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MEDICARE PRESCRIPTION DRUG DISCOUNT CARDS: IMMEDIATE SAVINGS FOR SENIORS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

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MEDICARE PRESCRIPTION DRUG DISCOUNT CARDS: IMMEDIATE SAVINGS FOR SENIORS

THURSDAY, MAY 20, 2004

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

The subcommittee met, pursuant to notice, at 10 a.m., in room 2123, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Hall, Upton, Greenwood, Deal, Burr, Whitfield, Shimkus, Wilson, Shadegg, Buyer, Ferguson, Rogers, Barton (ex officio), Brown, Waxman, Pallone, Eshoo, Stupak, Engel, Green, Strickland, Capps, Rush, and Dingell (ex officio).

Also present: Representatives Wu and Walden.

Staff present: Chuck Clapton, majority counsel; Ryan Long, majority professional staff; Jeremy Allen, health policy coordinator; Bill O'Brien, projects assistant; Eugenia Edwards, legislative clerk; Amy Hall, minority professional staff; Bridgett Taylor, minority professional staff; Purvee Kempf, minority professional staff; and Turney Hall, minority staff assistant.

Mr. BILIRAKIS. The hearing will come to order. Today, the Health Subcommittee will be focusing on a very important issue and that is the new Medicare Prescription Drug Discount Card Program. This is the first time most seniors will realize a tangible benefit from the recently enacted Medicare Modernization Act. Since Medicare beneficiaries will be able to use these new cards beginning June 1, I felt it was critical that the subcommittee explore the implementation of this program and its benefit.

I'd like to thank all of our witnesses for joining us today including and especially Dr. Mark McClellan, the Administrator of the Centers for Medicare and Medicaid Services. This is Dr. McClellan's first appearance before the subcommittee and this is a new role, God knows he's been here a few times before in other roles and we do welcome him and his always valuable insight.

I won't spend a lot of time discussing the details of the Medicare Prescription Drug Discount Card Program. Suffice it to say it will provide millions of seniors, particularly those with low incomes with much needed help in purchasing their prescription medications. While this is certainly not a panacea, it is an important first step.

I know that we will hear a good deal of criticism from certain members today about many aspects of this new law, including the

Prescription Drug Discount Card Program. Some will say, as they will, that the savings aren't large enough. To that I would say that the savings available through these cards and more importantly, the $600 per individual transitional assistance are a heck of a lot better than what many seniors were getting before this Congress and its President enacted to provide Medicare beneficiaries with prescription drug coverage.

I've always maintained that since we have limited resources available to us, we should target our resources to those who need help the most, the poorest and the sickest. The Transitional Assistance available under these cards will provide a lot of help to an awful lot of people.

I'm aware that other members will argue that the high number of drug discount card sponsors will needlessly confuse seniors. I know that the system still has a few kinks that need to be worked out and I agree that some beneficiaries will need extra assistance in choosing the card that's right for them. However, the Medicare Modernization Act is based on the principle that choice and free market competition will lower prices and continue to foster innovation.

As we will no doubt discuss today, this principle is already resulting, it's not really in effect yet, in discounted prices that continue to drop. In fact, CMS recently found that the average discounted price declined by approximately 11.5 percent from brand name drugs and 12.5 percent for generic drugs over a 1-week period.

It's clear to me that this new benefit is headed in the right direction and will provide seniors with real help. And that's why I continue to be so disappointed that some continue to demagogue this issue. When I learn of a partisan analysis, if you will, how the Prescription Drug Discount Card benefit that concludes that the program is a failure before a single beneficiary uses the card, well, let's just say it makes me wonder, although I guess I don't really wonder any more.

Scare tactics designed to frighten and confuse seniors will only ensure that some beneficiaries will choose not to access a benefit that could save them hundreds, if not thousands of dollars annually. I, along with many Members of this Congress, certainly members of this committee have fought for years to add a prescription drug benefit to Medicare. Finally, 39 years after the program was first created, Medicare will help seniors with the cost of their prescription medications.

I intend to diligently oversee the implementation of this benefit and I hope that we have the cooperation of everybody on both sides of the aisle to oversee the implementation so that every senior saves the greatest amount possible.

I again would like to thank our witnesses for joining us and I now yield to the ranking member, the gentleman from Ohio, Mr. Brown for an opening statement.

Mr. BROWN. Thank you Mr. Chairman. Year after year, surveys show that Medicare is more popular than private insurance. Medicare is reliable, it works, it's a single program with a single mission, to ensure that seniors and disabled Americans have access to the health care that they need. In fee for service Medicare, seniors

don't face endless choices. They face only the important ones, choice of doctor, choice of specialist, choice of hospital. The new Medicare Drug Discount Card Program begins to erase that legacy. It replaces the uniformity and clarity of Medicare with mountains of glossy brochures and government sponsored advertisements, some of them illegal, it turns out, conflicting claims about prices and coverage and a system that can change fundamentally week to week, all, Mr. Chairman, in the name of choice.

One constituent wrote to me, "I find everything related to the new Medicare law totally confusing. I have two master's degrees and it's beyond me. I don't know how most people are going to cope with this. What's wrong with these cards? There's no guarantee first that your plan covers your drugs at the rates they advertise. The real rates are often different from those catalogued on the Medicare website. The prices listed in the website are often different from those given out over the hotline, that is, if you can get someone on the hotline."

My constituents report to me that trying to get the help of a human being at 1-800-MEDICARE is nearly impossible. I hope that senior and disabled Americans benefit from these discount cards.

I'm pleased to joint Mr. Dingell and other members of this committee on legislation to automatically enroll low income beneficiaries into the program so they do, in fact, get the $600 subsidy. But this discount program should teach us a lesson. More is not always better. Multiple choice is not always the right answer. The mess of the discount cards, the confusion that seniors are experiencing, the clamor of competing drug companies and insurance companies, it's all a pretty good indicator, unfortunately, of what we can expect when the full drug benefit goes into effect in 2006.

Medicare, as we know, is now spending millions of dollars and hiring thousands trying to make this card less confusing. As we also know, in the papers today they've been doing this illegally. Those dollars could have instead been used to deliver real drug benefits to seniors, benefits that don't feature the huge donut hole, the huge gap in coverage.

I find it ironic that my colleagues on the other side of the aisle who for 38 years since the great majority of them opposed the creation of Medicare, attack Medicare as the pinnacle of big government. I find it ironic that they created what must be the big—might be the biggest bureaucratic nightmare in the Nation's history.

We could have a simple Medicare discount card where the government has negotiated the price on behalf of 40 million beneficiaries and get Canada or France or Germany or Japan or England-type drug prices instead of one simple card that a senior could go in and show. We have these. This card could be a discount for Fosamax. This card might be a discount for Vioxx. This card might be a discount for Lipitor. This card might be a discount for Zocor. This card might be a discount for Zoloft. This card might be a 22 percent discount, but then next week it becomes 12 percent. This discount card for Lipitor might be 15 percent and 2 weeks later drop to 12 percent.

We could have used instead, Mr. Chairman, the combined purchasing power of 39 million Medicare beneficiaries to secure real

discounts, but the President and my Republican colleagues again showing their allegiance to the prescription drug industry which will benefit $150 billion in additional profits from this bill, decided that instead of using the clout we could have to get real drug discounts, 50, 60, 70 percent, the way they do in Canada, instead of using that clout, we have surrendered it to the drug industry.

Republicans sheltered their friends in the drug industry at the expense of seniors and they capitalized on the desperate need for prescription drug relief in order to privatize Medicare. First, the choice of multiple private discount cards which feeds into the choice of multiple private prescription drug plans, after all, what better drug plan than the one associated with your discount card which bleeds into the choice of multiple private HMOs. After all, isn't it more convenient to consolidate all your coverage with an HMO than to have Medicare, plus Medigap, plus stand alone prescription drug coverage.

Mr. Chairman, we could have one discount where government could ensure that seniors would get a 40, 50, 60 percent discount. Instead, our friends in the drug industry, the President of the United States and the Republican leadership in this House has given us this confusing choice of discount cards which at best might give us 10 or 15 or 20 percent if, in fact, you qualify.

I yield back my time.

Mr. BILIRAKIS. I thank the gentleman for his discourse. I find it ironic, even though the gentleman himself was not here, that during the what two—better than two decades that his party controlled the House and controlled the White House at the same time during much of that time, no efforts were made to do what needed to be done for our senior citizens and it was this party that decided to take the bull by the horns, know it was not perfect, but we were going to—attempting to help some people, not all of the people, but some of the people, some of the time.

The Chair now would yield to the chairman of the full committee, Mr. Barton, for an opening statement.

Chairman BARTON. Thank you, Mr. Chairman, and I would ask unanimous consent that my formal statement be put into the record in its entirety.

Without objection, hopefully.

Mr. BILIRAKIS. You choose not to make a——

Chairman BARTON. I'm going to make an extemporaneous statement.

Mr. BILIRAKIS. By all means, the opening statement of all members of the subcommittee will be made a part of the record, without objection.

Chairman BARTON. All right, thank you, Mr. Chairman. I want to welcome Dr. McClellan to the full committee, former full-blooded Texan and I know his mother very well and worked with him at FDA and we're glad to have him at CMS.

I hope this hearing today will show the American people that the Medicare Prescription Drug Card Benefit Program is several things. No. 1, it's voluntary. If there are senior citizens out there that think it's too confusing or too complex or they don't feel that they need to participate or they just feel that they don't want to participate, they don't have to. It's totally voluntary, No. 1.

No. 2, if they do want to participate, I don't apologize for helping to create a program that gives seniors choices. That is a good thing, not a bad thing. Now admittedly in this beginning period with the various groups and companies scrambling to create the drug cards and I think we're somewhere in the neighborhood of 40 to 60 drug cards that out there on the national level, there's some glitches. It's a startup program. But I would point out that if the seniors want to wait a month or 2 and pick a card in July or August, they can do that. They don't have to pick a card right now and if they pick a card and they don't like it, they can change next year. They're not stuck for life with it. And how in the world it is a bad thing to create a new prescription drug benefit program that gives seniors choices on a voluntary basis is beyond me. I think it is a good thing. I'm going to sit down with my mother who lives in Waco, Texas next week and she's got a stack of mail on her desk and she's going to go through it with me and we're going to help try to sort out what's the best prescription drug benefit card for her, if any. She's got a pharmacist that's about two blocks from her house and we think they have some cards and we'll see.

So I know there's going to be a lot of rhetoric today at this hearing and various folks are going to engage in gnashing of teeth and all of this, but I don't want to forget the bottom line. We have a new prescription drug benefit for seniors. That is a good thing. It is voluntary. That is a good thing. There are lots of choices. Those choices may be confusing, but the fact that we give seniors choices is a good thing.

And if you're a low income senior, you get the benefits of the prescription drug discount, plus you get $600 to help defray the cost of your drugs. And for a fair number of seniors, that will mean they don't have to pay much of anything out of pocket, other than what ever the small co-pay is for the particular drug that they're using.

I look forward to the hearing. I look forward to a good dialog and debate on it, but I encourage all seniors that are thinking about participating to seriously look at the various number of cards that they have available to them and decide what's best for them.

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

Mr. BILIRAKIS. The Chair thanks the gentleman and yields to Mr. Dingell for an opening statement.

Mr. DINGELL. Mr. Chairman, thank you. I commend you for holding this hearing and Dr. McClellan, welcome to the committee. I am anxious to hear your testimony explaining how these cards are going to work. I've been concerned about these cards and the private companies that run them since the Bush Administration first proposed them 2 years ago.

Thus far, I've seen little to allay my concerns. I want to be clear. I do not find these cards bad. I do find them, however, often misleading, consistently confusing and of dubious workability. I also find the efforts of the administration to publicize them and to explain them to be of questionable character.

I would note that if they don't work, all of this is going to have serious implications for Medicare and the seniors who depend upon it and many seniors will be hurt. The confusion and difficulty pro-

duced thus far could well undermine the long-standing trust that seniors have in Medicare.

First, there's 73 cards to choose from, each one offering something different that changes constantly, while at the same time the seniors who are dependent upon these are chained to one card for a period of 1 year, regardless of whether they had made a mistake in choosing it or whether or not they are properly treated under it.

Second, I have yet to see convincing evidence that the savings from these cards would justify the difficulty and confusion for seniors and the expense to Medicare and the taxpayers. The amount of discount seniors are getting with these cards doesn't appear to be any better than what is available in the market today. The majority of pharmacies already give cash-paying seniors a 10 percent discount at the register. Places like drugstore.com or Costco have better or comparable discounts. And the Veterans' Administration has the best prices around.

I would direct your attention to a CMS chart which I will be showing you later which has since been recalled. I'm interested as to why it has been recalled, but I have both the original and the following one and after I think we have explored this, we will find why it has been recalled.

This chart shows how prices under various discount cards compare to Canadian prices and prices that the Veterans' Administration gets bear the test of reality. Prices in the supply schedule by the Federal Government were $300 lower than the most generous card listed on the CMS table for general basket of drugs commonly used by the elderly. This administration has fought bitterly, however, to prevent seniors from getting similar discounts.

Confusion and bureaucratic reluctance are hindering the one bright spot, the $600 for low income seniors. Unfortunately, the people eligible for this money are the most likely persons to be intimidated by the confusing process. CMS has not done what is needed to assure that all eligible beneficiaries receive this subsidy. In fact, there are predictions now that only 65 percent of those eligible will enroll in this subsidy and will be eligible to receive it by reason of that enrollment.

I don't think that you can justify the acceptability of this circumstance. CMS could automatically enroll low income seniors who are currently in the Medicare savings program in the discount card subsidy. It is doing so for seniors in the State Drug Assistant Programs. CMS has the information to enroll these other low income seniors who are also eligible for the $600. But you have for reasons suitable to yourself, declined to do so. I and other Democratic Members will be introducing a bill today to automatically enroll all low income seniors. It is the least we can do. It is strange that we must introduce legislation to assist you to do that which you could do without legislative authority because you already have that authority.

I look forward to your testimony and that of other witnesses and perhaps some explanations of the curious, confusing and difficult situation that seniors face in addressing the question of which card they may take and how they may avoid being skinned in the process.

Thank you, Mr. Chairman.

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

Mr. WHITFIELD. Mr. Chairman, thank you very much and I also want to welcome Dr. McClellan and to also commend him for the tremendous job that CMS has done in trying to implement this program. I'm sure it has been quite difficult and I know that the volumes of phone calls coming asking for assistance has been overwhelming, so although there are still a lot of problem areas out there, I think overall, you all have done a tremendous job and I want to thank you for that.

Those of us who supported this prescription drug benefit, I think we have a lot to be quite proud of. We have 6 months now before the election and I don't think any of us are surprised that there's a lot of criticism of this program. It's very easy to be critical of a program, particularly one that's getting started that is complicated. But one of the things that I am most proud of is that each one of us in our Districts represent a lot of people who are at the Federal poverty level or below and under this plan for the first time ever, under Medicare, people who are 135 percent of the poverty level and below, not only are they going to get a $600 credit this year and then also next year, but they're also going to be paying only a small co-pay for generic drugs and name brand drugs.

So the question about drug reimportation are all those things for those people, really does not make any difference at all because they basically are going to be getting free prescription drugs, a benefit that they've never had before.

So I don't think this Congress needs to apologize for anything in our efforts to look out for those people who need it most and this program is particularly effective at doing that. In addition to that, all of our seniors are going to benefit from this program.

I want to make one other comment. We hear a lot about price controls in Canada and in Europe and elsewhere. And we hear a lot on the other side about how we caved into the drug industry. I would just make this comment. That the drug industry, the pharmaceutical industry in the United States has been most effective, more so than any other drug industry in the world of coming up with new medicines to treat diseases and prolong the lives of people in America.

Unfortunately, the Europeans, the Canadians and others have been instituting price controls and they're making Americans pay for their low prices to benefit, so that their citizens can benefit from the research and development that our drug companies do in America. So from my perspective, they're really engaged in unfair trading practices and I think that is something that we need to explore on our side of the aisle because there's no reason that the Europeans and others will be benefiting from the research and development that our drug companies do.

And Mr. Chairman, I look forward to this hearing and commend you for your leadership.

Mr. BILIRAKIS. The Chair thanks the gentleman. Mr. Waxman for an opening statement.

Mr. WAXMAN. Thank you, Mr. Chairman. We can all agree on one goal for the discount cards. They should save as many seniors as possible as much money as possible in the simplest fashion pos-

sible. Unfortunately, after 3 weeks, it's pretty clear that the cards are failing that test for most Medicare beneficiaries. Seniors are confused, frustrated and angry and with good reason. They can't get enough accurate information about the discount cards. The 1-800-MEDICARE number is either busy or doesn't seem to be of much help when seniors can get through to it. And the Medicare.gov website is all but useless for most seniors. It is slow, confusing, and according to complaints from people who manage benefits from seniors and pharmacists, doesn't even provide accurate prices.

According to the Washington Post, seniors can't even get any accurate information on pricing for drugs that just come in pill or tablet form. According to the Wall Street Journal, posted prices are going up and down like a yo yo with no apparent rhyme or reason and seniors can't even get good information from their local pharmacists because the local pharmacists don't know which cards they will be accepting and don't have any sense of what prices they will be charging on June 1.

Well, this aggravation is worth it for low income seniors who at least get the $600 Transitional Assistance, but for other Medicare beneficiaries, even if they are finally able to wade through this jumble of confusion or have a son who is the chairman of the Energy and Commerce Committee to explain it to them, it's not at all clear that they will even see savings from these drug cards.

I take no joy in being right about this issue. I opposed the Medicare bill. I thought that this Medicare bill when it was written was legislation drafted to benefit the insurance companies and the drug manufacturers instead of the Medicare beneficiaries and the drug benefit and the drug cards could have been provided in a simple straight forward manner, but that wasn't what the Republican leaders in the Congress chose to do or what this administration told them to do.

Instead, we're faced with a situation where this complicated, confusing and poorly planned drug card program is undermining seniors' confidence in the entire Medicare program. Seniors rely on Medicare. They trust it implicitly, but with this discount card benefit they can no longer be certain that the Medicare brand name guarantees them the affordable, quality health care to which they have become accustomed.

We need to fix this problem and we need to fix it right away. If we don't, I fear that it'll be a prelude to a worse situation. My Republican colleagues seem to have lost sight of the goal of the Medicare program. It's not about experiments with privatization or give aways to health care providers or insurance companies or drug companies. Medicare is suppose to work for seniors. Let's fix this drug card program and this drug benefit so we can make sure that happens.

Mr. BILIRAKIS. The Chair thanks the gentleman. His time has expired.

Chairman BARTON. Mr. Chairman, could I be recognized by unanimous consent briefly?

Mr. BILIRAKIS. The gentleman is recognized.

Chairman BARTON. I just want to tell my good friend from California that we need an adjective, a caring chairman and a caring

son and I will be happy to help the gentleman from California, if he is over 65 and needs some help determining which card is best for him.

Mr. WAXMAN. I ask unanimous consent that my opening statement be revised to include the comments of caring son and all the other suggestions——

Mr. BILIRAKIS. Without objection.

Mr. WAXMAN. But I do take exception to the fact that you think I'm over 65.

Chairman BARTON. I didn't say that. I said if. I said if. I did not say that.

Mr. WAXMAN. That's bad enough.

Mr. BILIRAKIS. The Chair recognizes the gentleman from Illinois, Mr. Shimkus for an opening statement. Let's have some order, please.

Mr. SHIMKUS. Thank you, Mr. Chairman. I want to welcome Dr. McClellan and thank you for the work you're doing and trying expeditiously to move on these cards and then the implementation of the full plan.

I also want to welcome Mary Grealy from the Healthcare Leadership Council who is in the second panel. She came out to Illinois and we had a very successful educational seminar and I would encourage other members to do that.

The ranking member of the full committee mentioned that the discount card initiative was an executive branch initiative and it was not. For those of us who marked up the bill in this committee, know that it was led by five rogue members, John Shadegg, Steve Buyer, Charlie Norwood, now the full chairman and of course, Mike Bilirakis, working behind the scenes.

So this discount card is a House Commerce Committee at least Republican initiative. This was not part of the executive branch's original plan in that this whole Medicare prescription drug debate. And I'm going to let the individuals—and Richard Burr was another one. I'll let those folks be added but they wanted a bridge and I think it's going to be a very successful bridge and I really commend them for their work because they bucked, even the House leadership to have this provision in there. And they were successful and I want to congratulate them.

Also, Dr. McClellan, since I have your undivided attention, Illinois has passed a Hospital Provider Assessment which comports to Federal law. We would hope that CMs would swiftly evaluate and allow for this to be implemented in Illinois. I'm taking my privilege as a member to bring that up and I thank you, Mr. Chairman. I yield back my time.

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

Mr. PALLONE. Thank you, Mr. Chairman. I was somewhat concerned and I hope you don't take this personally with the opening statement you made about Democrats because you said that Democrats were demagoguing this issue and you know, we were using scare tactics and you talked about how we needed to marshall scarce resources and frankly, Mr. Chairman, the reason I am upset by that is because when I read today's Washington Post about how the GAO now says that the Department broke the law with their

Medicare video campaign, I think that we have an obligation not only as Democrats, but as nembers of this committee, to have some oversight about the extent to which the Department has broken the law. It's clear now, based on the GAO report, in my opinion, that laws were broken. My understanding is that there's an on-going investigation by the Inspector General about Foster and his statements and the fact that he wasn't allowed to bring up the costs of the Medicare bill.

And as much as I appreciate the fact that we are having this hearing today, I think that this subcommittee has an obligation to have more oversight over to what extend the Department has broken the law with this Medicare bill. And I know that my colleague on the Senate side, Senator Lautenbeg, is introducing a bill today that would require that the Bush campaign reimburse the Federal Government for the cost of this Medicare ad campaign and I intend to introduce a similar bill in the House because I think there is a real problem here and this administration and this Department continue to break the law.

And we have an obligation, I believe, on this subcommittee to have some sort of oversight, to have some hearings on this issue with the ads on the Foster issue. I know with regard to Nick Smith, the Ethics Committee is taking that up. Also the Ethics Conflicts with some of the previous Medicare Administrators, Scully. I think this needs to be done and I hope at some point we will do that.

As far as the drug discount card plan, I know someone was criticized on this side for saying it was a farce, but it is a farce. I tried to use this 800 number. It took 30 minutes to even get somebody to respond. My seniors are telling me they don't have the website. They don't have a computer where they can log in and make these comparisons and we've already been told by some of the companies that are on the website that there's misinformation on the site. How in the world is a senior citizen supposed to decipher all of this information? There's absolutely no way to do it.

I have a chart over there, if I could point to, that I think probably would be more helpful in navigating a senior through the discount drug card program than the HHS website. There are 50 steps on this chart, no promises except for massive bureaucratic confusion that quite frankly disgusts me when I think about the seniors who are forced to play these games with the drug and insurance industry and the stakes being their health and their lives. That chart is easier to figure out than the website and the other garbage that this Department is putting forward on this issue.

Mr. BILIRAKIS. The gentleman's time has expired. Mr. Buyer for an opening statement.

Mr. BUYER. I'll reserve my time.

Mr. BILIRAKIS. You'll reserve your time. Mr. Green for an opening statement.

Mr. GREEN. Thank you, Mr. Chairman and like the chairman of our committee, I'd like to welcome Dr. McClellan. I enjoyed working with you at FDA and again looking forward to working with you at CMS.

I'm glad we'll see some hopefully common sense brought to CMS and I know, I talked earlier, what we're going to talk about today,

it's Congress' fault and the administration, although you're part of it, but you're just new on that watch. So you're the messenger so far and not the culprit whereas I have enough problems with the bill we passed. I don't think there's anyone engaging in scare tactics because like a lot of my colleagues, I tried to on the Friday, the website was up, tried to negotiate that website for my seniors. And again, like a lot of seniors, particularly in a District that's 65 percent Hispanic, they don't have access to the web.

I couldn't do it on two zip codes. Now there's new information on it for the zip codes, but again, much less using the phone message. My concern is and our Chairman is right, there's no penalty for someone not joining or taking those cards, but in 2006, if a senior does not accept or not pay that $35 a month, they're penalized every year for not doing it. So there is a penalty in here, but it's not based on these cards.

But I'd like to thank Chairman Bilirakis for calling this hearing because of all the legislation in the number of years I've been on the committee, I think this is one of the most important in the health care area and I guess I'm disappointed because we talked about the limitation of the $400 billion. Mr. Chairman, if I had known we had $550 billion to expend, maybe we could have prepared a better plan. But when Medicare released its price comparison website, like a lot of folks, we tried to make it fit. And you know, again our seniors aren't typically internet savvy but even seniors who are willing to go through the steps on the website, it's confusing as my colleague from New Jersey has shown. Fortunately, I know firsthand, I tried to do it on that Friday morning to prepare information and just using compare prices for five commonly used drugs in one zip code, we came up with 12 cards, scores of pharmacies and a grand total of 27 pages of information. A senior would have to have the web to be able to navigate it and even that was difficult.

It's not only frustrating for seniors to sift through that information, and finally decide on what card, the sponsor is under no obligation to keep those advertised prices which is frustrating because as the chairman said our seniors are going to be stuck with that card for a year and yet they may find out that the prices on their particular list of pharmaceuticals has gone up on a weekly basis. To make matters worse, the benefits offered on these cards are questionable at best.

I know Mr. Waxman's staff in doing some comparison with prescription drugs, are obtained cheaper in Canada or even under our Federal Supply Schedule which the Veterans' Administration already uses. The Federal Supply Schedule is much cheaper than what's available under this card. I know it's frustrating for—and I'll go on with my questions later, Mr. Chairman, but I appreciate your calling the hearing so we can air our differences again on this issue.

Mr. BILIRAKIS. The Chair thanks the gentleman. The gentlelady from New Mexico, Ms. Wilson, for an opening statement.

Mrs. WILSON. Thank you, Mr. Chairman, and I thank you for holding this hearing today and Dr. McClellan, thank you for coming.

This is the biggest addition to Medicare in a long time and we all expect that there's going to be some glitches in the roll out. I was interested to see an article somebody sent me. It's from the Washington Post in 1966 and it says "the slow payments represent only one of several bugs to appear in the massive machinery of Medicare during its first 6 weeks of operation. 'We think there's some confusion' an official said."

Whenever you start a new program as big as this one, there are going to be some initial confusion as people learn what benefits are best for them, but I think we've done the right thing by making a voluntary benefit. And I think one of the things my friend, the rogue from Arizona and his colleagues did, was probably the best little idea in this bill which was to create an open, transparent, understandable market on a website and we've already seen the impact of competition.

My colleague from Ohio talks about how much better it would be if we only had one card and one set of prices and the government would negotiate what those prices were and whether your medicine was on the list at all. In the first 2 weeks of the cards even being posted on the website, the prices have gone down for regular drugs by 11.5 percent and generic drugs by even more, 12.5 percent because every one of those cards out there knows that in order to get people to sign up for their cards, they need to negotiate the best deal they possibly can.

I am aware of no program in the Federal Government that has managed to reduce its prices by that much in such a short period of time even before the program officially rolls out. Federal Government isn't that responsive. But the market is and that's yet another reason why I think we've probably gone in the right way.

As a Member, I think all of us have similar stories of helping people in our Districts to qualify, particularly those who are low income and get them information so that they and their families can make choices and give them help. I wish it wasn't a big election year because we have made a major new benefit available to America's seniors and instead of bickering about whether we did the right thing last year, all of us should be pulling together and helping seniors to understand a new benefit that is demonstrably of benefit and good for them and for their families. And it's time to stop that and get focused on the solutions and helping people with a marvelous new government service. And I look forward to working in that direction.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. The Chair thanks the gentlelady. Mr. Strickland for an opening statement.

Mr. STRICKLAND. Thank you, Mr. Chairman. Mr. Chairman, America's seniors get it. They understand what's being done to them and they understand what's not being done for them.

When I showed the Family USA video narrated by Walter Cronkite to the seniors in my District, they audibly gasped when learning the details of the Medicare plan we pushed through in the middle of the night. When I talk to them about the arm twisting, the accusations of bribery, the prohibition against importing cheaper drugs, the prohibition against negotiating lower prices, when I described the donut hole, when I talk to them about the fact that

we were given false information about the true cost of this plan, they are appalled.

Now I'm glad we're having this hearing today because I am hearing from seniors all over my District. They're confused about how to decide which card to choose and whether the card they choose will continue to save them money in August or September or December. And quite frankly, I'm confused. And I've been giving them the White House number to call or the 1-800-MEDICARE number to call, but now I'm going to give them Chainman Barton's number because apparently he knows and he's offered to help.

You know, when I explained to my seniors that the savings can change every 7 days, that the drugs offered for discount can change every 7 days, but when they make a decision, they're locked into that decision for the entire year, they're upset. My seniors are confused and they're disappointed because the benefits they will likely receive once they choose a card and start using it, may not provide any savings at all.

Since seniors are likely to take 6, 8, 10 and even 12 prescriptions at once, it is unlikely that all of their drugs will be discounted by a single card. And therefore, they will still be forced to pay undiscounted prices for the drugs that aren't covered by the card they choose. And the card they do choose may start out providing a 15 or 17 percent discount, but once the drug prices rise, seniors may be left with no more money in their pockets than they would have had otherwise.

So what if we get a discount card that provides a 10 or an 11 or a 15 percent discount and the drug prices go up 18 percent, the seniors are still going to be paying more. The answer for this is for us to provide a comprehensive drug benefit that is a part of traditional Medicare and get rid of these confusing, rather outlandish deceptive and deceitful, in my judgment efforts to hoodwink our seniors.

And I would like for my entire statement to be placed in the record, Mr. Chairman.

Mr. BILIRAKIS. You've already made that point and I wonder if the gentleman knew that Mr. Cronkite was paid an undisclosed sum for the video that he was referring to.

Mr. STRICKLAND. I don't think that that in any way undercuts the validity of what he says about this ridiculous program.

Mr. BILIRAKIS. For the record, he was paid for it. In any case, who is next? Mr. Ferguson, for an opening statement.

Mr. FERGUSON. Thank you, Mr. Chairman. I'd just say to my friend, Mr. Strickland, that Families USA video is a joke. It is a blatant, partisan, political attempt to discredit a program which is going to make prescription drugs cheaper for millions of American seniors and the fact that Walter Cronkite was paid some amount for that I think absolutely undercuts his ability to go out and bash the program.

I will say thank you to Dr. McClellan for being here. I'm delighted with your leadership at CMS. I think there are a few people who are going to be better able to handle the enormous tasks of implementing this important new program and I thank him for being here today.

We're here to discuss the immediate savings that our Nation's seniors are going to realize due to the prescription drug discount cards provided under the Medicare law that we wrote last year. After years of promises, this law fulfills our commitment to our Nation's seniors by providing the first ever universal prescription drug benefit under Medicare and that's a huge accomplishment.

One would think that these new benefits for seniors, coupled with the prescription drug discount card would be a cause for celebration. Rather than educate seniors on the benefits of the discount cards, the other side of the aisle has continued to simply play partisan politics with the issue and resorted to scare tactics toward our Nation's seniors and in some cases even suggest that our seniors are too dumb to figure out how this could benefit them. That's simply wrong.

Some have even suggested that there are some on the other side of the aisle who are discouraging seniors from signing up for the benefits that these cards offer. Folks, low income folks, will immediately get $600 of free medicine and some have suggested that there are those on the other side of the aisle who because perhaps they don't want a lot of seniors to sign up for this because that would suggest somehow that the program is a success, are discouraging seniors from taking advantage of $600 worth of free medicine. That's not just wrong, it's unconscionable. It's shameful and anyone who is engaged in that kind of practice should be ashamed of themselves.

In my home State of New Jersey, we have a very generous pharmaceutical assistance program called PAD. After working with our Governor and CMS, New Jersey has had the opportunity to directly enroll our low income seniors into the drug discount program. Out of the 81,000 seniors and people, persons with disabilities who are eligible for the Transition Assistance provided by the drug discount card, only 220 have opted out of the program, out of 81,000 people, 220 have opted out of the program.

As a result of the discount card and our delegation's work to get this card to New Jersey seniors, my home State will save $90 million on the cost of prescription drugs. These savings and my hope is that will be put back into the PAD program to provide expanded coverage for additional seniors New Jersey, I think is an example that other states hopefully will follow, by putting partisan politics aside, our delegated worked with CMS to provide simple process which benefits our State and our Nation's seniors.

Now today and I'm sure in the future, defying logic, you're going to hear members on the other side of the aisle, argue that the cost of prescription drugs will actually increase as a result of the discount card. For those members, I'd like to point to a May 14, as I close, study by CMS which shows that in the past week more cards have been offered, increased discounts for our Nation's seniors compared with prices offered the previous week. This is how markets work.

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

Mr. FERGUSON. I'll just finish, Mr. Chairman.

Mr. BILIRAKIS. I apologize to the gentleman.

Mr. FERGUSON. Some on the other side of the aisle would prefer a government-controlled——

Mr. BILIRAKIS. Ms. Capps for an opening statement.

Mr. FERGUSON. [continuing] where the government decides who gets what. That's not how markets work. It sounds more like the Soviet Union to me, than America.

Mr. BILIRAKIS. I hope you're not referring to the chairman.

Mr. FERGUSON. I ask my whole statement be made a part of the record. Thank you, Mr. Chairman.

[The prepared statement of Hon. Mike Ferguson follows:]

PREPARED STATEMENT OF HON. MIKE FERGUSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Today we are here to discuss the immediate savings that our nation's seniors realize due to the prescription drug discount cards provided by the Medicare Law that Congress wrote last year. After years of promises, this law fulfills our commitment to our nation's seniors by providing the first ever universal prescription drug benefit under Medicare.

One would think that these new benefits for seniors, coupled with the prescription drug discount card would be a cause for celebration. Rather than educate seniors on the benefits of the discount cards, the other side of aisle has continued to play politics with this issue and resorted to scare tactic towards our nation's seniors and in some cases suggest that seniors are too stupid to make decisions for themselves. There are even those who are discouraging seniors from signing up for the discount card. Perhaps because if seniors sign up, the program will be a success; that is not just wrong, it is unconscionable and shameful, and anyone who engages in that sort of behavior should be ashamed of themselves.

In my home state of New Jersey we have a very generous state pharmaceutical assistance program called PAAD. After working with our Governor and CMS, New Jersey has the opportunity to directly enroll seniors into the discount card program. Out of the 81,000 seniors and persons with disabilities who were eligible for the transition assistance provided by the discount card, only 350 opted out of the program. As a result of the discount card and our delegation's work to get this card to New Jersey's seniors, my state will save $90 million on the cost of prescription drugs. These savings can be put back into the PAAD program to provide expanded covered for additional seniors. New Jersey is one example that I encourage more states to follow. By putting partisan politics aside, our delegation worked with CMS to provide a simple process which benefits our state and our state's seniors.

Defying logic, today and in the future, you will hear members on the other side of the aisle argue that the cost of prescription drugs will increase as a result of the discount card. For those members I would like to point to a May 14th study by CMS which shows that in the past week more cards have offered increase discounts for our nation's seniors compared to prices offered the previous week. Sponsors are now comparing their discounts to their competitors, more cards are offering favorable prices, and CMS is working with card sponsors to make sure that the best discounts are published for Medicare beneficiaries. This is what happens when competition is injected into the marketplace. That's how markets work. Some on the other side of the aisle would prefer a government run, command and control system where bureaucrats or politicians tell people what medicines they can have, how much they can have and when and where they can have it. That sounds more like the former Soviet Union to me.

Today you will also hear members who will criticize the pharmaceutical industry for charging too much for prescription drugs. Yet they will not mention the miracle drugs or treatments these companies create. Representing the scientists and researchers who live in my district of New Jersey, I would like to highlight the good work that two of the pharmaceutical companies are doing to help seniors. Once a low-income beneficiary has exhausted his or her annual $600 transitional assistance allowance, Merck and Johnson and Johnson will provide its medicines free to that beneficiary's participating discount card plan or directly to the beneficiary, through the pharmacy. Neither company will receive any fees from these programs.

In closing, I encourage all members to put aside partisan politics and help seniors recognize the benefits of the drug discount card. This can be accomplished by working with CMS to clarify any questions our seniors may have and allowing seniors to realize the discounts that are available to all seniors through the discount card.

Mr. BILIRAKIS. Ms. Capps for an opening statement.

Ms. CAPPS. Mr. Chairman, thank you for holding this hearing.

Dr. McClellan, welcome.

I think it is critical that we look into this discount card program. We've heard the administration and many Members of Congress laud the prescription drug discount cards that have just been revealed and will go into effect soon. I don't see where there's much to crow about. The President created the card in order to hide the fact that his Medicare prescription drug benefit plan is a sham. The Medicare bill signed into law last year does nothing to actually lower the cost of prescription drugs. It prohibits Medicare from using the bargaining power of America's 40 million seniors to negotiate lower prices. And it upholds the prohibition on reimportation of American made drugs from Canada which would lower prices for seniors. And it is very doubtful that the discount cards we've been learning about will give seniors much more help either. If the discount card does not work at a senior's regular pharmacy, too bad. So far, these cards have been proven to be exceptionally confusing to my constituents who have discovered that many of the sponsors have even been providing inaccurate information. To get a card, a senior will have to pay $25 to $30. He or she will be limited to just one card, but after buying a card, a senior has no guarantee of anything. The cards do not give discounts for all drugs, nor do they provide a discount at all pharmacies. The discount itself is not guaranteed and once they sign up, seniors cannot change cards until the end of the year.

But the insurance company or drug company providing the card can change the cost of the medications at any time, really making the discount meaningless. And they can even change the drugs they cover on a weekly basis. If a senior needs a new medication that is not covered, too bad. The senior can't get a new card and thus won't get a discount. If the card sponsor stops covering the medication the senior is on a week after signing up, again, too bad. The senior can't get a new card and doesn't get a discount. If it doesn't work at their regular pharmacy, as I said, too bad. The senior can't get a new card and therefore has to go to a new pharmacist and if a senior has more than one medication and no card that covers them all, the senior has to choose which medication they want a discount on.

Seniors deserve better than this. They deserve real discounts and real drug coverage. So I hope this committee will work hard to correct the mistakes that the Congress made last year and give seniors the help they need and finally, I'd like to enter into the record, Mr. Chairman, an article from the Washington Post May 18, the byline, Lisa Barrett Mann, with the headline "She Thought Choosing Mom's Medicare Drug Card Would Be An Easy Trick, It Turned Into a Real Stumper." This is a personal narrative which I highly recommend to the committee.

Mr. BILIRAKIS. Without objection, that will be placed into the record, along with the article dated August 31, 1966 of the Washington Post entitled "Thousands Failed to Pay Premiums."

[The articles follows:]

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May 18, 2004 Tuesday
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SECTION: Health; F01

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HEADLINE: Pick a Card!#?;
She Thought Choosing Mom's Medicare Drug Card Would Be an Easy Trick. It Turned Into a Real Stumper.

BYLINE: Lisa Barrett Mann, Special to The Washington Post

BODY:

I live 50 miles away from my mom, who's 82. Because of the distance, it's not easy for me to drive her to the store or to doctor's appointments, like my sisters do.

So I offered to help pick out her Medicare drug discount card -- which, unless you've been living inside a sealed barrel in a Canadian drug warehouse for the past several weeks, you know the federal government has just introduced as its first step in making prescription drugs more affordable for Medicare recipients. Seniors can begin using the cards as early as June if they sign up for one this month.

Mom doesn't have Internet access, and since she has hearing problems, getting long, detailed information over the phone can be tough for her. And hey, I've been a health care reporter for more than a decade, conducting much of my research on the Internet. Picking the prescription card that would help my mom the most should be easy for me, right?

I figured the effort would take me an hour or so. Instead, I spent nine hours trying to track down accurate information on the phone and on the Web. The upshot? I'm not much closer to knowing which is the best card for her than when I started. I have, however, learned the following important lessons:

* Just because the Medicare.gov Web site says a drug isn't covered under a specific discount-card plan doesn't mean it really isn't.

* Just because Medicare.gov says a drug is covered doesn't mean it necessarily is.

* The prices Medicare.gov cites for medications under a given discount plan don't necessarily correspond to the prices the plan gives out over the phone.

* The prices that a card's sponsors give out over the phone can differ, depending on whom you talk with.

* Whether Medicare.gov says a pharmacy participates in a given plan doesn't seem to bear any relation to the info the plans, or even the pharmacies themselves, have.

* Calling 800-MEDICARE isn't much help. I tried the number seven times on a single day last week, starting at 9:40 a.m. and finishing at 11:20 p.m. I never got through to a human.

I started out well prepared. Mom made me a list of the nine drugs she has to pay for out-of-pocket for her fairly common conditions:

For asthma/chronic obstructive pulmonary disease (COPD): an albuterol inhaler, Serevent Diskus and prednisone (5 mg).

For allergies: Allegra (180 mg)

For apparent glaucoma: Isopto Carbachol eyedrops (3 percent) and methazolamide (50 mg.)

For sleep problems: Ambien (5 mg)

For congestive heart failure: Lanoxin (0.125 mg)

For water retention: hydrochlorothiazide (12.5 mg)

Mom told me she typically pays $453.96 per month for these medications, after her 10 percent senior citizen discount at the local pharmacy. She told me her monthly income and the amount in her savings account, so I could check whether she'd qualify for the $600 credit available to low-income seniors. I was set.

At 9:45 a.m. last Monday, I first called 800-MEDICARE. (Very) long story short: The automated voice system tells me there is an unusually high volume of calls and to try again later. Suggested times: before 6 a.m. (!) or after 6 p.m. Then I'm disconnected. I would try six more times that day -- the last call at close to midnight -- with no better luck.

Fine. I'll just go to the Web site. At Medicare.gov, the first thing I see is, "Find available Medicare-approved drug discount cards, and compare prices for your prescriptions." Perfect.

I click through and answer eight quick questions about Mom's income, assets, etc. Then I continue on to the next page, where I'm asked to select the drugs Mom needs.

Ambien, hydrochlorothiazide and methazolamide are missing from the Medicare list. How strange.

Maybe they're listed under different names? I don't see any help on the Medicare site for this, so I jump over to www.drugstore.com, where I'm able to quickly find all nine drugs. (I'm definitely spelling them right. I do this for a living.) I find possible names that the drugs might be listed under. Then back to Medicare.gov.

But no, the drugs aren't listed under these other names, either. I try calling 800-MEDICARE again, thinking maybe someone can help me. It's still tied up.

Okay, fine. If Mom can get discounts on even six of the nine drugs, that's some help, right? I click "continue" on the Medicare site.

The next page tells me Mom's not eligible for the $600 assistance. Fine. The page also lists 40 plans that are available in Mom's Zip code. I click the "Compare Prices" button.

Arrrrggghhh! For another three of the drugs -- Serevent, Lanoxin and albuterol -- I get a message saying, "Your selected drug was not found." Oh, come on. I'm not that familiar with Serevent and Lanoxin, but just about every asthmatic I know uses albuterol. How can this drug not be available?

I return to drugstore.com in search of other names these drugs might be listed under. I try all possibilities at Medicare.gov. Nada.

Now it appears that the best card will provide discounts on only three of the nine drugs Mom needs. These account for only $150.44 out of the $453.96 she's currently spending. This is looking less promising all the time.

For the remaining three drugs, I'm supposed to enter her dosages and how many she needs each month. No problem for prednisone or Allegra. But when I get to Isopto Carbachol, I'm stumped. For these eyedrops, Mom gets one bottle at a time, and uses four drops per day. The amount the system automatically suggests is "30 per month (e.g., 30 tablets, 1 bottle, 1 inhaler, etc)." Hmmm. I change the "30" to "1" and hit "Continue."

The system tells me there are 15 programs that provide the three drugs and have participating pharmacies with five miles of her house. I click through to a few, but quickly see that Isopto Carbachol is listed as costing between $4 and $5. Odd. She usually pays $44.99. "1" must have been the wrong dosage to select.

I try again to call for some help on this dosage question. Can't get through. I go back and pick "30." (I assume at first that it must refer to 30 days' supply. I later see that drugstore.com sells these drops in 30 ml bottles, so maybe that's the meaning of the "30" on the Medicare site. Hmmmm. But the next day I find out my mom's bottle is only 15 ml {ndash} so there's a good chance the price quotes I got are for twice as much as she usually uses in a month. Grrr.

For 30 days (ml?) of Isopto Carbachol 3 percent solution, all the plan prices run about $73 to $75 -- except for The Pharmacy SmartCard, which only charges $17.10. Wow! Now that's a deal. In fact, the Pharmacy SmartCard offers the best prices for the three drugs combined, $95.07, compared with other 14 cards, whose quotes run from $139.25 to $176.62 per month. But a closer look shows that the big price difference on the eyedrops accounts for all the big savings. Pharmacy SmartCard is actually a little pricier on the two other drugs. The annual enrollment fees range from free to $30.

All plans are also list as a participant the Calvert Arundel Pharmacy in Owings, Md., the store my mom has told me she wants to continue using. Perfect.

Pharmacy SmartCard definitely looks like the best deal. But something keeps nagging at me: The price for those eyedrops just sounds too good to be true.

So I find SmartCard's phone number on the Medicare Web site and call. A nice customer service rep answers promptly and looks up the pricing: $26, or $18 for generic.

"But Medicare.gov says your price is $17.10 for brand name."

She doesn't know why that is, but assures me the price is $26. And hey, that's still far better than the other company's prices.

After I get off the phone, it occurs to me: If the price was wrong on the eyedrops, is it wrong on the other stuff?

I call back SmartCard, saying I want prices on all of my mom's drugs and can't find all of them on the Medicare Web site. The customer service rep says I'd better talk to a pharmacist, who may know if the drugs are listed under different names. And guess what -- SmartCard has Medicare discount card prices for all nine drugs. The total comes to $414.47, a savings of around $40 a month, or almost 10 percent better than Mom's doing with Calvert Arundel's senior citizen discount.

But wait a minute. The pharmacist has quoted me $52.53 for the Isopto Carbachol -- the same drug the customer service rep said was $26 (and the Medicare Web site said was $17.10). What gives?

Well, the pharmacist explains, the customer service rep probably looked up the drops under "Isopto" instead of "Iso." But they are called "Isopto," I point out. Yes, that's true, she explains, but their computer system has a glitch in it that the customer service rep probably isn't aware of: You have to enter the drops as "Iso." If you enter them as "Isopto," you get pricing that hasn't been updated since 1997.

Great. If the info on the SmartCard is so messed up, what about the others? It's time to hit the phones.

The Medicare Web site listed "Precision Discounts (Option A)" as having the second best price -- $139.25 -- for my mom's three listed drugs (Isopto Carbachol, Allegra and prednisone). I call Precision to confirm.

The customer service rep tells me that they don't cover prednisone, but they do cover hydrochlorothiazide, Lanoxin (although only in double the dose my mom takes), methazolamide (for $54 to $67, more than the $52.99 she pays with her senior citizen discount and Serevent ($10, instead of Calvert Arundel's $99.54).

And she can only give me the price for Isopto Carbachol in pill form. "Um, these are drops that go in her eyes," I tell her. "Don't you think using pills would be painful?" She is not amused.

Worse, she tells me that my mom's pharmacy doesn't participate in the plan. "But the Medicare Web site says they do!" Sorry, Calvert Arundel is not in the Precision database.

