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PRESCRIPTION DRUG BENEFIT IN THE MEDICARE PROGRAM

HEARINGS

BEFORE THE

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SECOND SESSION

MARCH 22 AND 29, 2000

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PRESCRIPTION DRUG BENEFIT IN THE MEDICARE PROGRAM

WEDNESDAY, MARCH 22, 2000

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:50 a.m., in room SD–215, Dirksen Senate Office Building, Hon. William V. Roth, Jr. (chairman of the committee) presiding.

Also present: Senators Grassley, Hatch, Jeffords, Mack, Coverdell, Moynihan, Baucus, Rockefeller, Breaux, Graham, Bryan, and Robb.

OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will please be in order.

Today we will begin to take testimony on a major Medicare modernization issue, which is how best to address the issue of Medicare payment for outpatient prescription drugs.

It is important to note that Medicare currently pays for medically necessary prescription drugs provided to inpatients of hospitals or skilled nursing facilities, and in certain other special circumstances.

At present, Medicare is spending over $3 billion annually for this coverage. I would like to share certain goals related to today's topic of Medicare outpatient prescription drug coverage, and I think it is important that we work together in a bipartisan fashion to address the following considerations.

First, it is important in a reformed Medicare program to offer substantial protection from financial liabilities associated with higher prescription drug spending.

Second, we need to take into account the reasonably widespread drug coverage among the current Medicare population and try to minimize displacement of existing privately offered coverage. Many seniors have coverage that they are satisfied with, and we should take care not to disrupt those plans.

Finally, I consider it very important that these changes occur in the context of broader program reform.

I would like to conclude with a word about these hearings. Today we are scheduled to hear expert testimony on the extent of drug coverage among the Medicare population, and key factors to consider in drug benefit design and administration. That will be followed by industry and consumer perspectives.

Next week, on March 29, we plan to take testimony from a panel of our colleagues and the administration. These are joined by the common thread of having authored Medicare reform or drug coverage plans that have been in the public arena for consideration for several months.

We will then conclude with expert testimony drawn from the States and the private sector on lessons in designing and administering a major drug benefit.

It is now my pleasure to turn to my colleague and Ranking Member, Senator Moynihan.

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK

Senator MOYNIHAN. Mr. Chairman, you really are entitled to a victory lap, you know. Just minutes ago, the Senate, by a vote of 100 to zero, adopted a major change in Social Security legislation.

Nothing like that has ever happened, and I hope you feel as good about it as you should that we have abolished that irksome, and now counterproductive, earnings penalty that dates from the Depression in the 1930's.

I welcome, sir, your suggestion that a prescription drug benefit be part of a larger Medicare proposal because it is the most attractive feature that we have to offer citizenry that might have to take some medicine, as you might say, with the new benefit. Senator Breaux and Senator Frist have a prescription drug plan in their proposal.

I can report that the administration has now sent us their Medicare proposal, the President's proposal, and we can talk about that next week. I just had a personal thought that I would hope we could find a metric to use during this debate. It's very clear that prescription drugs have a wholly different role in medical care today than they did in 1965.

But one would like to have some measures of this. Ms. O'Sullivan and Dr. Scanlon, you are all good at that sort of thing. I think one pill has substantially reduced the number of stomach operations in American hospitals, and there are other such examples. The more we know of it, the better feeling we will have about how to deal with it. But, enough.

Thank you very much. Let us go.

The CHAIRMAN. Thank you, Senator Moynihan.

Senator BREAUX. Mr. Chairman, could I just make an inquiry or short statement on the process for a moment?

The CHAIRMAN. Yes.

OPENING STATEMENT OF HON. JOHN BREAUX, A U.S. SENATOR FROM LOUISIANA

Senator BREAUX. I would just say that I think this committee has really been extremely attentive to this issue, and you are to be congratulated, along with the Ranking Member, for the series of hearings that we have had.

This, I think, marks the tenth hearing in this Congress that this committee has had on Medicare, and now the second hearing that we have had specifically on the question of prescription drugs, with another hearing scheduled, I think, next week.

We have been listening to a lot of eloquent statements. I think we are fast approaching the time when it is time to quit listening and to start actually doing something with regard to actually writing a bill.

I would encourage all of our colleagues, the Chairman, and Ranking Member to perhaps start focusing in on when we can take the benefit of everything we have heard and actually move forward, because time does draw short every day to try to get something done in this Congress.

I would hope, with all due respect, on Social Security—I mean, today, just a minute ago, we did the easy lifting on Social Security. We made it easier for more people to collect more money, but we did not address the structural problems associated with Social Security. I would hope that we would not make that same mistake with Medicare. I think we have a unique opportunity to make sure that we do the right thing.

The CHAIRMAN. Thank you, Senator Breaux. We shall move as expeditiously as possible with the legislation.

Now I would like to turn to a panel consisting of Jennifer O'Sullivan, who is a Specialist in Social Legislation of the Congressional Research Service; William J. Scanlon, who of course is Director of Health Financing and Public Health Issues, General Accounting Office; and Edwin C. Hustead, who is, of course, a Consulting Actuary to the Congressional Research Service in Washington, DC.

We will start with you, Ms. O'Sullivan.

STATEMENT OF JENNIFER O'SULLIVAN, SPECIALIST IN SOCIAL LEGISLATION, CONGRESSIONAL RESEARCH SERVICE, WASHINGTON, DC

Ms. O'SULLIVAN. Good morning, Mr. Chairman and members of the committee. My name is Jennifer O'Sullivan. I am a Specialist in Social Legislation at the Congressional Research Service.

This morning I am going to provide a brief overview of prescription drug coverage for Medicare beneficiaries. I will also look at drug spending by beneficiary income.

As you know, in general, the current Medicare program does not cover outpatient prescription drugs. The two key exceptions are immunosuppressive drugs for a minimum of 3 years following a Medicare-covered organ transplant, and certain oral cancer drugs.

Most beneficiaries have private or public insurance to supplement their Medicare benefits, and for many this supplementary coverage includes drug benefits. In fact, over two-thirds of beneficiaries have supplementary coverage. This can be through a Medicare managed care plan, employer-sponsored retiree health insurance, individually purchased health insurance known as Medigap, Medicaid, or other sources.

Figure 1 shows the distribution of drug coverage for Medicare beneficiaries in 1996, and this is the latest year for which we have national data. As you can see from the figure, the largest single category is persons without drug coverage. They account for about one-third of the total. Persons enrolled in employer-sponsored plans were the largest group with drug coverage.

Figure 1 shows the percentage of beneficiaries with some type of coverage. It does not, however, show the extent and depth of that

coverage, which varies widely. It should also be noted that 1996 may represent a high point. There are many indications that coverage may be eroding for certain groups.

With that in mind, I would like to look briefly at the various sources of coverage. First, Medicare managed care plans. In the past, many managed care plans were able to offer drug coverage at little or no cost to beneficiaries. Many of these plans are now increasing charges to beneficiaries, capping benefits, or in a few cases, dropping drug coverage.

Beneficiaries can also get coverage through employer plans. The percentage of firms offering coverage to their retirees age 65 and over declined in the late 1980's and early 1990's. In the mid-1990s, there was a leveling off. However, very recently there appears to be a new decline.

A 1999 study of employee benefits by the Hay Group shows that, between 1997 to 1999, there was an eight percentage point drop among medium to large firms, and a six percentage point drop for large firms of over 10,000 employees. Virtually all large employers that offer health insurance include outpatient drug coverage, however, many are implementing strategies to cut their drug costs.

Beneficiaries may also purchase Medigap coverage. They have a choice of one of 10 plans, only three of which offer drug coverage. It is generally believed that only persons who think they will incur high drug costs actually purchase a Medigap policy with drug benefits. This adverse selection drives up the per capita cost of coverage.

Some low-income, aged, and disabled Medicare beneficiaries are also eligible for Medicaid. Those entitled to full Medicaid protection have prescription drug coverage. Some groups, known as qualified Medicare beneficiaries and specified low income beneficiaries, or QMBs and SLIMBs, are entitled to more limited protection which does not include drug benefits. QMBs and SLIMBs only receive drug coverage if they are also entitled to full Medicaid coverage.

There are significant differences both in utilization patterns and expenditures for persons with coverage versus those without. In 1996, beneficiaries with benefits filled five more prescriptions per year than those without. As would be expected, those with coverage also averaged higher overall expenditures.

I would like to turn for a moment to some key findings by income category. Figure 2 shows, by income category, the percentage of non-institutionalized beneficiaries who had drug coverage in 1996.

As you can see, persons in higher income brackets tended to have higher levels of coverage. This reflects the fact that these persons were more likely to have drug coverage through a former employer.

Persons below poverty had coverage levels slightly higher than persons just above poverty. This reflects the fact that many individuals below poverty were eligible for full Medicaid benefits. The lowest levels of coverage are those between 100 and 200 percent of poverty.

Figure 3 shows average annual per capital drug spending by income category. Nationwide, persons without coverage spent $463 per capita in 1996.

Senator HATCH. Could I interrupt you for just a second?

Ms. O'SULLIVAN. Sure.

Senator HATCH. You are saying the lowest coverage is between 100 and 200 percent of poverty. Below 100 percent, I missed how many of those are covered.

Ms. O'SULLIVAN. The percentage of persons below 100 percent of poverty that are covered is 67.7.

Senator HATCH. 67.7.

Ms. O'SULLIVAN. Right.

Senator HATCH. All right. Thanks.

Ms. O'SULLIVAN. Thank you, Senator. It is on Figure 2, Senator.

Figure 3 shows average annual per capital spending. Persons without coverage spent $463, those with coverage spent nearly two-thirds more.

As you can see from Figure 3, higher overall spending appears more closely associated with the presence of drug coverage rather than with income level.

Overall, beneficiaries pay roughly half of their total drug bill out of pocket. Of course, the percentage an individual pays depends upon whether or not they have coverage.

