AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

CREATING A MEDICARE PRESCRIPTION DRUG BENEFIT: ASSESSING EFFORTS TO HELP AMERICA'S LOW-INCOME SENIORS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

APRIL 17, 2002

Serial No. 107–101

Printed for the use of the Committee on Energy and Commerce

Available via the World Wide Web: http://www.access.gpo.gov/congress/house

U.S. GOVERNMENT PRINTING OFFICE

79–466CC WASHINGTON : 2002

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2250 Mail: Stop SSOP, Washington, DC 20402–0001

COMMITTEE ON ENERGY AND COMMERCE

W.J. "BILLY" TAUZIN, Louisiana, *Chairman*

MICHAEL BILIRAKIS, Florida
JOE BARTON, Texas
FRED UPTON, Michigan
CLIFF STEARNS, Florida
PAUL E. GILLMOR, Ohio
JAMES C. GREENWOOD, Pennsylvania
CHRISTOPHER COX, California
NATHAN DEAL, Georgia
RICHARD BURR, North Carolina
ED WHITFIELD, Kentucky
GREG GANSKE, Iowa
CHARLIE NORWOOD, Georgia
BARBARA CUBIN, Wyoming
JOHN SHIMKUS, Illinois
HEATHER WILSON, New Mexico
JOHN B. SHADEGG, Arizona
CHARLES "CHIP" PICKERING, Mississippi
VITO FOSSELLA, New York
ROY BLUNT, Missouri
TOM DAVIS, Virginia
ED BRYANT, Tennessee
ROBERT L. EHRLICH, Jr., Maryland
STEVE BUYER, Indiana
GEORGE RADANOVICH, California
CHARLES F. BASS, New Hampshire
JOSEPH R. PITTS, Pennsylvania
MARY BONO, California
GREG WALDEN, Oregon
LEE TERRY, Nebraska
ERNIE FLETCHER, Kentucky

JOHN D. DINGELL, Michigan
HENRY A. WAXMAN, California
EDWARD J. MARKEY, Massachusetts
RALPH M. HALL, Texas
RICK BOUCHER, Virginia
EDOLPHUS TOWNS, New York
FRANK PALLONE, Jr., New Jersey
SHERROD BROWN, Ohio
BART GORDON, Tennessee
PETER DEUTSCH, Florida
BOBBY L. RUSH, Illinois
ANNA G. ESHOO, California
BART STUPAK, Michigan
ELIOT L. ENGEL, New York
TOM SAWYER, Ohio
ALBERT R. WYNN, Maryland
GENE GREEN, Texas
KAREN McCARTHY, Missouri
TED STRICKLAND, Ohio
DIANA DeGETTE, Colorado
THOMAS M. BARRETT, Wisconsin
BILL LUTHER, Minnesota
LOIS CAPPS, California
MICHAEL F. DOYLE, Pennsylvania
CHRISTOPHER JOHN, Louisiana
JANE HARMAN, California

DAVID V. MARVENTANO, *Staff Director*
JAMES D. BARNETTE, *General Counsel*
REID P.F. STUNTZ, *Minority Staff Director and Chief Counsel*

SUBCOMMITTEE ON HEALTH

MICHAEL BILIRAKIS, Florida, *Chairman*

JOE BARTON, Texas
FRED UPTON, Michigan
JAMES C. GREENWOOD, Pennsylvania
NATHAN DEAL, Georgia
RICHARD BURR, North Carolina
ED WHITFIELD, Kentucky
GREG GANSKE, Iowa
CHARLIE NORWOOD, Georgia
Vice Chairman
BARBARA CUBIN, Wyoming
HEATHER WILSON, New Mexico
JOHN B. SHADEGG, Arizona
CHARLES "CHIP" PICKERING, Mississippi
ED BRYANT, Tennessee
ROBERT L. EHRLICH, Jr., Maryland
STEVE BUYER, Indiana
JOSEPH R. PITTS, Pennsylvania
W.J. "BILLY" TAUZIN, Louisiana
(Ex Officio)

SHERROD BROWN, Ohio
HENRY A. WAXMAN, California
TED STRICKLAND, Ohio
THOMAS M. BARRETT, Wisconsin
LOIS CAPPS, California
RALPH M. HALL, Texas
EDOLPHUS TOWNS, New York
FRANK PALLONE, Jr., New Jersey
PETER DEUTSCH, Florida
ANNA G. ESHOO, California
BART STUPAK, Michigan
ELIOT L. ENGEL, New York
ALBERT R. WYNN, Maryland
GENE GREEN, Texas
JOHN D. DINGELL, Michigan,
(Ex Officio)

CONTENTS

Page

Testimony of:
- Braun, Beatrice, Board of Directors, American Association of Retired Persons 70
- Fuller, Craig, President and CEO, National Association of Chain Drug Stores 99
- Hillerby, Michael D., Deputy Chief of Staff for Nevada Governor Kenny Guinn 92
- Lambrew, Jeanne M., Associate Professor, George Washington University 63
- McClellan, Mark, Member, Council of Economic Advisers 27
- Neuman, Patricia, Vice President, Kaiser Family Foundation, Director of Kaiser's Medicare Policy Project 78
- Tyler, Brian, Senior Vice President for Business Development and Strategy, McKesson Corporation 96

Material submitted for the record by:
- Braun, Beatrice, Board of Directors, American Association of Retired Persons, responses for the record 136
- Fuller, Craig, President and CEO, National Association of Chain Drug Stores, responses for the record 123
- Infectious Diseases Society of America, prepared statement of 120
- Lambrew, Jeanne M., Associate Professor, George Washington University, responses for the record 132
- Neuman, Patricia, Vice President, Kaiser Family Foundation, Director of Kaiser's Medicare Policy Project, responses for the record 128
- Rector, John M., Senior Vice President Government Affairs and General Counsel, National Community Pharmacists Association, prepared statement of 114
- Tyler, Brian, Senior Vice President for Business Development and Strategy, McKesson Corporation, responses for the record 126

CREATING A MEDICARE PRESCRIPTION DRUG BENEFIT: ASSESSING EFFORTS TO HELP AMERICA'S LOW-INCOME SENIORS

WEDNESDAY, APRIL 17, 2002

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, Barton, Deal, Burr, Whitfield, Ganske, Norwood, Cubin, Pickering, Bryant, Buyer, Pitts, Brown, Waxman, Strickland, Barrett, Capps, Pallone, Deutsch, Eshoo, Stupak, Engel, Wynn, Green, and Dingell (ex officio).

Also present: Representative Gordon.

Staff present: Chuck Clapton, majority counsel; Steven Tilton, health policy coordinator; Eugenia Edwards, legislative clerk; Amy Hall, minority professional staff; Bridgett Taylor, minority professional staff; Karen Folk, minority professional staff.

Mr. BILIRAKIS. Good morning. I now call to order this hearing of the Health Subcommittee, and would like to start by welcoming our witnesses and all of the subcommittee members. I would also like to thank our witnesses for taking the time to appear before the subcommittee today. I am sure your testimony will prove valuable as we consider how best to provide our Nation's Medicare beneficiaries with an affordable comprehensive prescription drug benefit. Moreover, I appreciate those of you in the audience for attending today's hearing. I know that you had a choice this morning to view a similar topic.

On that point, I would like to reiterate that we are working jointly with our colleagues on the Ways and Means Committee to develop a comprehensive Medicare bill. I believe it is best for our committees to work together and develop a common package for the House to consider.

We took this approach, if you will recall, on developing our Medicare Regulatory Relief Bill, which seems to be stuck in the Senate, and it proved very effective with the bill passing on the floor by a vote of 408 to zero.

Prescription drugs serve as a vital component in the practice of medicine today, and it is unconscionable that our current Medicare program does not include this benefit. Millions of Medicare bene-

ficiaries are finding it increasingly difficult to pay for their prescription drugs because they lack adequate drug coverage. Finding some way to help seniors pay for their drug coverage is a top priority not only for me, but I daresay for this entire committee. However, we must do so in a way that protects and strengthens Medicare and does not bankrupt this very vital program.

I firmly believe that one of the greatest legacies we can leave for future generations is a Medicare program that is on sound financial footing, and that is why I would like to think that we are all determined to protect the long-term solvency of Medicare.

We are also determined to provide our Medicare beneficiaries with a comprehensive prescription drug benefit that they can afford. Such a benefit would preserve individual choice without putting an excessive financial strain on the program. We will continue working to ensure that this vision becomes a reality as soon as possible.

I also believe that limited Federal resources should be targeted toward areas where they will have the greatest impact. There are millions of Americans who are suffering now, and as we consider how to develop a comprehensive prescription drug benefit I believe that we should focus some of our attention on strategies that will best help our poorest and sickest Medicare beneficiaries.

It is important to examine innovative ways to help vulnerable seniors within the context of a comprehensive benefit, and that is why I called today's hearing.

I would like again to offer a warm welcome to all of our panelists and to thank them for their time and effort in joining us, and now recognize ranking member, Mr. Brown, for an opening statement.

Mr. BROWN. Thank you, Mr. Chairman. I first point out that in light of the tax cut that Congress passed last year, I am glad that we can still afford to spend money on ourselves in this nice, new committee hearing room.

Mr. Chairman, I understand the title of this hearing is Creating a Medicare Prescription Drug Benefit: Assessing Efforts to Help America's Low-Income Seniors. I have read the testimony of our witnesses, and there clearly are lessons to be learned from these programs.

Michael Hillerby's testimony, for example, discusses how Nevada addressed risk selection and other obstacles to maximize participation in the program. Notably, Nevada's program evolved from two plans which proved confusing for beneficiaries, as we remember from a year or so ago, to a single plan. Nevada also found that the cost-sharing burden needed to be modest to attract enrollees and prevent risk selection.

Finally, based on written testimony in the Nevada plan submitted by State Assemblywoman Barbara Buckley, who testified here earlier, the decision to use a private insurer rather than directly administer the program has increased the State's cost significantly. Milliman and Robertson estimated the State could operate senior Rx in Nevada for $54 per member per month. The State is paying a private insurer, however, $81 per member per month to deliver the same benefit. Government simply does it better than the private sector, a single plan which could be administered at a lower cost by the government with modest cost-sharing. I don't

know about you, but to me that sounds a lot like Medicare Part B. It is something we should think about.

Congress should also take note of State efforts to achieve lower prices for prescription drugs. When it comes to making the prescription drug market more competitive, the States have been forced to do the heavy lifting on behalf of low-income seniors and all Americans. States are suing the drug industry for anti-competitive behavior and lobbying Congress about the Gap Bill. Joanne Emerson and I introduced the Gap Bill to close legal loopholes that drug companies consistently and persistently use to keep generics off the market.

Timely access to generic drugs can save consumers and third-party payers literally billions of dollars, but just as the States can't shoulder our responsibility when it comes to prescription drug coverage, they cannot do our work for us when it comes to prescription drug competition. Drug companies exploit Federal laws to block timely access to generics. It is going to take Federal action to stop them.

If Congress wants to provide meaningful assistance to the States without diverting finite resources away from a drug benefit for all seniors, we should take action on the Gap Bill. Note, I said "all seniors." The title of this hearing could be interpreted to mean we are looking for guidance on federally finance Stop-Gap measures like those in the President's Budget. I won't be party to that.

Low-income assistance, whether it takes the form of Medicaid or the form of State drug assistance programs or the much talked about discount card is a symptom of the problem, not a temporary or permanent solution to it. Of those seniors who lack drug coverage, 70 percent are above 150 percent of poverty—70 percent. Do we think those seniors are crying "wolf" when they say they need prescription drug coverage? Should we wait until prescription drug expenses push them into poverty before taking action? I refuse to minimize, much less ignore, the plight of those seniors, and I won't cater to the notion that we can't add a drug benefit to Medicare quickly so we must start with low-income assistance. That is a manufactured problem. We, to be sure, could add Medicare drug coverage—or drug coverage to the Medicare benefits package, and we could do it soon.

The inevitable delays are actually discretionary on the part of the administration and the part of Congress. The President and Congress do not have to tether prescription drug coverage to Medicare privatization. We don't have to force seniors into Medicare or into private drug plans, as my colleagues on the other side of the aisle have proposed, nor do we have to condition seniors' access to prescription drug coverage on their willingness to accept wholesale changes in the Medicare program, which is the position the President has taken.

The President and Congress could prioritize prescription drug coverage ahead of additional tax cuts. We have that choice. This body could, this body should, discard the ulterior motives, put its money where its mouth is, and add prescription drug coverage to the Medicare benefits package.

Mr. Chairman, that concludes my remarks. I would like to ask unanimous consent that anybody's statement, including Mr. Dingell's, be admitted into the record.

Mr. BILIRAKIS. Without objection, that will be the case. The Chair now recognizes Mr. Norwood for an opening statement.

Mr. NORWOOD. Thank you, Mr. Chairman, and thank you for holding this very important hearing. I am going to be brief so we can get right down to business and get down to our witnesses.

I believe there are two critical issues that motivate our concern about seniors and prescription drugs. One is that seniors need the security of knowing that the cost of prescription drugs will not bankrupt them as they become severely ill. That is why we should make Stop-Loss coverage a critical component of any prescription drug package.

The second critical issue is that low-income seniors are very sensitive to the cost of drugs. It doesn't take much before a senior is forced to decide between medications or food. Any prescription drug package must include comprehensive coverage for low-income seniors. That is why today's hearing is so very important.

While we can all agree that providing a benefit for low-income seniors is essential, we are far from consensus on how we should go about doing that.

I am particularly interested in Doug McClellan's testimony on the President's approach and how it will affect the State's ability to pay for Medicaid. I am also interested in Ms. Braun's testimony on the AARP position. I have my concerns about the direction the AARP is taking. Apparently, you all think that we just simply have a trillion dollars lying around to spend particularly at this time where Homeland Security is so important and our Nation is at war. I am hoping this testimony is going to make me feel a lot better about that.

I look forward, Mr. Chairman, to our witnesses' testimony, and I will yield back the balance of my time.

Mr. BILIRAKIS. The Chair thanks the gentleman, and I will recognize Mr. Pallone for an opening statement.

Mr. PALLONE. Thank you, Mr. Chairman. Mr. Chairman, I must start out by saying that I disagree with the basic notion of today's hearing, that we should address prescription drugs in the context of low-income people somehow separately from everyone else. I think it goes against the fundamental principle of Medicare as a guaranteed benefit which should be universal.

So, I think we should be talking about a Medicare prescription drug benefit that everyone has, that is guaranteed, and is not based on income. I think if you dwell on the low-income issue, you are basically, in a political sense, taking away from the larger issue. You are somehow giving the impression that if we address low-income seniors that that is okay, and that the rest of the seniors don't necessarily need to have a benefit.

I am also concerned about the fact that I don't hear any statement on the part of the Republicans or the President addressing the cost issue. Ultimately, we have to address the issue of cost and pricing and, frankly, that is something that not only would help seniors, but would help everyone, that we don't want prescription

drugs to get so unaffordable that people simply don't have access to them anymore.

And in that context, I do want to mention generics as well. I think that it is quite clear that low-cost, quality generic drugs will help pay for benefits and lower the overall cost. There was a Brandeis University study that came out within the last couple of months that shows very dramatically that you can bring down costs considerably by using prescription drugs. And in that context, we also need to address the legislation, as our ranking member said, to end the tactics the brand industry uses to delay generic competition.

Now, there are two proposals that have been put forward by the Bush Administration, and I think they are hardly adequate, with regard to low-income beneficiaries as well. One is the $77 billion offered to provide a low-income benefit pursuant—I guess for seniors that did not qualify for Medicaid—but this $77 billion would only cover 3 million of the nearly 40 million Medicare beneficiaries, and there is no guarantee that the proposed benefit would provide significant prescription drug purchasing relief, the other 37 million Medicare beneficiaries struggle to pay for increasingly expensive drugs. This attempt at proposing a low-income drug benefit is, I think, a political attempt to avoid fulfilling the President's promise to provide decent health care to all seniors, regardless of their income situation.

The administration's other proposal is, of course, the drug discount card, and I think that one is totally a sham because a number of individual companies like Merck and newly formed coalitions of drug companies already offer these kind of drug cards. I think those existing programs make the Bush proposal redundant, a sort of bandaid approach to solving the high cost of prescription drugs.

The National Association of Chain Drug Stores and other groups representing pharmacies have already filed suit against the administration because the proposal places an unfair burden on pharmacies. The plan would require drug stores to lower their prices, but stores may not necessarily see a reduction in wholesale prices.

So, basically, what I see here are two administration proposals—one to try to basically carve out low-income seniors, which I think takes away from the goal here of universal coverage that won't work, and the second one is the drug discount card which is essentially a sham.

Let us get back to the real issue, a universal benefit for all Medicare beneficiaries. Thank you, Mr. Chairman.

[The prepared statement of Hon. Frank Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. Chairman, thank you for holding this hearing on prescription drugs for low-income Medicare beneficiaries.

I commend you for addressing the needs of low-income seniors throughout the nation, and although I do agree that low-income seniors should receive extra assistance with prescription drug premiums and cost sharing, nevertheless, I think it is the responsibility of this Subcommittee to discuss and propose a universal prescription drug benefit.

The only two proposals that have been put forth by the administration are hardly adequate and in fact, have not convinced me that even low-income beneficiaries will receive appropriate prescription drug coverage. The two proposals that I am aware

of are: 1) $77 million in funding to states for drug-only coverage for low-income seniors that do not qualify for Medicaid and 2) A Medicare prescription drug card that would provide discounts on drugs.

The $77 billion offered in the proposal is grossly inadequate to provide prescription drug coverage for seniors. This amount would only cover 3 million of the nearly 40 million Medicare beneficiaries, and there is no guarantee that the proposed benefit would provide significant prescription drug purchasing relief. The other 37 million Medicare beneficiaries struggle to pay for increasingly expensive drugs as well. This attempt at proposing a low-income drug benefit is clearly a political attempt to avoid fulfilling a promise to provide decent health care to seniors.

The administration's other proposal builds on the proposed Medicare prescription drug card to supposedly give seniors access to drug discounts of 10 to 25 percent, by quickly putting in place the structure for a Medicare drug benefit that uses the best features of private drug benefits to get lower prices from drug manufacturers.

The plan is a sham because a number of individual companies, like Merck-Medco, and newly formed coalitions of drug companies already offer similar programs. This makes the offer by Bush a redundant discount and a band-aid approach to solving the high cost of prescription drugs, which is the biggest health crisis facing America's seniors.

The National Association of Chain Drug Stores and other groups representing pharmacies have already filed suit against the administration because the proposal places an unfair burden on pharmacies. The plan would require drugstores to lower their prices, but stores may not necessarily see a reduction in wholesale prices.

What we need to accomplish for our seniors is a prescription drug benefit that is defined, guaranteed, voluntary, affordable and accessible to all beneficiaries and part of the Medicare program. Democrats have been advocating for this type of a prescription drug benefit for Medicare beneficiaries. It is now time for Republicans put aside their substandard proposals, put aside their attempts at privatizing Medicare and pay attention to the needs of all Medicare beneficiaries.

Mr. BILIRAKIS. The Chair would recognize Mr. Whitfield for an opening statement.

Mr. WHITFIELD. Mr. Chairman, thank you very much, and of course this hearing is one of the more important hearings we are going to be having, and this subject matter I think is a priority for all Members of Congress today.

Those of us who represent rural areas particularly are aware of the needs of our senior citizens for a prescription drug benefit. Fifty percent of all beneficiaries living in rural areas lack drug coverage compared to 34 percent in metropolitan areas.

As you remember, the House passed a prescription drug benefit last year, and the Senate did not act on it. And I am convinced that the House will pass another prescription drug benefit this year, and I hope that the Senate will act on that.

Mr. Norwood mentioned the fact that there are so many different plans out there that it is difficult to come up with a consensus to move forward. We have plans ranging in cost from $70-75 billion a year up to $750 billion over a 10-year period, and I think that we do have to be responsible in moving forward, and we may not be able to come up with a Cadillac plan this year because we do not want to jeopardize the entire Medicare program with the cost of these programs.

We have been criticized on the Republican side for reducing taxes and trying to move for a permanent tax reduction, but I think there is a large segment of people in America today, particularly young people with children, who want to help their senior citizens on Medicare have a prescription drug benefit, and they are willing to pay their payroll taxes to do that.

They are also paying taxes so that those people in low-incomes, $20,000-or-so and below, receive their health care from Medicaid,

and prescription drugs from Medicaid, but many of these people in the middle range—they are not on Medicare, they are not on Medicaid—they cannot afford health care for themselves and their families, while at the same time paying for prescription drugs for seniors and those in low-income.

So, I am convinced that we have the ability to come up with a meaningful prescription drug benefit for our senior citizens while at the same time not bankrupting those in the middle areas. I am convinced that the House will have a meaningful prescription drug benefit, and I am anxious to work with our fellow members on the other side of the aisle in coming up with a constructive plan that is affordable, that is meaningful, that can make a difference in the lives of seniors.

I yield back the balance of my time.

Mr. BILIRAKIS. Mr. Stupak.

Mr. STUPAK. Thank you, Mr. Chairman, and thank you for holding this hearing. Mr. Chairman, year after year we have held hearings on prescription drug benefits for seniors. Year after year we have had many of the same witnesses who appear before us today say the same thing. All of them emphasize the need for a prescription drug benefit, yet year after year we have done nothing. That is because year after year we argue about what form this benefit will take.

We have in front of us today witnesses who will testify as to the various forms this benefit should take. I am concerned in particular with one proposal, that of a prescription drug card. Various prescription drug cards are already out there. Some of these cards are no solution at all.

One of them, entitled the National Prescription Health Plan, works this way: One of my constituents came up to me at a town hall meeting over Easter break, in Dollar Bay, Michigan, took out his card, told me that he paid a premium for it, and went to the local pharmacist when they had to refill two of their prescriptions. According to this card, they would save 30 to 35 percent. Using the National Prescription Health Plan, they saved 12 cents on one of their prescriptions, Combivent. The other prescription, Diltiazem, is actually a generic. But by using their National Prescription Health Plan, the price, by using the card, actually doubled. The cost of the generic high blood pressure medication jumped from $47.49 without the card, to $81.43 with the card. This makes me doubt the wisdom of this card. It is just another way for some pharmaceutical companies to game the system.

If pharmaceutical benefit managers can steer consumers to one drug and charge exorbitant fees for another, how does this really help the consumer?

I am a co-sponsor of Tom Allen's prescription drug bill, H.R. 1400, which would hold the cost down to the average of the prices paid by consumers in other foreign countries like Canada and Mexico. Perhaps it is time for Congress to consider cost-control measures. Last year, the average pharmaceutical prescription drugs rose approximately 18 percent for the third year in a row of high, double-digit inflation on prescription drugs.

I believe it is time for health care and prescription drug benefit for all Americans. I look forward to hearing testimony from our

witnesses today, Mr. Chairman. I look forward to working with you in the future on this issue. Thank you.

[The prepared statement of Hon. Bart Stupak follows:]

PREPARED STATEMENT OF HON. BART STUPAK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Thank you, Mr. Chairman, and thank you for holding this hearing.

Year after year we've held hearings on a prescription drug benefit for seniors.

Year after year we've had the same witnesses in front of us, saying the same thing.

All of them emphasize the need for a prescription drug benefit.

We all realize the need for a prescription drug benefit.

Yet year after year we've done nothing.

That's because year after year we argue about what form this benefit will take.

We have in front of us today witnesses who will testify as to the various forms this benefit should take.

I am concerned in particular with one proposal, that of a prescription drug card.

Various prescription drug cards are already out there.

Some of these cards are no solution at all. One of them, entitled the National Prescription Health Plan, works this way.

One of my constituents in Dollar Bay Michigan, took this card—which they paid a premium for—to their local pharmacist when they refilled two of their prescriptions.

Using this card, they saved 12 cents on one of their prescriptions. 12 cents.

The other prescription—if you can believe this—actually DOUBLED in price using this card.

The cost of a generic high blood pressure medication jumped from $41 to $81.

This makes me doubt the wisdom of a drug card.

If pharmaceutical benefit managers can steer consumers to one drug by charging exorbitant fees for another, how does that help a consumer?

I am a co-sponsor of Tom Allen of Maine's prescription drug bill, H.R. 1400, which would hold costs down to the average of prices paid by consumers in selected foreign nations.

Perhaps it is time for Congress to consider cost control measures.

Thank you Mr. Chairman, and I look forward to the testimony of today's witnesses.

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

Ms. CUBIN. Thank you, Mr. Chairman. Congress has every intent of drafting a prescription drug benefit under Medicare and make no mistake about it, we will get it done. I would like to remind everyone that the House of Representatives passed a prescription drug program before. It did not pass in the Senate, but to suggest that the House isn't working on it in a sincere way to get a plan passed for the most needy seniors certainly is wrong.

The problem we face at present is how to get some relief to seniors right now, as they face costs that continue to rise. This hearing will give us a good indication of the progress we are making with temporary prescription drug remedies, such as discount drug cards and expanding Medicaid programs.

There are a number of drug cards in the pipeline that are designed to help those seniors who have the highest of drug costs, while at the same time very low incomes. I truly applaud the collaborative effort of so many in the private sector to work together to implement these drug cards at a time when very much is needed.

I represent the State of Wyoming which is very, very rural. Seniors in my State not only need help with their drug costs, but they need help in accessing health care, period. For those who of you

who are not familiar with Wyoming, the State goes beyond what is commonly known as "rural status" to something called "frontier status," having a population density of less than six people per square mile. In fact, 22 of Wyoming's 23 counties have this "frontier" designation. Wyoming relies almost exclusively on three health insurers in the State, and that is it—three. We have no other choices. There are no Medicare+Choice plans which traditionally offer drug coverage, and the State's Medicaid Pharmacy Program is buckling from the weight of increased utilization and higher drug costs. For example, expenditures for prescription medication in Wyoming Medicaid Pharmacy Program have almost doubled between 1996 and 2000, from $13.3 million to $25.3 million. That is a staggering amount of money in a State that has only 490,000 people.

I am also very receptive to any drug proposal that can offer some help in the interim to seniors. This committee will continue to work to enact a comprehensive prescription drug benefit program under Medicare, but in the meantime we should continue to entertain proposals put forth by those in the private sector to take care of those seniors who are the most needy.

I am anxious to learn more from our witnesses today, and with that, Mr. Chairman, I yield back the balance of my time.

[The prepared statement of Hon. Barbara Cubin follows:]

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

Thank you, Mr. Chairman.

Congress has every intent of drafting a prescription drug benefit under Medicare, and make no mistake about it we will get it done.

The problem we face at present is how to get some relief to seniors right now as they face drug costs that continue to rise.

This hearing will give us a good indication of the progress we are making with temporary prescription drug remedies, such as discount drug cards and expanding Medicaid programs.

There are a number of drug cards in the pipeline that are designed to help those seniors who have the highest of drug costs while at the same time very low incomes.

I applaud the collaborative effort of so many in the private sector to work together to implement these drug cards, at a time when it is very much needed.

I represent the State of Wyoming, which is very rural. Seniors in my state not only need help with their drug costs, but they need help in accessing health care period.

For those of you not familiar with Wyoming, the state goes beyond what is commonly known as "rural" status to something called "

lation density of less than 6 people per square mile.

In 23 to 22 of Wyoming's 23 c., excep-

ee health insurers in the state, and that

ich traditionally offer drug coverage, and
1 -m the weight of increased uti-

ation in the WY Medicaid Phar-
and 2000, 1 -m 13.3 million to

0 sq. miles and 490,000 people.
t can offer some help in the in-

act a comprehensive prescription
we should continue to entertain
am anxious to learn more 1 -m
eld back the balance of my time.

Mr. BILIRAKIS. The Chair thanks the gentlelady. Mr. Wynn, for an opening statement. The Chair apologizes to Mr. Wynn, he should have been called much earlier.

Mr. WYNN. Thank you, Mr. Chairman. Certainly, no apology needed. I want to applaud you for calling this hearing. I think it is certainly very important. But I also want to join the chorus that is calling for a universal prescription drug benefit, a Medicare-type benefit.

The fact of the matter is that over 50 percent of the beneficiaries have incomes above 175 percent of poverty, which is to say middle-class and working-class seniors who worked and saved all of their lives are not being covered by the prescription drug benefit that the Republican side is discussing. And I don't think that that's fair. They shouldn't have to compromise the quality of their lives because of the high cost of prescription drugs.

Seniors suffer from heart disease, cancer, diabetes—you could name a wide range of illnesses—are basically having their lifestyle gouged because of the high cost of prescription drugs.

I note that the President is budgeting about $270 billion for prescription drug coverage whereas a universal plan would cost about $700 billion. I also note that this week we are poised to make permanent tax cuts that basically benefit the very wealthy, again leaving middle-class and working-class seniors without a prescription drug plan.

I think this is a worthy cause, this is an important issue, and we ought to be working toward a universal plan to cover all seniors. I relinquish the balance of my time.

Mr. BILIRAKIS. Mr. Burr for an opening statement.

Mr. BURR. I thank you, Mr. Chairman. I think most members of this committee would agree that in 1965 when Medicare was created, prescription drugs were not part of any health care plan. So it is not unusual to believe that at some point we would have a debate as to whether prescription drugs would become part of the seniors health plan in America. I think some may question why it has taken us so long to reach the point that we have, and it is because there are varying suggestions on how we get there, the scope of the benefit.

In the end, it is this committee, Ways and Means, ultimately this Congress, who will be challenged to make sure that the benefit is what seniors need and, as importantly, that our children can afford it. We do absolutely no good if we design a benefit that 10 years from now we find America can't pay for and, therefore, we revert to some of the things we've already tried in health care, which is to just continue to cut what we are willing to reimburse for the program.

I want to welcome all of our witnesses today. I think this is a valuable hearing, Mr. Chairman. I think that the benefit is needed. It is needed because, in fact, we have got to come up with a plan that is accessible, affordable and, more importantly, voluntary. It has got to incorporate the right incentives for employers that currently offer prescription drugs as a retirement benefit to stay in the business of supplying prescription drugs as a retirement benefit. It will challenge every bit of creativity that we can come up with, but I have got to go back to where I started.

If, in the end, we haven't designed something that our children can afford, then this Congress will have made a grave mistake. I look forward to the witnesses today, Mr. Chairman, and the questions that will be asked by this committee, and I yield.

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

Ms. CAPPS. Thank you, Mr. Chairman, and I want first to acknowledge the presence in our hearing room of 14 high school students from Santa Barbara, California, who are here in Washington, DC for the Washington Institute for Jewish Leadership and Values, with their Rabbi. And the fact that they are here, having traveled clear across the country from the central coast of California for this hearing on Medicare indicates to me the seriousness of this topic and the importance of it as well, importance of it in my congressional district when I go back on weekends to hold office hours, meet with senior and health groups, even if I am just walking down the street or in the grocery store, this is the issue that my constituents are talking with me about. It has not been on the front page of newspapers recently, or the lead story on the evening news, but it is foremost in the minds of my constituents. And I would note that in this morning's Washington Post, David Broder has a column called "Health Care in a death cycle," in which he is referring to a related issue, the staggering increases in insurance premiums. So, seniors ask me when Medicare is going to cover their medicine. Younger men and women ask when their parents are going to be able to get help from the government. This is the issue that consumes their thoughts and causes their deepest worries. This is what people on a fixed income and whose lives are—and all of our lives—are dependent upon an always improving prescription drugs. And because medical advances that are understanding of aging and new miracle drugs, because of all these advances, their lives have been extended far beyond what they expected and prepared for. These increased medical costs, particularly the rapid growth in prescription drug costs, are spiraling beyond the ability of any of them to pay for. Almost all of them are falling into this category.

Projections by the CBO give us information that seniors will spend $1.8 trillion over the next 10 years on prescription drugs not covered by Medicare. It is mind-boggling. We can't expect this to continue. That is why we are in agreement, we need to have a prescription drug benefit quickly dealt with.

But I have, along with others, serious concerns about the proposals put by the President. His recommendation would only help the poorest seniors, and that is what the topic of our hearing is today. This leaves out millions of our parents and grandparents facing the same kind of choices about whether to take their medicine or to pay for their other basic expenses.

I am also concerned about using a Federal matching system that would give seniors in different parts of the country different benefits with different cost-sharing. I am skeptical of approaches using private insurers to provide this benefit, as has been suggested by some.

Medicare was established because the private insurance system could not provide health care to seniors in a way they could afford

simply because it isn't good business for these older people. As we have experimented with privatization in the Medicare+Chose program, it has shown us the little success that we can expect. Since the program's inception, 2 million seniors have been dropped from their Medicare HMOs. Medicare+Choice is popular in my district primarily because of the prescription drug benefit it offers, but as the HMOs pull out, as cost-sharing increases, and as the very benefits they want are cut, seniors are losing patience.

Medicare is meant to help seniors get the care they need that private insurance won't provide, and now, as we update the standards of that care, I think it is important that we avoid making the mistakes of the past. We need to deliver a prescription drug benefit, Mr. Chairman. That benefit needs to be a standard benefit that they can count on no matter where they live or how much money they have.

I appreciate the opportunity to hear from out witnesses on this subject, and I look forward to working with you on the solution to these problems. I yield back.

[The prepared statement of Hon. Lois Capps follows:]

PREPARED STATEMENT OF HON. LOIS CAPPS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman, the single most important issue to the seniors in my district is a Prescription Drug Benefit.

When I return to my district, hold office hours, meet with senior and health groups, even when I am just walking down the street, this is the issue they talk to me about.

While this issue has not been on the front page of the newspapers recently, or the lead story on the evening news, it is foremost in the minds of my constituents.

Seniors ask me when Medicare will cover their medicines. Younger men and women ask when their parents will be able to get help from the government.

This is the issue that consumes their thoughts and causes their deepest worries.

This is about people who are on a fixed income and whose lives and quality of life are dependent on always improving prescription drugs.

And because medical advances, better understanding of aging, and new miracle drugs their lives have been extended far beyond what they expected and prepared for.

The increased medical costs, particularly the rapid growth in prescription drug costs are spiraling beyond their ability to pay.

According to projections by the Congressional Budget Office seniors will spend $1.8 trillion over the next ten years on prescription drugs not covered by Medicare.

This is mind-boggling. We cannot expect seniors who have to limit their spending to foot the bill without help.

That is why I think all of us are in agreement that we need to pass a prescription drug benefit quickly.

But I have serious concerns about the proposals put forward by the President and others. His recommendation would only help the poorest seniors and leave millions of our parents and grandparents facing choices medicine and other basic expenses.

I am also concerned about using a federal matching system that could give seniors in different parts of the country different benefits with different cost sharing.

And I am skeptical of any approach using private insurers to provide this benefit, as has been suggested by some.

Medicare was established because the private insurance system could not provide health care to seniors in a way they could afford, simply because it was not good business.

And we have experimented with privatization in the Medicare + Choice program, but with little success.

Since the program's inception 2 million seniors have been dropped from their Medicare HMOs.

Medicare+Choice is popular in my district because of the prescription drug benefit it offers. But as the HMOs pull out, as the cost-sharing increases, and as the very benefits they want are cut they are losing patience.

Medicare is meant to help seniors get the care they need that private insurance won't provide. And now, as we update the standard of that care, I think it is important that we avoid making the mistakes of the past.

We need to deliver a prescription drug benefit, Mr. Chairman, and that benefit needs to be a standard benefit that they can count on no matter where they live or how much money they have.

I appreciate this opportunity to hear from our witnesses on this subject and I look forward to working with you on a solution to these problems.

Mr. BILIRAKIS. The Chair thanks the gentlelady, and would like to welcome the young group from Santa Barbara on behalf of the entire committee.

Mr. Buyer for an opening statement.

Mr. BUYER. Mr. Chairman, I will be brief. I love living in America, a place where it is okay to dream big, a place where individuals embrace freedom, innovation, initiative, where we take the great minds of not only our own country but that come from all over the world to be here so that here in America we can push the bounds in human health, of science, biology, engineering, physics, into a realm where Mother Nature has never been. There have been great benefits to our society. Who wouldn't want access to all of those "benefits" that come?

Then the question about access is "who pays"? As I sat here and listened to some of my colleagues this morning, it is sort of "gee, let's just give everybody"—and you get the sense that it is "something for nothing." It is not.

I am anxious to hear from our witnesses, whether it is from the AARP or whomever, about what are the cost implications. Just as equally, what are the cost-shifting implications of what we are even proposing?

So, my bottom line is—I am going to yield back—whatever we do, I don't want anything to ever have a chilling impact upon a great country that I love, and that can deliver medicine that has a great benefit not only to us, but under the world that is jealous about what we have. I yield back.

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

Ms. ESHOO. Thank you, Mr. Chairman, for holding this hearing. It is an important one. It is not the first time we are discussing the issue. I think that everyone understands that we are not debating whether we should have a policy that guides us in offering a Medicare prescription drug benefit, the debate is over how. And I think that it is important to just give some ground truth on this thing.

We all say that we are for it, and we are because we know what the needs of our people are at home. They tell us every week when we go back to our congressional districts.

There is really a chasm between the Republican Party and the Democratic Party on this, and it really goes to the core of our views on how or what the government can and should do. This debate about only doing part of this—only doing part of this—I would like to pose this question. If, in fact, you are only going to offer a benefit that touches a handful of beneficiaries that are in the system, why don't you repeal Part A and Part B? Why don't you rewrite that and bring the same principle that is being offered today by the

administration and by my Republican colleagues, because that is really what you are talking about.

I have heard members say here in this committee that to offer a universal benefit is the equivalent of reparations for the elderly. Come on. Come on. This week we are going to vote on making permanent—making permanent—the 10-year tax cut. In the second 5 years of the 10-year plan, we will put permanently into the Tax Code $4 trillion for that tax cut. I am for some tax cuts. I come from a place where people like them. Most frankly, every American likes a tax cut. But, you know, you really have to put—this is on its head. We are saying that we can't afford it. We are saying that it only should have parentheses around it. We are saying we can't do a Cadillac plan. It is all of this driving with an emergency brake on.

I venture to say that if you are for something in Medicare, that you stick with the Medicare program. It is what people embrace. It is what they use. It is their insurance plan. And if you are not committed to that, the rest of it is just tinkering around the edges. And some of you may be surprised for me to come our really swinging as hard as I am on this, but what good is a plan if it isn't universal?

Do people in the next bracket in terms of fixed income not ever get sick? Come on. We are not protected that way. If a senior has a $20,000 a year income, you mean they can't get any coverage through Medicare?

I think the real test is, are you for A and B? If not, you know what? Repeal it. That is universal. One of it is voluntary. I support a voluntary participation in this.

I offered something legislatively that had competition in it. Republicans didn't come on it. Most frankly, Democrats didn't like it too much either. But it did meld both public and private. But this business of only doing a slice of this and saying we are for it but we can't afford it, when this massive issue is going to come to the floor and it will pass—it will pass—I think that we can do some tax cuts, but I want to tell you something, I really think that we should all go home and collectively hang our heads in shame if we can't and don't do this.

We are the greatest Nation on the face of this earth, and there is more than one national security here. Hubert Humphrey said that a Nation is measured on how it cares for those that are in the autumn of their lives as well as those that are in the spring of their lives. And you know what? Those words still stand. That is not just a bunch of junk. That is not a thought from the past.

We are kidding ourselves when we say we are going to breach this gap. There is a huge difference—and I respect my colleagues that view it a different way—but let us just call it for what it is. We are not going to offer something to seniors in this country with what is being promulgated. It is not even a half-baked plan.

So, you can tell that I am frustrated and I am a little angry, a little ticked off. I commend all those that are trying with the bandaids, the private sector, the drug companies to come up with cards and all that, the President's intentions are good, but you know what—they miss the mark. It is not enough.

We can do this without damaging the rest of our economy. We have to have the political will to do it. That is what is lacking here. That is the prescription that is lacking. Thank you, Mr. Chairman.

Mr. BILIRAKIS. The Chair thanks you. Mr. Pitts for an opening statement.

Mr. PITTS. Thank you, Mr. Chairman for holding this important hearing today. The series of hearings that this committee have been very helpful in getting an overview of the program and how we should craft a prescription drug provision, and we all owe our gratitude to the Chairman for his aggressive leadership on this important issue. I will be brief.

Almost daily we hear of new breakthrough treatments industry has developed to combat diseases, and I am hopeful that this committee will ensure that patients in need of these lifesaving treatments have access to them, and I am supportive of forming some sort of public-private partnership to make this happen.

Mr. Chairman, I will submit my entire statement for the record, but I look forward to working with you to strengthen, and modernize the Medicare program, and appreciate the opportunity to hear from our witnesses on this subject today. I yield back the balance of my time.

[The prepared statement of Hon. Joseph R. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Thank you, Mr. Chairman, for holding this important hearing today. I have appreciated the series of hearings this committee has held on this issue. The hearings have been very helpful to me in getting an overview of the program and how we should craft a prescription drug provision.

We all owe our gratitude to the Chairman for his aggressive leadership on this important issue.

I along with many of us here, have family members who are eligible for Medicare. And historically, Pennsylvania has one of the highest senior populations in the nation. For these reasons, it has become increasingly clear to me that Congress needs to modernize Medicare and bring the Program into the 21st Century as soon as possible.

I have a strong interest in ensuring we address the needs of our growing population senior population.

As you know, according to a recent Medicare Trustees Report, in the year 2030, there will be double the amount of beneficiaries than we have today. Conversely, the number of workers paying into the Medicare program will only increase by 15 percent. That is why, as we attempt to modernize the Medicare benefits package, we must also make necessary reforms to ensure the sustainability of the program.

Mr. Chairman, almost daily we hear of new breakthrough treatments industry has developed to combat diseases. I am hopeful that this committee will ensure that patients in need of these life saving treatments have access to them. I am supportive of forming some sort of public-private partnership to make this happen.

Mr. Chairman, I look forward to working with you to strengthen and modernize the Medicare program and to provide a quality, affordable and voluntary prescription drug plan.

I look forward to hearing from our witnesses and I yield back the balance of my time.

Mr. BILIRAKIS. I thank you, sir. Mr. Waxman for an opening statement.

Mr. WAXMAN. Thank you very much, Mr. Chairman. I, too, want to welcome the group from California, before they leave, to tell them how fortunate they are to have such a terrific representative as Congresswoman Capps. And I am reluctant to say anything in my opening statement because I think her statement was so superb

on the whole subject, and they should be proud of our colleague, Anna Eshoo from California, because the passion that she showed about this issue is exactly what I would hope the Congress would do when we look at the fact that so many seniors who were promised protection under the Medicare program have no prescription drug coverage. It would be like having a health insurance program that didn't cover doctor bills, or hospital bills. That would have been unthinkable in 1965. It really is unthinkable now to have a health care insurance plan that doesn't cover prescription drugs.

I have certainly been protecting low-income people. I have spent a great part of my career trying to expand programs for low-income. The coverage of long-term care services and prescription drugs that Medicaid have provided to supplement Medicare for low-income seniors and disabled persons has been absolutely critical in providing them with adequate health insurance, but the situation today demands that we approach coverage more broadly. We need a comprehensive uniformly available drug benefit for all seniors and disabled persons covered by Medicare. Drugs are a critical part of any health coverage plan today. It is not a benefit that can only be provided to a portion of the population. Of course, when a universal benefit is established, we will need to include extra help with cost-sharing and premiums for those without adequate income, just as we do now in the basic Medicare program. We can all expect to do that.

But the point is, real coverage for low- and moderate income people and for all Medicare beneficiaries is going to be best achieved by moving now to put a comprehensive and universal benefit in place, modeled on the way all benefits are provided in Medicare. Any other step will simply delay achievement of our ultimate goal to divert resources to programs that are going to be slow to implement and ultimately ineffective, and fail to meet the promise we made to Medicare seniors and disabled persons.

So, I am looking forward to the hearing today. I will have to be in and out of this hearing because there are conflicts in my schedule, but I would hope that we would have a record that would establish we care about low-income people, but if we are going to have prescription drug coverage, it ought to be for all Medicare beneficiaries. Everyone ought to have the benefit of a prescription drug package. Yield back the balance of my time.

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

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

Mr. Chairman, I am proud of the work I have done throughout my career to help bring health care coverage to low-income people. I have spent many years working to support, improve and extend the Medicaid program, and the coverage it provides to low-income children, families, disabled persons, and seniors.

The coverage of long-term care services and prescription drugs that Medicaid has provided to supplement Medicare for low-income seniors and disabled persons has been absolutely critical in providing them with adequate health care coverage.

But the situation today demands that we approach coverage more broadly. We need a comprehensive, uniformly available drug benefit for all seniors and disabled persons covered by Medicare. Drugs are a critical part of any health coverage plan today. It is not a benefit that can only be provided to a portion of the population.

Of course, when a universal benefit is established, we will need to include extra help with cost-sharing and premiums for those without adequate income, just as we do now in the basic Medicare program. We all expect to do that.

But the point is, real coverage for low and moderate income people, and for all Medicare beneficiaries, is going to be best achieved by moving now to put a comprehensive and universal benefit in place, modeled on the way all benefits are provided in Medicare.