I hang up and call back, getting a different rep.

"Is it true that Calvert Arundel Pharmacy isn't in the plan?" Yup.

"Is it also true that she can get Serevent for $10 if she uses one of the participating pharmacies?"

Well, the rep can't tell. . . . It seems that the database at Precision Discounts has its own little glitch: It can price only pills. Any liquids or inhalers come up with inaccurate information. (Okay, that may explain why the first rep had pill prices for the eyedrops.) But, she helpfully tells me, she can give me another phone number where someone can look up the Serevent price for me.

I call the other number and am put on hold. Five minutes later, a rep says she can't tell me the price of the Serevent unless my mother has already signed up for Precision Discounts.

"No, I need to know the price so we can decide whether it's worth it for her to join Precision Discounts."

Sorry, she is not allowed to disclose the information -- but she'll be happy to transfer me to a number where they'll sign Mom up, and then they can transfer me back to her and she'll tell me the price. I don't think so, I tell her.

I call two more plans, Advantra X-tra and BD Advantage. Neither covers prednisone. Both do cover Lanoxin for $4 to $6, vs. the $22 to $24 offered by Precision and SmartCard.

Alas, BD Advantage says (contrary to the Medicare Web site) that Calvert Arundel Pharmacy doesn't participate.

Then I have a brainstorm. I'll call that pharmacy, find out which plans it participates in, and work backward from there. Reverse engineering!

Alas, this proves impossible. Leo Mallard, the pharmacy owner, tells me that even he isn't sure which plans he's participating in. That's because the pharmacy benefit managers (PBMs) he works with -- companies that administer prescription drug programs -- have been signing him up for Medicare drug discount programs without telling him. In fact, his staff is working right now to try to pull together a list.

Many programs won't give seniors significant savings over the 10 percent discount he already offers them, says Mallard. The plans he likes best so far are Community Care Rx and Pharmacy Care Alliance.

But according to Medicare.gov, his pharmacy doesn't participate in those.

We'll wait a few weeks. There's no deadline for enrolling and, as far as I can tell, the savings aren't going to be so great (if there are any at all) that deferring the decision could cost Mom much. And once she signs up for a card, she's stuck with it for a while: Changes aren't allowed until open season at the end of the year. So I'll give Mom's pharmacy time to sort out which programs it participates in and then get a list from Mallard.

In the meantime, maybe Medicare will clear up some of the Web site glitches. Maybe the discount card programs will work out their customer service and database issues and update some of those 1997 prices. Maybe the PBMs will let the pharmacies know which programs they are working with. Maybe Medicare will spring for a few more phone operators and cut back on the TV commercials. And maybe a squad of flying pigs with MBAs will descend into seniors' homes and help them make decisions personally.

I figure that, in a few months, helping Mom pick a discount card will be easy. It should take about an hour.*

Lisa Barrett Mann, a regular contributor, has been following the Medicare prescription discount card program for the Health section.

LOAD-DATE: May 18, 2004

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Thousands Fail to Pay Premiums
By Philip Meyer
The Washington Post, Times Herald (1959-1973); Aug 21, 1966; ProQuest Historical Newspapers The Washington Post (1 M)

Medicare 'Bug'

Thousands Fail to Pay Premiums

By Philip Meyer
Chicago Daily News Service

Thousands of elderly workers have gotten off to a bad start with Medicare by failing to pay their premiums on time, the Social Security Administration has reported.

Delinquency rates for the $3-a-month payments are running as high as 50 per cent in some parts of the South, a spokesman said. Nationally, it is about 30 per cent. The payments were due July 1.

The slow payments represent only one of several bugs to appear in the massive machinery of Medicare during its first six weeks of operation. However, the program generally is working better than expected.

The problem of delinquent payment affects only the group of 2 million Medicare beneficiaries who are still working. Those who have retired have the monthly $3 checked off their retirement benefits.

Elderly workers who signed up for Plan B, the part of Medicare that covers doctor bills, were billed for $9 to cover the program's first three months. Payments of $3 or $6 also are accepted.

3 Months Grace Period

No one has yet lost any benefits for failure to pay, a Social Security spokesman said. The grace period is three months.

Biggest lag in premium payments is in Southern States, where as many as 50 per cent of the beneficiaries who are supposed to pay in cash failed to send in the money on time.

"We think there's some confusion," an official said.

The $3 premium is matched by another $3 from the Federal Treasury to support the program. It pays 80 per cent of doctor bills after the first $50.

That $50 deductible is also causing some confusion, the official reported.

"Some people thought they had to pay the first $50 charged by each doctor they saw," he said. "Others thought it was a premium they had to pay whether they needed a doctor or not."

As the rule actually works, the $50 deductible must be met only once in each calendar year.

Another problem reported to the Social Security Administration headquarters by district offices is that many people who turn 65 are late in signing up for Plan B.

Should Join Before 65

Those who wait for their 65th birthday to enroll miss the first month of eligibility. The proper time for joining is from one to three months before the birthday.

Once enrolled, many persons have caused themselves unnecessary inconvenience by becoming "overly protective" of their Medicare cards.

The wallet-sized cards are issued to identify beneficiaries to doctors and hospitals. Some people are so afraid of losing them, they have rented safe deposit boxes to store them in. Others have sent them to sons or daughters in distant cities for safekeeping.

"The card isn't all that important," the Social Security spokesman said. "It's nice to have, but losing it won't keep you from getting benefits. The worst that can happen is the inconvenience of applying for a new card."

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Ms. CAPPS. Thank you, and I would just want to recommend to our Chairman, Mr. Barton, that this is a similar kind of narrative that he's suggesting he embark upon with choosing his mother's, her Medicare card and those of us who he's also going to help.

Thank you and I now yield back.

Mr. BILIRAKIS. Thank you. Mr. Upton for an opening statement.

Mr. UPTON. Well, thank you, Mr. Chairman, I'm going to put my full statement into the record.

Dr. McClellan, I welcome you before this hearing today and I thank my Chairman for it. This is, I think, going to end up being a very good program. We look forward to having a constructive relationship with you and I'm going to relay just a little story.

I was at my son's Little League game and a woman came up to me and sadly her mom had had a stroke. And they didn't know how they were going to pay for an extra $600 a month in prescription drug costs in addition to the other things that she had. She said, "Mr. Upton," she said, "is the bill that you all passed, is that going to help?" And my guess is that it's going to help in a big way. My guess is that it's probably going to cover at the end of the day, probably about half of the cost that she would otherwise have to pay without this bill.

This next week I'm going to be in Michigan like most of our Members back in their home states. They're going to be talking to literally hundreds of seniors, talking to them in terms of how they can participate in this new program and I've got to tell you, as I have done that earlier this year, I was most alarmed, in fact, I was more than alarmed, I was visibly angry with the Families USA videotape that I'm told has been sent to all of my senior centers, all the way across the country. And as I sat and watched that, I said to myself, you know, if this was true, I would have voted against the bill. I would have taken time and spoken against the bill, because it is just flat out wrong.

And I think about this woman who has suffered with a stroke, the Little League grandma from the son and I see these stories that are in the papers today. They talk about these scam artists that are going out already. I guess some firms have been identified as sending information, trying to get people to hook up and it's just rip them off. It's just awful stories. You see this stuff now that the senior centers are beginning to witness and seniors are confused. My Dad is 80 years old, but there's a lot of folks in their 80's and 90's, they don't perhaps know how to use that computer as well as you and I can use it. They think that there's a program out there, there really is a benefit, but when they see this stuff, the wrong stories, the bait and switch stories that are out there, you can understand how they get confused. And that's why I'm glad you're there and I look forward to working with you. I look forward to working with my Chairman Bilirakis and Chairman Barton to tell the real story, for us to sit down with our seniors and show them how they can benefit from this program, rather than resort to partisan politics which sadly seems to be taking center stage.

I yield back the balance of my time.

[The prepared statement of Hon. Fred Upton follows:]

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

Dr. McClellan, I want to start today by commending you and your staff in the strongest possible way for the great job you have done in a scant five months to get the new Medicare drug discount card program up and going. I know it's been a Herculean task. Sure, there have been a few glitches—with an undertaking of this magnitude, that is bound to happen. But more importantly, you've found them and moved swiftly to correct them. Our nation's seniors and persons with disabilities are being well-served by you and will be well-served by this new Medicare drug discount card program.

Mr. Chairman, I am very glad we are holding this hearing today. I hope a lot of seniors and their loved ones are listening today. There are organizations out there claiming to represent the best interests of seniors—and especially low-income seniors—who want this new prescription drug plan to fail. If the new Medicare Modernization Act were as terrible as is being portrayed on the video tapes Families USA paid Walter Cronkite to make or in the dire emergency alert mailings going out from the National Committee to Preserve Social Security and Medicare, I wouldn't have spent over three years working on the law, and I sure wouldn't have voted for it.

I am concerned that because of these negative campaigns, seniors across the nation and in particular low-income seniors who will benefit the most from the drug discount cards may be discouraged from signing up. Let me set the record straight:

Right now, unless you already have prescription drug coverage under the Medicaid program, you are eligible to voluntarily sign up for a Medicare-certified prescription drug discount card. Card holders can expect discounts on brand name drugs of 10 to 20 percent or more and on generic drugs of 20 to 35 percent, with some drug card sponsors reporting discounts as high as 40 to 50 percent. There is an enrollment fee which will vary by card sponsors but cannot be more than $30 per year.

Importantly, if you are a beneficiary with an income at or below $12,569 ($16,852 for couples), your card will come with a $600 credit to be used for the purchase of your prescription drugs. Another $600 credit will be provided in 2005. Medicare will pay the enrollment fee.

For more information or to sign up for a card, you can call 1-800-MEDICARE (1-800-633-4277). The phone lines are open 24 hours a day. Or you can go on the Internet at www.medicare.gov and select "Prescription Drug and Other Assistance Programs." This is a very helpful website. It will allow you to enter your prescriptions, compare prices on the discount cards available in your area, and see which pharmacies in your neighborhood are participating.

Check it out, seniors. This is a solid program that will provide real assistance with your prescription drug costs. I am proud to have helped write it and pass it, and I stand by it.

Mr. BILIRAKIS. The gentleman's time has expired. Mr. Rush for an opening statement.

Mr. RUSH. Thank you, Mr. Chairman, and I also want to welcome Mr. McClellan.

Mr. Chairman, I sincerely hope that this hearing will be an informative hearing and I want to just make a comment on the statements that—one of the statements made by my colleague, my colleague and my friend from New Mexico. She said that this program has some glitches in it. Well, Mr. Chairman, I want you to know that in my estimation this program has some gaps, some extraordinary gaps in it. And while I have a lot of problems with this prescription drug discount program, basically for some of the same reasons that my colleagues have voiced.

I still remain hopeful that we can salvage some good out of this, in my estimation, ill-conceived discount card program and give the seniors in our nation some real relief, particularly some seniors from my State and from my District. And in this regard, I want to touch on the $600 Transitional Assistance to low income seniors. This subsidy is one of the few aspects of the discount program that supposedly offers beneficiaries guaranteed savings.

However, at a closer look, the program does virtually nothing for many low income senior citizens and proponents of this program greatly over-estimate the generosity of the yearly subsidy. In my home State of Illinois, CMS and the Illinois Department of Public Aid have estimated that 348,000 seniors could benefit from the $600 yearly subsidy. However, Mr. Chairman, they also concluded that the vast majority of these seniors are ineligible for the subsidy because Illinois already provides a Medicaid prescription drug benefit known as Senior Care for beneficiaries 200 percent above the poverty level.

Illinois' threshold is far greater than the 135 percent threshold under the discount program. Moreover, Illinois already offers a state prescription drug discount card which offers Illinois seniors an average of 21 percent in savings, far, far better than the estimate 10 to 25 percent in savings CMS estimates for its faulty discount card. As such, this discount card program does virtually nothing for the seniors in my State.

Mr. Chairman, with that, I'd like to submit for the record a letter from the Illinois Department of Public Aid——

Mr. BILIRAKIS. Please finish up.

Mr. RUSH. Dated May 20, 2004 and I would like, Mr. Chairman, at the time of the questions to the panelists to explain how this discount program, this hyped up program is going to help my senior constituents in Illinois.

[The letter follows:]

ILLINOIS DEPARTMENT OF PUBLIC AID
SPRINGFIELD, ILLINOIS 62763-0001
May 20, 2004

Rep. BOBBY RUSH
2416 Rayburn House Office Building
Washington, D.C. 20515

DEAR REP. RUSH: Your staff recently inquired about the number of Illinoisans who are currently covered by the existing Illinois drug programs and who are, therefore, excluded from the Medicare Discount Card Transitional Assistance. This letter responds to that inquiry and lays out the programs available to Illinoisans today.

Residents of Illinois benefit from a wide range of state programs providing them with increased access to affordable drugs. These programs include Medicaid, SeniorCare, Illinois Pharmaceutical Assistance Program and the Save Rx—the Illinois Discount Card.

The State of Illinois provides coverage through the Medicaid program for individuals who are Aged Blind or Disabled (AABD) whose income is below 100 percent of the Federal Poverty Level (FPL). As of April 30, 2004 , there were 372,262 Illinoisans enrolled in the AABD program. These enrollees receive a comprehensive drug benefit with minimal copays ($3 for brand name drugs and no copay for generic drugs).

The State of Illinois also provides comprehensive drug coverage for Illinois seniors whose income is less than 200 percent of FPL through the SeniorCare program, which is a Medicaid waiver. As of April 30, 2004, 173,726 Illinoisans were enrolled in this program. IDPA has previously estimated that the total population of seniors eligible for SeniorCare at approximately 360,000. There is no enrollment fee for SeniorCare. Copays are minimal ($4 for brand name drugs and $1 for generic drugs).

You asked whether seniors in Illinois would benefit from the $600 temporary assistance (TA) available through the Medicare discount card. Neither of the above mentioned populations, AABD or SeniorCare are eligible for the $600 temporary assistance as part of the Medicare discount card. TA is only available to individuals with incomes below 135 percent of FPL. Income eligibility for SeniorCare extends beyond the income eligibility for TA. Therefore, seniors who are eligible for TA would generally already be covered or eligible for the more comprehensive programs AABD or SeniorCare.

The only individuals in Illinois that would benefit from TA who are not eligible for the more comprehensive SeniorCare program are those under 65 years old who are disabled, whose income is between 100 percent of FPL and 135 percent of FPL and who are on Medicare but not enrolled in Medicaid. We anticipate that many of these individuals with drug need will currently be enrolled in the Illinois Pharmaceutical Assistance Program (IPAP), as described below.

IPAP is a drug program funded by the State of Illinois. It offers both seniors and disabled individuals access to a limited formulary of drugs for Alzheimer's disease, heart and blood pressure problems, arthritis, cancer, osteoporosis, diabetes, glaucoma, lung disease and smoking-related illnesses, multiple sclerosis and Parkinson's disease. This program is available to those whose income is up to approximately 240 percent of FPL. We estimate that a maximum of 9,237 of these individuals will be eligible for TA through the Medicare discount program.

I hope this information will be helpful to you.

Sincerely,

ANNE MARIE MURPHY, PH.D.
Medicaid Director for the State of Illinois

Mr. BILIRAKIS. Mr. Deal for an opening statement.

Mr. DEAL. Thank you, Mr. Chairman. I want to also welcome Dr. McClellan here and I thank him for undertaking a very huge job and for his dedication to that. I thank him also for meeting with me on a constituent matter that we've had and look forward to concluding that successfully.

The enormity of this job, I think is certainly one that we all have difficulty comprehending and I thank you for your efforts.

Mr. Chairman, we have heard a lot of talk today and I think there's one thing that my senior citizens in North Georgia understand and that's the difference between somebody who tries to do something and somebody who simply talks about it. The 10 years preceding, for a decade, Congress has simply talked about prescription drugs. My senior citizens understand that talking about it doesn't help them one bit. Doing something is what begins to help them.

We have taken that step. It may not be perfect and certainly I'm sure it's not perfect, but first of all, we can't even agree on what the definition of perfect is. So let's deal with what we have. Let's try to make it work.

Now if they think the discount card is confusing my 97-year-old mother who lives with me is a retired school teacher. She's under the public retirement system of the State of Georgia as a school teacher, which provides pharmaceutical benefits. They've just now put out a new proposal for the different plans that are available to them which include pharmaceutical benefits. Now if you think this is confusing, you ought to see those choices and try to select the plan that's going to cover the medicines that she takes.

Nothing is perfect. Let's take the issue that we have dealt with. Let's try to make it work to the best way possible, and if it needs perfecting, we can work on that in the days to come.

Thank you, Dr. McClellan, for being here.

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

Ms. ESHOO. Good morning, Mr. Chairman, and good morning, Dr. McClellan. Thank you for being here today and it's a pleasure to see you.

Mr. Chairman, thank you for holding the hearing. I think this is an important one.

As we move from one side to the other, there is a great deal of passion about this and it's understandable on the Democratic side, this is not the way the Democrats would have liked to have reformed Medicare and added this benefit and that's eminently clear and we really, I don't think, need to go after each other on it. This is really a major difference between the two major political parties in our country.

My Republican friends are proud of what they have constructed and now that the law is passed, we're here, we're here to talk about how this thing is working. And so that's what I'd like to make my comments about and that we concentrate on what is on the table and what's out there in terms of our constituents.

I have a town hall meeting coming up. Each one of us in our own way is responsible for putting this information out to the people we represent. Whether we vote for something or not, we still represent everyone and we have to explain it to them. So I think today I'd like to hear more about how we're going to move over some of the early very apparent bumps in the road which is not a surprise. Plus, this is complicated. It's not really the simplest thing to carry out.

What I want all of us, I think, to keep in mind is that over four decades Medicare has been the gold standard for seniors. They always want more things to be a part of it. They've never wanted it scrapped. They like what they have, but they have, with legitimacy wanted benefits added. So it's a trusted program. And I think that where we are right now, we have to be sure that that trust is not damaged and that's what I'm concerned about because I think the discount card is, well, the Republicans made fun of the Clinton health plan and said that it was a Rube Goldberg plan. I think that sometimes when you complain about something so much, that maybe it's a catchy disease. There's something that kind of smells and tastes and looks like that Rube Goldberg plan right now, because it is enormously complex.

Yesterday, the Wall Street Journal reported that there were wild fluctuations in the cost of drugs from 1 week to the next and no one could explain why. And the woman that wrote the article is someone that—oh, from the Washington Post, is the health writer. So this is a knowledgeable individual.

So today, Dr. McClellan, you know and it's been said by others, what the problems are right now. You know my District and there are a lot of people that are plugged in and make use of the internet, so they're going to be able to navigate.

What about the rest? And what about the things that have now surfaced? How are they going to be addressed?

I want to throw one more thing in, Mr. Chairman——

Mr. BILIRAKIS. Quickly.

Ms. ESHOO. The full chairman of the committee chaired INO here and I think that for the transparency and the importance of the Congress leaning in, we should have an INO hearing on the ruling that the GAO came out with. We are big enough, tall enough, mature enough and American enough to review those things and learn from them. Thank you very much.

Mr. BILIRAKIS. The gentlelady's time has expired. Mr. Shadegg for an opening statement.

Mr. SHADEGG. Thank you, Mr. Chairman, and I want to thank you for holding this hearing. I guess I want to begin by noting the title of the hearing, "Medicare Prescription Drug Discount Cards: Immediate Savings for Seniors."

There has been a great deal of criticism, but none of the criticism claims that we aren't doing something about the problem. And I want to kind of hue the line followed by my colleague, Mr. Deal, in talking about the difference between criticism and action.

I'd like to begin by thanking my colleague, Mr. Shimkus, for pointing out that under the leadership of Chairman Barton of this committee, Mr. Burr, Mr. Buyer, Mr. Norwood, and myself, it was this committee's so-called rogue group that produced the idea for a drug card and it became a part of this program.

I think it is not, of course, perfect. But I think that the vitriolic criticism of some people, which has gone so far as to discourage seniors to even try to make the card work for them, is inappropriate. I simply want to quote a rather famous quote from Theodore Roosevelt on the difference between criticism and action. Theodore Roosevelt once said, "it is not the critic who counts, not the one who points out how the strong man stumbled or where the doer of deeds could have done them better. The credit belongs to the one who is actually in the arena, whose face is marred by dust and sweat and blood, who strives valiantly, who errs and comes up short again and again because there is no effort without error and shortcomings, but who does actually strive to do the deeds, who knows the great enthusiasms, the great devotions, whose spends himself in a worthy cause, who at best knows in the end the triumph of high achievement and who at worst, if he fails, at least fails while daring greatly so that his place shall never be with those cold and timid souls who know neither victory nor defeat."

We enacted a drug discount card last year. It is the law of the Nation. We need to work to make it the best we can for the American people and I commend you, Mr. Chairman, and I think this hearing is a step in that direction.

Mr. BROWN. Mr. Shadegg, will the gentleman yield for a moment?

Mr. BILIRAKIS. Will the gentleman yield?

Mr. BROWN. Just for 30 seconds.

Mr. SHADEGG. Certainly.

Mr. BROWN. A lot of us wanted to be in the arena during the Medicare debate. We weren't allowed to offer floor amendments. We were pretty much locked out of the conference——

Mr. SHADEGG. Reclaim my time.

Mr. BROWN. I love that quote and I appreciate your bringing it up.

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

Mr. Stupak for an opening statement.

Mr. STUPAK. Thank you, Mr. Chairman, and thanks for holding this hearing. For almost 40 years, our seniors have counted on Medicare to be dependable, simple and affordable. These cards do not meet the Medicare standards. Our seniors need a prescription drug plan that they can understand and that will offer a real discount they can count on.

This drug card fiasco is not what seniors want or what they deserve. I think it will become very clear today that there's an infinite amount of confusion and frustration surrounding these cards.

Even though HHS is spending $18 million, now we understand the $18 million was illegally spent according to GAO, but they'll spend $18 million to tell of the savings generated by these cards, telling seniors to wait to enroll. Are seniors supposed to wait or not wait?

HHS says seniors should monitor the website for a week before choosing a card because prices will change. But there's evidence that the prices on the Medicare websites aren't always correct.

Many of the prescription drug card companies have said that the prices on the Medicare websites are wrong. HHS is still taking new applications for cards. And the drug prices and drugs covered can change weekly.

How can a senior, how can anyone, make good decisions when the administration is giving them bad information and information which is changing every week? The bottom line is that these discount cards do not have to be this confusing and we could have provided a real drug benefit.

Had we leveraged the bargaining power of the Federal Government as many of us have advocated, seniors would be receiving real savings. Instead, seniors under this plan are going to pay 75 percent more than what the VA pays for their drugs.

Why can't we have one card instead of 73, with a real benefit leveraging the purchasing power of all seniors? That's the question seniors across my District are asking me and that's the question I put to my colleagues and the administration.

I wish to thank Families USA and Walter Cronkite for their efforts to put forth accurate information in the videos that we have seen. Not only have they pointed out the pitfalls of the discount cards, but they have really looked at and examined how an individual applies, what are the qualifications, and put forth questions that I think we all need to ask, not just simply disregard the questions that are out there.

There are some complex issues with this card. I don't think it had to be that difficult and so with unanimous consent, Mr. Chairman, I'd like to put in my whole statement and also the Washington Post article of Tuesday, May 18, entitled "Pick a Card!#?$!". I believe you already said it would be accepted, but I just want to make sure it's part of my whole statement and part of my statement here this morning.

I yield back and I look forward to listening to Dr. McClellan and other panelists here today.

Mr. BILIRAKIS. Without objection. Mr. Hall for an opening statement.

Mr. HALL. Mr. Chairman, I'll not make an opening statement. I just want to put it in the record. I just commend you and Dr. McClellan and all on both sides of the aisle that are participating and have put some input into it. I just think it's great that Americans have a wide range of needs, and a one-size-fits-all program is not good. That's not what this is. I think of 39 cards to choose from in Texas alone, seniors can surely find one. The beauty of it is if they don't want or need a discount card and because of the vol-

untary nature of the program, they don't have to buy one. There's going to be bumps along the road, but I think that the Center has done a good job and I'm looking forward to this hearing today and listening to how they will be improving their service to the public in the coming weeks and months.

And I yield back my time.

Mr. BILIRAKIS. The Chair thanks the gentleman. Mr. Rogers for an opening statement.

Mr. ROGERS. I'll waive.

Mr. BILIRAKIS. Mr. Greenwood for an opening statement. That completes all of our opening statements. Let's move right into the first panel. We appreciate your patience, Dr. McClellan.

Mr. MCCLELLAN. Thank you, Mr. Chairman.

Mr. BILIRAKIS. The first panel consists of Dr. Mark McClellan, Administrator for the Centers for Medicare and Medicaid Services, in case any of you out there didn't already know that.

You have 10 minutes, sir. Please proceed.

STATEMENT OF MARK B. McCLELLAN, ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Mr. MCCLELLAN. Okay, Chairman Bilirakis, Representative Brown, all of the distinguished committee members here today, thank you for your strong interest in the Medicare-Approved Drug Discount Card and the $600 credit. As you know, Mr. Chairman, we are going to have a few extra minutes as part of my presentation to show you exactly how to get the benefits from this program.

As you all also know in the 5 brief months since the Medicare Modernization Act was signed into law, CMS has created and implemented the first major drug assistance program to be offered through Medicare. As we speak, Medicare beneficiaries who choose to do so are enrolling in the voluntary Medicare-approved drug discount cards to get some immediate relief from prescription drug costs. And they are. Studies of the card prices show significant savings of 11 to 18 percent off the average retail prices paid by all Americans; 16 to 30 percent off of the usual retail prices for brand name drugs and even greater discounts of 30 to 60 percent or more on generic drugs. Prices are also generally significantly lower for mail order drugs on Medicare-approved drug discount cards and are available on the internet. And many cards have open formularies, meaning discounts across the board on drugs.

An especially important feature of the cards, especially important, is the substantial help that has been mentioned before that's coming right now for the more than 7 million Medicare beneficiaries with incomes below 135 percent of the poverty level who don't have good drug coverage. Just this week CMS completed an analysis that shows low income Medicare beneficiaries will be able to see big savings of between 30 and 77 percent on bundles of brand name drugs that they commonly use and up to 92 percent on individual generic and brand name drugs when they combine the lower prices they'll be paying with the $1200 in credit available to them over the next year and a half. And these large savings don't include the low prices that many drug manufacturers are pro-

viding in working with us to the low income beneficiaries who use up their $600 credit.

As an example, one beneficiary's savings in this study increased from about 59 percent with the drug card alone, to 88 percent off their drug costs with the additional manufacturer offerings. Counting these special pricing arrangements, the significant discounts and the $1200 credit, the new sources of savings mean thousands of dollars in savings this year and next for low income beneficiaries, ahead of the comprehensive drug benefit. Starting next month, it's no longer talk about Medicare providing help with drug costs. And that overdue help is especially important for our beneficiaries who have been struggling between the costs of drugs and other basic necessities of life.

Of course, one of the cornerstones of the discount card program is the new Medicare price compare tool which we're going to demonstrate for you today. Through this feature on both our website and our 1-800-MEDICARE number, we're providing beneficiaries with information they've never before been able to access and we're using it to fundamentally change the way that Medicare helps people in this country to buy drugs. With the new ability for seniors to band together to negotiate lower prices from drug manufacturers, combined with an unprecedented ability to find out about drug prices at more than 50,000 retail and mail order pharmacies all over the country, it's also our responsibility to provide beneficiaries with the help they need to get the most out of this new program, based on their individual and diverse drug needs.

To get the most out of the program, you need to remember three things: your zip code, your medicines and their doses, and your total monthly income, if you think you may qualify for the drug credit. Zip code, medicines, income. With this information you can call 1-800-MEDICARE and talk to a trained customer service representative to find out about your best options. And we can also help you with special preferences about particular pharmacies or cards including low fee cards and free cards. Our customer service operators will even send a personalized brochure which many of you have an example of sitting at your table, with information on the best cards based on that individual beneficiary's drug needs and the simple two-page standard enrollment form. And we can typically do all of this in 15 minutes or less. Or you can get all of this personalized help by visiting our website at Medicare.gov. It's that simple.

We're committed to getting beneficiaries the information they need to get the most from this program, so we have expanded our phone and website support to ensure timely assistance 24/7 to respond to truly unprecedented call volume, averaging 400,000 calls per day during the beginning of May. We quadrupled the number of 1-800-MEDICARE customer service operators from more than 400 to more than 1600 and we've added more in the past week. We will be adding as many more as are needed. We've added voice messages to help callers be better prepared to speak to customer service representatives. We are providing self-service information in our voice response system and we developed best practices to help customer service representatives reduce call times. We're also making many improvements in our website which I'll be happy to

talk about as well in response to some very constructive feedback from consumers, from advocates, including some that are testifying today, and from reporters and others.

As a result of these improvements, we're getting to meet the demand. Waits are usually no more than a few minutes at our call centers this week and no more than 15 minutes even at the peak times. Moreover, we work with card sponsors to ensure that the prices they have submitted to us for posting on the website are prices that they can assure the beneficiaries when they go to the participating pharmacies. We believe the information now in the website reflects just that, the best assured price. We've also taken new steps to make sure that we can take effective action against cards that don't live up to their promises.

Now at this point I'd like to turn over this presentation to Mary Agnes Laureno from CMS' Center for Beneficiary Choices, who is going to walk us through a quick demonstration of the price compare tool.

Mary Agnes. I think you'll be able to see this on your viewers.

Ms. LAURENO. Thank you, Dr. McClellan. What you're seeing here——

Mr. BILIRAKIS. You'll have to pull that mic closer, please.

Ms. LAURENO. Thank you. What you're seeing here is the home page of the Medicare.gov website and you'll see that the first link under the features tool is our prescription drug and other assistance tool program. Now at the very beginning, the first thing that we tell them is what you need to get started and we explain it as Dr. McClellan mentioned. You need the name of your drug, the dose, the pill size, etcetera, so that they can be fully prepared to go through this tool.

We have a quick search feature for those individuals with higher incomes who aren't interested in learning about other assistance programs or the $600 Transitional Assistance. And then we have our screening questions for the rest of the individuals. And our first question is "do you currently have Medicare?"

We ask other screening questions that help us determine eligibility for the $600 credit and for the drug card such as "Are you currently receiving Medicare? Do you use TriCare, FEHBP or other insurance coverage?"

I'm going to demonstrate a low income beneficiary from Clearwater, Florida, so I'm going to enter her zip code. We ask screening questions about whether the individual is an American Indian using Indian Health Service pharmacies or in a long-term care facility because that helps us to determine whether they might be interested in one of the specialized drug cards. We ask whether the individual is married or single because that affects the income levels. And as I said, I'm going to enter a low income beneficiary with minimal resources.

We then simply click the continue button. The next bit of information that we ask the user for is for the drugs that they are currently taking. And this individual is taking Celebrex, so I type in the first few letters and Celebrex will come up. And she's taking Zocor to lower her cholesterol. And she's taking Paxil. And she's taking Norvasc. So those are the four drugs that she's taking and then again I'll click the continue button.

Now we're screening individuals based on the information they gave us, not only for eligibility for the discount card or for the $600 Transitional Assistance, but also for any other programs that might be a good fit for their individual situations. So in this particular example, this person would qualify or appears to qualify for Medicaid for the State of Florida. So we put information about the Medicaid program, the eligibility criteria, who is eligible, where to apply and any important notes about that program.

We also have information about other sources that she may be eligible for, but again, we put the one that looks like, the best fit for her in the first page so we have information about State pharmacy assistance programs, both the Prescription Discount Program in Florida as well as the Pharmacy Plus Silver Saver program that's available in Florida. Again, we put contact information, eligibility criteria, who has to apply, where to apply and how to contact them.

Similarly, we put information about pharmacy assistance programs that are available, again geared toward the specific drugs that this individual is taking. So for example, the GlaxoSmithKline program covers Paxil and again, we give all the information about eligibility and how this individual can go about applying and contacting Glaxo for that program.

We also want to make sure that individuals have all the information that they need about all the ways that they can save on their drugs. So on our More Ways to Save program, we also provide some educational information about generic alternatives and mail order. And again, we customize this to the individual drugs. So we list the drugs that she's taking and explain that there is a generic available for Paxil where she can save additional money.

For individuals who are interested in one of the Medicare managed care plan options or are currently enrolled in a Medicare managed care plan and want to see whether they offer a discount card, we have the simple tab there. We list all of the Medicare Plus Choice organizations available in the individual's zip code, the monthly plan premium. We provide information about whether that plan currently has a benefit that offers prescription drugs. If so, the co-pay information and then we tell them whether they currently offer a Medicare-approved discount card, yes or no, and whether there's a charge for that card. If the individual was interested in more information about the Humana Plan, they would simply click on that and pull up a full screen of all the benefits.

With that, I'm going to go ahead and go into the actual compare prices for the drug discount card. We have a simple link here called Compare Prices that will take you into the tool. We do have a user agreement to explain that we do not want unauthorized use of this for people to take the information and then sell it, for example. The user just simply clicks "agree."

We're now on the page where you enter the dosage and the frequency with which you're taking the particular drug. And this information, we do need in order to be able to accurately price it. So for this individual, she's taking 5 milligrams of Norvasc. She's taking 20 milligrams of Paxil. She's taking 40 milligrams of Zocor. And she's taking 200 milligrams of Celebrex. If I had forgotten to add one of my drugs, I could simply use this "add another drug"

button here. She does take these once a day, so she takes them 30 pills a month.

I have a choice if am I interested in looking for cards and pharmacies close to my zip code or do I want to go farther out and I'm going to just keep it close to my zip code. And I can have a choice of, am I interested in getting information on the mail order pricing and generic alternatives, which I'm going to say yes.

This is the summary information for the discount cards. It has a listing of all of the discount cards that are available that cover all of her drugs. You can see it's a nice list. We tell them how many pharmacies are available in the zip code radius. In this instance, one and a quarter miles around her zip code. We list the information by lowest to highest price, so Argus does have the best price for retail drugs for her area at $298.75 to $375. And we also offer the pricing information for the generic alternatives. Argus doesn't happen to have a mail order pharmacy, but U Share does, so where there is a mail order pharmacy available, we also offer information on that pricing.

And I'm going to say that I'm interested in information on the five drug cards that have the best retail pricing for this individual. I can then drill down to our pharmacy by pharmacy, drug by drug pricing information. So now I can see that I have, for example, the Argus drug card program that had three pharmacies in their area. And I can see Eckerd, Publix pharmacy and Walgreens. Walgreens seems to have the best pricing for the drugs that this individual currently offers. And I can go drug by drug to see exactly what the pricing is for Celebrex, Vorvasc, Paxil and Zocor. Since this individual was eligible for the $600 credit at the 5 percent co-share, we also list information on the co-share amount that they would currently pay. Again, I can go down card by card for the five drugs that I picked and look at each of the pharmacies that are in that drug card's network as well as the pricing that's available.

Thank you.

Mr. MCCLELLAN. Thank you, Mary Agnes. Mary Agnes is an example of the talent and hard work at the Agency that's enabled us in just the 5 months since the law was passed to begin to help Medicare beneficiaries, especially the millions of beneficiaries with low income and no coverage. On this example, if the person had called up, we would have gone through this with them. They would be mailed a personalized brochure with their name on it. I think you have copies of the kind of brochure that we send out in this case, which is a personalized booklet about prescription drug and other assistance programs including all those additional assistance programs that Mary Agnes mentioned, Medicaid, other public and private sources of drug savings, all designed for that individual beneficiary's needs. Very personalized service.

By combining this kind of unprecedented transparency in prescription drug pricing and the negotiating power of our beneficiaries, with this new level of personalized assistance, and also by listening to the constructive suggestions that we're getting in these early days about how we can do even better, Medicare is beginning to provide real help for beneficiaries with lower drug costs and that's definitely the case in this example where for her basket of drugs, the lowest price offered at retail pharmacy right in her

neighborhood was about $300. That was a savings of 18 percent off the national average retail prices of those drugs and many seniors can't even get those average prices because they don't get the same kind of discounts that people with public or private insurance are allowed to get. So this translates into savings of over the next 7 months, the rest of this year, totaling almost $500 for the discounts and if you include the $600 credit, the savings are well over $1000 or 41 percent of this beneficiary's medications' cost.

So thank you for the opportunity to testify today. Thank you for that opportunity to go through an example of how this program works and how beneficiaries can get the most out of it and I look forward to answering all of your questions.

[The prepared statement of Mark B. McClellan follows:]

PREPARED STATEMENT OF MARK MCCLELLAN, ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Chairman Bilirakis, Representative Brown, distinguished Committee members, thank you for inviting me to discuss the Medicare-Approved Drug Discount Card and the Transitional Assistance Program, which were enacted into law on December 8, 2003, as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). This May, we reached the five-month mark since the legislation was enacted. CMS worked diligently to meet this aggressive deadline to implement the drug card and transitional assistance program—and we succeeded. In that time, we issued an interim final regulation and guidance, set up the new drug discount card program with new information and outreach systems to support them. Drug card sponsors began marketing and enrollment efforts on May 3 as scheduled.

As we speak, Medicare beneficiaries are enrolling in Medicare-approved drug cards that will give them immediate assistance with high prescription drug costs. We are already seeing evidence of significant savings between 10-17 percent off the retail prices that the average American pays, and even greater discounts of 30-60 percent or more on generics. These cards will offer real help to those Medicare beneficiaries struggling with their drug costs. And many cards have a low annual fee (or no fee at all) so many beneficiaries can recoup the cost of enrollment in their first purchase. In addition to the real savings, low-income beneficiaries may get even more help in the form of a $600 annual credit on the discount card, nominal cost sharing, and other price reductions from manufacturers.

BENEFICIARY ACCESS IMPROVEMENTS

In spite of substantial progress we have made thus far and the fact that beneficiaries are seeing savings, we recognize there have been some operational problems. However, we are identifying and correcting these problems and, with each passing day, improving the efficiency of this program. As you all know, in the brief five months since MMA was signed into law, CMS took the drug card program—the first of its kind to be offered through Medicare—from conceptual idea to reality. Implementing the drug card in such a short period of time presented many challenges for the Agency, including developing the technical platforms to support public display of unprecedented amounts of drug pricing information.

The initial phase of a major new program is clearly a time of learning, and what we have seen is that millions of seniors and people with disabilities are very interested in learning about the best ways to save on their drugs. During the first few days of May, we averaged 400,000 calls to 1-800-MEDICARE each day. This is an extraordinary call volume for one week, particularly when you consider that we had 6 million calls in all of 2003. Responding to this volume of calls was a significant challenge to our high customer service standards in Medicare. Even with this unprecedented level of interest, we are committed at 1-800-MEDICARE to provide service that reliably gets customers the help they need in a matter of minutes.

We have worked quickly to improve the program and we will continue to do so as we identify problems. At 1-800-MEDICARE, we tripled the number of customer service operators from 400 to more than 1400 available by last week. In recent days, we added another 600 customer service staff, and we expect to add many more trained representatives in the next couple of weeks to handle the unprecedented number of callers in a timely and effective manner. We've also taken steps to reduce the time that our customers have to take when they call, by adding voice messages that can help callers to be better prepared when they reach a customer service rep-

resentative. We have also provided self-service information in our interactive voice response system so that callers can get information to address their questions without needing to speak with a customer service representative. And, we have also developed additional tools to help our customer service representatives use "best practices' to work more efficiently—reducing our call handle time significantly and allowing our representatives to serve more callers more quickly. As a result, we are achieving much better support results—the kind of results our beneficiaries deserve and expect. We are tracking our call center wait times and call times, and we are reaching the balance we want between calls and caller support. This week, during our busiest times of the day, the wait times were from 4 to 15 minutes (and we are advising beneficiaries about approximate wait times), and at many times the waits have been even less.

We are committed to getting people with Medicare the information they need to get the most out of the drug cards, and that starts with personalized facts now available in just a few minutes through 1-800-MEDICARE or Medicare.gov. To help callers and web visitors who have trouble matching up their medicines with the discount information, we have added a "drug lookup" feature to assist with the spelling of their drug names and we are expanding our drug entry list—a large and growing "dictionary" of drug names. In the interim, we have also provided instructions to users that they can "add another drug" if they do not find their drug on our initial drug entry screens. Further improvements to the drug and dosage entry screens will be in place in the next few weeks. We are committed to continuing improvements to the site navigation and functionality features based on feedback from all of our users.

We appreciate the unprecedented level of interest and feedback we are receiving from beneficiaries and others in the first days of this new program. We will continue to refine and improve our 800 number and our web site by using feedback from all interested parties, including the suggestions we have received from Members of Congress. By following a few simple steps—especially by being ready with zip code, drugs and doses, and income information—beneficiaries can get the personalized information they need quickly. And beneficiaries should remember that the drug card is voluntary—there's no deadline and no late enrollment penalty, although signing up by June 1 means that they will start seeing the discounts right away. We also know that beneficiaries have diverse needs and are waiting to get information to help make the choice that is best for them.

It's also important to remember that despite the challenges we face in implementing this brand new program, we are providing beneficiaries with information they have never before been able to access. Further, the drug card is a fundamental change in how Medicare helps beneficiaries buy drugs. Beneficiaries will get lower prices for their drug purchases because they will be able to band together to use their purchasing clout through the power of large purchasing pools to leverage discounts from drug makers. By combining unprecedented transparency of prescription drug prices with individualized assistance and educational resources, we are working with card sponsors to use modern technology to provide the medicines Medicare beneficiaries need at a lower cost. Transparent prices for Medicare-approved cards gives beneficiaries important information to help them choose the best card for their needs.

BENEFICIARY ELIGIBILITY FOR LOW-INCOME CREDIT

One of the most important messages I can convey today is the tremendous help the drug card will provide for low-income beneficiaries. Medicare beneficiaries are eligible to enroll in the drug card of their choosing, unless they have drug coverage through Medicaid. If beneficiaries receive help with prescription drug costs through other sources—retiree insurance, Medigap coverage, or health plan benefits, they don't have to enroll if they don't want to—the program is completely voluntary. However, beneficiaries with limited incomes who are struggling with prescription drug costs unquestionably can get much needed financial assistance. More than7 million beneficiaries with incomes below $1,047 a month ($12,569 a year) for single people or less than $1,405 a month ($16,862 a year) for couples who do not have drug coverage may qualify for the $600 drug credit as early as next month and an additional $600 again in January of next year. The discounts from the cards combined with the $600 credit available in June and again in January, and substantial additional manufacturer and pharmacy discounts specifically targeted at low-income individuals make this an exceptional program for low-income people with Medicare—our most vulnerable beneficiaries. We want to make sure that everyone who qualifies for the $600 credits get it. So, we have worked closely with our partners at the Social Security Administration (SSA) to send letters to millions of low-income

beneficiaries that are eligible for the $600 credit. We are also working closely with community organizations to make sure these beneficiaries are aware of the substantial savings and assistance now available to them through the drug card program.

PRICE COMPARE

We are doing everything we can to ease the drug card enrollment process for Medicare beneficiaries, and a big part of enrollment is selecting the best card for an individual's needs. Today, beneficiaries comparison-shop for many decisions in their daily lives comparing the price and quality of a product or a service. Medicare beneficiaries with and without prescription drug coverage often find it difficult to find the best prices on prescription drugs, especially at neighborhood pharmacies. That's changing with our new Medicare Price Compare tool, which we will demonstrate for you today. This is a feature on our website, www.Medicare.gov, that beneficiaries can use directly, or that they can have a representative from 1-800-MEDICARE helpline walk them through the same process. In addition, beneficiaries can consult with beneficiary advocates, such as the thousands of local trained State Health Insurance Assistance Program (SHIPS) volunteers, or consumer groups to find the best deal. And beneficiaries need only three key pieces of information: their zip code, the medicines they use, and their income.

The Medicare Price Compare feature—the website and the assistance available through 1-800-MEDICARE—is designed to help people with Medicare lower their drug costs by selecting the best discount card. Price Compare is a unique tool that allows users to customize their search to get the best prices available for that drug or mix of drugs. Making price comparisons on a drug-by-drug basis is difficult for many beneficiaries who take multiple medications, and Price Compare permits comparisons involving multiple drugs. Price Compare provides this information for the retail pharmacy setting—where most Medicare beneficiaries purchase their drugs. Moreover, card sponsors must assure beneficiaries that they will pay no more than the discounted prices listed on Price Compare. The price the beneficiary ultimately pays may be even lower due to the increased visibility of prices and ongoing competition among card sponsors.

Through the new website, beneficiaries for the first time in the Medicare program will have access to prices for approximately 60,000 products sold at nearly 75,000 pharmacies around the country—all turned into information they can use to get the best bargains on the drugs they need. Using the website's therapeutic alternative function, a person can look up a clinical condition like high cholesterol, and see average prices for Lipitor as well as for other cholesterol-lowering agents like Zocor and Crestor—options that may be worth discussing with their doctor if they are less expensive and clinically appropriate. In addition, patients can also get information on generic alternatives, which are just as safe and effective as the brand-name versions when approved by the FDA.

We are working with card sponsors to ensure that the prices they have submitted to us for posting on the website are prices they can guarantee to beneficiaries at the included participating pharmacies. We believe the information now on the website reflects just that, and we have also taken new steps to make sure that Medicare and the HHS Office of the Inspector General can take effective enforcement actions against cards that don't live up to their promises. Over the coming weeks, we will continue to work with the card sponsors to help consumers get consistent information whether they visit medicare.gov or the sponsor websites. But in the meantime, we remain committed to our requirement that beneficiaries must pay no more than the discounted price listed by Medicare.

With the unprecedented amount of information now available on drug prices through Price Compare, CMS has put comprehensive systems in place to help beneficiaries use this information to find the best deal on their prescription drugs. The 1-800 MEDICARE customer service representatives will provide detailed information over the phone and then follow up by sending out a personalized report that includes information on how the drug card program works and detailed information on the best cards for that beneficiary. Beneficiaries can even designate the number of cards they want to review—2, 3, or as many as they want. The Price Compare search can also turn up cards that get the lowest prices on certain drugs, cards with low or no fee, networks that include specific neighborhood pharmacies, and/or cards from specific sponsors familiar to beneficiaries. We'll also include information on total drug costs, and additional ways to save, such as purchasing generic drugs. The brochure also includes information on how to sign up for the card the beneficiary chooses—including the 1-800 numbers for the card sponsor choices for with the best prices for that beneficiary and our standard 2-page enrollment form. After enrolling, beneficiaries will get their cards in a matter of days.

But we're reminding beneficiaries that they don't need to sign up yet—this is a good time for beneficiaries to shop around to consider their options for Medicare-approved drug discount cards. They can window shop now on the website to see how cards compare on price, and visit again whenever they choose. For those individuals who sign up by the end of May, they will get the benefits of the discount program when it starts on June 1. Beneficiaries, however, are not required to choose a card in May; they can choose a card whenever they wish, with no penalty for enrolling later. However, we are encouraging beneficiaries with limited incomes to look into the program now, so they can start saving immediately on their prescription drug costs. Best of all, it doesn't cost low-income beneficiaries anything to enroll in a drug card of their choosing. The $600 credit this year and the $600 credit next year, plus additional discounts that a growing number of major drug manufacturers are offering to wrap around the discount cards and existing state-sponsored drug programs all translate into literally thousands of dollars in additional assistance for low-income beneficiaries.

