessary health care costs. New spending for Medicare should go toward helping beneficiaries reduce prescription drug costs and providing them with better health care coverage options. The key is taking action now. History teaches us that even the smallest, most incremental changes in Medicare can bring forth a variety of views. The Administration was pleased that many of the principles are reflected in the bill passed last June by the House of Representatives, and remains committed to working with all members of Congress to make Medicare stronger and more secure.

RELIABLE, AFFORDABLE HEALTH INSURANCE COVERAGE OPTIONS IN MEDICARE

The President's framework for strengthening Medicare and improving options for seniors and disabled Americans calls for a fair payment system for private plan options for Medicare beneficiaries. Today, 9 million Federal employees, retirees, and their families choose among private plans for their coverage (or wrap-around coverage) through the Federal Employees Health Benefits program. Likewise, private plans have long been the preferred choice of 5 million Medicare beneficiaries, and many more have expressed their desire to choose a plan if one were available to them. This is not surprising, because the private plans allow beneficiaries to receive more up-to-date benefits than are available under traditional Medicare. The enhanced benefits can include prescription drugs, disease management programs, and better preventive care services—benefits widely available to millions of Americans who are working today. Frequently, private plans have provided much lower cost sharing for required Medicare benefits as well.

Action is needed now to ensure that these benefits remain available to Medicare beneficiaries, because the current Medicare+Choice payment system is not giving all beneficiaries a choice of plans. Since the new payment system was implemented in 1998, hundreds of Medicare+Choice organizations have left the program or reduced their service areas, adversely affecting coverage for millions of beneficiaries—reversing what had been an upward trend in private plan availability and enrollment. In addition, the remaining plans are offering less generous drug benefits and other coverage. Moreover, open-network plans like Preferred Provider Organizations (PPOs) and point-of-service

plans have become popular among privately covered individuals, yet only two PPOs participate in a few counties in the entire Medicare program. The Administration is exploring a number of options to increase PPO participation in the Medicare+Choice program.

Unfortunately, Medicare beneficiaries in Oregon have not escaped the trend of declining participation in the Medicare+Choice program. Although Medicare+Choice has been, and continues to be, popular with many seniors in Oregon—28 percent of Oregon's Medicare beneficiaries are enrolled in a Medicare+Choice plan versus 13 percent nationally—Oregon has 16,000 fewer enrollees now than at 2000 peak enrollment levels. Nevertheless, the Portland area remains one of the locations where the program is strongest and was one of the first areas to participate in Medicare managed care. Six Medicare+Choice organizations serve beneficiaries in Oregon, and four of those organizations serve right here in Washington County. In addition, three plans available here offer coverage for prescription drugs.

Annual increases in Medicare+Choice funding do not reflect rising health care costs in many parts of the country, leading to unreliable options and reduced benefits for seniors. For example, between 1998 and 2002, Medicare+Choice rates increased 11.5 percent in counties that received the minimum payment update. This compares with a cumulative increase in fee-for-service spending of 16 percent over the same time period. Because payments to Medicare+Choice plans do not reflect conditions in the health care marketplace, plans are struggling to maintain benefit levels.

The President proposes to take urgently needed steps toward an equitable payment system for private plans. The proposal would modify the Medicare+Choice payment formula to better reflect actual health care cost increases and allocate additional resources in 2003 to counties that have received only minimum updates over the last few years. This would make it possible for more private plans to remain in the program. The President also has proposed incentive payments for new types of plans that enter Medicare+Choice to encourage a variety of new managed care plans (e.g., PPOs) to participate in the program. Proposals to help sustain private plans in Medicare are supported by both Democrats and Republicans.

BETTER MEDIGAP OPTIONS

As a further immediate step that can be implemented to begin to improve coverage, the President has proposed improving the Medicare benefit package and making it more affordable by adding two new Medigap plans to the existing 10. The new Medigap plans would offer prescription drug coverage, protect beneficiaries against catastrophic illness, and include modest beneficiary cost sharing, all at a more affordable cost than the most popular current Medigap plans. It is estimated that with a one-time opt-in for current beneficiaries, up to 1.5 million beneficiaries would choose these new policies once they were available—and that nearly half of these enrollees would be beneficiaries who do not have drug coverage now.

Medigap reform is important to overall strengthening of Medicare because two-thirds of seniors rely on individual or employer-sponsored supplemental plans. The current Medigap structure provides first-dollar wraparound coverage, which creates incentives for excess utilization. Moreover, it does not necessarily insulate seniors from high out-of-pocket costs. The independent Office of the Actuary at CMS estimates that service use is 23 percent higher for beneficiaries with Medigap than for those without supplemental insurance. Medicare pays most of these costs, but first-dollar coverage also leads to higher Medicare and Medigap premiums. The new plans would allow beneficiaries to get the protection from high costs that they need, while avoiding the incentives for excess utilization resulting from first dollar coverage.

PREVENTIVE BENEFITS

For too long, our health system has focused solely on treating disease, and Medicare policies have reflected that focus by maintaining financial barriers to preventive medicine. Currently, beneficiaries who receive screening for osteoporosis or for breast, prostate, or colorectal cancer must first meet the Part B deductible or pay a 20 percent copayment, or both. Beneficiaries who need diabetes self-management education and training, which is important for maintaining control of diabetes and reducing morbidity and mortality, also face out-of-pocket costs. Under the President's proposal, all these preventive services would be excluded from the deductible, with no copayments required. The House of Representatives took a step in the right direction, by passing a bill calling for these changes. Further, as the Secretary of Health and Human Services has made clear, helping Americans prevent and reduce disease, by encouraging changes in diet and exercise habits are priorities for this Administration.

A key, then, to strengthening and improving Medicare is to include modest incentives for beneficiaries to utilize the rest of the Medicare program more efficiently, while allowing them to get the protection they need—such as better preventive benefits and prescription drugs—at a lower cost. This underscores the importance of including a Medicare prescription drug benefit in the context of improvements in the traditional Medicare fee-for-service benefit package, as well as in an improved Medicare+Choice model. However, as the President has made clear, seniors and those approaching retirement should be able to keep existing Medicare coverage with no changes if they prefer that choice. To ensure a strong Medicare program for this generation and the next, policymakers must work together to provide good prescription drug coverage within an improved and modernized Medicare program.

ADMINISTRATION'S IMMEDIATE ACTION ON PRESCRIPTION DRUGS

Many in Congress have developed a variety of Medicare reform proposals, but it will take until 2005, at the earliest, to get a comprehensive drug benefit up and running. Seniors need help now, and there are steps that can be taken, like the drug card and low-income subsidies, to help seniors immediately as part of comprehensive legislation. Make no mistake—this Administration is committed to strengthening Medicare and committed

to providing a meaningful prescription drug benefit for America's seniors and people with disabilities, and to provide some assistance immediately.

The Administration is already getting started. To that end, I will discuss with you in greater detail what the Administration is doing now to modernize Medicare and help those beneficiaries in the greatest need for prescription drug assistance—the prescription drug card, the transitional low-income drug benefit, and the Pharmacy Plus initiative. The Administration is moving swiftly and working with Congress where necessary to implement these important changes.

Prescription Drug Card—The lack of drug coverage among American seniors is Medicare's most pressing challenge. Ten million Medicare beneficiaries have no prescription drug coverage. About 40 percent of these beneficiaries, or 4 million, had incomes below 150 percent of poverty, or an annual income of about $17, 910 for a family of two. In fact, Medicare beneficiaries who do not have drug coverage, and the uninsured, are the only Americans today that commonly pay full price for prescription drugs. That is simply unacceptable, and the problem must be addressed.

Last year, the President took the first step when he proposed the creation of a new Medicare-endorsed drug card initiative. Moreover, the Administration is encouraged that the House endorsed such a plan in its passage of a Medicare drug benefit, and hopes that the Senate will similarly support it. The drug card is not a comprehensive drug benefit, and it is not a substitute for one. It is, however, an important first step in helping seniors and those with disabilities afford the drugs they need today and it will start very soon.