Figure 4 shows the average annual out-of-pocket expenditures. Persons without coverage, of course, pay their whole bill. Persons with coverage paid about one-third of their total drug bill.

As might be expected from the preceding figure, higher overall out-of-pocket costs are more closely associated with the absence of drug coverage rather than with income level.

In summary, approximately two-thirds of beneficiaries have some coverage for drug costs and one-third do not. The lowest levels of coverage are for those between 100 and 200 percent of poverty. Drug spending is two-thirds higher for those with coverage than those without.

I should emphasize that this discussion has, of course, focused on averages. There are wide variations within categories in both the use of drugs and expenditures for drugs.

Thank you.

The CHAIRMAN. Thank you, Ms. O'Sullivan.

[The prepared statement of Ms. O'Sullivan appears in the appendix.]

The CHAIRMAN. Dr. Scanlon.

STATEMENT OF WILLIAM J. SCANLON, PH.D., DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Dr. SCANLON. Thank you very much, Mr. Chairman and members of the committee. I am very pleased to be here today as you discuss issues related to a prescription drug benefit for Medicare.

There is a growing consensus, as you have indicated, that the Medicare program should incorporate a benefit to address concerns about the beneficiaries who do lack access to prescription drug coverage.

Yet, the fear is that such a benefit would involve considerable cost, and therefore there is the challenge to make sure that, as we expand access to prescription drugs, we do it in the most efficient way possible in order to minimize the financial consequences for Medicare.

You have asked us to provide information on how the private sector entities are managing third party coverage of drugs. Private insurers and HMOs have adopted a variety of techniques to manage their drug benefits, which may be instructive for Medicare.

Many contract with pharmacy benefit managers, or PBMs, to develop and implement these cost control techniques and to perform other activities related to managing a drug benefit.

PBMs negotiate with drug manufacturers for discounts or rebates on their products. They often use formularies or lists of preferred drugs to influence beneficiary or physicians' choices when more than one therapeutically equivalent product is available.

They encourage use of the preferred drugs through lower co-payments or other incentives. Manufacturers then compete to be the preferred product by offering more favorable prices, as PBMs can promise a larger market share to the drugs they select.

Private sector cost control techniques also extend to the drug distribution network, with emphasis on negotiating lower reimbursement rates and dispensing fees with pharmacies in exchange for including the pharmacy in a plan's network.

Exactly how much these techniques affect expenditures for drugs is uncertain. Data on the size of rebates or discounts are proprietary, and how much the techniques have altered utilization is unknown.

Estimated savings reported to us and other researchers by insurers and PBMs range from 14 to 31 percent. However, several cautions about these numbers are appropriate.

First, the estimates are self-reports from plans not built upon data that we or others have analyzed. Second, they are several years old and the dynamics and changes within the pharmaceutical market have been considerable. Finally, a drug benefit, even with these types of savings which are relative to buying drugs on a retail basis, will still be expensive.

As you consider methods to manage a potential Medicare benefit, these private sector techniques offer a useful starting point. I would like to discuss, though, several issues that arise in considering how to adapt these methods to the unique characteristics of Medicare and its beneficiaries.

First, in a competitive model for Medicare such as exists today with the Medicare+Choice program or in the models envisioned in some reform proposals, cost containment strategies involving restrictions on coverage through formularies or pharmacy networks impose an obligation to adequately inform beneficiaries about plan policies.

Our work on the Medicare+Choice program has demonstrated that it is particularly difficult to ensure that beneficiaries are adequately informed about their options. Aggressive formulary management may control spending, but beneficiaries need to be aware of how differences in that management across plans may affect their access to needed drugs.

Second, adoption of PBM techniques within the traditional fee-for-service Medicare program on a nationwide basis could be difficult, given the program's size and its need for transparency in its actions. Determining whether a drug should be on the formulary typically involves a clinical evaluation based on drug safety and ef-

fectiveness, and the negotiated manufacturer's price. Plans and PBMs currently make these determinations privately, something that would not be tolerable for Medicare, which must have transparent policies that are determined openly. Given the stakes involved in a drug being selected as preferred on a Medicare formulary, one could imagine the intensive efforts to scrutinize and influence the selection process.

In addition, once the formulary is in place, it may be difficult to steer utilization and limit use of non-formulary drugs, especially in a fee-for-service environment where it may be hard to influence prescribing practices.

Although contracting with multiple PBMs to manage segments of the drug market could potentially mitigate some of the likely difficulties that Medicare would face, these PBMs could face some of the same types of difficulties. Furthermore, if each PBM had exclusive responsibility for a geographic area, beneficiaries who want certain drugs could be disadvantaged merely because of where they live.

To reduce variation, Medicare could, like some private sector purchasers, specify core benefits or maintain clinical control over formulary decisions. However, without the ability to create and manage a formulary, the ability of a PBM to extract discounts and have control of overall costs could be diminished.

If multiple PBMs compete in a single area, issues would arise in terms of informing beneficiaries about the differences in their policies, monitoring their marketing and recruitment strategies, and accounting for differences in the health status of beneficiaries using each PBM.

Finally, the efforts of PBMs to control expenditures involve a capacity to scrutinize claims more effectively and quickly than is typical of Medicare today. PMBs provide online, real-time drug utilization reviews to inform pharmacists about potential drug interactions, whether the prescribed drug is covered in the appropriate formulary, and what co-payments will apply. Currently, Medicare does not have that capability.

To duplicate the types of controls PBMs utilize will likely involve increasing the proportion of Medicare spending devoted to administrative costs. That share today is roughly 2 percent.

It is not possible to estimate the administrative cost that will be needed to implement a drug benefit with any precision, however, the number of prescriptions for Medicare beneficiaries could easily approach the current number of claims for all other services combined, which number about $900 million annually today. This suggests the total administrative cost would be quite substantial.

I would like to conclude by noting that we need to find the right balance between adapting some private sector practices that I discussed for Medicare. Adding a benefit to Medicare is obviously going to add to cost, and to the extent that we can incorporate tactics to make sure that we spend our dollars efficiently we will be better off, but we do need to strike the right balance between control and access to the benefit.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Dr. Scanlon.

[The prepared statement of Dr. Scanlon appears in the appendix.]

The CHAIRMAN. Mr. Hustead.

STATEMENT OF EDWIN C. HUSTEAD, CONSULTING ACTUARY TO THE CONGRESSIONAL RESEARCH SERVICE, WASHINGTON, DC

Mr. HUSTEAD. Yes. Thank you, Mr. Chairman, members of the committee.

I would like to cover four points to summarize my written testimony. The first, is the design of prescription drug coverage in private sector health plans. The second, is how that design may or may not apply to Medicare.

The third, is how the two proposals that have been discussed, the administration's Part D proposal and Breaux-Frist, deal with risk sharing, and fourth, how those proposals deal with adverse selection.

Dr. Scanlon has defined formularies quite well. I would add one thing to it and refer to it in my discussion. That is, there are open formularies under which the employee who is covered by the employer's health plan can select outside the formulary but has to pay more for it, and closed formularies under which the health plan will not cover any prescription drugs outside of the formulary.

In the private sector, predominately now what the design is, is called a drug card plan under which the employee is issued a drug card, presents that to the pharmacy, and often these days will pay three levels of cost depending on the type of drug that is under the prescription.

A common practice is to, say, charge $5 for a generic drug, $10 for a drug that is on the formulary, and in the case of open formularies, $20 to the employee for a drug that is not on the formulary. These are very popular plans with the employees and employers, and there are many pros and cons about the treatment, which is in my written testimony.

There are still a fair number of plans that have the traditional approach of covering prescription drugs and any other medically necessary treatment under a standard deductible and co-insurance.

In most of these plans there is a stop-loss, as is considered under Breaux-Frist, but also which covers any out-of-pocket payments including those for prescription drugs.

In dealing with accelerating costs of prescription drugs over the last four or five years, employers have brought a number of control measures into play. Primary among these is the formularies, both the closed type and the open type. There are continuing efforts at education, at computerization to trade information between the physicians, the pharmacists, and the health plan.

The old, reliable health plan approach is simply to charge more of the co-payment to the employees, so there has been an increase in co-payments. In prescription drugs, this is particularly effective because the more the employee has to pay toward the drug, the less likely the employee will purchase the drug in the first place. So, there's a double savings to the employer through shifting co-payment.

When we focus on Medicare and the ability to apply these lessons to Medicare, there are quite a few significant differences. Primary among them is the provision that has been discussed in this committee before, and that is, whatever proposal is presented, equitably and politically, has to give the Medicare beneficiaries access to the current plan structure with the current co-payment cost; unlike an employer who can simply throw out the existing health plan and say, here is your new plan with its networks of doctors and its formulary. And if you cannot go to the doctor you used to or buy the drug you used to, that is too bad. You cannot do that with Medicare.

So the result is, the proposals have to work around the edges. How do we add a prescription drug, how do we add options but keep the current options? That makes the situation much more difficult.

As far as the two proposals and the share of risk, the administration proposal reverses the insurance contract, if you will, that you find in the private sector where the employer shares the cost and often has a stop-loss limit.

The administration proposal, after the limit is reached of $5,000, eventually charges all of the cost to the beneficiary. So, this is the reverse of the usual situation.

Breaux-Frist would allow any coverage as long as that plan was worth at least $800. So you would see, if the Breaux-Frist proposal were to pass, a number of plans with different co-payment structures.

Finally, as far as adverse selection, again, because you are offering benefits at the fringes, and new options, and keeping the old option, there is certainly a very strong threat of adverse selection.

The administration proposal avoids this by offering a once-in-a-lifetime choice, so that if a beneficiary is facing low prescription drug costs next year, they will still probably join because they will not be able to later.

The Breaux-Frist proposal, with its high-end standard options, will undoubtedly lead to adverse selection against the high-options, as you have seen in the Federal Employees Health Benefit Program. The marketplace will act to sort these out, and those that can compete with the high-option will undoubtedly survive.

Thank you very much.