AUTOENROLL AND STANDARDIZED FORMS

Twenty states currently have programs that already provide drug benefits to low-income beneficiaries, many of whom will be eligible for the $600 credit. Since most of these Medicare beneficiaries may enroll in both the state program and the Medicare program at the same time, CMS recently announced that low-income Medicare beneficiaries enrolled in State Pharmacy Assistance Programs (SPAP) that provide discounts on prescriptions drugs and who act as the beneficiary's authorized representative in accordance with state law, may, at the state's option, be automatically enrolled for the $600 credit on a Medicare-approved drug discount card. Auto-enrollment benefits both Medicare beneficiaries and the states. Medicare and the states want low-income beneficiaries to get the additional $600 credit, and auto-enrollment is one way to maximize the number of people who enroll for transitional assistance. In addition, the states would be exempt from paying the first $600 for each of these beneficiaries, thus freeing up additional money to finance their own drug assistance programs.

We are going to work with states to automatically enroll their SPAP members into a Medicare-approved drug card and obtain the $600 credit so there is no loss in coverage or confusion for the beneficiaries. However, the auto-enrollment process must allow a beneficiary the choice to decline being enrolled in a Medicare-approved card before the actual automatic enrollment takes place. States that have agreed to automatically enroll Medicare beneficiaries include Connecticut, Maine, Michigan, New Jersey, New York, Pennsylvania and Massachusetts, as long as they are able to meet the CMS requirements. A number of other states are also considering auto-enrollment, and we will continue to work with states to facilitate this process.

While Medicare is providing price comparison information and assistance with enrollment, beneficiaries must enroll directly with the card sponsor they choose. CMS has established a standard enrollment form that all card sponsors must accept to make it even easier to sign up for a discount drug card as well as the $600 credit. This form will also be used by State Health Insurance Assistance Programs (SHIPs), and other partners and community-based organizations that assist beneficiaries with their health care decisions. CMS has made this model form available on the Internet at http://www.cms.hhs.gov/discountdrugs/forms/, and has included instructions for its use as well as access to the information needed to complete it.

SAVINGS REPORT—FINDINGS SO FAR

While we have long been confident that the drug card program will give beneficiaries real savings on their prescriptions, we are excited to have some data to reflect such savings. According to a recent CMS study, Medicare beneficiaries can, for the first time, get significantly lower prices through the Medicare-approved drug discount cards at their local retail pharmacies. This preliminary analysis, released May 6, compares the best Medicare-approved card prices from the Price Compare website using randomly selected zip codes to data on national average retail pharmacy prices actually paid by Americans. The findings indicate that savings of at least 10 to 17 percent compared with the average market prices actually paid by Americans for brand name drugs that can be obtained from Medicare drug discount cards. Potential savings from generics are even greater—30 to 60 percent. A recent Food and Drug Administration (FDA) analysis underscores the savings available through generic substitution. For mail-order prescriptions, which are generally less expensive because they are available less quickly, in higher volumes, and without face-to-face assistance and advice from a pharmacist, Medicare-approved drug dis-

count cards also compare favorably to mail-order prices available from such sources as drugstore.com and costco.com.

CMS has also recently completed analysis of the savings low-income beneficiaries (incomes below 135 percent of the federal poverty line, or FPL) who are eligible for $600 in transitional assistance and, in many cases, additional manufacturer discounts on drug prices, can expect to see under the drug card program. Our results indicate that our illustrative low-income beneficiaries can save 29-77 percent over the next 7-month period through the end of 2004 compared to national average retail prices for "baskets" of commonly used brand name drugs when both discounts and $600 in transitional assistance are taken into account. In addition, our analysis indicates that low-income beneficiaries can save 39 percent to over 96 percent on individual brand name drugs that are commonly used by the Medicare population when both the discount and transitional assistance are taken into account. Five of the nine brand name drugs we examined had savings of over 90 percent when including the transitional assistance.

The combination of the discounts and the $600 in transitional assistance result in a more than 92 percent savings for the random sample of drugs and geographic areas in the analysis. Furthermore, our analysis does not reflect the special pricing arrangements some manufacturers have with certain discount cards after the $600 in transitional assistance is spent. If all of these lower pricing arrangements could be captured, these new sources of savings may lead to thousands of dollars in savings this year and next through the Medicare-approved drug card program for low-income beneficiaries. For example, based on our analysis, one sample beneficiary's savings increased from 58.4 percent with the drug card alone to 88 percent with the added special manufacturer offerings.

The best way to illustrate the level of potential savings for low-income beneficiaries is through some case study examples. CMS analysts used the data from the FDA analysis to illustrate potential savings for low-income Medicare beneficiaries in a number of geographic areas. In all of these cases, Medicare would pay the annual enrollment fee, if any. For example:

- A typical person taking Celebrex (osteoarthritis), Zocor (high cholesterol), Paxil (depression), and Norvasc (hypertension) might expect to pay $2,545.20 without the discount card over the 7-month period. A low-income Medicare beneficiary residing in Pittsburgh, Pennsylvania could enroll in a Medicare-approved drug discount card and save about 42 percent between June 2004 and December 2004 (7 months). The savings include a discount of about 19 percent and $600 in transitional assistance.
- A person taking Prinivil (hypertension), Glucophage (diabetes) and Lasix (congestive heart failure) would expect to pay $913.50 over a 7-month period. A low-income Medicare beneficiary in Orange County, California could enroll in a Medicare-approved drug discount card and save 77 percent over the 7 months. The savings include a discount of 11.3 percent and $600 of transitional assistance.
- A typical person taking enalapril, a generic medication for hypertension, might expect to pay $170.10 over 7 months for this medicine. A beneficiary residing in Louisville, Kentucky with income over 100 percent FPL but no more than 135 percent FPL could enroll in a Medicare-approved discount drug card and save about 95 percent over 7 months, including savings from the discount and the transitional assistance. The beneficiary would have several hundred dollars to roll over for use, if necessary, in 2005.
- An individual taking Celebrex for osteoarthritis might expect to pay $636.30 over a 7-month period. A beneficiary with income at or below 100 percent FPL residing in Portland, Oregon could enroll in a Medicare-approved drug discount card and save over 95 percent over 7 months, a savings of over $609.

We are continuing to analyze the data on Price Compare, and are seeing drug prices continue to fall as more sponsors come online. According to our analysis, many Medicare-approved drug discounts cards are providing significantly lower drug prices and savings to beneficiaries over what they receive in retail pharmacies today. These initial price comparisons demonstrate that the Medicare-approved drug discount card program will help assure that beneficiaries without prescription drug insurance will no longer have to pay the highest prices of any American for their drugs.

CARD MONITORING

While the drug card is proving to be a success thus far, CMS remains vigilant in overseeing the program and working with outside groups to protect beneficiaries from cards that try to "bait and switch." CMS also is monitoring changes in overall

drug prices and identifying programs that stray from the expected changes in prices. Drug card sponsors have to report to CMS if prices increase in an amount that exceeds the corresponding increase in average wholesale price (AWP) and such increases must be based on a change in the sponsors' costs, such as changes in the discounts, rebates, or other price concessions received from a drug maker or pharmacy. We'll also engage in other activities to ensure that card sponsors are charging the advertised enrollment fees and following other Federal guidelines.

We expect that by making the prices of the 200 most commonly prescribed drugs used by Medicare beneficiaries available to the public, the prices will actually drop due to competition. And since the Price Compare site began operation on April 29th, we have been working with the card sponsors to ensure that we change our Price Compare database in a timely manner when they lower the prices even more. We stand by our policy of listing the best discount that beneficiaries can be assured to get on a card, but it is true that some card sponsors may be able to provide significantly better discounts on many prescriptions than the "assured" prices currently listed on Price Compare.

The discount card programs must get rebates from the drug manufacturers—along with other discounts—to help keep prices low. Those sponsors with the most Medicare enrollees will be able to negotiate the best prices. Because the Medicare-approved programs are competing for beneficiaries, the card programs have a real incentive to pass on the savings in the form of the lowest possible prices. The cards need to offer savings and service, and we're going to be taking steps to make sure beneficiaries get both. The simple fact is that if a drug card wants to succeed in holding onto its beneficiaries, and in building up its client base for when their drug benefit becomes available in 2006, the only way to do so is to offer consistently good deals and consistently reliable service to beneficiaries.

CONTINUED EDUCATION AND OUTREACH

In addition to Price Compare and the personalized drug card information services provided through 1-800-MEDICARE, CMS has a number of education and outreach efforts underway. In particular, CMS has prepared customer service representatives at 1-800-MEDICARE with up-to-date information on the drug card, as well as other CMS programs, and training on using the Price Compare website. As I mentioned earlier in my testimony, we are getting unprecedented volume at our 800 number and on the website. Our latest call volume statistics show that 1-800-MEDICARE received nearly 407,000 calls on May 3, the day drug card enrollment commenced—quadruple the last highest call record—and another 328,000 on the subsequent day. And during the first week of May, CMS received more than 10 times the regular call volume, with 1.6 million calls to 1-800-MEDICARE and more than 7 million internet visits. Based on our analysis, we estimate 1-800-MEDICARE will receive 12.8 million calls in FY2004. This compares to an FY2003 call volume of approximately 5.6 million calls. To handle this increased volume and attend to beneficiaries in a timely manner, we are in the process of increasing the number of customer service representatives at the Medicare call centers, bringing the total to close to 2,000. We are getting the additional help from trained customer service representatives from some Medicare contractors, including the private companies that process and pay Medicare Part B claims. Enhancements are also being implemented in Medicare's Price Compare services based on feedback from beneficiaries, customer service operators, and advocates. For example, www.medicare.gov now has a new, easily visible link making the Price Compare database easier to find, and the "drug dictionary" of drugs included on Price Compare is being expanded. We will continue to take user feedback to improve and refine these systems to assure beneficiaries get the most up-to-date and easy-to-use information as possible.

CMS also has a number of publications designed for beneficiaries that explain changes in the Medicare program. For example, CMS has published a small pamphlet with an overview of the drug card program and an introduction to the discount cards and the $600 low-income assistance, as well as a larger booklet with more detailed information about eligibility and enrollment. This larger booklet, the Guide to Choosing A Medicare-Approved Drug Discount Card, also includes a sample enrollment form and a step-by-step guide to comparing and choosing a discount card. The "Guide" is currently available in English, Braille and audio-tape (English). A Spanish-language copy is on the web, and Spanish copies are to be printed and available in late May.

In addition, a brief document that introduces beneficiaries to the discount cards and the Medicare-approved seal has been mailed directly to beneficiary households. CMS has already launched print, radio, and television advertisements to highlight

the upcoming changes to the Medicare program, including the addition of the drug discount card.

CMS has produced a variety of products geared toward educating physicians, pharmacists, and providers who often have one-on-one relationship with beneficiaries, to help them assist their patients in drug card enrollment decisions. The products include brochures, articles, and journal ads in major medical publications including the *New England Journal of Medicine* and the *Journal of the American Pharmacists Association.* For states, territories, the District of Columbia, and stakeholders, CMS will sponsor a variety of listening sessions and open door forums to make the latest drug card developments available nationwide. For example, we hosted in-person trainings at the Drug Card Kickoff Conference on April 7-8 and intend to host the National SHIP Conference on May 24-25, where CMS staff will provide technical assistance and support. In addition, we recently announced unprecedented new funding for the SHIPs. Last year we awarded $12.5 million in grants to the SHIPs. This year, we are increasing that amount by 69 percent, to $21.1 million. And next year we are proposing an even larger increase, to $31.7 million. We will continue to work with our partners on the challenge of getting information to beneficiaries so that they can make an informed decision about drug card enrollment, and begin lowering their drug bills now.

CONCLUSION

For the past thirty years, May has been recognized as "Older Americans Month"—a time to acknowledge the many contributions made by our nation's seniors. One of the best things we can do to thank them is to make sure they have access to affordable prescription drugs. The Medicare-approved drug discount card provides an unprecedented opportunity for beneficiaries to band together to get lower negotiated prices, along with large-scale public reporting of prescription drug prices. Starting June 1, 2004, this voluntary card program will provide immediate assistance by lowering prescription drug costs for Medicare beneficiaries until the new Medicare drug benefit takes effect on January 1, 2006. We recognize the importance of the discount cards and the low-income credit to Medicare beneficiaries, many of whom, for too long, have gone without outpatient prescription drug coverage. Medicare beneficiaries will soon have the kind of health care coverage that actually delivers on meeting their needs. Thank you again for this opportunity. Please allow me to turn the presentation over to Mary Agnes Laureno from CMS' Center for Beneficiary Choice, who will walk us through a demonstration of the Price Compare tool. After the demonstration, I look forward to answering any questions you might have.

Mr. BILIRAKIS. Thank you, Doctor. For these low income beneficiaries, I understand some of the manufacturers have indicated that when their $600 credit has expired, that they would still not charge them any more than that? Is that correct?

Mr. MCCLELLAN. That's right. A large number of major drug manufacturers are going to work with our program to allow beneficiaries on all of these cards to get access to very low prices, usually for just the cost of a dispensing fee or a little bit above it, $5 to $15 per prescription and that's why the savings for many low-income beneficiaries can be truly tremendous.

And some additional manufacturers have worked out additional discounts with particular cards that we can tell seniors about——

Mr. BILIRAKIS. How long after this do they start to receive these cards, how long after the first of June shall we say will we know how that is working in terms of that particular portion of it?

Mr. MCCLELLAN. Our plan is to have those wrap around discounts integrated into the cards themselves so that seniors can automatically get these additional discounts when they use their cards. Now they first use their $600 and for many seniors that will last them perhaps for the whole year, or at least for part of the year, so we may not be seeing the wrap arounds kicking in on a large scale basis for a few more months, but it's definitely our intent to make sure it works smoothly for the low-income beneficiaries so they get that extra help.

Mr. MCCLELLAN. Good. Well now, this particular beneficiary from Clearwater, Florida, it's just a coincidence, was she a low income?

Mr. MCCLELLAN. She was a low income beneficiary.

Mr. BILIRAKIS. And yet she had a computer? She had a computer and knew how to go to the website, etcetera?

Mr. MCCLELLAN. If she didn't have a computer and many low income seniors don't, they can get help from local State Health Insurance Assistance Plan Offices. We have one in Clearwater and we're in the process of doubling their funding right now. In addition, they can call us up at 1-800-MEDICARE and as I mentioned, because of all of the additional customer service representatives that we've added and the improvements that we're continuing to make in the way our phone assistance works, if she called us up, even at a peak time her wait this week would be at most 15 minutes to get to a customer service representative and then that representative who is trained would go through exactly the same process that Mary Agnes did in this demonstration, except she would be asking the beneficiary for this information, help her quickly get to the specific information she needs on how to get the most out of this program.

Mr. BILIRAKIS. How long would that conversation have taken?

Mr. MCCLELLAN. For beneficiaries that are primed and know if they come ready with their zip code and their pill bottles in front of them so we can find out quickly about their medicines and the doses that they want help with, their monthly income and any additional preferences they have about a particular pharmacy or a card with no fee or maybe about a pharmacy that's got an open formulary that provides the broad based discounts, typically, they can get through a call in 10 to 15 minutes.

Mr. BILIRAKIS. Ten or 15 minutes.

Mr. MCCLELLAN. And we'll send them that personalized brochure.

Mr. BILIRAKIS. Would that vary though? What if this lady did not have available computer, in one way or another, and it was strictly over the telephone?

Mr. MCCLELLAN. Well, over the telephone, our customer service representatives are there 24/7 and they'll stay on the line as long as is necessary to answer any questions a beneficiary has or after they get their personalized brochure and a lot of seniors like to look at the specific facts in front of them on paper, so they can go through it at their leisure. They can call us back with further questions, even after they've gotten that personalized information. So we'll work with them for as long as it takes, but we're trying to build as many features into this program as possible to keep that time down, the senior's time down and to enable our representatives to serve even more beneficiaries more quickly.

Mr. BILIRAKIS. But in every case, would that beneficiary have made a decision after that conversation?

Mr. GREENWOOD. Would the gentleman yield for 1 second? I just dialed 1-800-MEDICARE and I was instantly connected to a service representative.

Mr. MCCLELLAN. We've really been expanding our customer service representative connections. I'm glad to hear you got through.

She could sign up—we could tell her how to sign up at the end of that conversation, but what I think is probably more typical is that she get the personalized brochure from us, she'd have it in the mail the next day.

Mr. BILIRAKIS. What we're saying is that whether it be through the computer, the website or whether it be through just plain telephone, there would be a follow-up brochure that would be mailed to that individual?

Mr. MCCLELLAN. That's right, as you see in the brochure, there's a simple two-page form here, front and back, this is it, very large type for enrolling in the card, just this information, her enrolling—she qualifies for the low income credit, the automatic $600 as well and that's just this two-page form. So she could send that back in to any of the card sponsors that she chose or she could call up the card sponsor on the phone, they have 1-800 numbers too and enroll that way. So it's just a few minutes to fill out——

Mr. BILIRAKIS. My time has expired. I am concerned about the bait and switch potential here. We'll go into that particular area. I will now yield to Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. Dr. McClellan, nice to see you again. Thank you for being here.

Mr. MCCLELLAN. Nice to see you.

Mr. BROWN. I appreciate very much Mary Agnes' presentation, your presentation. I know that you're sincere and genuine about this. I just sit here and think we could have this card which would have brought real discount where we get 40, 50, 60 percent discount——

Mr. MCCLELLAN. what's that card?

Mr. BROWN. Just a Medicare card that we could take, that every senior could take to a drug store, where they would get a discount based on a negotiated price on behalf of 40 million beneficiaries. Instead, we have the presentation of Mary Agnes, which is a good presentation, if you have internet access and if you understand how to do it, or you can go to the State Health Insurance Program and go through this whole bureaucracy. It just sort of puzzles me that that was the choice that this Congress made.

I want to ask about the cost analysis, Dr. McClellan. I understand that CMS putout two versions of the cost analysis within a week of each other. The first contained a table comparing card prices to prices available in Canada and to prices obtained by the Federal Government through the Federal Supply Schedule for Veterans. It's a chart that Congressman Dingell highlighted earlier in the hearing. This comparison was removed from the second chart. Can you tell me why the comparison was removed?

Mr. MCCLELLAN. I think you're referring to a study that CMS did. I think that was a week or so ago looking at savings on the discount cards and what we saw then, as I mentioned before, savings at 11 to 18 percent off average retail prices and even larger savings on typical retail prices and savings on internet prices for U.S. pharmacies that are generally available to our seniors.

The additional information on Canadian prices and the VA price information was removed from the subsequent table for two reasons. One is that we couldn't verify the Canadian prices. Those prices have been changing a lot. The pharmacies often can't assure

that drugs are going to be delivered in a timely and for those reasons, what we're trying to do with this program is give beneficiaries actual prices that they can count on. And that's not the case with the Canadian internet pharmacy prices.

With respect to the VA prices, as you know, those prices are not generally available. They're only available to beneficiaries who are getting government-run health care in the VA's government-run hospitals and health care facilities on the VA's formulary. And it is true that VA negotiates a low price for their formulary drugs, but it's also true that not all of our beneficiaries prefer that particular kind of formulary, even if they could get it. So we focused in the revised report on the choices that are actually available widely to beneficiaries in this country where we could assure and report the prices correctly. I think assured prices are very important for seniors in making decisions about comparing the cards to other sources that they might use.

Mr. BROWN. I accept what you said about Canadian prices, that they move, although one of the reasons they move, apparently, is because some of the drug industry and my understanding is the White House has had some role in this, putting pressure about supply, a question of supply on Canadian—on behalf of the drug industry with Canadian pharmacists so that—because so many Americans are doing what some of my constituents are, taking buses to Canada.

But back to the Federal Supply Schedule. I mean the point here is not just that some information has been denied to the public, some information about drug prices, understanding of course that many seniors don't have access to those drug prices because they're not in the VA system. But it just begs the question that why are we doing it this way when the FSS prices are almost, I won't say they're in every single case, lower than the discount cards, but they clearly have much deeper discounts than the discount cards. It just seems there's this ideological, political slant to sort of everything in this legislation, everything your Agency does because privatization always works better than government. Well, privatization doesn't work better than government.

Medicare has a 2 or 3 percent administrative cost. Private insurance is much higher. But particularly on this, it's clear that every other country in the world uses the power of government to get lower drug prices. Our own government through Federal Supply Schedule uses the power of government on behalf of a large number of Veterans to get lower prices. I just ask again, why did your agency and the President push so hard to prohibit, literally prohibit your agency from negotiating lower drug prices?

Mr. MCCLELLAN. Well, again first, we're focused on getting the lowest prices for seniors that we can today and we are getting significantly lower prices because seniors through these cards are able to negotiate discounts from manufacturers and that was not present before. The cards require manufacturer rebates and they require them to be passed on to beneficiaries and we also are giving seniors a broad choice of formularies.

As you mentioned in one of your earlier statements, you want seniors in the Medicare program. We've got a great tradition of people being able to have choices about what they want, about

what kind of providers to use, doctors and what kind of medicines to use. The VA has one specific formulary and I'm not ready at this point to say that the best thing for Medicare is one single formulary for all of our beneficiaries. Many people might be interested in using drugs and do use drugs today that are not on the VA formulary and I want to provide that option as well, and I want to do it in a way that lets them get lower prices for the drugs and the types of formulary, maybe an open formulary that includes everything, that they want to use. That's not what the VA does. That kind of option may be good for some seniors and we want to encourage them to get it.

Mr. BROWN. I believe any drug is available in the Federal Supply Schedule, so that's not a restrictive formulary. Thank you.

Mr. BILIRAKIS. The gentleman's time has expired. The Chair recognizes the gentleman, the chairman of the full committee, the gentleman from Texas, Mr. Barton.

Chairman BARTON. We thank the chairman. Dr. McClellan, I just want to make one editorial comment. You've had to sit here for about an hour and a half before you got to make your presentation and we're a big family on this committee and we're a little cranky this morning. We want to go home. Memorial Weekend. Those of us that are World War II Veterans and we have Mr. Hall, Mr. Dingell both are World War II Veterans. They're being honored later this afternoon in the Statuary Hall in a special ceremony. So we're not disrespectful of you, we're just as in anybody when you're here together a long time, sometimes you get a little bit cranky, but we're going to work through it.

I want to ask the first question. There's been some concern about these drug prices that are posted on these websites that they're changing. Now I take that as a good sign if the general change is to continue to have lower prices. Is there any evidence that all these changing prices, that the prices are going up or is there evidence that as these various providers of the cards find out what the competition is doing they're actually lowering their prices? Which way does the trend seem to be, higher drug prices or lower drug prices?

Mr. MCCLELLAN. Mr. Chairman, what we've seen over these first 2 weeks are some big changes overall toward lower prices.

Chairman BARTON. Lower prices.

Mr. MCCLELLAN. We're seeing the cards that had higher prices initially coming way down. That happened again, 11 to 13 percent declines on average in the first week, a couple more percent this past week. That's not to say there will never be a price increase anywhere in the drug discount program. There are price increases all the time in every part of our economy, but there are some additional assurances built into the cards to make sure that prices don't go up for some kind of bait and switch tactic.

Chairman BARTON. Do you think the average senior citizen that sees that trend, they may be confused by the price being changed, but do you think most seniors will think drug prices trending downward is a good thing or a bad thing?

Mr. MCCLELLAN. I think they'll generally support that and hopefully they'll call us up and get right through at 1-800-MEDICARE and see exactly what lower prices they can get for their own drugs.

Chairman BARTON. I want to say that my friends on the other side do have a point about being able to get through. We've had several occasions we tried to get staff people through and you get a busy signal or you get this if you're calling and really in a hurry press 1 and if you're really not in a hurry press 2 and if you really don't care press 3. All of that. So I think that's valid. I mean any program this massive, you're going to have some startup problems. Do you all have a program in an effort to try to add additional numbers, additional help, whatever it is so that we can handle the demand of the seniors that are trying to get information?

Mr. MCCLELLAN. We do, Mr. Chairman. The first day of this program we had over 400,000 calls. That is unprecedented, not only in this program, but I think in any kind of telephone type of campaign. We exceeded the capacity of the phone system to support us and there were, unfortunately, callers who were dropped that day and people who couldn't get through. That's why we've taken steps like adding lots of additional customer service representatives.

Chairman BARTON. My point, you are doing that, you're not just sitting there with tough luck, call back in 3 months. You're adding capacity so that as people continue to call in——

Mr. MCCLELLAN. That's right, and we're tracking very closely how we're doing because our beneficiaries deserve prompt attention and that's the customer service standard that we want to maintain. At the peak times this week, the longest waits have been about 15 minutes and at most times the waits are not significantly longer than only a few minutes. We want to——

Chairman BARTON. You mean less than that.

Mr. MCCLELLAN. We want to get back into balance and we want to keep getting those times down.

Chairman BARTON. Now I also think it's a valid point, a lot of senior citizens, my mother does have a personal computer and she knows how to use it and all that, but there are a lot of seniors that either don't have the computer or they depend on somebody else to use them. How efficient is the system if you don't have a computer? How easy is it to get assistance if you're not computer literate?

Mr. MCCLELLAN. That's why we want you to call us and if you're ready with your zip code and your medicines in front of you, you know your income level and any other special preferences you have, we'll have a trained representative go through this process with you. You don't have to look at a computer at all. We'll ask you the questions. We'll help you along to make sure you're getting what is best for your particular needs and we'll follow up with a personalized brochure like this one that you can look at in front of you and make sure that you're seeing exactly what you want to get into before you sign up.

Chairman BARTON. Do you have any documentation of how many seniors have gone through the process and have chosen a card? Can you give us any——

Mr. MCCLELLAN. We've had hundreds of thousands of seniors go through this process successfully on the phone, get the personalized information and the brochures that they need. I don't have counts today of how many people have enrolled. As many of you have pointed out, there's no deadline for this program. People can enroll if and when they're ready to and they should do that based on

good, personalized information relevant to them. A lot of seniors have already signed up. Many thousands.

Chairman BARTON. But you can document that of the people that are touching base, we are getting seniors to sign up?

Mr. MCCLELLAN. That's right, many are signing up and we are also monitoring how well we're doing on getting the right information out to them. That's our customer service.

Chairman BARTON. Would you commit to continue to work with the committee to give us information?

Mr. MCCLELLAN. Absolutely. We want to keep a close eye on that and we appreciate the oversight in this area. It's very important.

Chairman BARTON. We are going to continue to oversee the implementation.

Mr. MCCLELLAN. I'm sure you will, Mr. Chairman.

Mr. BILIRAKIS. Thank you, Mr. Chairman. Mr. Dingell, is he there? Yes. Mr. Dingell to inquire?

Mr. DINGELL. Welcome, Doctor.

Mr. MCCLELLAN. Thank you.

Mr. DINGELL. I have before you two charts down there which are identical in all particulars save one, that one particular is that we do not, that the most recent one does not show the same drugs or programs under the FSS program which is a Federal Civil Service program or Canada's program. And I would note that the FSS plan which is an American plan is cheaper even than Canada.

There is one unique difference in those matters and that is that in the FSS plan, the entire negotiating power of the Federal Government is brought to play to get the lowest cost for the consumer and for the Federal Government. I would note that it is cheaper even than the Canadian plan.

I would note that the first plan which you chronicalled in the original release of your agency showed the FSS plan and the Canadian plan. I would note that the perfected plan which you have since issued does not show those things. Is there any reason other than that you did not want the American people to know how much better the FSS plan and the Canadian plans are than the discount plan which you have at this Department have worked out with the issuers of these cards? Is there any other reason other than the fact that you were denying the people the information on this?

Mr. MCCLELLAN. There's two reasons. First of all, we don't want to deny Americans any information and many members of this committee——

Mr. DINGELL. You excised the important information.

Mr. MCCLELLAN. [continuing] have made available this kind of information, so I think many people are aware of it, thanks to everyone's efforts. The purpose of this table was to provide information that's generally available to beneficiaries on the prices for drugs that are generally available——

Mr. DINGELL. I have limited amount of time. You've not told me that there's any other reason.

Mr. MCCLELLAN. The reason for the——

Mr. DINGELL. Now let's go to these other questions here because my time is very limited. These cards are Medicare approved, are they not?

Mr. MCCLELLAN. Yes sir.

Mr. DINGELL. Are there rules and regulations with regard to the issuance of these cards?

Mr. MCCLELLAN. Absolutely.

Mr. DINGELL. Would you please submit them to the record?

Mr. MCCLELLAN. We have issued regulations——

Mr. DINGELL. I ask unanimous consent that those regulations be inserted in the record.

Mr. MCCLELLAN. And we recently, the Office of Inspector General also just issued new consumer protection regulations for this program this week.

Mr. DINGELL. If you don't mind——

Mr. BILIRAKIS. Without objection——

Mr. DINGELL. [continuing] if you would hold yourself to the answer to the question.

Now having said that, what sanctions are imposed for disregard of those regulations?

Mr. BILIRAKIS. We have a broad range of sanctions available. They start with imposing marketing and other types of restrictions on the cards and we've done that in a few cases where cards don't provide the complete, reliable information that we require. We can also impose civil monetary penalties on the cards, not just us, but the Office of the Inspector General. We can remove a card from the program.

Mr. DINGELL. What will you impose civil monetary penalties for?

Mr. MCCLELLAN. For a range of consumer protection violations or violations of the terms of our contract.

Mr. DINGELL. What will the consumer protection violations be——

Mr. MCCLELLAN. Violations might include patterns of not providing accurate information about prices, not having discounts that people can actually get when they go to their drug stores. It might include patterns of inaccurate information about pharmacies that are participating——

Mr. DINGELL. How will that work since the issuer of the card may change the prices weekly?

Mr. MCCLELLAN. Well, if they change the prices downward, that's just fine. We're not going to bring an action for that.

Mr. DINGELL. And if they change them up, what sanctions——

Mr. MCCLELLAN. If they change them up, they have t provide documentation to us that their costs actually increased. They can't just increase the prices because they got somebody enrolled in their plan and they want to jack it up. They have to have a cost-based reason for the increase and we'll be monitoring that.

Mr. DINGELL. Now you have 73 cards issued. You are going to be supervising 73 cards. How many people are going to be doing the supervision? How many people do you have assigned to that responsibility?

Mr. MCCLELLAN. We have a large number.

Mr. DINGELL. How many?

Mr. MCCLELLAN. I can't give you an exact number now, but I'll send it to you.

Mr. DINGELL. Please submit for the record how many——

Mr. MCCLELLAN. It includes staff of the Office of Inspector General, staff at our national office, staff at our regional office.

Mr. DINGELL. I don't want an obfuscating—I just want you to tell me an answer to my question.

Now you have to follow the regular process with regard to opportunity for the Federal Government to impose sanctions and also you have to afford opportunity for the sponsor to appeal where there is wrong doing that is found. You could not, in a few words, describe the wrong doing for the changing of the drug or drug price on the card which may change weekly without any sanctions by the Federal Government.

How many people are you going to have enforcing this? Do you know?

Mr. MCCLELLAN. We're going to have individuals——

Mr. DINGELL. Just tell me number.

Mr. MCCLELLAN. We have very many staff. I don't have the exact number today, but I'd say dozens if not hundreds of staff involved, hundreds of staff in the Medicare program.

Mr. DINGELL. A hundred people you're going to have doing this for 73 cards that are going to be issued for how many million Americans?

Mr. MCCLELLAN. The cards are all Medicare beneficiaries that want to sign up and aren't enrolled in Medicaid.

Mr. DINGELL. I note my time has expired, Mr. Chairman. I would ask unanimous consent that I be permitted to write a letter to the good Doctor to allow him to explain these matters in greater detail.

Mr. MCCLELLAN. And I'd be delighted to respond to that.

Mr. DINGELL. If you please, Doctor. And that be inserted into the record.

Mr. BILIRAKIS. All right. I don't know that you need unanimous consent to write a letter, but as is customary after our witnesses testify, we always tell them that we will have written questions to them and we request timely responses, but by all means if that's what the gentleman wants unanimous consent for, we'll give it to him.

The gentleman's time has expired. Mr. Whitfield to insure.

Mr. WHITFIELD. Dr. McClellan, frequently those people who are opposed to this legislation refer to the fact that the Veterans' Administration negotiate lower prices and I notice even in Mr. Pollack's testimony that he said one of the shortcomings in this legislation and of our prescription drug plan is that they were unable to negotiate lower prices like the Veterans' Administration.

It's my understanding that the Federal Supply Schedule which regulates the VA's process, that the VA does not negotiate. Is that correct?

Mr. MCCLELLAN. They have a set schedule. They also have a single formulary. They don't allow beneficiaries in that program to choose what kind of formulary they want as well, so those are two kinds of important restrictions.

Mr. WHITFIELD. But it's all set by regulation and statutes so there's no negotiation.

Mr. MCCLELLAN. It is a statutory program, that's right.

Mr. WHITFIELD. So I think all this reference all the time to the VA negotiating, negotiating that that absolutely is not the case. And it's also my understanding that in the 1990's Congress took steps to allow Medicaid to have access to the VA system and as a

result of that the VA prescription drug costs increased by in some instances by 100 percent and that Congress had to go back and address that issue and reverse itself. Is that correct?

Mr. MCCLELLAN. That's correct. Part of the problem there is that if everybody's on this same schedule that's supposed to get a discount, then nobody is really getting a discount when more and more people come into it, the prices do tend to go up.

Mr. WHITFIELD. Mr. Chairman, I've got to go out and take one phone call, but I would at this time like to yield to Mr. Buyer, if he would like to make some comments because I know he has some real familiarity with the——

Mr. BILIRAKIS. He has 8 minutes of his own time coming, but if you want to yield your remaining 3 minutes to him, you're free to do so.

Mr. WHITFIELD. Thank you.

Mr. BUYER. I just want to add, the point that you brought up, we deal with this on the Veterans' Affairs Committee all the time and I'm just going to concur that you're absolutely correct. And it is a falsehood for anybody to put into the public domain that somehow that these are prices that are negotiated between the VA and the manufacturers, when in fact, Congress set the procedures in statute.

So anybody that says this, anybody that gives testimony, please you better start correcting your testimony because it's not correct at all. And the then Democrat-controlled Congress learned a very difficult lesson when they opened up the VA and the Medicaid, they immediately, immediately, had to come back in and say we've made a terrific mistake here and they made the right judgment in correcting it and then protecting the VA pricing.

Even when I was a subcommittee chairman on the personnel committee dealing with the military health delivery system, i.e., pharmaceutical benefit, we then tried to examine the difference between our pricing with regard to military drugs and the VA and discovered that well, even if we tried to gain access to that schedule, the same thing was going to happen. Those prices were going to increase within the VA.

So those of us in Congress who serve on the Veterans' Affairs committee of both parties, jealousy guard what has been said, rightfully so, by then the Democrat-controlled Congress. And we'll continue to jealously guard that schedule from those of whom had this belief that somehow if we only open up that access, that everybody can gain those lower costs. That, in fact, is a fallacy. Because you're correct, Dr. McClellan, all prices will increase.

I yield back to the gentleman.

Mr. BILIRAKIS. Mr. Waxman to inquire.

Mr. WAXMAN. Dr. McClellan, I've wondered if you had a chance to read the article in the Health Section of the Washington Post this week written by Lisa Barrett Mann, an experienced health reporter, on the difficulty she had trying to pick a good discount card for her mother and it presented a very different picture of how easy it is to get any information, let alone any accurate information. It took her over 9 hours. She couldn't figure out how to get information on eye drops because the site doesn't help with liquid dose. She couldn't get through the Medicare phone number, getting ad-

vice to call before 6 in the morning and after 9 at night. Now I know seniors are up at night worrying about drug prices, but that seems to be the time they're told maybe they can get through.

She called the card companies directly and they gave her completely different price information, asking the pharmacy what calls they'd honor, showed they had no idea what card they would be participating in.

So in other words, what she presented, and I'm hearing it from people all over the country, this is a mess. And the best advice people seem to get is to try again in a few weeks and see if the information is better. Now I really—my question was whether you read that article? If you have, do you understand what she had to say and if you haven't, I recommend it.

But the point that I want to make is I'm just stunned by the fact that I've been in politics for many, many decades and it used to be Republicans who were against deficit spending and bureaucracy. And now we've got Republicans supporting huge deficits and creating a monstrous bureaucracy in just discount cards that are made available to seniors for them to compare and choose and try to figure it all out. In Medicare, people don't have to do that for doctors, do they? They don't have to do it for hospitals? They don't have to go out and price the doctors and figure out which hospital or physician services they should go to. Medicare simply negotiates on behalf of seniors, sets a price and any doctor that participates in the Medicare program gets paid by Medicare and the seniors don't have to go through all this. Isn't that right?

Mr. MCCLELLAN. That is correct and I don't want to take up much of your time, but I do have a statement. I read that article with a lot of concern. It turned out the reporter contacted us on those very initial days of the program when we were getting an awful lot of calls in when we had not yet had a chance to respond to the constructive criticism we received on how to make the website work——

Mr. WAXMAN. I want to put that in the record.

Mr. MCCLELLAN. We've got that available.

Mr. WAXMAN. Good. I think we ought to have that in the record. But I'm going to ask you some specific questions.

Now I think we should have a negotiated price where the government represents seniors and everything is covered and they get a better price. Now we're told get a card and you'll get a discount. Can you tell us how the rebates under the drug program compare to the prices under the VA system?

Mr. MCCLELLAN. The rebates under the drug program compare very favorably, in fact, better than any choice that's generally available to seniors today. The VA program as Representative Buyer just noted, is not generally available to seniors today. For those seniors who are in VA, that's a good source of drugs.

Mr. WAXMAN. They get a better price if they're in the VA system, don't they?

Mr. MCCLELLAN. It's a special program. It's a drug insurance program.

Mr. WAXMAN. It's a drug insurance program run by the government.

Mr. MCCLELLAN. With a particular formulary.

Mr. WAXMAN. As I understand, a chart released by your office earlier this month showed that the VA has considerably better prices, for example, than the lowest card charging $119 for Aricept, but the VA price was $76. Just to correct the record for Mr. Buyer, and others, the VA system has a statutory schedule for all FDA-approved drugs and that statutory schedule makes sure that the prices that the VA pays for their members, their beneficiaries, is no more than the lowest price that the drug company charges any private insurance company.

And then second, on top of that, after they get the lowest price that any insurance company pays for it, the VA goes further to negotiate a formulary for thousands of drugs for even a better price. Am I wrong in how the VA operates?

Mr. MCCLELLAN. The statute says lowest price for an insurance company, but if you make that statute apply to basically every one in the country or every heavy user of drugs in this country, then nobody is going to end up with a discount. They're all going to be required to pay the same price and that's why the prices go up.

Mr. WAXMAN. I think the seniors are pretty annoyed that they're not getting the discount. Everybody else gets a discount. People in Canada get discounts. People in the VA get discounts. People on Medicaid get discounts. And they're told go call us on this bureaucratic website and phone line and see if you can sort through hundreds or 75 cards to figure it all out. That pushes the burden all on them and that sounds to me like the worst Kafkaesque nightmare of bureaucracy that the Republicans used to be against and I would hope you would still be against.

My time has expired. I have a lot of other questions and maybe we'll get back to you later.

Mr. BILIRAKIS. Mr. Shimkus to inquire.

Mr. SHIMKUS. Thank you, Mr. Chairman. I'll try to go quick. I want to give Dr. McClellan some time too, but what was the projection of the amount of call volume before we started? What did you think you'd get?

Mr. MCCLELLAN. We were expecting and had prepared for 100,000 to 200,000 calls per day.

Mr. SHIMKUS. And you moved up to 400,000. Let me go quickly so we can give you plenty of time. So you moved to 400,000. We have that same problem in our office. When there is a hot legislative item, the phones ring off the hook and there can't be a member here that's answering their phone every time.

I did what Congressman Greenwood did. I just called. I want to give you more time, but I challenge anybody, call it now. I just got answered. But I do have a problem in this booklet when you say 1-800-MEDICARE spell it right. M-E-D-I-C-A-R. Don't put the E on there because you're going to confuse people. I mean if you're going to dial 1-800-MEDICARE, don't put the full MEDICARE name there because it's longer than would be allowed on the telephone. So that might be a change.

Mr. MCCLELLAN. We do have a 7-digit number and we have increased the callers in, so when people call in, they can get through. Our beneficiaries deserve prompt service.

Mr. SHIMKUS. It's not criticism, but in the literature just put dial 1-800-MEDICAR, drop the E.

Mr. MCCLELLAN. Drop the E. Thank you. We're getting a lot of constructive suggestions on how we can do this as well as possible. I appreciate that one too.

Mr. SHIMKUS. What I liked about the plan was it directs people to if they have a State program that's beneficial, as my colleague Bobby Rush said. We have a great program. One of the parts of the Medicare prescription drug benefit was, in this bill was, addressing the dual eligibles which is going to bring millions of dollars back to Illinois because what we do on Medicaid. What we do. Illinois is benefiting in other venues because of this bill.

It will also, the pharmaceutical companies, when consumers had called us previously for help, which they do to the Members of Congress, we would go through the state-supported plan, we would work with them through Medicare. And Members of Congress know, we have like Big Five constituent service type problems dealing with a one system, large Federal bureaucracy. Medicare has a tremendous problem getting reimbursed from fees and coverage. Social Security, INS, IRS, VA, yeah, they do great benefits and they're very helpful, but to say that a one government-run plan is simplistic and clear, when I go out in my District, one of the best things we do is we help our constituents work through the Federal bureaucracy.

So make sure we understand the criticism as a whole. A large Federal bureaucracy, we fight against that all the time in all those other arenas. So a marketplace bureaucracy, I'm not that upset with respect to the other battles.

The 24/7, that means if you called at 2 a.m. on Sunday morning someone is going to answer the phone?

Mr. MCCLELLAN. Any time, day or night.

Mr. SHIMKUS. Eleven p.m. tonight?

Mr. MCCLELLAN. Any time.

Mr. SHIMKUS. Five fifty on Monday morning?

Mr. MCCLELLAN. Any time.

Mr. SHIMKUS. 24/7.

Mr. MCCLELLAN. That's right.

Mr. SHIMKUS. We'll give that a try, but I think that's noted that there's people going to be answering the phone.

I have a minute left, why don't you address some of the concerns that my colleague, Mr. Waxman, brought up with the Washington Post article?

Mr. MCCLELLAN. Those are good examples of why we're not trying to crate a bureaucracy here. What we're doing is giving seniors the assistance they need to get the most out of a program and since the time that that member of the press called, we have vastly increased our customer service support. We've improved our phone service system so that people can get through it quicker and as a result, when you call in, as you just did right now, there are no waits. You can get right to a person who can help you get the information that you need for finding out how to get the most out of this program. And if this person had been able to get through, she would have found out that there were cards available, a number of cards that covered every single one of the nine medications that her mother was taking and that her mother would have been able

to get 30 percent savings off of what she's paying now, more than $100 a month for in some cases cards that had no fees at all.

Mr. SHIMKUS. I have 5 seconds left. Let me just finish by saying maybe this reporter with all due respect to the fourth estate, maybe she should have allowed her mother to call and maybe her mom should call now. Maybe the story would be different.

Mr. MCCLELLAN. We'd certainly like to help her right now because our goal is to make sure that all of these patients who have very complex medication needs, including non-oral medicines, eye drops, and inhalers; that we can handle what they need quickly. We're making the improvements to make sure we do that reliably and it does mean real savings as it would in the case of this reporter's mother.

Mr. BILIRAKIS. The gentleman's time has expired. Mr. Pallone to inquire.

Mr. PALLONE. Thank you, Mr. Chairman. Dr. McClellan, I wanted to go back to these illegal actions on the part of the agency with regard to the ads. My understanding is that the White House has spent $18 million on these illegal ads promoting the drug cards and another $20 million on illegal ads about the new so-called Medicare benefit. Now these funds were secured from taxpayers and I would contrast that with you know, there's been a lot of talk here today about the Walter Cronkike Families USA ads which were paid for by a nonprofit organization as opposed to the Republican Bush Administration ads that are paid for by the taxpayers.

Now the GAO said in its decision yesterday, it's in today's paper, that the Medicare tv video news releases or ads were false, misleading, in violation of the law. They've made several suggestions. One is that they determined that the agency should report the misuse of funds to Congress and the President.

Is the Department going to do that?

Mr. MCCLELLAN. First, just a clarification. The ad campaigns have not been found to be illegal. In fact, the advertisement we do is a proven, effective way to——

Mr. PALLONE. What have they found to be illegal?

Mr. MCCLELLAN. The point that you were talking about is for one aspect of this video news release. That's not the ad campaign.

Mr. PALLONE. No, the video news release.

Mr. MCCLELLAN. Right. But be clear, the spinning on the advertising is to reach beneficiaries and inform them.

Mr. PALLONE. Are they going to comply with the GAO's determination and report the misuse of funds to Congress and the President?

Mr. MCCLELLAN. Well, we certainly are looking closely at the opinion. I'm absolutely committed to making sure that we take actions within the law.

Mr. PALLONE. So you're not sure. You're not sure if you're going to do it yet.

Mr. MCCLELLAN. What I am sure of is that there's some concerns about the findings here. VNRs have been widely used.

Mr. PALLONE. I just wanted to know if you were going to report the misuse of funds and you said you're not sure yet, you're going to make a decision.

Mr. MCCLELLAN. We're going to comply with the law.

Mr. PALLONE. Okay, second. Do you agree that these funds should be returned? In other words, do you agree that, as I said, I'm going to introduce a bill that the Bush Administration should take, should reimburse the government for these illegal activities with their own campaign funds. Would you agree with that?

Mr. MCCLELLAN. First, again, it's not the advertising campaign.

Mr. PALLONE. But whatever it is illegal, should they reimburse the government?

Mr. MCCLELLAN. We're going to look at this opinion. We're going to make sure we comply with the law.

Mr. PALLONE. Okay, so you're still thinking about it.

Mr. MCCLELLAN. Well, we just got this view yesterday. VNRs have been widely used by government entities.

Mr. PALLONE. Well, get back to us.

Mr. MCCLELLAN. And this one particular aspect of it——

Mr. PALLONE. How many more ads are going to be run? I know you spent $18 on the drug cards. $20 million on the so-called new benefit. How much more money is going to be spent?

Mr. MCCLELLAN. We are going to spend more education funding where we find that it has an effective impact.

Mr. PALLONE. Can you give us the amount?

Mr. MCCLELLAN. I can't tell you the amount because we design our campaign——

Mr. PALLONE. Through the chairman, could I ask that you get back to us with the specific amount?

Mr. MCCLELLAN. Absolutely. As we continue to plan our education effort——

Mr. PALLONE. All right, I appreciate——

Mr. MCCLELLAN. I absolutely will consult with you about it.

Mr. PALLONE. All right, now, can you tell me who at HHS or CMS authorized these video news releases that were found to be in violation of the law?

Mr. MCCLELLAN. I'm sure they were authorized and reviewed through standard procedures since these have been done——

Mr. PALLONE. What I'm trying to find out is whether there were specific people at the White House who were involved. For example, was Karl Rove involved or was Andy Card involved in putting these together?