The drug card is modeled on private health insurance programs, where consumers routinely benefit by receiving discounts from 10 to 35 percent. Private insurers, with their large numbers of customers, use their market power to pool their customers and secure significant rebates and discounts from drug manufacturers. All Federal employees, most state employees, and millions of working Americans with private coverage benefit from lower drug prices as a result of such pooling. Under the President's proposal, Medicare will endorse private drug cards that meet certain standards, allowing seniors to get the information they need to obtain manufacturer discounts and other valuable pharmacy services. These third-party plans, such as pharmacy benefit managers ("PBMs"), will negotiate discounts and rebates directly from drug manufacturers and pass the savings on to Medicare beneficiaries who choose to participate.

One of the strongest arguments for the drug card is that it is the building block for most Medicare prescription drug benefit proposals. For example, most Medicare drug benefit proposals being considered by Congress use pooling methods to secure good discounts for seniors. Further, Democrats have recently shown their support for a bill that included a pharmacy discount card, indicating bipartisan agreement that seniors should have access to private sector tools that are proven to reduce drug costs.

Under the President's drug card proposal, Medicare will annually endorse a number of discount card options operated by private organizations that meet certain qualifications, including financial stability, accessibility, availability of discounts, and other customer service features. Each endorsed card can use formularies, patient education, pharmacy networks, and other commonly used tools to secure deeper discounts for beneficiaries. Medicare beneficiaries could choose the card that best suits their prescription needs, for an annual enrollment fee of no more than $25. Beneficiaries will enroll with one particular card, but as their prescription needs change, they may switch cards as frequently as every six months to ensure they are getting the best discounts on their prescriptions and the best pharmacy services. Card sponsors will negotiate discounts with drug manufacturers, and will be required to provide comparative information to beneficiaries about the discounts and other services they offer. The drug card program will encourage competition among sponsors through better information and will simplify Medicare beneficiaries' decision making by requiring that comparisons of the drug discounts are published and available to beneficiaries. The card is not a panacea and is not all that is needed, but it is a key component to getting on track to implement a prescription drug benefit effectively. The Administration expects information about the cards to be available soon.

Transitional Medicare Low-Income Drug Assistance Program—While the nation has debated ways to cover prescription drugs under Medicare for several years, many states have taken action to assist the neediest seniors. Today, many of the lowest-income seniors receive prescription drug coverage by qualifying for the Medicaid dual-eligible program. In addition, seniors in 30 states have access to state-financed prescription drug assistance programs. Finally, some pharmaceutical manufacturers offer free or low-cost prescriptions for those who do not qualify for other programs. Yet many lower-income seniors still need assistance. The President believes that comprehensive Medicare legislation should take advantage of existing state infrastructure immediately, and supports the integration of existing state low-income programs into the new Medicare drug benefit, by helping states provide drug coverage for low-income seniors right away.

The Administration has proposed to provide immediate support for comprehensive drug coverage for Medicare beneficiaries up to 150 percent of poverty—$17, 910 for a family of two. This proposal, called the Transitional Medicare Low-Income Drug Assistance Program, would begin by using the existing administrative structure operated by the states (in cases where states have already set up drug assistance programs) and would also allow states to use the new Medicare drug card infrastructure to provide low-income assistance. For Medicare beneficiaries up to 100 percent of poverty, the program would pay for expanded drug-only coverage at current Medicaid matching rates, much like existing programs that subsidize Medicare premiums and cost-sharing for low-income Medicare beneficiaries. As an incentive for states to expand coverage, Medicare would pay 90 percent of the states' cost of drug-only coverage expansion between 100 percent and 150 percent of poverty. This policy is projected to expand drug coverage for up to 3 million beneficiaries who currently do not have prescription drug assistance. This transitional program would be fully integrated with a strengthened and improved Medicare program that includes prescription drug coverage.

H.R. 4954, as passed by the House, included the important step of $3 billion in transitional assistance with drug costs for low-income seniors, beginning next year. If the Senate also acts to provide immediate assistance until a full drug benefit can be established, millions of seniors who can least afford prescription drugs can begin getting relief next year.

Pharmacy Plus—To make drug coverage immediately available to certain low-income Medicare beneficiaries—even before the enactment of the Transitional Low-Income Drug Assistance Program—states can participate in a model drug waiver program called Pharmacy Plus. States choosing this option may provide drug-only coverage to Medicare beneficiaries up to 200 percent of poverty. States will use such tools as formularies and prior authorization to make the most of their funding. The savings generated from using these tools in states' existing populations can be used to finance additional drug coverage. The Administration has approved Pharmacy Plus waivers resulting in coverage for over 800,000 people in five states (Illinois, Wisconsin, South Carolina, Maryland, and Florida) and five other states have applications pending.

CONCLUSION

The President is committed to working with Congress to enact legislation consistent with his principles. By strengthening and improving Medicare and putting a prescription drug benefit in place, promises made will be promises kept to seniors and disabled Americans today, and for those who will rely on Medicare tomorrow. The Administration and the Congress must take this opportunity to take these important steps needed to improve the Medicare program. Seniors and disabled Americans should have a Medicare program that provides better benefits, better value for beneficiaries and the government, is fiscally sound, does not cause disruptions in the coverage people currently have, and continues the current rapid pace of medical innovation, which will bring tomorrow's cures to America's seniors. On June 28, the U.S. House of Representatives passed the Medicare Modernization and Prescription Drug Act of 2002 (H.R. 4954), a good step towards making Medicare a better program with prescription drug coverage available for all seniors. The Senate now has the opportunity to follow the House's example and act soon. By our working together, seniors will have a Medicare program that fulfills the promise of a secure and vibrant retirement. I thank you for the opportunity to discuss this very important topic with you today.

Senator SMITH. Thank you, Bobby.

I think one of the biggest debates, in the Senate anyway, and I am sure it is in the House, is the delivery system a prescription drug benefit we would use. Everybody agrees that there ought to be a prescription drug benefit system. The debate is over two ways, both of which can work, and the question is, what do people want and which will work the best?

You can do it through Medicare. In other words, the government manages these things, and it does it under a formulary, or you can do it through existing private insurance, and that can work, as well. Some insurance companies say they're interested and others say they're not. I have voted for both versions, anxious to get something to conference so we can get something to the President and get some relief quickly.

I think what you're telling me is that the discount card that you've come up with can be done immediately, and that is not a substitute for one of the other two delivery systems.

Mr. JINDAL. That is correct. Senator, you know, I applaud you. I know that you've been very willing to work in a bipartisan way to move this thing forward. Today's seniors in America want the drug benefit, and we agree with you.

We obviously believe that a delivery system should preserve within the private sector the innovations that are happening. We don't want to see something where the government is picking which drugs seniors can receive access to. We think it's better to give seniors options and want them to decide, and their doctors to decide, which medicines they get.

Like you, we also agree it doesn't make any sense to wait and continue fighting. The drug card is something that can be done right away. The low income assistance program is a program that can be done right away, as the Medigap options. Pharmacy Plus has already provided drug coverage to 800,000 seniors and will probably serve several more.

The Medigap reforms I am talking about can provide coverage for another 1.5 million seniors, including half of them whom that don't have coverage today. The low income program can provide coverage to 3 million seniors.

The drug discount card can provide 15 to 35 percent discounts to every senior. None of these is a substitute for comprehensive coverage. But you're absolutely right; that is one way we can take some immediate first steps while we put in place the more comprehensive coverage that serves every senior.

Senator SMITH. Just so you all know, the way I evaluated two bills and, frankly, the reason I supported the compromise, was my democratic colleague, Bob Graham. The democratic bill had two major flaws.

I don't have a problem with Medicaid or Medicare being the delivery system, frankly. It can work, and so can the other way. But it had two horrendous flaws. It was very open-ended in terms of availability and very little in terms of deductibles and things like that of requirements on Medicare.

But it was sunseted—I mean, the program ended in 7 years. Moreover, it had a formulary in order to control the cost that was

so limited that it only offered 10 percent of current available prescription drugs. That's all you could get.

I voted against that bill for that reason; in particular, the gimmick of the sunset, No. 1, and, frankly, a formulary that said the government was substituting its judgment for the prescriptions you need for that of your doctor. So I found that that policy was just wrong. It was very limited.

The Republican version, the version used in a private sector delivery, had a much more generous formulary system and ultimately left more discretion to you and your doctors to get what you need.

So these are the tradeoffs that you get, unless you're prepared to say everything is free, in which event, we're really fooling you. You've got to draw some lines, and this is the fight between the two contending views. But the frustrating part is that we're close, and we ought to get it done in this Congress and not the next.