The CHAIRMAN. Thank you, Mr. Hustead.

[The prepared statement of Mr. Hustead appears in the appendix.]

The CHAIRMAN. Dr. Scanlon, let me ask you. It has been suggested, I believe, in your testimony that HCFA would need to nearly double its capacity through contractors to process nearly $1 billion additional claims per year in addition to all of the other new tasks.

What are some of the key factors we would need to consider in assessing the scope and cost of new Federal responsibilities?

Dr. SCANLON. Well, Mr. Chairman, I think it is very important to recognize that it is not just the volume of claims that is involved here, but it is a very different kind of claim.

As I indicated, some of the effective management techniques that we have seen in the private sector involved what I will call real-

time processing, that when a beneficiary is at the pharmacy counter, it is actually possible for the claim to be reviewed by the payor and determine what is to be paid, whether or not this is a covered benefit, whether or not there is a contraindication because there is an interaction between this drug and some other drug the beneficiary is taking, and thereby enhance quality.

Contrast that with the situation we have today, where claims come into Medicare at some point after the service has been provided and there really is not any compilation or analysis of those claims for months, if not years, after the service has been provided. So, we really do need to have this real-time capacity. I think that is one sort of key thing.

The other issue, in terms of thinking about the resources that are going to be involved here, depends very much on the plan that is adopted because we have had plans that have been discussed where major responsibilities are going to be shifted to private entities, health plans, or others.

We have other plans where it is going to be retained largely in the traditional program, but there are also differences in terms of who is going to be eligible for different levels of subsidy, which creates a situation where one has to be able to assess that eligibility for the subsidies.

All of those details matter in terms of just being able to determine what it is going to take to institute and implement this benefit effectively.

The CHAIRMAN. Ms. O'Sullivan, you testified that the lowest levels of prescription drug coverage were persons between 100 and 200 percent of poverty. Now, if we were to begin adding prescription drugs by assisting all Medicare beneficiaries at 200 percent of poverty or below, how many beneficiaries would be helped, and what percentage would it be of the total population?

Ms. O'SULLIVAN. CRS has looked at these kinds of questions, Senator. If you were to go up to 200 percent of poverty, you would pick up slightly under two-thirds of those persons that are not currently covered and you would offer coverage to slightly over one-half of the Medicare population, which is about 19.7 million, based on a 36 million base. I am basing these answers on 1996 data.

I should mention, of course, that this presumably would be a voluntary program, so you might not necessarily actually pick up all of those people, but you could pick up probably pretty close to that number.

The CHAIRMAN. Now, you said that 1996 retirees with coverage filed an average of 21 prescriptions per year. Is there reliable data on whether that average number of drug claims per person is growing, and what is the average for seniors with poor health status?

Ms. O'SULLIVAN. Senator, 1996 is the latest year for which we have data for the elderly, but we do know that the recent increase in overall spending for prescription drugs is primarily driven by increases in volume, and therefore it is reasonable to assume that future surveys might record increases in the use of prescription drugs.

In answer to your second question, definitely the number of prescriptions used varies by the health status of the individual. For

example, still based on 1996 data, the overall average for persons with drug coverage was 21 prescriptions per year.

For persons in poor health, that rose to 38 prescriptions per year. For persons without coverage, the average across everyone was 16, and that rose to 27 for persons in poor health.

Another look at this is by functional status. Persons with no limitations with drug coverage averaged 18 per year, whereas those with limitations in three ADLs—activities of daily living—averaged 34 prescriptions per year. So you can see, there is a wide variation.

I should also point out that the number of persons who do not use any per year has remained relatively constant over the 1992 to 1996 period, at roughly 15 percent that do not use any.

The CHAIRMAN. Dr. Scanlon, I would like to request that GAO provide the committee with a preliminary estimate prior to our hearing on March 29 of what the potential administrative costs and workload might be for the Medicare program if a universal benefit were enacted this year. Is that possible?

Dr. SCANLON. Mr. Chairman, I think we could provide you with a lot of information, and we will try to do it with as much precision as possible to simplify it. But again, because of the variety of proposals out there, there are a lot of assumptions that will go into that. But we will do the best we can to get you the information by the 29th.

The CHAIRMAN. I would appreciate your help.

[The information referred to above can be found on page 197 of the appendix.]

The CHAIRMAN. Mr. Hustead, in your testimony you focused on the great importance of risk assumption, the management of risk to minimize adverse selection.

What are the implications of one of the key differences between the President's plan and the Breaux-Frist plan? That is, that the President would have the Medicare program hold the risk of drug benefit costs, and Breaux-Frist would have the risk borne by private entities contracting with the government.

Mr. HUSTEAD. Well, in the private sector and in the FEHBP national plans, the risk is held by the employer or by the government. It is entering into a new area in a plan of this scope by placing the risk on the insurers or the entities.

There is always the question of the risk adjustment process. What do you do with some plan who, through no fault of their own, got the higher cost people? It is a complex issue and would have to be dealt with carefully.

I think one concern there in particular, is that it looks like many of the entities that would be looked to to provide these plans would be PBMs, and they have not been in the business of providing insurance. So they would have to either share part of the risk or work with insurance companies. It is a whole new issue.

The CHAIRMAN. Now, you indicated that specification of drug benefits is more typical in the market today than relying on an average actuarial value. Could you elaborate on the pros and cons of these two approaches?

Mr. HUSTEAD. Well, actually, the specification of the benefit is almost universal in the private sector, and again in FEHBP. It would be something new and different to specify the actuarial value. It is

an intriguing idea. Of course, putting the word "actuary" in the law always helps my profession. [Laughter.] But to try to figure out what that is.

What it does allow by putting a value in rather than specifying the benefits, is it allows the various entities to design around that and does not restrict them. So, there is ability to use different approaches.

One major question I would have with it is how it treats the difference in benefit design, say, with a closed formulary versus open formulary. Do these have the same value or not?

The CHAIRMAN. Thank you.

Senator Moynihan.

Senator MOYNIHAN. First, thank you, all three, for wonderful testimony. We are going to hear from interested parties in our next panel and it is just a joy to hear such disinterested and lucid comments.

I would just like to ask each of you, and I will be brief, just a general question. Medicine once emphasized hospital care and physician-provided care, and there has been quite a transformation, as I understand, in the 35 years since we enacted Medicare and since the model of hospital-based care evolved.

Someone kindly gave me this as a prop; this is the Merck 1899 manual. It has all sorts of interesting things—cocaine, powdered opium. A century later, you can look at the new manual, just to highlight the extraordinary change.

The Centers for Disease Control estimates that 64 percent of all medical encounters—now result in the use of drug therapy.

So, is it not possible that, clearly, health care today should provide for prescription drugs? That sounds like an addition to existing costs and programs. Is it not as likely that, it is a substitution and we need not have any very large increase in costs as we look to a different mode of therapy?

Ms. O'Sullivan.

Ms. O'SULLIVAN. Senator, I do not believe at this point that there is a definite answer to that question, a dollar-for-dollar trade-off.

Senator MOYNIHAN. It is a central question, is it not?

Ms. O'SULLIVAN. It is a central question. I believe there are some individual research projects that have looked at one or another diagnoses and tried to evaluate the trade-offs. Unfortunately, the research is someone limited in this area, though clearly you do have some trade-offs here.

Senator MOYNIHAN. Yes.

Dr. Scanlon.

Dr. SCANLON. Senator Moynihan, I would agree with Ms. O'Sullivan in that the research has not been comprehensive. I think the general thrust of the feelings in the clinical community are that, while there are these substitution effects, there are still also an incredible number of dramatic breakthroughs in terms of the ability to treat diseases that we were not able to treat in either that 1898 Merck Manual, or even in the 1965 Merck Manual.

In terms of being able to deal with these conditions and these diseases, those are things that we really want to have as part of our health benefit package, but that they may add to the costs, just

as do new surgical techniques or other new types of medical techniques.

I would also point out that the Merck Manual is now available for free on the web, so the next time we have a hearing maybe you will need to bring a notebook computer with you. [Laughter.]

Senator MOYNIHAN. A fair point. It is well established that people will spend money to avoid death. [Laughter.]

Mr. Hustead, what do actuaries say on that?

Mr. HUSTEAD. I am afraid I will give you the cynical answer, which is that in my many years of dealing with FEHBP, and then later in the private sector, I have often heard the argument that, just increase this benefit and it will pay for itself, a second surgical opinion, full payment of outpatient treatments, and often the evidence was there purporting that that would happen.

Well, once you cover that by insurance and then you look back a couple of years, you find out that you, indeed, paid a lot more for that particular procedure but did not save anything in other areas.

So certainly the argument is there that there may be cross savings, but as an actuary, I think I would be inclined to say, conservatively, you should add the cost of prescription drugs and not assume any reduction otherwise.

Senator MOYNIHAN. A fair point. Unless you can direct some bureaucratic energies into reducing former arrangements in exchange for newer ones. That is always problematic.

Mr. HUSTEAD. That is.

Senator MOYNIHAN. Actuaries have proven that, I cannot doubt.

Thank you all very much. But you hear this question. I know we have all talked to ourselves about it. Any further thoughts, let us have them.

The CHAIRMAN. Next, we have Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman.

If I could just pick up on that last question. In 1965 when Medicare was established, it used as its base model the Blue Cross/Blue Shield plan that was in existence at that time.

Since that time, Blue Cross/Blue Shield has added prescription medication as a covered benefit. Is there any evidence of what has been the effect in private plans that have undergone a transformation towards the provision of prescription medication on an outpatient basis as to what changes in utilization of other sectors of their covered benefits has been as a result of that transformation?

Mr. HUSTEAD. Actually, Senator, prescription drugs have always been part of the basic package of private health plans, so we haven't had the opportunity to see that addition. Medicare is different in that it has not been there. So, there really has not been any experience as to what would happen if you add prescription drugs where they had not existed.