Mr. MCCLELLAN. I really don't think so. I think there's a standard procedure in the Agency in the Department for doing VNRs. The Department has done them before. They did——

Mr. PALLONE. If you can get back to us again with the permission of the Chair.

Mr. MCCLELLAN. [continuing] the last administration.

Mr. PALLONE. And tell us who specifically authorized them and whether there was anybody at the White House involved?

Mr. MCCLELLAN. I'll be happy to do that as well.

Mr. PALLONE. All right. You know, I have to say I'm kind of shocked when I hear you say that you still haven't made a decision about what you're going to do about it.

One of the things that bothers me also is that I've heard all this talk today about all the money that's going to be spent to hire people to explain this with the hotline and the website.

Don't you think it would make more sense, maybe to just take all the money that's involved in this and just use it maybe to plug up the donut hole of provide the seniors with more of a benefit? Have you given us any figures about how much it's going to cost to produce this website, to hire these people who are going to run the 800 number? Do you have any figures about that?

Mr. MCCLELLAN. I can give you the ballpark. We're talking about several thousand customer service representatives total for this program. That brings the cost with the advertising and everything else into tens of millions of dollar range. In return, seniors are going to get access to many billions of dollars in discounts and——

Mr. PALLONE. I only have a couple minutes. With the permission of the chairman, you're going to get back to me about the cost of the ad campaign and who was involved with it?

Mr. MCCLELLAN. Yes.

Mr. PALLONE. If you could also get back with us about the actual cost of running this website, the amount of money for the people that are hired for the 800 number, the website, the cost of all that.

Mr. MCCLELLAN. And we'll also get you information on the many billions of dollars in new savings that seniors are going to be able to get through the discount——

Mr. PALLONE. I would appreciate that too.

Mr. BILIRAKIS. The gentleman's time has expired. As you get back with us, Doctor, would you also let us know whether it might have been common practice over the years to use this type of release and when in your opinion it's been used in the past?

Mr. MCCLELLAN. It's absolutely been a common practice. That's right.

Mr. BILIRAKIS. Will you do that?

Mr. MCCLELLAN. Yes. And this one particular aspect of the VNR, not the VNR itself. VNRs are legal and most aspects of this VNR we have no problem with.

Mr. BILIRAKIS. The aspects that I believe the gentleman is referring to, let's see now—Mr. Buyer for 8 minutes.

Mr. BUYER. I think this is a pretty exciting day. It's an exciting day for those of us, five of us, along with our staffs that work together on creating a new idea, taking a vision, molding it into a concept, working with great minds, applying our analytical skills, putting it on paper based on principle, let people take shots at it, move it into the public domain and then get shoved into the ditch like a big bus. That's kind of what happened to us.

We wanted the drug discount card to be, in fact, the prescription drug benefit under Medicare. It didn't happen. We find ourselves in the minority position. The Democrat Party leadership completely different in their ideology on the issue wanting government control versus the benefit of the marketplace and individual choices. One size fits all versus individual choices.

So what do we do? We end up utilizing this as the transitional benefit. This is an exciting day for those of us who designed this because real people are going to get real savings based upon individual choices. Isn't what this is about, Dr. McClellan?

Mr. MCCLELLAN. Yes, that's right.

Mr. BUYER. Real people, not the rhetoric you get out of this town. What I'm listening here this morning reminds me of the story, Rob-

ert Fulton, invented the steamboat, 1807. There's a great story about it. Three thousand people were on the banks of the Hudson. The Clermont is there. He's had difficulty getting it started. So a little group in the crowd began to chant and then soon everybody starting chanting. Do you know what they were chanting, Dr. McClellan? "It will never start. It will never start. It will never start." Finally, they got the steamboat going. Breaks away from and it's headed right up the Hudson against the fast currents. It stunned the crowd into silence. Then what did the crowd start to do? "It will never stop. It will never stop. It will never stop."

It's a classic example of the critic has one role. They are the critic. So what have I heard here today? The drug discount card program, even though it's not even been introduced to the public, we're trying to get individual choices, making it right, what do they say, "it's confusing. It's complicated."

You now make an effort to educate people. How dare you educate people. If you educate people, they'll understand the program. They'll receive the benefits. "Oh no. If you educate people, you must be misusing government funds. How wrong that is for you to educate people, Dr. McClellan." You see, it's the critic. They've got their face on two sides of the coin so they'll always win. It's sort of cheating the process.

The critic also here today said "You can't get through on the hotline. It can't be done. Try calling. My mom couldn't get through." Really. So you go out and you hire additional people. You hire additional people, "oh my gosh, how dare you hire additional people. Do you know what the cost of that is? Give me the cost. Put it down in writing. We could use those funds to cover up the donut hole. How dare you put additional people." The critic is the critic.

You see it will never start, it will never start. It will never stop. It will never stop. It's the critic.

So I compliment you because what you've done here is you've taken the reins of a new program that's going to have real effect in the real lives of people. If the critic wants to confuse the American people about this transitional benefit that is a voluntary program that's going to affect them in a measured way, fine. Make your noise. Make your clamor. But please, don't confuse people of whom want to gain access to this benefit.

So I really, what I want to do here is praise you. I want to compliment you. I want to compliment your staff. You're working very hard with us. You've been in touch. You're saying is this your intent, is this how you want it to work, is this how it's supposed to happen? There can be some bumps along the way. There also can be true constructive criticisms. The constructive critic is the best critic. The critic is a pain in the—pain.

Let me ask this, taking a drug discount card program that is tailored to an individual's own health needs from a Federal Government standpoint in a country of almost 300 million people, quite a task, isn't it?

Mr. MCCLELLAN. It is. We've got 42 million beneficiaries, 15 million——

Mr. BUYER. When you narrow that to the eligible population, that is one task.

Mr. MCCLELLAN. That's right.

Mr. BUYER. So of the eligible population, it's what?

Mr. MCCLELLAN. Forty-two million beneficiaries over all, and many millions, about 15 million who don't have coverage now that helps them get their drug prices down, and 7 million low income beneficiaries who really are struggling between drugs and other basic necessities of life that we're trying to reach.

Mr. BUYER. When somebody makes a call and you have maybe Privacy Act concerns or problems, let's say I make a call on behalf of my mother. Do you cooperate on behalf of children who are helping out with their moms or dads. They've got the drugs in front of them. We're not pulling any—how are you working with them?

Mr. MCCLELLAN. We welcome those calls from children, from advocates, from reports, you name it. We want them to find out about the program and get the help or the information they need.

Mr. BUYER. So every community has individuals who are community leaders who help seniors in many capacities in a volunteer basis, is that correct?

Mr. MCCLELLAN. That's right and that's an area where we are increasing funding. We want more face to face individualized assistance for our very diverse population to help them get the most out of this program and all of the many public and private programs out there.

Mr. BUYER. And of course, the critic would say how dare you, you mean you're actually using government funds to help educate people so that people can actually help each other in a voluntary fashion to improve the quality of their life? I think that's pretty bizarre. Because you know what? That's the strength of our country is people helping people, really and truly volunteerism. So again, let me compliment you.

Getting that education function to the grass roots level into those volunteer organizations who are doing it because of their compassion for each other, it may even be a teacher that they had as a young student, or who was a mentor at some point in their lives. I think that's extremely important and I want to compliment you.

Mr. MCCLELLAN. Thank you. I came to this job from the FDA and one of the things that we see coming there is much more individualized medicine, genetically based treatments, based on our understanding of genomics and proteomics mean that hopefully 1 day soon we're going to know a lot more about exactly what works and what doesn't in individual patients. So it's not just some chance that you might get a 10 or 20 percent increase in survival, but we'll be able to tailor your medical care much more to your individual needs based on better information, better science.

We need to personalize Medicare programs to go along with that, that takes advantage of people in the community who care about our beneficiaries. It takes advantage of the volunteer programs that are supported by our State health insurance assistance plans. It takes advantage of the knowledge that doctors, pharmacists and other health professionals can bring to bear to make sure that an individual, an individual patient gets the best treatment. So that's definitely the goal here.

Mr. BUYER. Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman. We have three votes on the floor.

Dr. McClellan, what does your schedule look like?

Mr. MCCLELLAN. For you, Mr. Chairman, I make time.

Mr. BILIRAKIS. Well, the problem that I have is we're going to have to break because of those three votes.

Mr. MCCLELLAN. I do have a 1 o'clock——

Mr. BILIRAKIS. You do have a 1 o'clock. Even for me, you have a 1 o'clock.

Mr. MCCLELLAN. Sorry.

Mr. BILIRAKIS. Darn it. I don't know what to do. Gene, I know you're up next, Gene.

Mr. GREEN. Mr. Chairman, I think I can do my 5 minutes very quickly and then——

Mr. BILIRAKIS. If you can do your 5 minutes within maybe 3 minutes so we can break and I guess we'll try to be back——

Mr. GREEN. I'll do my 5 minutes, Mr. Chairman, and we should have 5 minutes.

Mr. BILIRAKIS. I don't want to miss the votes.

Mr. GREEN. Neither do I.

Mr. BILIRAKIS. I'll let him go, but the trouble is with Dr. McClellan, he's going to go too.

Mr. GREEN. Okay.

Mr. BILIRAKIS. Can you come back?

Mr. MCCLELLAN. I'm sure we'll be dealing with this issue, Mr. Chairman. I hope we'll have these continuing hearings, so as we learn more about it—

Mr. BILIRAKIS. Mr. Green, see if you can finish up in 3 minutes.

Mr. GREEN. I'll do the best I can.

Mr. BILIRAKIS. I'm sorry, I don't know what to say.

Mr. MCCLELLAN. We'll answer any additional questions you have in writing.

Mr. BILIRAKIS. In writing, right.

Mr. MCCLELLAN. I'll try to be as responsive—

Mr. BILIRAKIS. And we'll just get back about one or just as soon as we can after that third vote and I guess we will not be able to question Dr. McClellan, except in writing. C'est la vie.

Mr. GREEN. Let me go ahead and get started. First, let me talk about some of the discussion from all my colleagues, first, and I know Illinois has a great program for their citizens, but I point out that the legislation that the Congress passed and the President signed prohibits imports and I understand Illinois is actually benefiting from the Canadian import, lower cost.

My colleague from Indiana, the steamboat analogy, I can understand that, but I don't know if I want to experiment with the boilers blowing up before we have a lot of people hurt by it. And I think we have a duty to make sure that whatever plan is put out there is that something we don't have a lot of our seniors who think they're going to get a benefit, maybe drop their current employer or retiree coverage and pick this up and find out that boiler exploded before we had the success of a Fulton. So let's talk about analogies.

Let me point out and ask you, we'll consider the demonstration you gave in Medicare.gov. We saw that the particular beneficiary would pay $298 per month for these four drugs. Once the prescrip-

tion drug plan comes on line, this discount card program is completely scrapped, is that correct?

Mr. MCCLELLAN. Well, I'd like to build on the best features of this program, giving people accurate price information, giving them the ability to negotiate—

Mr. GREEN. Under the law, in 2006 this card program will go away?

Mr. MCCLELLAN. We want to take the best features—

Mr. GREEN. Let me finish my question because I'm cutting 5 minutes to 3 and you know us Texans talk pretty slow.

Is it fair to say that with $300 a month in drug costs or more, this beneficiary will hit that $2250 threshold in 7 months and will basically have to pay the remaining costs out of pocket because of that donut hole? That analogy you gave, $298 per month, we would hit that, that particular person would hit that before. It's just the math. I'm glad you used that analogy.

Mr. MCCLELLAN. First, you get discounts on the prices as she does here. Second, it's a higher level of spending where that possible gap will kick in. Third, since she's a low income beneficiary, she'd be paying no more than a few bucks for all these prescriptions anyway.

Mr. GREEN. But on average, some are not eligible for the low income would still fall in that donut hole.

And Mr. Chairman, I know I don't have enough time, but I'd like to submit a question and I'll read it because it will take a good while for the question.

We have a study that was done by the American Institute of Research found that Medicare did a better job of cost containment than private plans. The Congressional Budget Office also calculated that payments to private plans would add $14 billion in costs. In a study recently released today by the Common Wealth Fund indicates that Medicare and private plans are being paid an average of $552 more than each beneficiary than the fee for service plan. And in fact, their own estimates from the department in 2003 will show that the program that has the design like we have is wasteful in taxpayer dollars and I have a document from September 2003 from CMS actually stating greater number of PPOs yields greater cost and lower number of PPOs participating yields lower costs. And isn't it true that this competition level isn't necessarily cost beneficial? And is it fair to conclude that the rush to privatize Medicare isn't necessarily the best use of taxpayers' dollars during a time of our record-setting deficits? And I'll submit all of the copies of the letters and wouldn't it be logical to conclude that traditional Medicare offers a better program from a cost benefit perspective? Again, Mr. Chairman, we'll put this in writing with the supporting documents.

Mr. BILIRAKIS. Respond in writing, in other words?

Mr. MCCLELLAN. If I could just say very quickly that one of my main goals for evaluating our program is what beneficiaries pay and the most recent studies that we've done show a difference of about $800 in what beneficiaries pay out of pocket in the Medicare Advantage plan versus traditional Medicare for people who don't have access to good, comprehensive employer coverage and that's

an important consideration too, but I'll be happy to answer these questions more—

Mr. GREEN. And the concern I have is I agree that benefits for the person, but also if the goal is to reduce Medicare over the next 10 years, if we're paying more to the private sector, and it's not cost competitive for the taxpayers.

Mr. Chairman, I'll submit this and thank you, Dr. McClellan.

[The document follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Office of the Actuary

DATE: September 25, 2003

FROM: Richard S. Foster
Chief Actuary

TO: Thomas A. Scully
Administrator

SUBJECT: Number of PPOs per Region

Under H.R. 1, no more than three private health plans per region could be selected to participate as Medicare PPOs. Interest has been expressed in either increasing the allowable number of plans or permitting all interested plans to participate. This memorandum summarizes the key issues associated with the number of plans per region. Rough estimates are also provided illustrating the impact on plan costs, beneficiary premiums, Medicare payments to plans, and PPO enrollment levels.

Competition issues

The number of participating PPOs would affect competition through the following four factors:

- Primary competition—If the number of PPOs is limited, then plans will compete vigorously to be included among the "winning bidders." The importance of being selected as a participating plan should lead applicants to bid their best, bottom-dollar cost. This impact would be the greatest with only a single winning bidder, as with the TriCare program. Experts have advised us, however, that it is more important to have "some losers" than it is to have a single winner. In other words, to obtain a low price there must be some fear that too high of a price will leave the bidder out of the program. If five to seven plans (or coalitions of plans) submit bids, as was generally the case for TriCare, then acceptance of three winning plans would imply that other plans were not accepted, and this criteria would be met. If all plans can participate, then this competitive factor would have no favorable cost impact.

- Secondary competition—If more than one PPO is participating, then there will be competition among the plans to attract enrollees through low premiums, quality of care, and convenience. As a general rule, the more plans that are competing against each other, the greater this factor will be. Secondary competition among plans, however, would not necessarily be based solely on lower costs; beneficiaries could be attracted by broader provider networks, easier access to the latest medical technology, and other factors that are generally associated with higher costs.

- Market power—If a PPO can anticipate a large number of enrollees, and therefore a large volume of health services, it can negotiate favorable prices with health providers in exchange for including these providers on the preferred list. The fewer the number of participating PPOs, the greater this impact would be.

- Average efficiency—The average level of efficiency among the three most-efficient plans will obviously be better than among all plans. Average plan costs—which depend on PPOs' administrative efficiency, profit margins, negotiated prices with providers, and management of utilization—will generally be significantly lower with a limited number of winning bidders.

The following table summarizes these impacts for proposals that would allow three, five, or all PPOs to participate. The analysis is based on the assumption that about five to seven plans or coalitions of plans would bid in each region. Evidence is limited as to whether the primary or secondary aspect of competition is more critical to achieving lower costs; judgmentally, we would expect the former to have a greater impact than the latter.

	Number of plans allowed to participate		
Competitive factor	Three	Five	All
Primary competition—incentive to be included	Strong incentive.	Some incentive (but limited if only 5-7 plans bid).	No incentive—participation is automatic.
Secondary competition—degree of inter-plan competition	Significant.	Significant to substantial.	Substantial.
Market power	Strong.	Some.	Weak.
Overall efficiency of selected plans	Significantly above average.	Slightly above average.	Average.

The choice of three winning bidders, as originally included in the President's Framework for Medicare Reform and subsequently incorporated in H.R. 1, was based on the combination of both primary and secondary competition impacts, together with a significant level of market power. That is, plans would compete strongly to be included among the three selected plans, beneficiaries would still have a choice of several plans competing among themselves, and plans could offer a significant volume of services to participating health providers in exchange for favorable prices. An additional consideration in specifying three plans was to avoid the undue concentration of market power that could occur with a single regional contractor.

Other issues

Several other questions have been raised about the consequences of limiting the number of participating plans.

- Impact of plan terminations or non-renewals—With a small number of participating PPOs, the departure of a single plan could affect a relatively large number of beneficiaries. ("Departure" in this instance could result from either financial problems or failure to be selected as a winning bidder during a following round of competition.) This concern could be ameliorated somewhat by setting a contract period of at least three years (the original TriCare period was five years), establishing strict financial-resource requirements for plans, and employing risk-sharing arrangements.

- Number of bidders at second and later rounds of competition—Concern has been expressed that the initial set of successful bidders would have an undue competitive advantage in subsequent rounds of bidding. In other words, an existing contractor would already have a developed provider network, a solid base of experience on which to estimate future costs, an established beneficiary enrollment that might be predisposed to continue with their current plan, and other advantages over a new bidder. These advantages might result in few new bidders in the future, less competition, and higher costs among the "entrenched" plans.

  On the other hand, successful bidders in one region may wish to compete in one or more additional regions in later rounds of competition. These "new" bidders would have some of the same advantages as the existing PPOs. Also, if the existing contractors are profitable, the profit potential should encourage other new plans or coalitions to compete for the business. Finally, the government could use a bidding process that helps to level the playing field for new bidders as much as possible. For example, the experience database could be provided in the RFP, and the claims and enrollment processes could be standardized.

- Contract administrative process—A limited number of plans, selected through a competitive bidding process, implies a very significant administrative process. Considering the magnitude of the contracts, it would be critical to ensure that each bid is credible and that the plan has adequate financial and other resources. Moreover, the consequences of not being selected would undoubtedly lead a number of losing bidders to formally challenge the selection process. In TriCare, these administrative burdens contributed to a recent decision to combine several regions into one contract. If all interested plans could participate, the administrative burden would be at least somewhat lower—possibly to a level similar to the current ACR review process for Medicare+Choice plans under current law. It is important to note, however, that the savings arising from strong competition among plans should substantially outweigh the higher administrative cost associated with the competitive selection process.

Estimated impact of number of plans on plan costs, premiums, payments to plans, and enrollment levels

The attached table presents illustrative estimates of the average level of PPO costs, premiums, and net government payments to plans for two hypothetical regions, assuming three, five, or all participating plans. Also shown are rough estimates of the proportion of Medicare beneficiaries who would enroll in PPOs under each scenario.

In the case of three participating PPOs, we have previously estimated that the average plan cost would initially be about 101 percent of fee-for-service Medicare costs and that this ratio would very gradually decline over time.[1] Because this cost level is lower than the benchmarks established by H.R. 1 for most regions, enrollee premiums would be reduced significantly compared to fee-for-service premiums. In the two illustrative regions used in the table, average net enrollee premiums would be $236 and $472 less, respectively, than the projected fee-for-service level of $866 annually. (Regional benchmarks under H.R. 1 are estimated to average 108

[1] The Congressional Budget Office has estimated significantly higher cost levels for regional PPOs under H.R. 1. The basis for the Office of the Actuary's assumptions, together with a discussion of the CBO concerns, is available on pp. 9-16 of "Preferred Provider Organizations (PPOs): A Model for Medicare That Controls Cost and Enhances Quality," issued by the CMS Office of Legislation on May 30, 2003.

percent of fee-for-service costs; significant variation is likely from one region to another but would depend on which States or portions of States were combined as regions.) These premium rebates would encourage an estimated 25 and 33 percent of beneficiaries in the two regions, respectively, to enroll in Medicare PPOs.

If five PPOs are selected, we estimate that average plan costs would initially be about 104 percent of fee-for-service levels. Since this level would be significantly closer to the PPO benchmark levels, enrollee premiums would be correspondingly closer to fee-for-service levels. The annual premium rebates in the illustrative regions are reduced to only $4 for region A (that is, the net total enrollee premium would be negligibly different from the standard Part B premium) and $265 for region B. Because there would be a lower financial incentive for beneficiaries to join PPOs, the estimated enrollment percentages decline to 16 and 26 percent, respectively.

If all interested PPOs can participate, we estimate a further increase in average plan cost, to 105.4 percent of fee-for-service levels in 2006. In region A, this average cost would be somewhat above the estimated benchmark, with the result that the average enrollee premium would be $114 greater than the standard Part B premium. The average premium rebate for region B would be further reduced to $186 in the illustration. These changes would contribute to a decline in estimated PPO enrollments to 11 and 23 percent of beneficiaries for the two regions.

We did not have time to estimate the year-by-year changes in Medicare costs under the PPO provisions and the alternative numbers of participating plans. In general, we would expect that the *cost per beneficiary* of this provision in 2006-2009 would be lowest with three plans and highest with all plans. The *aggregate cost* before 2010, however, would have the opposite pattern because of the declining number of PPO enrollees. After 2010, the expected small savings under the "premium support" PPO competition would be reduced with more than three participating plans. We would expect this result because the weighted average plan cost would be higher and PPO enrollment percentages would be lower.

Conclusions and caveats

The operation of regional Medicare PPOs, and the implications of allowing a limited number of plans or all plans to participate, is necessarily uncertain. There are no Medicare program data under such an option, and no demonstrations of this type have been conducted. TriCare provides some insight, but its experience is not applicable in all respects. Consequently, it is not possible to anticipate or reliably assess all of the operational issues in advance. In this memorandum, we have tried to summarize the various concerns that have been raised regarding limited plan participation and to discuss the advantages and disadvantages fairly.

The illustrative PPO premiums, net government payments, and enrollment percentages shown in the attached table are very sensitive to the underlying plan cost assumptions. We have tried to develop reasonable assumptions for all of the relevant factors, but these, too, are inherently uncertain in the absence of program experience or demonstration results. As noted elsewhere, the cost assumptions developed by the Congressional Budget Office are significantly different, and use of their assumptions would have a substantial impact on the financial illustrations.

While evidence is limited, we believe that selection of three participating PPOs through a competitive process, as authorized in H.R. 1, would very likely result in lower PPO costs than would selection of five or more plans. Some of the other issues described in this memorandum must be judged on other, non-financial criteria. Please let Sally Burner or me know if you have any questions about this information.

Richard S. Foster, F.S.A.
Chief Actuary

Attachment

Estimated regional PPO annual costs, premiums, net government payments, and participation rates in 2006 under H.R. 1 and alternative scenarios

	3 Winning PPOs				5 Winning PPOs				All Willing PPOs			
Region	Average plan cost	Average premium	Average net government payment	PPO only participation rate	Average plan cost	Average premium	Average net government payment	PPO only participation rate	Average plan cost	Average premium	Average net government payment	PPO only participation rate
A	$7,952	$630	$7,323	25%	$8,262	$862	$7,400	16%	$8,382	$980	$7,401	11%
B	$7,082	$394	$6,688	33%	$7,358	$601	$6,757	26%	$7,464	$680	$6,784	23%

Office of the Actuary, CMS
September 25, 2003

Mr. BILIRAKIS. Dr. McClellan, your dedication is amazing. I know over the years we've worked together on health care matters for the American people and you are a dedicated servant and I've heard many members on this side of the aisle said the same thing. So I want you to know that and appreciate so much your coming here. And again, there will be a series of questions, as you know, and hopefully, you'll respond to them and we're going to have oversight, whether it be the Oversight and Investigations Subommittee or probably maybe a joint thing with the Health Subcommittee, but we'll have oversight over a period of time to see how things are working.

Mr. GREEN. Mr. Chairman, I'd just like to associate and since I'm the only one left on our side, say that we feel the same way. We obviously have a contentious issue, but again, I can't think of a better person to have there.

Mr. BILIRAKIS. Those good comments came from your side of the aisle. I wanted to make that clear. We're going to break until 1:15. I think it will give you all an opportunity to maybe do what you might have to do over that period of time.

Mr. MCCLELLAN. And I would just say in concluding, we will answer all of your additional questions. We look forward to additional close oversight and working with you to make sure we're doing all we can. We are getting beneficiaries lower prices and drug savings right now, especially low income beneficiaries and we need to do that effective.

Mr. BILIRAKIS. We need to follow up on the history of all that because it's continuing, is it not?

Mr. MCCLELLAN. That's right and I especially want to thank the staff.

Mr. BILIRAKIS. Thank you very much, Doctor.

[Off the record.]

Mr. BILIRAKIS. Let's have order, please. As you know, we've just completed three votes on the floor, so members, I trust, will be streaming in slowly. We've gotten the okay from the minority to get started and in the interest of time, we will.

Do we have all of our witnesses here? Panel 2 consists of Mr. Craig Fuller, President and Chief Executive Officer of the National Association of Chain Drug Stores; Mr. Ron Pollack, Executive Director of Families USA; Ms. Mary Grealy who was here, but stepped out. She'll be back, president, Healthcare Leadership Council; Mr. Robert M. Hayes, CEO, Medicare Rights Center, and Mr. Stan Baumhofer from Portland, Oregon.

Mr. Baumhofer, you have a couple of Oregon Members of Congress who wanted to be here to introduce you to us, so as they come in and as your turn arises, we'll have them do that. But I want you to know you have a lot of respect with those people.

All right, that being the case, we're going to start off with Mr. Fuller. Your written statement is a part of the record. We would hope that you would sort of complement, supplement that written statement. Five minutes. We try not to cut you off, but we really run pretty late, as you know, so hopefully, you can stay within that as much as you can.

That being the case, we'll start off with Mr. Fuller. Craig, please proceed.

STATEMENTS OF CRAIG L. FULLER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NATIONAL ASSOCIATION OF CHAIN DRUG STORES; RONALD F. POLLACK, EXECUTIVE DIRECTOR, FAMILIES USA; MARY R. GREALY, PRESIDENT, HEALTHCARE LEADERSHIP COUNCIL; ROBERT M. HAYES, CEO, MEDICARE RIGHTS CENTER; AND STAN BAUMHOFER, MEDICARE BENEFICIARY

Mr. FULLER. Thank you very much. It's a pleasure to be before you and your committee. As you said, I do represent the National Association of Chain Drug Stores. We have some 200 retailers with 120,000 pharmacists in nearly 35,000 stores across the country. Virtually all of them will participate in the Medicare-endorsed senior prescription drug discount card.

I wear another hat because along with Express Scripts, NACDS formed the Pharmacy Care Alliance. Pharmacy Care Alliance has sought and won Medicare endorsement for the Pharmacy Care Alliance card, and so I want to talk a little bit about that as well today.

I really wanted to just touch upon three items that are discussed more completely, perhaps, in my testimony. First, I wanted to just comment a little bit on the path that the retail community pharmacy industry has been on. As you know, when the administration first raised the idea of a discount card, we were opposed to it. We were opposed to it because it did not have a grounding in law. It did not have the benefit of this committee's deliberations and other committees within Congress. And we felt that in order to have a meaningful drug benefit for seniors, you had to have a program that brought both concessions from both, the pharmaceutical manufacturers as well as retail pharmacy.

The card program, of course, that was announced in 2001, while not enacted, it did spark manufacturing card programs and those programs have been embraced by retail pharmacy and in fact, our first efforts with the Pharmacy Care Alliance concept were to support that program.

We actively participated, as you know, in the discussions and deliberations last year. We felt very strongly about four or five significant points. We felt that anybody that—any pharmacy that wanted to participate in a drug discount card program should be able to. We felt that the program should provide a meaningful benefit to seniors. We felt that, in fact, there should be rules of transparency and assurance that rebates provided by the manufacturers flowed through to those seniors.

Those elements were all part of the legislation that was passed and that debate was one that ended with the passage of the law. With the passage of the law last year, the retail pharmacy community, at least the National Association of Chain Drug Stores, decided to work to do everything we could to make this law a reality. And so last December, with the authority of my board, we formed the Pharmacy Care Alliance.

We needed somebody to partner with, an organization that had experience running national card programs. Express Scripts is one of the three largest pharmacy benefit managers in the country with considerable experience in that area. And the first set of questions we asked were whether the principles on which we would run a

program if we were to join forces would be consistent with those principles that I just mentioned and that we articulated throughout the debate last year.

The leadership of Express Scripts assured us that they were in full alignment with those ideals and would run a program as we described it. With that, we went forward. The time lines were tight. I commend the Centers for Medicare and Medicaid Services, Mark McClellan and a very able staff for driving this process as effectively as they have, answering hundreds of our questions and those of the other sponsors.

With the endorsement, we began a process of education. And I wanted to just show, as I talk, a few of the slides that represent part of that process. First, we wanted to let people out in the community know that these cards were coming, that the marketing would begin on May 3. So with Medicare-approved materials, and I know the wording is too small to perhaps see, we began a process of making available in our stores not only the Medicare information, but our information as well, to begin that education process.

Next, it was very important to make sure that pharmacists began to better understand how the program would work. We have a pharmacy practice memo that goes to all pharmacists across the country, not just chain drug store pharmacists, the 120,000, but the 150,000 or 160,000 throughout retail pharmacy because we firmly believe that where most seniors are going to go for information about this program is, in fact, to their pharmacy and they will consult with their pharmacist and with pharmacy personnel. So that was an important element of that program.

Next the promotional materials began to tell people that they were going to be able to sign up for the Pharmacy Care Alliance card. This material began appearing in the stores, again, Medicare-endorsed material.

Go to the next slide. We have been actively engaged in running programs to reach seniors who could take advantage of this program. Some 260 educational and enrollment events have taken place and are scheduled across the country in 44 different markets nationwide. This is by no means the limit of activity because individual retailers may be doing their own work, but the Pharmacy Care Alliance and staff and personnel working with us and with Express Scripts are involved in these events. Indeed, our President of the Pharmacy Care Alliance who would be with me here today, but for the fact that she is out across the country for the next few weeks, meeting with seniors in community centers and pharmacies, talking to the local media, all designed to help people better understand the Medicare-endorsed prescription discount card. She's really leading that effort.

I also wanted to give you just a sense of sort of the early days and it's only been 2 weeks, but I hope in doing so, that I might share a little bit of the reality, as we see it, not theory, but the reality as we see it. First of all, Pharmacy Care Alliance has a website, 1-800-PCA 7015. We'll get you an answer in probably less than 30 seconds. For a while we were running it under 5 seconds. We have had hundreds and hundreds and hundreds of thousands of calls. We've had millions of hits on our website. We have seen twice the number of applications come in the second week as we

did the first week. And I think we are seeing really a steady growth every day. Interestingly, 42 percent of the applications we receive, we receive by mail.

Thirty-seven percent are faxed to us. Thirteen percent come off of our website, so to answer do seniors actually use the website, my answer is 13 percent are actually, not only using it, but they're submitting their applications to us that way. And 8 percent come in by phone.

Now the call center has been very active. I don't claim the same numbers that Dr. McClellan has by any means, but it has been a very, very active place and every time we get a call, we seek to better understand just where those callers learned about the Pharmacy Care Alliance Medicare Drug Discount Card Program. Perhaps not surprisingly because we're behind it, but 45 percent tell us they've learned about it from their pharmacy. And I think that is instructive. Again, we really believe seniors have a lot of information they can get at their local pharmacy. Thirteen percent heard about it from the Medicare website or the call center; 12 percent from television, 9 percent from newspapers and then others at less than 5 percent, family, friends and the like.

Mr. BILIRAKIS. Will you try to summarize?

Mr. FULLER. I sure will. Because the key here is probably best captured in this next slide. This is a real couple. Somebody wrote to me a letter indicating that they were very concerned about how this would affect their parents. Simply put, "we took the drugs, we were given permission and the drugs they were taking, we took the drugs they were taking, we applied the PCA card. The PCA card produced 24 percent savings all by itself, or $260 per month." They also had two drugs that together RX card would give them an additional $56 of savings. "It totaled $316 of savings for this couple every month, but then we also did what a pharmacist would do and we explained to them that there were some generic substitutions that would save them additional money which would total $341 or a 32 percent savings."

This is not hypothetical. It's an actual example. It's what people are doing on our website every day, helping seniors learn how they can save money. I think we have a competitive card out there. I actually think competition is a good thing. I know transparency is a good thing. We remain very determined to make this program work and we look forward to your questions.

[The prepared statement of Craig L. Fuller follows:]

PREPARED STATEMENT OF CRAIG L. FULLER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NATIONAL ASSOCIATION OF CHAIN DRUG STORES

Mr.Chairman and Members of the Health Subcommittee. I am Craig L. Fuller, President and CEO of the National Association of Chain Drug Stores (NACDS). NACDS is pleased to be here today to talk with you about our industry's views regarding the Medicare-approved prescription drug discount card program. In addition to today's discussion, we would like to invite all members of the Health Subcommittee, as well as your House colleagues, to visit a community pharmacy over the next few months to see first hand how the Medicare prescription drug discount program is being implemented.

NACDS represents more than 200 companies that operate more than 32,000 community retail chain pharmacies. Our members include traditional chain pharmacies, supermarket pharmacies and mass merchandisers that operate pharmacies. We represent large and small chain-operated pharmacies from all over the United States. Our industry employs more than 120,000 pharmacists, and almost 3 million total

individuals, providing more than 70 percent of all outpatient prescriptions in the United States. We believe that our industry plays a critical role in implementing the discount card program that will be utilized in less than two weeks, as well as the full Part D prescription drug coverage program in 2006. We appreciate the opportunity to express our views today.

There are three areas I would like to discuss in my presentation:

- First, a review of the path the National Association of Chain Drug Stores traveled during the past few years to reach our current alliance with Express Scripts, one of the nation's three largest pharmacy benefit managers (PBMs), in the sponsorship of a Medicare-approved drug discount card through the Pharmacy Care Alliance (PCA);
- Second, a review of our experience with the Pharmacy Care Alliance program and its implementation to date working with the Centers for Medicare and Medicaid Services (CMS);
- Finally, our experience in the early days of enrolling seniors in the PCA program.

COMMUNITY RETAIL PHARMACY: WORKING TO IMPLEMENT MMA

The enactment last year of the Medicare Modernization Act (MMA, P.L. 108-173) created the most significant expansion of Medicare benefits in the nearly 40-year history of the program. While NACDS participated in a healthy debate last year, there is only one view among NACDS members today. We must and will do everything possible to make this program work. We know you expect nothing less and America's seniors certainly deserve nothing less.

Of the nations nearly 45 million Medicare eligible seniors, about 25 percent have no prescription drug coverage, while others only have partial coverage. For those seniors who pay for their prescriptions out of pocket, they all too often cannot afford the medication they need or they pay for only some of what they need. Significantly, this card program can help millions of low income seniors by paying for $1200 in medications over the next 18 months. In addition, the card program can provide an additional safety check in detecting medication related problems, such as drug interactions, for seniors who might obtain their prescriptions from multiple pharmacies.

In our view, MMA took several important steps to improve the situation for our seniors. The Act also developed a framework for the structure of a meaningful discount card program. The structure addresses some of the most important elements we discussed last year during the formulation of the legislation. We said then, and we continue to believe that:

- **Patients Should Choose Pharmacy:** The patient should be the one to choose who should serve their medication needs. That is, choices among retail pharmacies and mail order pharmacies should be left to the patient;
- **Financial Incentives Should be Transparent:** There should be rules of transparency so that policymakers, the Administration, and seniors can see how the dollars flow to different interested parties in the management of any kind of Medicare related drug benefit;
- **Seniors Should Realize Savings:** The savings for the senior should come both from the pharmaceutical manufacturers—with rebates flowing through to the senior at the point of purchase—and from concessions made by retail pharmacy; and,
- **Pharmacies Should be Allowed to Participate:** Those pharmacies desiring to participate in a card sponsor's network should be able to do so. All these elements are all a part of the Pharmacy Care Alliance program which will be described in more detail later in this statement.

We had serious reservations about a card program regulatory initiative announced by the Department of Health and Human Services in July, 2001. Our concern was that, without deliberations by this committee and others, and without a law on the books, there was no framework for a meaningful senior drug discount card program. While we did oppose this Administration's effort, it did serve as the catalyst for the development of discount cards offered by pharmaceutical manufacturers. These included the TogetherRx Card, the Lilly Answers Card and the Pfizer Share card. For all practical purposes, these manufacturer-sponsored discount card programs were embraced by retail pharmacy, and in our view many seniors benefited by the discounts that were being offered by manufacturers to seniors through participating pharmacies.

NACDS initially formed the Pharmacy Care Alliance to help pharmacists and patients understand the value of these cards. We coordinated events with the sponsors and communicated regularly on the importance of these programs. Some of these cards will remain in the marketplace as the new Medicare card program is rolled

out, and we applaud those manufacturers who are working with card sponsors to make their programs seamless with the various CMS approved card sponsors.

THE PHARMACY CARE ALLIANCE (PCA)

Once MMA was enacted, the Board of NACDS expressed a commitment to do all we could do to make the program work for our patients and customers. Last year, we concluded that the best way for our industry to assure that we were full participants in the new law, as well as to protect the important principles we fought for, was to develop our own discount card program. Knowing that there were likely to be many competing cards in the marketplace, we wanted to work with a partner who had a proven ability to implement a national discount card program.

We spoke with several potential partners, but found Express Scripts to be an organization committed to our principles—as described previously. They have a leadership team that is committed to making the MMA work.

Our card program is structured around simple principles, which we believe are resonating with seniors. Namely, that seniors should have the right to choose the retail pharmacy from which they want to obtain their pharmacy services, and that seniors should have the ability to obtain their maintenance medications through their local retail pharmacy or mail order. That is, the card that we are offering will include a mail order component, but will not drive patients away from retail pharmacy by requiring them, or creating financial incentives for them, to use mail order. We believe that mail order should be an option for seniors under the PCA card program as well as the 2006 voluntary drug benefit, but seniors should not be economically coerced into using mail order.

THE CHALLENGES IN IMPLEMENTING PCA

Early this year, all prospective card sponsors had a challenge. By the end of January we were required to have our organization plans set for running a discount card program. We had materials designed for review by the Centers for Medicare and Medicaid Services, and we had to agree on a business model for going forward with a completely different kind of discount card program. Finally, we had to interact with and seek approval from CMS on all of these matters.

CMS Administrator Mark McClellan and his team at CMS have done an extraordinary job in driving forward the implementation of complex and historic legislation enacted only late last year. The outreach to us and other card sponsors has been constant. Literally thousands of questions have been fielded from sponsors, and currently CMS is dealing with millions of consumer inquiries. While everyone is hearing about bumps in the road, it is unrealistic to think that a program of this scope and magnitude could run without flaws in the initial ramp up.

We believe that challenges will continue to exist as the program moves forward, but we should all be committed to making this program work for seniors.

What specific tasks did PCA, as well as other card sponsors, have to perform to make this card program a reality? First, as part of the discount card program, Express Scripts, on behalf of the Pharmacy Care Alliance, built a network of retail pharmacies from across the country. Any retail pharmacy that wants to participate in the PCA network is able. This network currently consists of almost 44,000 retail pharmacies, including chain drug stores, independent drug stores, supermarket pharmacies, and mass retailers. By the start of the program, we believe that 50,000 retail pharmacies will be enrolled or almost 90 percent of all pharmacies. That is a very sizeable network—providing significant access for seniors to the local pharmacy of their choice.

At the same time the pharmacy network was being built, Express Scripts entered into negotiations with the pharmaceutical manufacturers to obtain concessions on their prices in the form of rebates that will be passed directly to the consumer at the point of purchase. Passing through manufacturer price concessions at the pharmacy counter is a relatively new phenomenon in discount card programs. To date, most of the price concessions that seniors have realized for prescriptions through commercially-available prescription drug discount card programs have come from price concessions made by retail pharmacies. We believe that the ultimate success of this program will depend on the desire of manufacturers to provide, and of card sponsors to pass through, the price concessions that they obtain from manufacturers.

NACDS AND PCA EDUCATIONAL INITIATIVES

We knew from the beginning of this discount card initiative that millions of seniors that currently come to our pharmacies to obtain their prescription medications would continue to do so after the discount card program was launched. As we said

earlier, our industry employs 120,000 pharmacists that interact with millions of individuals, including Medicare beneficiaries, each and every day. We also knew that many of them would seek our advice and counsel on how to choose among card programs, based on the medications they were taking.

NACDS has created several general educational materials for our pharmacists and seniors about the card program. For example, NACDS created a special continuing education program for our pharmacists to help them learn about the card, as well as a special edition of our regular "Practice Memo," which is a unique communications vehicle our industry uses to provide information to practicing pharmacists. We prepared two "Top 10" facts about the Medicare discount card and the transitional assistance benefit program.

The Pharmacy Care Alliance and its marketing partners have also created materials that are being used in retail pharmacies across the United States. PCA is expending considerable resources to conduct education and training programs. We have provided materials to participating pharmacies to use if they desire. We have provided booklets and information to the pharmacies to give to patients that will explain the program. All of these materials are reviewed and approved by CMS. In addition, we have trained hundreds of individuals who have in turn trained thousands of pharmacists.

Let me say that no one underestimates the tremendous task that lies ahead to educate Medicare beneficiaries about the card program in general, and their multiple options in particular. But, we believe that seniors, their caregivers, and the various public and private sector agencies representing the interests of seniors will help them sort through many options to make the best selection possible. Like any new program, there will be a learning curve and bumps ahead. However, we view this as an important trial run for the new Part D drug benefit that will ramp up late next year, and we all have a vested interest in taking lessons learned from the discount card program and applying them to the Part D program.

CARD PROGRAM ENROLLMENT: EXPERIENCES FROM THE FIRST TWO WEEKS

Let me now discuss our experiences in the first two weeks of marketing the PCA card to seniors and enrolling seniors in the program.

Through phone and personal conversations as well as website contact, we have seen growing interest among patients and caregivers seeking information about the card program. During the second week of promotions, we processed more enrollment applications than the first week—we continue to see growth daily.

While we cannot provide specific information for proprietary reasons, we can share with you some interesting statistics to give you a feel for how seniors are accessing information about the Pharmacy Care Alliance program. For example, as of May 18, 2004:

- We received twice as many applications the second week as we did the first week.
- Applications came to us by mail (42 percent), by phone to our call center (8 percent), by FAX (37 percent) and via the web (13 percent);
- Of the applications we received, 42 percent were for cards with "transitional assistance" and 58 percent were for regular discount cards;
- Our PCA call center is actively engaged in counseling Medicare beneficiaries, with the average length of a counseling call running about six and a half minutes;
- When we ask where a caller reaching our call center heard about the Pharmacy Care Alliance program, 45 percent say from their pharmacy; 13 percent say from the Medicare website, call center or materials; 12 percent say from television; 9 percent say newspaper, and there are a number of other sources below 5 percent ranging from family and friends to physicians and community groups.

At the heart of this program, of course, are not statistics, but rather savings for seniors. Below is an actual example of the savings that a senior couple in California would realize using the PCA card. The couple's son contacted NACDS personally, skeptical about the benefits of the card program for his parents, who take multiple medications. We sought permission to review his parent's medication needs and then to suggested how they may benefit from the discount card program.

- Based on the medications they were taking, we found substantial potential savings for the California couple, over 24 percent savings, or about **$260** each month using the *PCA discount card.*
- In addition to PCA discount card savings, the couple is also eligible for the *Together Rx discount card,* and can save an additional **$56** per month using both cards.
- Last but not least, many patients can realize additional savings each month simply by asking their community pharmacist if lower-priced generic alternatives or a lower-priced drug in the same therapeutic category exist for any of their

medications. In this case, we were able to find an additional **$25** in potential savings each month, allowing our couple in California to potentially save a grand total of **$341** each month, or 32 percent of what they are currently paying.

To conclude, our experiences thus far have been as expected. Patients with medication needs interact with their physician and their pharmacist. However, the pharmacist is available 24 hours a day, 7 days a week in many locations, and is available without an appointment or charge. So, it is not surprising that millions of seniors will consult their pharmacist about the availability of the Medicare approved discount cards. They seem to be doing this not all at once, but rather when they come in to fill prescriptions. This shows the application process will be spread out over more weeks, thus providing for more interaction in the pharmacy and in our call center.

Today, pharmacists around the country have choices in what they can recommend. The Pharmacy Care Alliance is but one choice. We have worked hard to make certain that is a good, competitive and trusted choice for both the patient and the pharmacist. By doing so we are convinced we are doing everything we can to help make this important program work.

SENIORS HAVE POSITIVE PERCEPTIONS OF DRUG CARD PROGRAM

As we launch this historic initiative, we thought it would be instructive to know what seniors really believed about the value of the card program. We asked Wirthlin Worldwide Research to study the perceptions toward the drug card program of Medicare-eligible seniors that do not have any other form of insurance that covers prescription drugs. Among those without any drug coverage, a slight majority (54 percent) have heard at least some information about recent Medicare changes. The results of this survey should demonstrate the importance of this card program to policymakers.

- First, most of this population favors the basic concept of these discount cards. Based on the simplest description of the cards, a majority (70 percent) say that the cards sound like a good idea. After hearing a number of more specific pieces of information about how the cards will work, 76 percent say the discount cards sound like a good idea (six percentage point increase), including 28 percent who say they sound like a very good idea, and another 48 percent who think they are a fairly good idea.
- In addition, a large majority (76 percent) believe the cards will be helpful to those without drug coverage, and more than four out of ten (43 percent) think the cards will be very helpful to others like themselves.
- A majority (58 percent) of those without coverage say they are likely to get a discount card. Among those who take any prescription drugs, 61 percent are likely to get a card, and among those who take three or more drugs, almost two-thirds (64 percent) are likely to get a card.
- When the Transitional Assistance program is described, more than four out of five (84 percent) believe the program will be helpful to low income Medicare recipients, including two-thirds (68 percent) who believe it will be very helpful. Two-thirds (67 percent) say they would probably apply for the Transitional Assistance if they qualified for it.

Thus, it appears that, while we are about 18 months away from the Part D coverage program, seniors find that this interim card program is a good first step toward helping them obtain their prescription drugs.

IMPLEMENTATION ISSUES FOR BENEFICIARIES AND PHARMACIES

Now we would like to provide additional detail about some of the issues relating to what seniors, pharmacies and the marketplace can expect as the discount card program is implemented on June 1st. First and foremost, pharmacies will be responsible for managing beneficiaries' expectations regarding the discount card program. This may be just as important in helping them manage their drug benefits or drug therapy. Pharmacies will have an important role in helping to explain to seniors the nature of the discount card program, that the discount card is not drug coverage, and that they still need to pay for their prescriptions out-of-pocket, minus their discount.

Price and Discount Expectations: It is clear that seniors will measure the success of this program by whether or not they are paying less for their medications at the pharmacy counter. Already, we are seeing dueling reports and studies trying to document the extent to which the various card programs are (or are not) saving money, and whether prescription prices have fallen since the CMS pricing website went live.