Any other step will simply delay achievement of our ultimate goal, divert resources to programs that are going to be slow to implement and ultimately ineffective, and fail to meet the promise we have made to Medicare seniors and disabled persons.

Mr. BILIRAKIS. I thank the gentleman and now recognize Mr. Barton for an opening statement.

Mr. BARTON. Thank you, Mr. Chairman. It is important that you hold this hearing. This is an important issue. As you know, we are working to put together a package—hopefully a bipartisan package—to present an Energy and Commerce Committee bill for consideration on the floor.

I will say that we need to be cognizant of the fact as we try to put the package together, that we also need to be cognizant of the cost of it. We are talking in numbers of $30-40 billion per year out to infinity, and this is in a year in which we are now expected to have budget deficit. Today's Wall Street Journal talked about the deficits probably going into the middle of this decade. So, I am working with Congressman Sam Johnson, as you well know. One of the alternatives to look at would be some sort of prescription medical savings account program that would give the seniors the option to opt into that, and then they could take that money to purchase any number of private sector or private and public sector backed plans. That is a plan that we hope to have available for people to take a look at in the next week or 2.

But I do appreciate you holding this hearing, and it is good to be in the hearing room. It is the first time I have actually been in the hearing room at a hearing since we had all this high-tech gadgetry. My question would be why you don't have the big screen at the back so we can see you. Chairman Tauzin, when he holds a hearing in here, I am told he has all the screens up and all the cameras focused on him. You are a much more humble man.

Mr. BILIRAKIS. I will not comment. Mr. Deutsch for an opening statement.

Mr. DEUTSCH. Thank you, Mr. Chairman. Having been back at home for the break and interacting with constituents, I can tell you that I don't think there is a more important, more real issue that people are facing, seniors are facing. I experienced it a little bit with my parents over the break as well when I had to fill a prescription for my dad who just had gotten out of the hospital. And this is real. It affects people's lives. And I think that we need to be broader, and I think ultimately we will be broader, and it is just a question of time before Congress catches up with the American people on this issue.

Mr. BILIRAKIS. I thank the gentleman. Dr. Ganske.

Mr. GANSKE. Thank you, Mr. Chairman. I believe that health care issues are going to be important for at least the next decade. We have certainly seen premiums rising for employers significantly. The cost of prescription drugs have gone up a lot to, some say, on an average of 18 percent per year.

I continue to get letters from senior citizens who are having to make decisions on whether to pay their high home heating bills or

buy their prescription drugs, and I believe that we have an opportunity to at least make an important first step this year.

We had $350 billion budgeted for Medicare in our budget. I had an opportunity to speak to President Bush just 2 days ago on this health care issue, and he, too, wants to do something about prescription drugs. But I pointed out to him that in Iowa where we rank 50th out of 50 States in terms of Medicare reimbursement, our small town rural hospitals are going bankrupt, payments to providers are so low that in many cases they are not taking new Medicare patients.

So, I believe that in addition to doing something about prescription drugs, we ought to look at the issue of increasing reimbursement for rural hospitals, for teaching hospitals, and for some other providers, too, because what good will it do my senior citizens in rural Iowa if they now have a very rich prescription drug benefit, but they don't have a hospital or a doctor to go to in their communities?

So, I think we need to look at something of a balanced approach when we are looking at a prescription drug benefit. I believe there is a way to offer help to low-income seniors. There is a way to offer a benefit to other seniors, and there is a way to help with other providers.

I am happy to, Mr. Chairman, work on your task force along with Congresswoman Johnson, in consultation between the Commerce Committees and the Ways and Means Committees, and with the administration, and to see if we can solve some problems. I mean, we need to get past the tired, old, bitter, partisan politics of "fingerpointing." This is just too important an issue to play political games with. And with that, I will yield back.

Mr. BILIRAKIS. Thank you, Dr. Ganske. Mr. Engel for an opening statement.

Mr. ENGEL. Thank you, Mr. Chairman. I look forward to this hearing. I believe there is nothing more significant that we can do to help seniors in this country than pass a meaningful prescription drug program. I speak with seniors all the time, and my mother is the best senior that I speak with, and she said that the best thing Congress can do, in her opinion, is to pass legislation providing for prescription drug help under the Medicare Health Program. I believe that is what this Congress ought to do.

We have danced around this issue for far too long. We talk about discount drug cards, invoking meaningless legislation that provides little or no benefit for seniors, and I believe that we demonstrated gross irresponsibility by cutting taxes to the extent we did when we could have enacted a comprehensive benefit instead.

We can't have it both ways. If we are going to cut back and cut back in taxes and go from a surplus to a deficit, then the truth of the matter is there is no money left for meaningful legislation for prescription drugs for seniors.

So, I think at some point we have to get beyond the rhetoric and the talking and put our money where our mouth is and do something for the senior citizens of this Nation. Providing seniors with affordable access to prescription drugs has been a priority of mine for years. I, like everyone else, have a number of seniors in my district and, again, I think this is their No. 1 concern. Medicare was

created to provide seniors with affordable access to high quality health care. It was enacted to prevent seniors from losing their life-savings when they became sick late in life.

As President Johnson signed the Medicare legislation into law, he said, "No longer will illness crush and destroy the savings seniors have so carefully put away over a lifetime so they might enjoy dignity in their later life." I believe the Medicare program, unfortunately, is no longer achieving that goal. Seniors are forced to spend their life savings on medicines or go without them, and we have heard, and my mother tells me stories of seniors cutting up pills or taking half-doses to save money. That is not high-quality care, and that is not living with dignity.

Congress cannot let this continue. We must enact a comprehensive benefit that will help all seniors—again, not a sham bill, but a comprehensive bill. We will hear testimony today about creating a drug discount card for seniors at 200 percent or 300 percent of poverty, and we will arbitrarily draw a line in the sand saying that these seniors get some help and those seniors don't because they are not yet poor enough. I have so many people in my district who tell me they are just a little bit above the line, they are middle-class, they are working class, they have worked hard all their lives, and yet they are not eligible. That should change.

So, I support helping low-income seniors with their drug costs, but I believe fervently a discount card is not the solution and will only impede efforts to enact a comprehensive benefit. I urge the committee to consider my legislation, H.R. 339, which provides a comprehensive drug benefit for all Medicare beneficiaries.

Again, I believe that with the huge tax cuts that Congress enacted, it really knocked a meaningful prescription drug benefit for seniors out of the box. We ought to right that wrong. Let us not continue to fail to enact a real meaningful prescription drug benefit under Medicare. Let us do it as soon as we can. I thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman. Mr. Deal for an opening statement.

Mr. DEAL. Thank you, Mr. Chairman. Having three senior citizens who reside in my home, two in the upper 80's and one in the middle 90's, I probably make as many runs to the local pharmacy to fill prescriptions as anyone in this room, and I understand the volume and the cost, and I understand the importance of it. But I think there are also some things we need to all keep in mind. All three of these who live in my home are retired school teachers, who have a pretty good prescription drug plan as a part of their retirement package. They don't want to lose that. They don't want the government to take that away from them. And they certainly don't want the government to replace it with something that is not as high a quality or is as good in terms of reimbursement as what they have, and that is certainly a concern.

But I can't help but think that most of us in this room today were here in 1997 when we wrestled with the reality that Medicare was going to go bankrupt as of last year. And anytime that we start talking about adding new programs and new cost factors, I think we have to also ask the hard questions, how and who is going to pay for it? And those are hard questions.

I think we don't need to be unrealistic in a program that we advocate. We need to make sure we can pay for it, and that we don't jeopardize the entire Medicare system in the process.

Just as those three senior citizens who live in my home are concerned about their prescription drugs, by the same token I think they are concerned that their grandchildren not be burdened with a cost factor that cannot be sustained over the long period of time. Obviously, these are not the kind of "promise everything" questions that some people want to talk about, but they are the realities of any program, and certainly one of the magnitude of the one we are talking about.

I thank you, Mr. Chairman, for holding this hearing, it is certainly timely. I yield back the balance of my time.

Mr. BILIRAKIS. Thank you, sir. Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman. Following my Georgia colleague, having a lot of retired district and my wife who will be a retired teacher in a couple of years, your Georgia plan must be better than our retired teachers plan in Texas for prescription drugs.

I appreciate the Chairman for holding this hearing today, and also for Dr. McClellan being here because, again, a prescription drug benefit plan is not something that's new to our committee. We have held these hearings for a number of years.

Prescription drugs are an essential component for our health care system for everyone, but especially for seniors. While seniors make up only 14 percent of our population, they use 43 percent of prescription drugs. In fact, more than 88 percent of Medicare's 39 million beneficiaries use prescription drugs, with the average older American using 18.5 prescriptions annually—18.5. I am happy that I only have two. And so we see that prescription drug costs are important to everyone, including private sector, but we also know that for seniors it is even more important.

Today, 38 percent of the beneficiaries have no insurance under Medicare for prescription drugs, and an additional 25 percent have coverage that is unreliable. In fact, again, I am using my Texas experience on teacher retirement system and health care plan, most of those teachers aren't eligible for Medicare because they never paid in or not qualified for Social Security. So that is also a concern.

The recent report by the Kaiser Family Foundation Health Research Education Trust found that the employer-sponsored health coverage is already eroding. There has been a decline of 43 percent in number of firms offering retiree coverage. So that is why instead of employers not covering retirees, we are already seeing they are eroding it, and Congress hasn't done anything for prescription drugs.

It is time for Congress to adopt a guaranteed Medicare prescription benefit for all seniors. This issue grows more and more urgent every year, especially as the drug costs continue to skyrocket.

According to a recent published survey by the National Institute of Health Care Management, spending on outpatient prescription drugs in retail outlets rose 17.1 percent last year—17.1 percent—$131 billion to $154 billion. 17.1 percent is well above the inflation rate for last year. And can you imagine seniors on a fixed income

having to cover that expense? About half of that increase occurred in the class of drugs that treat depression, high cholesterol, diabetes, arthritis, high blood pressure, and other chronic conditions that disproportionately affect seniors, and not surprising, the top 50 selling drugs accounted for 44 percent of the total outpatient retail drug sales in 2001, and these are also the same drugs that are heavily advertised on television, radio and magazine ads.

Whether or not Congress provides some assistance to low-income beneficiaries, drug costs will continue to be a growing burden for middle income individuals who make up the bulk of the Medicare beneficiaries. Providing assistance only to low-income beneficiaries will not do nearly enough to address the problem.

I know some of our witnesses on the panel today will talk about prescription discount cards that are now available, and I appreciate that. In fact, we are marketing that with my seniors in my own district, both in Spanish and English, saying these are available for seniors, but they usually do only provide some relief for low-income seniors. These programs are a start, and I appreciate the industry doing that, but we have to do much more, but we cannot let it end just at these prescription cards by the private sector. The simple truth is we need a comprehensive voluntary guaranteed benefit for all Medicare beneficiaries. We've been debating this issue too long. We need to actually get it started, even though we may not be able to pay for it this year, we need to get it started so seniors will know that there is some light at the end of the tunnel. I yield back my time.

[The prepared statement of Hon. Gene Green follows:]

PREPARED STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. Chairman, thank you for holding this hearing today on providing a Medicare prescription drug benefit to low-income seniors.

Prescription drugs are an essential component of our health care system, especially for seniors.

While seniors make up only 14% of the U.S. population, they use 43% of all prescription drugs. In fact, more than 88% of Medicare's 39 million beneficiaries use prescription drugs, with the average older American using 18.5 prescriptions annually.

Today, 38% of Medicare beneficiaries have no insurance coverage for prescription drugs. An additional 25% have coverage that is unreliable—inadequate, costly or both.

A recent report by the Kaiser Family Foundation and the Health Research and Educational Trust found that employer sponsored health coverage is eroding. There has been a 43% decline in the number of firms offering retiree coverage.

It is time for Congress to adopt a guaranteed Medicare prescription drug benefit for all seniors.

This is an issue that grows more and more urgent each year, especially as drug costs continue to skyrocket.

According to a recently published study by the National Institute for Health Care Management, spending on outpatient prescription drugs in retail outlets in the U.S. rose 17.1% in the last year, from $131.9 billion to $154.5 billion.

About half of that increase occurred in the classes of drugs that treat depression, high cholesterol, diabetes, arthritis, high blood pressure, and other chronic conditions that disproportionately affect seniors.

Not surprisingly, the top 50 selling drugs accounted for 44% of total outpatient retail drug sales in 2001. These are the same drugs that are most heavily advertised on television, the radio and in magazine ads.

Whether or not Congress provides some assistance to low-income beneficiaries, drug costs will be a growing burden for the middle income individuals who make up the bulk of Medicare beneficiaries.

Providing assistance only to low-income beneficiaries will not do nearly enough to address this problem.

I know that some of our witnesses will testify about the prescription drug discount cards that are available to some low-income seniors.

I have always appreciated that the industry created these cards and programs, because they usually do provide some relief for low-income seniors.

These programs are a start—but we cannot let them be the end.

The simple truth is that we need a comprehensive, voluntary, guaranteed benefit for all Medicare beneficiaries.

We have been debating this issue for the better part of the last decade. It is time for us to commit the resources, create the most cost-effective plan, and sign it into law.

To do anything less would be to shirk our responsibilities to the seniors who have worked their entire lives to make this country great. They are counting on us to do the right thing and provide a meaningful benefit.

Thank you, Mr. Chairman, and I yield back the balance of my time.

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

Mr. PICKERING. Thank you, Mr. Chairman, and I want to thank you for the work that you have done on this very important issue and the progress that we are beginning to make. It is time to stopho have We haor aho n(anoy to and

Over the past decade, even more troubling is the fact that the availability of retiree health benefits has been eroding, so the trend is heading in the wrong direction. We are going to see fewer and fewer employer-sponsored plans that are providing these benefits. That is why it is up to Congress to act, and I do hope we act to include this as a Medicare benefit.

It is also troubling to me to hear people say, "Well, we can't do this now," but at the same time that this Congress is dipping into the Medicare Trust Funds to pay for a permanent tax cut, Congress is essentially fiddling its violin and nothing is getting done on this issue.

Let us not have this permanent tax cut. Let us deal with this issue. This is a real pressing issue for people in this country. But even if we switch it to Medicare, we have to do more than that because simply switching who pays will not end the problem. As, again, probably everybody in this room knows, the rising prescription drug costs are the major factor in rising health insurance costs in this country.

We have been criticized, those of us who want to do something, saying that if we somehow take on the pharmaceutical industry, that we are going to hamper research. The last thing I want to do is hamper research. I think that this industry has done a tremendous job with research. I think it has allowed people to live longer, and I think it has allowed them to live healthier lives. So, I applaud the research that is being done, but we would be remiss if we didn't point out that a lot of the basic research is paid for with Federal tax dollars, and that allows a lot of the basic research in this country to go forward, and that is an important contribution that the taxpayers in this country are making.

The other part that is troubling to me—and there is a recent article that talks about—for the fourth straight year prescription drug spending rose more than 17 percent in 2001, driven in large measure by a few heavily advertised high-priced medications, a nonpartisan study released yesterday showed.

We have all seen these commercials. I was just with my wife over the weekend. We were watching one of these commercials on television, and I said, "Chris, I have got to get that drug." And she said, "Tom, you don't even have the illness." But these advertisements are so effective and people are going out and asking to buy these drugs when they could simply get a package of Tums.

What we have to do is we have to take this issue head-on, and I hope that this Congress finally, after years of talking, does that. And I would yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman. I believe that completes all of the opening statements of those who have chosen to attend the hearing this morning.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. JAMES C. GREENWOOD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENSYLVANIA

Thank you Mr. Chairman for holding this important hearing today. I will be brief so we can get to our witnesses.

I believe there are two critical issues that motivate our concern about seniors and prescription drugs. One is that seniors need the security of knowing that the cost of prescriptions drugs will not bankrupt them if they become severely ill. That is

why we have made stop-loss coverage a critical component of any prescription drug package.

The second critical issue is that low-income seniors are very sensitive to the cost of drugs. It doesn't take much before a senior is forced to decide between medications or food. Any prescription drug package must include comprehensive coverage for low-income seniors.

That is why today's hearing is so relevant. While we can all agree that providing a benefit for low-income seniors is essential, we are far from consensus on how we should do that. I am particularly interested in Dr. McClellan's testimony on the President's approach and how it will affect the states ability to pay for Medicaid. I am also interested in Ms. Braun's testimony on the AARP's position. I have my concerns about the direction the AARP has taken; apparently you all think that we have a trillion dollars just lying around to spend on prescription drugs. I am hoping you can make me feel better.

I look forward to our witnesses' testimony and yield back the balance of my time.

PREPARED STATEMENT OF HON. HEATHER WILSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

I want to thank the Chairman for holding this hearing to review the options to provide low-income seniors with prescription drug coverage. I hear from my constituents more about this issue than almost any other. One of my goals as we develop a new prescription drug benefit for Medicare is to offer extra help for low-income seniors.

I am very pleased to see the pharmaceutical manufacturers working to provide help for seniors who need it. I believe we should not inhibit the creation of new wonder drugs, but at the same time, these drugs should not be denied to seniors on limited fixed incomes.

I am also impressed by the work of the state of Nevada to cover its seniors. Many state budgets are currently facing several budget shortfalls, especially for their Medicaid programs, that I fear that few states will be able to afford similar programs to cover their seniors. Nonetheless, Nevada's commitment should be applauded and carefully studied as a model.

I look forward to hearing the testimony of all the witnesses.

PREPARED STATEMENT OF ROBERT L. EHRLICH, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. Chairman, thank you for holding this important hearing on ideas to create a Medicare prescription drug benefit. There are many initiatives currently being pursued by the Bush Administration, the states, and the private sector. I appreciate this opportunity to learn from these different approaches as we craft our own legislation to provide a prescription drug benefit plan through Medicare.

I am very concerned about the 13 million senior citizens in our country who do not currently have any insurance to help pay for their prescription drugs. While about two-thirds of all seniors do have some prescription drug coverage through employer-sponsored programs, Medicare+Choice plans, or supplemental Medigap or state Medicaid plans, still millions of seniors have no drug coverage at all. They are forced to make difficult choices every day to have the money they need pay for the bills and buy their medicines.

We are here today because I believe most people recognize the need for a Medicare prescription drug plan to help these seniors. I know Dr. Mark McClellan, a member of the Council of Economic Advisors for President Bush, has been working on this issue for the President. Others from the public and private sector have offered their own ideas on how to approach this problem.

As our Subcommittee examines ways to create a prescription drug benefit, there are a number of difficult questions we must answer, including: Who should such a plan cover? Should the plan cover all seniors or those most in need? How will the benefit plan work and how quickly can it be implemented to start benefitting seniors who need drug assistance now?

Mr. Chairman, I would like to commend our witnesses. Each offers different and interesting ideas on how to provide prescription drug coverage through various means. With these ideas in mind, I look forward to our efforts to craft a fiscally responsible, sustainable, and quality prescription drug plan for our nation's needy seniors. Our seniors need our help, and I believe the federal government should create an affordable plan to help them. Thank you for holding this important hearing, Mr. Chairman.

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

Mr. Chairman: Thank you for holding this hearing today on the very important issue of how to help low income seniors with their drug costs.

This is an issue that is critically important to our most vulnerable constituents. Seniors back in my district in Louisiana have to regularly make difficult choices about how they will be able to purchase their prescription drugs. They want to know how we can help then right now, and not just two or three years from now—the time it will take to implement any comprehensive Medicare drug benefit.

Make no mistake—transitional programs for low-incomes cannot and should not substitute for a comprehensive Medicare drug benefit. I continue to be absolutely committed to working with my colleagues to enact such a Medicare drug benefit this year. In fact, I expect that we will be moving legislation through the Committee within the next month that will create precisely this type of new Medicare benefit. It is my sincere hope that all of us in Congress can agree to pass this bill and send it to the President for his immediate approval.

Any new benefit we enact will take several years to get up and running. In the meantime, however, we need to ensure that many of our low-income seniors gain better access to drug coverage and some of the price discounts that are available in the private market. This hearing will highlight some of the initiatives that the Administration, States and the private sector are already pursuing to provide assistance to low-income seniors. Hopefully, some of these examples can provide models for what we in Congress can do to assist these seniors with their drug costs. The new Together Rx drug discount card and the Senior Rx program in Nevada are two exciting examples of such models that use private, market based forces to reduce drug costs for low-income seniors right now.

The Together Rx card will allow between eight and eleven million eligible Medicare beneficiaries with individual incomes of up to $28,000 to obtain significant discounts on 150 drugs made by the seven drug manufacturers who have agreed to participate in the program. It is estimated that these discounts will average between 20 and 40 percent, and will be passed along through the over 13,000 pharmacies that have agreed to serve in the Together Rx card network. This will mean real savings that will make an important difference in the lives of seniors who obtain this card.

Now, some may attempt to argue that the discounts under this program are relatively insignificant and will not truly help seniors. Seniors know better, however, which is why almost 100,000 of them have asked about enrolling in Together Rx since the new program was first announced last week.

Governor Guinn and his colleagues in the Nevada legislature should also be commended for coming up with a new and innovative model for assisting low-income seniors with their drug costs. Under the Nevada Senior Rx program, low-income seniors are able to receive their drugs and only pay modest co-payments. The State utilizes an insurance company that manages the program, which in turn contracts with a Pharmacy Benefit Manager to negotiate discounted drug prices for plan participants. Senior Rx cost Nevada only six million dollars last year, and it provided drug coverage for 6,000 low-income seniors, all of which was done without creating a major new state bureaucracy to manage this new benefit!

I also look forward to hearing more about the discount card idea contemplated by the National Association of Chain Drug Stores. It is good to see that they are becoming an advocate for the drug discount card concept.

I would be remiss if I did not take the time to also thank Mark McClellan for appearing today. He and the Administration should be congratulated for their excellent work in developing their proposals to provide assistance to low-income seniors. I look forward to working with Mark and this Administration to develop a comprehensive Medicare modernization bill—one that includes a universal prescription drug benefit and targeted reforms. We are fortunate to have an Administration so closely engaged in these important issues. With your help, Mark, as well as the help of all of the Members here today, perhaps we can find enough common ground to solve these vexing issues this year. I want to thank all of the witnesses for appearing today and will look forward to hearing their testimony.

PREPARED STATEMENT OF HON. TED STRICKLAND, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Thank you, Mr. Chairman, for convening today's hearing, and I want to thank the witnesses for their testimony.

Today we are going to hear about what I believe is one of the most important issues Congress is considering this year. One third of all seniors lack prescription drug coverage, and that percentage rises to nearly one half in rural areas.

This problem is compounded because seniors are much more likely than the rest of the population to need prescription drugs, and seniors without drug coverage are forced to pay manufacturers' sticker prices because they don't benefit from the bulk purchasing power HMOs have.

When Medicare was enacted, prescription drugs weren't as expensive or available as they are now, and I think it's safe to say that if Medicare was started today, it would be unthinkable not to include a prescription drug benefit in the program.

The prospect of adding such a benefit now is expensive. Today's hearing is focused on providing a drug benefit for only low income Medicare beneficiaries instead of for all seniors: the Administration's proposals would give states the option to provide drug-only plans to low-income Medicare beneficiaries and would put the Medicare stamp of approval on a private drug discount card. Although I am glad the Administration understands the importance of helping to pay for the cost of prescription drugs, I am concerned about both of these proposals, which do little to provide new coverage for the population it seeks to help. States can already provide prescription drug coverage to low income Medicare beneficiaries, and the Administration's plan doesn't give states incentives to expand on their existing coverage. And, a variety of private discount drug cards already exist, creating an often confusing array of options for seniors. A Medicare endorsed card may only serve to add to the confusion; at best it adds no benefit that doesn't already exist under current law.

Since its inception, Medicare has provided guaranteed quality health care for all seniors, regardless of their income or where they live, and these safety net characteristics have been the program's greatest success.

We must strengthen Medicare by creating a voluntary, comprehensive, and affordable prescription drug benefit for all seniors. Such a benefit would not discriminate based on a beneficiaries' geographic residence and it would be dependable.

Some of my colleagues might argue that this goal is an impossible burden given the state of our current budget, but I believe the costs to society and to the security of our seniors from the lack of an affordable, accessible drug benefit for all Medicare beneficiaries far outweigh the budgetary price tag. It is a matter of priorities: we must fulfill our obligation under the Medicare program to provide quality health care, which today must include prescription drugs, to our nation's elderly.

Thank you again, Mr. Chairman, and I look forward to hearing the witnesses' testimony. I yield back the remainder of my time.

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

Thank you, Chairmen Tauzin and Bilirakis, for holding this hearing. I am pleased with the Committee's interest in a Medicare prescription drug benefit. I am also pleased that today's discussion will include the topic of additional protections for low-income seniors and people with disabilities. However, I think that we would be neglecting our responsibilities as members of Congress if we only provide drug coverage to low-income beneficiaries.

The best way to help low-income seniors is to help all seniors. No senior is immune from the high cost of prescription drugs, and until we create a universal drug benefit, any senior is at risk of becoming low-income after spending all of his or her spare resources on needed medications.

Unfortunately, the President's budget contains no universal Medicare drug benefit. All the President's proposals concerning prescription drugs and Medicare are temporary measures designed to be implemented while Congress deliberates a universal drug benefit. I question whether we should be devoting our energies to temporary solutions, while ignoring the larger task at hand. Allow me to explain a few of the drawbacks I see with the President's partial solutions.

The President's budget contains several proposals targeted towards low-income seniors, based on the belief that a universal drug benefit will take too long to implement. These proposals include state low-income assistance programs, "Pharmacy Plus" Medicaid waivers, and discount drug cards.

While state low-income assistance programs can provide some help, only a little over half of all states offer them. It could be three years before programs are up and running in the other half—about the same amount of time it would take to implement a universal benefit. Drug discount cards do not guarantee a discount on every drug, nor do they guarantee whether the specific drug a low-income senior needs will be available. The most potentially damaging proposal of all is the Admin-

istration's "Pharmacy Plus" Medicaid waivers, which allow states to cut benefits for some low-income people in order to extend drug-only coverage to other, relatively higher-income seniors.

The President's budget includes one other temporary measure to provide assistance to low-income seniors. The Administration mentions that private plans have played an important role by offering drug coverage to seniors without supplemental insurance. However, instead of creating a Medicare prescription drug benefit for all seniors, the President's budget proposes increasing payments to managed care plans so that they can provide drugs to the 15 percent of seniors enrolled in them.

The common themes in the President's proposals are troubling ones—no guaranteed drug coverage for any senior, and what assistance seniors get and how much they pay for it depends on where they live. This is not the Medicare that seniors know and trust. I hope that this Committee does not go down this same path, because it would undermine all the principles that have made Medicare so successful.

Mr. BILIRAKIS. We will move right on to the panelists now.

The first panel consists of Dr. Mark McClellan, who is an M.D. as well as a Ph.D., member of the Council of Economic Advisers here in Washington. Doctor, we have set the clock at 10 minutes. By all means, if you are rolling and need another minute or 2, we won't stop you, but please proceed, sir.

STATEMENT OF MARK McCLELLAN, MEMBER, COUNCIL OF ECONOMIC ADVISERS

Mr. MCCLELLAN. Chairman Bilirakis, Representative Brown, distinguished committee members, thank you for inviting me here today to discuss the President's framework for strengthening Medicare with prescription drug coverage in Medicare for all Medicare beneficiaries, as well as our proposal for transitional low-income assistance and other transitional steps to strengthen Medicare as part of legislation that implements an effective prescription drug benefit.

As you all have made clear, the time is now to work together to address the urgent and fundamental challenges facing Medicare at the beginning of the 21st Century. Today, Medicare's promise of providing health security for seniors and persons with disabilities in the best health care system in the world, a private health care system, is threatened. It is threatened by outdated and inadequate benefits, including no prescription drug coverage, limited and costly protection against rising medical costs, an inability to deliver reliable health plan options, and a fee-for-service government plan that often fails to deliver responsive services to recipients and providers, or to ensure high quality care.

President Bush is firmly committed to working closely with you and other Members of Congress to modernize Medicare and strengthen it for current and future seniors. The President has outlined a framework for strengthening and improving Medicare. This framework recognizes that while we all want to provide a drug benefit for seniors, we cannot do so in a vacuum. Medicare beneficiaries are facing rapid increases in their out-of-pocket costs and the Medicare program itself is in serious financial trouble. These problems will only deepen in coming decades unless we act now to give Medicare beneficiaries access to better, more effective and efficient services.

We must get the most out of every dollar spent on Medicare's current benefits and any new benefits. Reflecting this goal, the President has developed a framework for bipartisan legislation. In

this framework, all seniors should have the option of a subsidized prescription drug benefit as part of modernized Medicare. In particular, as I discuss in more detail in my written testimony, it is critical to provide drug coverage through competing private plans in which they, not the government, help seniors pick the coverage that is best for their own needs. It is also critical to give seniors affordable protection against very high drug expenses. But it is also clear that if we add a drug benefit to Medicare without improving the rest of Medicare, we will deepen Medicare's financial crisis and fail to give seniors the improved benefits they deserve to use their prescription drug coverage effectively.

Therefore, the President believes that modernized Medicare should give seniors the option of choosing better coverage for preventive care and serious illnesses. In addition, the President believes seniors deserve reliable choices of different insurance options like those available to millions of Americans under 65, and to all Federal employees. Because the current Medicare+Choice payment system is fundamentally flawed, seniors are losing access to drug benefits and losing access to valuable disease management services, preventive care, and other innovative benefits, wellness programs and the like that help them use drugs more effectively and at a lower cost.

Medicare legislation should also strengthen the program's long-term financial security. I understand the administration and many in Congress have sometimes differed in their numbers. As our budget indicates, we believe that we can provide a secure benefit for less than $350 billion in the House Budget Resolution. While there is a range of views, however, let me be clear that we are firmly committed to working with the House to enact legislation to improve Medicare this year.

To make clear why we place such a priority on getting more value out of the Medicare program and on enacting a drug benefit that does not threaten Medicare's financial security, I would like to share with you an analysis done by the nonpartisan CMS actuaries of the implications for Medicare's benefit security of a drug benefit proposal to spend $750 billion on prescription drugs, and it would devote Part A surpluses to the new benefit.

If Part A surpluses of $400 billion were literally directed to the drug benefit, the consequences for Medicare's ability to provide benefits for the Baby Boom would be severe. The redirection of Medicare Part A funds could cut the life of this Trust Fund in half. The Trust Fund would begin losing money in 2008 and would become insolvent by 2016. Some might instead propose to use accounting gimmicks by creating yet another trust fund for the drug benefit and leaving it to future generations to figure out how to pay for it. But no accounting gimmicks can hide the fact that such a drug benefit would increase the program's long-term financial challenges by 50 to 100 percent. The excess cost of $400 billion in the first 10 years would balloon to $1.2 trillion in the next ten, just when the Baby Boomers are beginning to count on Medicare. And by 2030, this new drug benefit would require tax increases or reductions in government programs for future Americans amounting to almost 2 percent of our entire national product, and equivalent

to a tax of almost $2200 in today's dollars on every working American.

This example highlights that we must give seniors better benefits that will be there, and we must do it without overtaxing our children or threatening Medicare's existing benefits.

The President's Budget also proposes urgently needed steps that should be incorporated into Medicare legislation because it isn't good for seniors or the Medicare program to wait several years and hope to implement a full drug benefit and other improvements from scratch. These steps include Medicare-endorsed prescription drug card, transitional low-income drug assistance, more affordable Medigap option, and immediate steps to help make sure that seniors who prefer private health insurance coverage through the Medicare+Choice program can continue to get it.

As I describe in more detail in my written testimony, these changes will both pave the way for a modernized program, and provide rapid relief, including prescription drug coverage, for many millions of Medicare beneficiaries before the full drug benefit can be implemented at least 3 years from now. They will allow many millions of the 9 million seniors who do not have drug coverage today to get it even before the full Medicare drug benefit is set up.

Seniors need help now, and the Medicare program needs to start doing the work of implementing a drug benefit and other benefit improvements now.

As you know, we are working to implement the drug card program effectively, and are awaiting the results of the public comment period open to comments from all interested parties on that program now. But the private sector has already started to respond to the President's call to make lower drug prices available to seniors.

The recently announced drug card developed by the McKesson Corporation, the National Association of Chain Drug Stores, drug manufacturers, and other private organizations provide opportunities to make manufacturer discounts more widely available to seniors, especially those with low incomes. We applaud these private market approaches. They can provide significant help for seniors now and for keeping the cost down in a Medicare drug benefit in the future.

Conversely, as the Kaiser Foundation and others have shown, some existing cards provide small, if any, actual discounts, and it can be very difficult for experts, let alone seniors, to compare cards and identify the program that is best for them with no help at all. By helping seniors pool together and choose among cards that would have to compete directly on manufacturer discounts and high quality pharmacy services, the Medicare-endorsed card program could give all seniors access to 15 percent savings on drugs, and through innovative new programs like the McKesson Together Rx card, seniors with modest incomes could get savings of 20 to 40 percent, according to card sponsors.

The drug card has another important aspect, experience. As AARP and other senior advocates have noted, seniors, drug benefit managers, and the Medicare program would all get valuable experience with implementing a choice-based drug benefit. This will be a significant advantage as CMS moves to implement a comprehen-

sive Medicare prescription drug benefit, since all major Democratic and Republican proposals envision a competitive approach like this to providing drug coverage.

The President also believes that comprehensive Medicare legislation should take advantage of existing State infrastructure to identify and help provide assistance to low-income seniors right away, and should do so in a way that supports the integration of existing State low-income programs into the new Medicare drug benefit.

The administration has proposed to provide immediate support for comprehensive drug coverage for Medicare beneficiaries up to 150 percent of poverty, about $18,000 for a family of two. For Medicare beneficiaries up to 100 percent of poverty, the program would provide new Federal matching funds, at the Medicaid matching rate, for expanding drug coverage. As an added incentive, Medicare would pay 90 percent of the State's cost of drug-only covered expansion above 100 percent of poverty. This proposal is projected to expand drug coverage for up to 3 million beneficiaries who currently do not have prescription drug assistance, before the full Medicare prescription drug benefit is up and running.

The administration is ready to work with Congress to implement transitional low-income assistance effectively in a way that considers both the short-term goal of expanding coverage as quickly as possible, and the very important long-term goal of getting all beneficiaries—all beneficiaries including low-income beneficiaries—into the Medicare drug benefit as quickly as possible. All beneficiaries should be in the same mainstream coverage structure. That is very important for getting the gains in efficiency needed to keep the overall cost of the benefit down.

For example, using the transitional Federal funding that I just described, States could contract with one or more Medicare-endorsed drug cards to identify low-income residents and to provide additional prescription drug assistance beyond manufacturer discounts for them. The drug cards also provide a convenient mechanism for keeping track of out-of-pocket expenses so that States can work with the drug card administrators to provide assistance with catastrophic expenses for medically needy individuals who desperately need help right away.

In addition, to make expanded coverage immediately available even before enactment of the low-income drug assistance program, States can now participate in a model drug waiver program called Pharmacy-Plus. A principal mechanism that States can use in this waiver program is to adopt cost-saving private sector approaches to manage their benefits, allowing them to achieve budget neutrality and taking a step toward the competitive Medicare drug benefit. This is the kind of approach already taken by States like Nevada, and we believe the waiver program will encourage many other States to do the same based on the strong number of inquiries and actual applications that we have received already.

Thank you very much for this opportunity to discuss these critical topics for seniors and for the future of the American health care system today. Three decades from now, the promise of a financially secure retirement and the world's leading health care system should continue to be a reality for America's seniors. By working

together to enact legislation to strengthen Medicare this year, we can make sure it will be.

I ask that my written statement be submitted into the record, and I very much look forward to answering your questions. Thank you, Mr. Chairman.

[The prepared statement of Mark McClellan follows:]

PREPARED STATEMENT OF MARK MCCLELLAN, MEMBER, PRESIDENT'S COUNCIL OF ECONOMIC ADVISORS

Chairman Bilirakis, Representative Brown, distinguished Committee members, thank you for inviting me to discuss the President's proposals for strengthening Medicare, including prescription drug coverage. The Administration also appreciates the opportunity to provide more details on our proposal for transitional low-income prescription drug assistance and other transitional proposals that we believe should be part of legislation to implement a Medicare prescription drug benefit for all beneficiaries. As you all well know, when Medicare's original legislation was enacted, President Johnson said: "No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime." Thirty-seven years later, President Bush believes it is time for our Nation to come together and renew that commitment. The President believes that we have a moral obligation to fulfill Medicare's promise of health care security for America's seniors and people with disabilities, and that we must take action now to do so.

Medicare has provided health security to millions of Americans since 1965. But lack of prescription drug coverage is a clear demonstration that Medicare is not keeping up with the rapid advances in medical care. Looking ahead, medical care holds the promise of improving and extending life through countless innovations. But as we enter the 21st century, Medicare's promise is threatened by: outdated benefits; limited financial protection against high medical costs; a system that has not delivered reliable health plan options; and a traditional government plan that often fails to deliver responsive services to beneficiaries or ensure high-quality care.

As we implement legislation to strengthen Medicare, we must remember that the 77 million Americans who will be entitled to Medicare in 2030 are counting on up-to-date benefits that will give them access to medical services that are scarcely imaginable today. Yet even Medicare's current, outdated benefits are not secure for the retirement of the Baby Boom generation. Medicare's fund for hospital insurance will face cash flow deficits beginning in about 15 years and is projected to become insolvent within 30 years. Medicare's fund for its other benefits will require nearly a doubling of beneficiary premiums and massive infusions of general revenues to remain solvent over the next 10 years. Medicare's accounting disguises the program's true fiscal health and makes it difficult to plan ahead.

STRENGTHENING MEDICARE

Recognizing these problems, President Bush has worked with members of Congress from both parties to develop a framework for a modernized Medicare program and for keeping Medicare's benefits secure. The President's framework includes the following eight principles:

First, all seniors should have the option of a subsidized prescription drug benefit as part of modernized Medicare. In particular:

- Medicare's subsidized drug benefit should protect seniors against high drug expenses and should give seniors with limited means the additional assistance they need.
- The drug benefit should give all seniors the opportunity to choose among plans that use some or all of the tools widely used in private drug plans to lower drug costs and improve quality of care.
- The drug benefit should support and encourage the continuation of the effective prescription drug coverage now available to many seniors through retiree plans and private health insurance plans.
- The new drug benefit should also be available through Medigap plans and as a stand-alone drug plan for seniors who prefer these choices.

We believe it is critical for seniors to have a choice of drug plans so that they can pick the one that is best for their needs. This is not a decision the government should make for them, just as we should not be picking their doctor, determining their drug treatment, or giving them a one-size-fits-all health plan. As the members of this Committee know, both the independent CMS actuaries and the non-partisan

Congressional Budget Office experts fully expect private drug plans to participate in this benefit. As CBO and many economists have also confirmed, giving private plans the proper incentives to deliver high-quality pharmaceutical services at a low price is the way to get the best deal for Medicare beneficiaries and the program—yielding lower drug spending and lower monthly premiums through competition. Of course, the government has important roles to play as well: making sure seniors can get the protection against catastrophic drug costs that they need—protection which is often lacking today; taking the steps necessary to ensure that all eligible seniors and disabled individuals get the benefits to which they will be entitled; and providing the information and support that all beneficiaries need to make informed choices.

Some have argued that the criterion for designing a Medicare drug benefit should be whether most Medicare beneficiaries, many of whom have drug spending each year of $500 or less, are "better off" when taking into account the premiums they must pay and the additional assistance they will get beyond their existing coverage, based on their current drug spending. So, the argument goes, any kind of insurance protection against high medical costs that are rare today won't be popular. I believe this approach does a disservice to seniors who are counting on Congress enacting a drug benefit that will give them both health security and better care.

First, coverage that provides protection against high out-of-pocket expenses for a low premium is something that seniors want as we enter a new era of breakthroughs in drug design. In my own medical practice, I have treated many seniors who had serious illnesses or faced the risk of serious illnesses that might require costly treatments—more and more of them in recent years, as more such treatments have become available. The potential for the next 10 years is even greater, as treatments based on understanding a person's genetic predisposition to diseases become more prevalent. Seniors are very worried about the possibility of not being able to afford potentially lifesaving but very costly new treatments.

Second, the new Medicare drug benefit will get the most "bang for the buck" in improving coverage if it adds to rather than replaces the substantial private contributions already being made toward prescription drug coverage for Medicare beneficiaries. Many Medicare beneficiaries already have coverage for small to moderate drug expenses, through private plans, employer coverage, or (if they can afford it) Medigap plans. Providing protection against high drug expenses through a Medicare drug benefit not only is important for filling in the gaps in existing coverage, rather than simply replacing good coverage. It also makes generous insurance plans more affordable for all beneficiaries by reducing adverse selection. Right now, prescription drug coverage for seniors is subject to severe problems of adverse selection. Adverse selection occurs because beneficiaries who know for sure that they need such coverage buy it, driving up the premium, and then beneficiaries only think they might need coverage against high expenses don't buy it. By providing a large subsidy for drug coverage that protects seniors against high costs, Medicare would prevent persons with high costs from driving up the costs of the insurance premiums. This would reduce adverse selection, amounting to a premium subsidy for everyone to make comprehensive insurance more affordable. The potential for very high expenses would no longer drive up the costs of insurance that includes real protection against high out-of-pocket costs.

Second, modernized Medicare should provide better coverage for preventive care and serious illnesses. Medicare's current cost-sharing often imposes the highest costs on those who need the most care. Individuals who need hospital care currently face a payment of more than $800 for each spell—and they can have many spells in a year—and Medicare's coverage for hospitalizations can eventually run out altogether. And unlike most private insurance, Medicare does not provide "stop-loss" protection to limit the financial obligations imposed on beneficiaries. At the same time, poor benefit design in Medicare itself—or in the first-dollar Medigap plans that seniors are required to buy to fill in Medicare's large coverage gaps—often gives seniors no choice other than paying high and rapidly rising Medigap premiums and other out-of-pocket payments, without yielding noticeable improvements in health. Thus we believe Medicare's coverage should be improved so that seniors can get better protection when serious illnesses occur, more affordable Medigap coverage, and better coverage to help prevent illnesses in the first place—like having zero co-payments on Medicare's preventive benefits. Because the improved benefits will encourage better use of preventive care and other services, a better Medicare coverage package will also help seniors and the Medicare program get the best value from the new drug benefit. The savings from lower out-of-pocket payments will also make all medical services, including drugs, more affordable for seniors.

Third, today's beneficiaries and those approaching retirement should have the option of keeping the traditional Medicare plan with no changes.

The President strongly believes that no senior should be forced to accept sudden and significant changes they do not choose and are not prepared for. Although we believe that a modernized Medicare program will be attractive to many current beneficiaries, we believe the choice rightly rests with them on whether to move from the existing program to the modernized one.

Fourth, Medicare should provide better health insurance options, like those available to all Federal employees and retirees. For too long, Medicare has been a "one size fits all" program. At a time when many other Americans have access to a range of private insurance coverage options to meet their needs, more and more seniors are finding that their only choice is a single, outdated fee-for-service plan. Medicare beneficiaries deserve better. They deserve access to the kind of innovative disease management programs and other benefits that Assistant Secretary Jindal described to your Subcommittee on Health last month. For example:

- A Medicare+Choice plan in Boston instituted a comprehensive disease management program for its enrollees with diabetes. The result has been significant increases in the share of enrollees who received annual retinal eye exams and are monitored for diabetic nephropathy and substantial improvements in the management of their Hemoglobin and cholesterol levels. Improvements in these measures through tight diabetes control have been shown to improve quality and length of life significantly.
- A Medicare+Choice plan in Florida instituted a comprehensive disease management program to monitor, facilitate, and coordinate care for enrollees stricken with cancer. As a result, the number of acute hospital days per cancer case dropped by about 15% over two years and the share of inpatient admissions for complications with cancer has declined by 10 percent.
- Research has shown that individuals who receive after-care following hospital stays for mental illness are more likely to be compliant with their treatment regimens and less likely to be readmitted to the hospital. One Medicare+Choice plan in New York instituted a case management program for those hospitalized for mental health disorders and nearly doubled the share of its enrollees who received follow-up care within 7 days of their hospital discharge.

All of these disease management programs, and many other programs to prevent diseases and improve quality of care through better coordination and integration of services, are immensely valuable to seniors. These innovative benefits help seniors manage their prescription drug costs and get the most value from the drugs they use. This greater efficiency has helped permit most private plans in Medicare to provide prescription drug coverage today, and to offer much lower cost sharing for many of Medicare's required benefits. Programs like these are the reason that private plans have long been the preferred choice of millions of Medicare beneficiaries.

Unfortunately, the quality of care enjoyed by millions of seniors enrolled in these plans is threatened today by years of underpayments to the plans. The President's framework for strengthening Medicare calls for replacing the dysfunctional Medicare+Choice payment system with a fair payment system for private plan options for Medicare beneficiaries, like the system that provides reliable health insurance options to all Federal employees in the Federal Employees Health Benefits program. Private plans are a critical source of drug coverage and countless other innovative benefits for millions of seniors, and they should remain so.