Senator GRAHAM. We talk a lot about reform in the Medicare program. I personally believe that one of the most fundamental reforms to which we should commit ourselves is a transition of Medicare from its historic focus on acute care and chronic care for the consequences of major disease, illness, or accident, and towards a Medicare program that gives greater emphasis to the maintenance

of good health through effective screening, early intervention, and maintenance-type programs.

Is it possible to achieve this goal of Medicare with a greater emphasis on wellness without having general accessibility by Medicare beneficiaries to affordable prescription drugs?

Dr. SCANLON. Senator Graham, I think probably not. If you look at the data that Ms. O'Sullivan has about the use of prescription drugs by those in poor health or moderately poor health and you see the big difference between those with coverage and those without, you speculate that it is very reasonable to think that people that are not using as many drugs are potentially declining in terms of their health status at a faster rate and may potentially end up needing some more services. So, it is something where you could believe that the drugs can be efficacious in preventing that decline.

In the Balanced Budget Act, of course, there were certain preventive services added to Medicare, and we have seen that, while that is a positive step, we still do not have a large proportion of the elderly taking advantage of that.

So it is not just adding the coverage, it is also making people aware of what they need to get in the way of these kinds of services to maintain good health.

Senator GRAHAM. And do you think that the absence of general access to affordable prescription drugs has been one of the constraining factors on Medicare beneficiaries utilizing the preventive methods that are currently available?

Dr. SCANLON. I think it is an issue of some beneficiaries because, as has been indicated, about two-thirds of beneficiaries have coverage and one-third do not. Some of that one-third, it is by choice. They may believe that they can afford not to have coverage now, either because of their health status or because of their income.

But there definitely is a segment where lack of access to affordable coverage is an issue and it does, I think, influence their ability to access services that may be beneficial to their health.

Senator GRAHAM. I would like to focus on the issue of whether this plan, in its initial phase, should be universal, i.e., available to all those who voluntarily elect to adopt it, or should be primarily targeted by income groups.

Let me ask three questions that relate to that issue. One, if we started with a targeted plan, what would be that effect on the administrative complexities of instituting prescription medication?

Number two, how would a targeted plan initially benefit or retard an event transition to a universal plan? Three, are there any other currently covered services under Medicare which are universally available that also ought to be restricted to a specific group based on income as a means of reducing Medicare costs?

As an example, if Medicare had been developed 100 years earlier in 1865 instead of in 1965, there is a good chance that anesthesiology would not have been included. Would you suggest that anesthesiology, for instance, be removed from the universal service to a service based on income in Medicare today?

Dr. SCANLON. Senator, I think the primary issue, in terms of targeting, is one that I am afraid that we cannot answer from GAO. Certainly Controller General Walker has talked about the fiscal situation of the Medicare program suggested that we do need to be

very concerned about the path of expenditures over time, and that finding some way to engage in fundamental reform to bring those expenditures under control is critical.

In that context of constrained resources, targeting becomes kind of an obvious example of how one can constrain those resources. Targeting on the basis of income is one option, targeting on the basis of catastrophic expense is another option.

The question I would feel more comfortable, from a GAO perspective, in dealing with, is the issue of the administration of a targeted benefit. A targeted benefit is going to impose a requirement in terms of assessing eligibility for that benefit, but that same responsibility will exist if we have variable subsidies of benefits, which has been included in many of the universal proposals.

Many of the universal proposals would like to have premiums paid by beneficiaries, but still exempt lower income individuals from paying those premiums or to more heavily subsidize those premiums.

So we would be in a situation where we still have to determine eligibility for the amount of subsidy that we are willing to provide individuals under most of the proposals that have been made.

In terms of whether it deters movement towards a more universal benefit, I think that is an issue of the political perspective in terms of the resources that we have to devote to Medicare, whether they are under control, and whether there are sufficient resources to be able to expand the benefit at some future point.

Senator GRAHAM. Thank you.

Ms. O'Sullivan.

Ms. O'SULLIVAN. I would just add that, clearly, it is very important as to what process you would set in place for establishing eligibility. Income eligibility, now, is frequently determined by the States as part of their Medicaid programs, and you would have to decide how you wanted to go about that.

Once you set in place a system, either separate from or part of that process, would depend upon how easy or difficult it would be to expand it.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman. Thank the panel for their very helpful testimony.

Let me continue on with what Senator Graham was exploring, and that is what I think is probably the logical conclusion, and that is, we are not going to be able to do a comprehensive, total package on Medicare reform this year. I would daresay that we are not going to be able to have a universally covered prescription drug program that is subsidized for everybody passed this year as well.

But that is not to say that we could not take a combination of reforms that move us down the path to restructuring the Medicare program with real reforms, although not a total package but something along the lines of doing that, then having a step towards prescription drug coverage for everybody.

I was wondering if you think it would make sense, if we are going to do a stepped approach because of cost or unwillingness to tackle the whole problem of subsidizing everybody, what would you think about the efficiency or effectiveness of a program that would, for instance, just as a suggestion, be a subsidized program for those

poor people who are hurt by high costs, say up to 200 percent of poverty, have them have access to prescription drugs without any premium and without any cost to them? Then the second portion would be to cover those who have a catastrophic problem, and pick the number, $4,000 or above per year, which is about 5 percent of the Medicare people.

So you would have a drug package that would be covering the poorest of our society up to 200 percent, which is a significant number of people, and then a second portion which would cover those who have experienced catastrophic drug costs in a year. Then everybody else would have access to buying a high-option plan, but it would not be subsidized.

That would obviously lower the cost of a prescription drug program. The question is, can that be made to be effective in addressing this problem? Any thoughts on that from anybody?

Ms. O'SULLIVAN. Well, one thought, Senator, is where the cutoff comes and what the potential notch is for a person that might have a few dollars extra in income and what kind of disregards there would be.

Senator BREAUX. Yes. Say they are at 200 percent of poverty and $4,000 catastrophic, or play with those numbers, but have something that addresses the catastrophic problem and something that addresses the problem of poor people.

Ms. O'SULLIVAN. Well, that would certainly be one. As I mentioned to Senator Roth, if you go to 200 percent of poverty you are picking up over half of Medicare beneficiaries.

Senator BREAUX. I did not think it was that much. That is a significant number of people, if you just go up to 200 percent of poverty. That is a significant number of people who do not have access to drug coverage now.

Ms. O'SULLIVAN. Well, it is not that they do not have it now, but you would offer coverage to half of the population.

Senator BREAUX. That is a significant number of people that would be covered.

Any comments, Mr. Hustead.

Mr. HUSTEAD. To both yours and Senator Graham's question, I think it would be unfortunate if you would have to split it out and just do it piecemeal because that creates design problems. But, as you say, it might be necessary because of the cost and the climate.

Senator BREAUX. Everybody would have access to a Medicare prescription drug. You would just subsidize some of them, and others would not be subsidized. They would pay whatever the premium would cost. Then for catastrophic, you would be covered for that. So everybody would be covered, it is just that you would not subsidize everybody.

Mr. HUSTEAD. So you would at least have the availability.

Senator BREAUX. Absolutely.

Mr. HUSTEAD. I think it would probably have to be a national plan under one design rather than one offered by different insurers, because if you have that much of an insurance out there to people above the poverty level where it is being paid for entirely by the individuals, it would be difficult to offer competitive insurance programs.

Senator BREAUX. We need to explore that.

Dr. SCANLON. Senator Breaux, if I could add.

Senator BREAUX. I am sorry. Yes.

Dr. SCANLON. I think there is also an additional advantage to the idea of creating access to Medicare-sponsored health plans that provide the drug benefit, because then the individuals who are paying the full cost of the premium are going to be able to get that plan at a group rate.

Senator BREAUX. Oh, sure. Absolutely.

Dr. SCANLON. As well as get the benefit of group purchasing. Those two things are subsidies, in some respects.

Senator BREAUX. That, in itself, is a financial help to those who would be paying the full premium because it would be buying as part of a pool.

Mr. Hustead, you had pointed out the Breaux-Frist differing from the administration's proposal on the specificity of what is covered in a prescription drug program.

My concern, and the reason why Dr. Frist, I, and others have tried to work out a minimum actuarial value and allow different plans that meet that standard to put forth their proposal, is because if you get into specifying deductibles, how much they are, and how much percentage of co-insurance you have, how much is the cap benefit, if you rank that in the statute, it is a dinosaur within 24 months in the sense that that may be fine for today, but within 2 years that is archaic and it is ancient history.

So if you have an approach that has a minimum actuarial value that allows different types of combinations that would reflect what is needed at that time, we felt that that would be the right approach.

I thought that that is what FEHBP did. They do not really specify deductibles and co-payments in statute, do they?

Mr. HUSTEAD. What they do in FEHBP, is negotiate each plan and the benefit design of each plan.

Senator BREAUX. So it is not specified by statute exactly what the co-payments and deductibles are.

Mr. HUSTEAD. Right. I think within the construction of your proposal, definitely the approach of a standard actuarial value makes a lot of sense because you do not want to say, these are the only types of plans you can offer. Yes.

Senator BREAUX. Let me have one short question to follow up.

The CHAIRMAN. We are running out of time.

Senator BREAUX. These are such great witnesses.

The CHAIRMAN. Be very brief, please.

Senator BREAUX. We modified our plan in a letter to CBO with regard to the question you raised on adverse risk selection. In a sense, we have now sent to CBO in the scoring process a requirement that you would have a one-time enrollment in the high-option drug plan like we have now for Part B, that if you did not get into it initially when you first became eligible, if you got into it later when you needed it, you would pay a penalty, to try and encourage people to take advantage of it up front.

Is that something that could be helpful in that regard?

Mr. HUSTEAD. I am really not sure if you need to have the penalty or not. I do not know at this point.

Senator BREAUX. Could you do it just with a first-time enrollment requirement? In other words, when they become eligible they have to make a decision on whether to get the drug program or not.

Mr. HUSTEAD. I think you would still have your high and standard option, correct?