NACDS wants to offer some observations about the issues relating to prescription pricing, and how we should measure whether seniors are actually saving money through the card program.

- First, we should all recognize that every senior has different prescription drug needs, and that actual retail prescription drug prices do vary from pharmacy to pharmacy. Thus, studies on savings from the card program based on reduction from "average prescription prices" fails to recognize prescription prices variances, and that many seniors can already obtain a 10 percent discount on their medication by simply telling the pharmacist they are a senior citizen.
- We also have to recognize that part of the goal of this discount card program is to help seniors better manage their prescription drug spending by encouraging them to use more cost effective drugs, including generics. Thus, we should focus on helping seniors choose the best card for them, and assist them in reviewing their whole drug regimen to determine where their physician might prescribe more cost effective drugs.
- We can never forget, however, that at the end of the day, this effort cannot and should not be all about price. We should attempt to get seniors the best drugs, to treat their medical condition. And, assure they take the medications appropriately.

Because many discount cards existed before the Medicare-approved cards, many successes of the new Medicare-approved discount card program will depend on whether card sponsors are able to obtain significant rebates and discounts from manufacturers, and the extent to which they are passed along to beneficiaries. In that regard, we believe that the PCA card has been able to obtain significant discounts from manufacturers and will be passing those through to beneficiaries at the point of service. We also believe that the transparency brought to the market by the pricing website has also resulted in further price concessions by manufacturers to various card sponsors to make their prescription products attractive to an important and cost-conscious group of purchasers—seniors.

Pricing Website: While we support transparency in medication pricing at all levels, we believe that this discount card website will create some challenges to seniors and pharmacies. After some initial start up issues with the website, we believe that it contains accurate pricing information, at least for the PCA card, and think it will be a valuable tool for seniors. That is not to say that this pricing website does not have several issues which we would like to bring to your attention.

For example, once the program gets started, prices for prescription drugs under the card programs will be allowed to change weekly on this website, consistent with changes in manufacturers' charges for medications, as well as other changes in the market such as a change in discounts that are available from manufacturers or pharmacies. We believe that, consistent with free market principles, prescription prices under these card programs must be allowed to change since prices of pharmaceuticals increase, as does the cost of doing business. Anything less would be price controls on pharmacies.

But, by the time the beneficiary arrives at the pharmacy to purchase their prescription, those prices may have changed, and the beneficiary may have to pay a higher price than the one that was on the website. CMS must be diligent in all its educational materials—as should all card sponsors—to make clear to beneficiaries that card sponsor prescription drug prices will likely not remain the same during the year, and in fact, that there may be frequent price changes, and that drugs covered on the formulary might change as well.

Transparency in Rebates and Discounts: We think it is key for seniors, Medicare and Members of Congress to know whether card sponsors are obtaining significant price reductions from manufacturers and pharmacies, and whether these are being passed through to beneficiaries in the form of lower prices. The discount card law requires that this type of information be reported to CMS, which cannot make it public. We think it is important, however, to ensure that any PBM or other private health plan involved in the Medicare program be required to disclose any relevant financial data so that federal officials can monitor whether money is spent wisely, and savings are passed on to seniors.

In fact, we think this issue is so important that the PCA program will go beyond what is required by statute and have our own clear and rigorous rules regarding transparency, verified by an independent auditor, who will have the right to review proprietary information to ensure compliance. Congress, CMS, and Medicare beneficiaries should expect the same from every card program receiving CMS endorsement.

Transitional Assistance Issues: Pharmacies will also work with low-income seniors that are eligible for the $600 in annual transitional assistance to help them make the most of this dollar amount. We can do this by offering generic drugs where pos-

sible, and working with a beneficiary's physicians to assure they are taking the most cost-effective brand drugs possible.

In other words, pharmacies can make the $600 stretch further if we can work with the beneficiary and their physician on assuring appropriate prescription drug use. Because we often know our patients' financial ability (or inability) to obtain their medications, pharmacies are also in an excellent position of identifying low-income seniors that might be eligible for transitional assistance so we can encourage them to enroll in a card program.

Automatic Enrollment in Card Programs: Many states with individuals enrolled in state pharmaceutical assistance programs are taking advantage of CMS' recent decision to allow them to automatically enroll these individuals in the Medicare discount card program. Some states are requiring these individuals to enroll in only one card program, while some states are providing choices. We believe that automatic enrollment of these individuals in the card program—as well as individuals in the Medicare Savings Program—will enhance participation in the card program. This is particularly important for Medicare beneficiaries below 135 percent of poverty who qualify for the $600 annual transitional assistance. We believe, however, that automatic enrollment programs should give seniors a choice of card programs so they can select the one that best meets their needs for the drugs that they are taking, and the pharmacies that they want to use, before they are defaulted into one specific card program.

Administrative Issues Relating to Card Programs: We envision some potential administrative issues with the card program, especially in cases where state Medicaid or state pharmaceutical assistance programs decide to "wrap around" the benefit, and pay the copays or any additional coverage, for transitional assistance individuals. This information about "wrap around" benefits must be provided to pharmacies at the point of care in a real-time manner by the card sponsor to coordinate these benefits, without any charge by the card sponsor to the pharmacy for providing this necessary information. This information will help pharmacies determine who is responsible for paying for the prescription, and the pharmacist can bill the appropriate and liable third party.

We also see potential issues where beneficiaries have both a CMS-approved prescription drug discount card and multiple non-approved prescription drug discount cards, which is a very real possibility. Beneficiaries may ask pharmacies to determine which card provides them a better price for their medication, an approved card or a non-approved card.

Finally, consistent with current industry practices, CMS must also allow card sponsors to adjudicate claims transactions for drugs and supplies covered under the discount card program in an on-line, real time manner. CMS cannot require that any part of the transactions for this program be conducted in any form of batch transaction standards.

CONCLUSION

In conclusion, we believe that there will be many challenges for all stakeholders in implementing this Medicare-approved prescription drug discount card program. The next eighteen months will go a long way in helping us prepare for the prescription drug coverage program that will begin in 2006. Medicare beneficiaries will continue to rely on pharmacists—as they have done in the past—to help them understand how to use the new Medicare-approved discount card programs. We continue to meet this challenge.

We think that these card programs can be a success. Seniors will ultimately judge these programs on the discounts they offer—if they offer a wide range of choices for obtaining medications, and the level of customer service provided. We welcome the opportunity to provide additional information on any of the issues we discussed here. Thank you, Mr. Chairman and members of the Subcommittee for asking us to present our views here today.

Mr. BILIRAKIS. Thank you very much, sir, and you will get an opportunity, I trust, with the questioning to expand on what you have said.

Mr. Pollack, please proceed. You've done this before.

STATEMENT OF RONALD F. POLLACK

Mr. POLLACK. I have once or twice. And I want to thank you for your perseverance for holding the hearing.

First, I want to just say very briefly there are a couple of things that I'm pleased about with respect to the program, but then I want to get into the heart of the testimony. I'm pleased that there's a $600 transition benefit for low income people. It's crucially important. I wish it were more. I certainly hope that as many people eligible sign up and we're certainly helping with that. I'm also pleased that we're taking some steps, not enough, toward transparency. I think that's a step in the right direction.

Now let me summarize what I believe about this drug discount card program and I can best—

Mr. BILIRAKIS. Mr. Pollack, excuse me, sir. Are you aware or do you know or do you agree that there are some manufacturers who are basically expanding that $600 figure?

Mr. POLLACK. I've actually talked to them directly.

Mr. BILIRAKIS. You have? So you are aware that that is taking place.

Mr. POLLACK. I am.

Mr. BILIRAKIS. Good. You know, we hear these things, but it hasn't gone into effect yet and I just wondered, you agree that it is going to take place?

Mr. POLLACK. Well, the drug companies, they like people to know about it. They've let us know.

Mr. BILIRAKIS. Okay, good. Please proceed.

Mr. POLLACK. I guess I would summarize this whole drug discount card effort as much ado about very little. And let me tell you why I have that summary conclusion. First of all, if you take the administration's numbers at face value, which I think is the best we can do at this juncture, they tell us that they project that 7.4 million people are going to enroll in these discount cards. Another way of saying that is one out of six Medicare beneficiaries will get these discount cards, only 18 percent according to the administration's projections. And what that means is that the remaining five out of six seniors who are in the Medicare program will not receive direct relief from this program and they will bear the full brunt of cost increases that have been going on for each year over the past decade that I'll talk about in a moment.

Second, when somebody tells me, irrespective of what the product is, that I'm going to get a discount, whether it's a car or a television, I don't jump up and down right away. I normally ask discount off of what price? Because if the base price keeps on increasing, then surely I may be getting a discount, but I may not be getting any cost relief. And that indeed is a significant problem here because there is nothing in this regimen that deals with the base price. We have been looking at the base price for each year over the past decade. Last year, the base price rose 3.4 times the rate of inflation. We are about to issue another report that will show the latest year and we will do that soon and I will tell you that base price increase is unabated.

And so if nothing is done about the base price, sure, people are getting a discount, whether it's 10 percent, 11 percent, 17 percent, but in terms of what they're spending, if the base price goes up, it really doesn't help with respect to the discount.

Third point. If we were serious about trying to provide some real relief for the beneficiaries of Medicare, we had choices that we

could have made and unfortunately, the Congress rejected those choices.

Now there was discussion earlier this morning concerning the Veterans' Administration versus the discounts. Now in my testimony I took a look at the eight most prescribed drugs for seniors and we looked at what the prices are in some Districts and we looked at for you, Mr. Chairman, and for ranking member, so let me turn to Tampa, Florida so that we could see what really we could have done here. Lipitor. The lowest price under the discount card program in your area, Mr. Chairman, is $65. The highest price under these discount cards is $72. In contrast, the Veterans' Administration gets $41 and you can get the same drugs in Canada for $35.

Fosamax. In your community, the lowest price, $57 to $54; highest price, $71. VA gets $43. And Canada, it's $28. You'll see, we've listed it for all eight of the top drugs and in no place does it come close in terms of what the discount cards yield as opposed to what we could have done if we would have enabled the Medicare program to bargain on behalf of seniors.

Fourth point I guess I'd want to make is that one of the things we had recommended to CMS was that they explicitly place into the regulations rules governing the potential of bait and switch. And here, by that I mean in specific terms each of these card sponsors are saying which drugs are subject to a discount, what the size of the discount and yet even forgetting changes in the price, they can switch what drugs are subject to a discount. And now we hear the administration saying well, we're going to monitor this, but they refuse to put that in their regulations so that up front it would have been said to the discount card sponsors, you can't engage in these specific practices. We've lured people in based on certain drugs being subject to a discount and then they no longer are.

I must say, I feel that Mark McClellan is a wonderful Administrator. I think very highly of the man. I shared the comments you made at the end of the testimony. So this is not a personal observation. But can you imagine if 100,000 people sign up for a card and then all o fa sudden that card sponsor perpetrates these bait and switch practices and it knocks off a whole bunch of drugs that lured people onto that card. Are you going to tell people, the 100,000 people who have signed up for that card they no longer can benefit from that card or that they now have to re-enroll? I don't think that's likely to happen and it would have been much better if the administration would have said up front, these practices shall not be allowed. Those drugs that you advertise as being subject to a discount must stay as a discount throughout the course of the year.

Enough has been said about the administrative morass. I will just tell you in terms of our own efforts with respect to that, when we heard complaints about people trying to get through on the 1-800 number, we made calls ourselves. We made over 70 calls. And what we found is that almost half of those calls you did not speak to a live person. In a very high percentage you got cutoff, just cutoff. In other instances, we did the prompts, all these different prompts that take a whole bunch of minutes and after we did all

the prompts, we went back to the very first prompt, never speaking to a live person.

Now I believe that with the increase in the number of people answering the phones, hopefully it will be better. I will say, however, I want to say something complimentary. Once you get through and those instances where you did get through people were courteous and most of the time they answered questions accurately. And so I think that was—

Mr. BILIRAKIS. Can you summarize, please, sir? I kind of like what you're saying right now.

Mr. POLLACK. Selectively. I guess I would conclude, Mr. Chairman, that we're not telling people don't sign up for discount cards and particularly low income people we're not saying that. Quite the contrary. We're telling them to sign up. But if we were truly serious about doing something for America's seniors to get prices down, we had alternatives and unfortunately those alternatives were rejected and this is a pale substitute, a pale substitute that only one out of six seniors will even participate in and even that one out of six will get a relatively small benefit.

[The prepared statement of Ronald F. Pollack follows:]

PREPARED STATEMENT OF RONALD F. POLLACK, EXECUTIVE DIRECTOR, FAMILIES USA

Mr. Chairman, Members of the Committee: Thank you very much for this opportunity to testify on the Medicare prescription drug discount card program.

DISCOUNT CARDS: MUCH ADO ABOUT VERY LITTLE

The new drug discount card that goes into effect on June 1, 2004 is much ado about very little. This new card program, which the Department of Health and Human Services projects will enroll only 7.4 million Medicare beneficiaries—merely one out of every six people (18 percent) in the program—will be of no consequence for the vast majority of seniors. Those seniors will continue to face the brunt of ever-increasing prices that have risen at multiples of inflation for every year over the past decade.

Perhaps most important, this drug discount program is an extremely weak substitute for what should have been in the recent legislation—namely, enabling Medicare to bargain for lower prices with the drug companies, similar to what the Veterans' Administration does for veterans. This alternative would have helped all seniors, not simply the one out of six that receive discount cards. Moreover, for the one out of six seniors who enroll in the discount card program, it would have provided considerably larger savings.

Before I describe in greater detail why this discount card program is much ado about very little, I do want to make clear that we support the transitional assistance program that provides $600 per year for those under 135 percent of the federal poverty level. This benefit will be particularly useful, especially when it can be combined with state and pharmaceutical assistance programs, and we all must do all we can to help enroll eligible beneficiaries in this program.

Having said that, we feel that beneficiaries should be warned to approach the program with low expectations, so that they are not disappointed.

We do not know how much discount card prices may increase in coming months, but as Families USA's research work has repeatedly shown, brand name drug prices consistently inflate at approximately three or more times the underlying rate of inflation. Last year, we found that the cost of the 50 drugs most used by seniors increased at 3.4 times the rate of inflation in 2002. We will be releasing a new report on the rate of inflation of the most popular brand name drugs used by seniors soon. Thus a discount card may provide some much-needed relief, but the relief erodes—rapidly—as drug prices keep rising much faster than inflation.

Many of the companies involved in these discount cards have an inherent conflict of interest: they are likely to make more money by encouraging the use of more expensive prescriptions and keeping a portion of the larger absolute dollar discounts and rebates they receive from manufacturers of those more expensive

drugs. The just-announced Federal Court Order settlement with Merck-Medco is an example of the kind of anti-consumer practice "bait and switch" that needs to be guarded against if consumers are to obtain true savings.

The information available on the Medicare website may not be accurate and should be double-checked. At least one major news report notes major discrepancies between what's reported on the Internet and what local drugstores are actually willing to do (see *Washington Post* story cited below).

A MISSED OPPORTUNITY

In looking at the discount card prices, one is continually reminded of the missed opportunity: If the United States had the type of cost containment that other nations had, or if the purchasing power of the Department of Veterans Affairs had been used, huge savings could have been obtained, not only in discount cards, but for Medicare and Medicaid. These savings would have allowed Congress to provide a comprehensive benefit that would truly excite Medicare beneficiaries and that would have helped the states deal with their Medicaid budget crises.

In attachment #1, we have listed the high and low Medicare-endorsed discount card prices of the 8 most common prescription drugs used by Medicare beneficiaries. We then listed the VA price and the Canadian Ontario government prices for those same drugs in late April. We have picked six comparison zip codes corresponding to the three most senior Majority and Minority Members of this Subcommittee.

The data make it clear that the drug discount cards are a pale benefit compared to Medicare bargaining or re-importation of drugs from Canada. It shows savings are possible. And it shows those savings pale compared to the prices available when a government uses truly effective purchasing power.

NEED TO DO MORE TO CONTROL DRUG PRICES FOR SAKE OF MEDICARE AND TAXPAYERS

The failure of the new law to obtain any meaningful drug cost containment is a disaster for beneficiaries, Medicare, and taxpayers. Using the CBO's own data, because of drug inflation, the amount beneficiaries will pay will change as follows:

Benefit	2006, when program starts	2013, at end of CBO budget window
Estimated premium	$420	$696
Deductible	$250	$445
Initial coverage limit where beneficiary pays 25% between deductible and start of "donut"	$2,250	$4,000
Donut	$2,850	$5,066
Catastrophic threshold starts when your out-of-pocket expense equals	$3600	$6,400

Families USA believes that a "donut" of $5,066 is ridiculous. Beneficiary disappointment at a $2,850 gap in coverage will turn to anger at the thought of a yearly $5,066 gap.

If these inflation changes coincided with changes in income, it would not be as much of a problem. But drug inflation far exceeds seniors' income gains. Again using CBO numbers and Census estimates, the following is what a typical senior at median income and average drug use will experience between 2006 and 2013:

	2006 (est.)	2013 (est)
Average drug expense	$3,167	$5,425
What you would pay with those drug expenses (+ premium)	$2,087	$3,455
Income	$23,708	$28,181
Percent of your income spent on drugs and premiums	8.8%	12.3%

Because of the failure to obtain true cost containment, despite the expenditure of $400 or $534 billion over ten years, beneficiaries will still see more and more of their income consumed in drug expenses.

The recent 2004 Medicare Trustees' report makes the point even more starkly: the addition of the prescription drug benefit means that the combined premium/copay/deductible burden of Medicare Part B in 2010 rises from 16.6% of *Social Security* [1] income before the addition of Part D to *36%* of income after Part D is added. Obviously the new drug benefit saves beneficiaries significant amounts, but the Trustees'

[1] Note, this is Social Security income only. The previous paragraph referred to median total income, thus the different percentages.

report example shows how burdensome the gaps in the new program will be to those who live only on Social Security.

The failure to obtain cost containment is a major reason, of course, that the next Congress is likely to see the new law's 45% trigger reached[2], and that your Subcommittee will be faced with making major changes in the program just two years from now. Many of those changes could hurt beneficiaries.

THE NEW LAW IS TOO COMPLEX: THAT'S WHAT WE ARE HEARING FROM ALL OVER THE NATION FROM BENEFICIARIES

The new law, including the new discount card program, is much too complicated. That's what we are hearing from seniors all over the nation. If there were a single negotiated price, like the VA obtains, that would be simple, understandable, and popular.

We would like to include for the Record a piece from the Washington Post of May 18, 2004 entitled, "Pick a Card! #?$!" by Lisa Barrett Mann, a younger person who describes spending nine hours trying to help her 82-year-old mother get the best card. It is an excellent description, with perhaps one error: the writer says that "changes aren't allowed until open season at the end of the year." Actually, according to CMS, changes can occur at any time, both in price and the specific drug covered. Ms. Mann's article makes a good recommendation at the end:

> "We'll wait a few weeks. There's no deadline for enrolling and, as far as I can tell, the savings aren't going to be so great (if there are any at all) that deferring the decision could cost Mom much . . . So I'll give Mom's pharmacy time to sort out which programs it participates in and then get a list from Medicare.
>
> "In the meantime, maybe Medicare will clear up some of the Web site glitches. Maybe the discount card programs will work out their customer service and database issues and update some of those 1997 prices. Maybe the PBMs will let the pharmacies know which programs they are working with. Maybe Medicare will spring for a few more phone operators [note: they did!] and cut back on the TV commercials . . .
>
> "I figure that, in a few months, helping Mom pick a discount card will be easy. It should take about an hour."

Waiting until the data becomes more available and accurate is good advice, but for millions of seniors without help, it will still take much more than an hour. Most seniors are not internet comfortable. And most of all, we need to remember that about 20 percent of Medicare beneficiaries, about 9 million people, have some form of cognitive or mental illness. For these people, it is not a joy to shop among 40+ different plans—it is a nightmare—a task so daunting many will not even try.

THE $600 BENEFIT IS IMPORTANT FOR LOW INCOME INDIVIDUALS, BUT MANY WON'T GET IT BECAUSE OF CONFUSION: BENEFICIARIES IN MEDICARE SAVINGS PROGRAM SHOULD BE PRESUMPTIVELY ENROLLED.

Not only is the program confusing, when you add it to existing state programs of assistance, it becomes even more baffling. In an event in Illinois, a member of Families USA staff started to recommend the $600 card to lower-income seniors, but was corrected by local experts, who noted that such people should be advised to join the much better Illinois program. We note recent press reports that the Speaker of the House of Representatives, in an Illinois town meeting event attended by the Medicare Administrator, made the same "join Medicare discount" recommendation without mentioning the better Illinois program, but unfortunately was not corrected. I cite this just to indicate how terribly complicated the new program is, especially when it interfaces with local programs.

Historically, it has been very difficult to reach out to lower-income individuals and enroll them in key means-tested programs of assistance. Despite nearly 15 years of work enrolling Medicare beneficiaries in the Medicare Savings Programs (MSP),[3] only about half the eligibles have enrolled. Add the complexity of the new, temporary 19-month discount card program, and Families USA is very concerned that CMS will be unable to achieve its goal of enrolling 4.7 million out of a total of 7.2 million eligible low-income beneficiaries.

We hope we are wrong, and that the full 4.7 million and more are enrolled—but Congress should demand to know what the enrollment figures are early in June. If the enrollment levels are below CMS's predictions, it is not too late to act. Individuals who are enrolled in the MSP programs could be presumptively enrolled in

[2] MMA, Sections 801-804

[3] QMB, SLMB, and QI-1, which pay Part B premiums and, in the case of QMB, deductibles and copays.

the discount card program.[4] Senators Bingaman and Lincoln have just introduced legislation (S. 2413) that would provide for such a presumptive enrollment program, and we urge you to consider such legislation. It is certainly the type of legislation that could be passed on the suspension calendar—and probably the consent calendar. Enrolling these individuals would free up a tremendous amount of time and energy for outreach to other eligible individuals.

THE 1-800-MEDICARE NUMBER: CALL 911

The 1-800-Medicare number was overwhelmed in its first two weeks. It is certain to get better, but the initial experience has been a real turn-off—or one could say, disconnect. The *Washington Post* reporter cited above tried to get through seven times on one day and never did. Families USA decided to try a few calls last week to judge the accuracy of responses to some fairly simple test questions. We had better luck. On 70 calls, we were "only" disconnected 36 percent of the time, sometimes on purpose and with the warning "call back later," and other times abruptly and without warning. On another 9 percent of calls, we were told to punch various numbers on the phone, and found that after a circuitous route, we were eventually redirected to call 1-800-MEDICARE! There was no way to get to a human. When we did get through—the longest we were on hold was 17 minutes—I am pleased to report that the answers were 86 percent accurate, and the staff courteous, helpful, and willing to "walk the second mile."

There are clearly mechanical problems with the 1-800 number and some of its routing codes. They need to be fixed, ASAP. Unannounced disconnects are infuriating, and must be stopped.

Most importantly, CMS needs to learn from this experience and be better prepared for the fall of 2005, when the entire Medicare population will be trying to make sense of the new choices. Call volume is likely to be much higher than it is this May. The choices will, frankly, be much more important for people to understand. We need to do a better job. Disconnects at the 36 percent level are not acceptable.

Congress needs to make sure that CMS has the resources to meet this future, larger tsunami of calls. The new law provided an extra $1 billion for CMS in FY 2004 and 2005 for administrative start-up costs. This is money available outside the regular appropriations process. But that extra money runs out on September 30, 2005, 46 days before the new Part D enrollment period begins and three months before the new law starts. The following chart shows the very difficult budget situation facing CMS. The chart shows total administrative spending. As you can see, there is an increase of funding pre-FY 2006 largely due to the extra $1 billion, but then there is a dramatic reduction of half a billion dollars in FY 2006—before the new law starts! This is a train wreck coming! It will make this May's telephone and counseling situation seem efficient.

CMS ADMINISTRATIVE BUDGET ONLY, DRAWN FROM 2004 TRUSTEES REPORT

(numbers in billions of dollars)

Fiscal Year	HI	SMI	Rx D	Total
2002	2.5	1.8	N/A	4.3
2003	2.5	2.4	N/A	4.9
2004	2.8	3.0	0.3	6.1
2005	2.8	3.1	0.8	6.7
2006	**2.8**	**2.7**	**0.7**	**6.2**
2007	2.8	2.8	0.8	6.4
2008	2.8	2.9	0.8	6.5
2009	2.9	3.0	0.8	6.7
2010	2.9	3.1	0.9	6.9

Source: From 2004 Medicare Trustees' Report, prepared by Families USA

To avoid another rocky 1-800-Medicare start-up to the permanent program, Congress needs to ask tough questions about the resources available to CMS and prevent the huge fall-off in resources on October 1, 2005.

[4] The $600 benefit is not available to those in TRICARE, FEHBP, or who have other health insurance with any outpatient prescription drug coverage (except a M+C plan or a Medigap policy), but those under 135% of poverty are very, very unlikely to be eligible for or enrolled in such programs, and this provision should be presumed met.

MORE RESOURCES NEEDED FOR STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPS)

We also urge Congress to provide more money for the State Health Insurance Assistance Programs (SHIPs), the largely volunteer-run, state-based counseling services offered in each of the states. These programs provide one-on-one counseling to seniors and specialize in small meetings in local neighborhoods to help Medicare beneficiaries navigate the insurance system. Polling of seniors shows that they like the type of one-on-one, face-to-face assistance provided by SHIPs. The Internet and 1-800 numbers are not as useful. Providing more money for SHIP computers, training and recruitment would be one of the most effective ways to ensure a smoother launch of the permanent Medicare drug program.

Prices on 8 drugs commonly used by seniors, 30 day supply

Zip Code: **33618 Tampa, Florida**

Drug	Quantity	VA	Canada	CMS-endorsed retail discount card low price	CMS-endorsed retail discount card high price
Liptor	10 mg	$41	$35	$65	$72
Plavix	75 mg	$100	$53	$113	$123
Fosamax	70 mg, 4 tabs/month.	$43	$28	$57-$64*	$71
Norvasc	5 mg	$25	$28	$42	$48
Celebrex	200 mg	$63	$28	$77-$84	$88-$178 [5]
Zocor	20 mg	$69	$49	$101-$105	$129
Prevacid	30 mg	$71	$44	$111-$114	$131
Protonix	40 mg	$27	$42	$86—$89	$104
Price for all 8, in one card (i.e., the CMS column does not add cumulatively).		$439	$307	$657-$691	$765

** Where a range of prices are listed, it means that the price available using that low (or high) cost discount card varies by the amount of that range among different pharmacies within the zip code. So one can pick a ''low'' card, but one will still need to be careful which drugstore one uses.

[5] These $178 high numbers, listed for two cards, may be an error. It is hard to imagine that much difference between drugstores that have an agreement with the same card company.

Prices on 8 drugs commonly used by seniors, 30 day supply

Zip Code **75087, Rockwall, Texas**

Drug	Quantity	VA	Canada	CMS-endorsed retail discount card low price	CMS-endorsed retail discount card high price
Liptor	10 mg	$41	$35	$65	$72
Plavix	75 mg	$100	$53	$106	$124
Fosamax	70 mg, 4 tabs/month.	$43	$28	$61	$71
Norvasc	5 mg	$25	$28	$43	$48
Celebrex	200 mg	$63	$28	$78	$88
Zocor	20 mg	$69	$49	$101	$129
Prevacid	30 mg	$71	$44	$112	$131
Protonix	40 mg	$27	$42	$87	$104
Price for all 8, in one card (i.e., the CMS column does not add cumulatively).		$439	$307	$671	$765

Prices on 8 drugs commonly used by seniors, 30 day supply

Zip Code **49007, Kalamazoo, Michigan**

Drug	Quantity	VA	Canada	CMS-endorsed retail discount card low price	CMS-endorsed retail discount card high price
Liptor	10 mg	$41	$35	$65	$65
Plavix	75 mg	$100	$53	$113-$114 *	$128
Fosamax	70 mg, 4 tabs/month.	$43	$28	$57-$64	$74

Prices on 8 drugs commonly used by seniors, 30 day supply—Continued

Zip Code **49007, Kalamazoo, Michigan**

Drug	Quantity	VA	Canada	CMS-endorsed retail discount card low price	CMS-endorsed retail discount card high price
Norvasc	5 mg	$25	$28	$43-$44	$49
Celebrex	200 mg	$63	$28	$77-$84	$89
Zocor	20 mg	$69	$49	$101-$105	$134
Prevacid	30 mg	$71	$44	$111-$114	$136
Protonix40 mg	$27	$42	$86-$89	$108.	
Price for all 8, in one card (i.e., the CMS column does not add cumulatively).		$439	$307	$657-$691	$792

*Where a range of prices are listed, it means that the price available using that low (or high) cost discount card varies by the amount of that range among different pharmacies within the zip code. So one can pick a ''low'' card, but one will still need to be careful which drugstore one uses.

Prices on 8 drugs commonly used by seniors, 30 day supply

Zip Code **44052, Lorain, Ohio**

Drug	Quantity	VA	Canada	CMS-endorsed retail discount card low price	CMS-endorsed retail discount card high price
Liptor	10 mg	$41	$35	$65	$72
Plavix	75 mg	$100	$53	$113	$123
Fosamax	70 mg, 4 tabs/month.	$43	$28	$57-$64*	$71
Norvasc	5 mg	$25	$28	$43	$48
Celebrex	200 mg	$63	$28	$77-$84	$93
Zocor	20 mg	$69	$49	$101-$105	$129
Prevacid	30 mg	$71	$44	$111-$114	$145
Protonix	40 mg	$27	$42	$86-$89	$104
Price for all 8, in one card (i.e., the CMS column does not add cumulatively).		$439	$307	$657-$691	$765

*Where a range of prices are listed, it means that the price available using that low (or high) cost discount card varies by the amount of that range among different pharmacies within the zip code. So one can pick a ''low'' card, but one will still need to be careful which drugstore one uses.

Prices on 8 drugs commonly used by seniors, 30 day supply

Zip Code: **90048 Los Angeles, California**

Drug	Quantity	VA	Canada	CMS-endorsed retail discount card low price	CMS-endorsed retail discount card high price
Liptor	10 mg	$41	$35	$65	$72
Plavix	75 mg	$100	$53	$106	$123
Fosamax	70 mg, 4 tabs/month.	$43	$28	$61	$71
Norvasc	5 mg	$25	$28	$43	$48
Celebrex	200 mg	$63	$28	$78	$88
Zocor	20 mg	$69	$49	$101	$129
Prevacid	30 mg	$71	$44	$112	$131
Protonix	40 mg	$27	$42	$86	$104.33
Price for all 8, in one card (i.e., the CMS column does not add cumulatively).		$439	$307	$667-$679*	$765

*Where a range of prices are listed, it means that the price available using that low (or high) cost discount card varies by the amount of that range among different pharmacies within the zip code. So one can pick a ''low'' card, but one will still need to be careful which drugstore one uses.

Prices on 8 drugs commonly used by seniors, 30 day supply

Zip Code **11241 Brooklyn, New York**

Drug	Quantity	VA	Canada	CMS-endorsed retail discount card low price	CMS-endorsed retail discount card high price
Liptor	10 mg	$41	$35	$65	$74
Plavix	75 mg	$100	$53	$113	$127
Fosamax	70 mg, 4 tabs/ month.	$43	$28	$63	$74
Norvasc	5 mg	$25	$28	$43	$49
Celebrex	200 mg	$63	$28	$78	$89
Zocor	20 mg	$69	$49	$102	$134
Prevacid	30 mg	$71	$44	$112	$136
Protonix	40 mg	$27	$42	$87	$108
Price for all 8, in one card (i.e., the CMS column does not add cumulatively).		$439	$307	$671-$674	$790

*Where a range of prices are listed, it means that the price available using that low (or high) cost discount card varies by the amount of that range among different pharmacies within the zip code. So one can pick a ''low'' card, but one will still need to be careful which drugstore one uses.

Mr. BILIRAKIS. Thank you, sir.

Ms. Grealy.

STATEMENT OF MARY R. GREALY

Ms. GREALY. Good afternoon, Mr. Chairman, and members of the subcommittee. On behalf of the members of the Healthcare Leadership Council, I want to thank you for inviting me to testify today and convey to you that HLC's views on the Medicare prescription drug discount card program.

I will devote my time today discussing a study that the Healthcare Leadership Council has commissioned to fully understand the impact of the Medicare discount cards. Let me preface my remarks though by saying that the members of the Healthcare Leadership Council, an organization that represents the full spectrum of American health care believes that it is important for Medicare beneficiaries to have information about the discount card program. The drug discount card is an extremely important interim step, one that will provide financial assistance to millions of seniors who need that helping hand until the full prescription drug benefit takes effect on January 1, 2006.

How much money can Medicare beneficiaries save on their prescriptions by using the drug discount cards? That is the most relevant and important question on the minds of beneficiaries, particularly the millions who currently have no form of prescription drug coverage. And it's a question that the Healthcare Leadership Council is seeking to answer.

We have commissioned the Lewin Group, a nationally respected economic analysis firm to take a critical look at all of the discount cards that have price comparison information on the Medicare website.

We've approached this study in a way to make it relevant to the every day lives of the Medicare beneficiaries who will be using those cards. To do that, we have focused on 150 drugs that are most frequently used by senior citizens. We are looking at the difference between what a cash purchaser would pay for those drugs

at a retail pharmacy, compared to a buyer using the Medicare discount card.

We are also looking at the impact of the discount card for beneficiaries with chronic health conditions who take multiple medications.

I want to stress that these results are preliminary. we anticipate releasing a final version of the study next month. I also want to emphasize that we have taken a very conservative approach to these estimates.

If anything, I think we have underestimated rather than overestimated the average savings for discount card users. Well, here is what we have learned about these savings so far. Looking at these 150 most frequently used drugs, we are finding that the best available prices on those drugs, using the discount cards represent a weighted average savings of more than 20 percent in many states. Specifically, to list a few examples, we are seeing average savings of 27 percent in Florida; 26 percent in Louisiana; 25 percent in Illinois; and 23 percent in New York.

We are also finding very little geographic disparity in the drug discounts. The best price offered for a single drug rarely varies across markets. For example, the lowest available price for a best-selling brand new hypertension drug varies by less than $1 across 20 zip codes.

We're very pleased to see that the discount card users will receive significant savings regardless of the State or region in which they live.

Finally, we have found that there are considerable savings for beneficiaries who have chronic disease conditions and are using multiple drugs. These savings are even greater for low income beneficiaries who use the $600 low income credit available to them.

Let me cite one example. A beneficiary taking the most common combination of drugs for diabetes would spend on average almost $3,100 during the year if paying retail prices. The Medicare discount card that provides the best price on those drugs will save the individual over $753, a 24 percent savings. With the low income credit included, those savings increase to $1,353 or a 44 percent savings.

Low income seniors should also be aware that several of the major pharmaceutical companies have already announced that they will make drugs available at minimal or no cost to those beneficiaries who exhaust their $600 Transitional Assistance before the year is out.

Mr. Chairman, because our time is limited today, I won't go into more detail about this study, but we've provided information and would be happy to answer questions about it. But let me just add that the Healthcare Leadership Council will be continuing its effort to work with seniors like Mr. Baumhofer that we have here today, throughout the country to provide information and assistance on this program.

We look forward to working with this committee and to continue ensuring that Medicare beneficiaries receive the very best possible health care.

Thank you.

[The prepared statement of Mary R. Grealy follows:]

PREPARED STATEMENT OF MARY R. GREALY, PRESIDENT, HEALTHCARE LEADERSHIP COUNCIL

Good morning Chairman Bilirakis, Congressman Brown, and members of the subcommittee. Thank you for your invitation to appear here today to convey the views of the Healthcare Leadership Council on the Medicare prescription drug discount card program. I want to commend this committee for conducting this hearing and, in so doing, enabling the nation's seniors to learn more about this extremely important initiative. Along the same lines, I want to thank the committee for your leadership over the past several years in building a stronger Medicare program.

The Healthcare Leadership Council (HLC) represents providers and innovators from all sectors of American health care. Our membership is comprised of chief executives of leading companies and institutions from across the health spectrum.

Since its inception, the HLC has been dedicated to advancing a health care system that provides affordable, high-quality care in a patient-centered environment. We are committed to accessible medicines, technologies and treatments that can help people lead longer, more active and fulfilling lives. Consistent with this philosophy, we have long supported improvements to the Medicare program to give beneficiaries greater access to the high-quality preventive care that can bring greater health and enrichment for the disabled and the elderly.

The Medicare prescription drug discount card program is the first step—an important interim step—toward that goal. The Healthcare Leadership Council is involved in helping seniors to better understand the discount cards and the application process, and we have also undertaken research to fully comprehend what the discount cards will mean to Medicare beneficiaries in terms of cost savings. As part of my testimony, I will be very pleased to share the preliminary results of that research with you today.

BACKGROUND

When Congress passed, and President Bush signed into law, the Medicare Modernization Act of 2003, it represented a major advancement on behalf of millions of older and disabled Americans. With this legislation, Medicare is beginning to make a critical transformation into a 21st century health care program that makes prescription drugs, preventive care and diagnostic care more accessible to its beneficiaries.

In 2006, Medicare will, for the first time, offer a prescription drug benefit, a benefit that will substantially reduce beneficiaries' out-of-pocket costs. Realizing, though, that it will take time to put this benefit into effect, and that Medicare beneficiaries should begin to reap savings immediately, Congress wisely created the discount drug card program. This is an important interim step intended to give beneficiaries assistance right now, lasting until the full prescription drug benefit takes effect on January 1, 2006.

The structure of the discount card program enables participating seniors to have the power of consumer choice and the fruits of competition. With 73 vendors involved in the discount card program, beneficiaries have the opportunity to select the card that gives them the greatest savings on the specific prescription drugs they are using. And with the card vendors able to see, on the Centers for Medicare and Medicaid Services website, the discounted prices their competitors are offering, we have an environment in which market competition can bring lower prices and greater value to Medicare beneficiaries.

Seniors and disabled Americans are currently applying for their drug discount cards. Some media attention has been focused on the difficulties some seniors are having in negotiating the CMS website to gather comparative data on cards and prices. We support Administrator McClellan's efforts to correct problems on the site and to make it as user-friendly as possible. It should be pointed out, though, that individuals who are having difficulty with the CMS website or are simply not comfortable with the Internet can and should call 1-800-MEDICARE to receive personalized assistance with their discount drug card inquiries. I note that CMS has recently added even more customer service representatives to their 800 line, which should make it easier for callers to get through.

As well, there are numerous public and private organizations, such as State Health Insurance Assistance Programs, that are working with seniors to provide guidance and to ensure that they are able to register for the right discount card.

In fact, our own organization, the Healthcare Leadership Council, is working with senior centers throughout the country to provide information about the discount cards, and we're making a special effort to reach those low-income seniors who qualify for the $600 annual subsidy in addition to their drug discount cards.

THE LEWIN GROUP STUDY ON DISCOUNT CARD SAVINGS

How much money can Medicare beneficiaries save on their prescriptions by using the drug discount cards? That is a question the Healthcare Leadership Council is seeking to answer and, in so doing, give seniors a comprehensive sense of how the discount cards can affect their personal finances and their health care.

To answer this question, we have worked with The Lewin Group, a nationally-respected economic analysis firm that specializes in health and human services research and consulting. In structuring the Lewin study, we wanted to make it as relevant as possible to the everyday lives of the Medicare beneficiaries who will be using the discount cards. So, our analysis is focused upon 150 of the drugs that are most frequently used by senior citizens. We looked at the difference between what a cash purchaser would pay for those drugs and what someone would pay when using the Medicare discount card. We also took a look at the impact of the drug card for beneficiaries with chronic health conditions, using multiple medications. In this case, Lewin analyzed the total cost for the drug regimen for beneficiaries using the discount card and also for those using the discount card plus the $600 low-income credit.

Before I discuss what we have learned, thus far, from this study, I would like to make a couple of prefacing remarks. First, I would note that our retail price data is based on a national database of prescription drug utilization data compiled by Verispan. Verispan is considered one of the 12 months of price data, running through March of this year, to establish the average retail price for a customer without any insurance or discounts. I want to emphasize that, in conducting this research, we have chosen to err on the conservative side. If anything, this study underestimates, rather than overestimates, the average savings for discount card users. Our estimates are for people who do not currently benefit from an existing discount card or state pharmaceutical assistance program.

Second, I want to stress that the results I am sharing with you today are preliminary in nature. Our study is ongoing. And, in fact, just as Dr. McClellan has noted publicly that the discount card prices are moving downward as a result of price transparency and competition, our finalized study, to be released next month, may show even greater average savings than we are witnessing thus far.

With those points in mind, let me turn to the early findings of the Lewin study. These findings, by the way, can be found on the Healthcare Leadership Council website, www.hlc.org. Answering the question regarding how much a beneficiary can save overall, we worked from the premise that beneficiaries are likely to choose a discount card based upon the best savings for the drugs they take today. Looking at the 150 most frequently used drugs, we are finding that the best available prices on those drugs represent a weighted average savings of more than 20 percent in many states. (See attachment, Table 1)

Let's look at some specific examples. We're finding a weighted average savings of 27 percent in Florida, 26 percent in Louisiana, 25 percent in Illinois, 23 percent in New York, 21 percent in California and 19 percent in Michigan. We believe these estimates of savings are representative and that many beneficiaries will receive savings of similar magnitude.

In fact, it should also be pointed out that we are seeing very little in the way of geographic disparities in the discounted prices. The best price offered for a single drug rarely varies across markets. For example, the lowest available price for a best-selling brand name hypertension drug varies by less than one dollar across 20 zip codes and was offered by the same card sponsor in 18 of the 20 zip codes. This is a very positive finding. We're seeing that, regardless of the state or region in which a beneficiary lives, they will still receive the best price available nationally from the discount drug cards. (See attachment, Figure 1)

We have found, as well, that the savings are considerable for beneficiaries who have chronic disease conditions and are utilizing multiple drugs. Those savings are then significantly increased in cases in which the beneficiary is also using the $600 low-income credit for prescription purchases.

Again, allow me to provide some examples from our findings. A senior citizen taking the most frequently used combination of drugs for hypertension—a calcium blocker, an ACE inhibitor and thiazides—would pay an average retail price of $956.78 over the course of a year. With the drug card, that beneficiary will save $243.50, a savings of 25 percent. Add in the low-income credit, and the total savings increases to $843.50, or 88 percent off of the retail price.

In another hypothetical example, a beneficiary taking the most common combination of drugs for diabetes would spend $3,099.23 during the year if paying retail prices. With the discount card that provides the best price on those drugs, that person will save $753.59—a 24 percent savings. With the low income credit included,

the savings increase to $1,353.59, a 44 percent total discount from the retail price. Savings for each of the drug regimens identified in our study were estimated by collecting prices for the specific prescribed drugs using a single card at a single pharmacy. (See attachment, Table 3)

On the subject of low-income seniors, there is another fact that needs to be discussed that doesn't receive the visibility that it should. Several of the major pharmaceutical companies have already announced that they will make drugs available at minimal or no cost to those beneficiaries who exhaust their $600 transitional assistance before the year is out. That is in addition to the many company-sponsored patient assistance programs that are already providing medicines at no cost to people of limited means.

As I mentioned earlier, Mr. Chairman, this study is a work in progress. We are going to continue to monitor and analyze the prices that are available on the CMS website with the intent of producing a final report next month that gives a complete, accurate and comprehensive view of the savings Medicare beneficiaries can experience by using the Medicare drug discount cards.

And, in the meantime, the Healthcare Leadership Council will be continuing its efforts, working with seniors throughout the country to provide information and assistance so that all of those who can benefit from this program are able to do so.

We believe strongly that the Medicare drug discount card program is an important interim step, prior to the implementation of the prescription drug benefit in 2006. We believe, as well, that private organizations like ours and public institutions and officials should be working together to educate seniors on this interim assistance, to urge them to contact CMS for comparative information on the discount cards, and to encourage them to apply for a financial benefit that can bring considerable relief to those who need it the most. Thank you for your leadership on this issue, and we look forward to working with you to continue to improve America's Medicare program.