Fifth, Medicare legislation should strengthen the program's long-term financial security. In light of the recent Trustees' Report on Medicare one could conclude that our guiding principle should be "first, do not harm." The President's budget recognized that strengthening Medicare would require substantial new resources and proposed $190 billion for this important purpose. Despite the unprecedented and unique challenges facing our nation today, the President and Congress have clearly demonstrated their commitment to meeting the needs of seniors. Of course we are more than willing to work with Congress this year to enact this long-overdue legislation, and we understand that there are a range of views regarding how much new spending needs to be allocated for this purpose. We believe an effective program for strengthening Medicare and including a prescription drug benefit can be accomplished within the amount the President has allocated in his Budget. Without strong measures to make the program more efficient being incorporated along with new benefits, Medicare's current benefits will become less secure under some proposals.

At the same time, it is important to recognize risks to the long-term security of Medicare's promised benefits. For example, some have proposed a drug benefit as large as $750 billion, financed using surpluses generated over the next 10 years by the Medicare Part A Trust Fund. If the Part A surpluses literally were directed to augmenting prescription drug coverage, the consequences for Medicare's ability to provide benefits for the Baby Boom would be severe. According to the nonpartisan

CMS Actuaries, the redirection of Medicare Part A funds could cut the life of this trust fund in half—the trust fund would lose money beginning in 2008, and would become insolvent by 2016. Some might instead propose to use the accounting gimmicks that Medicare's bifurcated trust fund system encourages, by creating yet another trust fund for the drug benefit and leaving it to future generations to figure out how to pay for it. But no accounting gimmicks can hide the fact that such a drug benefit would increase the program's long-term financing challenges by 50 to 100 percent. The excess costs of $400 billion in the first 10 years would balloon to $1.2 trillion in the next ten, just when the Baby Boomers are counting on Medicare. The government's Medicare spending for current benefits (even after subtracting beneficiary premiums) is already expected to grow from 2% of GDP today to 4% by 2030. This new drug benefit would increase that share to almost 6%—a tax increase or reductions in government programs for future Americans amounting to almost 2% of our entire national product, and equivalent to a tax of $2,170 (in today's dollars) on every working American.

Thus, while we will work closely with Congress to enact a Medicare drug benefit this year, we also want to work closely with Congress to make sure that the benefits we promise today will be there for beneficiaries tomorrow. This is also why we support changes in Medicare's Trust Fund accounting to provide a plain and straightforward picture of Medicare's financial outlook. We have all seen clear examples of how poor accounting practices can lead to poor planning, with devastating consequences for many Americans. It is critically important that we avoid such practices in a program that is so important to all Americans.

In this context it is also important to consider the issue of provider payment reforms. Although certain provider payments may benefit from adjustment, we believe such adjustments can be accomplished without using new funds that are even more urgently needed for improving Medicare benefits. Indeed, the Administration believes that the first priority in Congress should be enacting legislation that improves Medicare benefits, not legislation that focuses on provider payments. As we move forward to achieve our shared goal of modernizing and strengthening Medicare, the Administration is willing to work with Congress to consider limited modifications to provider payment systems in order to address payment issues. In doing so, we must be systematic: all provider payment updates must be considered and any package must be budget neutral in the short and long term.. As we consider these changes, we need to focus on the adequacy of payment systems for providing access to care for beneficiaries, and recall that any increases in spending will be borne in part by beneficiaries, and will also have long-term implications for the security of Medicare's benefits.

Sixth, the management of the government Medicare plan should be strengthened so that it can provide better care for seniors. Secretary Thompson and Administrator Scully have taken many administrative actions to improve and streamline management at CMS. But legislation is required for further needed actions that have strong bipartisan support, such as competitive bidding so that Medicare and its beneficiaries can get better, market-based prices for the medical products it purchases while ensuring high quality, and Medicare contracting reform, to improve the cost-effectiveness of Medicare contractor operations and create an open marketplace for potential contracting partners.

Seventh, Medicare's regulations and administrative procedures should be updated and streamlined, while the instances of fraud and abuse should be reduced. Here too Secretary Thompson and Administrator Scully have moved aggressively, but the Administration now needs help from Congress. Any Medicare legislation this year should include the kind of sensible improvements that this Committee led through the House of Representatives with unanimous bipartisan support. Regulatory reforms and simplifications are needed to reduce burdens on providers and on CMS, a critically important goal at a time when we need to direct attention to implementing new benefits in Medicare.

Eighth, Medicare should encourage high-quality health care for all seniors. Recent reports from the Institute of Medicine and others have made clear that serious and widespread opportunities for improving patient care exist. These opportunities are especially likely to benefit seniors and persons with disabilities, because they tend to use more and more complex care. Many of the opportunities for quality improvement involve drugs—including the use of inappropriate and costly prescriptions when less costly treatments are available, and failures to use medications that could avoid complications. The reports provide compelling evidence that we need to change the environment for medical practice to one that encourages systematic and continuous improvements in care by dedicated professionals, not an environment that subjects them to endless and costly litigation.

Looking ahead, we will continue to have a healthy debate about how we should meet these principles. The key, however, is to take action this year, we intend to continue to work closely with Congress to implement a prescription drug benefit that Republicans and Democrats can support, that achieves the President's principles for Medicare legislation, and that begins to bring relief to seniors next year.

IMMEDIATE STEPS TOWARD IMPROVED BENEFITS AS PART OF MEDICARE LEGISLATION

The President recognizes that, under all Democratic and Republican proposals, it will take several years to implement the comprehensive improvements that Medicare needs. He also strongly believes that seniors have already waited too long for action to update their Medicare benefits, and that they need assistance now. Therefore the President's Budget also proposes urgently needed steps that should be incorporated into Medicare legislation: Medicare-endorsed prescription drug cards, transitional low-income drug assistance, more affordable Medigap options, and immediate steps to help make sure that seniors who prefer private health insurance coverage through the Medicare+Choice program in Medicare can continue to get it. These changes will both pave the way for a modernized Medicare program, and provide immediate relief including drug coverage for millions of Medicare beneficiaries before the full drug benefit can be implemented at least three years from now.

Medicare-Endorsed Prescription Drug Cards

About 9 million Medicare beneficiaries have no prescription drug coverage at all. About thirty-five percent of these beneficiaries had incomes below 150 percent of poverty, or an annual income of about $18,000 for a family of two. These Medicare beneficiaries and the uninsured are just about the only people in America today that commonly have to pay full price for prescription drugs. Last year, the Administration took the first important step to provide price relief for seniors who need it when it proposed the creation of a new Medicare-endorsed drug card program. The drug card is not a drug benefit and it is not a substitute for one. It is, however, an important first step toward helping seniors afford the drugs they need today, and in helping them receive other valuable pharmacy services.

The Medicare-endorsed drug card is a pooling mechanism modeled on private health insurance programs, where consumers routinely benefit from discounts of 10 to 35 percent. Private insurers, with their large numbers of customers, use their market power to secure significant rebates and discounts from manufacturers. This is exactly the kind of pooling envisioned as a source of lower drug prices in both Democratic and Republican drug benefit proposals. Under the President's proposal, Medicare would endorse private drug cards that met minimum standards, including a requirement of securing manufacturer discounts, allowing seniors to get the information they need to find the card that provides the best manufacturer discounts and other valuable pharmacy services for their needs. These third-party plans will negotiate discounts and rebates directly from drug manufacturers and pass the savings on to Medicare beneficiaries who choose to participate.

As we continue to work to implement the drug card program, the private sector has already responded. The recently-announced discount cards developed by McKesson, the National Association of Chain Drug Stores, drug manufacturers, and other private organizations provide opportunities to make manufacturer discounts more widely available to seniors, especially those with low incomes. We applaud these private market approaches. They can provide significant help for seniors now and for keeping down the costs of a Medicare drug benefit in the future. Conversely, as the Kaiser Foundation and others have shown, some existing cards provide small if any actual discounts, and it can be very difficult for experts—let alone seniors—to compare cards and identify the program that is best for them. By helping seniors pool together and choose among cards that would have to compete directly on manufacturer discounts and high-quality pharmacy services, the Medicare-endorsed card program could give all seniors access to 15 percent savings on drugs—and, through innovative new programs like the McKesson TogetherRx Card, seniors with modest incomes could get savings of 20 to 40 percent, according to card sponsors.

The drug card has another important aspect: experience. As AARP and other senior advocates have noted, seniors, drug benefit managers, and the Medicare program would all get valuable experience with implementing a choice-based drug benefit. This will be a significant advantage as CMS moves to implement a comprehensive Medicare prescription drug benefit, since all major Democratic and Republican proposals envision a competitive approach like this to providing drug coverage. And as I will describe in more detail next, the Medicare-endorsed drug cards can provide the infrastructure needed for rapid expansion of low-income assistance and other prescription benefit assistance.

Transitional Medicare Low-Income Drug Assistance Program

After many years without Congressional action to implement a Medicare prescription drug benefit, states have acted themselves to assist seniors with the greatest needs. The lowest-income seniors have received prescription drug coverage under the Medicaid program. In addition, 30 states have set up additional prescription drug assistance programs for seniors, and more states are considering such programs. Yet millions of lower-income seniors still get no help. The President believes that comprehensive Medicare legislation should take advantage of existing state infrastructure to identify and provide assistance to low-income seniors right away, and to support the integration of existing state low-income programs into the new Medicare drug benefit, by helping states provide transitional drug coverage for low-income seniors as part of comprehensive Medicare legislation.

The Administration has proposed to provide immediate support for comprehensive drug coverage for Medicare beneficiaries up to 150% of poverty—about $18,000 for a family of two. This proposal, called the Transitional Medicare Low-Income Drug Assistance Program, would use the existing administrative structure operated by the states to identify and assist low-income seniors, and would also encourage states to use the new Medicare drug card infrastructure or similar competitive approaches to provide expanded low-income assistance. For Medicare beneficiaries up to 100% of poverty, the program would provide new Federal matching funds at the Medicaid matching rate for expansions of drug coverage. As an added incentive for States to expand coverage up to 150% percent of poverty, Medicare would pay 90% of the States' cost of drug-only coverage expansion above 100% of poverty, leaving states responsible for covering the remaining 10%. This proposal is projected to expand drug coverage for up to 3 million beneficiaries who currently do not have prescription drug assistance. It would be fully integrated with the Medicare drug benefit once the reform Medicare program is implemented, as envisioned in all major Medicare drug benefit proposals.

The Administration is ready to work with Congress to implement transitional low-income assistance effectively, considering both the short-term goal to expand drug coverage and the long-term goal of getting all beneficiaries into the Medicare drug benefit as quickly as possible. For example, using the transitional Federal funding, states could contract with one or more Medicare-endorsed drug cards to identify low-income residents and provide additional prescription drug assistance beyond manufacturer discounts for them. The drug cards also provide a convenient mechanism for keeping track of out-of-pocket expenses, so that states can work with the drug card administrators to provide assistance with catastrophic expenses for medically needy individuals. When the Medicare benefit is set up, the drug card providers would have a clearer idea about the utilization habits and profiles of their beneficiaries, so they would not have to start from scratch in setting up efficient universal drug benefit programs. Low-income populations would even have a head start on getting a competitive, privately-provided drug benefit through a Medicare drug assistance infrastructure.

In addition, to make expanded drug coverage immediately available even before the enactment of the Transitional Low-Income Drug Assistance Program, states can immediately participate in a model drug waiver program called Pharmacy Plus that can cover Medicare beneficiaries up to 200% of poverty. In Illinois, for example, 368,000 additional low-income Medicare beneficiaries, up to 200% of poverty, will receive drug coverage under the waiver we approved last month. These waivers must be budget neutral to the federal government. A principal mechanism that states can use to provide this expanded coverage in a budget-neutral way is the adoption of private-sector drug benefit management tools. States like Nevada are already applying such tools to provide mainstream private drug benefits for lower-income seniors. The savings generated from these tools in states' existing populations can be used to finance additional drug coverage.

Reliable, Affordable Health Insurance Coverage Options In Medicare

As I have already noted, the President believes that a critical issue for modernizing Medicare is to replace the failing Medicare+Choice system for paying private plans with a fair payment system that gives beneficiaries the innovative coverage options they deserve—options that have long been available to millions of Americans under 65 and all Federal workers. After years of inadequate payment updates, action is needed now to ensure that the valuable and innovative benefits offered by Medicare+Choice plans remain available to Medicare beneficiaries. Since the Medicare+Choice payment system was implemented in 1998, hundreds of private plans have left the program or reduced their service areas and benefits, adversely affecting coverage for millions of beneficiaries—reversing what had been an upward trend in private plan availability, benefits, and enrollment.

The benefits offered by the plans that remain still provide a better deal for many seniors than fee-for-service Medicare plus an increasingly costly Medigap policy. But the remaining valuable benefits provided by private plans are threatened, and the trend away from the availability of affordable and innovative benefits in Medicare has made millions of seniors worse off. Without immediate corrective legislation this situation will only get worse—just at the time when rapid advances in care will make it even more important for seniors to have these options. Indeed, based on the latest projections of the Congressional Budget Office, enrollment in Medicare+Choice will fall by more than a million over the next 10 years as a result of inadequate payment updates. Moreover, open-network plans like Preferred Provider Organizations (PPOs) and point of service plans have become popular among privately covered individuals, yet only two PPOs participate in a few counties in the entire Medicare program.

We seek to address these problems both through legislation and administrative action. For example, the Department of Health and Human Services just announced a demonstration project to expand health plan options in Medicare + Choice. Preferred Provider Organizations (PPOs) have been successful in non-Medicare markets and CMS is conducting the demonstration to test ways to provide more health plan options to people with Medicare. We hope to award demonstrations later this year in up to 12 geographic areas that will be available to enroll beneficiaries during the Fall open enrollment period and begin to serve enrollees next January. This demonstration program will test changes in methods of payment for Medicare services that may be more efficient and cost effective while improving the quality of services available to beneficiaries. The demonstration plans will be considered Medicare+Choice (M+C) plans and must offer all of Medicare's required benefits, but will also have the flexibility to offer greater access to drug benefits.

The President's budget also proposes to take urgently needed transitional steps toward the equitable payment system for private plans proposed in the President's framework for strengthening Medicare. These proposals would modify the Medicare+Choice payment formula to better reflect actual healthcare cost increases, allocate additional resources in 2003 to counties that have received only minimum updates, and provide incentive payments for new types of plans to participate in Medicare+Choice, including PPOs. Together these augmented payments would address the problem of persistently low payment updates to most Medicare+Choice plans, making more plan choices available and improving benefits for millions of seniors. Because these proposals would allow many plans to provide or at least maintain drug coverage in their benefit package, they also provide another means of giving seniors prompt help with their drug costs.

New Medigap Options

Because of the major gaps in the benefit package in the fee-for-service program, supplemental coverage—often called Medigap—is an essential part of Medicare coverage for millions of our nation's elderly and disabled. The Administration shares the concerns some have expressed regarding the rapid increases in Medigap premiums in recent years: most seniors now pay much more for Medigap than they pay in Medicare premiums. We also agree with the leaders on this Committee that we can better design both Medicare and Medigap so that seniors and people with disabilities can get more affordable coverage, and get the most for the health care dollars they spend. Clearly the existing set of options, which require beneficiaries to purchase "first-dollar" coverage for hospitalizations and even basic services like doctor's visits before they can obtain any drug coverage, has become outdated.

To improve beneficiaries' Medigap options during the several years it will take to make a better benefit package with prescription drug coverage available, we have also proposed that two new affordable Medigap plans be added to improve beneficiaries' options quickly. They would substantially reduce cost-sharing for beneficiaries and provide much better protection against high costs. And they would increase the number of seniors with drug coverage. If we provide a one-time opt-in for current beneficiaries, we estimate that up to one and a half million beneficiaries would choose these new policies once they are available—and that nearly half of these enrollees would be beneficiaries who do not have drug coverage now. Moreover, we can achieve this significant increase in drug coverage among seniors right away, not several years down the road, while saving money for beneficiaries and the Medicare program. Of course, as the President has made clear, seniors should be able to keep their existing Medigap coverage with no changes if they prefer it.

CONCLUSION

We are committed to working constructively with Congress to enact legislation consistent with the President's principles—so that we can get started on putting a

prescription drug benefit into place this year. We all know that failing to act to meet these unavoidable challenges may lead to more extreme changes later, including government controls on prescription drugs and stricter coverage limits in Medicare. These changes would reduce access to needed treatments and slow the development of new technologies, such as promising new drugs for common cancers and other diseases. Instead, we must come together now to take the sound, careful, and deliberate steps needed to improve the Medicare program for today's seniors and tomorrow's. And we must take action now. These issues have been debated for years. Seniors cannot afford to wait any longer. Including the transitional steps that the President has suggested would begin to provide relief as soon as later this year—not off in the future. Millions of Medicare beneficiaries could get drug coverage, and all beneficiaries could benefit from lower drug prices and spending, well before the full prescription drug benefit is implemented.

Finally, we must take action that preserves Medicare's promise for the future. Medicare's promise should enable seniors today and tomorrow to benefit from the tremendous potential of our health care system. Through private-sector innovation and flexibility to adopt new technologies, our health care system leads the world in giving patients access to medical treatments that improve their lives. Through action now to update Medicare's benefits and to keep them financially secure, the promise of secure health care coverage that President Johnson made thirty-seven years ago can be renewed for seniors and persons with disabilities in the twenty-first century. I thank you for the opportunity to discuss this very important topic with you today, and I look forward to answering your questions.

Mr. BILIRAKIS. Thank you, Doctor. I haven't asked you this question either in committee or outside of committee. I think you know from the prior Congress my desire, outside of the scope of the Medicare program, to help the needy people, the poor people now, and the sick people now. We weren't able to get anywhere in the last Congress on that particular point.

So, whether it be that type of a program or whether it be something else which is, I think, in the minds of all of us, perhaps a temporary fix, in lieu of a permanent comprehensive fix, which is what we all want but maybe not able to get because the checks-and-balances that the Founders put in the Constitution, et cetera. I think the feeling among many members, particularly on the other side of the aisle, is, well, if you do something like that, that ends it, you're never going to revisit it again, and therefore this thing that you now call a temporary fix will become a permanent fix. Do you have an opinion about that?

Mr. MCCLELLAN. Yes, Mr. Chairman. Our view is that we need to move toward the comprehensive Medicare drug benefit as part of legislation, as I have said, to make efficient coverage and lower cost care more widely available to seniors as quickly as possible.

In thinking about how to do that as quickly as possible, the administration recognizes that there are a number of steps that need to be taken now to put us in a position to implement a full drug benefit effectively in a modernized Medicare program in several years.

To do that, Medicare needs some experience with providing competitive approaches to delivering a drug benefit, and our hope is that we can use that opportunity not only to give Medicare experience, but also to provide some help in the short-term for people who need it now. Our goal is not, by any means, to support a low-income-only approach to drug coverage, and I appreciate the opportunity to clarify that.

Our goal is to implement a drug benefit effectively as quickly as we can, and to take advantage of existing key infrastructures to do that. That includes the mechanisms available today through cards

like McKesson, the chain drug stores, and other opportunities to make discounts available to seniors, and to provide other valuable pharmacy services. These kinds of programs are going to be a key part of a full Medicare prescription drug benefit.

It also includes taking advantage of the infrastructure that States have available now to identify low-income beneficiaries who need help and to get additional assistance to them. So, for example, by making Medicare-endorsed cards available that States could use to provide additional assistance to people with high costs and people with low incomes, we can both help give Medicare the experience it needs for a comprehensive benefit and we can give people who desperately need help right away, not 3 years from now, the kind of assistance they need on the way to integrating them into a benefit for all seniors and all Medicare beneficiaries.

Mr. BILIRAKIS. So you have heard the opening statements and some members have made comments that the discount card is not the solution. I mean, you would agree that it is not a permanent solution, that the feeling on the part of the administration is that it might be a temporary measure, but even if it were to become permanent, that it would be a part of a comprehensive plan.

Mr. MCCLELLAN. Yes, sir. As the President has made clear from the first time he has talked about this, as we have made clear over the past month, a discount or prescription assistance program that doesn't provide a drug benefit is no substitute for a Medicare prescription drug benefit.

Our goal is simply to implement a Medicare drug benefit as quickly as possible for all seniors, and to get there we need to develop the kind of experience and take advantage of the infrastructure that exists already to help seniors.

Mr. BILIRAKIS. I think it is noteworthy—you mentioned it and Mr. Green and others did, the fact that the chain drug stores and industry have taken it upon themselves to come up with these discount plan cards to help people even now. I mean, if it is only the poor who receive immediate assistance, it helps somebody at least. And I don't know that we should be looking a gift horse in the mouth.

Now, I know that there is concern if we do something like that, that sort of puts the fire out, the immediate fire out, and therefore these guys are going to shift over into something else. Well, I suppose that can always happen, but I would like to think that would not be the case.

We haven't heard from them yet, and I don't know what their statements will be other than what we have in writing, and we haven't been able to really peruse all of them all that well yet, but I think we do—on behalf of the committee, I commend them for at least coming up with something that will be of some help now.

We will hear a witness on the second panel—my time is about to run out—regarding the Nevada plan. Just to shorten my question, very briefly, any comments on the Nevada plan?

Mr. MCCLELLAN. We think it is a very constructive step. It shows how States can move in the direction of providing—using private sector tools to deliver a more effective drug benefit, and we do think that Nevada's experience applied nationally could be done at significantly lower cost. That is one of the main mechanisms that

is available to States under our Pharmacy-Plus waiver program, to adopt competitive approaches like Nevada has used to keep overall drug costs down, and to use those savings to provide more prescription drug coverage and, at the same time, move the Medicaid program in the direction of the privately provided drug benefit that we all, Democrats and Republicans, have advocated in a prescription drug benefit.

Mr. BILIRAKIS. Will either you, or will you have someone sit in during the second panel so that they can listen to the testimony as well as the questions and the responses thereto, we would appreciate that.

Mr. MCCLELLAN. Yes, sir.

Mr. BILIRAKIS. Thank you very much. Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. Thank you, Dr. McClellan, for being here. I would add in response to the Chairman's question, that the private sector didn't do it as well—$81 per month to deliver when the State could have done it for less than $54. But on to the question.

You spoke glowingly about the Federal Employee Health Benefit Plan, largely subsidized by taxpayers which provides a basic prescription drug benefit that's available to all Federal employees. Do you participate in the FEHBP, as do most members of the government?

Mr. MCCLELLAN. Yes, sir.

Mr. BROWN. Would you describe briefly your prescription drug coverage?

Mr. MCCLELLAN. It is a prescription drug coverage that uses the kind of widely available private sector tools to manage benefit costs and help encourage effective use of——

Mr. BROWN. I mean your prescription drug coverage. Could you tell me about yours?

Mr. MCCLELLAN. It has a tiered formulary with co-pays at one level for drugs that are on-formulary, a higher level for drugs that are off-formulary, and it provides assistance with the cost of prescription drugs, has a deductible, I believe, and some protection against high out-of-pocket cost.

Mr. BROWN. Should seniors and other Medicare beneficiaries have a benefit that is significantly less generous, more generous, or significantly more generous, or about as generous as FEHBP does?

Mr. MCCLELLAN. I think our goal is to provide effective drug benefits along the lines of FEHBP or other styles of benefits that could provide a significant degree of protection for seniors.

I think, if I can read where your question is going, your question is, should the government pay for most of the cost of that benefit. What I would like to say is that there are some creative ways to provide protection on the back-end, stop-loss protection, as well as a good basic benefit package and the right structure for providing drug coverage assistance which seniors could then augment with private coverage or other sources of insurance to get more comprehensive assistance.

Under our proposal, every senior of limited means would get comprehensive drug coverage paid for by the government, and we would very much like to set up a structure that would allow all

seniors to get access to the kind of comprehensive assistance with their drug costs that the Federal employees title benefit provides.

Mr. BROWN. Precisely, should the plan that we pass here, regardless of how it is constructed, should it be a similarly generous benefit, similar kind of benefit in terms of the worth of the benefit, as we provide to Federal employees? Should we provide a similar kind of benefit to our Medicare seniors?

Mr. MCCLELLAN. The plan that you pass, we believe, should provide the structure that would enable seniors to get the same kind of protection against high drug costs and assistance with managing their drug costs that Federal employees get. That doesn't necessarily mean a fully federally financed $801 trillion drug benefit program. It means setting up a structure that ensures that seniors will have access to protection against high out-of-pocket cost and will have access to the tools widely available to Americans to keep their drug costs down, and will have the opportunity to augment that coverage with additional assistance like the kinds of employer plans that Representative Burr spoke about.

Mr. BROWN. So if I am reading between the lines—because you aren't quite as direct as I had hoped you would be—and we try to pass a benefit about as generous, roughly the same as FEHBP, the Congressional Budget Office said that will require Federal investment of over $800 billion in the next 10 years.

Now, if that is what we want to do, a similar kind of benefit, then who are we asking to subsidize—you in the past have said, the administration has said, we will spend less than $200 billion on this benefit. So, are seniors out-of-pocket paying the extra $600 billion if we are going to do this? How are we going to do this?

Mr. MCCLELLAN. No. We would rely on the existing coverage that many seniors have now. We would want to integrate the new benefit so that it takes advantage of the large amount of private contributions that already are out there for providing drug coverage.

Before, we have discussed the employer contributions that exist. We have also discussed contributions of Medicare+Choice plans. Even now when there is no drug benefit in Medicare, as long as they are reimbursed adequately, they can make a significant contribution toward drug benefits. We don't want to replace all of those private contributions.

The idea of a $750 or $800 billion program that really is crowding out $300 or $400 or $500 billion in existing private coverage is really not providing the kind of effective additional assistance that seniors need.

Mr. BROWN. I know this administration worships at the Holy Grail of free enterprise and free market solves all problems, but, Dr. McClellan, the fact is Medicare+Choice doesn't save money, that is pretty clear. They come back here—the only thing you put in your budget specifically to provide money for providers was money for Medicare+Choice.

In Nevada, the example that the Chairman and you touched on, the government could do it for less than $54 a month, the private sector did it for $81 per month. I don't know how you can think we can close this $600 billion gap. You are only putting $200 billion—the Congressional Budget Office thinks we need $800 billion—and I guess all to make room for your tax cuts—how are we

going to do this? I hear my friends on the other side of the aisle talking about they want to provide this benefit, but you are not paying for it. And it is pretty hard to come to this body and to this committee and say that this is going to be anything comparable to what Members of Congress and what Federal employees have in this benefit, except the seniors are going to have to reach in their own pocket and subsidize it. My time is expired.

Mr. BILIRAKIS. You certainly are welcome to respond to that, if you would like.

Mr. MCCLELLAN. Thank you, Mr. Chairman. We would very much look forward to continuing to work with you and your staff. We have had some discussions with your staff already. We would be happy to do a lot more. If you have a specific proposal for the kind of drug benefit that you would like to see, and the mechanism for paying for it, we would be open to doing that.

It has been a little bit difficult for us to figure out exactly what that proposal would be since there hasn't been a House Democratic proposal on the budget resolution, and since the Senate is not really passing, as far as I can tell, a budget resolution, just what the package is that you are proposing and how it would be paid for.

I just walked through some of the concerns that we have about a package of $800 billion that is not paid for. It amounts to a tax on every working American down the road of $2200 per person. That does not seem like a sustainable recipe, to me, for making a Medicare drug benefit that will be available to seniors in the future.

What we think is a much more effective way to go is to get the private sector tools that have worked well in keeping drug benefit costs down in the private sector, and that CBO and the CMS Actuaries say would save money, get lower priced drugs and lower cost drug coverage into Medicare, and do that right away. Get the structure in place that would allow Medicare beneficiaries to have access to assistance with all their drug costs, and that would complement, not replace, the existing private coverage that most seniors have today. And we have looked forward to working with you on that.

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

Mr. NORWOOD. Thank you, Mr. Chairman. Dr. McClellan, I am glad you are here. I want to go back to some of your previous statements about stop-loss. Did I understand you to say that the administration feels that any plan we produce should have some stop-loss protection?

Mr. MCCLELLAN. Yes, sir, that is correct.

Mr. NORWOOD. And did I understand you to say that would be measured by out-of-pocket expense?

Mr. MCCLELLAN. We think measuring it by out-of-pocket expense would be a potentially very effective way to do it, but obviously we want to work closely with you on exactly what the——

Mr. NORWOOD. Not the total cost of the medications, but how much the patient actually spent out of their pocket, is that where you are coming from?

Mr. MCCLELLAN. That seems like an effective way to go. It seems like it would be a natural way to complement a lot of the coverage that seniors have today. Many seniors—most seniors do have drug

coverage. Too often, however, it is limited to a capped amount or it is threatened, especially in the case of employer coverage, by employers worried about the open-ended liability they might have for very high back-end costs. So providing drug coverage that kicks in after seniors have hit a certain level of out-of-pocket spending seems like a very good way to complement much of that existing drug coverage.

Mr. NORWOOD. Two questions about that. How do you determine what out-of-pocket spending is?

Mr. MCCLELLAN. One way to determine it would be to use the kind of infrastructure that we would like to get available——

Mr. NORWOOD. What if you don't get the infrastructure?

Mr. MCCLELLAN. Well, there are electronic mechanisms available now to process claims with pharmacies. Pharmacies have actually been leading the way in electronic data systems, and companies like McKesson who can talk to you more about this, I think, on the next panel, could tell you ways to do that. If you have a card or something like that——

Mr. NORWOOD. Okay. You are telling me that physically can be done.

Mr. MCCLELLAN. Sure.

Mr. NORWOOD. You can determine what people actually pay out of their pocket?

Mr. MCCLELLAN. We think it can be done fairly quickly with the Medicare-endorsed card structure proposal——

Mr. NORWOOD. I catch on to that, but we don't know that that is going to be the case. What is a good stop-loss, $3,000? $4,000? $5,000?

Mr. MCCLELLAN. Well, I think, obviously, we would want to consider the cost implications of a lower level versus the higher value that it provides, and that is something that—you know, we have looked at different numbers—$2,000, $3,000, $4,000—for out-of-pocket expenses, and we will want to work with you on those specific details of what——

Mr. NORWOOD. What is the story on $3,000 then?

Mr. MCCLELLAN. I don't have that off the top of my head, but I would be happy to——

Mr. NORWOOD. When I call you this afternoon, will you tell me at the office?

Mr. MCCLELLAN. I don't know if I will have it this afternoon, but I will have it for you very soon.

Mr. NORWOOD. Do you know what $4,000 is?

Mr. MCCLELLAN. Not off the top of my head.

Mr. NORWOOD. But we can get that this afternoon by calling——

Mr. MCCLELLAN. We can get it for you quickly.

Mr. NORWOOD. It is pretty important. The last thing is, now, you are saying that you believe any package that Congress produced, at least this is a central part of what that package should be as a stop-loss?

Mr. MCCLELLAN. That is right. We think it has two valuable purposes. One is that more and more seniors are facing high out-of-pocket costs as we have more and more very impressive and useful medications based on even the genetic code of an individual to get

individually tailored treatments, but those are often costly treatments, and we know seniors want protection for that.

Mr. NORWOOD. Are any of my colleagues aware of this? I wasn't aware this was going to be a central part of a package. Are any of my colleagues aware that this is where——

Mr. MCCLELLAN. This is an element of the President's framework for prescription drug coverage in Medicare. He does think it is very important to give seniors the peace of mind that they need, especially in an era when we are seeing more and more valuable but costly drugs being developed and introduced. This is a critical part of Medicare going forward.

Mr. NORWOOD. If I were king and had all the money I wanted, what I would like is every senior citizen to be covered for any amount of medication they needed, with maybe a $5.00 premium and a $1.00 co-pay. That is what I would really like to see us be able to afford.

There are some in Congress and outside advocacy groups as well, that are advocating for creation of a new Medicare prescription drug plan that may cost in the neighborhood of $700 billion over 10 years. Now, I would like that, too, but I want you to be very specific with me. What effect will this type of entitlement have on Medicare, on the Medicare Trust Fund, on the Medicare Trust Fund as we go down the road in terms of specifically with its solvency. You know, it is great to have prescription drugs, but if you can't get access to the doctor who writes the prescription for the drug, something is not going to work right, is it?

Mr. MCCLELLAN. That is right.

Mr. NORWOOD. Tell me—just talk to me about that.

Mr. MCCLELLAN. We are very concerned about the threat that very large drug benefit like that would pose to the ability of Medicare to provide all of its promised benefits to seniors in the years ahead. If that kind of drug benefit was actually funded partly out of the Part A Trust Fund, the Part A surpluses, the solvency date for the Medicare Part A Trust Fund would move from 2030, as it is today, all the way up to 2016, and the Trust Fund would start losing money as soon as 2008.

If you try for the creative separate accounting and put it in its own separate trust fund and hope that somebody is going to figure out a way to pay for it later, the cost down the road would amount to almost 2 percent of our national product by 2030, and that is a tax on every working American in 2030 equivalent to $2200 today. That is a level of tax requirement or an equivalent impact on government's other priorities—remember, that is $2 out of every $100 in the United States economy at that point—that would have a fundamental effect on either the ability of Medicare to pay for its existing benefits, or the other critical priorities of the U.S. Government and the American population.

Mr. NORWOOD. Would that affect people under 65 and their ability to have health care?

Mr. MCCLELLAN. Well, they are right now facing rapid increases in their own health care costs, and in some of our discussions about the problem of the uninsured, people have told me that a premium of $2,000 is not affordable. This would cost even more.

Mr. NORWOOD. Thank you, Dr. McClellan.

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

Mr. PALLONE. Thank you, Mr. Chairman. Dr. McClellan, let me say first of all that I totally disagree with your strategy here, which I think is that you would like to see a universal Medicare prescription drug program, but that is long-term, and in this transitional period of, I guess, 2 or 3 years, whatever it is, we have got to look at other things.

I mean, I have two problems with that. I could be very cynical and say that this is part of some administration strategy that hopes that we will forget about the long-term proposal by concentrating on this low-income benefit and hoping that the other will simply go away, and that if we cover a few people who are low-income, then maybe politically that will satisfy our commitment long-term.

But even if I wasn't cynical and wanted to take everybody on their word and say you are trying to do your best and you are really trying to come up with a strategy that is going to help people—and I will assume that—I just don't see it. I don't see why it works. In other words, we have an experience with the CHIP program where we tried to put in this complicated situation where States would try to cover the kids, and it is a few years now—it has taken 2 or 3 years, and now most of the States are on it, and it seems to be working well, but that took a long time.

It seems to me that instead of looking at this transitional period and trying to help a few people—and it is going to be very few—it would make sense to just concentrate on trying to do the universal program, cover everybody, and spend our time and energy there.

Let me give you an example. I want to ask you a question, but let me give you an example. In my own State of New Jersey, we have a very generous program, and right now the State—and I don't blame them, and I support it—is trying to use the waiver that the Secretary has proposed to get $150 million back in Federal funds to finance their existing program. Now, that is commendable. We should get it. We certainly deserve it based on fairness, and I support it, but it is not going to put one additional person—it is not going to provide drug coverage for one additional person. So I think you have got the situation where you are going to go through this drawn-out strategy that could take years to cover very few people, or maybe even no people in some States, and instead you should concentrate on just trying to put the universal program in place.

Let me ask the question. The Congressional Budget Office analysis of the Bush Administration proposal indicates that—this is the low-income proposal—it would only provide 18 percent of low-income beneficiaries and 6 percent of all beneficiaries with a prescription drug benefit by 2007, while a Medicare prescription drug benefit for everyone would ensure nearly 100 percent coverage of all seniors as soon as it went into effect.

So, doesn't it make sense that the Congress and the administration focus on a workable, meaningful, effective drug benefit that is available and accessible to all seniors, rather than design a complicated, inefficient, and I believe, highly ineffective low-income-

only policy, especially when a low-income-only policy would only be in effect until this universal benefit begins? Explain to me why you think that that makes sense. It doesn't to me.

Mr. MCCLELLAN. Well, we are trying to work back from a comprehensive drug benefit that would be available to everyone. We completely agree with you, Representative Pallone, that that is our first priority—how can we get effective drug assistance implemented as quickly as possible?

Working back from that, it is clear that the Medicare program needs experience with managing a drug benefit assistance program. It doesn't have that now and, again, that is where the Medicare-endorsed drug cards would come in. We would get experience with managing competing ways of providing drug assistance. Seniors would get some experience with choosing a plan that is best for them.

Mr. PALLONE. What I don't understand, Doctor, is why would we and the administration devote our time and energy to establishing these 50 different State assistance programs that are going to take a number of years, you said, to set up, only to replace them with the broader Medicare benefit in 2 or 3 years? Doesn't it make more sense to just concentrate now on efforts to do a drug benefit for all? Politically, the atmosphere is right. Our constituents are demanding the comprehensive benefit. And I am just afraid that by doing this alternative which you have outlined today, you are missing the political opportunity to pass something that is going to help everyone, and instead put this complicated procedure that CBO says is going to help many people.

Mr. MCCLELLAN. We want to get legislation that includes a comprehensive benefit and it implements as effectively as possible with some help on the way. According to the actuaries' estimates, the low-income assistance would benefit up to 3 million seniors and could be done through the kind of drug cards and other competitive approaches to providing prescription drugs——

Mr. PALLONE. There are 37 million seniors that wouldn't benefit compared to those——

Mr. MCCLELLAN. There are 9 million seniors without drug coverage now, 3 million seniors getting coverage through this approach, another 700,000 getting coverage through our additional Medigap option, another 100,000 getting assistance now through the improved Medicare——

Mr. PALLONE. Let me ask you, if this is such a priority—I mean, the administration has allocated $190 billion over 10 years for Medicare prescription drugs in the 2003 budget. If this is such a priority for the President, why aren't they allocating more money?

Mr. MCCLELLAN. We believe that with strong measures that make the program more efficient in the long-run, which Medicare really needs for all the financial reasons that we have just discussed, that a prescription drug benefit, an effective prescription drug benefit, can be implemented in 2003 for the kind of net dollar commitment in the President's Budget. We have made clear that we are willing to work with Congress on this, but in doing so we want to keep a focus on the implications of any prescription drug benefit and other new benefits that we add for the long-term finan-

cial solvency of the Medicare program and its ability to keep all its existing benefits secure.

So, we will work closely with you on that, but we do not want to lose sight of the fact that Medicare is a promise that needs to be there for seniors not only today, but 20 or 30 years from now as well, and needs to be done in a way that doesn't overly burden the next generations of Americans.

Mr. BURR [presiding]. The gentleman's time has expired. The Chair would recognize himself for 5 minutes for questions.

Mark, again, thank you. To some degree, what we ask at this stage of administration witnesses, to try to be specific on something that they can't be specific because you understand the role that the House and the Senate play in the formation of policy. And, clearly, you understand we are all across-the-board today, even though this is the third or fourth or fifth year that I think we have debated the issue of prescription drugs, the one thing that certainly everybody here supports is the fact that we need to extend some type of benefit, and I think the White House has been bold in what they have proposed so far. And I would ask you simply about one specific piece and the importance that you feel that has, and that is the benefit card. That was something that the administration has proposed since the beginning, it is something that there has been a lot of effort put toward.

How important a component do you see that to the final product?

Mr. MCCLELLAN. We think it is a very helpful component for—as Representative Pallone was concerned about—making sure that we implement a comprehensive benefit effectively. I think all of us, Republicans and Democrats, agree that private sector tools should be used in providing the Medicare drug benefit when it is fully established. And the drug card is a good way to get the right tools in place early, to give seniors experience with it, to give the program experience with it, and to give the people that will actually be providing the drug benefit more direct experience with seniors and their drug costs and managing their benefits. So we think it is important from that standpoint.

We also think it is important from the standpoint of providing some relief for seniors and helping make sure we work out the bugs before we are playing with the full benefit dollar, the literally many billions of dollars that will be involved in this drug benefit, and the kinds of responses that we have seen since the President laid out this issue, from companies like McKesson, give us some confidence that with Medicare endorsing the best kinds of programs out there and helping seniors choose among them, we will find ways to do this that deliver some real assistance for seniors in the short-run, 20 to 40 percent reductions in drug prices seems nontrivial to me, before we get full drug coverage available, and also be done in a way that works for local pharmacies which are a critical part of delivering any drug benefit effectively.

So we would like to see a way to make this work to get us on the road toward a comprehensive benefit, as part of an overall legislative package.

Mr. BURR. In our second panel today, we will have testimony from the State of Nevada who, if I remember correctly, started with a benefit that had multiple plans and multiple options and, since

that time, have honed that down to one plan, one option, an option that I think from their testimony has been very successful in Nevada.

What should we, if anything, learn from their experience or the experiences that we have seen in any other State so far relative to prescription drugs and seniors?

Mr. MCCLELLAN. I think it is a valuable experience and that it shows that moving toward private innovative coverage can be done now to take us on the way toward the kind of mainstream private coverage that we want to have available for all seniors in a prescription drug benefit in Medicare.

Nevada, as a single State, with a limited number of seniors participating in the program—remember, many older Nevadans already have coverage through other means, this is a program targeted at lower income seniors that do not have coverage today—that is not an enormous number of people. It is not like the entire Medicare program that w would be talking about for a Medicare drug benefit. So, there are opportunities from the scale involved and the scope involved in the Medicare drug benefit to encourage effective competition and choices among private plans that may not be as easy to implement in a single State for a single low-income program, and that is what CBO, the CMS Actuaries and others have indicated is the right way to go for getting a Medicare drug benefit delivered as cost-effectively as possible.

Mr. BURR. Would you agree that there are multiple options that we could come up with to handle the low-income seniors based upon how targeted a population that is, not necessarily that we offer multiple plans, but we have multiple options now as to the directions that we could go in providing a benefit for low-income seniors?

Mr. MCCLELLAN. Sure.

Mr. BURR. If you will, comment on this last thing, and that is that first out of the chute this year was a plan—maybe not a plan—a dollar amount—AARP suggested that the drug benefit had to be $750 billion, if I remember correctly. I think since then maybe they have changed to some degree.

Comment, if you will, from the standpoint of the administration, can America today or tomorrow afford a $750 billion drug plan? If not, what would it cost?

Mr. MCCLELLAN. We don't think that $750 billion would be affordable. Earlier and in my written testimony I go through in some detail what the numbers associated with that are, and it is a level of spending that we think would not make it easy to sustain Medicare's benefits for the Baby Boom, would not make it easy to pursue the other high priorities of the U.S. Government, if we are spending 2 percent of our entire national product and over 10 percent of all Government spending on a drug benefit alone, and that is why we think it is incumbent upon us to find effective ways to deliver and provide a universal drug benefit at a lower cost. As AARP has said, it is not going to be easy to do that for the amount that we described in our budget or the $350 billion in the House Budget Resolution, but that is the best way to balance the need for providing real assistance for seniors now, with the promise of Medicare to be there for seniors in the future.

Mr. BROWN. Could I ask the gentleman to yield just to point a clarification of the $2200. I assume that is with no price controls or no constraints at all on drug company pricing?

Mr. MCCLELLAN. Well, that is the cost implication of spending $400 billion out of the Part A Medicare surplus funds in the next 10 years, and extending that same kind of spending for the 10 years after that and the 10 years after that.

Obviously, we had hoped to use the most effective cost control mechanisms possible through these private sector means, as CBO has said, to keep the overall cost of the benefit down. But if you are spending $750 billion on net on a prescription drug benefit, it is going to have fundamental implications for taxes that need to be raised on all Americans, or for the ability of the government to do just very basic key functions, since it would be such a large part of Federal Government spending down the road.

Mr. BURR. My time is expired. The gentleman from Michigan, Mr. Stupak, is recognized for questions.

Mr. STUPAK. Thank you, Mr. Chairman. Doctor, you said you want the most cost-effective plan, and your program here is based on the average wholesale price, correct?

Mr. MCCLELLAN. Our program is not generally based on the average wholesale price. As you know, drugs that are covered by Medicare today——

Mr. STUPAK. What is it based on?

Mr. MCCLELLAN. Our plan would be based on private sector competition, the same kind of approach that is used for the vast majority of Americans who have drug coverage today.

Mr. STUPAK. What is the private system? That is the price that is set by the drug companies, right?

Mr. MCCLELLAN. The private system uses a mechanism for negotiating discounts from drug manufacturers to get prices down in health insurance plans. These discounts can range anywhere from 10 to 40 percent. They are not set by the government, they are negotiated by the private sector through competitive means.

Mr. STUPAK. Well, let us talk about your plan then because probably the most effective lowest price drugs come from the Federal Supply Service, FSS, correct?

Mr. MCCLELLAN. The Federal Supply Service is one way of getting lower prices for more drugs.

Mr. STUPAK. We have done these studies in 1998——

Mr. MCCLELLAN. And as you know, there are some questions about whether it is working effectively.