Bobby, before I let you go, I have a couple other comments. Ron Wyden and I have been fighting pretty hard to get additional money for the Medicare+Choice program, and that's something that is very popular in Oregon. I wonder if the Bush Administration will support additional funding for that.

Mr. JINDAL. Absolutely, and we do applaud you and your fellow Senator from Oregon for doing that and for sending a letter to Senator Daschle and others. As part of the Administration's 2003 budget, we ask that Medicare providers be reimbursed in the budget in a neutral way, so that any additional spending will go to benefit beneficiaries.

One exception that we made was to say that we do think there needs to be additional funding for the Medicare+Choice program to stabilize enrollment and to provide those options that seniors want. I am not saying that everybody will want that and that anybody should have to be forced to choose that, but rather to say, for seniors that want those choices, they should have those choices. They should have those choices.

We do support efforts to stabilize that program. Since 1998, up until 1998, the program was flourishing, it was growing, providing more and more options, low premium programs, no premium programs for prescription drug coverage.

Since 1998, since those changes in many counties, these programs have received 2 percent updates per year. Anybody that has been reading the newspapers, anybody that's been watching the news, knows that medical inflation has been growing at a much higher rate than 2 percent per year.

So when you look at the cumulative effect, we had plans over the last several years that maybe received 11 percent inflation updates, whereas the government program received much more than that.

So all we're saying is, let's simply balance the playing field. Let's give those clients additional resources so they can continue offering preventive services and lower payments for seniors.

Senator SMITH. Bobby, has the Administration done any estimating in terms of savings to Medicare in terms of hospital costs with the addition of a prescription drug benefit? I would be interested to know what those savings are. The way these plans were costed out, they ranged anywhere from $370 billion over 10 years to $570

billion. But, in truth, one plan was probably a trillion dollars over 10 years, if the real costs were totaled up.

So I guess my question is, OK, those are potentially the costs. What are the savings? Do you have a calculation there?

Mr. JINDAL. I think you're absolutely right to ask that question. Part of the rationale in the Pharmacy Plus is we're allowing States who serve already 800,000 seniors and a lot of additional States to serve more. We know if we provide prescription drug coverage, we will keep seniors out of hospitals, out of nursing homes with a more comprehensive Medicaid package.

Up until now it's been all or nothing. You needed every benefit and you had to spend down into poverty or you'd get no assistance. Well, we're telling States it's more cost effective for the government to provide prescription drug assistance to help keep seniors out of the nursing homes, out of the hospitals, and living in the community.

In terms of the more comprehensive Medicare benefit, I know this is an issue that's been debated frequently by government actuaries and nonpartisan actuaries that do these form of estimates for Republicans and Democrats both. They continue to go back and forth on this question that I am exploring.

The Secretary is a strong believer—for example, not only will prescription drugs have some offsetting savings in other parts of the program, but adding things like preventive benefits will also have savings, doing things like allowing seniors to have free access to these types of screenings. The house added an upfront physical if you join the program, so your doctor can get an assessment of services you might need.

He's a strong believer that prevents other health care spending. This contingency is a source of debate. What other nonpartisan experts look at, they've never given us a tremendous number of savings. They've scored, for example, preventive services being quite expensive and will continue to do that.

Senator SMITH. Thank you, Bobby.

Mr. JINDAL. Thank you, Senator.

Senator SMITH. Roy Dancer.

STATEMENT OF ROY DANCER, RETIRED EDUCATOR AND SENIOR CITIZEN

Mr. DANCER. Thank you, Senator, for the opportunity to come and make our presentation.

My name is Roy Dancer, and I reside at 108080 Southwest Davies Road, Beaverton, OR, 97008. I was born in Oregon, I was raised in Oregon, I was educated in Oregon, and I have lived in Oregon my entire life. I am 76 years old, and I reside at Hearthstone and Murray Hill with 165 other senior citizens.

In the last 2 weeks, I have gone around at both lunch and dinnertime and visited with every table in the lunchroom and the dining hall of both the assisted living and the independent living, and my comments today are made from those observations and conversations with my fellow senior citizens.

I am certain that I speak for many of them this morning regarding the high cost of prescription drugs and how it has greatly impacted their standard of living. My wife is 77-years old. I didn't

mean to point out that I married an older woman, but she is 5 months older than I am.

Senator SMITH. You may not make that 50 years after all.

Mr. DANCER. I think she has her cane with her this morning.

I have heart disease which has resulted in numerous surgeries, including several angioplasties and two triple bypass, one 2 years ago in October, plus I have ulcers. My ulcer is kept under control by a prescription drug twice per day at a cost of $121 per month. Currently I am taking eight prescription drugs daily. I am far over the average that you found earlier.

My wife, Betty, is being treated for her high blood pressure, her diabetes, and her arthritis. Betty's drug prescriptions are also sky high. Betty and I spent over $5400 last year, as documented on our Federal income tax, over and above insurance. This was an out-of-pocket expense. Betty has Blue Cross HMO, and I have Medicare and an ODS supplement. The $5400 was over and above insurance. I don't know what people do without insurance.

I have talked to residents throughout our retirement community, and I discovered several of them have out-of-pocket expenses for prescription drugs which have exceeded $5,000 last year. I thought we were the only ones; we're not. I talked to one resident last week who has drug expenses which exceed $700 per month, and she has no insurance.

Three years ago when we were in Arizona visiting our daughter and family, Betty and I traveled to Mexico to buy prescription drugs and found them to be much cheaper. For example, my wife had paid $320 for a 3-month supply of two of her drugs here in the United States. In Mexico she bought a 6-month supply of not only those two drugs but six other prescriptions for $340. We're wondering why the difference between Mexico and the United States.

Carol Wiley, a 63-year-old cancer patient, saves over 80 percent of the retail price of her drugs by ordering from a Canadian mail order company. Carol buys one drug, which costs $52.50 U.S. money for 100 tablets of 20 milligram tablets. Portland area pharmacies charge her $300, six times that amount, for 100 tablets.

This is related in the Northwest Senior Life, August 2002, page 30. The Hillsboro Argus reported last week that prescription drugs had gone up over 30 percent in the last year, much higher than the cost of living.

Oh, a member of our community came up to me this morning and told me that she had ordered a drug 2 months ago, got a 60-day supply, went to reorder it yesterday, and the increased cost of the same drug, same company, had gone up 10 percent in 2 months. That's 10 percent in 2 months, 30 percent over the course of the year.

For us senior citizens who are on a fixed income, it is imperative that Congress give us major relief on our prescription drugs now. Thank you.

[The prepared statement of Mr. Dancer follows:]

Testimony of Roy Dancer
Retired Educator

U.S. Senate Special Committee on Aging
Beaverton, Oregon
August 15, 2002

My name is Roy Dancer and I reside at 10880 SW Davies Rd. Beaverton, Oregon 97008. I am 76 years old and I reside at Hearthstone at Murrayhill with 165 other senior citizens. I have visited with many, many of the residents and I am certain that I can speak for many of them regarding the high cost of prescription drugs and how it impacts their standard of living.

My wife is 77 years old and has diabetes and high blood pressure. I have heart disease, which has resulted in numerous surgeries including 6 stents, several angioplasties and two triple bypasses plus ulcers. My ulcer is kept under control by a prescription drug twice per day at a cost of $121 per month. Currently, I am taking 8 prescription drugs daily—furosemide, predisone, sotalol, prevacid, zestril, metocyopramide, flomax, ifedipine, and 2 baby aspirin.

My wife, Betty, is being treated for her high blood pressure, her diabetes, and her arthritis, Betty's drug prescriptions are also sky high. Betty and I spent over $5400 last year as documented on our income tax. This was out of pocket expense after insurance. Betty has a Blue Cross HMO and I have Medicare and an ODS supplement. I have talked to residents in our retirement community and I have discovered that several of them have out of pocket expenses for prescription drugs that exceed $5000 per year. I talked to one resident last week who has drug expenses, which exceed $700 per month with no insurance.

Three years ago when we were in Ariz. Betty and I traveled to Mexico to buy prescription drugs and found them to be much cheaper. For example my wife had paid $320 for a 3-month supply (after insurance) for mevacor and prilosec in the U.S. In Mexico she bought a 6-month supply of nevacor, prilosec, plus triametene, vasotec, and premarin for $340.