Figure 1. Best Available Price for a Hypertension Drug in 20 Markets

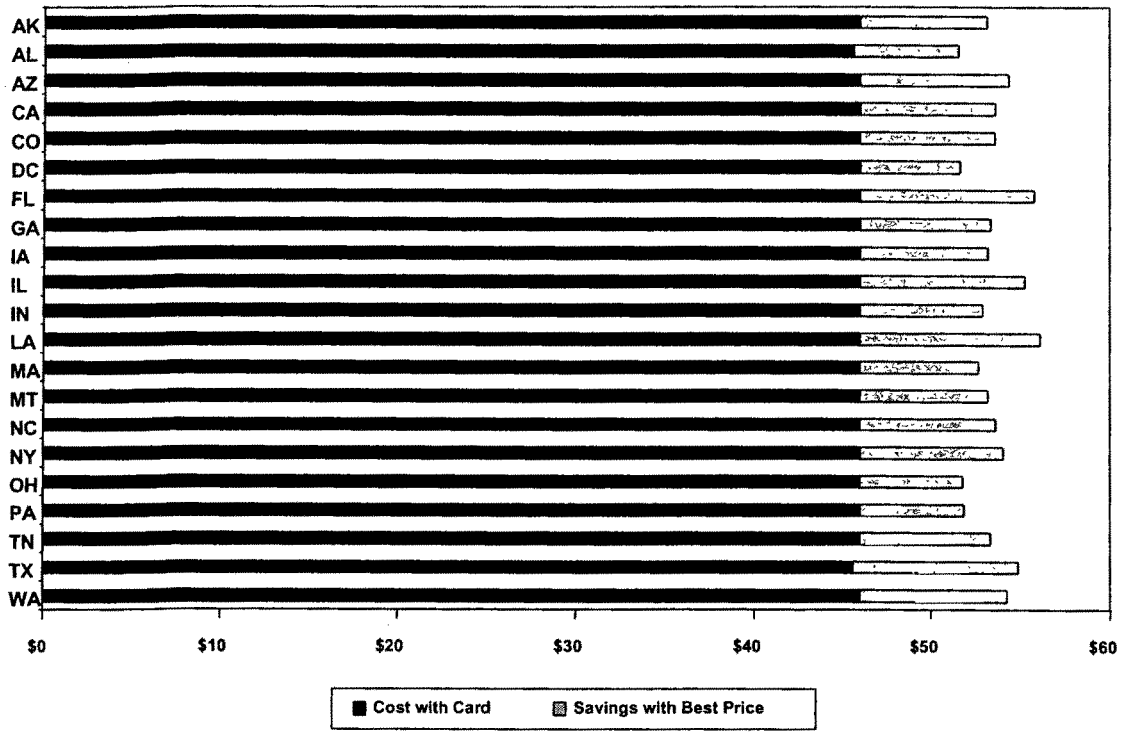

Table 1 – Best Available Price From Any Card Sponsor for Top 150 Drugs

Drug	Therapeutic Class	Used to Treat	Brand or Generic	Number of Rx Sold to Patients Over 65 (000s)	Best Price from Available Cards	Savings for 30-Day Supply																	
						Illinois		Alabama		California		Florida		Louisiana		Michigan		Minnesota		New York		Texas	
						($)	(%)	($)	(%)	($)	(%)	($)	(%)	($)	(%)	($)	(%)	($)	(%)	($)	(%)	($)	(%)
1	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	$7.12	10%	$7.12	10%
2	Thyroid Synthetics	Thyroid conditions	B	42,165	$13.76	$2.46	15%	$0.88	6%	$2.73	17%	$3.17	19%	$3.16	19%	$0.61	4%	$0.60	4%	$2.29	14%	$2.89	17%
3	Beta Blockers	Elevated blood pressure	G	39,411	$13.76	$12.04	76%	$11.04	80%	$11.46	84%	$11.41	83%	$12.77	93%	$9.620	70%	$10.04	73%	$10.84	79%	$12.78	79%
4	ACE Inhibitors	Cardiovascular disease	G	35,339	$7.36	$17.83	71%	$12.64	63%	$11.79	62%	$21.72	75%	$19.89	73%	$12.01	62%	$15.59	68%	$17.40	70%	$19.07	72%
5	Thiazides	High blood pressure	G	33,650	$2.77	$3.46	55%	$3.94	51%	$2.27	45%	$4.91	57%	$4.42	160%	$2.05	42%	$2.08	49%	$3.16	55%	$3.91	56%
6	Diuretics	High blood pressure, CHF	G	33,746	$2.08	$4.29	67%	$3.66	64%	$3.41	62%	$4.94	70%	$5.36	72%	$3.30	61%	$3.90	65%	$4.23	67%	$4.68	69%
7	Calcium Channel Blockers	High blood pressure	G	29,976	$42.68	$3.64	12%	$3.06	7%	$3.14	8%	$3.35	7%	$3.06	12%	$3.17	7%	$2.86	6%	$4.88	10%	$5.10	11%
8	Anti-depressants	Depression	B	27,801	$69.99	$14.98	18%	$8.61	11%	$10.74	13%	$14.20	17%	$14.52	17%	$9.43	12%	$9.36	12%	$11.35	14%	$11.90	15%
9	Beta Blockers	High blood pressure	B	25,267	$10.08	$6.52	25%	$4.67	20%	$6.74	25%	$7.02	27%	$5.72	23%	$4.59	19%	$4.45	20%	$5.84	23%	$6.88	26%
10	Statins	Lipid Lowering Agent	B	24,035	$101.42	$39.31	28%	$29.75	23%	$34.37	25%	$39.62	28%	$38.66	28%	$31.40	24%	$31.32	24%	$36.73	27%	$36.63	27%
11	Cephalosporins	Anti-infectives	G	23,760	$23.09	$72.51	76%	$42.47	65%	$44.48	68%	$52.78	78%	$50.50	76%	$40.59	67%	$42.11	73%	$53.69	77%	$51.12	76%
12	Proton Pump Inhibitors	Gastrointestinal	B	23,382	$110.03	$36.32	25%	$24.89	18%	$31.37	22%	$36.70	25%	$34.18	24%	$28.03	20%	$28.22	20%	$31.54	22%	$33.36	23%
13	Estrogens Oral	Menopause symptoms	B	22,056	$21.35	$9.06	30%	$7.07	25%	$7.82	27%	$8.70	30%	$9.55	31%	$6.97	24%	$6.99	24%	$8.27	28%	$8.73	28%
14	Corticoids	Anti-inflammatory	G	21,411	$4.83	$7.90	62%	$9.04	65%	$7.43	61%	$10.18	68%	$9.96	67%	$6.17	56%	$7.29	60%	$6.80	58%	$9.08	65%
15	Bisphosphonates	Osteoporosis	B	21,321	$16.61	$12.06	70%	$9.01	51%	$10.85	61%	$12.78	68%	$12.78	68%	$10.86	61%	$11.79	64%	$12.84	68%	$13.24	61%
16	Thyroid Synthetics	Thyroid conditions	B	21,281	$3.65	$9.88	73%	$8.56	70%	$8.94	71%	$9.72	73%	$10.35	74%	$8.74	71%	$9.09	71%	$9.70	73%	$9.85	73%
17	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
18	Anti-Histamines	Allergy	B	19,519	$59.14	$18.64	24%	$12.38	17%	$16.30	22%	$19.52	25%	$19.64	25%	$13.56	19%	$13.76	19%	$15.49	21%	$17.19	23%
19	COX-2 Inhibitors	Pain/Inflammation	B	19,409	$76.79	[illegible]	[illegible]	$37.68	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	$42.60	44%
20	Proton Pump Inhibitors	Gastrointestinal	B	18,692	$93.99	$49.13	34%	$37.13	28%	$43.48	32%	$49.59	35%	$47.29	33%	$39.42	30%	$39.50	30%	$43.17	32%	$45.46	33%
21	Beta Blockers	High blood pressure	G	18,468	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	$6.03	57%	$7.07	64%
22	Bisphosphonates	Osteoporosis	B	17,504	$57.43	$14.46	20%	$9.80	15%	$12.24	18%	$14.63	20%	$15.12	21%	$11.06	16%	$10.47	15%	$13.12	19%	$13.64	19%
23	Anti-Histamines	Allergy	B	17,240	$38.60	$11.88	17%	$10.00	10%	$13.02	14%	$13.95	17%	$11.58	17%	$10.41	15%	$12.53	17%	$10.81	13%	$10.06	15%
24	Leukotriene Agents	Asthma	B	17,227	$77.18	$18.54	19%	$11.67	13%	$15.16	16%	$19.89	20%	$19.49	20%	$13.08	14%	$12.92	14%	$16.38	18%	$17.07	18%
25	COX-2 Inhibitors	Pain/Inflammation	B	17,095	$70.70	$15.74	17%	$8.11	9%	$14.46	16%	$17.60	18%	$15.88	17%	$13.94	15%	$10.02	11%	$12.90	14%	$14.73	16%
26	Anti-depressants	Depression	B	16,105	$126.99	$62.95	33%	$47.94	27%	$54.26	30%	$63.39	33%	$63.92	33%	$52.47	29%	$50.85	29%	$54.99	30%	$57.69	31%
27	Erectile Treatments	Erectile Dysfunction	B	15,398	$41.00	$19.62	13%	$10.00	5%	$14.52	8%	$20.10	14%	$19.40	14%	$11.80	9%	$10.81	9%	$16.44	12%	$16.48	13%
28	Sexual Function Disorder	Erectile Dysfunction	B	15,207	$269.05	$46.89	15%	$37.27	12%	$36.76	12%	$46.74	15%	$45.51	14%	$26.12	9%	$37.02	12%	$46.44	15%	$37.97	12%
29	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
30	Antiplatelets	Reduce risk of stroke	B	13,789	$112.92	$16.11	12%	$8.67	7%	$14.14	11%	$17.02	13%	$15.72	12%	$9.77	8%	$9.14	7%	$13.99	11%	$14.19	11%
31	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
32	New Generation Anti-depressant	Depression	G	13,165	$4.09	$8.59	68%	$5.33	57%	$5.02	55%	$10.35	72%	$8.93	69%	$7.41	64%	$7.41	64%	$8.15	67%	$9.19	69%
33	Antidepressants	Depression	B	12,969	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
34	Quinolones	Anti-infectives	B	12,608	$262.37	$62.01	19%	$41.07	14%	$53.61	17%	$64.37	20%	$66.11	20%	$41.80	14%	$41.06	14%	$50.54	16%	$57.59	18%
35	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
36	Anti-Arthritics	Pain, Inflammation	G	12,204	$11.13	$41.92	79%	$16.28	59%	$17.85	82%	$49.80	82%	$38.85	78%	$22.07	66%	$34.21	75%	$29.78	73%	$44.44	80%
37	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
38	ACE Inhibitors	Cardiovascular disease	B	10,703	$44.32	$10.93	20%	$7.22	14%	$9.22	17%	$11.40	20%	$11.75	21%	$7.13	14%	$7.40	14%	$9.70	18%	$10.52	19%
39	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
40	Angiotensin II Receptor Blockers	High blood pressure	B	10,578	$43.70	$7.89	15%	$4.44	9%	$5.90	12%	$8.45	16%	$8.70	17%	$4.99	10%	$4.24	9%	$6.59	13%	$7.51	15%

Table 1 – Best Available Price From Any Card Sponsor for Top 150 Drugs (continued)

Drug	Therapeutic Class	Used to Treat	Brand or Generic	Number of Rx Sold to Patients Over 65 (000s)	Best Price from Available Cards	Savings for 30-Day Supply																			
						Illinois		Alabama		California		Florida		Louisiana		Michigan		Minnesota		New York		Texas	
						($)	(%)	($)	(%)	($)	(%)	($)	(%)	($)	(%)	($)	(%)	($)	(%)	($)	(%)	($)	(%)
41	ACE Inhibitors	Cardiovascular disease	G	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
42	Sulfonylureas	Diabetes	B	9,958	$51 50	$4 83	9%	$1 96	4%	$2 53	5%	$5 30	9%	$6 17	11%	$1 19	2%	$1 06	2%	$3 78	7%	$4 22	8%
43	Calcium Channel Blockers	High blood pressure	G	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
44	Cox-2 Inhibitors	Pain, Inflammation	B	9,210	$78 00	$21 85	22%	$13 04	14%	$21 95	22%	$21 70	22%	$19 20	20%	$14 01	15%	$15 78	16%	$18 09	19%	$19 19	20%
45	Thiazolidinediones	Anti-diabetic	G	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
46	Sulfonylureas	Diabetes	G	8,815	$6 07	$6 87	53%	$4 62	43%	$4 85	44%	$8 47	58%	$8 33	58%	$3 93	39%	$5 89	49%	$6 95	53%	$7 38	55%
47	Gout Specifics	Gout, Joint Pain	G	8,507	$3 08	$4 67	61%	$3 21	44%	$3 33	48%	$5 15	70%	$3 11	64%	$3 22	50%	$2 89	38%	$3 50	60%	$3 04	64%
48	Central Art Alone/Comb	High blood pressure	G	8,486	$5 27	$10 27	66%	$7 47	59%	$6 98	57%	$10 88	67%	$10 50	67%	$6 87	57%	$9 08	63%	$8 99	63%	$10 07	66%
49	Angiotensin II Receptor Blockers	High blood pressure	B	8,280	$40 08	$3 77	9%	$5 46	14%	$4 38	11%	$6 10	15%	$8 10	20%	$3 71	14%	$3 56	14%	$3 61	9%	$5 34	19%
50	Insulin Sensitizers	Diabetes	B	8,272	$134 53	$33 35	20%	$22 22	14%	$27 96	17%	$35 52	21%	$32 30	19%	$25 33	16%	$23 64	15%	$30 48	19%	$31 47	19%
51	Angiotensin II Receptor Blockers	High blood pressure	B	8,022	$40 08	$31 05	77%	$34 02	84%	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	$30 37	76%	$31 05	76%	$31 32	77%	$31 98	78%
52	Insulin Sensitizers	Diabetes	B	7,916	$73 39	$15 45	17%	$9 58	12%	$12 79	15%	$16 19	18%	$15 56	17%	$10 90	13%	$9 88	12%	$13 48	16%	$14 06	16%
53	Quinolones	Anti-infective	B	7,897	$110 03	$17 10	15%	$17 10	15%	$16 72	15%	$20 72	17%	$34 65	31%	$27 06	23%	$27 13	23%	$39 27	34%	$15 39	13%
54	Anti-Psychotics	Physychatric Disorders	B	7,894	$173 63	$42 25	20%	$26 42	13%	$34 60	17%	$39 94	19%	$37 88	18%	$28 55	14%	$26 62	13%	$36 22	17%	$34 64	17%
55	Antihyperlipidemics	Blood Clot Prevention	G	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
56	ACE Inhibitors	Cardiovascular disease	G	7,664	$11 40	$20 56	64%	$12 62	53%	$13 51	54%	$23 91	68%	$21 81	66%	$13 04	53%	$16 48	59%	$18 65	62%	$21 19	65%
57	Antihyperlipidemics	Cardiovascular disease	B	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
58	ACE Inhibitors	Cardiovascular disease	B	7,115	$31 46	$4 62	13%	$2 87	8%	$3 70	11%	$5 64	15%	$6 71	18%	$2 94	9%	$2 40	7%	$4 29	12%	$5 12	14%
59	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
60	Aminopenicillins	Anti-infectives	B	7,057	$10 41	$16 21	61%	$17 19	62%	$21 48	67%	$19 85	66%	$22 36	68%	$15 50	60%	$15 30	60%	$23 24	69%	$26 37	72%
61	Biguanides	Diabetes	B	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
62	Inotropics	Heart failure	B	6,923	$5 55	$3 26	37%	$3 05	35%	$3 09	36%	$3 14	36%	$3 02	41%	$2 58	32%	$2 36	30%	$3 39	38%	$3 15	36%
63	Statins	Pain, Inflammation	G	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
64	Bone Density Reg, Other	Osteoporosis	B	6,480	$66 99	$14 46	18%	$9 85	13%	$12 58	16%	$15 20	18%	$15 18	18%	$11 03	14%	$10 13	13%	$13 64	17%	$13 66	17%
65	Angiotensin II Receptor Blockers	High blood pressure	B	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
66	Sulfonylureas	Diabetes	B	6,260	$27 59	$6 25	18%	$4 16	13%	$5 41	16%	$6 68	19%	$6 79	20%	$4 38	14%	$4 41	14%	$5 59	17%	$6 15	18%
67	Antihistaminics	Allergies	G	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
68	Fibric Acid Derivative	Lipid Lowering Agent	B	6,193	$82 03	$13 07	14%	$6 66	8%	$9 31	10%	$13 97	15%	$13 21	14%	$7 96	9%	$7 77	9%	$11 11	12%	$11 67	12%
69	Diuretics Osmotic	Cardiovascular	G	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
70	Antibiotics, Macrolide	Anti-infectives	B	4,868	$208 87	$46 16	18%	$25 88	11%	$39 82	16%	$43 47	17%	$46 31	18%	$24 99	11%	$22 51	10%	$37 41	15%	$41 86	17%
71	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
72	Angiotensin II Receptor Blockers	High blood pressure	B	4,721	$41 04	$10 59	21%	$7.64	16%	$9 37	19%	$11 97	23%	$11 73	22%	$8 59	17%	$8 28	17%	$9 94	19%	$11 06	21%
73	Antihyperlipidemics	Blood Clot Prevention	G	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
74	Sulfonylureas	Diabetes	G	4,652	$6 69	$11 66	64%	$6 52	49%	$5 84	47%	$14 35	68%	$13 76	67%	$7 30	52%	$9 77	59%	$10 90	62%	$13 07	66%
75	Antihyperlipidemics	Blood Clot Prevention	G	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
76	Cephalosporins	Anti-infectives	B	4,616	$227 25	$58 50	20%	$38 92	15%	$43 05	16%	$62 75	22%	$62 56	22%	$39 73	15%	$50 02	18%	$47 17	17%	$56 35	20%
77	Alpha Blockers	Prostate Disorders	G	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
78	Urinary Tract Anti-Infective, Other	Anti-infective	B	4,541	$111 78	$33 92	23%	$23 42	17%	$27 99	20%	$35 08	24%	$36 96	25%	$22 64	17%	$21 34	16%	$28 76	20%	$34 12	23%
79	Beta Blockers	Cardiovascular	B	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
80	ACE Inhibitors	Cardiovascular disease	B	4,322	$16 57	$5.18	12%	$3 07	8%	$3.25	8%	$6 25	15%	$6 43	15%	$3 03	8%	$2 51	6%	$4 68	11%	$5 46	13%

Table 1 – Best Available Price From Any Card Sponsor for Top 150 Drugs (continued)

Drug	Therapeutic Class	Used to Treat	Brand or Generic	Number of Rx Sold to Patients Over 65 (000s)	Best Price from Available Cards	Savings for 30-Day Supply																			
						Illinois		Alabama		California		Florida		Louisiana		Michigan		Minnesota		New York		Texas	
						($)	(%)	($)	(%)	($)	(%)	($)	(%)	($)	(%)	($)	(%)	($)	(%)	($)	(%)	($)	(%)
81	Alzheimer's Disease	Alzheimer's Disease	B	2,482	$1.68	$2.07	12%	$1.62	10%	$1.79	11%	$1.84	10%	$1.92	12%	$1.84	10%	$1.85	11%	$1.89	12%	$1.90	12%
82	Antispas Urinary Tract	Bladder conditions	B	3,288	$81.66	$15.69	16%	$9.50	10%	$12.62	13%	$15.42	16%	$15.16	16%	$10.57	11%	$10.25	11%	$13.08	14%	$13.58	14%
83	Anti-Histamic Anti-Emetic	Gastrointestinal	G	1,117	$9.81	$7.09	54%	$7.14	54%	$7.14	54%	$7.23	55%	$7.13	55%	$5.82	44%	$7.76	59%	$8.20	62%	$8.09	65%
84	Folic Acid Analog	Cancer, psoriasis, arthritis	G	3,109	$40.41	$47.56	54%	$11.89	23%	$13.41	25%	$55.39	58%	$45.82	53%	$22.54	36%	$35.86	47%	$34.45	46%	$44.65	52%
85	Tetracyclines	Anti-Infective	B	3,045	$8.30	$5.85	55%	$5.16	51%	$5.62	55%	$5.03	51%	$5.20	53%	$4.03	53%	$5.83	52%	$6.44	55%	$7.94	60%
86	Anti-Arthritics	Pain, Inflammation	B	2,880	$74.68	$11.21	13%	$5.35	7%	$9.32	11%	$11.76	14%	$10.55	12%	$5.44	7%	$6.77	8%	$8.73	10%	$9.64	11%
87	Quinolones	Anti-Infective	B	2,599	$256.40	$47.84	16%	$18.99	7%	$31.41	11%	$50.62	18%	$43.01	14%	$19.15	7%	$35.21	12%	$30.05	10%	$41.43	14%
88	Angiotensin II Receptor Blockers	High blood pressure	B	2,767	$34.18	$14.19	29%	$10.86	24%	$12.92	27%	$14.51	30%	$14.88	30%	$11.80	26%	$11.11	25%	$13.35	28%	$12.90	27%
89	Antibiotics, Macrolide	Anti-Infective	B	2,789	$220.24	$47.09	17%	$28.66	11%	$35.66	14%	$50.23	18%	$53.62	19%	$29.32	11%	$34.28	13%	$39.74	15%	$44.97	16%
90	Inotropics	Heart failure	G	2,598	$3.23	$4.69	59%	$5.47	63%	$5.39	63%	$5.62	64%	$7.42	70%	$4.52	58%	$5.69	64%	$5.63	64%	$6.73	68%
91	Angiotensin II Receptor Blockers	High blood pressure	B	2,482	$44.65	$13.50	32%	$9.85	17%	$12.08	20%	$13.84	24%	$13.60	23%	$10.73	18%	$11.18	18%	$12.79	20%	$14.59	23%
92	Allylamines	Anti-Fungal	B	2,413	$258.57	$55.82	18%	$16.65	6%	$39.45	13%	$61.03	19%	$38.70	13%	$22.02	8%	$43.98	15%	$27.63	10%	$42.24	14%
93	Benign Prostate Disease	Prostate Disease	B	2,374	$71.08	$13.57	20%	$10.02	14%	$12.75	17%	$12.08	17%	$14.54	17%	$9.00	12%	$10.26	13%	$12.70	15%	$13.00	15%
94	Gout Specifics	Gout, kidney stones	G	2,254	$7.07	$10.09	59%	$9.56	57%	$9.99	59%	$10.62	60%	$12.10	63%	$9.57	58%	$10.16	59%	$10.07	59%	$11.19	61%
95	Calcium Channel Blockers	High blood pressure	B	2,254	$93.06	$7.49	12%	$3.13	5%	$3.80	6%	$7.97	12%	$7.87	12%	$4.14	7%	$1.47	3%	$6.17	10%	$6.79	11%
96	Quinolones	Anti-infectives	B	2,180	$256.40	$47.84	16%	$18.99	7%	$31.41	11%	$50.62	18%	$43.01	14%	$19.15	7%	$35.21	12%	$30.05	10%	$41.43	14%
97	Calcium Channel Blockers	High blood pressure	B	2,166	$6.92	$1.50	22%	$0.48	7%	$0.60	9%	$1.16	17%	$0.92	13%	$0.62	9%	$0.73	11%	$0.90	13%	$0.88	13%
98	H2 Antagonists	Gastrointestinal	B	1,748	$11.38	$120.52	91%	$111.90	91%	$114.47	91%	$119.55	91%	$118.33	91%	$111.23	91%	$111.72	91%	$115.72	91%	$115.39	91%
99	Calcium Channel Blockers	Anti-Hypertensive	B	1,686	$7.74	$1.14	15%	$0.54	7%	$0.83	11%	$1.07	14%	$1.07	14%	$0.57	7%	$0.80	10%	$1.14	15%	$1.05	14%
100	Biguanides	Diabetes	B	1,680	$33.01	$44.44	57%	$39.54	54%	$44.73	58%	$45.65	58%	$45.40	58%	$39.56	55%	$39.36	54%	$41.86	56%	$43.77	57%
101	ACE Inhibitors	Cardiovascular disease	B	1,564	$19.01	$16.01	84%	$12.01	63%	$15.70	83%	$16.90	89%	$17.00	89%	$13.15	69%	$11.67	61%	$13.06	69%	$13.71	72%
102	Hemostatics, Other Oral	Improve Blood Circulation	B	1,417	$56.42	$56.33	50%	$50.21	47%	$53.99	49%	$56.65	50%	$55.76	50%	$50.54	47%	$51.06	48%	$54.71	49%	$54.41	49%
103	Antidepressants	Depression	B	1,404	$37.00	$185.00	85%	$196.65	85%	$173.73	82%	$184.80	83%	$181.76	83%	$171.51	82%	$171.73	82%	$173.70	82%	$178.11	83%
104	Anti-Virals	Viral Infections	B	1,263	$437.55	$70.09	14%	$25.89	6%	$35.71	8%	$67.36	13%	$62.26	12%	$32.03	7%	$17.74	4%	$39.71	8%	$52.20	11%
105	Quinolones	Anti-Infective	B	1,167	$256.40	$57.11	22%	$19.02	7%	$40.02	15%	$59.30	22%	$50.58	20%	$46.00	18%	$51.06	19%	$50.11	20%	$53.76	21%
106	Diuretics	High blood pressure, CHF	B	1,126	$1.75	$9.76	85%	$9.44	84%	$10.00	85%	$9.73	85%	$10.44	86%	$8.95	84%	$9.04	84%	$9.65	85%	$9.93	85%
107	Sulfonylureas	Diabetes	B	1,120	$15.01	$2.62	17%	$1.19	8%	$1.60	11%	$2.61	17%	$2.57	17%	$1.64	10%	$1.70	11%	$2.57	17%	$1.66	10%
108	Alzheimer's Disease	Alzheimer's Disease	B	1,100	$133.87	$23.87	15%	$16.38	11%	$22.25	14%	$24.89	16%	$22.76	15%	$17.98	12%	$14.57	10%	$24.40	15%	$23.85	15%
109	Anti-Parkinson Other	Parkinson's Disease	B	1,082	$7.28	$3.22	42%	$1.59	20%	$1.83	23%	$1.01	13%	$1.77	23%	$1.78	23%	$1.55	21%	$1.98	26%	$1.48	19%
110	Calcium Channel Blockers	High blood pressure	B	1,048	$64.51	$11.39	15%	$6.64	9%	$9.20	12%	$11.51	15%	$10.28	14%	$7.27	10%	$6.06	9%	$10.49	14%	$10.66	14%
111	Diabetes Other	Diabetes	B	1,000	$1.00	$0.21	21%	$0.09	9%	$0.13	13%	$0.21	21%	$0.21	21%	$0.13	13%	$0.17	17%	$0.21	21%	$0.21	21%
112	Alzheimer's Disease	Alzheimer's Disease	B	848	$128.16	$29.56	19%	$21.64	14%	$27.01	17%	$28.25	18%	$26.48	17%	$21.36	14%	$19.76	13%	$26.73	17%	$26.08	17%
113	Antidepressant Tricyclic	Depression	B	805	$5.00	$1.00	20%	$0.60	12%	$0.80	16%	$1.00	20%	$1.00	20%	$0.60	12%	$0.60	12%	$1.00	20%	$1.00	20%
114	Diuretics	High blood pressure, CHF	B	799	$10.53	$8.49	45%	$7.30	41%	$8.40	44%	$8.77	45%	$9.16	47%	$7.04	40%	$6.86	39%	$8.13	44%	$8.65	45%
115	ACE Inhibitors	Cardiovascular disease	B	780	$12.00	$1.00	8%	$0.60	5%	$0.80	7%	$1.00	8%	$1.00	8%	$0.60	5%	$0.60	5%	$1.00	8%	$1.00	8%
116	Calcium Channel Blockers	High blood pressure	B	740	$45.23	$4.65	9%	$2.00	4%	$3.22	7%	$4.21	9%	$3.85	8%	$1.82	4%	$1.15	2%	$3.47	7%	$3.59	7%
117	Calcium Channel Blockers	High blood pressure	B	732	$12.00	$1.00	8%	$0.60	5%	$0.80	7%	$1.00	8%	$1.00	8%	$0.60	5%	$0.60	5%	$1.00	8%	$1.00	8%
118	Syn Non-narcotic non-injectable	Pain	B	732	$35.63	$105.37	75%	$94.89	73%	$103.11	74%	$104.72	75%	$104.13	75%	$96.07	73%	$97.37	73%	$99.46	74%	$101.34	74%
119	Antidepressant Tricyclic	Depression	B	715	$4.00	$0.80	20%	$0.48	12%	$0.64	16%	$0.80	20%	$0.80	20%	$0.48	12%	$0.48	12%	$0.80	20%	$0.80	20%
120	Benzodiazepines	Anxiety	B	596	$71.14	$7.03	9%	$1.26	2%	$4.93	6%	$7.55	10%	$6.10	8%	$0.05	0%	$2.52	3%	$3.21	4%	$6.12	8%

Table 1 – Best Available Price From Any Card Sponsor for Top 150 Drugs (continued)

Drug	Therapeutic Class	Used to Treat	Brand or Generic	Number of Rx Sold to Patients Over 65 (000s)	Best Price from Available Cards	Savings for 30-Day Supply																	
						Illinois		Alabama		California		Florida		Louisiana		Michigan		Minnesota		New York		Texas	
						($)	(%)	($)	(%)	($)	(%)	($)	(%)	($)	(%)	($)	(%)	($)	(%)	($)	(%)	($)	(%)
*121	Codeines	Pain	B	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
*122	Beta Blockers	High blood pressure	B	562	$3 66	$38 90	91%	$35 76	91%	$37 14	91%	$38 62	91%	$38 89	91%	$35 02	91%	$35 90	91%	$37 88	91%	$38 20	91%
*123	Calcium Channel Blockers	High blood pressure	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
124	Seizure Treatments	Seizure Disorders	B	502	$56 90	$11 95	17%	$6 45	10%	$7 64	12%	$9 45	14%	$9 85	15%	$7 00	11%	$4 27	7%	$11 78	17%	$10 56	16%
*125	ACE Inhibitors	Cardiovascular disease	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
126	Beta Blockers	High blood pressure	B	482	$5 22	$56 79	92%	$52 98	91%	$54 65	91%	$57 15	92%	$57 21	92%	$52 86	91%	$52 07	91%	$55 35	91%	$56 34	92%
*127	Alpha Blockers	High blood pressure	B	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
128	Statins	Lipid Lowering Agent	B	416	$57 31	$27 17	32%	$19 34	25%	$22 68	28%	$27 58	32%	$25 18	31%	$20 71	27%	$21 20	27%	$23 32	29%	$24 90	30%
*129	Cephalosporins	Antiinfective	B	401	$17 00	$39 11	57%	$37 72	51%	$16 66	18%	$37 61	51%	$42 72	8%	$10 39	31%	$8 28	3%	$21 53	18%	$29 26	8%
130	ACE Inhibitors	Cardiovascular disease	B	385	$17 47	$20 69	54%	$18 93	52%	$19 23	52%	$20 51	54%	$20 87	54%	$17 60	50%	$17 96	51%	$20 15	54%	$20 17	54%
*131	Beta/Alpha Beta Blockers Diuretics	High blood pressure	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
*132	Anti Nausea Anti Dopa Pheno	Nausea, vomiting	B	372	$26 94	$42 31	61%	$36 18	57%	$40 09	60%	$46 64	63%	$54 49	67%	$27 10	50%	$38 06	59%	$29 01	52%	$50 23	65%
*133	Antiulcer	Gastrointestinal disease	B	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
134	Calcium Channel Blockers	High blood pressure	B	288	$14 05	$50 96	78%	$47 09	77%	$48 31	77%	$50 58	78%	$50 58	78%	$47 08	77%	$45 45	76%	$48 71	78%	$50 39	78%
*135	Alpha Blockers	High blood pressure	B	282	$17 24	$19 92	26%	$14 98	21%	$15 55	22%	$19 46	26%	$19 19	26%	$15 00	21%	$16 28	23%	$17 49	27%	$17 96	27%
*136	Codeines	Pain	B	282	$25 58	$56 65	69%	$51 36	67%	$55 37	68%	$59 00	70%	$59 10	70%	$43 02	63%	$52 14	67%	$49 48	66%	$56 40	69%
*137	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
*138	ACE Inhibitors	Cardiovascular disease	B	235	$21 95	$21 61	50%	$18 53	46%	$19 24	47%	$22 33	50%	$21 72	50%	$18 26	45%	$18 96	46%	$20 71	49%	$21 30	49%
*139	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
*140	Diuretics	High blood pressure, CHF	B	158	$2 46	$40 99	94%	$38 26	94%	$38 72	94%	$40 47	94%	$40 93	94%	$37 11	94%	$37 54	94%	$38 61	94%	$40 04	94%
*141	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
142	Anti-Parkinson L-Dopa	Parkinson's Disease	B	147	$141 65	$43 18	23%	$35 32	20%	$37 08	21%	$39 45	22%	$44 18	24%	$34 28	19%	$33 18	19%	$38 87	22%	$40 57	22%
*143	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
*144	Anti-Parkinson L-Dopa	Parkinson's Disease	B	95	$54 46	$64 16	54%	$59 04	52%	$58 54	52%	$61 18	53%	$60 35	53%	$56 13	51%	$53 48	50%	$59 79	52%	$58 71	52%
*145	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
*146	Anti-Arthritics	Pain, Inflammation	B	69	$11 83	$99 36	89%	$93 28	89%	$95 94	89%	$102 19	90%	$102 88	90%	$92 21	89%	$90 39	88%	$95 76	89%	$100 27	89%
*147	Anti-Nausea Anti-Histamine	Motion Sickness	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
148	Sexual Function Disorder	Erectile Dysfunction	B	50	$251 70	$107 61	30%	$45 12	15%	$47 46	16%	$74 77	23%	$49 66	16%	$68 59	21%	$108 30	30%	$82 66	25%	$55 17	18%
*149	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
150	Anti-Arthritics	Pain, Inflammation	B	21	$86 24	$25 54	23%	$7 51	8%	$17 68	17%	$27 57	24%	$21 95	20%	$18 67	18%	$48 76	36%	$23 09	21%	$25 04	23%
*151	Alzheimer's Disease	Alzheimer's Disease	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		Weighted Savings Per Prescription				$20.56	25%	$13.37	18%	$16.09	21%	$21.86	27%	$21.04	26%	$14.13	19%	$15.48	20%	$17.89	23%	$19.53	25%

Note: Drugs marked with an asterisk indicate a possible data problems with prices posted on the CMS website.

Table 2 – Savings for Best Cards, 25 Commonly Prescribed Drugs

Drug	Therapeutic Class	Used to Treat	Total Number of Prescriptions for Over-65 Population	Weight	Illinois Retail Price	Card 1	Card 2	Card 3	Median Card
1	Statins	High cholesterol	[illegible]	[illegible]	$[illegible]	$67.[illegible]	$66.[illegible]	$67.[illegible]	$70.94
2	Thyroid Synthetics	Thyroid conditions	42,162	6.5%	$16 22	$15 51	$14 40	$14 93	$16 31
3	Beta Blockers	High blood pressure	[illegible]	[illegible]	$15.[illegible]	$4.97	$3.48	$4.95	$6.16
4	ACE Inhibitors	Cardiovascular disease	35,339	5 4%	$25.19	$7 36	$16 00	$15 83	$21 41
5	Thiazides	High blood pressure	33,850	5.2%	$8.22	$3.98	$2.77	$4.36	$6.72
6	Diuretics	High blood pressure, CHF	33,746	5 2%	$6 37	$4 77	$2 08	$3 98	$5 30
7	Calcium Channel Blockers	High blood pressure	29,978	4.6%	$46.82	$44.28	$42.99	$43.60	$46.61
8	Anti-depressants	Depression	27,801	4 3%	$84 97	$74 99	$69 99	$74 36	$78 50
9	Beta Blockers	High blood pressure	26,265	4.0%	$26.15	$21.39	$19.60	$20.92	$22.69
10	Statins	Lipid Lowering Agent	24,035	3 7%	$140.73	$102 42	$101 42	$103 25	$116 95
11	Cephalosporins	Anti-infectives	23,[illegible]	[illegible]	$[illegible]	$24.[illegible]	$3.[illegible]	$57.35	$33.51
12	Proton Pump Inhibitors	Heartburn, Gastrointestinal	23,383	3 6%	$146 35	$110 03	$110 86	$114 20	$130 43
13	Sulfonylureas	Manage diabetes	[illegible]	[illegible]	$[illegible]	$[illegible].75	$29.40	$25.[illegible]	$26.96
14	Corticoids	Anti-inflammatory	21,411	3 3%	$12 73	$6 29	$7 78	$5 44	$7 26
15	Diuretics	[illegible]	[illegible]	[illegible]	$[illegible]	$[illegible]	$[illegible]	$18.76	$24.84
16	Thyroid Synthetics	Thyroid conditions	21,282	3.3%	$13 53	$11 14	$12 30	$3 65	$10 30
17	Sedating Non-Benzodiazepines Other	Insomnia	[illegible]	[illegible]	$[illegible]	$[illegible].86	$72.65	$81.63	$83.61
18	Anti-Histamines	Allergy	19,519	3.0%	$77 78	$59 98	$63.89	$60 68	$60 73
19	Cox-2 Inhibitors	Pain/inflammation	19,[illegible]	[illegible]	$[illegible]	$81.[illegible]	$70.79	$80.92	$84.78
20	Proton Pump Inhibitors	Heartburn, Gastrointestinal	18,692	2 9%	$143.12	$106 45	$98 99	$107 30	$110 32
21	Beta Blockers	High blood pressure	18,465	2.8%	$12.53	$5.35	$4.98	$5.13	$5.61
22	Bisphosphonates	Osteoporosis	17,505	2 7%	$71.89	$63 50	$57 43	$63 60	$68 06
23	Anti-Histamines	Allergy	17,241	2.7%	$68.38	$58.04	$61.99	$57.38	$60.90
24	Leukotriene Agents	Asthma	17,227	2 7%	$95 72	$77 68	$83 21	$77 97	$82 57
25	Cox-2 Inhibitors	Pain/inflammation	17,099	2.6%	$93.44	$78.36	$77.70	$78.65	$83.40
			648,444	100 0%					
	Weighted Average Cost Per Prescription				$56.07	$42.49	$42.55	$43.87	$47.14
	Weighted Average Savings Per Prescription ($)					-$13.58	-$13.52	-$12.20	-$8.93
	Weighted Average Savings Per Prescription (%)					24.2%	24.1%	21.8%	15.9%

Note: Savings shown are for Illinois, based on data collected May 12 in zip code 60619.

Table 3 – Savings for Low Income Beneficiaries Eligible for $600 Credit, by Disease

		Brand / Generic	Annual Cost Without Discount	Savings with Card ($)	Savings with Card and Credit ($)	Savings with Card (%)	Savings with Card and Credit (%)
Diabetes Combination Therapy I			3,099.23	753.59	1,353.59	24%	44%
Drug A	Sulfonylurea	G					
Drug B	Biguanides	B					
Drug C	Insulin Sensitizers	B					
Diabetes Combination Therapy II			2,209.48	468.53	1,068.53	21%	48%
Drug D	Biguanides	G					
Drug E	Sulfonylurea	B					
Drug F	Insulin Sensitizers	B					
Diabetes with Hyperlipidemia I			3,846.63	825.87	1,425.87	21%	37%
Drug B	Biguanides	B					
Drug C	Insulin Sensitizers	B					
Drug G	HMG-CoA Reductase Inhibitor	B					
Diabetes with Hyperlipidemia II			3,430.75	696.55	1,296.55	20%	38%
Drug E	Sulfonylurea	B					
Drug F	Insulin Sensitizers	B					
Drug H	HMG-CoA Reductase Inhibitor	B					
Diabetes and Hypertension			2,646.56	332.24	932.24	13%	35%
Drug R	ACE Inhibitors	B					
Drug F	Insulin Sensitizers	B					
Drug G	HMG-CoA Reductase Inhibitor	B					
Hypertension Combination Therapy			956.78	243.50	843.50	25%	88%
Drug M	Calcium Blocker	B					
Drug N	ACE Inhibitor	G					
Drug O	Thiazides	G					
Congestive Heart Failure, Hypertension			1,788.46	511.42	1,111.42	29%	62%
Drug O	ACE Inhibitors	G					
Drug P	Alpha-Beta Blockers	B					
Drug Q	Diuretics	B					
Known Coronary Artery Disease			2,637.83	505.91	1,105.91	19%	42%
Drug T	Beta Blockers	B					
Drug R	ACE Inhibitors	B					
Drug U	HMG-CoA Reductase Inhibitor	B					
History of Atrial Fibrillation			429.21	99.69	396.26	23%	92%
Drug V	Inotropics	B					
Drug W	Anticoagulant	B					
Osteoporosis, Osteoarthritis, and Chronic Allergies			3,001.98	509.82	1,109.82	17%	37%
Drug I	Anti-Histamines	B					
Drug J	Cox-2 Inhibitors	B					
Drug K	Bone Density Reg. Other	B					
Multiple Chronic Conditions			5,948.06	1107.14	1,707.14	19%	29%
Drug X	Cox-2 Inhibitors	B					
Drug Y	Bone Density Reg. Other	B					
Drug Z	Proton Pump Inhibitors	B					
Drug AA	Leukotriene Agents	B					
Drug BB	Anti-depressants	B					
Drug CC	Beta Blockers	G					

Note: Preliminary estimates based on savings in Illinois.

Mr. BILIRAKIS. Thank you very much, Ms. Grealy.

Mr. Hayes.

STATEMENT OF ROBERT M. HAYES

Mr. HAYES. Thank you, Mr. Chairman, and committee members. Joining me this afternoon is Gene Smith. Ms. Smith is a retired school teacher from Charlottesville, Virginia and she works throughout the Commonwealth of Virginia on behalf of people with Medicare who have been struggling to find ways to pay for their prescription drugs. Ms. Smith is a member of the Medical Rights Center Consumer Action Board and she, among others, filters information into our policy work.

I'd like Ms. Smith to just explain briefly some of her efforts on behalf of folks in Virginia in recent days.

Mr. BILIRAKIS. Within your 5 minutes' period, Ms. Smith can do so. Go ahead, please proceed.

Ms. SMITH. Thank you. I'm an unpaid volunteer and I'm trying to help a neighbor who is a retired broadcaster. He has severe arthritis, hemochromatosis and other health problems and I tried to help him by calling 1-800-MEDICARE because he has hundreds of dollars in prescription drug costs and he's in severe pain without those drugs.

So I called 1-800-MEDICARE and after a few attempts on a day that was recommended to me, I got through to a human voice. Unfortunately, the voice, the woman said that she could not help me because not only did I not know his monthly gross income, but I did not know his total financial assets and I needed to know his total financial assets with exception of a car, home and burial plot.

Mr. BILIRAKIS. You know that the asset test does not apply. Go ahead.

Ms. SMITH. That's what she told.

Mr. BILIRAKIS. That's what she told you. Yes, I understand.

Ms. SMITH. So she said she couldn't help me. This week, early this week I went to a statewide video conference for training which was sponsored by the Department of Health in Virginia and the people who were training were members of CMS. We had the PDAP internet program and we had another slide presentation program and afterwards people who were there, social service people, substance abuse people, community health people asked questions and they couldn't get answers. The answers were always "we don't know, we will get back to you, just fill out the form and ask your question." So I left very frustrated and couldn't help my friend and I can't help anybody in my community because I can't get the answers.

Mr. HAYES. Let me say that we at the Medical Rights Center have been feeding this information into the folks at CMS. Dr. McClellan mentioned this morning that he was getting that and we have found receptivity, whether or not any human enterprise will be able to untangle these problems in the foreseeable future remains something for the committee to oversee.

Mr. Chairman, let me just take a couple of minutes to give some perspective from the trenches, in a sense, that we work in. We are as was discussed this morning, folks who are in the arena with people with Medicare. We've got a lot of blood, a lot of sweat and

a lot of tears these days in our office. We are striving mightily to try to help people work through the opportunities or the challenges that this discount program is presenting.

No. 1, Mr. Chairman, it's no exaggeration to say that the men and women who turn to us for help are indeed in a state of high anxiety. They're confused. They're angry. They're perplexed.

No. 2, and I don't think this needs to be seen as a partisan critique, it is no exaggeration to say that people with Medicare, most people with Medicare will receive little, if any benefit, from the discount cards.

But No. 3, there's also no exaggeration to say that some people, largely those without any drug coverage and unaware of existing discounts will be able to afford some medicine thanks to the Medicare discount card. And let me underscore, that is too important a point to lose. Because we do come today, Mr. Chairman, as critics of what is, in many ways, a tragically wasteful program, yet people will have better health, better access to medication by enrolling into this discount card and we consider it our responsibility day in and day out to help people enroll in the program and further to push the administration to make enrollment as feasible as possible.

So how can that be done? First, websites, voice automated phone systems will not be more than a small piece of the solution. Two well known facts: one in five people with Medicare has internet access. Sixty-two percent of people with Medicare, according to a recent poll, were unaware that there is a discount card out there. The angry, confused people are really a minority. The silent majority are unaware of the program.

We think the most way to assist people access, what is indeed, we all agree the most useful part of the benefit, the Transitional Assistance benefit, is to require automatic enrollment of anyone who can establish eligibility through some existing program, principally the Medicare Savings Programs, Medicare Buy-In programs.

Now we've heard from folks in the administration that this kind of auto-enrollment would undermine the voluntary nature of the drug benefit. Come on. Neither the White House, nor the Internal Revenue Service requires Americans to jump through hoops two summers ago to receive tax refunds. They were just mailed. People with Medicare, eligible for the $600 Transitional Assistance should be treated similarly.

I was happy to hear this morning, Mr. Ferguson of New Jersey, talk with praise about the auto-enrollment of people from his State who are enrolled in a State pharmaceutical assistance program. I think this is one area where people can come together from both sides of the aisle to help both access the Transitional Assistance which across the board we agree is a good thing.

[The prepared statement of Robert M. Hayes follows:]

PREPARED STATEMENT OF ROBERT M. HAYES, PRESIDENT, MEDICARE RIGHTS CENTER

Good afternoon, Mr. Chairman, Committee members. My name is Robert M. Hayes, and I am the President of the Medicare Rights Center. Joining me is Ms. Gene Smith, a retired school teacher from Charlottesville, Virginia. Mrs. Smith works throughout the Commonwealth of Virginia on behalf of people with Medicare struggling to find a way to pay for the medicines their doctors prescribe. She is a member of our Consumer Action Board, and filters her day to day experiences into MRC's policy work.

Without doubt, the greatest and gravest unmet need of older and disabled Americans is the unavailability of affordable prescription medicine. From the trenches in which we work, Mr. Chairman, the unaffordability of prescription medicine is a national emergency. It is within that reality that we approach the Medicare discount card program, and it is the faces of men and women who cannot afford needed medicine that we bring to you.

The Medicare Rights Center

The Medicare Rights Center ("MRC") is the largest independent source of Medicare information and assistance in the United States. Founded in 1989, MRC helps older adults and people with disabilities get good affordable health care. Day in and day out we work to assist people with Medicare access needed health care. Tens of thousands of callers use our help-lines annually, and we reach out to assist people with Medicare enroll in programs that can assist them.

The Medicare Rights Center is a not-for-profit consumer service organization, with offices in New York, Washington and Baltimore. It is supported by foundation grants, individual donations and contracts with both the public and private sectors. We are consumer driven and independent. We are not supported by the pharmaceutical industry, drug companies, insurance companies or any other special interest group.

Through national and state telephone hotlines, casework and both professional and public education programs, MRC provides direct assistance to people with Medicare from coast to coast. By way of example, MRC currently is providing, in partnership with the American Society on Aging, a series of web-based tele-trainings on the Medicare discount cards to social workers and other professionals across the country. You can access that training at www.asaging.org/medicare.

We are also bringing to counselors and consumers across the country Medicare Interactive, a web-based counseling tool that assists people with Medicare access the health care they need. Invitation: every Congressional district office that requests it will be provided a password to access Medicare Interactive to assist constituents with Medicare problems or questions.

MRC also gathers data on the health care needs of the elderly and disabled Americans that we serve. We share that data with researchers, policy makers and the media. Just one of MRC's services, its New York State Health Insurance Assistance Program (SHIP), offers counseling support to one out of every 14 Medicare recipients in the nation. Each year, the Medicare Rights Center receives some 70,000 calls for assistance from people with Medicare. By far, the greatest numbers of callers are seeking help in finding ways to pay for medicines that their doctors have prescribed.

For many, many years this Committee, this Congress, our nation have been numbed by the overwhelming data that has documented the human hardship, the needless pain, the lost lives caused by the unaffordability of prescription medicine. I cannot shake from my memory the elderly woman who tearfully told me that she lies to her husband whenever her doctor gives her a prescription. If she told him about the prescription, she said, her husband would insist that she fill it. She wants him to keep taking his heart medicine, and she knows they could not afford another prescription. That is an obscenity in America in the 21st Century, and I know that is why we are here today.

Ms. Smith faces these painful images routinely in her work in Virginia.

The most typical problem she reports is the question: "How can I afford my prescription drugs?" Heartened by the news that Medicare would be covering prescription drugs, many people turn to Ms. Smith for advice. As she puts it, "I have kept my ears to the ground to stay informed so that I could be of help to others."

Like many other people of good will, Ms. Smith had done all she could to learn more about the Medicare-approved drug discount cards. At a meeting earlier this week sponsored by the Virginia Department of Health, representatives of the Centers for Medicaid and Medicare Services came to train counselors on the new cards. Ms. Smith can report to you her own feelings: she left the meeting feeling confused, frustrated and angry—the experts were unable to answer many questions that Ms. Smith and her colleagues raised. The CMS representatives asked the counselors to write down questions, saying they would get back with answers.