Mr. STUPAK. [continuing] and here is a copy of it right here. Federal Supply Service was the lowest price cost drugs. Those are drugs that the Federal Government buys for the VA, for Medicaid, for Indian Health Services, and other beneficiaries, and we negotiate—the Federal Government—the best possible lowest price. And study after study has shown it is by far about 40 percent less than the average wholesale price, the independent price, the chain price, the major wholesaler price.

So, under your proposal then, are you going to guarantee that seniors will actually receive any savings?

Mr. MCCLELLAN. Yes, we would expect seniors to receive significant savings through two means. One is through lower negotiated

prices—and we want prices to be negotiated competitively, we don't want the government——

Mr. STUPAK. Lower negotiated prices, who is going to negotiate that price, the Federal Government or drug——

Mr. MCCLELLAN. The same kinds of organizations that negotiate lower prices on behalf of the health insurance plans used by millions of Americans today.

Mr. STUPAK. So that is one way, you are going to have these drug managers negotiate price. What is the other way?

Mr. MCCLELLAN. And the second approach is that—as you know, there is more to lowering drug expenses for seniors than just lowering prices. There are valuable tools provided to give seniors advice about generic alternatives. I think AARP is soon going to be working on a campaign about that, so making better information available to seniors about how to manage their drug costs.

Mr. STUPAK. Information and your price managers. I am trying to move on here because I have a number of questions and am limited in time.

Mr. MCCLELLAN. Sure.

Mr. STUPAK. So, basically—I brought up in my opening statement, I believe you were here, that it is like this National Prescription Health Plan, that would be one way, right, using a card?

Mr. MCCLELLAN. I don't think from the description I heard of that plan, that would be a drug card that would get any kind of Medicare endorsement. I think that is exactly why we need a Medicare-endorsement process.

Mr. STUPAK. Do you think Medicare is going to endorse which companies can do these drug cards out to seniors?

Mr. MCCLELLAN. That is right. Medicare is going to set some standards that would make sure that companies are providing assistance with a full range of drugs, are offering lower prices through manufacturer discounts——

Mr. STUPAK. So, as you are guaranteeing which plans, then tell me, if you will, what kind of discounts will seniors get?

Mr. MCCLELLAN. We think that the private sector would provide significant discounts. In the analysis that we did accompanying our release of the Notice of Proposed Rulemaking on this——

Mr. STUPAK. Significant discounts. Can you tell me 10 percent, 20 percent, 30 percent?

Mr. MCCLELLAN. Sure. Our analysis indicated savings of up to 15 percent on average for all seniors.

Mr. STUPAK. Fifteen percent, off of what——

Mr. MCCLELLAN. Off of the——

Mr. STUPAK. [continuing] the average wholesale price or the price set by the——

Mr. MCCLELLAN. Off of the price that seniors are paying today. Seniors are among the only people in the country——

Mr. STUPAK. [continuing] That seniors are paying today.

Mr. MCCLELLAN. Right.

Mr. STUPAK. What seniors are paying today is the amount set by the drug companies. So, it would be 15 percent off the price set by the drug companies.

Mr. MCCLELLAN. Well, and whatever markup the pharmacies provide but, as you know, that is a small markup.

Mr. STUPAK. All right, pharmacies is very small, 1, maybe 2 percent, at most.

Mr. MCCLELLAN. Well, it is more than that, but it is small.

Mr. STUPAK. The amount we pay is set by drug companies. That is what we do right now, and under your plan that will be the plan in the future. Whatever they set——

Mr. MCCLELLAN. No. Seniors would get lower prices from the ability of the cards to negotiate and get lower prices from drug manufacturers. That is what cards like——

Mr. STUPAK. Here is what the pharmaceutical is going to charge you. There is going to be about 15 percent off, you think. Tell me, does the drug proposal require the discount to be passed on to the seniors?

Mr. MCCLELLAN. The drug proposal would encourage seniors to sign up for cards that pass on discounts. Right now, seniors pay a full markup from manufacturers, private plans pay much less.

Mr. STUPAK. You said "encourage." It does not require them to pass on that 15 percent to seniors because that 15 percent can be given in other type of services, as you indicated, like talking to them about their drugs or counseling them about their drugs.

Mr. MCCLELLAN. Well, that seems like a worthwhile option. If seniors want more valuable services along with the drugs, we want to encourage that.

Mr. STUPAK. Agreed, good option, but it is not a 15 percent—does not necessarily have to then come off the drug, the cost of these other services.

Mr. MCCLELLAN. I am sorry, I misunderstood. The 15 percent is the savings in drug prices that seniors would realize on average, and for some cards the savings could be much larger, like the low-income cards that are now going to be widely—and we hope very widely—available with our help to seniors savings of 20 to 40 percent off what they are saving now—or off what they are paying now.

Mr. STUPAK. We have got a system here designed that drug companies will determine the amount, you are hoping they will get 15 percent off, that 15 percent does not necessarily have to come off the price of the drug, that can go for other services.

So, in short, you really believe that it is a good idea for Medicare, a program that is really recognized and respected by our seniors, to give its endorsement to these discount cards when the cards don't even have a discount that has to be given to the beneficiaries?

Mr. MCCLELLAN. We think it is a good idea for Medicare to use the same kind of approach that has worked well for millions of Americans, to get much lower prices for their drugs than seniors are paying today. Seniors are paying full price today. People in private industry are paying up to 40 percent off.

Mr. STUPAK. What are you going to do about the cost of drugs? You are going to give them 15 percent off. Last year—the numbers just came out about 2 weeks ago—it went up almost 18 percent. So after 1 year on your program, the seniors are now 3 percent in the hole from where they were from the time they signed up.

Mr. MCCLELLAN. That is the problem with rising drug costs, and that is why we need a Medicare prescription drug benefit along with other assistance implemented as soon as possible.

Mr. STUPAK. But you are going to do nothing——

Mr. MCCLELLAN. No, we are going to implement a drug benefit, and we are going to take these steps to get prices down. Seniors are paying too much. They are paying the full list price for drugs. People in private insurance are getting anywhere from 10 to 40 percent off. We want those same kinds of savings available to seniors.

Mr. STUPAK. Other than the card——

Mr. BILIRAKIS The gentleman's time has expired.

Mr. STUPAK. If I may just follow up——

Mr. BILIRAKIS. Very quickly because what happened is we didn't set the clock when you first started, so you are probably on your seventh question.

Mr. STUPAK. Thank you, Mr. Chairman. So, other than this card which may give you 15 percent off, there is no other way to control the cost of the rising pharmaceuticals we pay every day?

Mr. MCCLELLAN. According to CBO, the kind of approach that we are advocating is the approach that would provide the most savings for seniors and the most reduction in the cost of a drug benefit of any of the major proposals that have been——

Mr. STUPAK. That is for the government, but not for the beneficiary.

Mr. BILIRAKIS. The subject of possibly another hearing. Mr. Deal to inquire.

Mr. DEAL. Thank you, Mr. Chairman. I would like to first of all ask you with regard to the Medicare+Choice programs, did most of those provide some form of prescription drug benefit as a component?

Mr. MCCLELLAN. Historically, the vast majority of Medicare+Choice programs have well over 90 percent until just a year or 2 ago.

Mr. DEAL. Do you have any information as to whether or not that component of the Medicare+Choice package was a reason why many have now withdrawn from the program because of the cost of doing that?

Mr. MCCLELLAN. The overall problem is one of Medicare reimbursements not keeping up now for year after year, with the cost of providing a modern benefit package including prescription drugs.

As you know, since the Balanced Budget Act was implemented, the payments to Medicare+Choice plans in the vast majority of parts of the country have fallen well behind not only their cost increases, but the payment increases in the fee-for-service program, and it is that differential that is making it more and more difficult for the plans to continue in the program and offer a modern benefit package.

Mr. DEAL. And the prescription drug component of it complicated it even further.

Mr. MCCLELLAN. Absolutely.

Mr. DEAL. Is there any indication as to those plans whether or not the addition of the pharmaceutical benefit caused a significant increase in usage of pharmaceuticals as a result of that option being offered?

Mr. MCCLELLAN. That is a good question. I think evidence—and I don't have it all at my fingertips and I will try to follow up with

you on that—I think there is some evidence that providing prescription drug coverage does lead to more use of prescription drugs, however, the way that a lot of these Medicare+Choice plans have provided the drug coverage is in conjunction with other benefits that are not available in Medicare as well. These are things like disease management programs, preventive benefits, wellness programs, all of which encourage more appropriate use of all the many complex medications that are out there.

So, offsetting the fact that lower prices make it easier for seniors to use more drugs, is the fact that these programs enable them to use drugs more cost-effectively and to keep the overall costs down. These are benefits that I think are extremely important for seniors and need to be much more widely available in conjunction with the drug benefit.

Mr. DEAL. I understand that obviously the use of certain pharmaceuticals reduce the cost in other components of the Medicare service delivery package, but I would think it would be very difficult to project cost because of this extra usage component—very difficult to project the cost of a pharmaceutical program because I don't think you can really look at the Medicaid as a true indicator of what the cost is going to be. There is just really an unknown factor there in terms of what increased usage there might be to expand the benefit.

Mr. MCCLELLAN. Yes, sir, I think that is true. We are obviously facing a lot of uncertainty here.

Mr. DEAL. But even with the best of certainty, your indication is that if we were to look at a universal plan such as has been discussed previously here of some $750 billion over a 10-year period, that that would have serious, serious consequences on the financial stability of Medicare. I believe you indicate that if that were done, that in 6 years, by 2008, it would start going in the red again and would be bankrupt in 14 years. That is serious consequences as far as I would be concerned.

Your projections, too, of the cost, as I understand it, you are saying that today the cost of Medicare, as we know it, is roughly 2 percent of GDP.

Mr. MCCLELLAN. That is right.

Mr. DEAL. And if we added a prescription drug benefit, that by the year 2030 that prescription drug benefit alone would be 2 percent of GDP.

Mr. MCCLELLAN. Would be almost 2 percent of GDP, and by 2030 as well the cost of Medicare's existing benefit——

Mr. DEAL. Is going to double.

Mr. MCCLELLAN. [continuing] will have gone from 2 to 4 percent of GDP.

Mr. DEAL. So we are faced with this multiplication factor that goes into place. I have just done some real quick calculating here. My only grandchild is going to be 30 as of 2030, and if that is the case, the way I calculate it, she would have to pay about $550 a month just to sustain the cost of Medicare with that kind of drug component in it, $6,600 a year. I personally don't think that is a sustainable demand, and I compliment you for the proposal that approaches this in a much more modest fashion.

I think all of us get carried away in making promises on something that sounds good, but the most unsustainable of options is not the best in the long-term. And I compliment you for the proposal that you have made.

I assume, too, in the drug card program that you are proposing, that negotiated savings are what you anticipate is going to happen, and competition, of course, I think would stimulate those increased savings. Is that part of the factor?

Mr. MCCLELLAN. That is correct, and we have started to see that already with some of the drug cards that have become available since the administration's announcement.

Mr. DEAL. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Ms. Eshoo to inquire.

Ms. ESHOO. Thank you, Mr. Chairman, and thank you, Dr. McClellan, for your testimony today. Just a quick, but I think very important observation. There seems to be a highly concentrated effort here today to continue to describe what the burdens of a cost of a benefit would be in Medicare for a universal benefit.

Woe is America, woe is every American, woe is every future generation, if we do this, if we make this a benefit through coverage through Medicare.

What I have to observe—and I keep reading what CBO comes out with but, of course, the administration doesn't want to pay any attention to CBO, which is very interesting—I really think that the Republican mantle that has been carried for years about fiscal responsibility has not only fallen down, but it has crashed into a thousand pieces because what the administration is ignoring is fiscal responsibility of a $4 trillion cost of making the tax break package permanent. That is being ignored, and the concentration of the effort is on this. In fact, we would have the resources for homeland security, for prescription drug coverage benefit in Medicare, and the war on terrorism, as well as our other responsibilities, but for this fiscal irresponsibility or the overlooking of and leapfrogging over what is going to come to the floor.

So, when you are here representing economics, I think there is a 10,000-pound gorilla sitting in the middle of the room that is being ignored. And that is why I want to make this observation.

I have two questions for you. In your testimony, you outline the President's vision for the drug benefit to protect seniors from catastrophic drug costs. Specifically, you say that many seniors have annual drug costs of under $500. I think your details are a little vague, and I am concerned that the plan creates a huge gap in coverage for those who have moderate to high drug costs perhaps of $100 per month. Can you tell us, or give us some more specifics, about how the President's plan is going to help those seniors, many who have incomes of less than $30,000 a year?

And my second question is that in the President's Budget, in order to pay for prescription drug benefits, he has said that the AWP must be fixed. He accounts for it being fixed in his budget, but doesn't say how. Can you tell us how?

And then the third point that I want to make is, what I want to give to you—and then I would like you to respond to me in writing—is the bill that I introduced, that I referenced in my opening statement. It has a voluntary Part B. There is stop-loss coverage.

There is competition through PBMs, and the OPM is the administrator, and not HCFA—I know we changed the name of HCFA, but I can't think of it—so to address that whole bureaucratic whatever issue. And I really would like a serious response to that.

I think, obviously, that it is a helluva bill because it incorporates both coverage and public-private issues and competition. So, I want to give that to you and ask you to respond in writing, but if you could just comment on the two questions that I posed and, again, thank you for being here today. And you know that I don't agree with you, but obviously you are the game in town. You are the ones that we have to work with, but I think that we are fiddling while this issue burns across the country. Again, I want to acknowledge what others are doing, cards and discounts and all of that. But you know what, it is an attempt—and I think it is wrong to ridicule it and whatever, I am not here to do that. And I thank people for attempting to do something, but it is not going to do what needs to be done in terms of insurance coverage. Take it to your mother and explain it to her, Mr. MCCLELLAN. I have had a chance to do that already.

Ms. ESHOO. She will give you hell. She is going to say, "It sounds terrific, but how does this work for me?" So, your answer——

Mr. MCCLELLAN. Very good question, and maybe a couple of minutes——

Mr. DEAL [presiding]. Well, the lady expired all of her time with her question, but we will allow you to respond.

Mr. MCCLELLAN. We will take a close look at your bill. I think we have already had some opportunity to look at it, and especially if you have got a proposal for how the bill is paid for, you know, how it fits into a Budget Resolution which we are still hoping to see from the Democrats, that will be very useful because that would give us some confidence about making sure that this is a benefit that will really be there in the years ahead for the Baby Boom.

With respect to your two questions, all of us here are clearly supportive of a comprehensive drug benefit for low-income seniors, so that is going to be included in any kind of prescription drug bill——

Ms. ESHOO. Why is that only low-income people get sick?

Mr. MCCLELLAN. No, I didn't say that.

Ms. ESHOO. What about others? How do they get——

Mr. MCCLELLAN. The lower-income seniors are the ones that have the least ability to pay for their own benefit, and just as with other aspects of Medicare, there will be a basic benefit package that they would be in, a prescription drug benefit for all seniors, and they would get additional help so that they would have minimal out-of-pocket payments since they are least able to afford it.

Beyond that, on both of these questions, I think my answer is in part going to be we want to work with you on this, on the drug benefit design. I think we, the committee, Ways and Means and so forth, all envision having a drug benefit that does more than just provide some back-end catastrophic or high expense protection, which I think we all agree also is very important. So we would be happy to work with you on ideas on how to specify that, and we

do think that all seniors need some additional assistance beyond catastrophic-only.

With respect to the AWP question, as we said in our budget, we want to work very closely with Congress on developing and implementing the best possible idea for reforming that payment system. Everyone agrees it doesn't work. You all have had extensive hearings about it. There is clear bipartisan support for moving forward. I know there are some ideas being developed around here on moving to an average sales price approach. Those are very good ideas, and our main goal is just to do this effectively and do this this year, and do it in a way that preserves access to Medicare drugs through fair payments, and also preserves adequate reimbursement for the physicians and others who are prescribing these drugs. We will do it this year.

Mr. DEAL. The Chair recognizes Mr. Barton.

Mr. BARTON. My question is a little bit simpler than Congresswoman Eshoo's. She knows the buzz words a lot better than I do. I couldn't even understand her question, it was so intelligent and well meaning.

I come at this a little bit different way. I think our entire health care system is verging on collapse. It is very complicated. Patients are frustrated. The doctors are frustrated. The hospitals are frustrated. We have tried managed care for the last 10 years. It helped restrain cost, but it had some quality of service problems. So I am a long-term proponent of totally scraping the existing system and going to Medical Savings Accounts where it is the doctor, the health care provider and the patient.

Now, in all this debate on a prescription drug benefit, I don't see anywhere in the Bush Administration any cognizance of the fact that we could do a prescription drug benefit savings account. So, as I said in my opening statement, I am working with Congressman Johnson on the Ways and Means Committee, and we are going to come up with some proposals that we are going to share with our colleagues on using a prescription drug benefit savings account approach where the money could be used for any number of options which might have to be precleared by—and I don't know what the success or buzz word is for HCFA either, so I will use HCFA, too. Has the administration looked at a prescription drug benefit savings account as an option, maybe either as a stand-alone option or as an option where you put the money in and you let the marketplace develop the option?

Mr. MCCLELLAN. We have certainly looked at the general idea of that, but we would be very interested in seeing your proposal. As you know, we have been trying to work fairly closely with the committees in coming up with a consensus approach that is going to give seniors protection against very high costs, and it is going to provide a benefit that is effective and that will keep the cost down in the long-run.

As you know, more generally, the administration strongly supports improving the existing medical savings account options that are available to Americans, and we would like to see an option for that approach to be available to seniors as well. It is clearly not working under the Medicare+Choice system, but we would be very interested in pursuing that.

Mr. BARTON. If you look at your bullets on page 3 of your written testimony, none of those general policy goals seem to be at variance with an option of a prescription drug benefit savings account either as the option or as one of several options that seniors could choose from. And that is all I am asking, is that we give it a chance because we have had several members talk about their mothers and their fathers. I will guarantee you, my mother—my father is deceased, but my mother has had years where she used almost no prescription drugs. She was very healthy. And then she has had two heart operations in the last 2 years, and now she is using a lot. So, if you had a savings account approach, in the lean years you save up and have some sort of a catastrophic prescription drug benefit, and in the years you need it, it is there, and it is money that is your money, and you work with your health care provider. I think it would be at least an option that a lot of seniors would look at.

Mr. MCCLELLAN. Well, clearly, some new ideas are needed for keeping costs down and delivering effective care and, as you have said, what we have tried to do is lay out some general guidelines in our framework and then work closely with you here in the Congress——

Mr. BARTON. It is not something that you in your position, or others in the Bush Administration have taken off the table. It is something that you will work with us on, at least to pursue in a serious vein.

Mr. MCCLELLAN. We would certainly like to pursue it in a serious manner. We know that time is short this year, and coming together in this committee and in the Ways and Means Committee in an approach to providing Medicare prescription drugs and modernizing the program effectively, but we would certainly like to consider all good ideas in that process, and this seems like it has got some promise.

Mr. BARTON. Thank you, Doctor, and I yield back.

Mr. DEAL. The Chair recognizes Ms. Capps.

Ms. CAPPS. You didn't get to hear me say thank you very much, but I think you recognize that I did that, for the time that you have spent with us.

I appreciate the seriousness of this topic, as you do as well, and I want to ask you a question based on your premise that of course our goal long-term is to include a prescription drug benefit as a part of Medicare so all seniors can take advantage of it, or at least something thereabouts, that that would be the ideal plan. And several who have also espoused the President's plan have reiterated that overlying goal. And I guess it is maybe too simple a question, but I would like to have you respond with when would such a time be? What would the scenario be that would allow us to consider this and what ingredients are now present today?

I mean, we are now on the edge of the Baby Boom generation wanting to take advantage of the benefits of Medicare. And what would we need to have in place so that we could consider a universal—a Part D, if you will, of Medicare that includes prescription medication?

Mr. MCCLELLAN. Let me be very clear that the President wants to see legislation enacted this year that provides a prescription drug benefit for all seniors—for all Medicare beneficiaries.

Ms. CAPPS. This year?

Mr. MCCLELLAN. This year. And he would also like that legislation to include the key steps that would be needed to make sure that we implement that benefit as quickly and as effectively as possible.

Ms. CAPPS. Why don't we start on that now, then?

Mr. MCCLELLAN. I couldn't agree with you more. So we would love to see this legislation include the prescription drug benefit and include a clear path for getting from here to there as quickly as possible, and for helping as many seniors on the way as possible. That is what we want.

Ms. CAPPS. Well, then I propose that we—any plan that is an intermediary plan that is as widespread as Medicare that covers so many seniors is going to take some time and cost to implement. If we waste our time, if you will, on a first step, we will probably not get to the ultimate goal.

But I want to shift a bit because Medicare was instituted in the 1960's because the private sector couldn't deal with health care for seniors, and we didn't include prescription drugs then. People acknowledge there weren't as many, but now it is a very different scene. However, you want us to be cost-effective, and I just want you to comment on the fact that the Federal Employees Health Benefit Plan premiums went up 13 percent in 2002. I acknowledged in my opening remarks that the 1.2 million member California Public Employees Retirement System—it is supposed to be a really hard-nosed plan—has just announced that they are going to have premium increases of 13 to 41 percent. This is in California where managed care has reigned supreme for a long time. We have many, many plans there. That is a pretty high percentage now.

The OMB has projected that Medicare itself will increase 4 percent between 2003 and 2012. Comment, if you would, on those comparisons.

Mr. MCCLELLAN. I think they all go to the point that we do need to take action now to provide more assistance for seniors—and for other Americans, frankly—who are having trouble affording health care. I come from California as well, before being in the administration. Actually, Representative Eshoo is my representative. And I saw first-hand in my practice the consequences——

Moving right along with this question, I actually was already moved to Washington by the time of the last election—seeing first-hand in my practice the consequences of people not being able to afford health care, and it is not just seniors, it is many working Americans, people that have health insurance and are worried about losing it, and the growing number of people who are just deciding they can't possibly afford it. We need to do a lot more.

I don't know that a solution is an approach that involves price controls. We have the most innovative privately based health care system in the world, and the kinds of medical technologies that have been made available in the past 30 years I think are just a fraction of what we are going to see over the next 30, if we keep encouraging that. It is probably going to cost more in the process,

and that means that we need to pay very careful attention to doing all we can to help as many Americans as possible meet those rising costs. I very much appreciate your interest in trying to do that with the Medicare program here today.

Ms. CAPPS. Well, the fact that you are—I guess I am quite surprised to think that the President would say that during this year we could consider a prescription drug benefit under Medicare, and with all due haste I believe we should set aside the intermediary step and get right to that most pressing task at hand. Thank you.

Mr. DEAL. The Chair recognizes Mr. Bryant.

Mr. BRYANT. Thank you, Mr. Chairman. I do have a number of comments and some questions that certainly I feel like could be addressed, but I understand that our witness is very late for a press conference, and I simply will waive all that to the extent that I don't go ahead and submit statements to you for your answers to be late-filed. But I also want to commend the administration for your efforts and your support in this very important issue, and with that I will yield back the balance of my time.

Mr. DEAL. Thank the gentleman. The gentleman from California.

Mr. WAXMAN. Thank you, Mr. Chairman, and Dr. McClellan, it is nice to see you here. I was concerned about this waiver program where the States, if they offered a prescription drug coverage, they could get Federal support for it. I think this was known as the administration's Health Insurance Flexibility and Accountability Act waiver process for drug-only pharmacy-plus waivers.

The pharmacy-plus-waiver proposal allows the States to get the Federal Medicaid funding for State-only programs that are currently in operation. It buys out the State programs, in effect. Will the pharmacy-plus-waivers require that the State expand coverage beyond the current level in order to be eligible for a Federal buyout for the program?

Mr. MCCLELLAN. The entire point, as you know, of the pharmacy-plus-waiver program is to expand coverage. So, yes, we expect to see coverage expansions in every proposal we get. That has certainly been the case so far with the ten States that have either submitted applications or expressed interest.

Mr. WAXMAN. Well, at a time when people believe that we can't afford a generous Medicare drug benefit because of budget pressures, aren't we spending Federal resources on programs that are already operational? Is there a requirement of new coverage, or are we simply going to supplant what the States are already doing?

Mr. MCCLELLAN. The pharmacy-plus-waiver is intended to expand coverage, and your staff, I believe has seen—if they haven't, let me know and I will get it to you—the draft documents describing the details of the pharmacy-plus-waiver process. So, if there are some concerns about this not going far enough to encourage expansions of coverage, I hope you will let us know. We haven't finalized that yet, but absolutely the intent is to get States to expand coverage as much as possible.

As you know better than anybody here, under Medicaid we can't require States, the scope, the duration, the content of benefits, all——

Mr. WAXMAN. You can't require it, but there are some Medicaid standards in effect if they do have drug coverage. Would this waiv-

er allow the States the option of less than the Federal requirements if a drug program is adopted by the State for their Medicaid population?

Mr. MCCLELLAN. The Medicaid requirements for drug benefits would be the same as under current law. We are not changing current law, so the States have the freedom now to design waivers in terms of the scope and content.

Mr. WAXMAN. Well, what I am asking is, if they want a waiver to include a new population in addition to the Medicaid population that is already there, would this waiver allow them to have a drug benefit that is less than what they have for their Medicaid population that is already covered?

Mr. MCCLELLAN. For their existing population, it could. They could have higher co-pays. They could use different formulary structure, but the point would be, as you said, to expand coverage.

Mr. WAXMAN. Well, I am troubled by that because then you have two classes of low-income people. One group will have more generous coverage for pharmaceuticals, another group could have less generous coverage for pharmaceuticals and, of course, at some point the State will say, "Well, why don't we just make it all the same," and it is unlikely they are going to make it all the same for the higher benefit, they are going to make it all the same for the lower benefit.

But isn't all this supposed to be cost-neutral?

Mr. MCCLELLAN. Yes, it is supposed to be cost-neutral and, yes, we are concerned about the two different classes of low-income citizens. I am actually more concerned about the two classes that exist now, those with coverage and those with no coverage at all.

The way that this would be budget-neutral is, there are two main mechanisms. One is that there is clearly a number of people who are near the Medicaid eligibility line that in order to get drug coverage—and now, under current law, they have to get the entire Medicaid benefit package—so they will adjust their income downward, they will take steps to become eligible for Medicaid. They will become eligible for the entire Medicaid benefit package which is more costly than the direct coverage that they really need.

Mr. WAXMAN. The cost-neutrality I was concerned about was a requirement of the States that if they get this waiver, they have got to make sure they are not spending anymore on the Medicaid program than they already are.

Mr. MCCLELLAN. They have to do it in a budget-neutral way, that is right.

Mr. WAXMAN. How would they do that? This is not a capped program. Would they have to anticipate their cost, make an evaluation of what the cost would be, and then stay to those costs? In other words, internally the State would have to figure out how to cap their programs so that they are not spending anymore overall on Medicaid.

Mr. MCCLELLAN. My guess is that different States will take different approaches, and certainly different States have expressed interest in different kinds of approaches in their discussions with CMS so far.

Mr. WAXMAN. They have to come in and talk to you and you have to approve them, or HCFA—the administration—and they will

have to say, "Well, we want this ability to cover drug-only Medicaid, but we want it to be cost-neutral, and this is how we are going to have it cost-neutral," so you are going to have to approve whether it is really cost-neutral or not. What will you tell them if they ask you, "How do we show the cost neutrality," will you require them to cut back on other benefits for people under Medicaid, to pay these new benefits?

Mr. MCCLELLAN. It is true that one way to do it—and this may be what you are getting at, I am sorry if I missed that earlier—is that States could achieve budget neutrality by finding more cost-effective ways of delivering their Medicaid benefits. They could do that for the new population, they could do that for some of that for some of their old population, for example, by going to a private sector coverage——

Mr. WAXMAN. If they can do something cost-effective, why aren't they doing it? After all, the States are putting in money. I think cost-effective becomes a euphemism for cutting back on a lot of low-income eligibility, don't you think that——

Mr. MCCLELLAN. Well, we are certainly worried about that, and we think that the more that we can do to help States manage their benefits cost-effectively, the less real cutbacks we will see. There is a lot of pressure right now, as you know, for States to cut back their Medicaid programs, and we think that anything we can do to help them find more cost-effective ways of managing their benefits, keeping those benefits and hopefully expanding them is the right way to go.

Mr. WAXMAN. Well, I think you ought to do that with an increase in the Federal match, and then we can make sure that they will have the resources to do it. My time is expired. Thank you, Mr. Chairman.

Mr. DEAL. I understand Mr. Gordon, a member of the full committee, has questions. Mr. Gordon.

Mr. GORDON. Thank you, Mr. Chairman. Dr. McClellan, you have been in the hot seat a long time, so I will try to be quick here, and my apologies to the second panel that I know would like to get up and going, but I wanted just to follow up on a line of questioning.

Within the context of Medicare, when a new drug is introduced and the drug is priced in such a way that it provides a financial incentive to the physicians and hospitals via higher AWP, what action can the CMS take to assess the impact on the Federal budget relative to the new drug?

Mr. MCCLELLAN. CMS has—you are asking about a policy change and the way that we reimburse drugs under AWP, or an alternative mechanism?

Mr. GORDON. Yes.

Mr. MCCLELLAN. CMS has the flexibility under current law to adjust payment systems in cases where there are overpayments and Medicare is not billing efficiently. As we made clear in our Budget Proposal this year, we have some ideas about how to potentially do that for overpayments in the AWP system, recognizing the need to provide adequate reimbursement for the drugs and for the services in providing them.

We would like very much to work with your committee in finding the most effective way to do that, and doing it legislatively would

be just fine with us. We have participated in the hearings that you have had on this topic late last year, and I think we are working fairly closely with your committee now on ideas for going forward on finding a better payment system for correcting the imbalances in the AWP system.

Mr. GORDON. And do you have a way to assess that impact on the budget?

Mr. MCCLELLAN. We would, in conjunction with any kind of proposal, any kind of specific proposal, do a cost analysis, certainly.

Mr. GORDON. What action can CMS take to reduce the cost to the system when there is a financial incentive that is provided to the hospitals and physicians by drugs with higher AWPs and currently covered by——

Mr. MCCLELLAN. I think the goal is to get rid of the disturbing financial incentive of—that is created by basically the overpayment. If the hospital gets reimbursed at a much higher price than they are getting the drug for, and that they need to cover the cost of administering the drug as well, if there is a big margin there, then, sure, that is going to provide an incentive for hospitals, and doctors for that matter, to use those kinds of drugs in cases where they may not be the most appropriate or effective treatment, and it is exactly that problem that we would like to address, working with you, but, if necessary, we would address late this year or sometime soon, administratively.

Mr. GORDON. Thank you, Dr. McClellan. Thank you, Mr. Chairman and Ranking Member Brown.

Mr. BILIRAKIS. You are welcome, sir. I think that finally we can excuse Dr. McClellan.

Mr. MCCLELLAN. Thank you, it has been a pleasure.

Mr. BILIRAKIS. Thank you. Thank you so much for being here and for working on this issue, and it is a very important one to all of us not only politically, but practically out there, and we look forward to continuing to work with you. Thank you very much.

The next panel consists of Dr. Brian Tyler, Senior Vice President for Business Development and Strategy with McKesson Corporation; Mr. Michael Hillerby, Deputy Chief of Staff for Nevada Governor Kenny Guinn; Mr. Craig Fuller, President and CEO, National Association of Chain Drug Stores; Dr. Patricia Neuman, Vice President, Kaiser Family Foundation, Director of Kaiser's Medicare Policy Project; Dr. Beatrice Braun, Board of Directors, American Association of Retired Persons, and Dr. Jeanne Lambrew, Associate Professor, George Washington University.

Welcome. Thank you so much for your patience and for your understanding. Some of you have done this before, many like Dr. Braun many times, so you understand what it is like just sitting there waiting and waiting and waiting. We have been fortunate we haven't had any votes called, probably be another hour or so before we have any called, so hopefully we can continue on pretty well. I am advised by staff that I should start with Dr. Lambrew, so we will set the clock at 5 minutes and hopefully you all can sort of convey your message to us within that period of time, and continue on when we inquire with our questions. Dr. Lambrew, please proceed.

STATEMENTS OF JEANNE M. LAMBREW, ASSOCIATE PROFESSOR, GEORGE WASHINGTON UNIVERSITY; BEATRICE BRAUN, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS; PATRICIA NEUMAN, VICE PRESIDENT, KAISER FAMILY FOUNDATION, DIRECTOR OF KAISER'S MEDICARE POLICY PROJECT; MICHAEL D. HILLERBY, DEPUTY CHIEF OF STAFF FOR NEVADA GOVERNOR KENNY GUINN; CRAIG FULLER, PRESIDENT AND CEO, NATIONAL ASSOCIATION OF CHAIN DRUG STORES; AND BRIAN TYLER, SENIOR VICE PRESIDENT FOR BUSINESS DEVELOPMENT AND STRATEGY, McKESSON CORPORATION

Ms. LAMBREW. Thank you, Chairman. Thank you, Congressman Brown and distinguished subcommittee members. I am an Associate Professor at the George Washington University, who worked for the previous administration, and I would like to address this issue of the President's Proposal for low-income drug benefits.

There is no question that low-income Medicare beneficiaries need extra assistance in affording prescription drugs. As previous witnesses have described, low-income beneficiaries, like other beneficiaries, face high prescription drug costs, but have far fewer resources to pay for needed medications.

Recognizing this, all major legislative proposals to add a prescription drug benefit to Medicare have, to different degrees, provided extra assistance to make Medicare drug coverage affordable for low-income beneficiaries. The question is whether Congress should create a new low-income prescription drug benefit to provide relief before the implementation of a Medicare drug benefit.

As Dr. McClellan testified, the President's proposal will allow States to receive Federal matching payments up to 90 percent for extending prescription drug coverage to Medicare beneficiaries whose income is below 150 percent of poverty. This proposal costs $77 billion over 10 years according to the administration, $57 billion over 10 years according to the Congressional Budget Office.

Some low-income seniors in some States would likely benefit from a State-based low-income prescription drug policy prior to the implementation of a Medicare benefit. However, I would like to make four points about this proposal.

First, all States will not opt to extend prescription drug coverage to additional seniors. States are strong and essential partners in providing health care to vulnerable populations. The success of the Children's Health Insurance Program proves that States can come to the plate when there is bipartisan and Federal and State agreement on the goal. However, there is no such agreement when it comes to Medicare beneficiaries.

States argue that the Federal Government should bear the cost and responsibility for seniors health care, including a prescription drug benefit. Medicaid already pays for one-fifth of the Nation's prescription drug spending, and while there are many non-Medicaid programs aimed at filling benefit gaps, States have only invested $1.7 billion in these programs, less than 2 percent of all drug spending for Medicare beneficiaries in 2002.

The increased Federal contribution may not be enough to offset concerns about the rising cost in strained State budgets. Moreover, States may not want to make investments in temporary programs.

Under all proposals, Medicare will assume responsibility for prescription drugs when its benefit finally takes place. Reflecting these issues, the Congressional Budget Office assumed that States with 35 percent of eligible low-income Medicare beneficiaries would not participate in the President's plan.

My second point is that State-based low-income programs may miss many eligible seniors. Nearly one in four Medicare beneficiaries is eligible for some type of Medicaid assistance, yet only about 45 to 55 percent of eligible beneficiaries are estimated to enroll in such programs. Some of this may be explained by lower priority given to States to the elderly versus other populations like children. There also may be lack of information, misperceptions about eligibility, and a reluctance to ask for help.

My third point is that leaving benefit standards out of this proposal could cause access problems, yet putting benefit standards into this proposal could also cause delays in enactment. The President's plan appears to give States full discretion to define the low-income drug benefit. That means that they could charge deductibles as high as $500, cap benefits, and limit the types of drugs that are covered.

Congress could, and probably would, limit these potential health and financial consequences, yet, in so doing, it may take time. The experience in CHIP suggests that developing benefit standards is not easy, and it may be even less contentious than the process of developing a Medicare drug benefit itself.

My fourth point on a low-income drug benefit is that Medicare would probably provide low-income seniors with a better prescription drug benefit more quickly and more effectively than the 50 States combined. A Medicare drug benefit would help all low-income Medicare beneficiaries in all States. If enacted this year, a Medicare benefit could be implemented in 2005, 2 years before the Congressional Budget Office assumes the States that opt for the President's plan would fully implement their own programs.

I would like to close by stressing the urgency of acting on a meaningful Medicare prescription drug benefit. The budget outlook, although weakened, is strong enough to fund more than the $190 billion allocated by the President. This amount could only buy a proposal like that passed by the House 2 years ago, which has a $72 monthly premium, includes a benefit gap of $4700, and does not help over two-thirds of Medicare beneficiaries who lack prescription drug coverage today according to recent estimates by the Congressional Budget Office.

CBO projects that there is a Federal budget surplus of $2.3 trillion over the next decade. A $750 billion investment, which would barely afford the Federal Employees Health Benefit that was described earlier, would represent about one-third of that projected surplus and, in fact, is less than the amount in the President's budget for Medicare and tax cuts combined.

I would quickly like to make three observations, if I may, about the analysis that Dr. McClellan presented today. The first is, to the best of my knowledge, no Member of Congress has proposed to divert payroll revenue dedicated to covering Part A services for a prescription drug benefit. All new general revenue and premium contributions, to different degrees, to fund a prescription drug benefit.

Second, Dr. McClellan claimed the $750 billion investment will cost $1.2 trillion in the next decade and that we can't afford that. Yet, as Representative Eshoo noted, the administration is advocating for extending a tax cut that would reduce the General Revenue base by $4 trillion by in the next decade. This is not a debate about resources, it is a debate about priorities.

And, third, less than 10 years ago, the same CMS Actuaries projected that the Medicare Trust Fund would be insolvent today, in 2002. Congress acted, projections changed, and now the Trust Fund is projected to be solvent for the next 28 years. Thus, we should take projections of what the individual tax burden of a drug benefit in 2030 would be with a grain of salt.

I would like to close by saying that developing a bipartisan Medicare prescription drug benefit is a major undertaking that I would argue should be put ahead of all other Medicare reforms, as well as legislative efforts to provide Stopgap or interim prescription drug coverage. Each year a greater number of Medicare beneficiaries lose their prescription drug coverage. The time is right to make the necessary investment and enact a single Medicare reform that has eluded so many Congresses, the addition of a meaningful drug benefit to Medicare.

[The prepared statement of Jeanne M. Lambrew follows:]

PREPARED STATEMENT OF JEANNE M. LAMBREW, ASSOCIATE PROFESSOR, GEORGE WASHINGTON UNIVERSITY [1]

Chairman Bilirakis, Congressman Brown, and distinguished Subcommittee Members, thank you for the opportunity to offer my views on a prescription drug benefit for Medicare beneficiaries. I am an Associate Professor at the George Washington University. I worked for the previous Administration as the Principal Associate Director for Health, Personnel and Veterans at the Office of Management and Budget and at the White House National Economic Council. My past policy experience and current research include the study of how to best provide a prescription drug benefit to Medicare beneficiaries.

SUMMARY

In this testimony, I would like to make two points. First, the quickest and most effective way to provide prescription drug coverage for the nation's low-income seniors—as well as middle-class beneficiaries who also need such coverage—is to enact a Medicare prescription drug benefit. Evidence and analysis suggest that a new low-income prescription drug program neither provides immediate relief to all eligible low-income seniors nor prepares states for their role in supplementing a Medicare prescription drug benefit. These seniors would receive better, more accessible and, in some states, more immediate prescription drug coverage through Medicare.

Second, if adding a prescription drug benefit to Medicare is inevitable, now is the time to do it. A Medicare prescription drug benefit enacted this year would provide all beneficiaries, including low-income seniors, with prescription drug coverage by 2005. The budget outlook, while weaker than in recent years, remains sufficiently strong to finance a meaningful Medicare prescription drug benefit, defined as one that ensures continuous insurance coverage, extra protection for financially vulnerable beneficiaries, and an affordable monthly premium. With a $2.3 trillion surplus over the next 10 years, there is no budgetary reason to provide a drug benefit only to low-income beneficiaries or to skimp on a drug benefit for all beneficiaries. Moreover, it is probably more affordable to implement and improve a prescription drug benefit in this decade before Medicare is confronted with the challenges of the retirement of the baby boom generation. Finally, while other Medicare reforms are needed, none are as compelling or as difficult as adding a prescription drug benefit to Medicare. I urge this Committee and this Congress to make enacting a Medicare prescription drug benefit its first priority and its lasting legacy.

[1] The views expressed in this paper do not represent those of George Washington University or the Department of Health Services Management and Policy.

HELPING LOW-INCOME BENEFICIARIES ACCESS PRESCRIPTION DRUGS

There is no question that low-income Medicare beneficiaries need extra assistance in affording prescription drugs. About 40 percent of Medicare beneficiaries with income below $20,000 lack coverage for prescription drugs.[1] The average Medicare beneficiary is projected to spend $2,440 for prescription drugs in 2003[2]; even a fraction of this amount would consume a large proportion of a low-income beneficiary's income. All legislative proposals to add a prescription drug benefit to Medicare have, to different degrees, provided extra assistance to make Medicare drug coverage affordable for low-income beneficiaries.

As such, the question is not whether to help low-income beneficiaries, it is whether Congress should create a new low-income prescription drug program to provide relief before the implementation of a Medicare drug benefit. The President has proposed to do this. His budget includes a proposal that allows states to:

- Extend prescription drug coverage (as a stand-alone benefit) to Medicare beneficiaries with income up to 100 percent of poverty, with the Federal government matching state costs at the regular Medicaid matching rate (which averages a 57 percent Federal contribution); and
- Extend prescription drug coverage to beneficiaries with income from 100 to 150 percent of poverty, with a 90 percent Federal matching rate.[3]

Since this new benefit does not appear to be part of Medicaid, states could provide a less generous prescription drug benefit than Medicaid's (e.g., limit the amount of assistance) or cap enrollment. This Federal funding could also be used by states to refinance existing state pharmacy assistance program spending.[4] The President's budget estimates that this proposal costs $77 billion over 10 years, 40 percent of its $190 billion allocation for Medicare and prescription drugs. The Congressional Budget Office (CBO) estimates that the same proposal costs $57 billion over 10 years.[5]

While some low-income seniors in some states would likely benefit from a state-based low-income drug policy prior to implementation of a Medicare benefit, evidence and arguments suggest that:

- Not all states will participate, since many want neither the responsibility nor the costs of a prescription drug benefit for seniors (CBO assumes that states with 35 percent of eligible low-income beneficiaries would not participate in the President's proposal);
- Not all eligible individuals in participating states will enroll (CBO assumes that 40 percent of eligible low-income beneficiaries would not participate the President's proposal);
- Lack of benefit standards could result in access problems and defining benefit standards would likely cause delays in enacting and implementing legislation, given experience with the State Children's Health Insurance Program (CHIP); and
- Medicare could implement a prescription drug benefit faster than could 50 states, and would be more effective at assisting all low-income beneficiaries (CBO assumes that a Medicare benefit with low-income protections would provide 100% of Medicare beneficiaries with drug coverage by 2005[6] while a state-based low income benefit would provide 18% of low-income beneficiaries and 6% of all beneficiaries with drug coverage by 2007).
- These points are described in greater detail below.

Low-income seniors in some states will not be eligible. States are strong and essential partners in providing needed health care to those low-income and disadvantaged populations who have no other health insurance options. Today, Medicaid covers as many people today as does Medicare; 30 percent of Medicaid beneficiaries are eligible at states' discretion.[7] Recent experience with CHIP proves that policies to give states additional funding and flexibility—when there is bipartisan and Federal-state agreement on the goal—can successfully expand coverage and reduce the number of uninsured. In 2001, nearly 5 million children were helped by CHIP[8] and the number of uninsured children in the United States fell in 1999 and 2000.[9]

However, recent arguments and evidence suggest that, even with the increased funding and flexibility, some states will not voluntarily extend prescription drug coverage to Medicare beneficiaries. Most governors and the National Governors' Association (NGA) have argued for years that the Federal government, not states, should bear responsibility for Medicare beneficiaries.[10] States have expressed strong concerns about the sustainability of financing services not covered by Medicare and its premiums and cost sharing for low-income beneficiaries. These concerns extend to prescription drugs. Prescription drug costs are named by 48 states as a major factor in Medicaid cost growth.[11] In 2002, Medicaid will pay an estimated $28 billion

for prescription drugs—nearly 20 percent of the nation's total prescription drug spending.[12] This helps explain the official position of the NGA: "If Congress decides to expand prescription drug coverage to seniors, it should not shift that responsibility or its costs to the states and territories."[13]

Reflecting these concerns, states' efforts to extend prescription drug coverage, to date, have been limited. Only 15 states and the District of Columbia have elected to extend Medicaid coverage, including prescription drugs, to all poor seniors and people with disabilities.[14] Ten of these states plus 14 others have implemented non-Medicaid state pharmacy assistance programs that provide partial or full coverage for certain low-income Medicare beneficiaries. An additional 5 states offer discounts (rather than coverage) for prescription drugs for certain low-income elderly.[15] While the majority of states are involved in such activities, their combined impact is relatively small. Self-reported data suggest that states spend about $1.7 billion on non-Medicaid prescription drug coverage[16], less than 2 percent of CBO's 2002 baseline for Medicare beneficiaries' prescription drug spending.