Carol Wiley, a 63-year-old cancer patient saves over 80% of the retail price of her drugs by ordering from a Canadian mail order company. Carol buys Tamoxifen, which costs $52.20 US money for 100 of the 20-mg. tablets. Portland area pharmacies charge her
$300, 6 times that amount for 100 tablets. (Northwest Senior Life, August 2002 page 30).

For senior citizens on a fixed income it is imperative that the government gives us some relief on out prescription drugs.

Senator SMITH. Do you think your experience that you've just testified to is not just your experience but everybody you live with at the center?

Mr. DANCER. Yes. As I said, I went around and visited every table in both the assisted living and the independent living, got ideas from them, and talked to them about the cost of their drugs. You know, I went to a table and said, what do you think about the high cost of prescription drugs? I went down like you did and said, how many of you spent over $100 last month? Then when I got to this $700, I almost fainted.

Senator SMITH. You know, I think one of the factors of the debate between Canada and Mexico versus us, we just have to admit and understand as American people that the pharmaceutical industry is located in the United States, not in other countries. Even foreign developers, they come here for the simple reason that we are not a socialist system in terms of producing pharmaceuticals.

As a result of that, there is still a profit motive that is there. There have been abuses by pharmaceutical companies in terms of patents and things. We passed a bill to stop those before we left Congress. We hope that gets out of conference and the President signs it. We're certain he will.

There is also another, yet another bill, in terms of re-importing from Canada or Mexico, drugs that they buy through their national governments. There is one side of this story that everybody ought to understand. You can go to Canada or Mexico to buy some drugs; you cannot go there to buy all drugs. Because their governments, frankly, are riding on the back of our private industry to buy in volume what they approve on their formulary, and I don't know how expensive their formulary is.

But the other untold story is of Canadians coming to America to buy the miracle drugs because their government, through their taxpayers, do not buy those drugs. So you and I—unfortunately, are bearing the burden of other countries who buy in volume or, through their provinces, large amounts of a number of prescription drugs.

We buy individually or through our insurance plans. What we have to do is simply figure out how to better pool, either through Medicare or insurance companies or larger groups, ways to buy a generous enough group of drugs under a formulary that would cover 90 percent, not 10 percent of your needs.

In answer to your question, why the difference, that is the difference, and we are on the case. We've got to finish the deal.

Thank you very much for your excellent testimony.

Senator SMITH. Now, we will invite our second panel forward. We'll begin with Ms. Lydia Lissman, Assistant Director for seniors and people with disabilities for the Oregon Department of Health Services.

Ms. Lissman, better than anyone else I know, can describe the characteristics and demographics of seniors in Oregon, as well as future trends. Ms. Lissman, the committee welcomes you, and thanks you for being here.

Our final witness will be Dr. Michael Kositch. Dr. Kositch is the Medical Director of the operations and primary care services at Kaiser Permanente Northwest. Dr. Kositch will address the clinical

aspects of prescription drug use and the availability of Medicare benefits, beneficiaries for Medicare+Choice enrollees at Kaiser Permanente.

Dr. Kositch, the committee also welcomes you. But Ms. Lissman, we'll start with you.

Ms. Lissman. Thank you.

STATEMENT OF LYDIA LISSMAN, ASSISTANT DIRECTOR, OREGON DEPARTMENT OF HUMAN SERVICES, SENIORS AND PEOPLE WITH DISABILITIES

Ms. LISSMAN. Good morning, Senator Smith. I am Lydia Lissman, Assistant Director for the Oregon Department of Human Services, and I am responsible for the statewide programs and policies for seniors and people with disabilities.

I am also the Director of the State unit on aging, responsible for programs and services that are provided through the Older American Act.

First of all, Senator Smith, before I begin with my testimony, I would like to thank you for your efforts to increase the Federal medical assistance percentage as a part of the prescription drug initiatives considered last month in the Senate.

As you know, Oregon's economy lags severely behind many other States, while the demand for human services has been on the rise, so we sincerely appreciate your recognition of this reality.

I also want to thank you today for holding this field hearing to look at the impact of prescription drugs on Oregon seniors. My written testimony today touches on a number of issues, and I am going to limit my remarks this morning to a couple of things.

I am going to touch upon the demographic issues and changes a little bit on access and payment, and then I am going to talk a little bit about one of Oregon's own efforts to better serve seniors in the area of prescription drugs. Last, but not least, I will offer a few recommendations that will echo what you have heard from the first two presenters.

Seniors represent a very large and growing portion of Oregon's population. Between now and the year 2030, our State will experience an unprecedented shift in the age of our population. According to the U.S. census in the year 2000, the population in Oregon that was 65 or over the age of 65 was nearly 13 percent of the total Oregon population. That is a little bit higher than the national average, which is just over 12 percent. But what is significant is that by the year 2030, which really isn't that very far off, the senior population will comprise more than 20 percent of the Oregon population.

What's really important to know about now is there are areas of Oregon, counties in Oregon, that are already at or above 25 percent of their population being the age of 65 or older. There are areas that are seeing very rapid growth. Some of those include Coos, Curry, Jackson, Josephine, and Deschutes counties. In those areas, we have fast approached that point.

Senator SMITH. So 25 percent are at 65 and older in those rural counties?

Ms. LISSMAN. They are getting very close to that, yes, in those rural counties. Because we have had unprecedented growth, and

some of these areas have been very popular areas for seniors to either locate in for retirement, or they have been areas where, in fact, the population is simply aging. We don't have as many young people coming into the area or people staying in the area, which is, in part, reflective of the economic environment that we have.

Senator SMITH. Maybe housing and fixed costs like that, are cheaper there, so they are not coming, moving to populated areas.

Ms. LISSMAN. Those are some of the issues, as well. So in some of the areas we have people staying. But again, because of the economic issues, families are not moving into those areas, so the proportion of the population that is older is disproportionate to other areas.

Medications play a very crucial role, as you've heard today, in maintaining and managing the health of Oregonians and, in particular, seniors. I think the last presenter certainly illustrated that.

Slightly more than 37,000, out of a total of 438,000, seniors in Oregon receive Medicaid. I think people are aware of the very low standards of income and assets to qualify for Medicaid. While seniors represent about 8.9 percent of the total number of Medicaid recipients in Oregon, this group accounts for 23 percent of all the Medicaid pharmacy expenditures in this State.

It is estimated that slightly over 30 percent of all the seniors in Oregon have income below 200 percent of the Federal poverty level. That is a significant number. I think, again, this is reflective, in part, of the cost of living increases we've seen over time, inflation.

Senator SMITH. Can you state that number again for the record, please?

Ms. LISSMAN. Slightly over 30 percent of seniors in Oregon have incomes below 200 percent of the Federal poverty level.

Senator SMITH. You know, it's interesting. The bill Senator Graham and I produced, it covered seniors at 100 percent of coverage. Below 200 percent of poverty, the average in the Nation is, it would have covered about 47 percent of seniors. Nearly half of seniors live at 200 percent below the poverty level, which is pretty remarkable, actually. We're relatively better off than many other places in the country.

Ms. LISSMAN. There are several major issues that affect seniors and their access to vital prescription medications, and you've heard about a couple of those today.

Again, I have some information in my written testimony, but certainly access and ability to pay is a significant issue, and I am going to talk a little bit more about that. But medication management, chronic disease self-management, and medication administration are very significant issues, and those also have been mentioned.

What I would say about the access and cost is that seniors make a lot of dangerous choices in Oregon, as they do in other places, because of the expense of prescription drugs. Some of them forego even filling prescriptions or they forego some of these prescriptions that are newer prescriptions and perhaps more costly and have a significant impact on the quality and length of their lives.

They skip dosages or they reduce dosages or they try cheaper remedies. Noncompliance with what a physician indicates is re-

quired for their prescriptions results in very poor health outcomes, and those range from progression of a chronic disease to increase in preventable complications and disability.

Let me tell you from a State's perspective, as has been mentioned, and as you yourself mentioned, Senator Smith, it not only results in a very significant impact on the quality of lives, but on loss of productivity and on the increase of costs as a result of avoidable hospitalizations and premature need for long-term care services.

Certainly what I hear from our field offices is that we see people who come into the long-term care system because their condition has degenerated as a result of either the lack of appropriate use of prescriptions or the lack of prescriptions, and those are very significant issues. This increased cost is borne by both the public and private sector, so there is definitely a shift of cost related to this.