Senator BREAUX. Sure.

Mr. HUSTEAD. So as long as they chose one option at the beginning and shifted options, then I do not think you need a penalty. But if they do not choose any option and later on want to join, then you should have the penalty applied, yes.

Senator BREAUX. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Robb?

Senator ROBB. Thank you, Mr. Chairman.

Just a couple of quick, more generalized questions. I am not going to get into the plans right at this moment. I hope to be able to come back after a couple of appointments.

But Mr. Hustead, you made a statement, and I want to make sure that I understood it. It was in relationship to, in effect, being able to score the difference that preventive or other types of medical treatment brought about, or the advent of prescription drugs as a preventive part of medical treatment would be difficult to score, I guess is the easiest term, in terms of some off-subject benefit. That is not a very clear way of saying it.

But the concern I have, is I am left with the impression that, no matter how much we think we are improving the overall health, longevity, et cetera of an individual patient, that we do not have any means at this point of actually putting in, in some accountable fashion, the benefit that would accrue from the administration of prescription drugs.

Am I misinterpreting that, or is it just because of the difficulty of assessing which part of the treatment process is responsible for improvements in health condition, or whatever?

Mr. HUSTEAD. I am just saying that, in my experience, when you add a new coverage to a health plan, even though it is sometimes asserted that it will reduce other costs, that that rarely occurs. I really have not seen it occur. So in the act of extending insurance, you do not consider any offsetting savings and I would not do it here either.

Senator ROBB. All right. Let me just ask then one other broad question, if I may, that goes to process.

Ms. O'Sullivan, in your charts here and in all of our discussions, particularly when we are talking about the various percentages of poverty, we are able to compile data based on a look-back after the fact in terms of who is participating, and whatever the case may be.

Certainly for the States, for Medicaid eligible, they have a means of determining who is Medicaid eligible under the income formulas. But if we were to go to a plan that had a particular percentage of the Medicaid eligible who were eligible for either a reduced cost, no cost, limited co-pay, whatever the case may be, what kind of mechanism do we have in place today that could handle that kind of determination so that we could make decisions on real time and not a year after the fact, which may or may not encourage the kind of

activity that would improve the health of individuals? What is our range of options?

Ms. O'SULLIVAN. Well, Senator, currently we have the qualified Medicare beneficiary program and the specified low income Medicare beneficiary program. The eligibility for QMBs is 100 percent of poverty, and the eligibility for SLIMBs is 120 percent of poverty. That is administered by the States under their Medicaid program, so they do have a mechanism in place.

Arguably, these programs have not reached all of the people who meet the eligibility criteria, and there are various reasons advanced for that. Some people think, that it is viewed as welfare assistance. Particularly for the SLIMB program, it only gives you the advantages to have your Medicare Part B premium paid. Some people do not go through the full route.

But there is a mechanism in place for that level of eligibility. If you start talking about increasing the eligibility, going more toward 200 percent, you would have to determine what kind of an eligibility mechanism you wanted in place.

Senator ROBB. But at this point we would be relying on State eligibility determiners.

Ms. O'SULLIVAN. At this point we do for the QMB/SLIMB populations. Also, of course, the Medicaid population, which is why they also do the QMB/SLIMB.

Senator ROBB. But when you get into Medicare, you are talking about an exclusively Federal program.

Ms. O'SULLIVAN. Correct.

Senator ROBB. I am trying to figure out how we would administer that aspect of it and what kind of machinery, what type of hardware and software, we would need to have available.

Dr. SCANLON. Senator Robb, if I could add. We already do have a very extensive coordination of benefit capability that exists between Medicare and Medicaid because we have a large number of dual eligibles, and Medicare is the primary payor for many services. Therefore, claims for those services will go to Medicare first. The Medicaid eligibility will be noted on those claims, and they will be passed on to Medicaid.

Senator ROBB. But that is a determination that has already been made for the dual eligible, is it not?

Dr. SCANLON. That is likely the case under some scenarios that we will identify someone as being eligible for this benefit, and they will be eligible for that benefit for a period of time.

The real-time processing that I was talking about that the pharmacy benefit managers have today involves determination of eligibility for an individual prescription.

Senator ROBB. That is what I am talking about.

Dr. SCANLON. I think that is where the complication would come in for any of these programs because it is an issue of, have you met the deductible, is this a covered drug, have you exceeded a limit, what is your co-pay going to be. That is the kind of capability that we would have to either buy or build.

Senator ROBB. If we have any literature on the subject, it would be welcome.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Baucus, then Senator Mack.

Senator Baucus, first.

Senator BAUCUS. Thank you, Mr. Chairman.

I would just be curious of the panel's reaction to this. It seems to me that, given where we are and following on the basic observations of most here, including Senator Breaux, Senator Graham, and others, that we are not going to have wide-sweeping Medicare reform, we are not going to have a comprehensive prescription drug benefit passed this year.

So I am wondering, and along the lines of Senator Breaux, if we should just start off with something. It is the old thing, do not vent everything all at once, do not let perfection be the enemy of the good, but at least start out with something.

Also, because otherwise it is going to take a long time for some people who really need help to get the help. There is a lot of talk around here. Anything we do is going to take some time to implement.

So the thought is, because you in the panel have somewhat concentrated on people between 100 and 200 percent of poverty as the group that seemingly needs the help the most, that we target that group. It seems to be there are various ways to do it. One is through Medicaid, another is through Medicare, another might be a block grant.

I have a bill in through Medicaid. Basically, the thought is that those persons—my bill is 176 percent of poverty, but it can be any level—get prescription drug benefits through the mechanism of Medicaid.

Now, of course, there are problems doing that. First, it is not permanent, but it is intended, again, as a backstop for the time being. There is a mechanism already in place.

It does not provide stop-loss coverage, something that we are concerned with here. Medicaid does differ among the States, so there is that potential problem. But it does provide a benefit to those who need it the most, and it is available right now.

So my question is, your reaction, why not just start out with something like this, or block grant the States, maybe through Medicare as has been suggested? It just seems to me that maybe through Medicaid, something that is already there, as a temporary measure, we at least have done something that can be in effect next year. Otherwise, we are waiting around until 2003 before anything goes into effect. In the meantime, we can also perfect and think more clearly and constructively about what we want to pass.

Ms. O'SULLIVAN. Senator, I would only make the comment, if you add it to the Medicaid program, I do not know if you are talking about fully federally funded or not.

Senator BAUCUS. The same, Federal/State match.

Ms. O'SULLIVAN. Some States who have lower coverage levels now, probably lower income States, would have to bring up a larger portion of their population into the program and they might be somewhat reluctant to take on this new mandate.

Senator BAUCUS. What if we were to pick up all of the extra costs?

Ms. O'SULLIVAN. Well, that would be a different issue, obviously, Senator. You still have substantial variations among the States, both in terms of their eligibility cutoffs now, but also in terms of

the package of drug benefits. It is not insurmountable, but you have differences in cost sharing charges, et cetera, so you would essentially end up with 50 slightly different programs.

Senator BAUCUS. Well, slightly different is not that bad, is it?

Ms. O'SULLIVAN. No. I am not saying it is bad. I am just pointing it out as a design issue.

Senator BAUCUS. Is there anything good about it?

Ms. O'SULLIVAN. You would essentially be providing coverage to, as I was answering before the question of who you would cover if you would go below 200 percent of poverty. I do not have a 175 percent of poverty figure, but I do have——

Senator BAUCUS. But you know what I am talking about.

Ms. O'SULLIVAN. Correct.

Senator BAUCUS. Just the general principle, I am talking about.

Ms. O'SULLIVAN. You would be adding coverage or making coverage available for some persons who currently do not have it available.

Senator BAUCUS. All right.

Dr. Scanlon, your thoughts?

Dr. SCANLON. Certainly, the Medicaid program provides the immediately available apparatus with which to implement a drug benefit, because Medicaid is already paying for drugs. I think that is a distinct advantage.

The idea that you will pick up, or the Federal Government will pick up, the cost is certainly an important factor here, because I think as Ms. O'Sullivan indicated, there would be States that would be differentially affected and feel somewhat more reluctant to take this on.

A big piece of that, from the experience with the QMB and SLIMB populations, we realized that just offering this benefit or offering eligibility is not enough. There needs to be very aggressive outreach so that people are aware of it so they will enroll. So, that would be another piece of this.

Now, the management of the benefits can be very different than what I talked about in terms of how the private sector works. Medicaid works off of getting a rebate and paying for whatever drug manufacturers have.

Senator BAUCUS. That is good or not good?

Dr. SCANLON. We do not have exact data in terms of which one is potentially the most efficient. But, I think that what the private sector techniques are trying to target drugs that are effective, get better discounts, may be more effective in the long run. So we would be postponing our attempt to adopt those techniques in the public sector.

Senator BAUCUS. Thank you.

Mr. Hustead.

Mr. HUSTEAD. Well, Medicare, as we have been talking, is a very complex program. I would hope you could come up with a solution that includes prescription drugs in it. I do not know about what type of partial solution would be best, though.

Senator BAUCUS. What about the thought, seniors at 200 percent of poverty, Medicaid?

Mr. HUSTEAD. I really do not know.

Senator BAUCUS. All right. Thanks.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Mack.

Senator MACK. Thank you, Mr. Chairman.

Mr. Hustead, I want to go to a portion of your testimony where you, I think, made a major point, that in the control of drug benefits in employer-based plans, there is someone who really attempts to manage, or to watch closely, those benefits.

I raise the question in two areas. In FEHBP, how is it handled there, and is there any system similar to the employer perspective that would be taking a close look at the cost of prescription drugs in the Medicare program?

Mr. HUSTEAD. Both in FEHBP and in the private sector, I think a key to successful design has been the ability to consider the program as a whole, prescription drugs, inpatient, outpatient, to bring into play networks of physicians, and networks of physicians that understand the formularies. But you cannot change the whole Medicare program like that.