States' reaction to the President's proposal to provide incentives to extend drug coverage to Medicare beneficiaries is likely to be mixed. States with existing programs would probably participate in the President's proposal, since they could receive Federal matching payments for their existing programs. However, states with no or limited programs must balance the increased Federal contribution with the risk of rising drug costs, unmet need, and limited state budgets. This calculation is complicated by the temporary nature of a low-income drug program: it would stop providing primary prescription drug coverage when a Medicare benefit is implemented. All proposals would shift primary coverage for prescription drugs to Medicare, leaving states with the much-simpler job of providing additional assistance with premiums and cost sharing, as they do today for Medicare's current benefits. As such, even those states that are willing to take on an extension of prescription drug coverage may find that the start-up costs for a temporary program outweigh the benefits of this time-limited assistance. One of CHIP's lessons is that considerable time and investment are required to set up a new health insurance program, especially if it is not a simple extension of Medicaid.

Probably reflecting some of these issues, CBO did not assume that all states would participate in the President's low-income prescription drug proposal.[17] States where 65 percent of eligible low-income beneficiaries live are assumed to participate. In other words, an estimated one in three low-income Medicare beneficiaries would not be eligible for assistance under the proposal.

Low-income programs often miss many eligible seniors. A problem that has plagued Medicaid and other state-based programs for Medicare beneficiaries is low participation. Since the early 1990s, Medicaid has been authorized to pay Medicare's premiums and most cost sharing for poor beneficiaries.[2] Nearly one in four Medicare beneficiaries is eligible for some type of Medicaid assistance, yet only about 45 to 55 percent of eligible beneficiaries are estimated to enroll in such programs.[18] Some of this may be explained by the lower priority that states give to this population versus others, like children. For example, one study found that only 24 states used a simplified application, 12 states had outreach materials about eligibility in other languages, and about one-third of states made eligibility screening tools available to outside agencies (e.g., clinics, senior centers rather than welfare offices) [19]—all strategies used my most states in CHIP. Lack of information, misperceptions about eligibility, and reluctance to ask for help appear to be equally important barriers to enrollment. A focus-group study found that being "in the right place at the right time" had a greater impact on enrollment than official outreach efforts.[20] Some state prescription drug programs have experienced similar problems. Several of the major state programs (e.g., Massachusetts and New York) found that they had to change and increase their outreach efforts due to low enrollment and that, even with changes, enrollment has been lower than expected.[21]

CBO assumed that, within states that extend coverage through the President's proposal, 60 percent of eligible low-income beneficiaries would participate when

---

[2] The Qualified Medicare Beneficiary (QMB) program pays for Medicare's premiums, deductibles and coinsurance for all beneficiaries whose income is below 100 percent of the Federal poverty level and whose resources are at or below twice the SSI limits. The Specified Low-Income Medicare Beneficiary (SLMB) program pays for the Medicare Part B premium (not the Part A premium) for beneficiaries with income between 100 and 120 percent of poverty. The Qualified Individual-1 (QI-1) program provides states an option—with 100 percent Federal funding through a capped grant that expires in FY 2002—to pay for the Part B premium for beneficiaries with income between 120 and 135 percent of poverty. And the Qualified Beneficiary-2 (QI-2) program uses the same structure as QI-1 to subsidize the part of the Medicare Part B premium attributable to the increase in that premium do to shift of the home health benefit to Medicare Part B.

state programs are fully implemented, in 2007. This participation rate drops to 39 percent when compared to the low-income beneficiaries who would be eligible if their states participated; 18 percent when compared to all low-income beneficiaries (including those covered by Medicaid); and 6 percent when compared to all Medicare beneficiaries regardless of income.

Lack of a standard prescription drug benefit could cause access and other problems. Even the minority of low-income beneficiaries that would be helped by this proposal may find that this help is limited. It appears that states have full discretion under the President's proposal to determine the nature of the drug coverage offered to low-income beneficiaries. Under Medicaid rules, states may limit the number of prescriptions filled per month, but cannot charge significant cost sharing, place dollar limits on the amount of coverage, use restrictive formularies, or limit enrollment through caps. Such practices are common in state pharmacy assistance programs: several states require a $500 deductible for some or all participants (e.g., AZ, NY, PA, SC); some states cap the annual amount of assistance a beneficiary may receive (e.g., IN, MO, WI, NC, OR); and a smaller number of states limit the type of drugs that are covered (e.g., KS covers only maintenance drugs).[22] Thus, what low-income Medicare beneficiaries would get under a state-based program would depend on there they live.

Research suggests that practices like high cost sharing or enrollment caps could defeat the goal of improving access to prescription drugs for low-income seniors. A recent study found that one-third of non-elderly Medicaid beneficiaries in states with aggressive cost-control methods (e.g., restricting the number of covered prescriptions, imposing cost sharing) could not get a prescription drug due to cost.[23] Experience with CHIP shows that enrollment caps could make the already-difficult challenge of encouraging low-income seniors to enroll even more daunting. When North Carolina capped its enrollment of children at 72,000, actual enrollment fell by over 20,000 children, in part due to a loss of trust in the program. A local official stated, "We think we're going to have to put more energy in because this program hasn't delivered. It was shut down for nine months; now we have to build people's support and confidence that this is a real program that's going to be continuing."[24]

Congress could and probably would limit the potential health and financial consequences of unrestricted benefit flexibility through standards—especially since the proposed Federal investment exceeds that of CHIP. Yet, the process of developing those standards would take time and is not without controversy. It took months for the House, Senate and White House to come to agreement over the minimum benefit standards for children in CHIP and, in fact, these standards were among the last issues resolved in the entire Balanced Budget Act of 1997. It is not safe to assume that achieving a bipartisan consensus on standards for a new low-income prescription drug program will be easier than it was in CHIP—or less contentious than the process of developing a Medicare prescription drug benefit itself.

Medicare would be more effective at quickly providing a meaningful drug benefit to all low-income beneficiaries. If Congress is seeking the most effective way to provide prescription drug coverage to low-income Medicare beneficiaries, it should look to Medicare. Experts agree that all Medicare beneficiaries, including those with low income, would be eligible for and receive prescription drug coverage under proposals that include adequate Federal assistance.[3] All major proposals charge no prescription drug premium for beneficiaries with income below 150 percent of poverty, and most proposals subsidize cost sharing for those with income below 135 percent of poverty.[4] As such, Congress has already come close to consensus on providing a meaningful prescription drug benefit for low-income beneficiaries. This benefit may be accessible more quickly for many (if not most) low-income seniors through Medicare than through a state-based low-income program. If enacted this year, a Medicare benefit could be implemented in 2005, two years before CBO assumes that states that opt for the President's plan would fully implement their programs (see Exhibit 1). While 2005 may seem too long to wait, consider that if Congress had passed a drug benefit in 1999, when the current debate over

---

[3] CBO estimated that proposals by President Clinton and Senator Robb would ensure that 100 percent of Medicare beneficiaries have prescription drug coverage; proposals by Senators Breaux and Frist and HR 4680 would exclude 8 to 18 percent of Medicare beneficiaries, respectively (CBO, April 8, 2002).

[4] Note that proposals by Senators Breaux and Frist and HR 4680 include benefit "gaps", meaning that the insurance benefit is capped at an annual dollar limit after which beneficiaries pay 100 percent of drug costs until their total out-of-pocket spending exceeds a stop-loss. Neither proposal subsidizes low-income beneficiaries for prescription drug spending in this gap (which would total $4,700 in 2005) (CBO, April 8, 2002).

a prescription drug benefit began, Medicare would be providing prescription drug coverage today.

IMPORTANCE OF ENACTING A PRESCRIPTION DRUG BENEFIT THIS YEAR

Providing relief to low-income beneficiaries is one of several reasons why Congress should pass a Medicare prescription drug benefit this year. While weakened, the budget outlook is strong enough to pass a meaningful prescription drug benefit. In March, CBO projected a Federal budget surplus totaling $2.3 trillion over the next decade.[25] Medicare was created during a time of budget deficits, and all subsequent health reforms have been enacted during periods with far fewer Federal resources. An $750 billion investment, which could buy a decent prescription drug benefit with an affordable premium, would represent about one-third percent of the projected surplus and would equal the amount in the President's budget for Medicare and tax cuts combined.[5] Thus, different policy priorities are what drive discussions of rationing or scaling back on a meaningful prescription drug benefit, not real budget constraints.

Not only can this nation afford a prescription drug benefit; we may not be able to afford to wait. In the next decade, not only will Medicare enrollment surge as the baby boom begins to retire, but the first round of genetically engineered drugs may begin entering the market.[26] It seems inevitable that Medicare will cover these prescription drugs for this population, but waiting to implement a new benefit until that point is probably more expensive than implementing it now. This is because operating a Medicare drug benefit in the next several years without the cost pressures of the baby boomers would allow for learning from early mistakes and making mid-course corrections. These same mistakes committed in the next decade would probably be many times more expensive.

Finally, Medicare faces no equally compelling problem in 2002. Its cost growth is under control and its Hospital Insurance Trust Fund is solvent through 2030. Medicare's provider payment rates may need adjustments, per the recommendations of the Medicare Payment Assessment Commission[27], but these adjustments are minor relative to the cost and need for a drug benefit. Supplemental coverage, through private sources and Medicare managed care, is deteriorating, but the fact remains that 3 times as many beneficiaries lack prescription drug coverage as lack supplemental coverage (37.7 versus 12.5 percent in 1999).[28] In contrast, developing a bipartisan Medicare prescription drug benefit is a major undertaking that I would argue should be put ahead of all other Medicare reforms as well as legislative efforts to provide stop-gap and interim prescription drug coverage. Each year, a greater number of Medicare beneficiaries lose their prescription drug coverage, causing problems in accessing needed drugs.[29] Prescription drug costs are crippling not only for low-income beneficiaries but also for the millions of middle-income beneficiaries whose limited savings are being eroded by the costs of needed medications. The time is right to make the necessary investment and enact the single Medicare reform that has eluded so many Congresses: the addition of a meaningful prescription drug benefit to Medicare.

[1] Laschober MA, Kitchman M, Neuman P, Stabic AA. (February 27, 2002). "Trends in Medicare supplemental insurance and prescription drug coverage, 1996-1999." *Health Affairs,* Web Exclusive, pp. W127-W138.

[2] Crippen DL. (March 7, 2002). "Projections of Medicare and Prescription Drug Spending," Testimony before the Committee on Finance, United States Senate. Washington, DC: Congressional Budget Office.

[3] Office of Management and Budget. (February 2002). *Budget of the United States Government.* Washington, DC: U.S. Government Printing Office.

[4] National Governors Association. (February 22, 2002). "Medicare/Prescription Drug Coverage for Seniors: Issues," http://www.nga.org/nga/lobbyIssues/1,1169,D—2009,00.html.

[5] Crippen DL. (March 7, 2002). "Projections of Medicare and Prescription Drug Spending," Testimony before the Committee on Finance, United States Senate. Washington, DC: Congressional Budget Office.

[6] Congressional Budget Office. (April 8, 2002). "Updated Estimates of Proposals for a Medicare Prescription Drug Benefit." Washington, DC: CBO.

[7] Kaiser Commission on Medicaid and the Uninsured. (June 2001). *Medicaid "Mandatory" and "Optional" Eligibility and Benefits.* Washington, DC: The Henry J. Kaiser Family Foundation.

[8] Centers for Medicare and Medicaid Services. (February 6, 2002). "The State Children's Health Insurance Program Annual Enrollment Report, Federal Fiscal Year 2001." Baltimore, MD: CMS.

---

[5] The President's budget includes $603 billion for tax cuts and $169 billion for Medicare for FY 2003-12, according to CBO.

[9] U.S. Census Bureau. (2000, 2001). *Health Insurance Coverage: 1999, 2000.* Suitland, MD: U.S. Department of Commerce, Economics and Statistics Administration, Reports P60-215 and P60-211.

[10] Sheppach R. (February 24, 2001). "Finding the Right Fit: Medicare, Prescription Drugs, & Current Coverage Options," Testimony before the Committee on Finance, United States Senate. Washington, DC: National Governors Association.

[11] Kaiser Commission on Medicaid and the Uninsured. (October 2001). *The Role of Medicaid in State Budgets.* Washington, DC: The Henry J. Kaiser Family Foundation.

[12] Office of the Actuary. (March 2002). "National Health Expenditures, Projections." Baltimore, MD: Centers for Medicare and Medicaid Services.

[13] National Governors Association. (Winter 2002). "HR-39. Seniors Prescription Drugs Policy." Washington, DC: NGA, http://www.nga.org/nga/legislativeUpdate/1,1169,C—POLICY—POSITION^D—557,00.html.

[14] Schwalberg R; Bellamy H; Giffin M; Millder C; Schreiber S; Elam L. (October 2001). *Medicaid Outpatient Prescription Drug Benefits: Findings from a National Survey and Selected Case Highlights.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

[15] National Governors Association. (December 17, 2001). "State Pharmaceutical Assistance Programs." Washington, DC: NGA, http://www.nga.org/cda/files/STATEPHARM.pdf.

[16] National Governors Association. (December 17, 2001).

[17] Crippen DL. (March 6, 2002). "An Analysis of the President's Budgetary Proposals for 2003," Testimony before the Committee on the Budget, United States Senate. Washington, DC: Congressional Budget Office.

[18] Laschober MA, Topoleski C. Barrents Group LLS. (April 7, 1999). *A Profile of QMB-Eligible and SLMB-Eligible Medicare Beneficiaries.* Baltimore, MD: U.S. Health Care Financing Administration; General Accounting Office (April 1999). *Low-Income Medicare Beneficiaries: Further Outreach and Administrative Simplification Could Increase Enrollment.* Washington, DC: U.S. GAO, GAO/HEHS-99-61.

[19] Nemore PB. (December 1999). *State Medicaid Buy-In Programs: Variations in Policy and Practice.* Menlo Park, CA: The Henry J. Kaiser Family Foundation.

[20] Perry MJ; Kannel S; Dulio A. (January 2002). *Barriers to Medicaid Enrollment for Low-Income Seniors: Focus Group Findings.* Washington, DC: The Kaiser Commission on the Future of Medicaid and the Uninsured.

[21] Tilly J; Wiener JM. (September/October 2001). "State pharmaceutical assistance programs for older and disabled Americans." *Health Affairs,* 20(5): 223-232.

[22] National Governors Association. (December 17, 2001).

[23] Cunningham PJ. (April 2002). *Prescription Drug Access: Not Just a Medicare Problem.* Washington, DC: Center for Studying Health System Change, Issue Brief No. 51.

[24] Wilson T. (September 29, 2001). "Freeze hits health plan hard; growing pains dog kids' program." *Raleigh News and Observer.* Raleigh, NC.

[25] Congressional Budget Office. (March 18, 2002). "CBO's Current Budget Projections: Effects of the Economic Stimulus Package on CBO's Baseline Projection of the Surplus." Washington, DC: Congressional Budget Office.

[26] Collins F. (April 2001). Interview in "Cracking the Code of Life," NOVA, Public Broadcasting System.

[27] Medicare Payment Advisory Commission. (March 2002). *Report to the Congress: Medicare Payment Policy.* Washington, DC: MedPAC.

[28] Laschober et al. (February 27, 2002).

[29] Briesacher B; Stuart B; Shea D. (January 2002). *Drug Coverage for Medicare Beneficiaries: Why Protection May Be in Jeopardy.* New York: The Commonwealth Fund.

Mr. BILIRAKIS. Thank you, Doctor. Before we continue, Dr. Braun, Dr. Neuman, let me ask you, have you had the testimony of Mr. Fuller, Mr. Hillerby, Dr. Tyler available to you? Are you familiar with their testimony? Are you familiar with, let us say, the Nevada Plan that Mr. Hillerby is going to talk about?

Ms. BRAUN. Not in detail, but in general.

Mr. BILIRAKIS. Dr. Neuman, you are?

Ms. NEUMAN. Yes.

Mr. BILIRAKIS. The discount card concept that Dr. Tyler and Mr. Fuller are going to talk about, you are familiar with those?

Ms. NEUMAN. Yes.

Mr. BILIRAKIS. Well, all right. I was just wondering if maybe we should hear from them first so that you might comment. No. All right. Dr. Braun, go ahead.

STATEMENT OF BEATRICE BRAUN

Ms. BRAUN. Mr. Chairman and distinguished committee members, thank you for inviting AARP to again address the need for a Medicare prescription drug benefit. Comprehensive prescription

drug coverage in Medicare this year is an urgent priority for our 35 million members and for virtually all Americans.

Our older members now find their drug coverage options increasingly limited, expensive, unstable, or unavailable. Our members and their families need and expect a meaningful Medicare benefit that is affordable and available to all beneficiaries.

It is important to note that this is a problem for nearly all older Americans, and not just those with low income. Further, while AARP strongly supports additional financial assistance in Medicare for low-income individuals, low-income assistance is not a substitute for a prescription drug benefit in Medicare. It will not solve the problem for millions of beneficiaries who are unable to afford their medications. In addition, because AARP opposes means testing within Medicare, we could not support a low-income-only benefit unless it were outside of Medicare.

The challenge in crafting a voluntary Medicare drug benefit is considerable. To succeed, it must attract enough enrollees to make it a viable program. We realize this will require a sizable commitment of Federal dollars. We also recognize that budget constraints are greater this year than last year. But a program funded inadequately, which means meager benefits and high premiums, is going to fail because it won't pass the "kitchen table" test and not enough beneficiaries will enroll, and you will have an insurance death spiral.

That is why AARP recommended a flexible budget approach. In addition to the money the House earmarked in its budget resolution, we also proposed a reserve fund to give the Congress the flexibility to allow sound policy to guide the benefit design rather than an arbitrary budget ceiling.

At this point, we don't know what workable affordable benefit will ultimately cost, but we do know that proposals offered last year were not sufficient to attract enough beneficiaries to enroll. Based on our research, only a small fraction of beneficiaries would find the kind of benefit package proposed worth the relatively high premiums.

There were also two more components to our prescription drug recommendation. The first is that we would oppose funding for a give-back package before agreement is reached on a Medicare prescription drug benefit. While we have always said that providers should be paid fairly, it is inappropriate to use Medicare or Social Security surplus dollars to increase provider payments, without first ensuring that older Americans get the drug coverage they need. Every dollar for a give-backs package means one less available dollar for a Medicare drug benefit.

The second additional component is that we believe cost-containment measures are necessary to help keep a Medicare drug benefit fiscally sustainable over time. We also recognize the serious quality problems in the over-use, under-use, and mis-use of drugs. I would just say that we just lost an AARP Board of Directors member, and it looks as if it was a medication error.

We believe there is a role for both the Government and consumers to play here, and AARP is taking several initiatives to address these problems. This month, AARP is launching a National Public Education Program designed to improve the wise and safe

use of medications. Part of this campaign will focus on the savings to consumers from greater use of generic drugs. We also intend to become involved in litigation against drug companies that have delayed the entry of lower-priced generics into the market.

We pledge to provide assistance in every way we can, and to work with members on both sides of the aisle to promote a meaningful Medicare drug benefit for all beneficiaries. The needs of older and disabled Americans who lack adequate drug coverage can no longer go unheeded. Older Americans have waited a generation for a drug benefit. We call on Congress to act now. Thank you, and I would be happy to take any questions you have.

[The prepared statement of Beatrice Braun follows:]

PREPARED STATEMENT OF BEATRICE BRAUN, AARP BOARD MEMBER

Mr. Chairman and members of the Committee, I am Bea Braun, a member of AARP's Board of Directors. On behalf of our organization and its 35 million members, I want to thank you for convening this hearing and for continuing your efforts to consider approaches for adding a much needed prescription drug benefit to the Medicare program.

As AARP looks toward building retirement security for today's older Americans and the baby boom population, we believe no person is economically secure without adequate medical insurance. The structure of retirement security is no longer simply the "three-legged stool" of Social Security, private pensions, and personal savings, but rather four pillars consisting of: Social Security, pensions and savings, earnings, and, importantly, stable, affordable and adequate health insurance.

Consequently, now more than ever, Americans of all ages are looking to Medicare's guarantee of affordable health care coverage as part of the foundation of their retirement planning. But there is a serious gap in Medicare's protection—the absence of reliable prescription drug coverage.

While modern medicine increasingly relies on drug therapies, the benefits of these prescription drugs elude more Medicare beneficiaries every day. Drug costs continue to rise unabated. Employer-based retiree health coverage is eroding. Managed care plans in Medicare have scaled back their drug benefits. The cost of private coverage is increasingly unaffordable. State programs provide only a limited safety net. Therefore, the need for a Medicare drug benefit for all beneficiaries will only continue to grow.

Given the prominence of drug therapies in the practice of medicine, if Medicare were being designed today—rather than in 1965—not including a prescription drug benefit would be as absurd as not covering doctor visits or hospital stays. That is one of the reasons why ensuring that prescription drug coverage is included in Medicare's defined benefit package is AARP's number one legislative priority this year. Our members and their families need and expect a meaningful benefit that is affordable and available to all beneficiaries. They expect us to be their champion on this issue, and we will be.

We are pleased to be here today to discuss the need for a Medicare prescription drug benefit, some of our recommendations for moving forward, and some initial findings of the public's reaction to prescription drug proposals as well as comment on the President's prescription drug proposal.

THE NEED FOR A MEDICARE PRESCRIPTION DRUG BENEFIT

Increasing need, high drug prices, and inadequate insurance coverage pose serious problems for today's Medicare beneficiaries. A chronic health problem necessitating new and expensive prescription drugs can quickly deplete a retiree's financial resources. Even a beneficiary who has planned well for his or her retirement may not be prepared for drug bills that exceed several hundred dollars a month. Further, it is important to note that support for making a prescription drug benefit part of Medicare is overwhelmingly high for all of our members. Americans of all ages recognize the value of prescription drug coverage. In recent polling conducted for AARP, eight in ten Americans age 45 and over favor making prescription drug coverage part of Medicare. Support was, in fact, greatest among the younger age brackets.

The majority of Medicare beneficiaries—not just those with low incomes—need drug coverage. While AARP strongly supports *additional* financial assistance in Medicare for low-income individuals, low-income assistance is *not* a substitute for

a prescription drug benefit in Medicare. It will not solve the problem for millions of people with Medicare who are unable to afford their medications. Further, because AARP opposes means-testing within the Medicare program, we could not support a low-income-only drug benefit unless it were outside of Medicare.

Because of Medicare's current lack of prescription drug coverage, many beneficiaries must pay for all or some of their prescription drugs out-of-pocket. Although about two-thirds of Medicare beneficiaries have some type of coverage for prescription drugs, this figure can be very misleading. The principal sources of coverage that offer a prescription drug benefit—employer-based retiree coverage, private supplemental coverage, or Medicare HMOs—are often inadequate, limited, expensive, and unstable. Moreover, many Medicare beneficiaries do not have continuous prescription drug coverage. A Commonwealth study released earlier this year reported that nearly 42 percent of beneficiaries lacked drug coverage at some point in 1998. More recently, a new study published by *Health Affairs* reports that nearly 40 percent of Medicare beneficiaries had no drug coverage in the fall of 1999. It is also important to understand that those Medicare beneficiaries without coverage pay top dollar for their prescriptions because they do not benefit from discounts negotiated by third party payers. Most of those currently covered by insurance, including most workers, benefit from such discounted prices.

Let me give you some illustrative examples of how middle income people have difficulty in obtaining access to affordable and dependable drug coverage:

- A retired couple has significantly saved for retirement and have an income of $40,000 a year. Both take prescription drugs for heart disease and high cholesterol and the wife also needs medication for breast cancer and osteoporosis. They do not have access to retiree health benefits through a former employer, there are no Medicare+Choice plans available in their area, and a Medigap plan offering some drug coverage would cost them $260 a month each.
- A retired couple have an income of $30,000 a year, significantly above the threshold for Medicaid and most state and private pharmacy assistance programs. They have prescription drug coverage through a Medicare HMO. This year they learn, however, that their HMO plans to terminate its contract with Medicare, effective December 31. There are no other Medicare HMOs in their area, and while they can afford supplemental insurance and are guaranteed access to certain Medigap plans (A,B,C, and F), none of these plans include drug coverage.
- A 75-year old widow is enrolled in a Medicare HMO that offers drug coverage. She currently has prescriptions for a cholesterol-lowering medication at $97.51 a month and an allergy medication at $46.94 a month. While initially her drug coverage was quite generous, this year her drug benefit is capped at $300 a year. As a result, she basically has no drug coverage for three-quarters of the year.

As the Committee moves forward with a prescription drug proposal, it will be critical to judge the proposal on not only whether it could improve the situation for people illustrated in the examples above, but also if it is both affordable and attractive enough to yield a broad risk pool and viable program.

WHAT OLDER AMERICANS NEED

Affordable Drug Coverage—Older Americans need *affordable* drug coverage. A *voluntary* drug benefit needs to be affordable to assure enough participation to avoid the dangers of risk selection. The government contribution will need to be sufficient to yield a beneficiary premium that is affordable and a benefit design that is attractive to the majority of beneficiaries. If the benefit is not set at an affordable level, only those beneficiaries who have high risk will want to purchase it. This will lead to a risk pool composed only of those with high drug costs, and program costs will escalate rapidly into what is often referred to as an "insurance death spiral." This is not simply a matter of what beneficiaries would like to pay, it is an issue of how to assure fiscal viability of the risk pool. Medicare Part B is a model in this regard.

The Part B benefit is voluntary on its face, but Medicare's contribution toward the cost of the benefit elicits virtually universal participation. Actuarial work done for AARP last year by the William M. Mercer Company that we shared with the Committee identified the keys to success for a Medicare prescription drug benefit:

- develop a benefit design that will encourage participation by a broad range of beneficiaries in order to spread risk;
- ensure clear and concise communication to improve participation;
- balance the breadth of coverage and beneficiary premium;
- implement cost-containment techniques; and
- limit the enrollment period.

Dependable Drug Coverage—Older Americans also need *dependable* drug coverage. Current prescription drug coverage options are not reliable. For example, beneficiaries who obtain prescription drug coverage from their former employer are finding that coverage to be unstable. Retiree health benefits that include prescription drug coverage are becoming more scarce. While an estimated 40 percent of employers with 500 or more employees offered retiree medical coverage in 1993, only 23 percent did so in 2001. Of those employers who offered retiree medical benefits, 21 percent did not offer drug coverage to Medicare eligible retirees.

In addition, beneficiaries who have drug coverage through Medicare HMOs cannot depend on having this coverage from year to year, as plans can change benefits on an annual basis or even terminate participation in Medicare. For example, this year many beneficiaries in Medicare+Choice plans are living through abrupt changes in their prescription drug coverage that they did not foresee when they enrolled. Some of the most visible of these changes include:

- Increasing premiums. Over the past few years, more and more Medicare+Choice plans have been charging premiums for their coverage, and those premiums are escalating. For example, between 2001 and 2002, the percentage of Medicare HMO enrollees with zero premiums declined from 47 to 39 percent. This year, nearly one-third of Medicare HMO enrollees (32 percent) will have basic premiums over $50 compared to 14 percent in 2001.
- Higher cost-sharing—Unlike the 1990s, all Medicare HMOs that offer prescription drugs are charging copays for prescription drugs and the average beneficiary copay has increased significantly.
- Decreasing benefit—More plans are lowering the annual cap on the typical Medicare+Choice drug benefit. While in 1999 10.6 percent of Medicare HMOs had an annual cap of $500 or less on their drug benefit, 20.6 percent of plans had a $500 cap in 2000.
- Loss of benefit—Over the last few years, several Medicare+Choice plans have dropped their prescription drug benefit entirely. While 88 percent of Medicare HMOs offered some drug coverage in 1999, that number declined to 63 percent in 2001. Although Medicare+Choice has provided beneficiaries with an opportunity for drug coverage, the volatility of the Medicare+Choice market has made that coverage unpredictable and unstable from year to year.

AARP RECOMMENDATIONS

Adequate Funding—AARP knows that to craft the kind of prescription drug coverage that beneficiaries will find affordable and reliable—and will thus *voluntarily* choose to sign up for—will require a sizable commitment of federal dollars. We also recognize that budget constraints are greater than last year. But while the budget situation changes from year to year, the situation facing millions of older and disabled persons who cannot afford the drugs they need continues to worsen, and constitutes a health care and financial emergency that cannot continue to be ignored.

We do not, at this point, have an estimate of what an adequate drug benefit will cost. We know the plans costing $300 billion offered last year did not find public acceptance. However, we believe the new CBO estimates for drug proposals that include beneficiary monthly premiums starting in the $50, $60, and $70 range will not yield an acceptable benefit. We believe Congress and this Committee should focus on the design of a sustainable benefit that will work for beneficiaries and remain flexible as to the projected cost.

That is why in our budget recommendation we asked Congress to renew its commitment from last year, adjust it for inflation and another year of coverage, and earmark $350 billion for prescription drugs and reforms that strengthen the program. However, because we believe that even this level of funding is inadequate to pay for what our members would consider an adequate and affordable benefit, we also recommended that Congress create a reserve fund of about $400 billion, or an amount roughly equal to the amount of the 10-year surplus in the Medicare Hospital Insurance (HI) Trust Fund. A majority of the respondents to our recent poll favored borrowing from the Medicare surplus to pay for a prescription drug benefit. The range created by the $350 billion commitment based on last year, plus the roughly $400 billion reserve fund, will give the Congress the flexibility it needs to craft a prescription drug benefit that beneficiaries will perceive as having real value.

Priority for drugs—In addition to our prescription drug recommendation, we also have said that it would be inappropriate to use Medicare or Social Security surplus dollars to increase provider payments without first ensuring that older Americans get the prescription drug coverage they need. Our members would not understand why Congress could find money to help providers but not to meet their increasing prescription drug needs. Further, every dollar for a "givebacks" package

means one less available dollar for a Medicare prescription drug benefit. And any giveback package that increases Medicare Part B spending will increase beneficiary premiums because monthly premiums represent 25 percent of Part B costs. We, therefore, would strongly oppose funding for a givebacks package before agreement is reached on a Medicare prescription drug benefit.

Cost Containment—We recognize that strong and effective cost containment measures are a necessary part of a Medicare prescription drug benefit. In order for a drug benefit to be sustainable over the long run, mechanisms must be in place to control the rising costs of prescription drugs. AARP actively supports solid cost containment methods as long as patient safety and well-being is not compromised and access to needed prescription drugs is not impeded. Therefore, we support the use of formularies, such as a 3-tiered approach, as long as they are developed in a responsible manner and include an exceptions process.

We also support the responsible promotion of generic drugs as one effective cost containment tool in a Medicare benefit. In fact, because we believe both the government and the consumer have an important role to play in helping to control costs, AARP is rolling out a national public education campaign, beginning this month, to educate our members and the public at large about the wise use of medications—including generic drugs. We will encourage our members to talk with their doctors and pharmacists to reduce unnecessary costs associated with use of medications.

In addition to these cost containment methods, we also would like to work with the Committee in other efforts to control drug costs, including correcting the current AWP pricing structure and stopping abuse of current drug patent laws. AARP has already begun to pursue the need to correct abuse of drug patents through the courts. AARP intends to be involved in litigation against certain brand and generic companies that made agreements that delayed the entry of a generic drug into the market and in litigation against a brand name drug company that unfairly extended its patents to forestall its generic competition.

INITIAL REACTIONS TO DRUG PROPOSALS

We have asked our members and the general public what kind of benefit package would generate the kind of high level of participation necessary for a viable benefit, and we have learned the following thus far:

- Beneficiaries will generally perform what we call the "kitchen table test" in determining whether they would purchase a new voluntary drug benefit. That is, they will likely calculate their current prescription drug costs, their Medicare premium ($54 a month in 2002 and rising to $104.90 in 2012), any drug coverage they might have, and their present financial situation, to determine whether a proposed benefit is a real value for them.
- Medicare beneficiaries are willing to pay their fair share for a solid prescription drug benefit, but the premium and coinsurance must be reasonable. We know, for instance, that beneficiaries would not be likely to enroll in a prescription drug plan with a premium of $50 a month.
- While the amount of the beneficiary premium drives the equation, our members also look at the program design features in combination with one another. This means it is difficult to simply assess a single component of a package. For instance, some beneficiaries might look more favorably on a higher level of coinsurance if the premium was lower, or vice versa. In a recent poll conducted for AARP of 885 individuals age 45 and over, only one-third of those 65 and over would be likely to participate in a prescription drug plan that included: a $35 monthly premium, 50% coinsurance, a $200 annual deductible, and a $4,000 stop loss. Clearly, this low level of voluntary participation is not enough to create a broad risk pool and sustainable program.
- Most Medicare beneficiaries are concerned about the unpredictability of health care costs and want to know what they will be expected to pay out-of-pocket. This makes real catastrophic stop-loss protection that limits out-of-pocket costs an important component of any package. We know from past experience that a $6,000 catastrophic stop-loss is viewed by beneficiaries as too high, and even a $4,000 cap is not viewed as providing meaningful benefit protection. For example, if there were a $4,000 cap included in a benefit that also imposed 50 percent beneficiary co-insurance, a beneficiary would have to incur $8,000 (and a couple $16,000) in prescription drug costs before the stop-loss protection would kick in. With the majority of beneficiaries earning less than $25,000 a year, those figures are not seen as providing realistic protection.

We realize that some on the Committee may believe that we are asking for a "Cadillac plan," however, we emphasize we are bringing to you what our members are telling us they need and expect to join a voluntary drug benefit. We will con-

tinue to try to educate our members about what is realistic and seek the views of current and future members on specific design packages. We will be happy to work with the Committee as your proposals are developed to test our members' reactions.

As for the President's FY 2003 budget request and proposal to modernize Medicare that was released at the start of the year, AARP is pleased that the President continues to make Medicare prescription drug coverage a priority for his Administration and has indicated his willingness to work with the Congress on this issue, but we believe that the dollar amount proposed is insufficient to provide an affordable and meaningful drug benefit for all Medicare beneficiaries. We also have raised several questions about how the various components of the proposal would help people with Medicare.

In particular, we have raised questions about $77 billion earmarked for low-income drug coverage. The budget proposes an enhanced federal match to enable states to cover drug costs for Medicare beneficiaries between 100 and 150 percent of poverty.

However, the Administration's proposal does not provide details on how the proposed targeted low-income assistance would be used (e.g., in Medicaid expansions or state pharmacy assistance programs), how this effort would improve the current patchwork of drug assistance available, and how many people would actually be helped. Further, the Administration's budget leaves open the question of whether states that could not raise their Medicaid thresholds would be eligible for the new enhanced federal match between 100 to 150 percent of poverty.

The Administration's proposal also does not prevent "dollar trading" by the states that already have higher thresholds. The end result for $77 billion in federal funding could be little or no extension of prescription drug protections for more needy seniors than are being served now.

The President's budget also includes the Administration's proposal to implement a Medicare drug discount card that would give beneficiaries immediate access to drug discounts and other pharmacy services.

AARP is working with the Administration as it continues to refine its drug discount card proposal. There are several issues that we will try to clarify and some consumer protections we will try to add, including: defining what constitutes a "substantial" discount, obtaining firm details on how manufacturer discounts will be disclosed and passed on to consumers, assuring that consumers can compare drug card discount rates to actual retail prices, and making sure drug cards help consumers get generic drugs whenever they are medically appropriate and the least costly option.

However, AARP is encouraged that—unlike current industry card proposals—the President's proposed discount card is designed to establish the drug card program as a building block for a full Medicare drug benefit. We emphasize, however, that neither the Administration's discount card nor the current industry cards are a substitute for a real drug benefit.

We also believe that while the actual discounts would be relatively modest, the President's discount card program would provide at least some help to beneficiaries in buying the drugs they need. It could provide important safeguards to improve the appropriate use of prescription drugs, and this could help avoid unnecessary health care costs due to drug interactions, mis-medications, or poor compliance. It also, importantly, would help the federal government learn valuable lessons about the pharmacy benefit managers (PBMs) that run discount card programs and are included as the delivery system in virtually every drug benefit proposal before Congress. As a result, it will help the Medicare program become more familiar with how PBMs and drug benefit programs work.

Finally, we are concerned that the limited amount of funding in the Administration budget for both drug coverage and other program changes is insufficient to add a meaningful drug benefit and strengthen the program for current and future beneficiaries.

AARP supports efforts to modernize the Medicare program. Clearly, the creation of a prescription drug benefit that is available in all Medicare options is the most significant improvement, but other changes are also important and would serve beneficiaries and the program well. For instance, most private health insurance plans offer a cap on out-of-pocket expenses, yet there is no such limit in the Medicare program. Creating an out-of-pocket cap for services currently covered by Medicare Parts A and B would not only bring Medicare more in line with what individuals under the age of 65 currently have, but would also make the program more affordable for beneficiaries.

AARP also remains open to the possibility of combining the Part A and B deductible, provided it is structured to be affordable and does not produce beneficiary "sticker shock." Since most beneficiaries meet the annual $100 Part B deductible

but significantly less meet the Part A hospital deductible, a combined and increased deductible will affect the majority of beneficiaries. We are opposed, however, to merging the Part A and B Trust Funds. The new solvency measure included in the President'

- Among individuals aged 65+ who have prescription coverage, out of pocket drug expenses are also a factor in whether or not they will accept this plan. Almost four in ten (38%) of those aged 65+ with drug coverage but with current average monthly out of pocket expenses of $60 or more are likely to accept this plan. Only 23% of the 65+ population with drug coverage and monthly out of pocket expenses lower than $60 are likely to accept this plan.

METHODOLOGY

Reed Haldy McIntosh collected the data contained in this survey for AARP through the Market Facts Telenation omnibus survey conducted March 1 through March 3, 2002. All questions in the survey were asked of those aged 45 and over (n=885), with the exception of questions 10 and 11 which were asked of all age groups (18+) in the omnibus (n=2,000). The margin of error for this survey is +/- 3.5 percentage points.

Mr. BILIRAKIS. Thank you very much, Doctor.

Dr. Neuman.

STATEMENT OF PATRICIA NEUMAN

Ms. NEUMAN. Thank you, Mr. Chairman and Mr. Brown and members of this committee. I am pleased to be here to discuss the very pressing issue of Medicare and prescription drugs. Thirty-eight percent of all Medicare beneficiaries lacked drug coverage in the Fall of 1999. Seniors living in rural areas, those 85 and older, are most apt to be without drug coverage. Lack of drug coverage affects beneficiaries at all income levels, but it is the near-poor who are most likely to be without it.

Today, beneficiaries rely upon a patchwork of supplemental sources to help with their drug costs, but as drug costs rise current sources of coverage are eroding.

There are several approaches for improving prescription drug coverage for Medicare beneficiaries under discussion, ranging from short-term incremental strategies to comprehensive proposals. A Medicare discount card is one of the proposals by the administration that would be an interim strategy giving seniors access to drug discounts, building on the experiences of existing programs.

Today, private discount card programs vary widely in terms of how they operate, the savings they offer, and ultimately their impact on consumers. In general, these programs are not considered insurance and are not regulated. Discount cards tend to be available to consumers of all ages and incomes. They are often sponsored by pharmacy benefit managers and retail stores, although cards sponsored by drug manufacturers, such as Together Rx, are increasingly common.

For the consumer, cost comparisons across existing discount card programs can be a challenge. There is no single place where seniors can go to get drug prices under the many available programs. Often, prices are not posted on the Web. Even when cost information is available, the manner in which discounts are presented varies from program-to-program, making simple cost comparisons nearly impossible even for the same drug with the same strength and the same number of doses.

Frequent fluctuations in prices further complicates comparisons, while making it hard for seniors to budget for their drug expenses. It is difficult to assess the extent to which drug cards reduce seniors' drug costs. Savings would depend on the medication seniors take, their access to specific pharmacies, and their comfort using

mail order. In all likelihood, seniors using multiple medications may do best with multiple cards, if no single card offers discounts on their prescriptions. When seniors do use a drug card, they typically pay less than full retail, but still far more than they would with drug coverage.

Figure 9 of my testimony compares monthly drug expenses for an illustrative elderly woman living on a mean annual income of $16,000 per year. A discount drug card would clearly lower her monthly bills, but still would require her to pay 25 percent of her income on prescriptions. If she had the BlueCross/BlueShield PPO plan, her prescriptions would amount to 8 percent of her income.

A Medicare endorsed card as proposed by the administration could lower cost, if Medicare seal of approval attracts beneficiaries, and helps card sponsors negotiate steeper discounts, but if discounts are not passed on to consumers or do not apply to all drugs, then the value to consumers would be limited.

A program that is targeted to low-income beneficiaries is another option to incrementally improve coverage. The administration's proposal would use Medicare funds to extend drug coverage under Medicaid or other State programs, as we have heard this morning. Another approach featured in many proposals would create a national Medicare drug benefit, with additional protections for low-income beneficiaries administered and supplemented by the States. Targeted low-income assistance would help seniors in greatest financial need, and clearly be less costly than a universal Medicare benefit, but a low-income program would leave millions of seniors without drug coverage. The majority of beneficiaries without drug coverage today have incomes above 150 percent of poverty.

Furthermore, if a low-income program builds on State programs, it would likely perpetuate existing disparities in drug coverage for Medicare's poor, given already wide variation in both eligibility and benefits under Medicaid and State pharmacy assistance programs. And in the current fiscal climate, it is unclear whether States would be willing to expand drug coverage beyond current levels. Less than a third of all States today have elected to provide Medicaid drug benefits to those with incomes up to the poverty level.

Beyond incremental strategies, there appears to be broad consensus on the goal of assisting all seniors needing drug coverage, yet debate continues over how to finance, structure and deliver affordable drug coverage to all beneficiaries no matter where they live or what their incomes are.

In sum, Medicare without medicine is anachronism. Incremental approaches could offer relief to some on Medicare who lack drug coverage, but are not a substitute for a Medicare benefit. A meaningful drug benefit will require a substantial investment of Federal dollars and, as we have heard today, this puts seniors and their prescription drug needs in direct competition with other national spending priorities. Thank you, and I would be happy to take your questions.

[The prepared statement of Patricia Neuman follows:]

PREPARED STATEMENT OF PATRICIA NEUMAN, VICE PRESIDENT AND DIRECTOR, MEDICARE POLICY PROJECT, THE HENRY J. KAISER FAMILY FOUNDATION

Thank you, Mr. Chairman and Members of the Committee, for the opportunity to testify on efforts to improve prescription drug coverage for Medicare beneficiaries.

I am Patricia Neuman, a vice president of the Kaiser Family Foundation and Director of the Foundation's Medicare Policy Project. I am also an associate faculty member in the Department of Health Policy and Management at The Johns Hopkins University School of Public Health.

By many measures, Medicare has been and continues to be one of the nation's most successful federal programs. Medicare has provided a vital source of health coverage for seniors and younger Americans with disabilities, a population that faced significant difficulties obtaining health insurance before Medicare was created. Since its enactment in 1965, Medicare has been reformed incrementally over time to address many of the program's problems as they have emerged. In the current environment, finding affordable prescription medicines is a critical issue for many beneficiaries.

My testimony today begins with a brief review of existing sources of prescription drug coverage and a discussion of how the lack of coverage affects beneficiaries. It then reviews broad approaches to improving prescription drug coverage, considers the key tradeoffs that each presents, and the implications for beneficiaries.

WHO LACKS PRESCRIPTION DRUG COVERAGE?

Thirty-eight percent of all Medicare beneficiaries living in the community were without drug coverage in the fall of 1999, according to recently published national survey data (Figure 1). Lack of drug coverage disproportionately impacts beneficiaries living in rural areas, the oldest-old (ages 85 and older), and the near-poor (Figure 2).

Fully half of all beneficiaries living in rural areas (50 percent) lacked drug coverage in the fall of 1999, compared to 34 percent of those in metropolitan areas. Seniors in rural areas tend to be poorer and less healthy than those living in urban areas, but are less likely to have been in jobs that offer retiree health benefits or to live in areas where drug coverage is available through Medicare+Choice plans. Nearly half of all beneficiaries ages 85 and older (45 percent) were without coverage in the fall of 1999 compared to 35 percent of those ages 65 to 74, despite the need for multiple medications that commonly arises with advancing age. This lack of drug coverage comes at a time when the income and retirement savings of seniors are often insufficient to pay for expensive medications.

The absence of drug coverage is a problem for beneficiaries in all income groups, but it is the near-poor who are the most likely to be without drug coverage. Forty-four percent of those with incomes between $10,000 and $20,000 lacked drug benefits in the fall of 1999, compared with about a third of those with higher incomes. The near-poor are less likely than higher income beneficiaries to have employer-sponsored coverage, but have incomes and assets that typically exceed the levels required to qualify for Medicaid, which leaves them vulnerable to being without drug coverage.

WHAT IS THE CURRENT STATE OF PRESCRIPTION DRUG COVERAGE?