What I would like to talk about now, very briefly, is one of the efforts that Oregon is making to seek some solution, but I also want to point out there are some real limitations to this solution. In the last Oregon legislative session in 2001, the Oregon legislature authorized a senior prescription drug program.

This is a program that seniors will be able to apply for. It's hoped that it will become available and implemented in November of this year. It's a one-page application, and, for a $50 fee, Oregonians over 65 with incomes less than 185 percent of the Federal poverty level will be able to purchase their medications at the current Medicaid rate.

The current Medicaid rate is 100 percent of the average wholesale price minus 14 percent, so that will be available to Oregonians. We estimate that somewhere around 100,000 seniors may be eligible.

But the important thing here I want to point out is that there is also an asset limitation, and it mirrors the asset limitations for Medicaid that's $2,000. That's a very small amount of assets. It does not include your home or vehicle, but that is not very much in terms of——

Senator SMITH. Anything above that disqualifies you?

Ms. LISSMAN. That's correct.

Senator SMITH. So 200 percent of poverty is——

Ms. LISSMAN. 185 percent for one individual senior would be roughly $1,366 a month gross.

There are a number of other things. But first, let me move now to my closing remarks, which would be the things that, from my perspective, I really want to encourage the Special Committee on Aging to pursue. Certainly foremost is the coverage of prescription medications through the Medicare program.

This is extremely important to maintaining the health of our aging Oregonians and to reducing both the Medicare and Medicaid acute and long-term care costs. We encourage you to support Medicare coverage for medication and chronic disease management that has been mentioned previously, and we encourage you to urge the pharmaceutical industry to consolidate and simplify and provide outreach for their reduced cost of medication programs.

I want to acknowledge that they do have these programs, and I want to acknowledge our Area's Agencies on Aging who really

make every attempt to connect our senior population with those programs. But much more needs to be done in that arena, and there's certainly not funding locally to support that.

I want to encourage the committee also to seek and, where possible, fund solutions to what is a crisis in this country, a growing crisis, around the work force shortage of nursing and other caregivers. Very important.

Also, it's important to support those efforts that are being made around national caregivers and family caregivers for our aging population; and last, to fund Medicare coverage of technology. There's terrific new technology that's emerging in the area of medication and administration, including the smart pill bottles, and technology that can remind people to take medications that are very important for seniors to remain safe and independent.

I want to thank you for the opportunity to share my thoughts on this challenging issue, and I want to commit to you that we look forward to working with you and our other Federal partners to identify solutions to what is a very difficult and challenging problem that is very much to the hearts and minds of our senior population here in Oregon.

[The prepared statement of Ms. Lissman follows:]

Testimony of Lydia Lissman, Assistant Director
Oregon Department of Human Services, Seniors and People with Disabilities

Before the US Senate Special Committee on Aging
Field Hearing
Beaverton, Oregon

August 15, 2002

Good afternoon, Senator Smith and Senator Wyden. I am Lydia Lissman, Assistant Director for the Oregon Department of Human Services with responsibility for program and policies for Seniors and People with Disabilities. I am also the director of the State Unit on Aging and programs and services provided through the Older American Act.

First of all, Senator Smith I would like to thank you for your efforts to increase the Federal Medical Assistant Percentage as part of the prescription drug initiatives considered last month in the Senate. As you know, Oregon's economy lags behind many other states, while the demand for human services has been on the rise. We appreciate your recognition of this reality.

Thank you also for today's field hearing on the impact of the cost of prescription medications on Oregon's seniors. Among its many programs, the Oregon Department of Human Services serves low income Oregonians through Medicaid and the long-term care system, including home and community based services.

My testimony touches on the following issues facing Oregon's seniors and policy makers: demographic changes, access and payment, medication management, chronic disease management, and Oregon's own efforts to better serve seniors. I will offer a few recommendations for the Committee to consider as it develops its own proposals in this important area.

Seniors represent a large and growing portion of Oregon's population. Between now and 2030, our state will experience an unprecedented shift in the age of our population. According to the US Census, in 2000 individuals 65 years of age and older comprised nearly 13 percent of Oregon's population. This places the state slightly higher than the national average of just over 12 percent. By 2030, seniors will comprise more than 20 percent of the state's population. Certain counties

such as Coos, Curry, Jackson, Josephine and Deschutes have already seen a dramatic increase in the older population. In some areas, seniors already make up 25 percent of the total county population.

Seniors are living longer, too. By 2030, the 85-plus-age cohort is projected to increase from 1.7 percent of the overall population to nearly 3 percent.

Medications play a crucial role in maintaining and managing the health of many Oregonians, especially seniors. Slightly more than 37,000 out of a total of over 438,000 seniors in Oregon receive Medicaid. Seniors represent 8.9 percent of the total number of Medicaid recipients, while this group accounts for 23 percent of the state's Medicaid pharmacy expenditures. It is estimated that slightly over 30 percent of seniors in Oregon have incomes below 200 percent of the Federal Poverty Level.

Three major issues affect seniors and their access to vital prescription medications:

1. **Access to prescription medication and the ability to pay.**
   Despite the increasing role of pharmaceuticals in the maintenance of health for Oregonians, many seniors find themselves unable to afford the very medications that prolong their life. According to a study published in *Health Affairs*, February 2002, 38 percent of Medicare beneficiaries who were not institutionalized lacked prescription drug services, while 45 percent of those in the 85 years and older cohort lacked drug coverage. Seniors with supplemental health care coverage that includes prescription drugs still incur significant out of pocket expenses due to the number of medications and substantial cost sharing in these plans.

   Anecdotally, seniors speak of difficult choices. Should their limited resources go to medications or other necessities, such as housing, heat or transportation? Anecdotes also describe an increasing use of credit cards by seniors struggling to pay for needed medications.

   To control expenses, seniors can make some dangerous choices. Some individuals forgo certain costly prescriptions, skip doses, reduce doses or try cheaper remedies. The noncompliance results in poor health outcomes ranging

from progression of chronic diseases to increases in preventable complications and disabilities.

From a state's perspective, this not only results in loss of productivity, but increased costs as a result of avoidable hospitalization and premature need for long-term care services. These increased costs are borne by both the public and private sectors.

2. **Medication Management and Chronic Disease Self Management**
Seniors are more likely to take multiple medications and their physiology makes them more likely to experience drug interactions and side effects. According to research from the Henry J. Kaiser Family Foundation, 55 percent of Americans over the age of 65 take three or more prescription drugs on a regular basis and 40 percent had more than five prescription drugs in their medicine cabinet.

Medication overuse and misuse results in hospitalization, declining health, falls, and other complications. Multiple prescribers, use of old, discontinued medications, and unclear/misunderstood/forgotten instructions often contribute to the problem. Programs that allow seniors to bring all their medications to a pharmacist for review and similar interventions (pharmacy hot-lines) can improve the health and well-being of seniors and reduce costs through effective use. Good medication management can reduce hospitalization rates, the need for long-term care, and decreases visits to the physician.

However, adequate medication management is only half of the solution; another key component is chronic disease management and consumer education. When people have the skills and supports to manage their own chronic disease, not only are resources more effectively used, people remain healthier and more satisfied. In one study (*Medical Care*, 1999), subjects of a chronic disease management program demonstrated significant improvements in exercise, cognitive symptom management, communication with physicians, self-reported general health, health distress, fatigue, disability, and social/role activities limitations. They spent fewer days in the hospital and there was a trend toward fewer outpatient visits and hospitalizations. The data indicate that each dollar invested in such efforts results in $10 of savings.

3. Medication Administration
As Oregonians age, many lose the skills to safely administer their own medication. Loss of ability to administer medications is a major reason for an individual to be placed in an institutional or community based care setting.

Current Actions in Oregon
While Oregon's efforts do not approach a solution, there are a few efforts that hold the promise of helping Oregonians safely get the medications they need at a price they can afford. Such programs include:

1. **Oregon Senior Drug Program.** In 2001, the Oregon Legislature authorized the Senior Drug Program. With a one-page application and a $50 fee, Oregonians over 65 years with incomes less than 185 percent of the federal poverty level will be able to purchase their medication at the current Medicaid rate.
2. **Reduced-cost medications.** Over the past year, the number of reduced-cost pharmaceutical programs has expanded. However, the rules for each program are complicated and applications can be difficult for seniors. State and Area Agency on Aging case managers often help seniors complete the applications.
3. **Brown Bag Drug Reviews.** Seniors can bring all their prescription medications to volunteer pharmacists for review. These programs are very limited and have no ongoing support.