Ms. Smith asks the obvious: How can she explain this to one of her neighbors who holds out hope that she can help him at last secure affordable drugs. He is a retired broadcaster, has no drug coverage and suffers from severe arthritis. His medications cost hundreds of dollars a month but without them he would live in constant pain. Here's what Ms. Smith reported to me:

"To try and help him find a Medicare-approved drug discount card, I called 1-800-MEDICARE. After a number of attempts—including on a day that the recording rec-

ommended I call—I finally got through. It was a shock to hear the representative say she could not help me, because I did not know my neighbor's monthly income or have any information about his assets. I explained the one thing I did know was that he was not eligible for a card that came with low-income assistance, so I could not understand why this information was necessary. Additionally, I didn't feel comfortable asking my neighbor about this. The customer representative said that there was absolutely nothing she could do to help me until I had all of his financial information. She suggested I get the information and call again. Despite my efforts to arm myself with information about the cards at a CMS training program and my attempts to get help from 1-800-MEDICARE, I now feel even more frustrated and less equipped to assist people with Medicare who knock on my door because they need help to pay for their prescription drugs."

I will take just a couple minutes to outline what consumers are experiencing in the wake of the Medicare discount card roll out.

One, it is no exaggeration to say that the men and women who turn to us for help are in a state of high anxiety, feeling both confused and angry.

Two, it is no exaggeration to say that most people with Medicare will receive little if any benefit from the Medicare discount card program.

Three, it is no exaggeration to say that some people—largely those without any drug coverage and unaware of existing discounts—will be able to afford some medicine thanks to the Medicare discount program. This is far too important a point to lose.

We are indeed critics of this tragically wasteful program. Yet some people will have improved health and a better life if they enroll in the discount program, especially transitional assistance. We consider it our responsibility to help enroll these people, and to push this Administration into making enrollment of them as feasible as possible.

How can that be done?

First, recognize that web sites and voice automated phone systems are—even if they worked—a sliver of a solution. Two well known points: one in five people with Medicare currently have internet access. More basic: the most recent Kaiser Family Foundation poll showed that 62 percent of older Americans did not even know that Medicare discount drug cards would be available. This indeed is the silent majority—the angry, confused people are among the best informed.

The most useful step to assist people access the $1200 transitional benefit—as it is now designed—is to require automatic enrollment of anyone who has established eligibility through some existing program, principally the Medicare Savings or Medicare buy-in programs. We have heard from some in the Administration that auto-enrollment would undermine the voluntary nature of the drug benefit. Come on. Neither the White House nor the Administration forced Americans to jump through hoops to claim their tax refunds two summers ago. It was just mailed to you. People with Medicare eligible for the $600 transitional assistance should be treated similarly.

I won't speak about the difficulties of the CMS web site or the 800-MEDICARE phone line now; we have provided CMS with a good deal of feedback since late last month. We recognize that CMS is trying, but it is also true that not just consumers, but CMS as well, has been dealt a cruel hand by the structure of the discount card program. At the end of the day, a reasonably informed choice for most people with Medicare will be impossible. Congress should not allow the spending of millions of tax dollars in futile attempts to explain nuanced choices involving scores of plans offering hundreds of medical products and services. Rather than providing multiple choices with scant benefits, provide a few well vetted options that provide meaningful benefit. The structure of the discount program, and we expect the 2006 benefit as currently designed, does not work and no magic by a CMS webmaster can change that.

Scores of choices of discount cards allow no real choice. The chaos and pain of this crazed market should send a plain lesson to the next Congress on one three-word remedy for the 2006 drug benefit: simplify, simplify, simplify.

And at the end of the day, the obligation to drive the prices of prescription drugs down remains the great lost opportunity of the 2003 Medicare legislation. The sound and fury of the discount cards, and of the 2006 benefit, cannot obscure that.

The discount cards will do some people some important good, but the discount cards are leaving the overwhelming majority of people with Medicare without help and angry. Look ahead, use the government's market power to drive down drug prices for all Americans, and then create a benefit with three words in mind: simplify, simplify, simplify.

Mr. BILIRAKIS. Thank you, Mr. Hayes. If only we would stop sniping at each other and almost expressing hate at times toward one another we could probably accomplish a heck of a lot more than we do, but unfortunately that's the nature of the beast, I guess. The Founders, I suppose, I hate to keep saying it, the Founders, I suppose, intended it this way. I'd like to think they did not intend it to be with the animosity that we now have.

Mr. STUPAK. Will the chairman yield on that point?

Mr. BILIRAKIS. I don't have time, but go ahead.

Mr. STUPAK. We don't mean to snipe, we just want to be included in the discussions and help draft the legislation. We were totally excluded and never even offered a chance to offer an amendment. You're sort of excluding us. We don't mean to snipe. We just want to be part of the process. We represent 49 percent of the country.

Mr. BILIRAKIS. Mr. Baumhofer, Mr. Walden from your State and Mr. Wu from your State both wanted to be here to introduce you and I guess because of the delays in the votes that we had and what not, we got all mixed up. If they walk in, we'll give them an opportunity to say a thing or two.

In the meantime, please proceed.

STATEMENT OF STAN BAUMHOFER

Mr. BAUMHOFER. As you've mentioned to the committee, my name is Stan Baumhofer. I live in Portland, Oregon where I've lived for the last 55 years. I feel a little unique here today because I may be one of the few or maybe the only one in the room that's going to benefit from this program, a real user of the discount card.

You may wonder why did a retiree, 75 years old, come all the way across the country here to appear before you. The reason is very simple. I came here to thank you for helping save my life. My written testimony explains that I have a friendship in our local Toastmasters Club and his wife is a volunteer that helps senior citizens. She encouraged me to pay attention to the mailings I was getting from Social Security and to inquire about the discount card. She even made some estimates and said it looks like you should really inquire, Stan.

Well, I called the 800 number and in less than 10 minutes I was talking to a very pleasant, knowledgeable lady. She to my surprise, calculated the benefits to the medications that I am using. She clarified my eligibility. And the most surprising thing to me was that she made comparisons with five drug stores that are within walking distance of my apartment. It was local information, two of which I had been buying drugs from already.

You can also see from my written testimony that I live only on my Social Security. This amounts to just a little over $16,000 a year. My daily medications cost over $400 a month. And with the use of this card I will be reducing that cost by $150, a little over 35 percent of my medication costs. Now my health story is also quite simple. I have enjoyed good health all of my life until a year ago. I required a stent implant for a clogged artery. My cardiologist prescribed five medications that I take daily to cover the body's reaction to this stent and to keep my blood flowing properly. So naturally, when I heard of this Medicare discount card program, I was

one of the, maybe one of the 400,000 that the Doctor alluded to this morning that called.

Now not only will it help me, but it's going to help many people who are applying for this discount card. I live in an apartment building of over 250 senior citizens and many of them are low income and will benefit from the $600 credit which I will not be eligible for. I also volunteer about 20 hours a week at a hospital and meet many people in the predicament of having prescriptions prescribed for them and they're unable to pay for them.

Well, I'm here to testify that Congress did a very, very good thing for senior citizens and I congratulate you.

My last point, I think, would be to try to dismiss a couple of comments that had been made earlier concerning the negative side of this program. Now it is completely untrue in my experience and from others that I've talked to that it's difficult to get through or to get a calculation made. And when there's a savings to me of over a third of my drug costs, that's a Godsend to me. You referred that it may not be a panacea this morning, but to me, it certainly is close to that.

And the matter of choices. Shopping is recreation for senior citizens. It has to be, not only for recreation, but for survival in many cases. So we enjoy the fact that there are recreations and it gives us a chance to do some shopping. So Mr. Chairman, you and your colleagues have done a great service to seniors and I for one am here to say thank you in helping me to avoid ever having to take this nitroglycerin that I carry with me constantly. Thank you.

[The prepared statement of Stan Baumhofer follows:]

PREPARED STATEMENT OF STAN BAUMHOFER

Mr. Chairman and members of the committee, my name is Stan Baumhofer. I live in Portland, Oregon, and I appreciate you making the time for me to say a few words this morning about the new Medicare discount drug cards.

I should probably begin by telling you what brings me here to tell my story. I'm involved in the Toastmasters organization in Portland, and I got to know someone in my local chapter who is involved in helping senior citizens understand how these discount drug cards work and how to apply for them.

Well, I'm a senior citizen, 75 years young. I live in subsidized housing in Portland and make do on my fixed Social Security income of $16,000 per year. I was eager to pick her brain and find out if this discount card program could make a difference in my life.

To cut right to the chase, this card is going to mean a lot to me in terms of helping pay for my prescriptions. So, I volunteered to come to Washington and tell my story in the hope that other seniors on Medicare will hear what I have to say and go take advantage of this program themselves.

My story is this. I received a stent implant last June to alleviate a clogged artery. In order to offset my body's reaction to the stent, and to keep my blood flowing, my cardiologist has me on four prescription medications. Once each day, I take 20 milligrams of Lipitor, 30 milligrams of Lisinipril, 75 milligrams of Plavix and 50 milligrams of Toprol. So, naturally, when I heard about this Medicare discount program, I was ready to be one of the first in line to see if it would work for me.

I called the Medicare 800 number, 1-800-MEDICARE, and I had the pleasure of speaking with someone on the other end of the line who was very pleasant, very knowledgeable and very helpful. She took down the information about where I live and what types of prescription drugs I'm taking. I could hear her punching the information into her computer as we talked. Not long after I finished giving her my information, she told me which discount card would work best for me and how much money I would be able to save on my prescriptions.

Well, let me tell you, for someone who has lived a frugal life and who does not have much in the way of excess funds, this came as very welcome news.

The drugs that have been costing me $403.31 each month will now cost $250.60. monthly. That's a more than 30 percent decrease in my monthly medicine bill. My savings will add up to over $1,750 for the year. Maybe, to some people, that amount of money doesn't seem like a lot, but it means a lot to me and also to many of my friends in Portland who are also on fixed incomes and also finding out that these cards are going to save them money at the pharmacy counter.

Let me make another point, Mr. Chairman. A number of people I know are not only going to apply for the discount drug card, but they also qualify for the $600 credit for low-income seniors. With the discount card and that $600, they are going to be able to buy their medicines without having to make difficult sacrifices in other parts of their lives. Congress did the right thing in passing this law, and you should all be proud of how you've helped people.

I want to say one last thing before I finish. You know, I read the newspapers and I see some people picking this discount card program to pieces. They say it's too complicated, or that it doesn't offer enough help. I have to shake my head at these criticisms, because my experience, and the experiences of people I know, is completely different. It's easy to get information over the Medicare 800 number. With the discount card, I'm going to be paying less for my prescriptions in June than I am today—quite a bit less, for that matter. So, all I can say is, what's not to like?

Mr. Chairman, you and your colleagues did a good thing for seniors in passing this law, and this is one senior who is pleased to be here to say thank you.

Mr. BILIRAKIS. Thank you very much. First, let me commend Ms. Smith, Mr. Baumhofer and the volunteer that Mr. Hayes or somebody referred to earlier and all the volunteers out there who take time. Mr. Baumhofer, you're not exactly in the best of shape and yet here you are donating 20 hours of your week volunteering to help others and I think that's just a terrific thing. We probably would have more of that were it not for the fact that we've all gotten accustomed to sort of looking to government or to others for what we need.

The bait and switch, Mr. Pollack. You have heard me refer to that a couple of times before you even testified. I think we all feel very strongly about that and hopefully we're going to fulfill our obligation as far as following up on oversight and what not to keep that sort of thing from happening. The Doctor did refer to the fact that there are established rules and established punishments and what not. He couldn't go into any details regarding the workings of the entire process which would include, of course, the bait and switch. So we feel very strongly about it, about as much as you do.

Mr. POLLACK. Mr. Chairman, I just want to say that there are regulations concerning changes in prices. They're not regulations about changing what drugs are subject to a discount. So to the extent that you are—you're going to focus on this issue, I would urge that you focus on both facets.

Mr. BILIRAKIS. Basically, what you've said, what others have said, in terms of the discount card program being complex, God knows it is. Is there confusion there? Certainly there is.

Now I referred to an article which we put into the record, the Washington Post article dated August 1966, right after the Medicare program was put into effect. And it talked about the same things. It talked about the complexities. It talked about the confusion. I said to Mr. Brown earlier that when my Dad, God rest his soul, passed away in the mid-1980's and I tried to help my mom with the paperwork and things of that nature, I threw up my hands in disgust saying it was just too complex. And I guess we gave it to a professional or whatever to try to do whatever they could. So we're still talking about complexities and maybe even confusions in the program.

But certainly and who knows, going back at that time what the rhetoric was. There were Members of Congress who were against it. I was not in Congress at the time, but I was very supportive of the program. And if we had given up or if they had given up at that time because there were so many nay sayers out there and said it's confusing and it's complex and will never work and that sort of thing. Mr. Buyer put it pretty darn well, we certainly would not have Medicaid as we know it today and we've all acknowledged the fact that it's a Godsend of a program.

So there we are and something was done. Something was accomplished. Is it perfect? Is it a panacea. Mr. Baumhofer says it was in his eyes. I think it probably could have been better. There are a lot of glitches. There are a lot of mistakes. As time goes on, hopefully, we're going to be able to improve upon those. But we had a group of people here who took a lot of courage to basically say hey, it's time to quick talking about and to try to do something about it.

The discount card program came in late in the game. It was not part, as was stated earlier, part of the administration's process. It came later in the game as a transitional kind of a thing. Could it have been better? I suppose so.

But it is the law and I think what we are trying to do here today is to help our constituents out there understand that it does exist and it's going to be helpful to an awful lot of people and we should be encouraged. I'm very pleased to hear Mr. Pollack say and Mr. Hayes and others say and Mr. Brown said it probably too, he said he was encouraging people to take advantage of the card as many of them would be able to get some advantage, good advantage out of it. So that's really where we are. There are a series of questions here. I'm not going to go into them in the interest of time. You all have been very patient and waited for an awfully long time for your time, your turn to come up.

Mr. POLLACK. Mr. Chairman, when you recounted the history going back to 1965 and 1966—

Mr. BILIRAKIS. I was not here then, but go ahead.

Mr. POLLACK. You were in elementary school.

Mr. BILIRAKIS. Go ahead.

Mr. POLLACK. One of the things that we've learned, I think in examining the history of the Medicare program is that even when changes get made, they get changed again and they get modified and they get perfected. And I suggest to you we're going to be doing that again with this legislation. I don't believe——

Mr. BILIRAKIS. I think you're right.

Mr. POLLACK. I don't think that this Congress, I don't believe that ultimately whoever is in the White House, is going to stand for the enormous costs of this program that are going to be borne (a) by seniors and (b) by the taxpayers. And I suggest that what happened earlier with the Medicare program, with respect to in-patient care and out-patient care, where the political price to pay in order to get those benefits included was a lack of meaningful cost containment. That ultimately got corrected. And I suggest to you that we're going to have to do that with respect to prescription drugs and it's not going to be through the palliative of a discount card. It's going to have to be to take a look at what we have been

able to achieve in other contexts, like with Veterans, and try to do the same thing, both for the benefit of seniors and for the benefit of the taxpayer. And so I think it's important—

Mr. BILIRAKIS. You've made that clear, Mr. Pollack, and told it very, very well.

Let's see who do we have over there? Mr. Brown, just in time. You're going to waive.

Ms. SMITH. Mr. Chairman, Mr. Chairman. Could I just ask a question? When I was speaking and telling you that the CMS said total financial assets, you said that wasn't true.

Mr. BILIRAKIS. No, no, I didn't say that. What I said is the asset test has nothing to do with the discount card, but they are asking that question for other purposes. In other words, there are State programs, you know, State programs that exist that are available, depending on certain asset tests and things of that nature. So they have reasons for asking that, but not directly associated with the discount card.

Ms. SMITH. It was supposed to be with that and then—

Mr. BILIRAKIS. That's why they're asking the question. Let me go on here because my time has long expired.

Mr. Stupak.

Mr. STUPAK. Thank you, Mr. Chairman. Ma'am, you said when you were at the Virginia Training Center there were some questions CMS didn't know the answers to?

Ms. SMITH. Yes.

Mr. STUPAK. Could you tell us what those questions were?

Ms. SMITH. One was because people in rural areas are often elderly, often illiterate and how can you have illiterate access this program and then also how do people without computers access this program? And then also the Social Services people and the substance abuse people and the community health clinic people and the rural health outreach people are not getting any additional funding to help them when they answer these questions. The only funding is going to the Virginia insurance, what's called VICAP, Virginia Insurance Counseling and Advocacy Program or SHIP. All these other people will be helping others and this is just more or less like an unfunded mandate to these professional people.

Mr. STUPAK. Thank you. Mr. Pollack, we've had testimony that there are 73 different cards out there right now being offered under this program and I'm concerned that seniors really aren't going to get the best discounts they otherwise could have because of many cards being offered. As I understand it, a manufacturer or pharmacy will give a greater discount to a card sponsor, if the card sponsor can guarantee them a greater volume of business. Do you think having fewer cards or one card would have gotten Medicare beneficiaries just as good, if not a greater, discount?

Mr. POLLACK. I think that when you have the benefit of a big pool of people, you obviously have far greater bargaining power. That's why it would have been far better if Medicare were doing this bargaining, rather than 73 different cards.

But you know you raised a very important issue here that I just want to touch upon and that is the card sponsors are going to be bargaining to try to get some kind of discount or rebate and the regulations in no way say that those rebates need to be passed on

to the consumer. And that creates a potential for conflict of interest because if the card sponsor is making a significant portion of their money from those rebates and they're holding on to those rebates, and under the regulations they can retain and untold percentage of it, they're more likely to place on their list of those drugs that are subject to a discount the more expensive drugs for which they're going to get a higher rebate.

Mr. STUPAK. Sure.

Mr. POLLACK. And so I think it creates an inherent conflict of interest.

Mr. STUPAK. Thank you. Ms. Grealy, you indicated a study that's on-going right now and you hope to have the results next month. I want to ask a couple of questions about the methodology, if I can, in the report that you cited. Is it true that the report compared drug card prices to a nominal retail average price or the usual and customary price that's reported by the pharmacies?

Ms. GREALY. I have the Lewin researcher here. I'll describe it as best as I can.

Mr. STUPAK. Sure.

Ms. GREALY. The firm that collects the data is called Verispan and on a State by State basis, collected the prices for the 150 drugs that we have listed there at the retail pharmacy level.

Mr. STUPAK. Right.

Ms. GREALY. So in other words, what a cash customer, someone with no insurance coverage.

Mr. STUPAK. No insurance. So you're going to base this discount on the highest possible price that a non-insured senior is going to pay?

Ms. GREALY. Retail, cash paying customers. Because you're going to have a whole variety of prices if you're trying to figure out the discounts that have been negotiated for those seniors that have coverage.

Mr. STUPAK. Sure, but don't you think the seniors should get the largest possible discount and not compare it to that cash and over-the-counter sale?

Ms. GREALY. Well, this goes to a point, I think that Ron mentioned, the fact that not all Medicare beneficiaries in his view are going to be helped by this. I look at it another way. What we found as we were beginning this debate on Medicare prescription drug coverage, that there are many seniors probably around 70 percent that already have someone negotiating lower prices on their behalf.

Mr. STUPAK. Sure.

Ms. GREALY. And I think the challenge for Congress was to try and develop coverage and discounts for those that don't currently have the benefit of that coverage and someone negotiating for them.

Mr. STUPAK. And isn't it true, even the retail person who is paying cash who has nothing behind him to back him up, no insurance, won't they get 10 percent just by paying cash? Don't they get 10 percent discount rate on cash?

Ms. GREALY. One, if shopping can probably do it. What I think we see as an advantage here is you can go to the pharmacy that you want to go to in your neighborhood. The card is doing the shopping on your behalf and getting you a larger discount than you can.

Craig might be able to address that a little better.

Mr. STUPAK. Your study is really not factoring in things about the 10 percent discount that they would pick up, what other people paid based upon average wholesale price, a big insurance company, the Federal Supply Schedule. You're not taking those comparisons, right?

Ms. GREALY. To make it consistent, we were looking at those seniors that have no coverage and are going in and paying cash for their drugs. And we think also that it's a conservative estimate as well, that the base that we're using—

Mr. BILIRAKIS. The gentleman's time has expired. Mr. Shimkus, please.

Mr. SHIMKUS. Thank you, Mr. Chairman. The first two questions, I'd like a yes or no answer. Starting with Mr. Fuller, do you qualify for Medicare?

Mr. FULLER. No.

Mr. SHIMKUS. Mr. Pollack, do you personally qualify for Medicare?

Mr. POLLACK. I aspire for it, but not yet.

Mr. SHIMKUS. Okay, great. So that's a no.

Mr. POLLACK. I think so.

Mr. SHIMKUS. Ms. Grealy?

Ms. GREALY. No.

Mr. SHIMKUS. Mr. Hayes?

Mr. HAYES. No sir.

Mr. SHIMKUS. Mr. Baumhofer?

Mr. BAUMHOFER. Yes sir.

Mr. SHIMKUS. Thank you. Ms. Smith?

Mr. HAYES. Ms. Smith?

Mr. SHIMKUS. No, I said you, members of the panel.

Second question. Who has tried on this panel, who has tried to access the Medicare information for themselves.

Have you, Mr. Fuller, for yourself?

Mr. FULLER. No.

Mr. SHIMKUS. No, because you don't qualify for it.

Mr. Pollack?

Mr. POLLACK. I think the answer is rhetorical.

Mr. SHIMKUS. That's probably correct. So I will take that as a no?

Mr. POLLACK. You may.

Mr. SHIMKUS. Ms. Grealy?

Ms. GREALY. Not for myself.

Mr. SHIMKUS. Great, thank you. Mr. Hayes?

Mr. HAYES. We help hundreds of people every day.

Mr. SHIMKUS. The question is for yourself, sir?

Mr. HAYES. I'm trying to be responsive and helpful, sir.

Mr. SHIMKUS. You'll be helpful by answering the question.

Mr. HAYES. I'm not going to answer that question.

Mr. SHIMKUS. You're not going to answer the question?

The question is one, do you qualify for Medicare. You answered no.

The second question is have you tried to access the Medicare prescription drug information for yourself and I asked for a yes or no answer.

Have you tried to access it for yourself?

Mr. BILIRAKIS. Let's move on here. Mr. Hayes, I'm sure your answer is no?

Mr. HAYES. Of course, it's no.

Mr. SHIMKUS. Thank you, thank you. Mr. Baumhofer?

Mr. BAUMHOFER. Yes sir.

Mr. SHIMKUS. So you're the only one on the panel who qualifies for Medicare and tried to see if this is the benefit to yourself?

Mr. BAUMHOFER. Evidently.

Mr. SHIMKUS. And your testimony is clear that you have received a lot of benefit from it, is it not?

Mr. BAUMHOFER. Yes.

Mr. SHIMKUS. I think you testified $360 a month?

Mr. BAUMHOFER. It will save about $150 a month.

Mr. SHIMKUS. So over a year that's?

Mr. BAUMHOFER. $1,800.

Mr. SHIMKUS. And you think that's helpful?

Mr. BAUMHOFER. You bet it is.

Mr. SHIMKUS. Thank you, sir. You also do not fall into the poverty categories of this benefit, is that correct?

Mr. BAUMHOFER. That's correct.

Mr. SHIMKUS. But you know people who do?

Mr. BAUMHOFER. Very many.

Mr. SHIMKUS. Are they receiving a benefit from this card?

Mr. BAUMHOFER. They will be.

Mr. SHIMKUS. Have you attempted to assist any of these folks in knowledge of the opportunity to access these cards?

Mr. BAUMHOFER. Approximately half a dozen to date.

Mr. SHIMKUS. Have you had any problems in doing so?

Mr. BAUMHOFER. Not any insurmountable ones, no.

Mr. SHIMKUS. I appreciate that. This hearing is on whether we agree with the public policy or not, the legislation has been passed to offer a bridge, a prescription drug benefit card until the full plan comes forward. And I just think it should be noted that of the two panels, we have one Medicare recipient, one person who's accessed the plan and one person who has testified that they're receiving benefits.

I know there's also been talk about getting information about and a lot of things are saying well, not now, it's one out of five, who are accessing now. The best form of advertising in this world is also the cheapest and that's word of mouth. You do it for your barber, you do it for hairdressers, best grocery stores, local pharmacists.

Mr. Baumhofer, have you told people about your benefit other than the committee here?

Mr. BAUMHOFER. Very few. I'm fearful that I'd be deluged with requests for help, frankly.

Mr. SHIMKUS. But since you have a positive benefit, that would be a good story to have out there, would it not?

Mr. BAUMHOFER. Certainly.

Mr. SHIMKUS. Would it encourage more seniors to take a look at what's offered by CMS and take—should we not as a country, if we have a defined benefit, albeit not perfect, that we should do all in our power to make sure that we fully provide information for our

seniors to have access to a program that could be, I'll qualify it, could be helpful to them?

Mr. BAUMHOFER. Absolutely.

Mr. SHIMKUS. Mr. Baumhofer, I'm a little biased, I'll have to admit, although David Wu and Mr. Walden is not here. My wife is a graduate of Concordia, Portland, a Lutheran college, university now, in downtown Portland and I visited it a couple of times. We're glad to have you. Thank you for your testimony.

I yield back the balance of my time.

Mr. BILIRAKIS. The Chair thanks the gentleman. Mr. Brown to inquire.

Mr. BROWN. Thank you, Mr. Chairman. I apologize for having to leave and I've looked at your testimony. I have come comment on Mr. Baumhofer's testimony and I'm glad to see the discount card is I guess you—your testimony you mentioned RX Plus and you get your drugs now, you're taking four drugs and according to your testimony you were originally paying $403.31 each month. Now you'll pay $250.60, correct?

Mr. BAUMHOFER. That's correct.

Mr. BROWN. That's good. That's obviously great for you, but if you could qualify for VA or more to the point if Congress would have passed something that you would not have had to go through all this bureaucracy and you simply would have had one Medicare card and it would be equivalent to the VA negotiated price, something we've been talking about here, you would be paying $188 per month for your drugs, for those four drugs.

So I guess I'm not asking a question, I'm just pointing out that as I said earlier today, we have this choice of seniors have in my state, 50 some cards to choose from, 73 overall, around the country. But this drug may take care of Lipitor, this one may take care of Fosamax and this one might be 12 percent this week, but only 10 percent next, instead of one card with a negotiated price where we really could save 40, 50, 60, 70 percent, similar to what the Canadians pay or similar in our own country to what the VA has negotiated.

Mr. Pollack, I would like to hear your comments about, would you speak to the types of discounts seniors can get or negotiate outside of Medicare today? You had said in your testimony that the discount cards are not significant compared to prices that seniors may be getting in the market already, not that the cards are all bad, by a long shot, but we could have done so much better. Tell us, sort of the lay of the land now that prior to these cards before these cards go into effect, what kind of discounts can people get, AAA senior discounts, other non-Medicare approved card discounts?

Mr. POLLACK. Well, as you know, Congressman Brown, there are a host of different discount cards that were in effect prior to this program going into effect. Some of the drug manufacturers were offering discount cards. AARP was offering discount cards. Some of the retail companies were offering discount cards. And when you take a look at the CMS website, some of them are below, some of them are above. But when you take a look at what you could have gotten prior to this time, in the commercial world, it's not a signifi-

cant savings at all, but I think the more important point is the point that you were making a moment ago.

In my testimony, I showed for each of the top drugs, in six Districts, including yours, what the savings would have been for each of the drugs had we done what you had suggested, namely, had a single discount system where Medicare did the bargaining, the savings would have been extraordinarily different. And that's what we should have tried to do.

Mr. BROWN. Ms. Grealy, who funds the Healthcare Leadership Council?

Ms. GREALY. We're a dues based organization with very diverse membership, as I mentioned. We do have pharmaceutical manufacturers as part of our membership, along with hospitals, medical device manufacturers, health plans, hospital——

Mr. BROWN. Insurance companies too?

Ms. GREALY. Insurance companies.

Mr. BROWN. What percent of your dues come from insurance companies and drug makers?

Ms. GREALY. All together totaled, 27 percent.

Mr. BROWN. It just seems, and I appreciate Mr. Baumhofer for coming in. It just seems to me the only senior sitting here other than Ms. Smith who is not allowed to answer, I guess, Mr. Bilirakis, the chairman was very good about it. Mr. Shimkus did not seem to want to hear from her on a question earlier as one of the seniors. But the only senior here comes from the Healthcare Leadership Council which sort of makes sense on this piece of legislation when you consider that this legislation was written for the drug companies, the insurance companies with seniors coming in a distant third and I guess I should expect the make up of the panel to be somewhat similar to that.

Ms. GREALY. Well, Congressman Brown, we have many members that are very interested in keeping drug prices as low as possible.

Mr. BROWN. That must cause a conflict in your group, huh?

Ms. GREALY. They're all very interested in making the marketplace work and if that is the better way to drive down prices, we're already beginning to see that with the new transparency.

Mr. BROWN. We're beginning to see it?

Ms. GREALY. Rather than——

Mr. BROWN. You know, Ms. Grealy, we're beginning to see drug prices, we're beginning to see prices come down. I've heard this all—I'm sorry, I stepped out for an hour, but I've heard this all morning from the Director of CMS and now to this panel that drug prices are coming down. Drug costs in this country have gone up 17 percent a year in the last 6 years. We're going to give a discount at 12 percent and then we're going to dislocate our arms by patting ourselves on the back and saying boy, we're bringing drug prices down because of competition.

If we want to bring drug prices down, forget all these cards, forget this bureaucracy that my friends want to set up, get a discount on behalf of 39 million Medicare beneficiaries and do it like every other country in the world that knows how to bring prices down so seniors don't have to choose between their food and their medicine or in my part of the country, their heat and their medicine. It just doesn't make sense.

Mr. Chairman, thank you.

Mr. SHIMKUS [presiding]. I suppose, Mr. Brown, if you wanted America to have socialized medicine, then it would make sense. At this point I yield to the chairman of the full committee, Mr. Barton, you're recognized for 5 minutes.

Chairman BARTON. Thank you, Mr. Chairman. I want to welcome this panel. I'm sorry I wasn't here to hear your testimony but I have scanned it in its written format.

In the interest of full disclosure, I'm for the prescription drug benefit. I was one of the group that offered the prescription drug discount card as an alternative to the full-blown insurance program. I was one of the more adamant ones that if we're going to have a prescription drug benefit, some of that benefit ought to be available this year, not 2 or 3 years from now. So I make no apologies that we have it in the program and that we're offering it to seniors now.

My good friend from Ohio, Mr. Brown, is opposed to the benefit program and he's got every right to do that and have an alternative and that's what democracy is all about, but before I ask my questions, I want the world to know that I'm for this program.

Now when we were preparing for this hearing, we got witnesses that the Majority wanted and we got some witnesses that the Minority wanted, so we should have a diverse panel in terms of pros or cons. So my first question is a general question, do any of this panel believe that this voluntary program is going to be harmful to seniors?

Mr. BAUMHOFER. I would speak to that. In no way, do I see it harmful at all. In fact, if I might speak to our third place role here as alluded to, being in the race is better than not at all.

Chairman BARTON. It's a voluntary program and I think you can argue plausibly that it might be neutral and obviously a senior is not going to be forced to participate in the prescription drug discount benefit card, but I see no way it can be harmful. Are we all in agreement on that, at best, at worst, it's neutral, that no way is it harmful?

Mr. POLLACK. Mr. Chairman, I certainly don't think this is a harmful program. Quite the contrary and in terms of low income people, I want them to get the $600 in Transitional Assistance. I do say it's a very disappointing program and it's much ado about very little, but it's not a harmful thing.

Mr. FULLER. Mr. Chairman? If I may, I would add that it's not only not harmful, it is very beneficial to those seniors who have the greatest need. As has been pointed out 42 million seniors are eligible for Medicare; 15 million lack any coverage whatsoever and they pay cash. They pay the highest prices today. That's why the comparisons are done against cash prices. Not only is there great benefit in terms of price, there's also for the first time for many of these people a real opportunity to have the medications they're taking reviewed by a pharmacist because they're going to be captured in the system. There is enormous benefit. There's also enormous benefit to all of us and I think I'm the only up here who's offering or involved in offering as a sponsor of a card. It's enormous benefit to us as we prepare to understand how to better serve the entire Medicare population as we move toward 2006.

Chairman BARTON. Well, Mr. Fuller, you represent the retail pharmacies, I think, is that correct?

Mr. FULLER. Correct.

Chairman BARTON. What's been the general reaction of your constituency, your association, the pharmacists, the corner drug store, literally. Do they tend to think this is something they are ecstatic over or they think it's a good idea, it's got some flaws or they just not rather be bothered with it or——

Mr. FULLER. That's an excellent question. Let me answer it in a few ways. First of all, I also indicated at the outset that I'm here because the National Association of Chain Drug Stores, along with Express Scripps formed the Pharmacy Care Alliance and we actively went into the marketplace, sought and won Medicare endorsement for our card program.

We have now over 43,000 individual pharmacies in our network. I fully expect in June when the program is up and live, we're still adding more to have 50,000. Fifty thousand individual pharmacies participating in the network. By the way, my membership is comprised of 35,000 individual pharmacies. Obviously, we not only have chain pharmacies, we have independent pharmacies participating as well.

Chairman BARTON. Now we've documented in the first panel, with Dr. McClellan, like any large program that's getting started, there's some glitches, inability to get through on these hotlines and the webpages and the usual misinformation because it's a new program. Would it be fair to say that as the program matures that those are going to work their way through the system and that in a reasonable future, we're going to have a program that seniors can access and make intelligent decisions on.

Mr. FULLER. First, I want to publicly indicate that Dr. McClellan and his staff have been extraordinarily good to work with. We have had issues as one would expect in something like this. They are worked on and resolved quickly. Hundreds and hundreds of questions have been dealt with. We have our own call center for the Pharmacy Care Alliance. The response times were less than 5 seconds. Initially, I think today if you call 1-800-PCA1075, I think you'll get a response in well under 15 seconds. In fact, if Ms. Smith has time available, one of my colleagues here is a pharmacist. In 15 minutes, I think we can walk through, if she has medication information available, walk through and get an answer to the kinds of questions she has.

All of this is improving. The prices have come into, I think conformity on our site and their site as well as other sponsors. I can't speak for them, but I think all of those kinds of issues are beginning to get resolved. One of the reasons that our call times are about 6 minutes when we talk with a senior on the phone which is much less than we anticipated, I am convinced is because people are getting through to the Medicare site. They are reading the materials in the stores. They are reading the materials that's been mailed to them. They are seeing the television advertising. So they're coming as a better informed consumer.

I honestly do not think any of you should beat yourself up about the law that was passed last year. We're working with the law. We'll be happy to discuss policy alternatives as we go forward, but

the law today is one that is going to bring a real benefit to seniors and they're coming to us better and better informed as we go forward and we think, you ask how the stores are doing. We're seeing a steady climb in the number of applications that we are receiving day after day after day. We're only into the second week. We actually think this will simply keep rising into June when the actual benefits are being received in the store.

Chairman BARTON. My time is expired. I would encourage all of these panelists as the program actually begins if you were to let problems, opportunities for corrections, anything at all about how to improve the administration of the program and if you think there's some technical things that need to be done to change the law to make it an improvement in terms of just applicability, we would be happy to receive those comments from you?

Mr. POLLACK. Mr. Chairman, may I just take that invitation and just second something that was said earlier. I don't know whether you were in the hearing room at the time and that pertains to this low income population. Mr. Hayes testified to something that I think is extraordinarily important and it's something I would hope can be done on a bipartisan basis and that is that the very poor who we think could get help through this thing, there are a whole bunch of poor folks who have been getting the benefit of a variety of Medicare/Medicaid subsidization programs. We call them the Qualified Medicare Beneficiary, QMB, SLMB. All of those people by virtue of their being eligible for those programs are below the income levels of 135 percent of poverty.

I think it would behoove us to say anybody who has gone through that process and has been certified for low income assistance should automatically be enrolled in terms of getting this Transitional Assistance. This is something I know Mr. McClellan is taking under consideration.

I would urge on a bipartisan basis do that. If we want to make this program work as best as possible, putting aside the differences that we may have about bigger policies, that's something that can be done. You can do it on the suspension calendar and do it real quickly and you will enroll many, many more people than you will if we fail to do——

Chairman BARTON. We'll take everything under advisement. I reserve the right to look at the details and all that, but we certainly want to encourage constructive participation and implementation of the program.

I yield back. Thank each of you.

Mr. SHIMKUS. Mr. Engel, you're recognized for 5 minutes.

Mr. ENGEL. Thank you, Mr. Chairman. First of all, I want to take issue with my colleague from Illinois, Mr. Shimkus. I talked to many seniors in my District. They're confused. They believe that they might make a wrong choice and be locked in and frankly, I think it's ridiculous to question people's ages on the panel and imply that only someone who is a senior citizen can understand what is being done. Obviously, the people on the panel who are not seniors work with seniors and I don't mean to denigrate Mr. Baumhofer's testimony, but frankly I can get 100 seniors that will say just the opposite of what Mr. Baumhofer said.

And you know, in relation to what my friend, the chairman, said. I don't think this bill is harmful, but I think to some degree it's harmful if it builds up seniors' expectations and then they find that they're really not getting much of a discount after all or that they cannot make clear choice because as Mr. Brown showed when he held up all those cards, people are just simply confused.

Also, the prices of drugs are going up every single year way beyond the rate of inflation to simply say we're going to give people a discount which is less than that really doesn't give them a net balance discount at all.

Now I'm hearing from some of the pharmacies in my District that they don't even know what prices they're going to be able to charge come June 1. It's being said that they will be offering it at X amount, but there have been no negotiations. I'm also hearing from pharmacies in my District that some pharmacies are showing up as providers for the $600 cash discount cards, but they haven't been asked nor have they signed any agreements. They've not agreed to any reimbursement number and are concerned about seniors being scammed. They're concerned that seniors will show up with cards that have no value and also some of the pharmacies are telling me in New York that many of the card networks have listed pharmacies that closed down years ago and some are just vacant lots, boarded up buildings, things like that. So I want to ask, let me start and ask Mr. Hayes, have you heard about these horror stories? Is this problem across the country or only in New York? What can you tell us about it?

Mr. HAYES. Mr. Engel, it's not merely in New York. I mean those startup points whether they're glitches or are a product, an inevitable product of the structure of the program, I guess remains in debate, but without question the overwhelming sense of frustration is something we've experienced, but are trying to do good with, frankly, because one of the lateral benefits of the discount cards, good or bad for any particular individual, is that there are many other opportunities that go beyond the discount cards approved by Medicare to help a better informed consumer.

And I'm intending to talk to Mr. Baumhofer, in fact, after this meeting because there may well be deeper discounts that he'll be able to find. We're hoping that the attention consumers are paying to the Medicare discount cards may trigger other explorations.

Sadly, a small piece of the Medicare population, however, who aren't at the level of sophistication that Mr. Baumhofer is.

Mr. ENGEL. The other piece that I'm hearing is that perhaps some of these card networks are not acting in good faith, that many simply want to get their foot in the door by listing pharmacies that don't exist to boost their networks and what it might do is coerce or force seniors to use mail order to get their pharmaceuticals. If people like to use mail order, great for them. I think my preference is to be able to see a pharmacist and be able to discuss my individual needs with those pharmacists. I don't want to see seniors being pushed into mail order if that's not what they want.

Mr. POLLACK. Mr. Engel, there's one issue that I think that we'll have to take a look at particularly as we move closer to 2006 and that is as these discount card sponsors serve people who enroll in

their programs, they're going to have new data concerning the drug usages of people who have enrolled in those plans. One of the things that we're going to have to look at very closely is whether the data that's being collected is going to result in a clear understanding that there are people you don't want enrolled starting in 2006 versus there are people that you do want enrolled in 2006. In 2006, I believe you're going to see many private plans are going to do what they can to avoid the high users of drugs. And now, with the data that can be and will be collected as a result of the discount card program, they're going to know who the high and low users are. So one of the things we're going to have to do as we move toward 2006 is to make sure that the collection of that data does not result in discrimination against those people who need drug care the most.

Mr. SHIMKUS. Thank you. Mr. Rogers, you're now recognized for 8 minutes. Thank you, Mr. Engel.

Mr. ROGERS. Thank you, Mr. Chairman. I have to tell you I'm confused, not about the bill, but what I find back in the District. I have never seen a more coordinated effort by a bunch of individuals to deny information to senior citizens in my entire life. And I was an FBI Agent and I saw some pretty rotten dogs out there doing some pretty bad things. I

I have talked to seniors with tears in their eyes who are confused and they're scared, one of which happened to see your video, Mr. Pollack, with Mr. Cronkite on it and Mr. Brown brought up some good questions to Ms. Grealy and I want to follow up on that. Because I'm confused. I want you to help me understand what this is all about. The bill passes, I hear you today say this is not bad for seniors, this is good. We're encouraging them to do it. I saw that video and there is nothing in there that says this is a good bill and that we ought to encourage you to participate, and by the way, seniors who are low income are finally for the first time in their live going to have access to prescription drugs that may increase the quality and their longevity. Wow, powerful stuff.

You sent out a video just after the bill passed to all of these seniors, people who I talked to, people who I had the chance to visit and talk about other things and this as well. Why did you do that?

Mr. POLLACK. Well, I'm very proud of that video and I'm glad you raised it. I think it provides extraordinary information, far more than you get from the government. If you took a look, for example, at what HHS was circulating, they had a 30 second commercial that provided no information, used a fake set of people who were actors. We provided information that all across the country when we showed that video people felt they learned a great deal about the legislation. By the way, if you remember from that video, I personally was quoted in talking positively about the low income benefit. I don't know if you remember that. But my quote is very specific with respect to the low income benefit. I said it was a good thing.

Mr. ROGERS. And you also said in your testimony it would be no consequence to any of the other seniors. This bill will be of no consequence, quote unquote.

Mr. POLLACK. I didn't say it would be harm, but on the other hand, I want to be clear, Mr. Rogers——

Mr. ROGERS. My time is limited. I understand that you want——

Mr. POLLACK. Well, if you want to pull——

Mr. ROGERS. Just a minute, you made an interesting point. You said you used actors. Was Walter Cronkite a paid advocate for you? Did he receive remuneration for appearing your video?

Mr. POLLACK. The answer is yes, he did.

Mr. ROGERS. Can I ask how much he received?

Mr. POLLACK. You may ask, but Mr. Cronkite——

Mr. ROGERS. Are you going to answer my question, sir? How much was Mr. Cronkite paid?

Mr. POLLACK. I'm not going to tell——

Mr. ROGERS. How much was the production value of that video? What did you pay in total costs to print the video, get the video out and mail it to every senior home?

Mr. POLLACK. It was over $100,000.

Mr. ROGERS. How much over $100,000?

Mr. POLLACK. I believe and I'd have to calculate, probably about $125,000. And I have to say and I want to say very quickly to the extent that there's any concern that you have with respect to Mr. Cronkite being paid, by the way, at a cost that was considerably lower than what he charges people in the commercial field because he thought this was a very important service.

But if you're concerned about that, I think you'd be horribly offended that the administration used paid actors and tried to portray them as regular individuals and use——

Mr. ROGERS. But it's okay for you to use paid actors to communicate your point, but apparently the administration can't—next question I have—excuse me, sir, it's my time.

Mr. POLLACK. [continuing] was not a——

Mr. ROGERS. Excuse me, sir, it's my time. You talked about your worry of inflation and before this card has even gotten in the year yet, that card hasn't been on the counter yet 1 day. Prices have dropped according to the first panel 11 percent and we're watching the free market starting to work a little bit. That is a very powerful thing and my friends on the other side of the aisle seem to have ignored that point and you've ignored the point and you've said there's nothing in here that keeps costs down, that put pressure on costs.

Mr. POLLACK. I didn't say that.

Mr. ROGERS. Yes, you did, sir, in your testimony. Let me finish my quote——

Mr. POLLACK. You're misquoting me. What I did say is that the base price keeps on going very substantially and when you get a discount off a base price that keeps on increasing, it's like going to used a car salesman and the used car salesman says "I'm going to give you a $3,000 discount" and just before that he increased the sticker price by $4,000.

Mr. ROGERS. I appreciate that. The total disregard for the work of the market is astounding to me and the fact that you would take money from folks to go out and mislead the public I say shame on you, sir. Here's a great example, happened right in my District. Somebody got up, they wanted to have this press conference and say boy, this is bad and it's awful. And they had an 80-year-old woman up there, God love her, and said she was going to have to

go to Canada to save 40 percent on her drugs and this was awful and there was nothing in the bill to help her and this is terrible things and it's terrible that we're doing this to our seniors. And they listed her drugs in this particular press conference. So went back and we just—let's say she's a higher earner. We don't have a clue if she fits all the low income criteria. She pays $160 a month. So we plugged it into the computer and what does this bill do for somebody just like this, even if she's not a low income earner? It happened just very recently, unfortunately. She was $160 per month. Her monthly drug spending would fall between $80 and $87 for almost every card that's available in my area in Michigan. And that's 50 percent at the lowest end over 50 percent at the best end.

And you know what? They're U.S. safe-produced drugs that she can get in the car and drive just a few miles away and get. She doesn't have to get on a bus. This poor woman was never given the information and is scared to death about this bill. She doesn't even want to get on—she's scared of it because folks and organizations like yours are getting out there and saying yes, be afraid of it.

Now here you say it's really good because the cameras are drafting away and half the audience is gone, but you're going to go back and you're going to spend that money for people who have, as a matter of fact, your largest contributor said his whole goal in life is to beat George W. Bush. That doesn't sound non-partisan to me. Doesn't sound like you're doing something for seniors to me. It doesn't sound like you're caring enough to try to get them the right information so that one woman who is in her house maybe crying today, that lack of compassion here is astounding to me, that you would appear before this panel and try to play it off that you are this non-partisan helpful group when you're providing deliberate misinformation for people who are counting on us to provide solution. It may not be perfect, but you know what, next month, they're going to get over 50 percent off on their drugs?

Mr. POLLACK. Mr. Rogers, I would suggest, tell me one thing, either in the video or in the written materials that is incorrect and I suggest to you, you can't do it. The reason you can't do it is there's nothing misleading in our materials. There's nothing misleading in the video. And by the way, if we're really talking about doing something for America's seniors, then we would have done the thing that——

Mr. ROGERS. We would have done, we would have done—you're deliberately misleading the point and that's my concern——

Mr. POLLACK. [continuing] we would have enabled people all across the country to get the benefit of bargained prices that would have been considerably lower and that, I think, would have been the more compassionate thing to do.

Mr. ROGERS. Your organization in the past was supportive of, as I understand it, and I think the New York Times quoted you as saying as the de facto public relations manager for the Clinton Administration's campaign for comprehensive health care legislation.

Mr. Brown talked about cost containment. You talk about cost containment of other countries like Canada. Just so I understand your organization, you support rationing, limited drug use, pharmaceutical use. Do you support those issues?

Mr. POLLACK. What do you mean by rationing?

Mr. ROGERS. In Canada, if you reach a certain age, you get put on a list and if your health reaches a certain point, you can be taken off the list for care because they have to ration health care because of the socialized, capitated health care provider system. They also do that for pharmaceuticals as well. They don't have access to the wide variety of pharmaceuticals that we do in the United States. So if I understand this argument correctly, you're saying Canada is a good system to go. So you support rationing health care for American citizens and limiting the ability for them to have access to pharmaceutical treatment in order to keep costs down. Is that correct, sir?

Mr. POLLACK. No, that's not correct.

Mr. ROGERS. And so you embrace the tenets of a socialized medicine system, but you don't want to embrace the way they use it to keep their costs down. So you don't support a nationalized, socialist system of health care, is that correct?