You have to keep, again, politically and equitably, access to the current A and B benefits with approximately the same cost. That means you have to design around the fringes, so the design within Medicare is going to be much more complicated. In the private sector and FEHBP, all of the benefits are considered as a whole.

Senator MACK. What do you think the likelihood is that, in the Medicare program, we will be able to achieve the same kinds of oversight cost savings that apparently are taking place in the private sector?

Mr. HUSTEAD. I think you probably cannot introduce a national plan with a closed formulary, so there cannot be the savings that you can achieve in the private sector there.

Where a program or different insurers can offer different options, as in the Breaux-Frist plan, then each insurance company operates by itself so you cannot achieve it there either.

So I think you start from a position that you cannot achieve the savings under prescription drugs in the Medicare program that you have been able to in the private sector and in FEHBP. The design does not work. But you can go a long way toward that by considering things that you can do within the open formularies, within using PBMs.

Senator MACK. Any additional comments?

Dr. SCANLON. I think I would say that, while it is going to be difficult to apply some of these private sector techniques to Medicare and there will be limits on how much we can apply, we should not forget the size of the Medicare program in terms of, if we apply these techniques on a limited basis, that leverage may result in some substantial discounts, even though they are not as effective in terms of steering utilization as a closed formulary might be.

Senator MACK. Let me move then to another area related to costs and savings, cost sharing, co-pays, and so forth. How effective have they been in the Federal employees' plan? Can we look forward to those approaches being effective in a prescription drug plan in Medicare?

Mr. HUSTEAD. I mentioned in the summary, and in more detail in the testimony, that the prescription drug card plan that you see

widely used in the private sector seems to work quite well for the employees; employers and employees both like it; it is a very simple approach of giving a card and having a charge of $5, $10, or $20, and it does seem to help achieve cost savings.

In FEHBP, in the Blue Cross program, there is also this differential between the drugs that are on the formulary and those that are not, and those do seem to work.

Now, the administration proposal does not introduce that difference. I am not sure why. So you lose a lot of the advantage of individuals at the counter saying, you can use this drug if you want but you have got to pay twice as much.

Senator MACK. All right. I had another question having to do with actuaries, but there is no way we are going to cover that in the time that I have.

The CHAIRMAN. Thank you, Senator Mack.

Senator Bryan.

Senator BRYAN. Thank you very much, Mr. Chairman.

A question for you, Ms. O'Sullivan. The 39 million people who are currently beneficiaries of Medicare. The benefits that are provided are universal. One of the issues, obviously, that we are going to have to deal with as we wrestle with this is whether to make the prescription drug benefit universal or to target it to certain income sectors.

In the context of that discussion, you and those of us who are on the other side of the table here often talk about 150 percent of poverty, 200 percent of poverty. With great respect to the dialogue we have had, most people out in the country do not have any idea what we are talking about.

So let me, first of all, make sure that my assumption is correct before I ask the question. If we are talking about 150 percent of poverty, we are talking about a couple with an annual income of about $17,000 a year. Am I roughly on target on that?

Ms. O'SULLIVAN. For 2000, for a couple, the Federal guidelines, is $11,250.

Senator BRYAN. Is $11,250.

Ms. O'SULLIVAN. For 100 percent of poverty.

Senator BRYAN. No. One hundred and fifty percent, was my question.

Ms. O'SULLIVAN. For 150 percent of poverty, it would be $18,788 this year.

Senator BRYAN. All right. And for 200 percent, it is something like $21,000, $22,000 a year.

Ms. O'SULLIVAN. Correct.

Senator BRYAN. So we are not talking about folks that have a whole lot of money. I think the perception that many people in America have in terms of poverty would be numbers that are very much lower than that. Most people think of themselves in that category as being very, very low income people. A $17,000, $19,000, $20,000 a year couple is not a lot of income.

So I guess the question I would have, of those 39 million, assume for the sake of argument we targeted the benefit at 150 percent of poverty, or 200 percent of poverty. How many people would be left out in that universe of 39 million Medicare beneficiaries?

Ms. O'SULLIVAN. Senator, based on our analysis of the 1996 data, if you went to 150 percent of poverty, you would offer coverage to 37 percent of Medicare beneficiaries. So, about 37 percent of that 39 million would have coverage.

Senator BRYAN. So nearly two-thirds then would not have coverage.

Ms. O'SULLIVAN. Well, you would pick up roughly 44 percent of those who currently do not have coverage.

Senator BRYAN. Let us do it in, how many will have coverage and how many would not at the end of the day? I think that is more helpful for us to understand.

Ms. O'SULLIVAN. All right. If you do not mind my using the 1996 numbers, Senator, and then extrapolate.

Senator BRYAN. Please. If that is the data that you have, we can extrapolate.

Ms. O'SULLIVAN. If you went to 150 percent of poverty, assuming that everybody enrolled, you would pick up 44 percent of those that do not currently have coverage and you would have a drug benefit available to 37 percent of the Medicare population.

Senator BRYAN. Thirty-seven percent would have it, 63 percent would not. Now, give us the 200 percent of poverty, if you can.

Ms. O'SULLIVAN. The 200 percent of poverty, is you would pick up close to two-thirds. You would pick up 64 percent of the people that do not have it now and you would offer coverage to 54 percent of the population.

Senator BRYAN. All right. So even if we went to 200 percent, 46 percent of the Medicare beneficiaries would not be covered by such a targeted plan. If we kept it at 150 percent, 63 percent would not have coverage. Am I correct on that?

Ms. O'SULLIVAN. That is correct.

Senator BRYAN. All right.

Ms. O'SULLIVAN. If you went to the 200 percent of poverty——

Senator BRYAN. It would not be subsidized. Yes.

Ms. O'SULLIVAN [continuing]. You would, of course, still have the people that would keep whatever they have now. So, using 1996 data, you would have 4.3 million that would be left without coverage.

Senator BRYAN. Well, I think it is important as we discuss this, the percentages—I think people tend to relate to income rather than 150 percent, 200 percent of poverty.

Dr. Scanlon, as you know, the pharmaceutical industry urges us in this approach to provide supplemental insurance subsidies, kind of a Medigap-type of approach. You have done a lot of work in Medigap.

Tell us, in terms of its cost, its availability, are there any risk selection factors there, what should we know before we proceed along that path, based upon your experience?

Dr. SCANLON. I think the most important factor to keep in mind is that Medigap is individual insurance and that, therefore, the administrative costs for the insurer, which are borne by the policyholder, are much higher than they would be for group insurance. So any time that you can choose group insurance, it is going to be a better deal.

Senator BRYAN. So cost would be higher. Administrative costs would be higher.

Dr. SCANLON. The costs are going to be higher.

What we have found in the past, is there is a major concern about people that would want a drug benefit as part of a Medigap policy, that they are people that are recognizing that they are going to have higher expenses and, therefore, there is adverse selection and the insurers need to protect themselves from that.

So something that is more universal gives the benefit of spreading risk across a larger population and keeps the costs down for individuals.

Senator BRYAN. How about affordability and availability?

Dr. SCANLON. Well, at this point in time the affordability of the Medigap plans that cover drugs is relatively limited. They are very expensive and they have a very limited benefit.

Senator BRYAN. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Jeffords.

Senator JEFFORDS. Thank you, Mr. Chairman.

Dr. Scanlon, like everyone else, I have tried to figure out why you can cross the border of Vermont into Canada and pay much lower prices for drugs. With group purchasing, costs are lower still. I know that part of the equation is how you spread the R&D.

But I would like your comments on another area: the huge increase in direct advertising. I believe the tab is about $2 billion per year.

How does that get recovered, and who is paying for it? We Americans or the Canadians? Where exactly does the money go, and how does it come back?

Dr. SCANLON. It is very hard to trace all of the dollars exactly, but I think the issue is in terms of, when an entity has some leverage in the marketplace, they are able to negotiate a better price.

It applies both to countries that negotiate on behalf of all of their citizens or specify the price they are willing to pay by fiat, as well as the pharmacy benefit managers that I was talking about that, if you have market power because you represent a large number of people, then you will be able to get a better price in the marketplace. It is the individual that walks into the drug store that is going to pay cash who faces the highest drug prices and has the greatest bit of difficulty.

The advertising is obviously something that becomes an expense to a drug company, an expense that they must feel is worthwhile in terms of the additional demand that it generates for the drugs.

We have heard concerns about how it adds to spending. We also hear concerns from physicians about how they do not like the fact that people come in and say, I heard about this drug and I need it for my condition, and the difficulties that it creates because the drug may not be appropriate for someone's condition. The information coming through the advertising is not enough information for a person to have before you make a judgment about whether you need a drug for your condition.

Senator JEFFORDS. Where are those costs recovered? Is it the purchaser, at whom the advertising is directed, who picks up that cost, or is it passed along some other way? Do you have any idea?

Dr. SCANLON. Well, again, trying to decide who pays what share of the cost of drug manufacturers is hard. The reality is, everybody who is a purchaser of drugs contributes somewhat. Those that are paying the higher prices are probably contributing more, so that the retail purchaser is likely contributing most to the cost of advertising.

Senator JEFFORDS. Should we be concerned about equity to purchasers, or is it something that is so involved with the market system that——

Dr. SCANLON. It certainly is involved with the market system. I think our primary concern to date has been the issue of the accuracy and reliability of that advertising, to make sure that the information is sufficient, that for consumers, and even more important the doctors who are the decision makers, have adequate information about the drugs to be able to prescribe them appropriately.

Senator JEFFORDS. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Jeffords.

Let me express my appreciation to the panel. We will keep the record open until close of business today for any written questions that may be submitted. I think all three of you have been extraordinarily helpful and we appreciate your continued advice.

Senator MOYNIHAN. Thank you, indeed.

The CHAIRMAN. We will now call our second panel, consisting of Alan F. Holmer, president, Pharmaceutical Research and Manufacturers of America; Charles Kahn, who is president, Health Insurance Association of America.