Recommendations
We recommend to the Special Committee on Aging the following:

- Support the coverage of prescription medication through the Medicare program. This promises to improve the health of senior Oregonians and reduce both Medicare and Medicaid acute and long-term care costs.
- Support Medicare coverage for medication and chronic disease management.
- Urge the pharmaceutical industry to consolidate, simplify, and provide outreach for their reduced-cost medication programs.
- Seek and fund solutions to the national workforce shortage of nursing and other caregivers.

- Fund Medicare coverage of technology that assists with medication administration, such as "smart pill bottles" which remind people to take their medications and track actual medication usage.

Thank you again for this opportunity to share my thoughts on this very challenging issue. We look forward to working with you and our federal government partners to identify solutions to the very difficult problems that affect senior Oregonians.

Senator Smith. Lydia, thank you, for your excellent testimony. The point of this hearing is to get an Oregon perspective on the prescription drug issue, and you did that very, very nicely.

Dr. Kositch, welcome. It is nice to have you here.

STATEMENT OF MICHAEL KOSITCH, M.D., MEDICAL DIRECTOR FOR PRIMARY CARE SERVICES, KAISER PERMANENTE NORTHWEST REGION

Dr. KOSITCH. Thank you for the opportunity to speak to you today about the role of prescription drugs and health care needs of our Oregon senior citizens.

I have been in the practice of medicine for over 15 years here in Oregon, and I am certified in both internal medicine and geriatric medicine. I work with Kaiser Permanente Northwest, which is a fully integrated health care system that operates in Portland and Salem in Oregon, as well as Southwest Washington.

Our regional membership is 450,000. 225,000 members live in Oregon and 128,000 are in Washington. Among those members we have 46,000 Medicare members, 42,000 enrolled in our Senior Advantage, our Medicare+Choice program, and also 4,000 in our Senior Advantage II, our social HMO program.

In the early part of the 20th century, discovery of the first effective antibiotics was the beginning of the development of effective medical prescriptions as a fundamental tool in providing quality healthy care. Now, medications are very much the cornerstone of nearly all medical care, particularly for the elderly who struggle with a large number of chronic illnesses.

Innovations in pharmaceuticals over the last half of the last century have contributed to a substantial increase of lifespan and an improved quality of that longer life for all Americans. In the 20th century, prescription drugs are now irreplaceable tools that physicians use in the treatment of acute and mostly chronic illnesses affecting the disabled and those over 65. I believe that the medications enable practicing physicians to shorten the hospital length of stays and, in some cases, eliminate need for hospitalization. For example——

Senator Smith. Do you have a number on that, a percentage?

Dr. KOSITCH. No, I think it's too hard to separate it from everything else that's gone on with diet and exercise in our society, and to attribute it all to one cause is unfair.

Senator Smith. But it's reasonable to deduce from that there would be some savings on hospital and other acute care?

Dr. KOSITCH. Yes, on an annual basis. The quandary is is that we will lengthen people's lives. If you lengthen people's lives, they will use more health care. I can tell you individuals may use more costs over the rest of their lives, but I can tell you individuals will use less cost in a given year.

An example along those lines is, 40 years ago, a 65-year-old man who suffered a heart attack, a myocardial infarction, frequently was hospitalized for 3 weeks and usually was unable to resume work or any—he was advised not to do any physical activities at all recreationally.

Now, many times that person doesn't have that heart attack or has it much later in life. If they have that heart attack, they might

expect only 3 to 6 days in the hospital, and they have a very good expectation of eventually resuming a level of activity similar to what they had before.

As with any tool, these prescriptions, to be effective, have to be used according to specific instructions. Dosage strength, frequency of admission, and the duration of treatment all are key in predicting the benefits. When any of these parameters are changed or interrupted, the expected outcome will be altered and may not be achieved at all.

That means that the benefits that patients take their medicines for may not ever occur. Compliance with the drug administration is important to getting those successes. But when a barrier exists to the use of prescription drug medicines, high quality effective health care that is available in the 21st century is compromised.

Among senior citizens, the most disturbing barrier for prescription drug usage is the financial cost. The difficulty in admitting patients to obtain these benefits creates an inability to get the services that we can give them in modern medical care. Patients are frequently having to choose whether they can afford their medicines.

This problem exists in Oregon as well as throughout the country. Seniors choose either to forego the prescribed medicine altogether, or they make choices about which medicine to fill, sometimes eliminating the medicine that has the most benefit for preventing future complications in favor of one that is either more affordable or one that perhaps minimizes their symptoms.

Many of these patients, as a result, may live in pain, may see their condition not improve as we can hope for, or actually experience a worsening of their condition due to the cost of prescription medicine.

Senator SMITH. Doctor, along that point, I think what we've seen a lot of seniors do is to emphasize what it means when a senior will reduce the dosage, cut it in pieces, stretch it out. What is the impact of that, in your medical opinion?

Dr. KOSITCH. Well, the three most common chronic diseases in our elderly Americans are hypertension, diabetes, and high cholesterol. In each one of those medicines, the benefits of treatment are in many ways proportional to the degree of reduction in the abnormal blood values that they monitor.

So by reducing your dose in half, crudely, one can say you're getting half the benefit. It's better than nothing, and I am thankful that they do take some. But there are more opportunities for it improving the health, delaying first major events, and improving the quality of that longer life, as well.

Senator SMITH. In the converse of that, my wife always tells me, if one works, that doesn't mean two works better.

Dr. KOSITCH. I do encourage my patients, as your wife does, to talk to their doctor first before making that change.

Now, I am proud to report that for Kaiser Permanente members here in Oregon and Washington, the situation may not be quite as bad as it is for many other Americans, because both of our Medicare+Choice plans offer a prescription drug benefit and always have since the early 1980's when these programs were first offered.

It is the policy and practice of Kaiser Permanente Northwest to offer a comprehensive health plan, and the definition of a comprehensive health plan includes some prescription benefit. As a physician, I work at Kaiser Permanente because I knew an inability to use prescriptions would effectively tie my hands in helping patients.

In our standard plan, prescriptions are covered at a 30 percent benefit, and the out-of-pocket outlay for a member is capped, so they would pay no more than $75 for one prescription.

In our social HMO, Medicare+Choice program, Senior Advantage II, we offer one of the most comprehensive programs in the Nation. A member only pays a $10 copayment for generic and a $20 copayment for brand name drugs. There is not an annual drug dollar limit on the pharmacy benefit, and it does not expire.

Last, I would like to thank you, Senator Smith, for introducing Senate bill 2782 to propose making Senior Advantage II a permanent rather than a demonstration project. In many ways, the social HMO is the preferred health care model for the future, I believe, and I thank you for your foresight in leadership in converting this product from a time-limited demonstration product to perhaps a permanent offering for all Oregonians.

[The prepared statement of Dr. Kositch follows:]

Testimony of Michael Kositch, M.D.
Kaiser Permanente Northwest Region

Senate Special Committee on Aging
"Expanding and Improving Medicare: Prescription Drugs – An Oregon Perspective"
August 15, 2002
Portland, Oregon

Mr. Chairman, thank you for the opportunity to speak to you today about the role of prescription drugs in the health care needs of Oregon's senior citizens. I am Michael Kositch, MD, Medical Director for Primary Care Services, with Kaiser Permanente's Northwest Region. I have been in the clinical practice of medicine for over 15 years and am board certified in both internal medicine and geriatric medicine. Kaiser Permanente Northwest is a fully integrated health care system that operates in the Portland and Salem areas in Oregon as well as southwest Washington. Today, our total membership is approximately 453,000, with 225,000 members in Oregon and 128,000 members in Washington. Among those members, we serve 46,000 Medicare members, 42,000 are enrolled in Senior Advantage, our standard M+C plan and 4,000 in Senior Advantage II, our Social HMO.