Mr. POLLACK. That's correct.

Mr. ROGERS. You do not?

Mr. POLLACK. I do not.

Mr. ROGERS. That's a wonderful thing. That's a little different than what you just told us earlier.

Mr. POLLACK. No, that's not—no sir, that is not different than anything I've said here today or in the past.

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

Mr. ROGERS. I yield back, Mr. Chairman.

Mr. SHIMKUS. The Chair would yield himself, oh, Mr. Dingell.

Mr. DINGELL. I appreciate your courtesy. Thank you, Mr. Chairman.

These questions are for Mr. Pollack. Mr. Pollack, I'm concerned about the games that drug card sponsors might play at the expense of seniors enrolled in a drug discount card. A number of recent lawsuits such as the Merck Medco suit in Massachusetts have shown how pharmacy benefit managers or PBMs are not passing along the discounts they negotiated with the pharmaceutical manufacturers.

Can you briefly describe what in the PBM case was doing to scam the system?

Mr. POLLACK. Sure. Medco negotiated large discounts from manufacturers that were supposed to be passed along and passed along 95 percent of those savings. They only passed on a portion by renaming some of the discounts that were generally referred in the contract as formulary savings to rebates. In fact, in this instance, the PBM passed along $9 million in rebates, but kept $10 million in rebates for themselves.

Mr. DINGELL. I believe that is stated in the complaint.

Mr. Chairman, I ask unanimous consent that the complaint be inserted into the record at the appropriate point so we can see what's going on here?

Mr. SHIMKUS. Please identify the complaint?

Mr. DINGELL. Yes, I have it here and I will submit it to the committee. And I thank you, Mr. Chairman.

Mr. SHIMKUS. Mr. Dingell, could you identify the complaint?

Mr. DINGELL. Yes, it's entitled United States of America, et al., versus Merck Medco Managed Care, LLC, Medco Health Solutions,

Inc. It's in United States District Court for the Eastern District of Pennsylvania.

Mr. SHIMKUS. It shall be entered into the record. Thank you.

Mr. DINGELL. Thank you, Mr. Chairman, I appreciate your courtesy.

Mr. Pollack, I'm concerned that the drug sponsors could be doing similar things to seniors under the prescription drug discount card by playing games that they define as discounts, sponsors could still claim they're passing on all the pharmaceutical manufacturers' discounts to senior when, in fact, they're skimming off a portion for themselves. Do you see this happening or being possible to happen under the Medicare drug discount card and if so, to what extent?

Mr. POLLACK. Well, Mr. Dingell, one of the things that we had suggested to CMS was that any kind of rebates that would be negotiated with the pharmaceutical companies would actually be passed on to America's seniors. Unfortunately, the regulation——

Mr. DINGELL. And there was the Cantwell Amendment in the Senate which got dropped in conference.

Mr. POLLACK. That's right. And instead, what the regulations say is that the PBM can hold on to an undefined portion of the savings they achieve. It doesn't indicate that there's any kind of a cap on how much they retain. They have to pass along some portion of the savings, but what portion it is and whether it's a significant portion——

Mr. DINGELL. Well, first of all, there is little transparency in the way the matter has been dealt with. Second of all, there is a significant weakness in the regulations to control this kind of behavior and third of all, there's virtually nonexistent enforcement authority on the part of HHS and Federal Government to address these matters. Is that not so?

Mr. POLLACK. It is and we had hoped and explicitly asked that any kind of savings achieved through this negotiation process actually wind up to the benefit of America's senior. Unfortunately, the regulations do not actually require that any specific portion of those savings be passed on.

Mr. DINGELL. Now this could be a problem then when the benefit is implemented in 2006, could it not?

Mr. POLLACK. Absolutely.

Mr. DINGELL. And as I mentioned earlier, the Cantwell Amendment offered by Senator Cantwell and adopted by the Senate required transparency for both prices and rebates, but that was dropped in conference. Isn't that right?

Mr. POLLACK. That's correct.

Mr. DINGELL. Is there any remaining authority on the part of the Federal Government to address the possibility of this kind of game being played on seniors either in connection with the drug discount card or in connection with the actual delivery of the prescription pharmaceuticals to the seniors when the insurance companies are managing the matter?

Mr. POLLACK. I'm not clear whether that's going to require a statutory change or whether that could be done through regulations. My belief is it probably needs to be done via statute.

Mr. DINGELL. Thank you. Mr. Chairman, I notice I have 19 seconds left which I gladly yield back to the Chair.

Mr. SHIMKUS. Thank you, Mr. Dingell. The Chair yields himself 8 minutes.

And I continue my enthusiasm. Mr. Hayes, I was out of the room when you expressed your pride in being a critic. I've never claimed to be a critic because I believe people discount them pretty quick. Being constructive to the process, being a constructive critic is probably what you should really pride yourself in.

Mr. HAYES. Sir, maybe being out of the room you missed what I said which was two things. One, with regard to constructive criticism that CMS has indeed been quite welcoming of the on-going information we've given them with regard to the so-called glitches in the project. And second, with regard to the quote from President Roosevelt——

Mr. SHIMKUS. I don't care about that—President Roosevelt? I don't care about that.

Mr. HAYES. Your colleague was interested.

Mr. SHIMKUS. I don't care about that. Mr. Fuller, I have a question and I'm going to go down the line. In the designing of this program and thinking about individuals and their health care needs, even to the two critics who are here at the table, place ourselves in how we best want to help people. We want to help people by saying what are your individual health needs and requirements, right? And how do we then keep them in the comfort of being able to obtain their drugs from their local pharmacy and so as we design the drug discount card, we felt that it was a very, very positive thing to do, a very positive element to have a card whereby seniors have the ability to choose a card that best fits their individual health needs and then be served by their individual pharmacists. Isn't that not yet a positive element of this program?

Mr. Fuller, yes or no?

Mr. FULLER. Yes sir, it's a very positive element.

Mr. SHIMKUS. Mr. Pollack? Yes or no?

Mr. POLLACK. Yes, and it would have been a whole lot better——

Mr. SHIMKUS. Thank you. Ms. Grealy, yes or no.

Mr. POLLACK. It would have been a whole lot better——

Mr. SHIMKUS. Ms. Grealy, yes or no?

Ms. GREALY. Yes.

Mr. SHIMKUS. Mr. Hayes, yes or no?

Mr. HAYES. I can't honestly answer that yes or no, sir. I'm sorry.

Mr. SHIMKUS. Then you are being the critic. Mr. Baumhofer?

Mr. BAUMHOFER. Yes.

Mr. SHIMKUS. Yes, it is. Thank you. It does dumbfound me though, Mr. Hayes. I choose not to quibble with you. You have a role for which you've chosen to play here today.

Mr. HAYES. I regret you've neither read nor heard our testimony, sir, because you basically have mischaracterized——

Mr. SHIMKUS. Mr. Hayes, excuse me. I'm not going to quibble here. I have a question with Ms. Grealy regarding Mr. Waxman's report from the Government Reform Committee, released a report only hours when this program came on line.

Can you tell me, have you conducted a study or analysis of what Mr. Waxman had done, the Healthcare Leadership Council?

Ms. GREALY. No.

Mr. SHIMKUS. Can you comment with regard to what has happened with regard to drug price since the Waxman report first came out?

Ms. GREALY. What we had seen, even in the first 2 weeks that the prices have been available and were more transparent than ever before, that there has been a lowering of the prices.

Mr. SHIMKUS. Mr. Fuller?

Mr. FULLER. We did check our website against the prices listed that Mr. Waxman provided and Pharmacy Care Alliance prices are now about $140 less than what was represented and actually takes us to the lowest of all of the price listings he offered which does at least suggest for whatever reason may be out there with our card, anyway, that using the prices on April 29 versus using the prices today, you'll get a distinctly lower answer today than you did on April 29.

Mr. SHIMKUS. I'll go personal for a second. Being one of the five authors of this program, I had an interesting discussion with Mom. My mother is a diabetic. Uses insulin every day, and so I asked Mom has she called 1-800-MEDICARE and she had not. And I said Mom, why? And she said well, I have the American Legion drug discount card and I can obtain my drugs through my insurance company and I don't think it's going to benefit me. And I said well, Mom, I'll tell you what. Why don't you just do me a favor. Why don't you call 1-800-MEDICARE and do this for me. Why don't you tell me how long it took you to get on line, document everything, how you were treated, what questions they asked, the whole thing. So I took my notes from the conversation. She called me back and she said you know, I couldn't get on between 11:22 and 11:25, then finally I was answered at 11:25. There was a computer that assisted me, answered my questions. The whole entire process took 10 minutes. Only one of her drugs was not covered and that she was excited to learn that she would save $407 and she goes I didn't think this was going to save me anything. $407. And she got excited at the fact that yes, this is really going to save me. I said well, get Dad's medications together, please call on behalf of Dad and maybe you can find you may even save $800 or $1,000. And so your testimony, Mr. Baumhofer?

Mr. BAUMHOFER. Stan.

Mr. SHIMKUS. Stan, your testimony, Stan, when I listened to you, I just had to smile because you sounded just like my mother. And so there are individuals of whom have chosen to say it means nothing. Well, it means something to you. And I assure you listening to my mother on the other end of the phone, being able to obtain those types of savings, when in fact, she believes she wasn't going to be able to obtain any savings at all. She said she's really anxious to get the report from CMS and this is a Mom making the phone calls.

So I don't want to really get into the politics of this. Mr. Fuller, Mr. Hayes, you have your ideology, you have your ideals about what you want to do. I just want you to know that there are five of us wanting to make a difference in the lives of people and that you may, you obviously disagree with what we've done, but what I would ask is that you can be helpful in the process to the seniors,

rather than—well, you can be helpful to the process. That's why we made the system voluntary.

I noticed from your testimony, you'd even disagree with the volunteer aspects of the program, but I just wanted to let you know from an author, from an author, I believe in a country that is about freedom and individual liberties and how do we get people more interested in their own health care and taking care of their bodies and this is—when one of you testified about the intangible benefits of the program, getting people more actively involved and price conscious, I think it's an exciting intangible.

Mr. Fuller?

Mr. FULLER. I would just add to that point that one of the things we absolutely know as a certainty is that when the price of medication is more affordable, these seniors will actually take the medication as it's prescribed and therefore and thereby improve the outcome of using medication. All too often, seniors are forced to choose in our stores, between food and medicine. By having the medication more affordable, a great many, thousands of seniors will actually be able to use the medication as it's prescribed and not take it every other day which in many cases renders it almost ineffective.

Mr. SHIMKUS. Thank you. At this time, I'll yield to Mr. Green. You're recognized for 5 minutes.

Mr. GREEN. Thank you, Mr. Chairman. I appreciate our panel being here. It seems like every time I turn to ask questions we have votes. That's what you get for not having seniority.

Because then I hope—I didn't vote for the plan. I spoke against it. We spent all night here in this subcommittee on our committee drafting up this plan and I hope it works. I just know that there's been a lot of problems in the last 2 weeks and maybe CMS has corrected it in the last 10 days, but let me just ask Mr. Baumhofer, did you actually call the pharmacies in Portland, Oregon and get these drug prices?

Mr. BAUMHOFER. Yes sir, I did.

Mr. GREEN. Since everybody was going out and calling CMS, our office tried to call the pharmacies in Portland, Oregon and the pharmacists wouldn't confirm any of the drug prices that you had. And perhaps the discounts are being shown in CMS website, but there was no guarantee that they were actually available in Portland, Oregon. Again, we just called to see because I've been frustrated trying to serve my own constituents and my senior citizens in dealing with it.

And again, the voluntary plan is correct. You don't have to go out and choose one of these cards now, but in 2006, if you don't choose it, a card, for every year you don't you will be penalized, so that's not very voluntary to me. And so for 2 years may be a card, but once you select it, I think the structure of the legislation, hopefully we'll revisit that and some of these hearings we're going to have in oversight on our committee, the full committee or the Health Subcommittee, will be able to look at that and say we are creating a problem. It's effective in 2006.

Mr. Pollack, regarding your enrollment in the program, well, for one thing, I heard from Mr. Rogers that the video cost about $100,000, maybe CMS should have probably contracted with whoever you did to provide it because it would have saved a lot of tax-

payers' dollars, but HHS projects that only 7.4 million Medicare beneficiaries will enroll in this program.

First, do you think that's a reasonable figure of their projection?

Mr. POLLACK. I don't know what a reasonable figure is, but I must say I find myself amused hearing people talk about Walter Cronkite being paid money which he was. We've been very open about that. But then the same people are saying there's nothing wrong with the government paying actors to portray real people and to mislead the public with respect to what that is designed to portray and there's no concern about that whatsoever.

We usee the most respected narrator in America and he provided information that is not misleading or wrong in any way and so I'm very proud of it.

Mr. GREEN. Well, I viewed both of the tapes and again, maybe if we want to question Walter Cronkike, we could bring him in. In your testimony, you state that the drug card is very little or no consequence, that five out of six of the Medicare beneficiaries will probably not select one of these drug cards. Is that correct?

Mr. POLLACK. I can just go by what CMS is telling us. CMS is telling us that at most, there are going to be 7.4 million people who will enroll in this program. That's 18 percent of those in the Medicare program, 1 out of 6. that means that 5 out of 6 seniors will not participate in this program. Where in the alternative that you and others had wished to offer that would enable Medicare to bargain on behalf of everyone, it would have helped everybody.

Mr. GREEN. I've got a whole bunch of questions. One of them is, and I'll ask anyone on the panel. Has there been any focus groups, you know in the last 2 weeks or something that you could share with us the problems that or the factors that are dissuading beneficiaries from signing up?

Mr. FULLER. Actually, we've done a considerable amount of research because we're a card sponsor. We need to know how people feel. It's very important to remember of the 42 million seniors, almost three quarters of them have coverage to date. Not all of it's good, but they have coverage. You've got to look at the 15 million without coverage. Sixty percent, almost 60 percent of those people when we surveyed that population, the population that pays cash today, almost 60 percent said they thought the card was a good idea and they would sign up for it. When they got a little more information those percentages went up to about three quarters. And 84 percent——

Mr. GREEN. I'm asking the questions and I'll let you answer when I get a chance.

When you said that you provided more information, I hope it wasn't provided by someone who maybe was trying to give them maybe questionable information because when I have a witness that tells me that, whether it's you or Mr. Pollack, I want to know what was your criteria.

Mr. GREEN. Sir, I represent 120,000 pharmacists who deal with seniors millions of them every day and 35,000 stores across the country. We treat them honestly and with respect. We don't mislead them. On top of that, the information presented to them is the information that Medicare approves and has official condoned to educate seniors with. The only point I was making is if they have

more information, they're interested in signing up for the card and the TA population tells us at a rate of about 84 percent that they want to sign up.

Now the information, the marketing information that's approved by Medicare wasn't even made available by regulation until May 3. We've only had a couple of weeks to make the information available. It is being made available by 120,000 of our pharmacists, another 30,000 or 40,000 independent pharmacists who counsel with patients every day.

I just urge you let this program work. We'll be back here in a couple of months with metrics to explain——

Mr. GREEN. We're not going to stop it from going forward. It's going forward, but again, these oversight hearings are trying to correct the problems that we see may happen and hopefully, they won't happen.

Mr. SHIMKUS. The gentleman's time has expired. Mr. Walden, you are now recognized.

Mr. WALDEN. Thank you, Mr. Chairman. Stan, welcome, we're delighted to have you here and I'm delighted you found that this card can be very helpful to you. How much do you think you can save a year on your drugs?

Mr. BAUMHOFER. Approximately $150 a month or $1800 over the year which is substantial in my condition.

Mr. WALDEN. You know, I think you hit it on the head here. Is changing Medicare sometimes confusing for some? Of course, it is. When it was rolled out in the 1960's, there were front page stores all across America about the confusion about the new program. But what's the benefit? That's what we have to look at.

Mr. Chairman, I'm delighted your parents are going to receive the savings that you've outlined. Unfortunately, mine both passed away waiting for this Congress and the last Congresses to act in this area as did a lot of seniors. They died waiting for Medicare to be modernized.

We have taken a giant step forward, I think, to provide assistance to those most in need.

Now did you find it confusing?

Mr. BAUMHOFER. Not at all. In my written testimony, I explained how simple it had been to get the information and how quickly the comparison of prices and I feel complimented that the chairman compared me to his mother.

Mr. WALDEN. By voice, not appearance.

Mr. BAUMHOFER. Thank you. I feel a little bit like a piece of rope here in this tug of war today, but the rope's life is dull and being in the game is better than not at all. In my case, my medical incident cost over $22,000. Medicare paid $14,000 of that. I hope that this discount card allows me to not have a similar incident and saves that $14,000 for Medicare.

Mr. WALDEN. That's been one of our—certainly my concerns and I think a driving force behind what this committee and this Congress has done. Because if we can allow for seniors and I think Mr. Fuller, you spoke to this. If they take their prescriptions as requested by their physicians because they can now afford and have accesss to them, maybe we prevent a heart attack. If you can get

them on Lipitor for $67 a month, maybe you avoid a $20,000 bypass surgery which I think is very important.

I know Mr. Dingell in the conference was supportive of this drug card benefit and sure, there are going to be some bumps in the road. We all recognize that. And we're going to work to fix it. We're going to watch it closely. And as I've gone out and met with seniors, they start out having heard sort of the Mediscare rhetoric from some and they're a little confused and I walk them through how it works. I invite them to work with CMS to make the call to 1-800-MEDICARE or to go to the website.

One of the most important things I think we've done is encouraged the harnessing of the internet power to comparison price shop so you don't have to make the phone calls.

Have you found that to be helpful? Have you gone on and used the web?

Mr. BAUMHOFER. I have, yes, and I made the phone call also and they both were helpful.

Mr. WALDEN. I ran into a senior out in Ontario, Oregon where I did a Medicare workshop and he said I'm not sure I'm going to do the card because I call around, my wife and I do every month to various pharmacies in our area to find the best price. I said well, you know, you might not have to do that now. If that's how you want to do it, that's fair, that's fine, that's your choice, it's voluntary. And I'm being given the cue card here that we're out of time because the votes on, but I wanted to thank you for coming from Oregon and the other panelists for your participation today. Thank you, Mr. Chairman.

Mr. SHIMKUS. I thank all the panelists for coming. This hearing is now concluded. Mr. Brown, I appreciate your contribution.

[Whereupon, at 3:10 p.m., the hearing was concluded.]

[Additional material submitted for the record follows:]

RESPONSES FOR THE RECORD BY MARK MCCLELLAN, ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES

QUESTIONS BY REP. PALLONE

Question: What is the specific amount to be spent on educational efforts connected to the drug card?

Answer: CMS has spent $18 million on media buys for TV ads informing the public about the drug card program. This number includes ads about the general card program and one on the availability of the $600 in transitional assistance.

We spent $10 million for a mailing to all beneficiary households containing a short fact sheet on the card program. We will also include information on the drug card in the regularly mailed handbook that goes out in the fall of each year.

We also spent money on print ads, with costs running under $500,000. The Social Security Administration also mailed information concerning the card program to low-income beneficiaries, but CMS did not bear that costs.

Spending on outreach and education in the future will depend on response to the card program and what CMS believes needs to be done in order to ensure that people who can benefit from the cards are enrolling in them.

We are tentatively planning additional ads for August. Costs for these new ads are not well known at this time, because we are waiting to see where the need for this information is greatest before proceeding. It is likely that any future media buys will not be as costly as our initial efforts.

In FY 2004, SHIP funding will total $21,062,500. This amount consists of $13.5 million in basic funding, $1,562,500 additional funding to help the SHIPs prepare for activity related to the Medicare-approved Prescription Drug Card, and $6 million additional funding to help them prepare for activities related to the Drug Card and the upcoming Part D Prescription Drug Benefit.

In FY 2005, SHIP funding will be $31,675,000. This will include $14,175,000 in basic funding, $2,500,000 to assist SHIPs with Prescription Drug Card related activity, and $15,000,000 for activities related to the Part D Prescription Drug benefit.

CMS has also awarded a $4.16 million task order to Ogilvy PR Worldwide for the purpose of supporting the work of community-based organizations (CBOs) to help low-income Medicare beneficiaries learn about Medicare-approved discount drug cards and how to enroll in the program. With the support of the Administration on Aging the funding for this task has been increased by another 1.75 million. The focus of this effort is to identify at least 200 CBOs that can conduct outreach activities in the top 30 markets; these top 30 markets target the locations where approximately 70 percent of the low-income beneficiaries reside. The activities of these CBOs will complement and extend other outreach efforts of the National Medicare & You Education Program (NMEP). The task order includes monies that will be used to fund the grassroots, community-based organizations; the remaining funds will be used to obtain the support of national organizations who have been engaged to help coordinate the outreach effort and contractual overhead and management fees.

In addition, CMS is in the process of engaging in several other Federal Agency partnerships to provide additional resources to organizations/efforts that inform low-income, diverse populations about the drug card and to assist them in enrolling. Examples include an Interagency Agreement (IA) with the Indian Health Service and an IA with USDA to provide training to their Extension Services to educate rural and urban low-income audiences about MMA and the discount drug card.

Moreover, these outreach efforts under the drug card will be useful for more than just the drug card. By reaching out to the drug card population now we are starting to be able to reach out to beneficiaries for the drug benefit as well. This is particularly important for the low-income populations who have frequently been hard to reach—so the payoff on outreach will extend way beyond the drug card to the drug benefit.

Question: Who, specifically, within HHS, authorized the release of the VNR that has recently attracted criticism and were specific people in the White House, such as Karl Rove, or Andy Card, involved in putting together that VNR?

Answer: The release of the VNR was authorized by Kevin Keane, Assistant Secretary for Public Affairs in HHS. The VNR was done in a professional manner by a recognized public relations firm, and it meets the highest standards for production of VNRs, which are a common and accepted public relations tool used by the private sector, the government and members of Congress. There was absolutely no involvement by anyone from the White House

Question: What is the actual cost of running the www.medicare.gov site, and the cost for the CSRs at 1-800-MEDICARE?

Answer: Please find the total investment from December 8, 2003 until June 21, 2004 by month, on the 1-800 MEDICARE call centers, including data on incoming calls and average length of call:

1-800 Monthly Call Volume

12/2003 = 684,450
01/2004 = 763,393
02/2004 = 681,409
03/2004 = 946,306
04/2004 = 1,261,908
05/2004 = 3,811,455
06/2004 = 446,897 (as of 06/19/2004)

On the average, the unit cost is about $1.00 per minute. This is a fully loaded cost. The cost does fluctuate based on the introduction of new initiatives. Sometimes these new initiatives require mass hiring and ramping up of staff such as in the case of MMA. Traditionally, our average length of call for 1-800 MEDICARE is 7.5 minutes but a longer length of call can occur due to special campaigns and new Department or CMS initiatives. Based on the call volume from 12/2003 through 06/19/2004 and an average call length of 7.5 minutes, the overall average cost is $64.4 million.

How much did the additional CSRs cost?

As of June 2004, we have about 3,000 Customer Service Representatives (CSRs) on duty at 1-800 MEDICARE. In January 2004 we had approximately 738 CSRs. The average cost of a 1-800 MEDICARE CSR is about $35,000 per year. This is a fully loaded amount that includes health and benefit packages, training, etc. The costs for the CSRs are included in the fully loaded $1.00 per minute cost. Traditionally, labor costs account for a significant amount of the overall 1-800 MEDICARE operating budget.

www.medicare.gov website

Please find below how much it cost CMS to add the additional features and resources to the drug compare website (include contracts, etc.). Also, included is the total cost of the contract (beyond implementing, running it too) in 2004 and 2005:

The costs of the changes and enhancements to PDAP are incremental. Current and projected costs are:

Jan-June 2004—$3.2M
June-Sept 2004—$700,000
FY05—$1.5M

CMS chose to incorporate the drug pricing information for the Medicare-approved drug discount card programs into the existing Prescription Drug and Other Assistance Programs database on www.medicare.gov. This decision provided people with Medicare with the ability to access the new drug pricing information through a tool that was familiar to many people and that had been enhanced based on consumer research. Prescription pricing information is provided for both brand and generic drugs offered through retail pharmacies and mail order pharmacies.

CMS is currently exploring a means to use similar technology to provide similar prescription drug pricing information to people with Medicare when the actual drug benefit is implemented in 2006. CMS will utilize a "lessons learned" approach when developing a Web based tool for the drug benefit. A thorough analysis of information received from people with Medicare, consumer research, and other sources will be used to provide people with Medicare with an accurate and easy to use tool to access information about the Medicare drug benefit.

Volunteered information on the many billions of dollars in new savings available to seniors as a result of the discount cards:

- CMS studies indicate that any Medicare beneficiary in America today can save 11 to 18 percent, or much more compared to average market prices, on their drug costs with a drug discount card. These average market prices include discounts available through private health insurance, Medicaid plans, and other discount sources like manufacturer drug cards. Before the Medicare-approved prescription drug cards, beneficiaries without drug coverage paid the highest prices in the nation for their prescriptions. Savings of 11 to 18 percent beyond private health insurance levels is a significant improvement for America's seniors. This base level of savings is expected to grow as market competition drives discounts even lower.[1]
- A June 4, 2004 study by CMS showed that beneficiaries could save even more than 11 to 17 percent by substituting generic drugs—which are chemically equivalent and just as safe and effective as their brand name counterparts—for branded drugs. The study indicates that beneficiaries who switch to generics can save between 46 and 92 percent off the prices of branded drugs. This savings is the result of two factors: generic drugs are cheaper than brand-name drugs and card sponsors are negotiating extremely low prices with generic manufacturers. In fact, generics purchased with Medicare-approved drug discount cards cost 37 to 65 percent less than the national average price for generics. In the study, 7 out of 10 generic drugs paid for the $30 enrollment fee in less than two months—and that is with savings on only one drug. Generic substitution combines with the Medicare-approved drug discount card to afford beneficiaries huge savings on the order of 46 to 92 percent, without any additional subsidy.[2]
- CMS studies indicate that our illustrative low-income beneficiaries can save 32 to 86 percent over a 7-month period compared to national average retail prices for "baskets" of commonly used brand name drugs when both discounts and $600 in transitional assistance are taken into account.
- The drug discount cards can be especially helpful to eligible low-income beneficiaries who do not have drug coverage through Medicaid by:
  - Offering additional discounts off retail prices that are, in some instances, more than the 11-18 percent for brand name drugs and 3 0-60 percent off generic drugs being offered to non low-income beneficiaries;
  - Providing $600 in each of 2004 and 2005 for the purchase of prescription drugs;
  - Having the annual enrollment fee, if any, paid by Medicare;

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[1] *Medicare Approved Drug Discount Cards Provide Drug Prices Significantly Below, Average Paid by Americans.* Centers for Medicare and Medicaid Services. May 6, 2004.

[2] *Medicare-approved Drug Discount Cards Provide Substantial Savings with Generic Drugs.* Centers for Medicare and Medicaid Services. June 4, 2004.

- Offering free or low-cost prescription drugs from several manufacturers including Abbott, Astra Zeneca, Eli Lilly and Company, Merck, Novartis, Pfizer and Wyeth for beneficiaries enrolling in certain Medicare-approved drug discount cards who exhaust their $600 credit;
- Therefore, when multiplying the savings by 7 million beneficiaries expected to enroll in the drug discount card only or the drug discount card with the $600 transitional assistance, it is clear that Medicare beneficiaries will see billions of dollars in savings. With more than 4 million people already in a drug card program, the savings have already greatly exceeded the administrative costs of establishing the program.

QUESTIONS BY REP. DINGELL

Question: How many people will be working on oversight of the 73 approved cards? Specifically, how many people will be working on issues of consumer protection and "bait and switch" ?

Answer: A broad array of government and contractor personnel will ensure the integrity of the drug card program. CMS personnel have been conducting statistical analysis of pricing data submitted by card sponsors since they began providing us with that data. We have recently signed an agreement with a contractor who will focus specifically on analyzing data provided by card sponsors to ensure that price fluctuations are justified and appropriate. Certain CMS employees, in their role as card managers, are overseeing our communications with each card sponsor and examining and investigating beneficiary complaints about card sponsor programs. CMS program integrity employees have hired an additional contractor to look at price changes and to ensure consumer protection against "bait and switch." as well. Another contractor will conduct "mystery shopping" with the drug card sponsors to ensure that pharmacies that are supposed to be participating in a given card sponsor's network do in fact participate in that card sponsor's pharmacy network. Any inappropriate activities will be reported to CMS and in some instances, the HHS Inspector General's office. We will also work with the resources of the Department of Justice, should we need to do so. In addition, each of the ten CMS regional offices maintains a fraud unit that can be used to assist any efforts to reduce fraud and abuse. We believe that the array of personnel we have looking at these issues will ensure a high degree of integrity within the program and make it possible for beneficiaries to take advantage of this very beneficial program.

Question: Pharmaceutical discounts or rebates come from two different areas: (1) volume—having a lot of people who will buy your particular drug, and (2) moving market share—that is the ability to move people to a certain drug or brand. The more people a card has enrolled, the better discounts or rebates for beneficiaries. Let me cite two examples:

a. A CMS document dated September 25, 2003, states, "If a PPO can anticipate a large number of enrollees, and therefore a large VOLUME of services, it can negotiate favorable prices . . ." The document also notes, "The cost per beneficiary would be . . . lowest with three plans." CMS advocated for fewer PPOs in order to get better prices and lower costs per beneficiary.

b. The State of Michigan expects to realize $8 million in savings on their Medicaid program this year by banding together with Vermont to purchase drugs. They expect to get even greater savings next year when they aggregate their purchasing power with other states—they will have $2 billion in purchasing power—the VA system is $3 billion and they are getting some of the lowest prices around, even lower than Canada. Again, greater numbers of people give better leverage in negotiating discounts.

CMS, however, set up the drug discount card program to have 73 different cards, greatly diffusing any negotiating leverage that seniors and individuals with disabilities could expect to achieve by banding together.

When CMS implemented the drug discount cards, why did you set up a program that ran counter to your own recognition that the smaller number of entities providing the service, the better the prices for seniors? How does protecting drug manufacturers from stronger negotiation help seniors?

Answer: The Medicare-approved drug card sponsors are competing for beneficiaries and have a real incentive to negotiate and pass on savings in the form of the lowest possible prices for the drugs that their beneficiaries need. To obtain these discounts, the card sponsors negotiate prices on the drugs that are included on their formularies. In a discount program like this one, the only way that cards can generate any revenues is by providing attractive prices on the drugs that beneficiaries want, so that beneficiaries use the cards to fill their prescriptions. However, no one formulary possibly could meet the diverse needs of the Medicare population. To best

serve Medicare beneficiaries, the program is designed to allow a number of card programs to participate, enabling beneficiaries to have choices based on the drugs they need and the pharmacies that are closest to them. The cards need to offer savings and service, and we will be monitoring card programs to make sure beneficiaries get both. Thus, to succeed in holding onto its beneficiaries, and in building up its client base for when their drug benefit becomes available in 2006, a card must offer consistently good deals and consistently reliable service to beneficiaries.

Question: Will CMS limit the number of private prescription drug plans in order to help seniors get better discounts? Or will you again allow so many choices that seniors are paralyzed, and discounts are diffused?

Answer: As required by the statute, CMS will ensure that at least two drug plans are available in each region of the country, although we are not limited to just two plans and seniors may well have the opportunity to select a plan that best fits their needs from among a range of plans. The plans will compete with each other directly, and this competition will work to lower prices for seniors who voluntarily select such coverage. Our experience with the drug card program has conclusively demonstrated that when drug programs compete, prices drop. As we have done with the drug card, CMS will provide educational information and personal assistance to beneficiaries to help them select a drug program that best fits their needs and saves them the most money. CMS will provide assistance in determining which plan best suits a particular beneficiary's needs.

Question: What level of rebate are drug cards getting from the drug manufacturers? (Not the discount at the register but the actual amount of rebate that manufacturers are providing)? How do the rebates compare with what people would get under the Medicaid best price rule? How do the rebates under the drug card program compare to prices under the VA system? According to representatives of the Pennsylvania PACE program drug card, that program is only receiving a four percent discount from manufacturers. Are there any cards that are getting manufacturer rebates of less than four percent? Are there any cards getting manufacturer rebates that are greater than 15 percent?

Answer: We're still looking at the data, and the information may change over the coming weeks as more sponsors come online, but so far we are seeing that many Medicare-approved drug discounts cards will provide significant discounts to beneficiaries:

- For brand name prescription drugs, sponsors are reporting discounts off AWP that are generally 15%, with some discounts of 20% or more—(we plan to have information on drug card sponsors' rebate level as this is a reporting requirement);
- Larger discounts are available on some cards for mail-order drugs;
- For generic prescription drugs, sponsors are reporting average discounts off AWP in the 20-35% range, with some as high as 40-50%

As for comparing prices under the drug card program to those under the VA, in October 2000, GAO issued a report that examined the possibility of expanding the VA pharmacy benefit to Medicare. The report discovered that such a scenario would result in negative ramifications for the entire health care system. In addition, any Medicare savings would be short-lived.

It is difficult to make comparison between the drug card program and the VA system, because the VA system is a drug insurance program with a particular formulary. While the VA system is a good source for seniors who qualify for coverage, it is typically not available to seniors. In addition, statute dictates how prices are determined for drugs that are included on the VA's formulary. If that statute applied to practically everyone in the country, competition would be hampered and prices would increase for everyone.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

UNITED STATES OF AMERICA, ex rel. GEORGE BRADFORD HUNT and WALTER W. GAUGER, Relators, and the States of FLORIDA, ILLINOIS, TENNESSEE, NEVADA, MASSACHUSETTS, VIRGINIA, and the DISTRICT OF COLUMBIA,	)	Hon. Clarence C. Newcomer
Plaintiffs,	)	Case No. 2:00-cv-737-CN
v.	)	
MERCK-MEDCO MANAGED CARE, L.L.C., and MEDCO HEALTH SOLUTIONS, INC.	)	
Defendants.	)	

COMPLAINT BY THE COMMONWEALTH OF MASSACHUSETTS

1. This civil action is brought by the Massachusetts Attorney General pursuant to Massachusetts G.L. c. 12, § 5A *et seq.*, the Massachusetts False Claims Law, arising out of the defendants' performance of pharmacy benefit management services for the Commonwealth.

THE PARTIES

2. The plaintiff, Commonwealth of Massachusetts, is represented by the Attorney General who brings this action in the public interest pursuant to G.L. c. 12, § 5D and G.L. c. 12, § 10. The Attorney General brings this action to enforce Massachusetts False Claims Law and on behalf of the Commonwealth's Group Insurance Commission, which provides health benefits to Massachusetts public employees and retirees.

3. Defendant, Medco Health Solutions, Inc. is a Delaware Limited Liability Corporation

with a principal place of business in New Jersey and with business facilities located in 12 states, formerly including Massachusetts.

4. Medco Health Solutions is the corporate successor to the defendant, Merck-Medco Managed Care, L.L.C. Merck-Medco Managed Care and Medco Health Solutions are collectively referred to herein as "Medco.

5. Medco provides pharmacy benefit management ("PBM) services to persons nationwide. From at least 1994 through July 1, 2000, Medco provided PBM services to the Commonwealth or its political subdivisions, through a contract between Medco and the Massachusetts Group Insurance Commission ("GIC). Medco provided services to GIC in Massachusetts directly and through its subsidiaries or affiliated companies, including PAID Prescriptions, L.L.C. and Merck-Medco Rx Services of Massachusetts, L.L.C.

JURISDICTION AND VENUE

6. This court has jurisdiction over the subject matter and defendants of this action pursuant to 31 U.S.C. § 3732(b), 28 U.S.C. § 1331 and 28 U.S.C. § 1367.

7. In accordance with 28 U.S.C. § 1391, venue is proper in the Eastern District of Pennsylvania because the defendant transacts business in this district.

FACTS

8. The Massachusetts False Claims Law, G.L. c. 12, § 5A-5O, among other things, establishes civil liability for any person who:

> knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval to the Commonwealth (G.L. c. 12, § 5B(1));
>
> knowingly makes, uses or causes to be made or used, a false record or statement to obtain payment or approval of a claim to the Commonwealth (*Id.* § 5B(2));

> conspires to defraud the commonwealth through the allowance or payment of a false or fraudulent claim (*Id.* § 5B(3));
>
> enters into an agreement, contract or understanding with one or more officials of the commonwealth knowing the information contained therein is false or fraudulent (*Id.* § 5B(7));
>
> knowingly makes, uses or causes to be made or used a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the commonwealth (*Id.* § 5B(8)); or
>
> is a beneficiary of an inadvertent submission of a false claim to the commonwealth, subsequently discovers the falsity of the claim, and fails to disclose the false claim to the commonwealth within a reasonable time after the discovery of the false claim (*Id.* § 5B(9)).

9. The Massachusetts False Claims Law provides that any person violating the False Claims Law shall be liable for a civil penalty of not less than $5,000 and not more than $10,000 per violation, plus three times the amount of damages, including consequential damages, sustained by the Commonwealth because of the person's conduct. The False Claims Law also requires a violator to pay the expenses of this civil action, including, without limitation, attorneys fees, expert's fees, and the costs of investigation. *Id.* § 5B.

10. The Group Insurance Commission (hereafter "GIC) is a political subdivision of the Commonwealth, established by the Massachusetts legislature to provide health insurance and other benefits to employees and retirees of the Commonwealth, their dependents and survivors.

11. The Commonwealth of Massachusetts, through GIC, contracted with the defendant, Medco, to provide services. From 1994 through 1997, GIC contracted with Medco to provide mail order pharmacy services. In late 1996, GIC solicited bid proposals for the provision of PBM services to GIC, to begin July 1, 1997.

12. Medco submitted a PBM bid proposal to GIC in or about January 1997. In or about

March 1997, GIC selected Medco to provide PBM services to GIC. On or about July 1, 1997, Medco entered into an agreement with GIC to provide PBM services to GIC. The agreement between GIC and Medco incorporated by reference the provisions of both GIC's Request for Proposal and Medco's response. That GIC/Medco contract remained in effect until June 30, 2000, when GIC contracted with another PBM to administer a pharmacy benefit to GIC beneficiaries.

13. The 1997 contract between GIC and Medco provided that GIC would participate in Medco's "Preferred Prescription Formulary and Medco's "formulary management program, which "may include cost containment initiatives, communications with [GIC beneficiaries], Participating Pharmacies and/or physicians, and financial incentives for Participating Pharmacies for their participation. The contract stated that "compliance with Medco's Preferred Prescription Formulary and formulary management program will result in Formulary Rebates, a defined term under the contract, as set forth below.

14. Section 6.2 of the Medco/GIC contract, captioned "Formulary Savings, explained that:

> "[Medco and its affiliates] receive "Formulary Rebates from certain drug manufacturers as a result of the inclusion of such manufacturer's branded products on the Formulary. Medco also conducts therapeutic interchange programs for formulary drugs which will lead to cost savings, measured on an AWP basis ("AWP Savings). (Formulary Rebates and AWP Savings are jointly referred to as "Formulary Savings.) PAID will provide GIC 100% of the Formulary Savings received by Medco based on the dispensing of each manufacturer's formulary drugs under GIC's program, less a formulary management fee equal to 5% of the greater of such Formulary Savings or Guaranteed Savings.

Medco thus promised that its Preferred Prescriptions Formulary, together with its "formulary management program would result in "Formulary Savings, 95% of which Medco would pay to GIC.

Medco Failed to Timely Pay GIC Certain Rebates Under the Contract

15. During the term of its contract with GIC, Medco paid money to GIC, by way of invoice credits, attributable to formulary savings. Roughly two quarters (six months) after a calendar quarter, GIC's bi-weekly invoice from Medco reflected the formulary savings for a preceding quarter. These quarterly credits ranged between $400,000 (third quarter 1997) and $1.4 million (second quarter 2000).

16. Because of the delay between GIC's accrual of formulary savings in one quarter and Medco's invoice credit to GIC several months later, Medco owed GIC accrued rebates when the contract terminated on June 30, 2000.

17. On or about February 14, 2001, more than seven months after the GIC contract ended, Medco forwarded to GIC a letter together with a check for more than $2.1 million. A Medco account manager stated to GIC, in pertinent part:

> Enclosed please find a check in the amount of $2,170,016.98.00(sic) for the first two quarter's rebates in 2000.
>
> This should conclude any further payments to the Group Insurance Commission.

18. Since the February 14, 2001 correspondence from Medco to GIC, Medco did not advise GIC that additional rebates had been accrued but not yet paid, or that certain manufacturer rebates were delayed in any fashion. Medco has not paid rebates to GIC since February 14, 2001.

19. Notwithstanding Medco's February 14, 2001 letter and Medco's subsequent silence, Medco owes, but has failed to pay, additional formulary savings to GIC which accrued during the GIC contract term. The Commonwealth has reason to believe that Medco owes GIC approximately $784,000 in formulary rebates pursuant to the GIC/Medco contract.

20. Medco failed to advise GIC, in any manner, of the outstanding amount owed GIC. Medco disclosed the accrued but unpaid rebates in December 2003, in response to an investigation by the Commonwealth.

21. By its communications to GIC and its conduct, including but not limited to Medco's February 14, 2001 letter, Medco knowingly made, used, or caused to be made or used, a false record or statement to conceal, avoid or decrease its obligation to pay or transmit money to GIC. G.L. c. 12, § 5B(8).

Medco Failed to Pay GIC Certain Rebates that May Have Been "Formulary Rebates" Owed Under the Contract

22. Medco vied for and won the GIC contract based, in large measure, on its claimed ability to save GIC money on prescription drugs. Central to Medco's cost savings initiatives were its Preferred Prescription Formulary ("PPF) and its formulary management programs, which Medco uses to promote the use of certain "preferred formulary drugs over other "non-preferred drugs. Indeed, Medco's 1997 bid proposal to GIC, with respect to costs, was premised on GIC's participation in the PPF and Medco's formulary management programs.

23. In its official bid in response to GIC's Request for Proposals, and in its subsequent contract with GIC, Medco emphasized that its formulary and formulary compliance efforts would save GIC money by generating rebates from drug manufacturers.

24. Medco's contract with GIC also stated that its formulary and formulary compliance would generate rebates, and that Medco would provide GIC "100% of those rebates. Medco described that its formulary compliance programs included drug switching calls and other communications to doctors or beneficiaries, and promised that GIC's compliance with Medco's

formulary management program "will result in Formulary Rebates.

25. With respect to "Formulary Rebates, as well as "AWP Savings achieved by soliciting drug switches, Medco promised that 100 percent of those types of "Formulary Savings would be paid through to GIC, minus a 5% formulary management fee to Medco. Medco thus promised that its formulary placement decisions and its formulary compliance programs, including drug switching, would save GIC money because: i) those programs would generate "formulary savings, and ii) 95% of formulary savings would be passed through to GIC.

26. Although Medco's contract with GIC also mentioned that Medco may receive and retain other money from drug manufacturers, both Medco's bid proposal and its contract emphasized that Medco would pass through to GIC "100% of "Formulary Savings. On information and belief, at no point during the contracting stage did Medco disclose to GIC or its agents the magnitude of non-"formulary rebates that Medco might receive from drug manufacturers, and retain for itself.

27. Contrary to its bid proposal and its contract with GIC, Medco failed to pay to GIC 95% of all "Formulary Savings, that is, money paid by drug manufacturers for formulary placement and formulary compliance measures. Instead, Medco consistently retained for itself money from drug manufacturers that Medco characterized as something other than "formulary rebates, even though some of those manufacturer payments may have comprised "formulary savings as described in the Medco/GIC contract.

28. During the GIC contract, Medco received roughly $9 million in "formulary rebates from drug manufacturers attributable to the GIC contract, which Medco passed through to GIC pursuant to the contract. During the same contract period, on information and belief, Medco received more than $10 million in rebates and other payments from drug manufacturers allocable to

the GIC contract, which Medco retained and did not pass through to GIC.

29. Medco thus retained for itself more money from drug manufacturers than it provided to GIC during the contract period. At no point during the contract period did Medco disclose to GIC or its agents the nature and magnitude of Medco-retained payments from drug manufacturers.

30. Medco was able to retain for itself certain drug manufacturer payments that might have been paid to GIC, due to Medco's ability to characterize the payments it received from drug manufacturers. On information and belief, in its dealings with drug manufacturers, Medco itself was able to designate the nature of monies paid to Medco by manufacturers. With respect to Medco's clients like GIC, depending on what Medco calls the manufacturer payments, the money may be treated as "formulary savings and thus passed through to GIC, or given some other designation, so that the money is not passed through.

31. Because Medco could control how manufacturer payments are characterized, Medco has kept for itself monies that are properly attributable to the formulary or formulary management efforts like drug switching, and accordingly should have been passed through to GIC. By controlling the designation of payments from manufacturers, Medco was able to try to avoid its obligation to pass through payments to its clients. As a result, Medco sometimes failed to satisfy its obligation to pass through to GIC all "Formulary Savings.

32. In light of Medco's actual rebates practice of retaining a significant portion of all manufacturer rebates, Medco used misleading statements to induce GIC to enter into the 1997 contract with Medco, and, on information and belief, entered into the GIC contract knowing that it contained false information. G.L. c. 12, § 5B(9).

33. When Medco reported and credited or paid to GIC its quarterly "formulary savings,

Medco inaccurately stated or implied that it had paid GIC all rebates and savings due under contract. Medco knowingly made, used or caused to be made or used a false record or statement to conceal, avoid or decrease its obligation to pay GIC all rebates and savings due under the contract. G.L. c. 12, § 5B(8).

CAUSE OF ACTION

Count One
(Violation of the Massachusetts False Claim Law, G.L. c. 12, § 5B)

34. The Commonwealth incorporates by reference the allegations of paragraphs 1 through 33 of the Complaint.

35. Medco entered into an agreement, contract or understanding with one or more officials of the Commonwealth, knowing the information contained therein was false or fraudulent, in violation of G.L. c. 12, § 5B(7).

36. Medco knowingly made, used or caused to be made or used a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the Commonwealth, in violation of G.L. c. 12, § 5B(8).

37. Medco knowingly made, used or caused to be made or used, a false record or statement to obtain payment or approval of a claim to the Commonwealth, in violation of G.L. c. 12, § 5B(2).

38. Medco knowingly presented, or caused to be presented, false or fraudulent claims for payment or approval to the Commonwealth in violation of G.L. c. 12, § 5B(1). Claims by Medco were false or fraudulent because, *inter alia*, the claims were made pursuant to a contract induced by Medco's false or fraudulent representations.

RELIEF REQUESTED

WHEREFORE, the Commonwealth requests entry of judgment in its favor, and against defendants, in an amount equal to triple the damages sustained by reason of Medco's conduct, together with civil penalties under G.L. c. 12, § 5B, costs of investigation and litigation, including attorneys fees, and such other and further relief as the Court deems equitable and proper.

Respectfully submitted,

COMMONWEALTH OF MASSACHUSETTS

THOMAS F. REILLY
ATTORNEY GENERAL

Date: April 23, 2004

By: _____/s/_____

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CERTIFICATE OF SERVICE

The undersigned, Christopher Barry-Smith, hereby certifies that, on **April 23, 2004**, I served, by first class mail, a copy of the Commonwealth's Complaint, on the persons listed immediately below.

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