More than half of all Medicare beneficiaries have some type of supplemental coverage that helps with drug expenses. Sources of coverage include employer-sponsored retiree plans, Medigap policies, Medicare+Choice plans and Medicaid. During the period between 1996 and 1999, there was an increase in the share of beneficiaries with drug benefits, from 56.8 to 62.3 percent (Laschober et al, 2002). This increase appears to have been due to the rapid rise in Medicare+Choice enrollment, which offset a decline in Medigap coverage. Since 1999, however, the evidence points to attrition in drug coverage across a variety of sources "reversing the more positive trend in the late 1990's.

Employer-Sponsored Retiree Health Benefits

Employer-sponsored retiree health benefits, the leading source of drug coverage for seniors, provided relatively comprehensive drug benefits to 28 percent of the Medicare population in the fall of 1999. Since then, the share of firms with 200 or more workers that offer health benefits to Medicare-age retirees declined from 33 percent in 1999 to 23 percent in 2001, according to a report released earlier this week from the Kaiser Family Foundation, the Commonwealth Fund, and Health Research and Educational Trust. Among employers who continue to offer health benefits to Medicare-age retirees, 32 percent say they increased cost-sharing for drug benefits in the past two years. Looking to the future, continued reductions in drug benefits appear to be on the horizon, with half (51 percent) of all surveyed employers that offer retiree benefits saying they are likely to cut back on drug benefits for retirees in the next two years (Figure 3).

Medicare+Choice

Medicare+Choice plans, once a promising source of affordable drug coverage, assisted 15 percent of beneficiaries in 1999. Since that time, however, access to drug coverage under Medicare HMOs has been on the decline. Since 1999, the number of HMO plans contracting with Medicare dropped from 309 to 178; the share of Medicare HMOs that offer prescription drug benefits in their basic plan fell from 84 percent to 70 percent; while the percentage of plans imposing an annual drug cap of $750 or less increased from 21 percent to 39 percent (Figure 4). Recent trends call into question the future capacity of the Medicare+Choice program to meet the prescription drug needs of seniors who choose to enroll in them.

Individually-Purchased Medigap

Individually-purchased Medigap policies have been another source of prescription drug coverage for the Medicare population, although only seven percent of all beneficiaries reported having drug coverage through a Medigap policy in the fall of 1999. In more recent years, however, Medigap premiums have experienced double-digit increases, climbing by 16 percent, on average, between 1998 and 2000 for the seven Medigap plans that do not cover pharmaceuticals and by 37 percent for plans that offer limited drug benefits, according to Weiss Ratings, Inc. Increasingly unaffordable premiums are likely to make Medigap an even less affordable source of drug coverage in the future.

Medicaid

For Medicare beneficiaries with low incomes, Medicaid is a critical source of drug coverage primarily helping those receiving cash assistance through the Supplemental Security Income (SSI) program and those living in nursing homes. Although states are not required to provide drug coverage under Medicaid, all include it as part of their Medicaid benefits package. While Medicaid remains a safety net for Medicare's poor, close to half of all beneficiaries living below the poverty level do not have Medicaid (Figure 5). Relatively low participation in Medicaid among the low-income Medicare population is due to a variety of factors that vary by state, including strict eligibility criteria, limited knowledge about the program's benefits for seniors or how to apply, and the administrative challenges of signing up and remaining enrolled in the program.

Many states are experiencing tremendous financial pressure alim3m

dence of beneficiaries not taking their medications as prescribed by their doctor because of costs, by skipping doses, splitting pills, and sharing medicines with friends or family members. Systematic underutilization of prescribed medications may pose a threat to quality of care and potentially increase costs to the system in terms of avoidable emergency room and hospital admissions, physician visits, and nursing home stays.

Beneficiaries without drug coverage also face high out-of-pocket costs. Those without coverage spent, on average, $247 more in 1999 than did beneficiaries with drug coverage, according to a recent study by Bruce Stuart of the University of Maryland (Figure 8). Beneficiaries without drug coverage incur relatively high costs both because they do not have an insurer to help pay for their prescriptions and because they often pay the full retail price when they go to the pharmacy. By contrast, those with drug coverage are at least partially shielded from the full effect of high and rising drug costs because their plan covers a portion of their drug expenses and they benefit from pharmacy discounts negotiated by their health plan. But even among those with drug coverage, there are substantial differences in the level of financial protections provided, reflecting the variability in benefit design across plans. Beneficiaries with Medigap, for example, spent on average, $261 more than did beneficiaries with Medicare+Choice drug coverage ($545 vs. $284).

Drug costs are predicted to rise rapidly over the course of the next decade, which will likely compound fiscal concerns facing health plans and programs, potentially shifting costs on to beneficiaries and increasing the burden on those without coverage.

APPROACHES FOR EXPANDING PRESCRIPTION DRUG COVERAGE

With rising drug costs, declining benefits, and the steady influx of new, promising drugs, public support for a Medicare drug benefit remains strong. A variety of options are now under consideration, ranging from short-term, incremental strategies in anticipation of a more universal benefit down the road, to full-blown comprehensive proposals. These approaches include a Medicare-endorsed discount card program modeled on the array of discount programs currently available in the private market; a benefit that would be targeted—at least initially—to low-income Medicare beneficiaries; and a voluntary Medicare drug benefit that would be available to all beneficiaries.

A Medicare-Endorsed Discount Card Program

As an interim strategy, the Administration recently proposed a Medicare-endorsed discount card program to give seniors access to discounts on the drugs they take, while giving qualified discount card sponsors the opportunity to use a Medicare emblem in their marketing materials.

According to a recent study prepared by Health Policy Alternatives, Inc. for the Kaiser Family Foundation, private discount card programs currently being offered vary widely in terms of how they operate, the savings they offer, and ultimately, their impact on consumers. These programs are relatively new. They are generally not considered insurance and are typically unregulated. Most are marketed nationwide and are available to the public regardless of income or age. Typically, there is an enrollment fee and consumers are free to sign up for more than one program. Some offer additional benefits such as dental and vision discounts.

Discount drug card programs tend to be sponsored by private entities such as pharmacy benefit managers and retail stores, although cards sponsored by drug manufacturers are becoming increasingly common. Just last week for instance, seven drug companies announced their plan to offer a single discount card, Together Rx, which would offer savings on the prescription drugs they produce to low- and moderate-income seniors.

Discount drug card programs offered by entities other than the manufacturers themselves achieve savings off full retail prices by negotiating lower pharmacy dispensing fees, using internet and mail-order services, and obtaining volume discounts or rebates from drug manufacturers. Most of the consumer discounts result from concessions on pharmacy mark-ups and dispensing fees, rather than manufacturer rebates, according to the report by Health Policy Alternatives, Inc. And, among programs that do get rebates, there is considerable variation in the degree to which they are passed on to consumers.

In the current environment, it is difficult for consumers to determine if discount card programs will help lower costs. There is no central source of information that describes available discount drug card programs or publishes cost information to permit consumers to shop for the best price. It is up to seniors, or their families, to consult each discount card program individually to get prices for each of the drugs they take. And, even if seniors are able to obtain prices from several pro-

grams, the discounts are not presented in a standard manner, making direct comparisons—even for the same drug—virtually impossible. Some programs show the actual cost of a 30-day prescription. Others present discounts as "retail minus a specified percentage." Still others show the dollar amount of the discount without disclosing what consumers would ultimately pay. Comparisons are further complicated by frequent fluctuations in drug prices, enrollment fees, and postal fees for mail-order options.

In addition to the basic challenge of comparing prices, it is difficult to assess how effective these cards are in lowering seniors' drug costs. When seniors go to a pharmacy with a discount card, they tend to pay less than full retail, but still far more than those with drug coverage. Take, for example, an elderly woman who uses four commonly prescribed medications and is living on about $1,300 a month or $16,000 a year, which is the mean annual income for women ages 65 and older. As Figure 9 shows, she would save money by using her discount card, but still spend about 25 percent of her income filling her prescriptions. By contrast, her prescriptions would account for only 8 percent of her income if she had drug coverage under the Federal Employees Health Benefits Program Blue Cross/Blue Shield PPO plan.

As the General Accounting Office recently reported, discount cards can lower costs somewhat, but discount levels vary widely across programs and, within program, from drug to drug. For a given individual, the potential savings from a discount card program would depend on the specific drugs they take and for how long, their access to specific pharmacies, and their level of comfort with using the mail-order option. The bottom line is that a card that is good for one senior may not be good for another.

Under the Administration's proposal, qualified private discount drug card programs would receive a Medicare endorsement, with the hope of using Medicare's seal of approval to attract more beneficiaries and negotiate steeper discounts. If the endorsement increases volume, then the proposal could lower drug costs somewhat further than under existing programs. However, if negotiated discounts under Medicare-endorsed discount card programs are not passed through to consumers or do not apply to all drugs, then the value to the individual could be compromised.

A Low-Income Drug Benefit

Another general approach under discussion is the idea of moving forward on a Medicare drug benefit incrementally by beginning with assistance targeted to low-income beneficiaries. While lack of drug coverage is not strictly a low-income problem, greater than four in ten without drug coverage have incomes below 150 percent of the federal poverty level (Figure 10). With this in mind, the Administration has proposed a strategy that would expand state programs, such as Medicaid, to help the low-income population while the debate over a universal Medicare drug benefit proceeds. Others have proposed subsidized benefits for the low-income population in the form of a national Medicare benefit, but one that is administered and supplemented by states.

The Administration's proposal would use Medicare funds to extend prescription drug coverage to low-income beneficiaries under Medicaid or other state programs. As under current law, states would be permitted to extend drug coverage only to Medicare beneficiaries up to 100% poverty (about $8,900 per year for a single individual) at current Medicaid matching rates of about 57% on average, but ranging from 50 to 83 percent. (States already have the option to extend all Medicaid benefits, including drug coverage, to these Medicare beneficiaries). For those beneficiaries with incomes between $8,900 and $13,300 per year (100-150% of poverty), states could offer drug assistance through the Medicaid or other state programs, at a 90% federal matching rate.

In addition, the Administration proposes to use existing waiver authority under section 1115 of the Social Security Act to allow states to use Federal Medicaid matching funds to purchase drug coverage for Medicare beneficiaries who are not eligible for Medicaid and whose incomes are below 200% of poverty, or about $17,700 per year. One state, Illinois, has already been granted such a waiver, and the Administration is developing a template for other states to use. Because these waivers are by definition budget neutral, they do not bring more Federal Medicaid matching funds into a state for drug coverage than the state would otherwise receive under current policy. Savings on the current population could need to be achieved in order to offset the costs of new individuals who receive drug coverage.

While an approach targeted to low-income seniors would both extend benefits to those in greatest financial need first and impose considerably less fiscal pressure on the federal government than would a benefit for all people on Medicare, it also raises several challenges and issues for consideration.

The first and perhaps most obvious consideration is that such an approach would not reach more than half of all beneficiaries who lack drug coverage today. While the near-poor—those just above the poverty level—are the most likely to be without coverage as they are generally ineligible for Medicaid coverage, even those with moderate incomes currently face substantial out-of-pocket burdens given the high and rising costs of prescription drugs.

Another consideration is the potential challenge in ultimately creating a national Medicare benefit, given the wide variations in state-based programs. Today, there are differences across the states in terms of their Medicaid eligibility criteria, whether they offer drug coverage through a state pharmacy assistance program, and—if so—what type of benefits they offer. For example, less than half of all states (17) offer Medicaid drug benefits to Medicare beneficiaries with incomes up to 100 percent of the federal poverty level. Of these 17 states, 12 also have a state pharmacy assistance program. The majority of states do not currently cover seniors with incomes up to the poverty level, although many of these states have some form of pharmacy assistance program (Figure 11).

In addition, there are also significant differences in the scope of drug benefits covered under Medicaid by state, involving cost-sharing requirements, limits on prescriptions and refills, generic substitution rules and other utilization controls. Because of these variations in eligibility and coverage, the safety net for Medicare's poor varies widely from state-to-state. As a result, an approach to expanding prescription drug coverage that builds on a state base could perpetuate existing geographic disparities in drug coverage for low-income Medicare beneficiaries.

Another key consideration to this type of an approach must acknowledge the fiscal environment in many states. Prescription drugs are the fastest-rising cost item in state Medicaid budgets, with a disproportionate share of Medicaid drug spending on aged and disabled beneficiaries (Figure 12). In the face of current budgetary shortfalls, many states are beginning to implement a range of cost-control strategies to constrain spending on their prescription drug benefits. Under these circumstances, it is unclear whether and how states—particularly those that do not do not now offer coverage up to 100 percent of poverty—will find the funds or be willing to extend drug coverage any further.

Finally, implementing a new program, with a new administrative structure, can take a considerable amount of time, based on the experiences of both the State Children's Health Insurance Program and many state pharmacy assistance programs.

A Medicare Drug Benefit

There appears to be broad consensus on the goal of assisting all beneficiaries needing prescription drug coverage with a Medicare benefit. However, there continues to be debate over difficult issues involving how to design and implement the new benefit. Bridging these differences remains a major challenge particularly in light of today's fiscal environment.

Drawing on models recently introduced in Congress, the basic approaches to a universal benefit that have been proposed include: an integrated Medicare drug benefit to be administered by private entities such as pharmacy benefit managers; a drug benefit that would be offered along with other Medicare benefits through high-option plans as part of a broader framework for reform; and a stand-alone Medicare drug benefit that would be offered by private health insurance plans. While these approaches reflect a range of philosophical perspectives and policy priorities, there are notable areas of agreement.

First, most proposals offer additional protections for low-income beneficiaries, recognizing the needs of seniors living on fixed incomes. Second, most would provide relief to the relatively small share of beneficiaries with high-end, or "catastrophic" drug expenditures. Third, reflecting one of the chief lessons of the ill-fated Medicare Catastrophic Coverage Act (MCCA) of 1988, virtually all proposals would create a voluntary benefit, rather than require seniors to participate.

Despite these areas of agreement, there remain a number of critical decisions and policy challenges that have significant implications for beneficiaries and program spending. Chief among these is the difficult process of designing a benefit that guarantees meaningful and affordable drug coverage to beneficiaries in the context of current federal budget considerations. With this in mind, perhaps the biggest policy question is that of how much to spend on a new Medicare drug benefit, and how to finance it. Based on the new spending estimates recently released by CBO, drug coverage comparable to what most workers get today would require a major commitment of national resources.

Clearly, the design of the Medicare drug benefit will influence the extent to which the plan shields beneficiaries from rising drug costs, the level of program spending that will be required, and the rate at which spending will grow over time. Seniors

are eager for coverage that resembles the benefits offered to most insured workers today, yet the benefits specified in many proposals would involve relatively substantial enrollee contributions through premiums, deductibles, coinsurance, and other cost-sharing requirements, which sometimes result in what is known as the "hole in the donut". Proposed Medicare drug benefits generally provide less assistance than do drug benefits typically covered by large employers.

In addition to questions involving benefit design and program spending, other critical policy questions remain. For example, while most would agree on the need to assist low-income beneficiaries, there is less agreement on the tougher questions involving who should receive subsidies, the level of assistance, or how subsidies should be administered and financed. Another issue concerns the role of private plans in administering the new Medicare benefit, including both the extent to which they should be required to bear risk and also the latitude they are given to control costs. Finally, a key outstanding question is the extent to which a new Medicare benefit should be linked to broader efforts to reform and restructure the program.

The resolution of these policy issues will have important implications for beneficiaries, and have a significant impact on federal and state budgets.

CONCLUSION

Medicare without medicine is an anachronism. When the public is asked about modernizing or reforming Medicare, our research shows they are thinking almost exclusively about benefit improvements, primarily prescription drugs (McInturff and Garin, 2001). Incremental strategies, such as discount card programs, may help lower costs for some beneficiaries for some drugs, but are not a substitute for Medicare coverage. As the Administration notes, the proposed discount card program would not deliver the same level of savings as a full Medicare benefit.

Targeted assistance for the poor could offer help to those with greatest financial need, depending on how well the program is designed, promoted, and implemented. Yet, even if successful, more than half of all seniors without coverage today would remain unprotected under most low-income approaches.

A universal approach to a Medicare drug benefit will require a substantial investment of federal dollars "putting seniors and their prescription drug needs in direct competition with other national spending priorities. However, given current trends in drug coverage and spending, the absence of a Medicare drug benefit will impose higher costs onto our nation's parents and grandparents.

References

Achman, Lori and Marsha Gold, "Medicare+Choice 1999-2001: An Analysis of Managed Care Plan Withdrawals and Trends in Benefits and Premiums," for the Commonwealth Fund, February 2002.

Kaiser/HRET/Commonwealth, "Erosion of Private Health Insurance Coverage for Retirees: Findings From the 2000 and 2001 Retiree Health and Prescription Drug Coverage Survey," April 2002.

Lake, Snell, Perry and Associates, "Barriers to Medicaid Enrollment for Low-Income Seniors: Focus Group Findings," for the Kaiser Family Foundation, January 2002.

Laschober, et al., "Trends in Medicare Supplemental Insurance and Prescription Drug Coverage, 1996-1999," *Health Affairs*, 27 February 2002.

Public Opinion Strategies and Peter D. Hart Research Associates, "Medicare and Prescription Drug Focus Groups," for the Kaiser Family Foundation, July 2001.

Schneider, Andy and Linda Elam, "Medicaid: Purchasing Prescription Drugs," prepared for the Kaiser Commission on Medicaid and the Uninsured, January 2002.

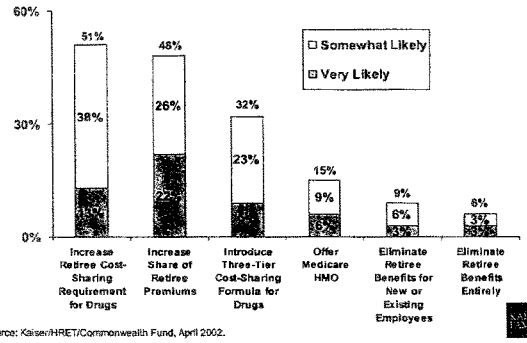
State Pharmaceutical Assistance Programs, National Conference of State Legislatures, <http://www.ncsl.org/programs/health/drugaid.htm>, as of 16 April 2002.

Weiss Ratings, Inc., "Prescription Drug Costs Boost Medigap Premiums Dramatically," 26 March 2001.

Figure 1

Figure 3

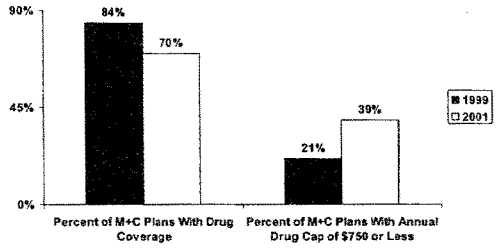
Among Firms With 200 or More Workers Offering Retiree Health Benefits, Percentage Planning Various Changes in Retiree Health Coverage in the Next Two Years, 2001



Source: Kaiser/HRET/Commonwealth Fund, April 2002.

Figure 4

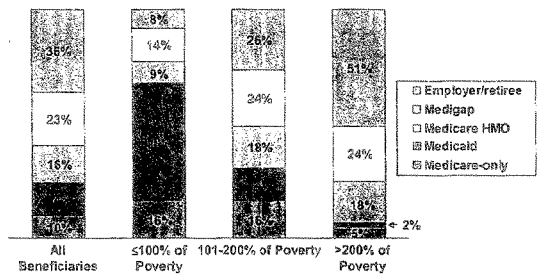
Prescription Drug Benefits Offered By Medicare+Choice Plans in their Basic Plan, 1999-2001



Note: Percentages weighted by enrollment; 2001 data are for March through December.
SOURCE: Achman, L. and Gold, M., for the Commonwealth Fund, February 2002.

Figure 5

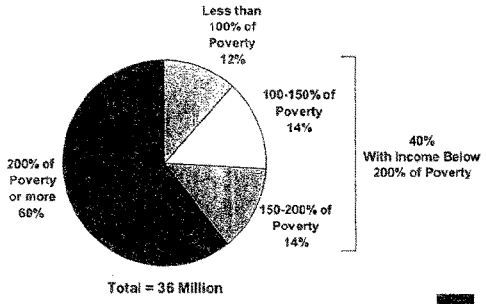
Health Insurance Coverage of Medicare Beneficiaries, 1998



Note: Columns may not sum to 100%; employer/retiree includes both beneficiaries who have supplemental insurance from a former employer or union and those who are still working and whose current employer is their primary source of insurance.
Source: Urban Institute analysis of 1998 Medicare Current Beneficiary Survey.

Figure 6

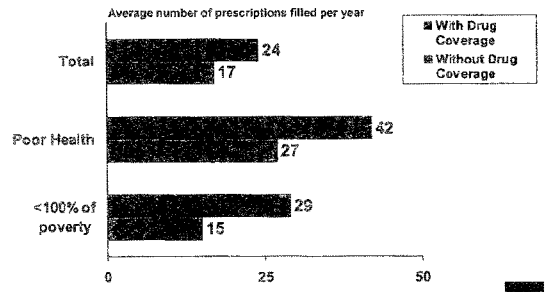
The Non-Institutionalized Medicare Population by Poverty Level, 1999



Note: 1999 federal poverty was $8,240 for individuals; $11,060 for couples.
Source: Urban Institute estimates based on 2000 Current Population Survey.

Figure 7

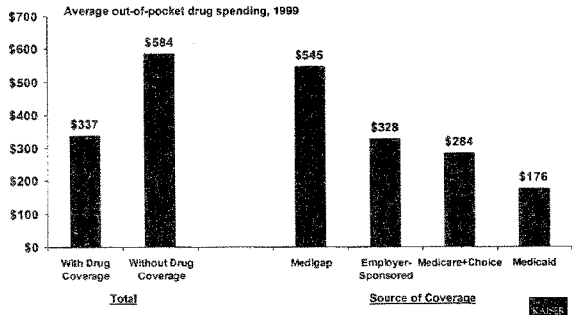
Medicare beneficiaries *without* drug coverage fill fewer prescriptions, 1998



SOURCE: Poisal, J.A. and L. Murray. *Health Affairs*, March/April 2001.

Figure 8

Out-of-Pocket Drug Spending Varies By Source of Coverage, 1999



SOURCE: Stuart, B. and Briesacher, B. Analysis of 1999 MCBS Cost and Use File, 2002.

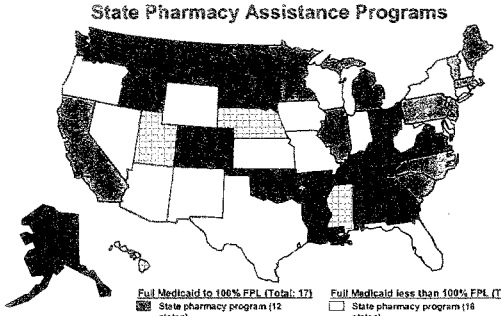
Figure 9

Illustrative Comparison of Retail Prescription Drug Prices

Drug	Washington, DC Average Retail Price (a)	Discount Card Retail Price (b)	FEHBP BC/BS PPO Co-Payment (c)
Prilosec, 20mg (Gastrointestinal agent)	$121.64	$115.00	$25.00
Zocor, 20mg (Lipid lowering agent)	$122.25	$112.79	$25.00
Premarin, .625mg (Estrogen replacement)	$22.84	$21.40	$25.00*

Figure 11

Eligibility for Prescription Drug Coverage Under Medicaid and State Pharmacy Assistance Programs



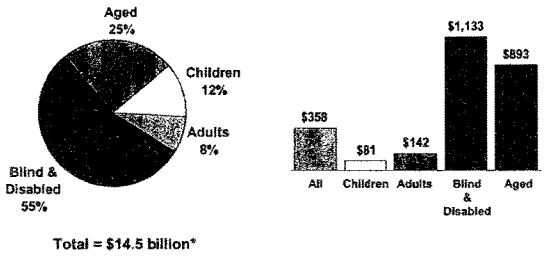
Full Medicaid to 100% FPL (Total: 17)
- State pharmacy program (12 states)
- No state pharmacy program (4 states and DC)

Full Medicaid less than 100% FPL (Total: 34)
- State pharmacy program (18 states)
- No state pharmacy program (16 states)

Note: Oregon, Texas, and Wisconsin have enacted, but not yet implemented their programs. California, New Hampshire, Iowa, New Mexico, and West Virginia offer discount programs.
SOURCE: SPAP data: NCSL, 2002; Medicaid data: APHSA, 2002; except for information on Nevada and Colorado, which is from Families USA, 2001.

Figure 12

Medicaid Prescription Drug Spending, 1998



* 8.2% of total Medicaid spending on services. Includes both fee-for-service expenditures and estimated drug spending by managed care plans.
SOURCE: Urban Institute Estimates, 2000.

Mr. BILIRAKIS. Thank you very much, Doctor. I am going to skip Mr. Fuller for the time being. I guess you are getting accustomed to being skipped, aren't you. Mr. Hillerby.

STATEMENT OF MICHAEL D. HILLERBY

Mr. HILLERBY. Thank you, Mr. Chairman and members of the committee. For the record, my name is Michael D. Hillerby, Deputy Chief of Staff to Nevada Governor Kenny Guinn.

Thank you for this opportunity to testify on Nevada's work to help low-income seniors with their prescription drug needs. Your recognition of the success of this unique State program is appreciated, and on behalf of Governor Guinn I look forward to answering your questions about our efforts.

I would like to provide you with a brief history and overview of Nevada's Senior Rx Program, and the reason we build this first-of-its-kind program using private insurance to underwrite the risk involved.

First, here are the highlights of the current plan: To be eligible for the plan, seniors must be age 62 or over; have an annual income of $21,500 or less—that is roughly 250 percent of poverty, and we do not use an assets test; they cannot be eligible for Medicaid assistance; and they must have been a Nevada resident for 12 months.

This application process also allows us to notify those seniors that would be Medicaid-eligible that we can enroll them in our plan.

The benefits of the plan include a maximum benefit per year per member of $5,000—that is relatively unique in the pharmacy benefit in the insurance market; seniors pay a $10 co-pay for generic medications; $25 co-pay for Preferred medications, or for any other drug deemed medically necessary; all other drugs to be available at provider's discounted rate; and there is no premium expense to the senior.

The program costs the State annually $981, or roughly $81.75 per month, that is inclusive of a prepayment discount. Approximately $66 per month is the anticipated cost of prescriptions per member. The remaining less than 20 percent of the premium pays for the insurance premium tax charged by the State, management, marketing, enrollment, pharmacy benefit manager, and the reinsurance product to insure claims over $66.

In the new contract beginning in 2002, the State will receive 100 percent of any savings between projected and actual claims levels—the $66 per month fee. These funds will be used to enroll more seniors.

That addresses the comments Mr. Brown made earlier about the Milliman and Robertson actuarial study. The administration did not believe that those numbers were adequate for either the claims volume that was expected, did not adequately address the actual cost of administering the State program, and didn't acknowledge the fact that we use a set funding source for ours, and if the claims did come in higher, there was no financial backstop for that.

Senior Rx is funded by a set percentage of Nevada's tobacco settlement, projected at just over $6 million this year dedicated to this program.

The senior, again, pays no premium or deductible cost and is only responsible for the co-pay on actual prescription filled.

Demographics of our program: 75 percent of our enrollees make less than $17,500 per year, and half have incomes less than $12,700. Sixty-one percent of enrollees are between the ages of 65 and 80, 20 percent are 81 or older.

The plan was improved in 2001 with administrative and legislative changes, and is now running at full capacity and has enrolled 7,500 seniors in Nevada. Based on national statistics, this may be as many as 30 to 50 percent of low-income seniors in Nevada who do not currently have prescription drug insurance.

The committee has received previous testimony questioning the quality of the program, its costs to seniors, and the success of using a private insurance model. While there were challenges involved in building the current successful Senior Rx, the lessons we learned may be helpful to you and to other States considering such a program.

Because Senior Rx is a voluntary, stand-alone product, the risks of adverse selection are very real. That is, participants could easily weigh the costs of their premium against their current prescription bills, and only enroll when they would see a net benefit. This could obviously create a plan where most members received more in benefits than was paid in premiums. Because the plan is now free to low-income seniors, it benefits both those with low and high prescription bills.

When originally devised, the State asked insurers to submit proposals that included specifying plan design and benefit levels. Because of both the novelty of this type of program and the risk of adverse selection, insurers were hesitant to bid on a confusing RFP. States considering such a plan should do an honest assessment of their own strengths in contracting, plan design and managing such a program. A voluntary program takes significant outreach and marketing to reach the target population.

Once successfully awarded, Senior Rx consisted of two plan levels, each with different premiums, co-pays, formularies and benefits. Co-payments ranged from $10 for generic drugs to as much as 50 percent of the cost of a preferred drug. Seniors would apply to the State for a subsidy based on their income, and then enroll in one of the two plans at a cost of anywhere from $39 to $94 per month, plus prescription co-pays. Seniors told us loud and clear that the process was somewhat confusing, and because they still paid a share of the monthly premium, a deductible and co-pays, it was still too expensive. This cost share also exacerbated the problem of adverse selection, and the claims exceeded premiums throughout much of the first year of operation.

In 2001, we made significant changes, both legislative and administrative, to the plan. Senior Rx now offers one plan level that retains the $5,000 annual benefit, and is now free to qualifying seniors. The formulary is better, includes more drugs senior advocates asked for, and Senior Rx is easier to apply for and use.

Because funding for Senior Rx is limited to a set percentage of the tobacco settlement, it was essential that we use an insurance model to cover the risk of offering each senior a maximum benefit of $5,000 per year. Risk was also spread across the full spectrum

of seniors because Senior Rx is now free, and attractive to those with limited prescription needs as well. While not every senior will use such a rich benefit, the theoretical risk to the State is over $35 million. Nevada does not have the financial resources available to cover the full risk involved.

In addition, the insurer has significant resources, experience, marketing and management expertise, and economies of scale that the State does not. Our approach also limits the size, complexity and cost of a State bureaucracy, enabling us to dedicate the money to covering seniors.

Governor Guinn believes that Senior Rx can be a model for other States, and potentially for a national prescription benefit for seniors. Our participants should provide useful statistical data about the potential for such a program, as well as the real prescription needs and expenses of low-income seniors. While we all face the same budget realities, it is our hope that our country can at least begin to offer low-income seniors some assistance with their prescription bills. This is not a battle States can win on our own, and this population desperately needs our assistance.

Thank you for the opportunity to speak with you today, and I look forward to answering any questions.

[The prepared statement of Michael Hillerby follows:]

PREPARED STATEMENT OF MICHAEL D. HILLERBY, DEPUTY CHIEF OF STAFF, OFFICE OF THE GOVERNOR, CARSON CITY, NV

Mr. Chairman and members of the Committee, for the record my name is Michael D. Hillerby, and I am Deputy Chief of Staff to Nevada Governor Kenny Guinn.

Thank you for this opportunity to testify on Nevada's work to help low-income seniors with their prescription drug needs. Your recognition of the success of this unique state program is appreciated, and on behalf of Governor Guinn, I look forward to answering your questions about our efforts.

I would like to provide you with a brief history and overview of Nevada's Senior Rx Program, and the reasons we built this first-of-its-kind program using private insurance to underwrite the risk involved.

First, here are the highlights of the current plan:

Eligible Seniors:

—Age 62 or over;
—Annual income $21,500 or less (no assets test);
—Not eligible for Medicaid assistance;
—Nevada resident for 12 months.

(The application process allows us to notify seniors who qualify that Medicaid benefits may be available to them.)

Benefits:

—Maximum benefit of $5,000 per year;
—$10 copay for generic medications;
—$25 copay for Preferred medications; or for any other drug deemed medically necessary; all others at provider's discounted rate;
—No premium expense to senior.

State Costs:

—Annual premium is $981, or $81.75 per month (inclusive of prepayment discount).
—Approximately $66 per month is the anticipated cost of prescriptions per member.
—The remaining less than 20% of the premium pays for the insurance premium tax, management, marketing, enrollment, pharmacy benefit manager and the reinsurance product to insure claims over $66.
—In the new contract, the state will receive 100% of any savings between projected and actual claims levels (the $66 per month fee). These funds will be used to enroll more seniors.
—Senior Rx is funded by a set percentage of Nevada's tobacco settlement, projected at just over $6 million dedicated to the program this year.

—Approximately $135,000 is used by the State of Nevada for administrative expenses related to eligibility determinations, contract management, outreach and related staffing.

—The senior pays no premium or deductible costs, and is only responsible for the copay on actual prescriptions filled.

Demographics:

—75% of enrollees make less than $17,000 per year, and half have incomes less

Thank you for the opportunity to speak with you today and I look forward to answering any questions you might have.

Mr. BILIRAKIS. Thank you very much, sir.

Dr. Tyler.

STATEMENT OF BRIAN TYLER

Mr. TYLER. Thank you, and good afternoon, Mr. Chairman, members of the committee. My name is Brian Tyler. I am Senior Vice President with McKesson Corporation. McKesson is a Fortune 35 health care services company. We are not a manufacturer of drugs, but we do occupy a fairly unique position in the supply chain serving both the retailer and the manufacturer constituents.

As part of our reach and services available to them, we have been asked to administer the Together Rx card, and I ma here today to talk about McKesson's role as the administrator of the Together Rx Card Program.

The Together Rx card from the beginning was designed as an interim solution. It is a savings program targeted at Medicare enrollees with incomes below 300 percent of the Federal poverty level, and no existing prescription coverage. It was funded by seven leading manufacturers—Abbott Labs, AstraZeneca, Aventis, Bristol-Myers Squibb, GlaxoSmithKline, Johnson & Johnson, and Novartis. I would like to quickly just highlight four important elements of the program.

First, savings. The design is to provide meaningful savings direct to the eligible senior participant. We offer an average savings of 20 to 40 percent of the drugs on this program. I should also note importantly, the enrollment process will be linked to existing patient assistance programs. These programs for the most needy of the eligible enrollees provide drugs at no cost or at nominal fee. This will further enhance the 20 to 40 percent savings.

The second aspect I would like to outline is broad access to medications. Currently there are over 150 medications as part of this program, drugs like Glucophage, Voltaren, Paxil, Gleevec and Pravachol, for the treatment of diabetes, depression, cancer and high cholesterol, just to name a few.

The third thing I would like to point out is the wide reach. This is the most inclusive program in terms of eligibility requirements, and we estimate that between 8- and 11 million Medicare enrollees will be able to participate in this program.

And, last, and very importantly, the ease of use aspect. This card is easy to use for the senior. It is easy to use for the pharmacist. It is free to the patient. It is a single card, which eliminates a lot of confusion and disruption at the pharmacy counter. There is a single enrollment process, one phone number, to be eligible for all the products covered under this card. And, again, it is tied to the seven distinct patient assistance programs. This program requires only a signature to enroll and become eligible for.

The Together Rx card has been endorsed by many of our friends in the retail community, including Wal-Mart, CVS, Eckard, Safeway, Albertson's, Costco, many others. Independent pharmacists will be accepting this card, including the 4,000 members of McKesson's voluntary network. We also have been very fortunate to have the support by many leading health care agencies and sen-

ior organizations, including AARP and the National Council on Aging.

We have very significant plans to promote this card to make sure we get the uptake we all desire. Let me highlight two of these features. One, the 3,000 sales representatives of the member manufacturers will be distributing materials directly to the physician's office, and NCOA, through its 17,000 affiliated community centers, will make enrollment forms available.

The program has just very recently been announced, April 10 was the official announcement of this program. The response has been extraordinary. Over 50,000 individuals accessing our Web site, generating 2 million hits, over 40,000 calls to our call center. We have received numerous expressions of interest from additional manufacturers, retailers, existing discount card programs, and other interested agencies on how they, too, might collaborate. And we are excited about following up on all those conversations.

I want to stress, we view this as an interim solution, and we commend the President and the Members of Congress who are pursuing a more comprehensive Medicare prescription benefit program. The Together Rx card is senior-friendly, pharmacist-friendly, and we believe will provide significant benefit to those in need.

Thank you very much, Mr. Chairman and members of the committee.

[The prepared statement of Brian Tyler follows:]

PREPARED STATEMENT OF BRIAN TYLER, SENIOR VICE PRESIDENT, BUSINESS DEVELOPMENT & STRATEGY, MCKESSON CORPORATION

Good morning, Mr. Chairman and members of the committee.

INTRODUCTION

My name is Brian Tyler, and I am Senior Vice President, Business Development and Strategy, at McKesson Corporation. Thank you for inviting me here today on behalf of McKesson Corporation to discuss our role as the administrator of the Together Rx™ Card.

TOGETHER RX™ CARD

Medicare seniors on limited income who don't have prescription drug coverage sometimes have to make difficult choices between essential medicines or food on the table. The Together Rx™ Card combines the resources of seven major pharmaceutical manufacturing companies to address this need by offering average savings of 20% to 40% on more than 150 widely prescribed medicines. This free, easy-to-use card is available to seniors who lack any public or private prescription drug coverage and have incomes that meet the eligibility thresholds. These income thresholds, at $28,000 per year for individuals or $38,000 for couples, or approximately 300% of the federal poverty level, exceed those of any other drug savings card now available; thus, more seniors in need will be eligible for this Card.

The founding members of Together Rx, L.L.C., are: Abbott Laboratories, AstraZeneca, Aventis Pharmaceuticals, Bristol-Myers Squibb Company, Glaxo SmithKline, Johnson & Johnson (through its Ortho-McNeil Pharmaceutical, Inc. and Janssen Pharmaceutica Products L.P. companies.), and Novartis Pharmaceuticals Corporation. McKesson is facilitating this single card that offers access to savings on more medicines than any existing pharmaceutical company prescription savings program. As a result, the Together Rx™ Card makes it more convenient and easier for those enrolled in Medicare to get medicines, such as Glucophage, Voltaren, Paxil, Monopril, Reminyl, Glivec, Synthroid and Pravachol, which they so critically need to fight diabetes, arthritis, depression, hypertension, Alzheimer's disease, cancer, hypothyroidism and high cholesterol.

We have seen tremendous enthusiasm for and interest in this initiative. In the first 24 hours since the Card was unveiled on April 10, more than 10,000 consumers visited the Together Rx Web site and we received nearly 11,000 phone calls. As of

two days ago, that number had grown to 50,000 consumer visits to the Web site and 40,000 calls. By June 1, when the Card is effective, we hope to reach a large percentage of the estimated eight million to 11 million Medicare recipients who are eligible for this Card.

This is truly an extraordinary response, which we hope will continue as the seven manufacturing companies combine their marketing expertise to expand the universe of eligible seniors. More than 30,000 sales representatives of the seven manufacturers will distribute enrollment materials in physicians' offices, while the Card is also promoted through continued advertising and outreach at senior centers. Together Rx™ has been endorsed by many leading healthcare and senior citizen organizations, including AARP and the National Council on Aging, both important partners in publicizing this Card. Through the NCOA's extensive network of over 17,000 affiliated community centers and its online web site, benefits checkup.org, we will be able to reach out widely and quickly to Medicare enrollees in communities across the country, and ensure they have the necessary information to enroll in the program.

As noted earlier, McKesson Corporation serves as the administrator of the Together Rx™ Card. We currently administer the prescription discount program for Novartis and have scaled our offering (enrollment processing, consumer and pharmacist hotlines, pharmacy transaction adjudication, manufacturer-to-pharmacy reimbursement) to facilitate the technological standardization of the prescription savings programs offered by the seven Together Rx companies. As the Together Rx™ Card administrator, McKesson will process card applications, offer help and information via a dedicated toll-free number (1-800-865-7211) and Web site (www.Together-Rx.com), distribute cards to enrollees, facilitate pharmacy participation and adjudicate transactions. We are uniquely positioned to connect three important constituencies: the low-income senior citizen, the pharmacy and the manufacturer. Our technology makes it possible for savings to be realized at the point-of-sale in the pharmacy, and the use of a single card offers unprecedented ease of use to patients and pharmacists.

McKesson was chosen to administer this Card as a result of our unique position and capabilities in the U.S. health care delivery system and our proven expertise and experience in providing services and technological connectivity to deploy programs such as the Together Rx™ card successfully. Headquartered in San Francisco, McKesson is a Fortune 35 corporation and the world's largest healthcare services company. As one of the largest nationwide distributors of pharmaceuticals and medical-surgical products to pharmacies and other health care providers, we serve as the interface between the manufacturing and the retail pharmacy community. For the past 165 years, McKesson has served as a safe and efficient channel for the fast delivery of critical medicines to our pharmacy customers, which include thousands of independent and chain drug stores as well as hospitals, clinics, nursing homes and physicians' offices across the country.

Through our expertise in advanced healthcare information technology, McKesson is also a leader in designing Patient Assistance Programs (PAPs), which allow many of the world's leading drug companies to meet the needs of lower income patients who lack insurance coverage. We currently manage 10 PAPs and have served more than 2 million patients over the past few years. As a unique characteristic of the Together Rx™, McKesson will screen applications during the enrollment process and notify those at the very lowest income levels of their eligibility for even greater savings—and, in some cases, free medicines—from the patient assistance programs offered by the individual pharmaceutical companies or by foundations supported by the individual companies. Currently, such eligibility is determined by physicians or other health care providers, and many eligible and underserved populations are unaware of these patient assistance programs.

Let me emphasize that the Together Rx™ Card has no formulary. McKesson is not paid to drive compliance or market share, or encourage therapeutic substitution. McKesson will receive an administrative fee for its role in the Together Rx™ Card program that is borne entirely by the participating manufacturers, but neither McKesson nor the pharmacist retains any portion of the savings provided by the manufacturer. Chain drug stores across the country, including Wal-Mart, Rite Aid, Walgreens, Target, Albertson's, Costco, Kroger, Safeway, and Eckerd have shown strong support for the Together Rx™ card, along with thousands of independent drug stores, including the over 4000 retailers who are part of McKesson's voluntary network of Valu-Rite stores. By accepting the card at their retail outlets in communities across America, participating pharmacies have made the commitment to pass through directly to the patient 100% of the savings being offered by the pharmaceutical companies. We are actively speaking with many other pharmacies and expect to enlist additional support and commitment in the near future.

CLOSING

I would like to close by reiterating that the Together Rx™ Card provides much-needed assistance to people on Medicare who are of limited income and currently struggle with the lack of prescription drug coverage. This program is an immediate, interim step that will provide drugs in a convenient and expeditious manner to those most in need of drug coverage until a comprehensive Medicare prescription drug benefit is enacted and implemented.

The lack of prescription drug coverage among Medicare beneficiaries remains a serious national problem that no single company can solve. We at McKesson commend President Bush and those in Congress who are calling for enactment of a comprehensive Medicare prescription drug benefit this year.

While we wait for that to become reality, however, we would like to applaud the efforts of the founding members of the Together Rx™ Card program. We are proud to be part of an interim solution to help low-income seniors realize needed savings at the same time that they gain broad access to medicines.

Thank you very much, Mr. Chairman and members of the Committee. I would be happy to take your questions.

Mr. BILIRAKIS. Thank you very much, Dr. Tyler.

Last, but not least, Mr. Fuller.

STATEMENT OF CRAIG L. FULLER

Mr. FULLER. Thank you very much, Mr. Chairman, Mr. Brown, good to be with you today. I have a statement which I will submit to the record, but I thought I might best use a few minutes here before going to questions just to talk a little bit about the path we have traveled.

I represent the National Association of Chain Drug Stores. We have some 200 retail members, with some 35,000 chains. Nearly 90 percent, in some stores more than 90 percent, of the people that come to those stores purchase their prescription medication with some sort of third-party payer. Indeed, most seniors have some kind of a plan for their prescription drugs. But our pharmacists, 100,000-some strong, are faced every day with the senior who lacks any drug coverage whatsoever, trying to pay for that product which is going to help them either recover from an illness or deal with a chronic illness, and so we have been very concerned about this issue. And I guess I am here to say, with all due respect to the members' opening comments, that I don't think one should walk away from interim measures because I think they can be bold, I know they can be very beneficial for the families of people who can't afford their prescription medication.

We looked last year very closely at what the administration was proposing. We believed and said then, and we continue to say, that the proposal the administration has come forward with on a discount card ought to come here for airing and discussion. And so we were very pleased that Dr. McClellan was here. Indeed, we have had a number of conversations with him, and understand their approach, and to share with him our approach.

I thought one of the most important developments last year actually was the fact that manufacturers looked at ways, innovative ways, to come forward with programs and card programs that would provide seniors with meaningful benefits. And, indeed, over time, I think the natural competition out in the marketplace delivered at the end of the cycle, before this most recent announcement, delivered benefit cards from manufacturers where there is no guessing. For one of the manufacturers the drug is $15, for the other it is $12.

We believe now with seven companies—actually, one of them already was in the plan, but six new companies coming onboard with the Together Rx card—a total of nine companies now having programs for seniors that are available through cards, that this is a good development, that in fact it is a very meaningful development for seniors.

Our concern was that for seniors to take advantage of these programs, they had to be able to get the best program available through a single card, or at least fewer than ten of 15 cards. And so we began last year and early this year, a process of looking at ways that that might be accomplished.