In the early part of the 20th Century, the discovery of effective antibiotics was the first step in the development of medical prescriptions as a fundamental tool in providing high quality medical care. Today, medications are very much the cornerstone of nearly all medical care, particularly for the elderly who most often struggle with chronic illness. Innovations in pharmaceuticals over the second

half of the 20th century have contributed to a substantial increase of life span, and improved quality of life, for all Americans. Now, in the 21st century, prescription drugs are irreplaceable "tools" that physicians use in the treatment of acute, and especially chronic, illness among the disabled and over age-65 patients. I believe that medications enable the practicing physician to shorten hospital lengths of stay, and in some cases eliminate the need for hospitalization. For instance, 40 years ago when a 65 year-old man suffered a myocardial infarction, a heart attack, he frequently was hospitalized for 3 weeks, and thereafter was often unable to participate in employment or active recreational activities for the rest of his life. Today that same individual would expect to spend three - six days in a hospital and lead a functionally normal life for years to come.

As with any tool, for optimal effect and outcome, the instructions accompanying a medication must be followed. A prescription should have very specific instructions for its use. Besides dosage strength, prescriptions indicate a frequency for administration as well as a duration during which the drug is to be taken. When any of these three parameters are changed or interrupted, the expected outcome may be altered or never achieved, the patient's condition may not improve, or may worsen, thereby requiring more health care services. Therefore, patient compliance with prescribed drug administration is very important to achieving the potential successes of contemporary medical care.

Whenever a barrier exists to the use of prescription drug medications, high quality and effective health care is compromised. Among senior citizens, the biggest and most disturbing barrier to prescription drug administration, and thereby improving patient health, is financial. The difficulty of many patients to obtain these medications can be a fundamental barrier to their ability to receive the benefits of modern medical care. The difficulty for patients, particularly the elderly, to be able to afford their prescribed prescription drugs, exists here in Oregon as it does in all other parts of our nation. Seniors may either forego taking the prescribed medication altogether, or only take what they can afford to purchase, thereby compromising their treatment plan. As a result, many of these individuals may live in pain, not see their condition improve, or experience a worsening of their condition.

I am happy to report that for Kaiser Permanente members here in Oregon and Washington, the situation is not that bad because both of our M+C plans offer a prescription drug benefit and always have since the early 80's when we were the first plan offered. Then, and now, it is both the policy and practice of Kaiser Permanente that we only offer comprehensive health benefit plans – and a comprehensive benefit plan includes prescription drug coverage. Otherwise, as a physician, my hands are tied in effectively and efficiently treating my patients. In our standard plan for individuals, prescriptions are covered at 30 percent, yet out-of pocket outlay for the member is capped so they will not have to pay more than $75 per prescription. In our Social HMO, we offer one of the most

comprehensive programs in the nation – a member only pays a $10 copayment for generic drugs and $20 for brand-name drugs. We at KPNW do not place an annual dollar limit on the benefit. It does not expire.

Last, I would like to thank Senator Gordon Smith for introducing Senate Bill 2782 that would make permanent our Senior Advantage II, Kaiser Permanente's Social HMO. The Social HMO is probably the preferred health care model for the future. We thank the Senator for his foresight and leadership in converting this product, unique to our service area, from a time-limited demonstration project to a permanent offering for Oregonians.

I would like to conclude by saying that the care of the elderly revolves around managing, not curing chronic diseases. The problem around the availability and cost of prescription medicines for the elderly is not unique to heart disease. Stroke, lung disease, cancer and most other afflictions of older Americans have treatments that require the daily use of costly prescriptions. The advent of new pharmaceuticals each year presents ever-new hopes for longer and better lives, but the costs of these medicines limit the ability of many older Americans to share in this hope.

Thank you. I am happy to respond to any questions the Committee may have.

Senator SMITH. Thank you, Doctor.

I talked earlier about the delivery system; do you do it through Medicare or do you use private insurance? You work for a private insurance company, an HMO, and a good one, from everything I have ever heard. I am wondering if you think that the private sector can carry this benefit to our Medicare population.

Dr. KOSITCH. Well, it's a complex question. I think either delivery system creates its own complexities. Speaking to your earlier comments, your concerns about a formulary restricted from 90 percent of the medicines is the one that I have concern about. It's quite clear to me that marketing by pharmaceutical companies, that they can drive demand for medications which are more expensive but are not more effective in any scientifically proven way.

In covering 90 percent of the medicines, it looks to me like it's Medicare encouraging that sort of behavior rather than encouraging a cost effective prescribing to be done by physicians and used by their patients. I welcome discussion from my patients when they say, is there another medicine that works as well as that but doesn't cost as much?

I think if you cover 90 percent, there's no incentive for a drug company to create a cost effective medicine, only one that has a good ad budget.

Senator SMITH. That's a wonderful question. Everybody has probably followed the whole debate about formularies and are much more educated than most folks about this very issue the doctor has cited, and it is really one that deserves the best thinking we can put to it.

In my view, 10 percent of available medicine was a fatal flaw of the proposal of the other side and warranted a no vote on my part. But 90 percent, you're saying, is too much. What is, you know, the Goldilocks? What is just right?

Dr. KOSITCH. It's a process rather than a number.

Senator SMITH. OK.

Dr. KOSITCH. We currently don't have a standard, but the FDA could easily be a group that was charged to take evidence based medicine and indicate which medicines are cost effective within a certain range.

I believe the economic forces that drive pharmaceutical companies could cause them to have a certain interest in that. Just as the elaborate rules around patent expiration and extension that you dealt with, a formal Federal review of cost effectiveness would put a counterweight, and what percentage of medication on a formulary—somewhere between 10 and 90 is a fine number with me. It's the process of getting to a second part of the conversation, I think, is a more important part.

Because I can live with even 90 percent if it's 90 percent that an objective agency is looking at and saying, these medicines make sense, not that these medicines just don't hurt you.

Senator SMITH. A formulary should have enough, not flexibility but adaptability that, as new drugs are developed, some can be added and others can be dropped.

Dr. KOSITCH. Absolutely. In our organization, one of my colleagues sits on committees as a physician, and they review dozens of medicines every month trying to understand, is this a new medi-

cine bringing a new benefit? Is this a new medicine bringing the same benefit or more convenience or better cost or better safety, or is this just what we call a me too medicine, another medicine that someone else can put on an ad and have patients say, I want the new thing.

Senator SMITH. Doctor, it's been very, very helpful.

We do have 15 minutes remaining in this hearing, I believe, and so we do have some time for questions from the audience of our panel. We invite the earlier witnesses to come forward, and I will read the questions you've turned in in the order I received them.

So the first one is by Dick Means. Dick says, when doctors prescribe more and when seniors take more than they need, should prescription drugs become a government benefit?

Many of you might have that thought. Would doctors churn this system? Would they give more than the seniors need if the government took it over? In other words, if everything is free——

Dr. KOSITCH. People could take more. Would they take too much? I think it goes to your belief of the human condition. Because I would believe it's always good to have some recognition of the cost. On the other hand, no one likes going up to open up one of those impossible-to-open bottles and taking out one of those impossibly small pills and putting it in their mouth three times a day.

Senator SMITH. The next question is by Phyllis Rand. Will lawmakers act to get a prescription drug benefit in Medicare this year?

I think, honestly, the chance is sort of 50/50, and I will explain why. We are in the middle of a political season. I have been in politics for 10 years, and what I have noticed is that, after each election, when the Congress or legislature goes back into session, there's a window of opportunity where problem solvers can form majorities across the aisle, and you can actually make policy.

As you get closer to elections, politics trump policy. That's an unfortunate thing, but it's part of our democratic process, and it leads to an election that will lead, in some cases, to new players and in a new dynamic that leads you back to making policy.

Having said that, I would say the political imperative on this issue is so acute that I think both sides have incentive to revisit this issue in September. If we do, I think we can get something. We should get something that hits 60 votes in the Senate and then goes to a House/Senate conference, which then works with the White House to come up with a final package, goes to the White House for the President's signature.

I think it's a 50/50 proposition. But if we don't get it done in the 6 weeks of work time remaining, I think at that point the stars will surely align in the President's own reelection effort, and the Congress and the new Members of Congress with the President surely will have to have this resolved on some level.

Anybody want to correct me on that?

Senator SMITH. The next question is from Bobby Jindal. I am sorry if I am mispronouncing your name.

I am fortunate I am not taking prescription drugs at this time. I do receive chiropractic and acupuncture for back pain which is not part of Medicare. But the Medicare claims process is so complex that it can be months before a claim is paid.

That's just a fact. You know, we talk about the complexities of going the private route versus the public route. I mean, Medicare isn't exactly the most efficient system that you've experienced in life, I suspect, and adding to its complexity doesn't mean it's going to get more efficient and better.