I am particularly pleased to welcome Alan Levin, who is chairman, president, and chief executive officer of Happy Harry's, and vice chairman of the National Association of Chain Drug Stores Board of Directors, and who was at one time associated with me. It is nice to welcome you, Alan.

Senator MOYNIHAN. Mr. Chairman, Happy Harry's does not sound like a pharmaceutical company.

The CHAIRMAN. You did not know his father. He was a great guy, and tremendously successful.

Next, we have Deborah Briceland-Betts, who is executive director of the Older Women's League.

It is a pleasure to welcome all four of you. Mr. Holmer, we will start with you, please. Nice to see you again.

STATEMENT OF ALAN F. HOLMER, PRESIDENT, PHARMACEUTICAL RESEARCH AND MANUFACTURERS ASSOCIATION, WASHINGTON, DC

Mr. HOLMER. Good to see you, Mr. Chairman, Senator Moynihan, Senator Breaux.

I guess, Senator Moynihan, I am pleased to be here as one of those interested parties that you referred to earlier. I hope at the outset that we can agree on at least four things. First, that expanded drug coverage for seniors is going to happen. The pharmaceutical industry wants to be a part of the solution to achieve that.

Second, expanded drug coverage for seniors will be a good thing, particularly because of the extraordinary value that our medicines provide.

Third, as we consider alternatives, we need to be sure that we do not disrupt the pharmaceutical industry's extraordinary record of success in bringing new breakthrough medicines to market. We cannot forget one fundamental fact: seniors want access to our medicines because they were invented.

Finally, we need to make sure that we always put the interests of patients first, addressing the needs of those who need access to our medicines, but also those who are waiting for the discovery of medicines that today exist only in our dreams.

We believe the best way to address this issue is to expand drug coverage for seniors as part, as we have heard before, of comprehensive reform of the Medicare program.

You have heard all of the reasons as to why comprehensive reform is so important, and I will not belabor them here. But we are very encouraged by the Breaux-Frist-Kerrey-Hagel bill. We think it is a good start.

We share the views of those, and Senator Breaux referenced this earlier, who are concerned that if we do the easy part first, if you add a drug benefit before addressing the hard issues in comprehensive reform, reform may never happen. My mom always taught me that if you eat dessert before your dinner, you may never eat your spinach.

Nonetheless, if this committee were to consider an interim drug benefit, we believe it is essential that it be consistent with, and a step toward, as you referred, Senator Breaux, to comprehensive reform.

In my testimony, I describe a set of principles of any incremental drug benefit. Now, it will come as no surprise to any members of this committee that the pharmaceutical industry believes that government price controls are unacceptable. They would inevitably harm our ability to bring new medicines to patients.

We urge you to say no to price controls, not direct price controls, not indirect price controls, not by accident, not by stealth, not by baby steps.

The answer, instead of government price controls, is vigorous competition on the private sector, resulting in freely negotiated discounts with each individual drug manufacturer.

Estimates of such private sector discounts range from 14 to 31 percent, estimated by Professor Grabowski of Duke, or 20 to 27 percent of those discounts estimated by the General Accounting Office.

Now, some have said that this is just too hard, that a private insurance program will not work, particularly because of the difficult challenge of adverse selection. So we asked the experts for assistance. We commissioned analyses by leading actuarial and economic firms, including Milliman & Robertson, Apt Associates, and Towers Perrin. These independent opinions are appended to my testimony.

They each conclude that a private prescription drug program can work if it is designed correctly, including various tools to minimize the impact of adverse selection that are described in my testimony.

We believe that a properly described prescription drug insurance benefit would attract many buyers and many sellers. Why are we so confident? Well, in the market today there are private insurance products for goats, for carriage rides, and for the weather on the

day of your daughter's wedding. There are private health insurance policies for cancer, sports accidents, emergency room visits, pregnancy complications, and campers.

We believe that there are similar opportunities for private market solutions to increase access to prescription drug coverage for the elderly and for disabled Americans.

Now, what I have tried to do, Mr. Chairman, is to highlight our industry's support for expanded drug coverage for seniors, but doing it the right way. Some say this issue is life or death for the American pharmaceutical industry, America's premier high-technology industry.

After the debate is over and the dust has settled, we will still have a pharmaceutical industry, but depending on what you do on this issue, the industry could be profoundly different and the results for patients could be demonstrably less.

So if I could leave you today just with one thought, let it be this. As the debate unfolds, I hope that you will remember the millions of Americans waiting impatiently for new cures and treatments. My children both have cystic fibrosis and our family is waiting, too.

We can provide quality health care for seniors and the disabled, including better prescription drug coverage, but we need to do it the correct way. If we do it the wrong way, the industry and the patients we serve will undoubtedly suffer the consequences.

Thank you.

The CHAIRMAN. Thank you, Mr. Holmer.

Next, Mr. Kahn.

[The prepared statement of Mr. Holmer appears in the appendix.]

STATEMENT OF CHARLES N. KAHN III, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, DC

Mr. KAHN. Thank you, Mr. Chairman, Senator Moynihan, Senator Breaux. I am Chip Kahn, president of the Health Insurance Association of America, and I appreciate the opportunity to be here today.

Drugs are essential for the treatment of many illnesses and conditions, but today's medical miracles do not come without a hefty price. This is particularly true for seniors. So HIAA stands ready to work with the Congress, to work with you, to help make prescription drugs more affordable for our seniors.

While about two-thirds of the Nation's seniors have some type of drug coverage, millions of Americans, millions of seniors, go without. HIAA agrees with the members of this committee that the Medicare program is in need of overall reform and that the long-term solution to the issue of drug coverage for seniors should be dealt with in the context of securing Medicare for the baby boom generation.

However, in the short-run, meaningful steps can be taken outside of Medicare policy to provide seniors with relief for their drug costs. We think that these principles should be followed.

First, that whatever policy is put in place should not disrupt the current private coverage that seniors depend on. Second, that no policy should preclude fundamental Medicare reform in the future

or foreclose options for including drug coverage into a restructured Medicare.

HIAA has developed a proposal that meets these objectives. It includes special assistance for low-income seniors, tax credits for out-of-pocket drug expenses for other seniors, and fair payments for seniors enrolled in Medicare+Choice plans which are struggling to provide drug coverage to their enrollees.

The HIAA believes this proposal can be put in place quickly, it would provide immediate relief for seniors, it would not disrupt the private insurance coverage options that beneficiaries now rely on, and it would not foreclose the options for drug coverage under a broader Medicare reform.

At the same time, as insurers we also know that some of the short-term proposals that have been discussed would provide coverage through new private insurance options or mandates. We believe these would do more harm than good, and at best the proposals are empty promises to the seniors.

Stand-alone drug-only insurance policies simply would not work in practice. Designing a theoretical drug coverage model through legislative language does not guarantee that private insurers will offer the coverage or that beneficiaries will purchase it.

I personally worked on the Balanced Budget Act in 1997, and there are provisions regarding Medicare+Choice, PSOs, private option, fee-for-service under Medicare which no insurer has yet taken up.

It should be noted that insurers are constantly looking for ways to better serve consumers. If this alternative or private option were a viable product, it would be offered today.

Let me highlight just some of the reasons why there are practical barriers to such coverage. First, adverse selection concerns may occur with any insurance coverage, but would be exacerbated in this case because the coverage would be limited to a very narrow benefit.

This is the case because there is a high probability that individual purchasers know what their use of drugs are in a given year. Seniors who expect low or no expenses will be reticent to buy the coverage, while those who know they will have sufficient drug coverage will want to buy it.

Consequently, premiums will be high. In many cases, seniors will simply be prepaying premiums for the drugs they will need. Adding to the problem of adverse selection would be in the nature of the drug benefit itself. The costs of drugs are increasing rapidly, and as the chart shows, it is difficult to predict how fast those costs will grow.

Imagine the bind an insurance company would be in if it had set a premium and had a policy based on government estimates on drug costs just last March. When the policy went on sale in September, they would have been met with the news that drug costs actually would grow 30 percent more than had been predicted just 6 months before.

The fact is, insurers are subject to rate regulation in every State and it is unlikely that State insurance commissioners would approve premium increases over time sufficient to keep pace with the

drug costs projected to grow in the double digits over the next decade.

Put plainly, some of the very groups who back this private insurance notion will likely lobby against the tools of managed care in Congress and the State Houses, such as tiered co-pays and formularies, that are essential to keep coverage affordable.

Let me underscore just a few additional regulatory hurdles that would make this option an even greater risk for consumers. First, if such policies were practical, it would take years to get to the market. Second, guaranteed renewability is a solid consumer protection. We would expect it to be extended to drug policies. The problem is, it would prevent insurers from leaving the business should this coverage turn out as badly as we predict.

Frankly, the industry is concerned that we would be caught in a class catch-22. Either we would offer the offer and get trapped by guaranteed renewability when we had to withdraw from markets, or we would not enter the market and we would get blamed for failing to meet the promise to ensure private drug coverage for seniors. Either way, it is not the insurance industry that loses, but the very seniors we all want to help.

We also oppose mandating coverage on Medigap, and I will be happy to discuss that in the question period, if you would like.

Finally, let me just say, in conclusion, that we believe a policy to help seniors is important, but it can be done outside the context of private insurance or outside the context of Medicare at this time.

Thank you.

The CHAIRMAN. At this time it is my pleasure to call on Mr. Levin.

STATEMENT OF ALAN B. LEVIN, CHAIRMAN, PRESIDENT, AND CHIEF EXECUTIVE OFFICER, HAPPY HARRY'S, INC., AND VICE CHAIRMAN, NATIONAL ASSOCIATION OF CHAIN DRUG STORES BOARD OF DIRECTORS, NEWARK, DE

Mr. LEVIN. Thank you, Mr. Chairman, Senator Moynihan, Senator Breaux. It is a pleasure to be here today.