We do believe, and we would support legislation, that would within CMS or HCFA—as some fondly still refer to it—that we do believe that an entity could be created that would retain an administrator for a single card program. A single card program would allow manufacturers to come forward with whatever program they wanted to provide to seniors, and that program could be made available in the retail setting to the seniors currently without coverage.

Another very important role for government in that regard is the whole determination of eligibility because, obviously, there are privacy concerns and other issues, and we think the government could play an important role there.

Perhaps most importantly, and I think addressing one of the messages we have certainly heard from a number of the members this morning, is that with a stop-loss provision, all Medicare-eligible seniors could have a benefit, a stop-loss benefit, that they would be entitled to if there was an outlay of cash equal to whatever level you want to set. We haven't priced it out precisely. I would look forward to the administration's estimates of that. We would look favorably at $6,000, $4,000, whatever level was felt could be afforded. But the combination of a stop-loss provision and a single card program within CMS, we think, would be very beneficial.

Last, I will say that in the course of developing this, we found a number of manufacturers interested in looking at simply a private step and, therefore, we sought and we announced recently the creation of a program we think would be helpful, the creation of a Pharmacy Care Alliance, that we would try to bring as many groups into as possible to help educate low-income seniors on the availability of these benefits, and the creation of a Pharmacy CareOneCard.

We are not really in a naming competition, and I am very pleased to say that we have had a number of talks for several weeks—actually, 2 months—with McKesson and with the companies there, and the concept of a common card with multiple manufacturers is something that we think is very beneficial to seniors, and it is much more workable in the marketplace, so we applied what they have done, and we look forward to working with them to make that a reality.

I will stop there, and would welcome your questions.

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

PREPARED STATEMENT OF CRAIG L. FULLER, PRESIDENT & CEO, NATIONAL ASSOCIATION OF CHAIN DRUG STORES

Mr. Chairman and Members of the Subcommittee, I am Craig Fuller, President and CEO of the National Association of Chain Drug Stores (NACDS). NACDS represents about 200 chain pharmacy companies that operate about 34,000 retail pharmacies all across the United States.

Chain pharmacy is the single largest segment of pharmacy practice. Our members include the traditional chain pharmacies, the food/pharmacy combinations, and the mass merchandise pharmacy operations. We filled about 70 percent of the 3.1 billion prescriptions provided across the nation last year. We appreciate the opportunity to describe for you our ideas on both interim steps that the Congress can take to help seniors obtain necessary medications, as well providing a comprehensive Medicare prescription drug benefit.

INTERIM APPROACHES TO PHARMACY COVERAGE

First, let me talk about interim steps that we encourage Congress to take if a comprehensive drug benefit is not achievable this year. If we cannot come to agreement, or insufficient time exists to develop a voluntary benefit for all seniors, then we think we should start with making medications more accessible for the most vulnerable in society, and those with the highest medication bills.

Consolidated Manufacturer Card Program with "Stop Loss" Coverage: NACDS supports an interim approach that would have two components. The first component would create the necessary Federal infrastructure for low-income seniors to more easily access the various drug manufacturer medication subsidy and discount programs that are being developed. The second component would provide a full pharmacy benefit for seniors who need "stop loss" coverage because they have high out of pocket drug costs.

First, let me talk about our ideas on the manufacturer-based programs. At last count, nine manufacturers have developed these programs over the past few months. Some of these programs provide discounts, while others provide subsidies, such as paying the full cost of the prescription other than a $12 or $15 co-pay.

However, each program has been issuing its own "card" to seniors to access these discounts and subsidies at the pharmacy. Moreover, each program has different eligibility criteria and enrollment forms, and other requirements to access the program. While NACDS views these programs as very worthy, we are concerned that seniors will be confused by the multiple programs, and that they will create operational difficulties for pharmacies having to deal with multiple cards for seniors.

As a result, NACDS announced last month that it was launching the **Pharmacy Care Alliance**, which represents a strong first step by retail pharmacy leaders to help seniors obtain needed prescription drugs. Among other activities, the Alliance will help educate seniors about these programs so that they can be used to the maximum extent possible.

We have also created the **PharmacyCare***OneCard*—a new concept that would allow low-income seniors to carry a single card for participating in a broad number of these manufacturers' discount and subsidy programs. We hope all pharmaceutical manufacturers that sponsor special programs for seniors "whether they maintain their own card program or not—will become partners in the Alliance and offer their programs to a national network of retail pharmacies through the **PharmacyCare***OneCard*. We hope to build an open, flexible program that allows individual manufacturers and retailers to choose whether and how to participate.

We already have seen results from our efforts to push for a consolidated approach. Over the last few days, several manufacturers have responded to our call for a "one card", and have joined forces to create the "Together Rx" program, which would allow seniors to access these manufacturers' discount programs through the use of one card. We are hopeful that this card program might eventually be joined with our program—as well as other manufacturer card programs that exist in the market—to offer these programs to seniors through the use of a true, single standard card.

While the "Together Rx" card clearly moves in the right direction, we believe that legislation is needed to facilitate the evolution of the goal of creating one card, and making the program more permanent for seniors. We believe that Federal legislation should be enacted to create a single administrative structure that can be used by any manufacturer that wants to offer a discount or subsidy program. Seniors would be able to use one card at the pharmacy—rather than multiple cards—to obtain lower medication prices.

Quality of care would also be enhanced, since a single electronic prescription processing system would allow the pharmacist to check for any potential adverse reac-

tions in filling prescriptions for seniors. This could not be achievable without a Federal solution. Our hope is that all manufacturers with these programs would use this approach to offering their discounts and subsidies.

Second, as part of our interim proposal, we would support full pharmacy "stop loss" coverage for seniors who incur more than a certain amount in unreimbursed drug expenses each year, such as $6,000. The same infrastructure that is used to administer the manufacturer subsidy and discount programs can be used to implement this "stop loss" coverage program. Offering this coverage will start us down the road to providing more comprehensive coverage for prescription drugs, beginning with the population that needs help the most. Over time, Congress can take steps to lower the "stop loss" amount so that more seniors become eligible for coverage. But, at least we've been able to take the first step this year.

Medicare-Endorsed Discount Card: Before turning to comprehensive approaches to pharmacy coverage, I should share with you that we continue to oppose the Administration's efforts to establish a Medicare-endorsed prescription drug discount program. The Bush Administration does, however, deserve credit for starting last year a serious examination of innovative private approaches that can provide meaningful pharmacy benefits to low-income seniors. However, their program will not result in meaningful reductions in the price of prescription medicines for seniors. Moreover, any reductions will likely just come from reduced pharmacy prices, and not a reduction in the price of the medication from the drug manufacturer. This debate was moved forward in very productive ways with the result that many manufacturers are now offering meaningful price reductions on the cost of their medications.

In addition, we don't think that HHS should be picking winners and losers in this market through their endorsement program, or that its appropriate to lend Medicare's time-trusted name to private-sector entities without strict standards. Finally, we do not believe that the Department has the legislative authority to develop this program, not do we support Congress giving it to them as an interim measure.

COMPREHENSIVE APPROACHES TO PHARMACY COVERAGE

Now, let me turn my attention to our ideas for comprehensive pharmacy coverage. NACDS supports enactment of a comprehensive pharmacy benefit for seniors. In particular, we strongly support **H.R. 3626, the Medicare Drug and Service Coverage Act of 2002**, which has been introduced by Representatives Jo Ann Emerson and Mike Ross. This is the only comprehensive bipartisan prescription drug bill that has been introduced in the House, and contains the many elements that we think are important in a meaningful, quality drug benefit for seniors.

This includes ensuring that seniors have access to the pharmacy of their choice, that they are provided with community-based pharmacy services with provisions for adequate payment for these services, and that the use of low-cost generic drugs is encouraged. We are grateful to these two members for their leadership on this issue, and we also appreciate the cosponsorship of the Members of Congress that support this bill. This bill is supported not only by NACDS, but the entire pharmacy community, including the independent pharmacies, hospital pharmacies, and nursing home pharmacies.

In terms of the recent drug benefit proposal that passed the House in June 2000, HR 4680—the Medicare Rx Act—you should know that NACDS and all of organized pharmacy is concerned with the approach used in that bill. I believe we would have similar concerns with that type of bill if it were brought to the House floor again this year. In general, we have concerns with "drugs-only" insurance-based and PBM-based approaches to providing prescription drug benefits. We do not support the approaches used by these entities to contain costs, because they are primarily focused on reducing access to prescription medications, and reducing pharmacy reimbursement. Moreover, we also do not believe that the Medicare program needs to turn to these middlemen to obtain the savings on medications that Medicare should obtain, given its purchasing power in the market.

We believe that the experience of the government's own FEHBP should be instructive to Members of Congress as they consider the true effectiveness of this approach to providing a prescription drug benefit for seniors. Our analysis indicates that escalating prescription drug spending in the FEHBP program—which is administered by the same PBMs that would be used for Medicare—has contributed significantly in recent years to the sharp premium increases seen in the program.

For example, in 2001, 40 percent of the 10.5 percent increase in FEHBP premiums was attributable to drug spending increases. In 2002, 37 percent of the 13.3 percent increase in FEHBP premiums was attributable to drug spending increases.

Keep in mind that the FEHBP population is not typical of the traditional older Medicare population, which uses more drugs and has higher per capita expenditures than the much-younger FEHBP population. If the PBMs have not been able to manage prescription drug spending in the FEHBP program, why should we believe that they would be any more effective in the higher-cost Medicare population?

CONCLUSION

Mr. Chairman, NACDS wants to be constructive players in the debate on both interim and comprehensive solutions to pharmacy coverage for seniors. Our industry is an important player in this debate, because we are the primary vehicle by which pharmacy services are actually delivered to the patient. We operate an efficient, low-margin, but highly effective primary health care delivery system that is accessible in many places 24-hours a day, 7-days a week.

We look forward to working with you and members of the Committee in making this happen now and in the future. Thank you again for the opportunity to be here today.

Mr. BILIRAKIS. Thank you very much, Mr. Fuller.

Well, those of you who have attended some of our hearings and testified—even if you have attended and haven't testified—know what my general philosophy is. My general philosophy is the intent here is to help people in such a way so hopefully they can help themselves when it comes to health care.

It seems like an awful lot of Members of Congress are concerned about doing it and doing it one way and only one way, and if that isn't the way that it is done, then don't do it. And that has been sort of my biggest—I am frustrated with a lot of things up here. This is my 20th year, and I don't know how in the world I have been able to take it for 20 years. So there are many things that I am frustrated with, but that particularly.

I know a few years ago we had a piece of legislation, and it would have helped people right then and there. And, well, it wasn't what other people wanted and, therefore, it just went by the wayside. In the meantime, I wonder how many poor and very sick people were not able to get the pharmaceuticals that they needed, that they could have gotten if we had done something as an interim.

I mean, all of you have used that. I appreciated Dr. Braun—I know she has testified here so many times and does such a great job—but I appreciated her making the comment that if there is something done for the low-income that it would be outside of the scope of Medicare, but the point is she was willing to go along with something like that. And I am very pleased that AARP has—I don't know whether "endorsed" is the right word—endorsed the drug discount card, the McKesson, discount card. Is "endorsed" the right word?

Ms. BRAUN. I think we have seen perhaps advantages with the discount card that the President is suggesting, or a multi-card. I think that does have its advantages.

I would just like to bring up, Mr. Chairman——

Mr. BILIRAKIS. Yes, please do.

Ms. BRAUN. [continuing] another thought on the discount card. I do think our members do want a comprehensive plan. I mean, I think that ought to be——

Mr. BILIRAKIS. Yes, we all do.

Ms. BRAUN. [continuing] but as far as the discount card, I certainly would agree with Dr. McClellan that it has possibilities of educating, helping CMS understand how these kinds of things work and so forth. And one of the things that comes to my mind

that did not come up this morning is that hopefully, if CMS is involved, there would be some ability to find out what the costs actually are to the PBMs and what is being passed on to the consumers.

I just recently have had the experience, about a year ago a drug that I am taking went off patent. So I checked to see—I was paying $153 for my prescription. Went off patent, and I checked where I could get it, and I found I could get it for $10, what they had charged $153, which is a drug company in Long Island, by mail order.

Mr. BILIRAKIS. You did that through the Internet?

Ms. BRAUN. No, I was aware of this—for years I had been getting generic drugs from this company, so I knew—and I wanted to see what they would be charging for it—to be exact, $9.35.

So then I decided to see what would happen—that is someplace where physicians can get medication. However, I decided to find out what someone else would pay for it if I gave them a prescription for this medication. What I found out was that what I could pay $10 for, they could get it from Wal-Mart for $49. They could get it from AARP mail order for $84. They could get it from Walgreen for $107. Or they could go to Eckard's and pay $137.

Now, true, they would save something on $153, but it is nothing compared to what could be saved, and obviously all of those other PBMs, chain drug stores, what have you, they could be getting it from the same source. I am sure Darby's Drug is not losing money selling it to me for $9.35.

So, I have a real concern about that gap. I would be hopeful that if something did come up with a discount card, that if the government is involved, if CMS is involved, they can require that they know what the costs are to the PBM, just like they require to find out what the cost is——

Mr. BILIRAKIS. Well, that is right. You know, we see 15 percent and 20 percent and 40 percent and all that, and that is a question that we all raise. Actually, you are leading me on to exactly what I wanted to talk to Dr. Tyler about.

But I would ask you this, because the discount cards are out there—and my time is already up—but because the discount cards are out there, is AARP making available to its members information on the cards, how to use them, and things of that nature?

Ms. BRAUN. Well, I think that may be part of this campaign that we are going to do, but I do think it is getting more and more confusing, and none of the cards really give you any decent amount of discount.

Mr. BILIRAKIS. Including the McKesson? I realize it is brand new, but——

Ms. BRAUN. I have not really seen the McKesson situation and what that will do, but I do think ultimately—of course, the members are very anxious to have an insurance program that will cover all of them, but I do think that it would be helpful if CMS was involved with these cards, and not just with the drug companies starting them when we have no idea.

Mr. BILIRAKIS. Any comment on that, Dr. Tyler?

Mr. TYLER. Yes. Thank you, just maybe a couple of quick things. One, we would ask for a little bit of time to improve our commu-

nication and get the information out and widely available. The program has been live for only 5 days, and I can assure you you will continue to see a stream of information forthcoming.

I think the question was raised as to whether the discount will be meaningful, and I think based on the experiences of a lot of discount cards previously in the marketplace, that is probably a fair question to ask.

I can tell you that the design of this program is different than the programs that you have seen in the past, which were mainly funded by retailers and/or PBMs.

This plan is sponsored by the drug companies. They have specified specific discounts off of their wholesale acquisition costs. That creates a specific dollar amount for each product that is intended to be passed through to the patient. Think of that as an electronic coupon, if you will.

Mr. BILIRAKIS. So that would be the wholesale acquisition cost?

Mr. TYLER. That is correct, which essentially think of as a list price. So they have created a discount off of a list price, an absolute dollar amount, with the intention to be passed through to the customer at the time of the point of sale transaction.

Now, another nuance in the program is it essentially sets a maximum price by linking the maximum price you can charge to an AWP. So it was just referenced that lots of products are charged lots of different prices in lots of different marketplaces based on lots of different local competitive dynamics. This would essentially set a maximum reimbursable price off of which the discount would come.

So, with time, as this program comes to market and transactions are being processed, which should be in June, the discounts—there should be great transparency.

Mr. BILIRAKIS. Mr. Fuller, any comment?

Mr. FULLER. Well, I think that, first of all, I would say that one of the issues is delivering to the senior an easily accessible and meaningful benefit, and I think that when you see the kinds of benefits that are recently being offered where manufacturers are taking brand name products that might be selling for $100 or $150 and selling them for $12 or $15, or as Dr. Tyler is describing, having a set reduction, that is meaningful, and that is a very important step forward, which I think we ought to embrace and help seniors understand how to take advantage of that.

I would also indicate and associate myself with some of the comments Dr. Braun made by saying that the role of the pharmacist in this, when individuals come in as cash-paying customers without benefits, the role of the pharmacist is very beneficial for all of the health-related reasons and counseling reasons we have talked about, but also because it is pretty clearly demonstrated that there is a much higher utilization of generic drugs. And I think the point being made is that patients who need medication ought to get counseling and understand how to find the best drug for them that they can also afford.

And so some of these discrepancies that were being described relate to the difference between the cost of a generic drug and the cost of a brand drug, and that is something that we in pharmacy

do support and are supportive of. And I think that is another area where there are some very important savings for seniors.

Ms. BRAUN. Those were all generic.

Mr. BILIRAKIS. I am sorry, what?

Ms. BRAUN. Those were all generic, the prices that I quoted.

Mr. BILIRAKIS. All generic, and yet such a wide range.

Ms. BRAUN. The brand price was $153. All the others were generic. Everywhere from $10 to $137 for the same drug.

Mr. BILIRAKIS. Well, I am going to yield to Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. It is a pleasure, Dr. Braun, to hear a consumer so sophisticated that she counts down the number of days until a drug goes off patent.

Ms. BRAUN. You are right.

Mr. BROWN. You don't see that often, obviously. I think your statement at the end, when you said that, just underscores so much of what all of this is about.

The loopholes created accidentally, obviously, by Waxman-Hatch on generics that we want to close, that Representative Emerson and Mr. Stupak and some of us want to close the so-called GAP bill as supported by Mr. Fuller's group and supported by all the auto companies, the United Auto Workers, by all the telecom companies, the Baby Bells and the CWA, it is supported by Marriott, it is supported by BlueCross/BlueShield and other insurers, it is supported by darn near everybody except the prescription drug companies and the Bush Administration and, come to think of it, those are many of the same people. And it is important, I think, when I hear the previous witness come in—I just sit here amazed today when I think about—he talked about—over and over and over the script was, from many people on that side of the aisle, it is going to cost $2200 down the road, per person. We are going to have to raise taxes to do that.

The same week that the majority is going to pass a huge tax cut that goes overwhelmingly to the richest people in this country, at the same time the administration nor the majority will do anything about the price of prescription drugs, allowing these drug companies to continue to scam on the patent, on the extension of the patent. You know, you illustrated that very well.

There is a wide range of generic costs, that is competition. That is fine as long as the competition is there. Mr. Fuller's stores can compete among one another. Maybe some of them will charge $100, maybe some of them will charge $10, that is all fine.

But the fact is, we sit here, we bemoan the cost of $2200 per senior—wherever that came from, from the previous panel witness—but nothing about these tax cuts and nothing about any cost controls or price controls or restraints on costs. As Dr. Lambrew said so well, it is clearly a question of—it is not a question of resources, it is a question of priorities, and this Congress doesn't have it together. We are going to continue to put off this decision. We can include this in a Medicare prescription drug benefit. We could do something about prices. Instead, Congress' priorities are let us do a huge tax cut for our richest friends and the largest corporations in the country, and all come to committee, and let us just talk about how much we all want to do a prescription drug benefit, and send a news release out to our constituents saying "I am for pre-

scription drug benefit," even though I am not really funding it, even though I am more for a tax cut, but they forget to write that part.

Dr. Lambrew, the President's Budget, as you know, contains no comprehensive drug benefit for all beneficiaries in States that access—would be part of a Medicare Reform Plan, a plan presumably to, in some form, privatize Medicare. The President has had principles for reform for almost a year, but we have not seen a plan there. What does all this mean? The President seems to believe that Congress can't afford to add a prescription drug benefit until the entire program is reformed, while at the same time having far too few dollars because we have to pay for the tax cut. Where does this take us?

Ms. LAMBREW. I would just make two comments on that. The first is, when we think about Medicare, we should recognize the fact that today, in 2002, we haven't seen such a positive cost outlook in decades, that Medicare per capita cost curve is now growing below the private sector—we heard about this health care crisis coming back—is not in the projections for Medicare yet. Equally important, the Trust Fund is solvent through 2030, according to the latest projections.

So the question is, what is the financial crisis that Medicare is facing today? And you could make a clear case that it is not necessarily facing a financial crisis today. Certainly, it may be, you know. As soon as the Baby Boom generation comes into the system, we will have challenges, but do we need to focus on it this year? I would argue no. We do know that Medicare beneficiaries are losing prescription drug coverage almost on a daily basis. We do know that drug prices are going up 17, 18 percent every year. So, that, I think, you could define as a real crisis whereas the financing issues are at least not in the next decade as pressing.

Mr. BROWN. Thank you. I have a couple more questions, but just so the panel doesn't have to stay through the votes, I will yield my time to Mr. Stupak, if you want to do that, or just give him the 5 minutes.

Mr. BILIRAKIS. I will just give him whatever time we can take, and obviously questions will be raised to you in writing, and we are requesting, as per usual, that you respond to them. You have waited a long time, and we have rushed right through, and we apologize for that, but your testimony is in the record itself. Go ahead.

Mr. STUPAK. Thank you, Mr. Chairman. Sorry I missed part of it, I had some conflicts so I couldn't be here through the testimony, but I did read some of it. Dr. Tyler, I had a question I wanted to ask you on the McKesson Company.

We are looking at it there, and a drug card, as I said in my opening statement, sometimes promises big savings, sometimes does not. For one constituent it was 12 cents, and when they used their drug card again, it actually doubled the cost of it. So, I was disturbed.

And the way I understood your testimony was that you are going to be offering discounts on a number of drugs, but not necessarily generics. And in your testimony, you said it wasn't really McKesson's policy to encourage therapeutic substitutions. So, in other words, the way I took that was if your card is for a regular

drug but there is a cheaper generic, how does the senior ever know, if they are using your card, that they could actually buy something cheaper, like a generic drug as opposed to McKesson's drug?

Mr. TYLER. Let me make a couple of points. One, the physician in writing the prescription plays an important role in this process. Certainly, we don't want to begin to influence that in our role as the administrator.

Two, we certainly welcome generic companies to participate in this program. It is an open program. We would like to make it as inclusive as possible. And, last, to note that if the price of the brand is not taken below the generic, there is still no reason that the consumer can't purchase the generic alternative, and that is part of the value of the conversation with the pharmacist.

Mr. STUPAK. But my question to the last witness, the Doctor who was here on behalf of the administration, you were looking for efficiency and effectiveness and save everybody money, but if they are dealing—according to your testimony, the burden is really upon the patient to explore that out, that just because you have a card, that is not——

Mr. TYLER. This is not a benefit, this is a savings program for the products that are included under that program, many of which don't have generic alternatives. It produces meaningful savings for each of the drugs, and if there is a generic alternative, we hope that the consumer finds his way.

Mr. STUPAK. Let the buyer beware, in other words, Mr. TYLER. Well, it is no different than the system is today. The only difference is we have taken discounts off of the brand, which translates directly into the pocket of the senior.

Mr. STUPAK. And the reason why we are having this hearing, because the system we have today doesn't work.

Mr. TYLER. And we haven't professed this to be the complete answer to——

Mr. STUPAK. For the drug companies, it is working, I will grant you that, when you can raise it 17 and 18 percent per year, that is a pretty good return on your buck. But isn't there some responsibility here for these drug benefit managers and for the companies that are participating, when you get that card, to make sure that not only does the senior get the best possible price, but also let them know that there are these generics, because according to the last witness, instead of passing the alleged 15 percent savings to the consumer, you could use that 15 percent for consulting and telling the patient—I am sorry—the consumer how best to reduce their cost, at least to the Medicaid program, so there are other alternatives in there. Don't you feel like you have a sense of responsibility here to help out these consumers when they come there and they look at these exorbitant prices that they have to pay?

Mr. TYLER. I guess I would say I feel that compared to what was available prior to the announcement of this program, we have taken significant steps to deliver meaningful value by reducing the price of what today is 150 products, part of our role as the administrator is to be neutral in administering that program.

Mr. STUPAK. So, bottom line is consumer beware, basically.

Mr. TYLER. Bottom line is 20 to 40 percent savings.

Mr. STUPAK. The last witness was pushing the plan that was going to be 15 percent. Underneath your 150 products, it would be 20 to 40 percent?

Mr. TYLER. We project the average saving is 20 to 40 percent.

Mr. STUPAK. On each prescription?

Mr. TYLER. On each product in the program, there is a minimum savings amount that you must contribute to be eligible for the card.

Mr. STUPAK. For each product in the program?

Mr. TYLER. One hundred fifty products.

Mr. STUPAK. Were your newest drugs in the program? Because we all know the expensive part of drugs are the top 50 sellers, not the 2,000 that are out there.

Mr. TYLER. I am not a manufacturer. I can tell you that the way the drugs were chosen for the program was for the disease states that are common in the elderly population and treated in the outpatient setting.

Mr. STUPAK. Sure, but take Tagament The brand price is $144, generic price is $28. There is a difference of 80 percent there. So, is Tagamin going to be part of it, or are we going to have some other drug substitute for Tagamin that doesn't cost as much? Are we getting the popular brand drugs here, or are we just getting whatever the companies want to put up there?

Mr. BILIRAKIS. We have got 3 minutes left before we have to cast our vote.

Mr. TYLER. I believe at our Web site you can find a list of all the drugs, and there are many common ones in addition to the ones I named in my testimony.

Mr. BROWN. Mr. Chairman, I would like to ask unanimous consent before we go, to enter the statement in the record from Majority Floor Leader Buckley of Nevada, and the statement from GM calling for universal——

Mr. BILIRAKIS. Without objection, that will be the case.

[The prepared statement of Barbara E. Buckley follows:]

PREPARED STATEMENT OF BARBARA E. BUCKLEY, ASSEMBLYWOMAN

DEAR CHAIRMAN BILIRAKIS AND RANKING MEMBER BROWN: Thank you for the opportunity to provide written testimony on the issue of U.S. House of Representatives providing prescription drugs for seniors. I enjoyed testifying before your committee last year and appreciate the opportunity to offer additional thoughts this year.

At the outset, let me state that seniors are in as desperate need of prescription drug coverage this year as they were last year. While the attention of the nation has turned to the tragic events of September 11th and the war on terrorism, seniors on fixed incomes continue to go without prescriptions because of their unaffordability. It is also clear to me that adding a prescription drug benefit to Medicare makes the most sense; states are grappling with finite resources and severe budget shortfalls. States cannot make much of a dent in this problem; a national solution would also allow each State to use its finite resources on other senior needs, such as receiving long term care in their own homes instead of being institutionalized.

As to Nevada's own Senior Rx program, you are fortunate to have Michael Hillerby, Senior Advisor to the Honorable Kenny C. Guinn, Governor of the State of Nevada, at your hearing to offer testimony. He will undoubtedly share much of the same information with you. I am honored to be asked to share my perspective with you as well.

BACKGROUND

The program was an insurance-based program and was operational from January 2001-June 2001. The program was administered through a contract with a private

insurance company. The state was responsible for eligibility determinations and contract monitoring. The maximum benefit was $5,000 per year and participants were required to pay a deductible of $100 per year. Benefits were provided to seniors 62 years of age or older with a household income under $21,500 per year. A base premium of $40 per month was subsidized by the state based on the annual income of the participant. For those individuals with household income under $12,700, the state paid 90 percent of the base premium with the remaining 10 percent the responsibility of the participant. The subsidy was graduated with only 10 percent of the base premium being paid by the state for those individuals with household income between $19,100 and $21,500. In addition, participants were required to pay a monthly premium for the two programs that were offered: Nevada Blue and Nevada Silver.

The additional monthly premium paid by participants for the Nevada Blue Program (base benefits) was $34.76, while the premium for the Nevada Silver Program (enhanced benefits) was $58.31 per month. Therefore, the total cost (premium + subsidy) of the Nevada Blue Program was $74.76 per month ($40 +$34.76) and the total cost of the Nevada Silver Program was $98.31 per month ($40 +$58.31). These costs do not include the cost of eligibility determinations and contract monitoring done by the State of Nevada.

Co-payments required under the Nevada Blue Program were $10 for generic drugs and $35 or 50 percent of the cost (whichever was greater) for preferred drugs. Non-preferred drugs were not covered. Under the Nevada Silver Program co-payments of $10 for generic drugs and $25 for preferred drugs were required. Non-preferred drugs required a co-payment of $40 or 40 percent of the cost (whichever was greater). Nevada physicians reviewing the formulary felt it did not include drugs seniors commonly needed.

Only a few hundred individuals actually enrolled in the Senior Rx Program through the first six months of operation. The lack of enrollment in the Senior Rx Program prompted decision-makers to question whether the program should be restructured in order to increase the number of seniors receiving benefits.

Discussions that took place during the 2001 Legislative Session centered on how the program should be structured. The Governor favored continuing Senior Rx on an insurance-based model. A working task force of Assembly members favored contracting with a pharmaceutical benefit manager or going to a state-operated program. The Legislature engaged the actuarial firm of Milliman & Robertson to estimate the cost of a state-operated program. Milliman & Robertson's review indicated that a state program could be operated at an estimated cost of $53.95 per member per month including the cost of administration. The argument for retaining an insurance-based program was that the cost to the state was fixed and the insurance company assumed the risk of program costs exceeding projected levels. The argument for a PBM or state-operated program was that it could be run at a lower cost and therefore provide benefits to a larger number of seniors.

After spirited debate between the Governor and the Legislature, Senate Bill 539 was enacted into law. The program continues to operate as an insurance-based model. Eligibility for the program also remains unchanged and is provided to seniors 62 years of age or over with household income under $21,500 per year. Individuals are no longer required to pay a monthly premium to participate in the program; the entire premium cost is paid by the state. A deductible paid by the participant is no longer required. The maximum benefit remains at $5,000 per year. Co-payments of $10 for generic drugs and $25 for preferred drugs are required. Non-preferred drugs are provided based on medical necessity. The formulary was revised to include drugs seniors commonly need. The premium paid by the state was $106.64 per member per month from July 2001-December 2001. The premium paid by the state was reduced to $85.27 per member per month for calendar year 2002 (the monthly premium can be further reduced by 3 percent if paid in advance for the entire year). It should be noted that there is a provision in the contract effective January 1, 2002, that should paid claims fall below $65.55 per member per month, the entire amount below $65.55 per member per month will be returned to the state.

The monthly premium cost does not include the expenses incurred by the State of Nevada for eligibility determinations and contract monitoring. In fiscal year 2001-02, approximately $136,000 in administrative expenses is allocated to the Senior Rx Program for the cost of the eligibility function and contract monitoring. Based on full enrollment of 7,500 individuals for the entire year, this represents an additional $1.51 per member per month over the current premium paid of $85.27 per month.

As of April 5, 2002, a total of 7,252 participants are enrolled in the Senior Rx program. Applications are currently being processed to increase enrollment in the Senior Rx program to the maximum level of 7,500 participants. However, with 15 percent of Nevada's tobacco settlement proceeds funding the Senior Rx Program,

funding will not support 7,500 participants on an ongoing basis. Due to the slow start of the program a funding reserve has been generated which is being utilized to increase the number of individuals that can be served. If reserve funds were not available, the ongoing funding stream would only support approximately 6,600 participants at the current premium cost of $85.27 per member per month.

Demand for the Senior Rx Program has increased dramatically based on the legislative changes made to the program. Currently there are 741 individuals on a waiting list to receive benefits from the program.

The actual cost of the Senior Rx Program has been much lower than the premium paid by the state under the terms of the contract with the insurance company that operates the program. For the period of July 2001 through December 2001 there were an average of 3,029 participants per month (as of April 5, 2002 there are 7,252 participants). During this six-month period the per member per month (PMPM) cost averaged $37.64 in direct pharmacy costs. This PMPM cost does not include the contractor's administrative costs for items such as insurance premium taxes paid to the state, risk charges, reinsurance costs, and other administrative costs including payments made to the pharmacy benefits manager. The contractor's administrative costs are not specifically identified so only rough approximations can be made in estimating these costs. However, based on the premium paid during the July 2001 through December 2001 period of $106.64 per month, it is clear that the contractor made a significant amount of money during this six-month period. Even if the contractor's total administrative costs amounted to 35 percent of the PMPM costs, the contractor would have received in excess of $1 million over the total program costs incurred during the six-month period between July 2001 and December 2001.

As indicated earlier, the premium was lowered to $85.27 per month beginning January 2002. The latest information available on costs is for the month of February 2002. The PMPM cost in February 2002 was $38.46 which does not include administrative expenses of the insurance company or the state for the eligibility function and contract monitoring. The PMPM costs will be monitored throughout the year to determine if the monthly premium is appropriate or needs to be modified when the contract is awarded for calendar year 2003.

CONCLUSION

With mounting fiscal problems in many states, States do not have the financial ability to help all seniors in need of help with prescription drug coverage. Individuals with disabilities are receiving no help in many states. Individuals moving from state to state have a difficult time accessing different state programs with different eligibility standards. Adding a prescription drug benefit to Medicare would be the best solution for those on Medicare without prescription drug coverage.

In our own state, the debate between models for prescription drug coverage will likely be settled objectively: which program is the most cost effective and covers the largest number of seniors. I believe every elected official wants to make the most of our limited funds and will support the program that accomplishes that goal. In another year, we should have enough actuarial information to tell us which model is most affordable and can guide our future action accordingly. In the meantime, I urge our federal representatives to take meaningful action to help the states with this critical need.

PREPARED STATEMENT OF BRUCE E. BRADLEY, DIRECTOR, HEALTH PLAN STRATEGY AND PUBLIC POLICY, GENERAL MOTORS CORPORATION

Mr. Chairman and distinguished Committee members, I am Bruce Bradley, Director of Health Plan Strategy and Public Policy at General Motors (GM). It is an honor to submit this statement to this Committee as you work to design and to pass a Medicare prescription drug benefit.

There are few issues more important to seniors, eligible people with disabilities, their families—and employers—as filling the coverage gap represented by the absence of a Medicare prescription drug benefit. Moreover, a meaningful prescription drug benefit is critically important to employers, who are struggling to provide retiree health coverage while facing double-digit increases in health insurance premiums and pharmaceutical costs.

GM faces extraordinary financing and delivery challenges in the administration of our prescription drug benefits, particularly as it relates to the benefits we provide to our retirees. We have a great deal of experience in administering drug benefits and well recognize the challenges you face in attempting to design a workable and meaningful drug benefit for the Medicare program.

We commend the Energy and Commerce Committee for addressing this issue. My statement will focus on the challenge GM faces in the delivery of our pharmaceutical benefit, how we manage it, and what our priorities would be for a Medicare prescription drug benefit. It is our hope that the lessons we've learned can be useful to this Committee as it takes critical steps towards achieving a bipartisan agreement on a meaningful and universal Medicare prescription drug benefit.

PRESCRIPTION DRUG COST CHALLENGES FACING GM

GM insures 1.2 million workers, retirees and their families. We are the largest private provider of health care coverage. GM spends over $1.3 billion a year on prescription drugs for its current and retired workforce and their families. Despite our aggressive management of our prescription drug benefit and associated costs, the current 15-20 percent annual growth rate still more than quadruples the general inflation rate, and clearly represents a troubling trend.

From our perspective, these drug costs are driven by a multitude of factors, including increased utilization (both appropriate and inappropriate), and price. While we are attempting to manage these costs through a number of interventions that will be outlined later in this testimony, we do not see significant potential to reduce the trend without assistance from the federal government. More specifically, only the federal government can pass legislation to increase coverage by enacting a Medicare drug benefit.

Although GM's Medicare-eligible population represents only 33 percent of our covered population, it accounts for about nearly half of the prescription drug cost or $508 million. The current financing challenges that our Medicare-eligible population poses will only grow worse as the baby boom generation starts to retire less than ten years from today. The growing financial burden posed by prescription drug costs literally threatens the ability of many U.S. companies to be effective competitors within the world marketplace. If we do not get a handle on these costs in short order, companies will have to make undesirable choices that may limit access or shift costs to current and retired workforce. Faced with overwhelming retiree health cost challenges, many other companies have actually chosen to drop health benefits for this population. In fact, between 1994 and 2001, there was a 43 percent decline in firms offering retiree coverage.[1]

GM MANAGEMENT OF DRUG BENEFIT PLANS

GM has responded to the multi-faceted challenge of rising prescription drug costs with a multi-faceted management response, with a mind to assuring the best medical outcomes and value. We have a great deal of experience in administering a drug benefit and believe that our management techniques have made a positive difference in the quality and value of the benefit we offer, and could be applied to the design of a Medicare drug benefit.

We have utilized pharmacy benefit managers (PBMs) to help effectively purchase medications, and have ensured that the company receives the benefits of their negotiations through very explicit performance standards. Our contracts with PBMs encourage medically appropriate and cost-effective prescribing and dispensing practices. Among the tools our PBMs use are:

- **Partners for Healthy Aging:** An enrollee/patient and physician education effort which provides information on issues of pharmaceutical safety and use among the elderly
- **Therapeutic Interchange:** Contacts with physicians to encourage use of formulary medications
- **Physician Profiling and Peer Rating:** An expansion on the above which provides feedback on quality and utilization performance
- **Severe Drug-Drug Interaction Edits:** On-line, electronic feedback at the time of dispensing that prevents dispensing drugs that could represent life-threatening interactions. This situation often arises when an enrollee is seeing more than one physician and the respective physicians are not aware of all of the drugs the enrollee is taking. When one of these cases arises, the pharmacist contacts the prescribing physician and reviews the facts of the case before dispensing the potentially conflicting medication.
- **Digestive Health Solutions:** Addresses unique concerns of patients with gastrointestinal disease. It provides educational materials to enrollees and encourages appropriate prescribing practices by physicians.

[1] William P. Mercer. Health Benefit Costs Up 11.2% in 2001—Highest Jump in 10 Years. National Survey of Employer-Sponsored Health Plans 2001. New York: William P. Mercer, Inc.

- **Dose Optimization:** Simplifies the dosing regimen for patients and capitalizes on cost savings of taking one pill versus two.
- **Encourage High Quality, Cost-Effective Generic Drug Use:** When an appropriate generic drug is available, it is dispensed unless the physician specifies "dispense as written" or the enrollee requests the brand drug. If the brand drug is dispensed at the enrollee request, the enrollee pays the difference between the cost of the generic and brand, in addition to the normal co-pay.

GM'S PRIORITIES FOR A MEDICARE BENEFIT

GM believes that all Medicare beneficiaries—both seniors and eligible people with disabilities alike—should have access to an affordable, meaningful Medicare drug benefit. Notwithstanding our concerns about prescription drug costs, we regard such coverage as necessary because in many cases, prescription drugs are the most clinically appropriate and cost-effective treatment.

We therefore believe that any Medicare drug benefit should include the following four components:

- First, a Medicare drug benefit should be universal in nature. All Medicare beneficiaries should have the choice of an affordable drug benefit. The Medicare program has largely been a great success, representing the only population in this nation with the benefit of universal coverage. Virtually every private insurer for the under-65 population recognizes that it is essential to have a prescription drug benefit for quality medical care today.
- Moreover, the distribution of seniors without prescription drug coverage is not limited to low-income populations. In fact, fully half of those seniors without coverage have incomes over 200 percent of the poverty level. Further, of those seniors who do have coverage today, many have extremely limited coverage or are at risk of losing their good coverage because of cost. Addressing this problem effectively, therefore, means designing a universal benefit.
- Second, a Medicare prescription drug benefit should be meaningful and affordable to both beneficiaries and taxpayers. To ensure a stable and accessible drug benefit that is voluntarily chosen by all beneficiaries, it will be necessary to design a substantive benefit that has an affordable premium. This will require a significant investment of federal dollars. We well recognize, however, that Congress has to achieve a bipartisan consensus around what level of federal dollars are available for such an investment, and clearly resources are not infinite. This underscores the importance of a well-managed, cost-effective prescription drug benefit.
- Third, the design of the Medicare prescription drug benefit must be oriented to achieve positive medical outcomes and value. Just as important as designing an affordable, meaningful, and universal drug benefit is managing it well. It would be irresponsible for the Congress to pass a drug benefit without significant attention towards ensuring that the benefit is cost-effectively designed and managed. To that end, the benefit should be designed to encourage appropriate use of high-quality, cost-effective generic medications, require cost-sharing that guards against excessive and inappropriate utilization, and integrates state-of-the-art pharmacy management techniques that ensure the use of high-quality, high-value pharmaceuticals.
- Lastly, a prescription drug benefit should provide incentives for employers who are already financing prescription drug coverage for Medicare-eligible individuals to continue to do so. We recognize that the Congress may not be able to afford the same level of benefits that many leading corporations provide to their beneficiaries, but it should provide a much-needed floor of protection. As such, it should ensure that employers and health plans currently providing drug coverage can design benefits to wrap around Medicare. Or, alternatively, Medicare should provide these entities with direct financial subsidies that are equivalent to the value of the underlying Medicare benefit. Such policies would appropriately avoid penalizing firms who have generously and voluntarily provided such coverage and slow the recent trend of companies withdrawing their benefits for these populations.

CONCLUSION

GM well recognizes the design, financing, and other challenges the Congress faces in constructing and passing a Medicare prescription drug benefit. There are few domestic policy issues that are more important to successfully address. We hope that our experience, as well as our support, can help you develop and pass a long-overdue Medicare drug benefit. We look forward to working with you in the days and months to come.

Mr. BILIRAKIS. Additionally, I have already indicated we will have a large number of questions for all of you. Thank you so very much for taking time to be here. Appreciate it.

[Whereupon, at 1:33 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

PREPARED STATEMENT OF JOHN M. RECTOR, SENIOR VICE PRESIDENT GOVERNMENT AFFAIRS AND GENERAL COUNSEL, NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

Mr. Chairman, Members of the Committee,[1] I am John M. Rector, I serve as Senior Vice President Government Affairs and General Counsel for the National Community Pharmacists Association.

The National Community Pharmacists Association (NCPA) represents more than 25,000 independent pharmacies, where over 75,000 pharmacists dispense more than 50% of the nation's prescription drugs and related services. Independent pharmacists serve 18 million persons daily. NCPA has long been acknowledged as the sole advocate for this vital component of the free enterprise system. For decades NCPA has been the only national pharmacy association with universal state association membership, including those of the Committee's members.

The National Association of Retail Druggists (NARD), founded in 1898, has been the association representing the professional and proprietary interests of the nation's community pharmacists. To mark our centennial year, the NARD House of Delegates voted to change the Association's name to the National Community Pharmacists Association (NCPA).

NCPA members are primarily family businesses. We have roots in America's communities. The neighborhood independent pharmacist typifies the reliability, stability, yet adventuresome ness that has made our country great.

As owners, managers and staff pharmacist employees of independent pharmacies, our members are committed to legislative and regulatory initiatives designed to protect the public and to provide pharmacists a level playing field and a fair chance to compete. We appreciate the opportunity to assist the Committee in fashioning a new benefit for Medicare beneficiaries to include drug product coverage and related pharmacist professional services.

Competition in retail pharmacies is alive and well. Competition is an incentive for efficiency and the price competition in retail pharmacy is typically greater than can be found among other providers of health services and products.

The independent community pharmacist of today is simultaneously a health care professional and a small businessperson. NCPA and its members vigorously support the American free enterprise system, which provides the only meaningful climate under which a small business can economically survive, have the opportunity to succeed through personal efforts, and provide an important and essential service to the community.

Community pharmacists are especially trained to assist you and your constituents with the proper use of medications. Medicines, *only when used properly,* can save lives and improve the quality of lives, and only when medicines are used properly can consumers, employers and governments enjoy actual systemic savings.

The pharmacies and the 75,000 pharmacists that NCPA represents are interested in a wide range of health and business issues such as estate tax reform, ergonomics, small business tax relief, confidentiality of pharmacist-physician-patient communications and of pharmacy records, payment for pharmacists professional services and assuring that PBMs process claims but are not allowed to practice medicine or pharmacy, accountability for "managed care," elimination of discrimination in favor of mail order, and internet sales tax collection.

The small business independent health care professionals we represent are the preferred choice of American consumers, including your constituents. Our members function in the market in a variety of forms. They do business as single stores rang-

[1] Members of the House Committee on Ways & Means: William M. Thomas (CA), Chairman, Philip M. Crane (IL), E. Clay Shaw, Jr. (FL), Nancy L. Johnson (CT), Amory Houghton (NY), Wally Herger (CA), Jim McCrery (LA), Dave Camp (MI), Jim Ramstad (MN), Jim Nussle (IA), Sam Johnson (TX), Jennifer Dunn (WA), Mac Collins (GA), Robert Portman (OH), Phil English (PA), Wes Watkins (OK), J.D. Hayworth (AZ), Jerry Weller (IL), Kenny C. Hulshof (MO), Scott McInnis (CO), Ron Lewis (KY), Mark Foley (FL), Kevin Brady (TX), Paul Ryan (WI), Charles B. Rangel (NY), Ranking, Fortney Pete Stark (CA), Robert T. Matsui (CA), William J. Coyne (PA), Sander M. Levin (MI), Benjamin L. Cardin (MD), Jim McDermott (WA), Gerald D. Kleczka (WI), John Lewis (GA), Richard E. Neal (MA), Michael R. McNulty (NY), William J. Jefferson (LA), John S. Tanner (TN), Xavier Becerra (CA), Karen L. Thurman (FL), Lloyd Doggett (TX), and Earl Pomeroy (ND).

ing from apothecaries to full line high volume pharmacies; as independent chains (e.g. 100 pharmacies) and as franchises. Whatever the form of business entity, independent pharmacists are the decision makers for the diverse NCPA member companies.