But again, it can work. It's just that government works slowly. HMOs and private insurance can work. But then you've got a gatekeeper in the private sector with a financial incentive to say no. It can work, but it's frustrating to seniors. Again, these are the tradeoffs we're wrestling with.

Is there any hope that Medicare claims can be simplified, and can coverage be extended to cover acupuncture and other alternative treatments?

I think, Bobby, you're the one to answer that. You represent the Secretary of Health and Human Services.

Mr. JINDAL. Sure. I would say two things about that. First, in terms of simplifying the claims and speeding up payment, there was a bipartisan bill that actually I think was approved—if not unanimously, with one or two exceptions—out of the House of Representatives that's intended to modernize and streamline the Medicare program; to do things like encourage electronic billing and electronic payment, speed up the process. It has bipartisan support and that of the Finance Committee, as well. So we do anticipate that reaching the President's desk.

However, I think that the woman with the question, the person who wrote that question, reaches a more profound point, which is, the CEO of the Mayo Clinic, counted 130,000 pages of rules and regulations in the Medicare program. He basically testified that the Medicare commission in the Congress, that's the fundamental challenge for providers and beneficiaries staying in the program.

Senator SMITH. How many pages?

Mr. JINDAL. 130,000 pages.

Senator SMITH. That's bigger than the Bible.

Mr. JINDAL. Sir, I don't believe anybody in Washington has 130,000 pages of things to tell the Mayo Clinic on how to practice medicine or provide health care. So there's a question of, what is the best way to make the program more flexible and responsible?

When you look at the history of the program, it has never been particularly aggressive in adding benefits. Whether it's been preventive services, immunizations, or other services, it's really lagged behind the private sector.

One of the reasons the Administration was very encouraged by that tripartisan approach—one of the things I should have said, because Senator Breaux is chairman of this panel, you know, and we encourage the work that he has done with Senator Jeffords and other members of the Senate, including your support is to encourage the use of private plans and private options.

Historically, those private plans are much more nimble and much more quick and responded much more quickly to these seniors and adapted new preventive services. So probably the best way for Medicare to add new benefits and be more responsive in the marketplace is to give seniors more choices. What we have seen does not work is to allow the Federal Government to make those

decisions. It is a very political process and very slow process when that happens.

Senator SMITH. I appreciate those comments. Hopefully we'll get that to the President, and we can at least bring Medicare billing up to today's technology and make it work.

Next is from Naomi Ballard. She writes, increasingly physicians in Washington County are opting out of Medicare. This limits access to Medicare. What plans are being made to alter this trend?

Again, that goes back to Bobby.

Mr. JINDAL. Sure. There's something called the sustainable growth rate, one of these complicated formulas used by Medicare, to reimburse physicians. Back in 1998, 1999, everybody agrees there were some mistakes built into a formula which resulted in last year almost a 5 percent decrease in Medicare payments to doctors. This year there will be another decrease and, until we fix it, it will continue to have decreases.

Now, the Administration, we consistently think any new spending should benefit the beneficiaries. We've been firm to say, we want the first thing that Congress does is to have a prescription drug benefit. We've also said of the providers, we absolutely do think that the physicians do make a good case and have presented convincing data.

We need to do something to help our physicians. I think everybody agrees that we needed to do something to adjust the formula to acknowledge that.

Senator SMITH. Very good.

Jacqueline Stoble writes, most times patients are forced to use generic drugs. Many times generics are not quite the same. If you can't tolerate generics, will you be denied brand medicines?

In all of the plans that I have seen, both are offered. Generics come at a lower copay than the brand, which has a higher copay. Instead of 2.50, it's like a $5.00 copay. So it's not substantially more, but they are available.

Mr. JINDAL. Senator, also remember, in the tripartisan and other bills, it was also an option for medical appeals that if you and your doctor certify that the patient has a clinical reason for a drug, that there will be a way to cover that drug. So you're absolutely right.

Senator SMITH. This is a question for you, Bobby. You're on the hot seat right now.

This is from Mary Ann Warhol. Mary Ann writes, many believe that the universal health care, such as Hawaii's, which includes a prescription drug benefit, is the best long-term solution for Oregonians. Do you support this notion? Why or why not?

Mr. JINDAL. Two things. One, I work for a Secretary that used to be the Governor of Wisconsin who, in turn, worked for the President, who used to be the Governor of Texas. Both of them are very eager to give their fellow Governors and their States more flexibility for programs.

Almost 2 million people have additional benefit and additional coverage. Almost 5 million people have gotten additional benefits, simply by the Secretary saying, we want the States to have the flexibility. They receive Federal assistance. We want them to have flexibility. We don't want them to be tied up in red tape.

The Secretary supports giving States more flexibility to be the innovators, the ones blazing new paths to show how health care can be more efficient. The second aspect of that question deals with universal care. It is one of the challenges facing our health care system. We have 38.7 million uninsured. That number only dropped in the last 2 years and probably will increase now, despite 10 years of rapid economic growth.

By having that many uninsured, you have individuals who are not getting access to preventive care, but are going to the emergency room. They are shifting costs to other individuals, and so they're receiving the more expensive, least effective type of care, and we do believe that's wrong.

That's why the President has proposed almost $80 billion in refundable tax credits to allow the working poor to have coverage. That's why he's made over $3 billion available in expiring SCHIP dollars. That is why he's supporting doubling the number of community health centers, as well as 40 million additional dollars for health professionals to go in shortages to pay their costs, their loans, their tuition, so they can go serve the underserved population.

So the Administration strongly believes that the answer is in allowing people to have the best access to high quality, affordable insurance. Our message is consistent with our message on Medicare. We want to help those who cannot afford coverage. We don't want to displace coverage that exists, but we also don't want to increase government bureaucracy.

Senator SMITH. Sounds to me like a no on universal coverage.

Mr. JINDAL. The answer to universal coverage is to allow States to have the flexibility so they can do——

Senator SMITH. If they want to have it like Hawaii.

Mr. JINDAL. That's right. The States should have the flexibility to do that. The Federal Government, we don't support the Federal Government nationalizing or socializing the health care system. We do support everybody having access to health care coverage, though.

Senator SMITH. Absolutely.

This is for Dr. Kositch. Does the fact that Kaiser applies evidence-based research in setting a prescription drug formulary in practice help better assure patients and physicians that they choose the right drug for the best price? Should this approach be carried forth beyond an HMO model?

Good question from Jeffrey Cohen.

Dr. KOSITCH. It sounds like I wrote that question for myself. The short answer is yes. I think it spoke to what I said earlier, that if there is a rigorous, scientific approach to encouraging effective use of medications that should be a goal to provide as much coverage for many as people as possible by trying to identify what works the best and what things are priced at a market whim rather than any scientific basis.

Senator SMITH. The answer to that will change with every research fund.

Dr. KOSITCH. It does. But I think you can easily say on an annual basis you could update such a list. While there are people who would want it to be done sooner, an annual basis is more than

enough. As long as it's understood there is a process that will go on year after year, and it wasn't a one-time thing.

Senator SMITH. Very good.

This is to you, as well, Doctor.

Oregon's innovative prescription drug research authorized under some Senate bills this year provides consumer health care providers with consumer reports like Gray to identify the right drug at the right price, called evidence based research. Oregon's process has been praised by PHRMA and AARP alike. How can Congress support and promote expansion of this work?

Dr. KOSITCH. I am unfamiliar with this specific product, although I am very aware that the state Medicaid program comes to us asking for advice on how to screen prescriptions for effectiveness, so I am assuming it's a related process.

Giving information to consumers is another way, as I said, also giving the information to the FDA, of using scientific knowledge in a way of allocating a resource.

Senator SMITH. There are a couple other questions, but they really do duplicate ones that have already been asked. So before we adjourn, I would like to remind all of you that caseworkers from my office and Senator Wyden's office are present. Raise your hand if you're from my office and Senator Wyden's office to help here.

These folks are here to answer your questions and tell you about programs available in Oregon and help you deal with any problems you may be having. There's also coffee and cookies available in the back.

I truly hope that you have found this Oregon focus on the prescription drug issue of value. I have, and I return to Congress as committed as ever, but more determined to get a result, the sooner the better, and I hope in the 107th Congress. Because this is an issue, as I said in the beginning, whose time has come, not for debate but for resolution.

Thank you all.

[Whereupon, at 12 p.m., the committee adjourned.]

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