The most in-depth consumer pharmacy preference survey to date, was published by Consumer Reports, in October of 1999. They surveyed 18,000 consumers and found that consumers, especially seniors, preferred independently owned pharmacies for several reasons:

Independents provided more personal attention

Independents provided more useful information about both prescription and non-prescription drugs

Independent druggists were seen as more professional, more sensitive to families' needs, and easier to talk to

Independents kept consumers waiting less time for drugs, had prescriptions ready for pickup more often, and provided out-of-stock medicine faster

The 1200 plus independently owned pharmacies in the Medicine Shoppes franchise were ranked second; the supermarket drugstores (7,800 stores) were third, the mass merchandisers (5,300 stores) were fourth; and last were the big corporate run chains (19,300 stores). No preference was expressed for mail order.

Numerous studies have documented the cost savings of comprehensive community pharmacy services.

When properly utilized, community pharmacists services including compliance and persistence programs, for example, can save the health care system billions of dollars by reducing the need for much more costly medical services, including emergency room visits, hospitalization, and nursing home admissions.

The failure by the insurers/PBMs to provide incentives for full pharmacist services has led to unnecessary and inappropriate prescriptions; to uncounseled prescription drug use; and to reduced patient compliance with appropriate drug regi-

with our small businesses through their mail order pharmacy subsidiaries or through contracts with other mail order companies.

Today the marketplace for insured prescription coverage is dominated by so-called "managed care" companies (a.k.a. PBMs). The dominance of such companies has *created additional barriers to competition, it has not enhanced competition.* Those attempting to "manage" our market seek to reduce the number of viable competitors and to steer unwilling consumers to a few select competitors often including, as noted, their own mail order companies.

It is important to understand that your independent pharmacists are not engaging in idle speculation when they express concerns that unrestricted PBMs would shift consumers away from their local pharmacy to the PBM's own mail order companies with their characteristic high profits and under utilization of generic drugs. It is estimated by Wall Street PBM analysts that the PBM makes 2 to 4 times as much profit on an insured mail order prescription than on an insured prescription dispensed in a community pharmacy.

For the past several years the major PBMs have aggressively attempted to switch patients to their mail order programs often switching them to a prescription drug not based on the patients health care needs but based on rebates from the highest bidder. Often the patient is switched to more expensive drugs and denied access to appropriate generics.

The impact of their "so-called" care has been equally negative: reduced quality control and reduced quality of providers to which consumers have access, including providers unlicensed in the consumer's state. In fact, the trend for the past decade for insured prescriptions has seen PBMs focus exclusively on the prescription drug product and eliminating payment for traditional professional community pharmacist services. Among the consequences of this "commodity only" approach has been a significant increase in non-compliance with the drug regimen prescribed by physicians and as a consequence diminished quality of life for covered consumers and their families.

NCPA members are forced to accept whatever payment the insurance industry and its PBMs dictate. *Simultaneously the insurance industry and its' allies brazenly characterize such payments as discounts "negotiated" by pharmacies.*

Experts on the insurance industry and their PBM's practices know that to characterize the payment for pharmacists fixed by the insurance industry and its PBM intermediaries in "take-it-or-leave it" contracts as negotiated by the pharmacists is akin to characterizing the victim of an armed robbery as having donated cash to the assailant's favorite charity.

PBMs refuse to negotiate with independent pharmacies and it is unlawful for several independent pharmacies to collectively negotiate prescription drug contracts with PBMs. In the last Congress the House of Representatives voted 276 to 136 for H.R.1304, the Quality Health Care Coalition Act, which would have authorized such small business contract negotiations. It is enlightening to recall that the PBMs, represented by Express Scripts, unsuccessfully urged the House Judiciary Committee to deny independent pharmacists and their consumers, including seniors, economies of scale regarding products and services achievable through fair negotiations.

Rather than further erode the small business pharmacy infrastructure through the dictates of our "managed care" competitors, the Committee should guarantee Medicare beneficiaries protections similar to those provided by H.R.1304. Allowing pharmacists to negotiate would help put an end to the present ability of the insurance industry and its PBM intermediaries to unilaterally fix pharmacy payments and to reduce the quality of care. Negotiations would help to put an end to the tying of prescription insurance coverage to the mandatory or coercive use of mail order pharmacy, which denies consumers equal access to neighborhood pharmacies and the services of independent pharmacists. Incidentally, this bipartisan legislation has been reintroduced as H.R.3897, by Representative Bob Barr (R-GA) and John Conyers (D-MI).

We also recommend that the Committee carefully review the growing number of lawsuits against PBMs brought by patients, health plans, employers, and others alleging PBM violations of their fiduciary duties. The PBMs have countered by claiming that they are not obligated to fulfill a fiduciary duty and are only obligated to lookout for their bottom line interests. Would this be the case with Medicare?

Regarding the affordability of prescription drugs for all Americans, including Medicare eligible persons, we recommend two steps: First, the full implementation of the Medicine Equity and Drugs Safety Act (MEDS) P.L.106-387, which would allow the importation by pharmacists of FDA approved drugs from select countries, principally, Canada, United Kingdom, and the European Union. Secondly, the enactment of Representatives Cliff Stearns (R-FL)—H.R.1127, which would restore, for federal tax purposes, the first dollar deductibility of prescription drugs.

wtrustnd groupof thealthprovfss inal s.

On behalf of the members of the National Community Pharmacists Association, we thank the Committee for the opportunity to provide our views on Medicare reform.

(Exhibit 1)

ASSURING A QUALITY, COST-EFFECTIVE PHARMACY BENEFIT FOR AMERICA'S SENIORS

A Unified Agenda for American Pharmacy

ACADEMY OF MANAGED CARE PHARMACY (AMCP) (WITHDREW SUPPORT)

AMERICAN COLLEGE OF CLINICAL PHARMACY (ACCP)

AMERICAN PHARMACEUTICAL ASSOCIATION (APHA)

AMERICAN SOCIETY OF CONSULTANT PHARMACISTS (ASCP)

AMERICAN SOCIETY OF HEALTH-SYSTEM PHARMACISTS (ASHP)

NATIONAL ASSOCIATION OF CHAIN DRUG STORES (NACDS)

NATIONAL COMMUNITY PHARMACISTS ASSOCIATION (NCPA)

NATIONAL COUNCIL OF STATE PHARMACEUTICAL ASSOCIATION EXECUTIVES (NCSPAE)

As policymakers discuss a comprehensive Medicare outpatient pharmacy benefit, we encourage Congress and the Administration to carefully consider the views of the nation's pharmacists

these services and products—as well as a reasonable return on investment—in every type of pharmacy practice setting in which the care and services are provided.

OUR KEY CONCERN

None of the legislative proposals introduced to date in the 107th Congress adequately address our two core beliefs: **access to and coverage of both medications and pharmacists' medication therapy management services.** In reviewing the bills currently being considered, one would conclude that Congress believes that it will have served Medicare beneficiaries well if it can simply find a way to help Medicare buy medications at the reduced prices currently being paid by other federal purchasers and then turn the administration, management, and delivery of services over to 91 private sector" entities sometimes referred to as prescription benefits managers (PBM's).

For example, under several existing proposals, PBM's are charged with "managing care," "developing drug formularies," "increasing generic drug use," "negotiating discounts with pharmaceutical manufacturers," "placing price controls on community pharmacies," and "providing medication therapy management programs to seniors."

While we believe that PBM's can and do have an important role in performing many of the administrative tasks associated with providing the pharmacy benefit to seniors, we have serious reservations about the nature and scope of "patient care and cost management" tasks that many of the current proposals would assign to PBM's. In fact, some evidence suggests that PBM's are not effective in performing these latter activities. Pharmacists and pharmacies are the real "private sector' providers of care and service to patients. Pharmacists and pharmacies provide services and work with patients at their point of care to accomplish appropriate medication use and accurate dispensing. It is pharmacists and pharmacies, our members, upon whom senior citizens and the Medicare program will ultimately rely to achieve the outcomes we all seek for a successful Medicare pharmacy benefit.

WHAT SHOULD BE DONE

Our organizations are jointly committed, prepared, and able to work with the 107th Congress, the Bush Administration, the pharmaceutical industry, HCFA, physician organizations, senior advocacy groups, and other interested parties to help design a Medicare outpatient pharmacy benefit that improves medication use, helps control overall health care costs, and enhances the quality of seniors' lives. The pharmacy, medical, and health care literature all provide ample evidence that these goals are compatible, not mutually exclusive.1ts, we have to wortoge othen to

crana HHS Seinctary T coy T(whpsoign tered aplishhe natireal)Tj-1 -1 TD1.2775 Twpanelty oe aly of thesredkeholvi

and

a) The PCMA testimony to the Committee on June 13, 2002 at page 5, where they stated: "Any legislation that does not empower us as PBMs to negotiate discounts and other pricing concessions from drug manufacturers and pharmacies—as we do today in private plans—will not be able to deliver the anticipated cost savings. Our members are strongly united on this point."

b) The 3/22/00 GAO presentation to the Committee and to the Senate Finance Committee entitled *Prescription Drug Benefits: Applying Private Sector Management Methods to Medicare* at page 6: "Similar to their negotiations with manufacturers, PBMs negotiate with retail pharmacies to obtain prices that are well below pharmacies' usual price for customers without drug coverage."

c) The PhRMA 6/12/00 ad in National Journal's Congress Daily AM at page 7, which states "For 150,000 Americans with a prescription drug insurance benefit, their private health plans have had considerable success negotiating meaningful price discounts on pharmaceuticals. However, 12 million senior Americans now have no prescription drug insurance coverage. As a result, most of them pay full price for their medicines. That's because they don't have the market clout that comes with a drug insurance benefit. If all seniors had access to private market discounts, the medicines they need, on average, would cost 30% to 39% less."

As noted in 2000, H.R.1304, which would allow our members to negotiate with health plans and PBMs was approved on 6/29/00 by 276 to 136. Committee members voted 19 to 37 (9 R's and 10 D's) for H.R.1304.

2. Regarding the PBM corporate strategy to shift patients to their highly profitable mail order businesses the following references are enlightening:

- FAC Equities—Division of the First Albany Corporation—October 4, 2001 Research Report on Express Scripts, Inc. recommending a Buy

Page 3 of the report under Investment Merits states that "mail order sales are roughly 2 times to 3 times more profitable on a per adjusted script basis than retail script."

- WR Hambrecht Company Report—March 22, 2001 on CareMark Rx recommending a Buy

Page 2 of the report notes "PBM mail order script margins are 4 times higher than retail scripts.

- CareMark Rx Inc. 10K—December 21, 2000

Page 3 "In 2002 the company, implemented a program designed to encourage its' customers to refill prescription which were originally filled in its' retail network through its automated mail service pharmacy." The company also operates a network of 17 smaller mail service pharmacies.

3. According to IMS Health (See enclosed bar graph), the PBMs under utilize generic drugs. We believe that the Committee should help assure that any new Medicare benefit provide seniors with no fewer than the 50 to 55% level of generic prescriptions made available currently to seniors and others through independents community pharmacies.

A related issue is the pricing of generic drugs. PBMs seem not only to under utilize generics but also reportedly charge significantly higher prices for generics. For example, earlier this year, a Merck-Medco plan for Connecticut state retired teachers entitled "Prescription Drug Server" mandated mail order coverage. One consequence of eliminating local pharmacies as a choice for retired teachers was prices for generic drugs three times greater than the change in independent community pharmacies in Connecticut. (For example, the charge for a community pharmacy of $34.23 and for Merck-Medco mail a order charge of $100.38 for a 90 day supply of 300 tablets of the same generic drugs). Fortunately, on April 1, 2002, this Merck-Medco mandatory mail order program for Connecticut retired teachers dropped its' mandatory mail order requirement in response to protests about the Merck-Medco generic drug overcharges. Unfortunately, the retired teachers plan still discourages the teachers from using their community pharmacy through discriminatory co-payments that favor Merck-Medco's mail order business.

Initially, the AARP mail order pharmacy business was synonymous with generic drugs. Since IMS Health data does not capture the marketing practices of our non-profit competitors, such as AARP, we can only speculate as to whether AARP may also under utilize generic drugs.

4. Numerous studies, as noted, underscore the systemic value of coverage and payment for pharmacist care services. On such study is entitled "The $76 Billion Dollar Question" funded by our foundation; the National Institute for Pharmacist Care Outcomes; and Merck. Interestingly, the former director of health benefits at GM, Mr. Beach Hall in 1992 observed in this study, "that pharmacist care is the most critical quality and cost controlled vehicle we have in the entire health care system."

As Committee member, Representative Portman observed rather than $76 billion, our health care system is now wasting $150 billion annually due to inappropriate prescription drug use and unnecessary hospitalizations and nursing home placements. In other words, a dollar wasted for every dollar spent annually on prescription drugs. Appropriate payment for pharmacist professional services could significantly reduce these unnecessary expenditures.

It is important, in our view, that the Committee is aware of the joint statement on prescription drug benefit under Medicare announced by our group and Pfizer on 6/11/01. It stresses the value of pharmacist care services, including, persistency, patient compliance, and appropriate counseling.

It is noteworthy that the 1988 Medicare catastrophic law established per prescription payment for a participating pharmacy as AWP + $4.50 indexed. In today's marketplace, fourteen years later, had the bipartisan law signed by President Ronald Reagan not been repealed, the payment would be $10.94.

Representative Nussle raised a question regarding the ability to retain pharmacists in rural areas. Senate legislation, S.10 has an incentive provision for payment for independent pharmacists in rural areas. Importantly, H.R.3626 by Representatives Emerson and Ross recognizes the value of pharmacist professional services for a new Medicare benefit.

5. Regarding Representative Foley's expressed enthusiasm for the Administration's "so-called" discount card, the Committee should carefully review the 12/01 GAO report stating an average savings of approximately 11%. This percent did not reflect the monthly fees, (for example, $9.95 for an individual and $19.95 for a family) charged for the cards. Savings, if any, were somewhere between 1 and 5 percent.

Regarding Mr. Foley's expressed intent to legislate the Administration' s proposed card, it is important to recall the Federal Judge Paul Friedman on 9/6/01 in *NACDS/NCPA* v. *HHS* enjoined the plan because HHS had no authority to undertake an endorsement plan and had proceeded unlawfully. The bottom line, however, was that the Court found that implementation of the plan would cause irreparable harm, especially to the small business pharmacies that we represent. Enacting legislation would only institutionalize the irreparable harm to small businesses.

6. Mention was made that allowing Medicare to negotiate with drug makers could "distort" the marketplace. The independent pharmacy marketplace where pharmacists are not able to negotiate has been totally distorted by one sided contracts dictated by PBMs. Assuring pharmacists, the ability to negotiate would help ameliorate the distortion.

Please see the enclosed 4/02 article in America's Pharmacist entitled "The Tug of Wars with PBMs", which highlights the various facets of PBM distortion of our marketplace.

Once again, we especially appreciate the opportunity to assist the Committee and staff as you revisit the subject of Medicare pharmacy benefit.

PREPARED STATEMENT OF INFECTIOUS DISEASES SOCIETY OF AMERICA

As the House Ways and Means Committee debates providing prescription drug coverage to one of the nation's most vulnerable populations—the elderly—under the Medicare program and develops legislation to implement this important change, the Infectious Diseases Society of America (IDSA) strongly urges Committee Members to include coverage for home-based outpatient intravenous (IV) antimicrobial therapy and the related physician case management services and supplies in this new benefit. IDSA represents nearly 7,000 physicians and scientists devoted to patient care, education, research, and community health planning in infectious diseases. As the physicians who coordinate care for patients with serious infections, our members are keenly aware of the how Medicare's failure to cover home-based outpatient IV antimicrobial therapy disadvantages both American taxpayers and the Medicare beneficiaries.

Medicare policy prohibiting coverage of outpatient, self-administered drugs has severely limited access of Medicare patients to ambulatory IV therapy, thus forcing them to rely on more costly and less-convenient inpatient hospital care. Covering home-based outpatient IV antimicrobial therapy and its related services and supplies under Medicare would greatly benefit American taxpayers as home-based therapy is a safe and much less-expensive alternative to providing it in the hospital. This is why most private insurers and many Medicare HMOs cover this service. The benefit to elderly patients receiving this therapy in their home is improved quality of life, convenience and time-saved.

IDSA understands that Congressional leaders are considering adding a limited drug benefit that would cover cancer drugs to the Medicare program. We applaud

and encourage the addition of this important new benefit, but strongly urge that such a benefit also include coverage of outpatient IV antimicrobial therapy. In addition to IDSA, the American Medical Association also has endorsed this approach. Their written policy states that AMA "endorses the use of home injections and/or infusions . . . (including chemotherapy and/or antibiotic therapy) for appropriate patients under physician supervision, and encourages [CMS] and/or other insurers to provide adequate reimbursement for such treatment" due to "the benefits of such treatments in terms of cost savings, increased quality of life and decreased morbidity." [AMA policy H-55.986]

The Problem

Unlike many private insurers and Medicare health maintenance organizations (HMOs), the Medicare fee-for-service program does not cover IV antimicrobial therapy provided in the home whether self-administered or administered by a trained health professional. This means that patients must stay in a hospital, sometimes for several weeks, where they are at risk of exposure to hospital-acquired infections, or travel to their physician's office, sometimes twice a day to receive this treatment. Not only is home-based drug infusion therapy safe and effective, it also is much less expensive. Whereas hospital-based antimicrobial IV therapy typically costs $1,000 per day, home-based therapy costs less than $200 a day. One study estimates that Medicare can save approximately $5.3 billion in 10 years simply by covering home-based IV antimicrobial therapy.

Medicare patients are often outraged when they discover that Medicare won't cover this essential therapy unless they are hospitalized for long periods of time or visit their doctor's office as often as seven days a week for weeks on end. For rural patients, this can mean traveling 150 miles a day to receive this 15-minute treatment that they could easily receive at home. Their frustration is exacerbated when they discover that patients who are privately insured or covered by Medicare HMOs are released from the hospital to continue drug therapy *at home.*

Treating Medicare beneficiaries in their homes also would reduce their exposure to hospital-acquired, antimicrobial-resistant infections. Hospital-acquired infections affect over 5 percent of hospitalized patients and result in increased costs to the Medicare program. On average, hospital-acquired infections tend to add four days to a patient's hospital stay and cause more than 20,000 deaths a year.

When is IV Antimicrobial Therapy Necessary?

Physicians routinely prescribe antimicrobial IV therapy for serious infections that cannot be treated with oral antimicrobial agents. When prescribed with a physician's oversight, IV antimicrobial therapy is a safe and effective way to treat a number of infections, including certain bone and skin infections, endocarditis (an infection of the heart valves), pneumonia, bronchitis, urinary tract infections and pelvic inflammatory disease. Osteomyelitis, a bone infection, frequently requires long courses of therapy with high concentrations of intravenously administered antimicrobials. Drug treatment for four or more weeks is common. Cellulitis, an infection of the skin and surrounding tissue, is another condition commonly treated in this manner. Serious fungal and viral infections often occur in people who have impaired immune systems, such as those with AIDS, diabetes or who have received an organ transplant. Moreover, antimicrobial infusion therapy can be tremendously beneficial for people predisposed to repeated infections, such as those with cystic fibrosis. Traditionally, these individuals must be admitted to hospitals frequently to treat recurring infections. They also are those at highest risk for catching new infections in a hospital.

Osteomyelitis, cellulitis, endocarditis, and pneumonia account for over 80 percent of all cases requiring IV antimicrobial therapy. Together, these conditions account for nearly six percent of the 12 million annual Medicare hospital discharges, at a cost of over $4 billion annually.

Services and Supplies Necessary for Outpatient Drug Therapy

In addition to antimicrobial drugs, other services and supplies are necessary for safe and effective outpatient IV antimicrobial therapy. First, physicians must prescribe and oversee the therapy. Physicians select the appropriate drug, dosage, and length of treatment; monitor the patient's progress; look for side effects of the therapy; and respond to any emergencies. Second, nurses usually educate patients and their caretakers about administering the infusion and caring for the infusion site. They also may monitor the patient's progress, coordinate care, and oversee the actual IV infusion. Third, pharmacists prepare and distribute the prescribed drugs and respond to patients' questions regarding the therapy and its side effects. Sometimes they monitor laboratory results and collaborate with physicians and nurses

to adjust drug dosages. Finally, laboratory services are necessary to monitor the patient's status and response to therapy.

Medicare currently does not reimburse physicians for their services unless they see the patient directly or the patient is enrolled in the home health or hospice program. Safe and effective home drug therapy, however, requires continuous, active oversight by a knowledgeable physician. Ongoing physician involvement is as important in the outpatient setting as it is in the hospital. Although physicians probably will need to meet with patients weekly while the outpatient IV antimicrobial therapy is underway, they also will need to spend a significant amount of time coordinating care with the patient and other health professionals, reviewing laboratory test results, and generally monitoring the patient's progress and any complications.

As for equipment, two types are critical. First, there must be an access device to insert the drug into the body. Peripheral (IV) catheters, central catheters and subcutaneous ports are examples. Next, an infusion device controls the rate of drug flow. Infusion devices range from sophisticated pumps that allow for the infusion of multiple drugs at different rates to simple syringes and gravity drip systems. As opposed to narcotics and other pain medication, IV antimicrobial agents tend to use fairly simple and inexpensive access and control devices. Other equipment that may be needed include IV poles, tubing, and dressing supplies.

Finally, it is not clear that physician dispensing of the drugs and pump used in outpatient antimicrobial therapy to patients in their homes is exempt from the Stark law's prohibition on self-referrals. Thus, we urge Congress to strongly consider a remedy to ensure that physicians be permitted to dispense these drug therapies and the necessary pumps.

The expansion of Medicare coverage to include outpatient IV antimicrobial therapy is a cost-effective reform that will give Medicare beneficiaries access to the same therapies, safety and convenience as their private sector counterparts. Modernizing Medicare benefits to include coverage for this drug therapy makes good common sense and is essential to the good health of our nation's elderly people.

RESPONSES FOR THE RECORD OF CRAIG L. FULLER, PRESIDENT AND CEO, NATIONAL ASSOCIATION OF CHAIN DRUG STORES

1. What was NACDS' motivation for announcing the Pharmacy Benefit One Card? What requirements do you have for your card that are not in the President's proposed card? Also, what type of discounts would your card provide, and would these be greater, less than or equal to those programs that McKesson has and the President is proposing?

NACDS' Pharmacy Care One Card is not a discount card. NACDS has developed a two-part strategy to help seniors better access manufacturer subsidy and discount programs. First, we formed the Pharmacy Care Alliance that will help educate seniors about manufacturers' pharmaceutical discount card programs. We also created the Pharmacy Care One Card, with the goal of universalizing the many manufacturer discount and subsidy card programs with "one card" to facilitate use by low-income seniors and processing by the pharmacy.

The card will allow eligible seniors to conveniently access multiple manufacturer discount and subsidy programs for multiple prescriptions. NACDS announced the program because all the information the pharmacist needs to help the senior fill multiple prescriptions should be available through one database source. The Pharmacy Care One Card will also save time for pharmacists, giving them more time to counsel seniors

who have questions about multiple medications. The Pharmacy Care One Card also reduces confusion and inconvenience for senior, and maximizes seniors' choice since all manufacturers and pharmacies can participate.

The type of discounts that would be provided under the Pharmacy One Card really depend on the individual manufacturers offering the discounts. It is up to the manufacturers to decide the parameters of their program, including eligibility and discounts. We believe that this card program is superior to the Bush Administration proposal for several reasons. First, we believe that most of the discounts to seniors under the Bush plan would come from low-margin pharmacies, not the drug manufacturers. Card sponsors (i.e. PBMs), have every incentive to collect and retain rebates under the Bush plan with no obligation to pass these leveraged dollars onto the consumer.

Second, the Bush plan would restrict seniors' use of card programs to one endorsed card program in any given six-month period. The Pharmacy Care One Card would allow seniors to access any manufacturer discount or subsidy program without restrictions as long as they meet eligibility criteria.

2. Is the profit margin for cash paying customers higher than the margin for customers with drug coverage? Will you please break out those differences and share the percentage of cash paying customers versus those with drug coverage?

Net profits in community pharmacies are only about 2 percent. In general, over 85 percent of all prescriptions are paid for by third party plans, including Medicaid prescriptions. Only about 15 percent of the average pharmacy's prescription business is paid for out-of-pocket, or in cash.

The profitability of third-party prescription plan business really depends on several factors, including the number of prescriptions paid for by that plan, the mix of drugs and the use of generics in that plan, and the percentage of times that the pharmacy's usual and customary charge serves as the payment rate for the third party plan. It is no secret that many third party plans and PBMs pay pharmacies less than their costs of dispensing prescriptions and providing professional services. Many pharmacies compensate for this inadequate reimbursement in the majority of their prescription sales business through sales of non-prescription and other non health related products and services. In fact, gross margins on third party prescriptions have dropped precipitously over the last few years.

Moreover, while it is assumed that pharmacies have greater profits or margins on cash prescriptions, pharmacies also do not have significant flexibility on cash pricing. That is because pharmacies operate in a highly-competitive marketplace. Consumers shop for price for prescriptions. While margins may be slightly higher on the mix of cash prescriptions that a pharmacy provides, that is not always the case. It depends on the location of the pharmacy, the type and mix of drugs dispensed and the use of generics.

3. On average how much time do pharmacists spend with customers? Can you elaborate on the types of activities that pharmacists engage in when helping patients?

Under Federal Medicaid law and almost all state laws, pharmacists are required to offer to counsel all customers on the proper use of their medications. Some medications are complex to use and require that the pharmacist spend a significant amount of time explaining how to use the drug. Other medications take less time. The type of services provided by a pharmacist to a patient depends also upon the nature of the patient's condition. For example, some pharmacists have special training in disease management, such as diabetes, osteoporosis, and glaucoma. These pharmacists might spend additional time with patients beyond the normal counseling functions. It is important to assure that pharmacists are paid adequately for both providing the medications, explaining how it works, and providing the services. Unfortunately, third party payors, including PBMS, who pay for more than 85 percent of all prescriptions, do not value these important services and rarely pay pharmacists for these services.

4. Do pharmacists fill and dispense all medicines that are distributed in a pharmacy?

Pharmacists are responsible for filling and dispensing all prescription medications in a pharmacy. Pharmacists are often assisted by trained support personnel, such as pharmacy technicians, in performing some of the manual and administrative tasks in filling and preparing the prescription for dispensing. Additionally, there are new technologies in some pharmacies – such as central fill stations and robotics – that assist the pharmacist with the prescription filling process. In all these cases, the professional tasks relating to assuring the prescription was filled correctly, and that the patient is counseled on medication use, ultimately rest with the pharmacist.

5. In your view, why is the Pharmacy One Card a better approach than other prescription drug card programs?

We hope that the PharmacyCareOneCard will be viewed by President and Congress as an innovative and earnest response to helping seniors. We believe that the PharmacyCareOneCard puts freedom of choice in the hands of the consumer; relies on the competitive market power of manufacturers and community pharmacies; won't incentivize the use of unregulated mail services, so it gives seniors essential face-to-face counseling from a pharmacist. The power of a "one card" concept has already been demonstrated in the marketplace. Manufacturers have been competing with one another to offer better and better subsidies or discounts on their products. Traditional prescription drug discount card programs do not create this kind of true competition, and rely on obtaining most of their discounts from retail pharmacies.

Responses to questions from Chairman Bilirakis
Following April 17, 2002 hearing on "Creating a Medicare Prescription Drug Benefit: Assessing Efforts to Help America's Low-Income Services"

Submitted by Brian Tyler, Ph.D.
Senior Vice President, Business Development and Strategy
McKesson Corporation

McKesson Corporation serves as Administrator of the Together Rx™ Card

1. Why was McKesson chosen as Administrator of the Together Rx™ Card?

The companies chose McKesson because of its extensive experience administering patient assistance programs and its leading position in serving the retail pharmacy market. McKesson's broad relationship with pharmacy will help the Together Rx™ Card enlist the participation of pharmacies throughout the United States.

2. Has the response exceeded your expectations? If so, do you have the capacity to handle such a voluminous response?

We are happy to report that since the card launched on April 10th, there has been tremendous enthusiasm and support. As of May 12th, we have received nearly 450,000 requests for application forms, and have recorded 1.4 million Web site page views by people seeking more information about the Together Rx™ Card. Our systems are designed to handle this capacity.

By the time the card is operational in June, we hope to have reached a large percentage of the estimated 8 million to 11 million Americans who might be eligible for the program.

3. Have most of the major retail drug chains agreed to honor the Card? What about independents? Will beneficiaries in small towns or rural areas be able to use the benefits of the Together Rx™ Card?

We are very pleased that thousands of pharmacies across the country have already agreed to accept the Together Rx™ Card. These include major chains that serve both rural and urban areas, such as Wal-Mart, Rite Aid, CVS, Walgreens, Target, Albertson's, Costco, Kroger, Safeway and Eckerd as well as more than 4,000 independent pharmacies across the United States in both rural and urban regions. Importantly, the participating pharmacies have agreed to pass-through to the cardholders 100% of the savings offered by the participating Together Rx™ companies on their included products.

4. Will you please explain in more detail how the discounts achieved in the Together Rx™ Card will be passed through to cardholders, and how much of a savings will they actually see?

The Together Rx™ Card is designed to provide assistance to eligible Medicare enrollees in the form of a dollar amount that the participating manufacturer will provide directly to a consumer on its specific product in the form of a direct-to-consumer savings (i) that the consumer may use to pay a portion of his or her pharmacy's charge for a prescription drug or (ii) that will result in the consumer receiving a supply of a prescription drug for a fixed amount. The minimum savings that will be offered by a member company under the Together Rx™ program is equal to 15% percent of the manufacturer's "list price to wholesalers" for the specific drug. Each participating pharmaceutical company makes its own decision regarding which of its drugs it will include in the Together Rx™ Card and sets its own savings independently.

[redacted]

will receive savings at the point of sale on prescription medicines from the seven participating companies that are included in the program. Eligible consumers may expect to save approximately 20 percent to 40 percent and, in some cases substantially more, off the price they usually pay at their pharmacy for prescription medicines from the participating companies. The companies, in turn, will reimburse the pharmacies through McKesson for this savings amount.

Actual consumer savings will vary depending on their pharmacy's customary pricing for the specific drug. Usual and customary pricing refers to the price generally charged by a pharmacy to a cash customer. To participate in the Together Rx™ program, pharmacies must limit their charge to the patient so that the patient will receive the full benefit of the savings provided by the manufacturers. To compete in their local market, pharmacies may choose to reduce their prices even further. However, retailers have a broad range of pricing policies, so cardholders should also

Tricia Neuman, Sc.D.
Vice President and Director, Medicare Policy Project
Henry J. Kaiser Family Foundation

Responses to written questions submitted following hearing on "Creating a Medicare Prescription Drug Benefit: Assessing Efforts to Help America's Low-Income Seniors" (April 17, 2002)

1. The President is proposing that Congress enact a drug benefit for low-income seniors only. Under the President's plan, states would have the option to cover seniors with incomes up to 150% of the federal poverty level – about $13,300 per year for an individual – through drug only assistance programs. Your testimony included many statistics on seniors without drug coverage, not all of whom are low-income. Could you tell me which seniors the President's plan would leave out?

The Administration proposes to give states the option of providing drug assistance to

Medicare beneficiaries with incomes up to 150% of the federal poverty level through state programs. While this approach would target beneficiaries in greatest financial need, it would not help the majority of seniors who lack drug coverage. More than half (59%) of beneficiaries without prescription drug coverage throughout the year in 1998 (the most recent year for which such data are available)—or about 6 million beneficiaries—had incomes above 150% of poverty and would be ineligible for assistance under this proposal. If states do not elect to participate under the proposed program, the numbers ineligible for assistance would be higher.

elaborate on the types of assistance these programs offer and how comprehensive it is?

Some state pharmacy assistance programs operate more like traditional insurance, with subsidized benefits, but target assistance to beneficiaries with low-income beneficiaries (PA and NY, for example). Others, such as California, operate as discount programs and offer price reductions to any individual who presents a Medicare card at their local pharmacy. Due to this variation and the associated challenges of tracking data on enrollment and utilization of these benefits, it is very difficult to draw conclusions about how comprehensive (or universal) these programs are. States are likely to face increasing challenges in continuing such coverage given the rising costs of prescription drugs and current budgetary shortfalls.

how benefits would vary across states.

d. The President's proposal would provide funds at a 90% federal match for states to extend drug coverage to low-income seniors between 100% and 150% of the federal poverty level. In order to receive these funds, states that did not already provide drug coverage to seniors up to 100% of poverty would need to do so first. The money to cover seniors up to 100% of poverty would be available to states at the regular Medicaid match rate, which is much lower than 90%. How many states would first need to spend money at the regular Medicaid match rate to cover seniors up to 100% of poverty? What is the likelihood that these states will take on additional fiscal responsibility at this point, if they are struggling to balance their budgets?

   It is not specified in the Administration's proposal whether states that do not already offer coverage to those up to the poverty level would need to do so in order to draw down additional federal dollars at the enhanced federal match for those between 100%-150% of poverty. As of today, only 16 states (and the District of Columbia) provide full Medicaid benefits (and thus drug coverage) to those with incomes up to the poverty level. If states are required to cover beneficiaries up to poverty level before taking advantage of the higher matching rate, then the majority of states (34) would first have to expand coverage to assist low-income seniors up to 100% poverty before they could expand their programs at the 90% federal matching rate. Again, it is not clear whether many states would elect to expand coverage at the current matching rate, given that prescription drugs are currently the fastest-rising cost item in state Medicaid budgets and that 40 states are facing budgetary shortfalls (as of January 2002).

e. The Administration has stated that states could implement low-income assistance programs faster than the Federal Government could implement a drug benefit for all seniors. This is part of the Administration's rationale for proposing a low-income only drug benefit. Based on your knowledge of state programs, how long will it take all states to get low-income programs up and running?

   There is currently great variation across the states in terms of the infrastructures they have in place for providing drug coverage to low-income Medicare beneficiaries. The ease and speed with which an individual state will be able to get an expanded program up and running will depend on whether they have a state pharmacy assistance program already in place—and, if so, what kind—as well as on the efficiency and versatility of its Medicaid program. States that have devised successful outreach and enrollment processes for their state pharmacy assistance programs will likely have an easier time adapting their programs to an expanded pool of beneficiaries. In those states that have less well-developed programs in place—or, in the case

of state pharmacy programs, no program at all—the administrative burdens of eligibility determination and enrollment may prove especially cumbersome, and time consuming.

f. In general, are there problems with leaving the design and administration of a low-income drug benefit up to the states? If so, please describe.

Many proposals under discussion would rely on states to administer benefits to low-income beneficiaries, but proposals differ widely on the additional responsibilities given to the states. Virtually all proposals would have states determine eligibility for benefits, but proposals vary on other key issues, including whether the basic structure of the program is defined by the state, and the role of the state in financing benefits and subsidies. The Administration's proposal would give states great flexibility in designing both the structure of the program and the scope of covered benefits. Based on the experience of other state-based initiatives, under this approach, low-income beneficiaries would fare very differently depending on the state in which they live. This would have a significant impact on whether benefits are offered in the first place. In addition, the generosity of benefits and the time it takes to implement the new program would vary from state to state.

3. The Subcommittee's April 17th hearing on prescription drugs focused on providing a benefit for low-income seniors. Medicare already has several programs in place that help low-income beneficiaries. However, enrollment in low-income assistance programs is historically low, and many people believe that these programs are not well-administered. What are some of the ways that administration of low-income assistance programs could be improved? What can Congress do to improve access for low-income seniors to these programs?

While there are various state programs in place that are designed to assist low-income seniors, low participation is a well-documented concern. Findings from a series of focus groups recently conducted for the Foundation with low-income Medicare beneficiaries indicate that many seniors have not heard of many programs for which they may be eligible. Even if they have heard of programs, such as Medicaid, many assume it is a program for women and children, rather than seniors. When seniors with some experience are asked about Medicaid, a variety of issues were raised: some did not know where to go to apply for benefits; once they begin the application process, many found the forms difficult to read and hard to complete without substantial assistance. With this in mind, states could take several measures to improve the process of helping low-income beneficiaries apply for new benefits. These include:

simplify the application forms and make them more widely and readily available;
allow beneficiaries to "self-certify" their income (with verification conducted periodically and at random, much like the audit procedures used by the IRS);
allow beneficiaries to apply for and enroll in the program once or less frequently than annually (or quarterly);
eliminate or index asset requirements; and
improve marketing and outreach efforts, drawing upon the lessons learned in the context of state CHIP programs.

SCHOOL OF PUBLIC HEALTH AND HEALTH SERVICES
CENTER FOR HEALTH SERVICES RESEARCH & POLICY

May 8, 2002

John D. Dingell
Ranking Member
Committee on Energy and Commerce

U.S. House of Representatives
Washington, DC 20515-6115

Dear Congressman Dingell:

Attached please find my responses to your questions from the hearing entitled, "Creating a Medicare Prescription Drug Benefit: Assessing Efforts to Help America's Low-Income Seniors," held by the Subcommittee on Health on April 17, 2002.

I appreciate your interest in my views and, more importantly, your leadership in efforts to enact a meaningful prescription drug benefit. Please let me know if I can be of further assistance.

Sincerely,

Jeanne M. Lambrew

Jeanne M. Lambrew, PhD
Associate Professor
George Washington University

Attachment

Responses of Jeanne Lambrew
George Washington University

Question 1. "The President seems to be of the belief that Congress cannot afford to add a prescription drug benefit to Medicare until the entire program is reformed. What do you think of that argument?"

Recent evidence and analysis suggests that Medicare's biggest challenge is not better managing what it already covers, but covering what it currently excludes, specifically prescription drugs. In response to high cost growth and trust fund problems in the 1990s, policy makers modified Medicare policy and, for the past 5 years, Medicare cost growth has remained well below that of private health insurance growth and premium growth for the Federal Employees' Health Benefits Plan. Reflecting the effectiveness of existing policies, both the Congressional Budget Office (CBO) and the Office of Management and Budget project continued low growth of Medicare into the future. While Congress can and should deliberate over whether Medicare is paying providers appropriate, evidence suggests that restructuring is not needed to manage Medicare cost growth.

What is also clear from the evidence is that Medicare's lack of coverage of outpatient prescription drugs has resulted in access, health and financial problems for its beneficiaries. According to a recent study, Medicare beneficiaries without drug coverage filled 30 percent fewer prescriptions than those with drug coverage; this differential is even larger among beneficiaries in poor health who particularly need prescription drugs. Other research suggests that seniors who do not have coverage for prescription drugs often skip doses, split pills or simply go without needed medications, resulting in worse health outcomes. Compounding this, CBO projects that the average cost of prescription drugs for Medicare beneficiaries will exceed $2,400 next year and, by 2005, nearly one in five beneficiaries will spend more than $5,000 per year on medications. As such, Medicare's historical protection of seniors against the economic consequences of high health care costs is now threatened by rising drug costs and its lack of a drug benefit.

For these reasons, the priority for Medicare reform is clear: before all else, Congress should address Medicare's lack of a prescription drug benefit.

Question a. Are these "reforms" the President refers to going to save enough money so that the Administration can provide a more generous drug benefit? Or could these reforms actually cost money? What kind of drug benefit could the President provide with $190 billion?

It is unlikely that reasonable Medicare reforms could generate sufficient savings to help fund a prescription drug benefit. CBO estimated that the specific proposals in the President's budget would save $6 billion over 10 years. These savings probably are completely offset by the proposed increase in payments to Medicare managed care (CBO scored this policy as $3 billion over 3 years; it did not estimate the 2006-12 costs which presumably exceed $3 billion). Thus, the President's budget does not include explicit savings for a drug benefit.

The President could support additional reforms for savings, which would take one of three forms: reduced provider payments, reduced benefits, or increased cost sharing by beneficiaries. It does not appear that there are significant savings to be gained through reducing Medicare's provider payment rates. According to CBO, Medicare's projected per capita cost growth over the next 10 years is 4.8 percent – only slightly above medical inflation (4.4%) and significantly below projected private health insurance spending growth per person (6.1%). It does not seem reasonable that Medicare spending growth could be constrained even further. In fact, the Medicare Payment Assessment Commission has suggested the Medicare payment rates should be increased, not decreased, to ensure access.

It also seems unlikely that reducing benefits could generate savings. In recent years, there has been a growing, bipartisan recognition that Medicare's benefits are out-dated and need to be expanded, not contracted. To that end, policy makers have not only been debating adding a prescription drug benefit, but improving Medicare's preventive services, mental health benefit and other benefit gaps.

Similarly, increasing Medicare's cost sharing does not appear to be a viable strategy to produce significant savings. Medicare's current cost sharing in many cases exceeds that of private plans, which is why most Medicare beneficiaries have one (or more) additional sources of health insurance. Medicare only pays for about 55 percent of the health care costs of its beneficiaries. The average cost sharing for Medicare beneficiaries – about $3,142 in 2000 – represents about 22 percent of elderly beneficiaries' income. While there are some services for which modest increases in cost sharing could produce savings (e.g., lab services), the savings is likely to be too small to make a $190 billion drug benefit larger.

You asked what type of prescription drug benefit could be funded by the $190 billion that the President allocated for Medicare. Rough estimates can be derived using CBO's prescription drug baseline. Setting aside $67 billion for the President's low-income program, Medicare could afford a plan with:

- 50% coinsurance that ends when insurance spending hits $750, for a monthly premium of $23, or
- 100% coinsurance through a $6,000 stop-loss, for a monthly premium of $24.

Note that these estimates do not include any cost management, price, and utilization effects and are not how CBO would score these options. It is also important to note that these benefit designs are less generous than virtually all sources of supplemental drug coverage today, although the premium is lower due to the government subsidy. These benefit designs have much higher cost sharing than Federal Employees' Blue Cross Blue Shield Standard Option and than most other private insurance plans. Relative to these standards, the benefit afforded by $190 billion is clearly inadequate.

Question b. If Congress waits to provide a drug benefit until a reform plan can be agreed upon, what will the effect be upon seniors?

Delaying enactment of a prescription drug benefit could exacerbate the health and economic burdens faced by seniors who lack drug coverage today. CBO projects that the cost of prescription drugs per beneficiary will rise by 10 percent per year over the next decade. This is over three times the rate of inflation that is used to calculate annual Social Security cost of living adjustments (COLAs). For those who rely on Social Security, a delay in a Medicare prescription drug benefit means additional years of decline in real income due to drug costs – or continued lack of access to needed medications.

Delays could affect also affect those with prescription drug coverage today. Most experts agree that rising prescription drug costs will result in a deterioration of supplemental coverage. As such, the number of beneficiaries who are uninsured for prescription drugs for all or part of the year will likely climb in the next several years.

Response by Beatrice Braun to Question by Representative Dingell

A **What do you foresee for prescription drug benefits two years from now, if Congress still has not enacted a universal drug benefit? Could the existing coverage that seniors have today either further erode or disappear altogether?**

AARP is very concerned that the drug coverage options available today for people with Medicare will become more expensive, more limited, or even disappear. As noted in our testimony, today people with drug coverage receive it from either employer-based retiree coverage, Medigap supplemental policies, or Medicare+Choice plans. We continue to see employers scale back on their retiree benefits – for example, while an estimated 40 percent of employers with 500 or more employees offered retiree medical coverage in 1993, only 23 percent did so in 2001. The premiums for private supplemental plans continue to rise, sometimes becoming unaffordable for current policyholders. Beneficiaries who have drug coverage through Medicare HMOs cannot depend on having this coverage from year to year, as plans can change benefits on an annual basis or even terminate participation in Medicare. There is no indication that these trends will change or the trend of increasing prescription drug prices, making it even more imperative that Congress establish an affordable prescription drug benefit for all people with Medicare.

B **Some people have stated that since creating a universal Medicare drug benefit will be expensive, Congress should start with a drug benefit that targets senior without drug coverage. However, the seniors who have coverage today may be without it in a year, after a temporary benefit has already been designed and enacted. Would you agree that seniors with drug coverage are also in need of our help? Do you favor creating a universal Medicare drug benefit to protect seniors whose existing coverage is not secure?**

AARP strongly supports creating a ***universal*** and ***voluntary*** Medicare drug benefit. Although about two-thirds of Medicare beneficiaries have some type of coverage for prescription drugs, much of the coverage available now is inadequate, limited, unstable and very expensive. Moreover, many beneficiaries who carry coverage, do not have it continuously throughout the year. A Commonwealth study released earlier this year reported that nearly 42 percent of beneficiaries lacked drug coverage at some point in 1998. Therefore, even those seniors with coverage are not necessarily protected.

It's ridiculous to think about a 21st century health insurance program that doesn't include prescription drug coverage. If we were enacting Medicare today, no one would even think of not having prescription drug coverage as part of the program. We need to create a drug benefit that is available to all people with Medicare.

○