My name is Alan Levin. I am president, chairman, and chief executive officer of Happy Harry's, a regional chain pharmacy company headquartered in the State of Delaware. We currently operate 43 community pharmacies in Delaware, Maryland, New Jersey, and Pennsylvania.

I am here today in my capacity as acting chairman of the National Association of Chain Drugs Stores, NACDS, and also as the owner of a regional chain pharmacy whose pharmacists provide health care services to thousands of residents in our market.

Collectively, the 143 chain pharmacy companies represented by NACDS operate over 31,000 community-based chain pharmacies, providing practice settings for over 94,000 pharmacists who dispense, today, over 60 percent of the 3 billion prescriptions dispensed annually in the United States.

NACDS and its members support expanding prescription drug coverage to all Medicare beneficiaries as a part of a comprehensive Medicare reform. However, we do not believe such form can be realistically enacted in this election year with the very limited legislative days remaining the session.

At the same time, however, we must recognize that millions of low-income seniors are in need of prescription drugs today. Every day our pharmacists see the consequences of seniors without prescription drug coverage.

So what can we do this year to help these seniors and not impede future progress towards meaningful Medicare reform? Community pharmacy organizations, pharmacists, consumers, and others are offering a plan called "SenioRx Gold." It is not a long-term solution. In fact, it is designed to sunset within 5 years to keep the debate focused on developing comprehensive Medicare reform.

Very simply, SenioRx Gold proposes Federal funding for a State-based prescription drug assistance program, designed to meet the needs of the most needy of our elderly, those at low income, about 7 million seniors who are at 200 percent or below poverty and who currently lack prescription drug coverage. As a group, these seniors have the highest out-of-pocket spending on prescription drugs and are the least able to afford them.

Our SenioRx Gold proposal is designed only as an interim, or stop-gap, approach. By providing Federal assistance to States that voluntarily elect to develop prescription assistance programs, SenioRx Gold gives the States the flexibility to meet the needs of 61 percent of those Medicare beneficiaries without prescription drug coverage.

In fact, SenioRx Gold would provide a more comprehensive benefit than other proposals. With no premiums, no annual deductible, and lower co-pays, needy seniors would not be deterred from participating.

Very importantly, SenioRx Gold would avoid the political and public policy problems of untested solutions that may represent empty promises for our seniors and could take years to implement.

Members of the committee, time does not permit me to elaborate upon all of the details of our program. These details are contained in the extensive written testimony which I have submitted for the record.

Let me close by focusing on the task before us. Members of the committee, the SenioRx Gold plan is not complicated. It builds on the success and simplicity of prescription assistance programs already in place in 15 States, and contemplated in 18 others. It is doable now and could provide assistance years sooner than would be possible from any proposal currently on the table.

Meeting the needs of our Nation's needy senior citizens should not, and must not, be a partisan pursuit; it is not a Democratic issue, it is not a Republican issue.

If members of Congress look at this challenge as a partisan issue, we are apt to face a debacle far greater than the Medicare catastrophic reform effort of 1988. Experience teaches us that slower is better when it comes to comprehensive reform, but the daily crisis of millions of seniors who need prescription medications cannot wait.

Senators, if you could join me at the beginning of the month when the majority of seniors visit our stores for their maintenance medications, you would see the anguish in their faces over whether to purchase the medication or to purchase food instead.

It is not unusual to hear them ask us to fill only half of their prescriptions, saying they will come back later in the month for the balance, knowing full well that they will not. But in their mind, these customers believe that some medication is better than none, even if it is not the full amount prescribed by their physician.

Mr. Chairman, members of the committee, the richest Nation on earth should not force its most vulnerable citizens to make this decision. It does not necessarily take courage to do the right thing, but it does take wisdom and a sense of reality that action is needed now for today's needy senior citizens, not years from now. After all, public service is what we in pharmacy and you in Congress are committed to providing.

Thank you.

The CHAIRMAN. Thank you, Alan.

[The prepared statement of Mr. Levin appears in the appendix.]

The CHAIRMAN. Now it is my pleasure to call on Ms. Briceland-Betts.

STATEMENT OF DEBORAH BRICELAND-BETTS, EXECUTIVE DIRECTOR, OLDER WOMEN'S LEAGUE, WASHINGTON, DC

Ms. BRICELAND-BETTS. Mr. Chairman, Senator Moynihan, Senator Breaux, thank you for the opportunity to be here today.

As the executive director of OWL, the only national grassroots membership organization dedicated solely to addressing issues unique to women as we age, I assure you that our members are fired up about this issue.

Women are, quite literally, the face of Medicare. Let me paint a picture for you of the typical Medicare recipient. She is 58 percent of the Medicare population at age 65, and 71 percent at age 85. As you know, the fastest-growing portion of our population is age 85-plus.

She is managing more than one chronic illness at a time. At age 65, 9 in 10 women have at least one chronic illness, 73 percent have two or more chronic illnesses. She is 75 percent of the elderly poor. Women's retirement income is almost less than half of men's, with a median annual income of less than $10,000.

She is paying an average of 22 percent of her annual income, or about $218 a month, for out-of-pocket expenses such as prescription drug and supplemental health insurance. This compares to 17 percent for male Medicare recipients.

Women with incomes of less than $10,000 and no Medicaid spend an average of 53 percent of their income out-of-pocket on medical expenses. But I want to be clear here today: access to prescription drugs is not simply a problem for the poor.

Over half of older Americans who lack prescription drug coverage are above 150 percent of poverty. While older Americans comprise only 12 percent of the U.S. population, they account for one-third of all prescription drug spending.

These are people like OWL member Dee and her husband Chuck, who are from Cleveland, Ohio. Dee is 85, has high blood pressure, heart problems, and arthritis. Chuck is 89. He has glaucoma, heart problems, and also arthritis.

They have $2,100 monthly income. They pay Medicare premiums and they have a Medigap policy, but they cannot afford one that

includes prescription drug coverage so they spend $500 monthly on prescription drugs.

Chuck is well-known for taking one pill a day instead of the prescribed two, and taking one pill every other day instead of every day, so that his medication and their income stretches further. Dee has a prescription for heart medicine that she just has not filled because it is too expensive. This couple and their illnesses are not exceptional.

I must stress that the catch-22 decisions are not limited to the poor. The barriers are very real for those with moderate incomes like Dee and Chuck, and simple Medicaid enhancement will, therefore, not solve the full scope of the problem.

It is also obvious that existing approaches to this issue are not enough. Medigap coverage is limited and spotty, and I certainly do not have to tell the members of this committee what a serious issue that is in rural areas.

HMO coverage is decreasing and often unreliable and employer-sponsored coverage is just plain declining. One in every three Americans over age 65 has no prescription drug coverage, and millions have only limited coverage which is slipping away as HMOs and company retirement plans cut back or drop altogether their drug benefits.

It is not an issue of being uninsured. Older Americans find today's prescription drug coverage unaffordable, unreliable, or just not very meaningful and they are afraid.

OWL strongly believes that prescription drug coverage for seniors is needed to modernize Medicare. OWL's principles for coverage include a benefit that is universally available to all Medicare beneficiaries regardless of income, voluntarily allowing beneficiaries to keep their current coverage if they choose to do so, affordable, with premiums, co-pays, and deductibles that are within reach of all seniors, part of a defined benefit package of a modernized Medicare program.

It must assure access to medically-appropriate drug therapies, including high-end, cutting-edge drugs that many older women need in order to manage their chronic illnesses.

It should be indexed to inflation to ensure that coverage keeps pace with the rising cost of prescription drugs. Beneficiaries are not unwilling to see changes in Medicare. In fact, OWL supports changes that would make the program more competitive without altering the integrity of the program.

OWL members are willing to help pay the cost of this new benefit through cost sharing and deductibles under Medicare. However, we must caution that making those too high would likely discourage many women for whom out-of-pocket health expenses are already a hardship from seeking the health care they need.

Proposals to provide a set of money to purchase Medicare coverage would unfairly disadvantage women who could not afford the high cost of comprehensive coverage. Frankly, if prescription drug coverage is available but not affordable, it just does not work. Medigap is an excellent example of this concept. It is available, but most people do not buy because they just cannot pay the bill.

Whenever prescription drug coverage is discussed, there is always an 800-pound gorilla in the room, the issue of price controls. Truthfully, we know this cat is already out of the bag.

As representatives of the American people, I know that you, as members of Congress, are struggling to give your constituents an answer to these simple questions. Why do Americans pay more, and what can be done to reduce the disproportionate burden on American consumers? Any reform measures you adopt should also address these key public concerns.

I respectfully urge that in undertaking any type of Medicare reform, policy makers develop a program that reflects this simple fact: women are the face of Medicare and if it does not work for women, it just does not work.

Thank you.

[The prepared statement of Ms. Briceland-Betts appears in the appendix.]

The CHAIRMAN. Thank you.

Mr. Holmer, Ms. Briceland-Betts raised a question on the minds of many, and that is, why are the costs of drugs higher in this country than in Canada? I have to say that this is a matter that I constantly hear about, not only from my constituents, but from others throughout the country. What is your answer?

Mr. HOLMER. The principal reason why prices are lower in Canada than in the United States is because the Canadian government, at both the Federal Government level and the provincial level, have price controls.

They have a very poor health care system, including as it relates to prescription drugs. They have a system that is kind of anti-innovation. It has all of the innovation and creative thinking, I think, of Soviet agriculture in the 1950's.

Eighty percent of Canadian seniors say their system is in crisis. Out of the 29 OECD countries, Canada ranks fifth with respect to health care expenditures, yet they are on the bottom third with respect to available medical technology.

The Frazier Institute out in British Columbia recently issued a report that said that 27 percent of the physicians in British Columbia say they have had to send a patient to the hospital or to the emergency room because of mandatory drug switching that was required by the government.

So, yes. Often for innovative medicines prices are lower in Canada once they are available, which is much slower in Canada than it is in the United States. But it is at a very serious price, I think, to Canadian patients, which is why you see so many Canadian patients streaming to the United States for treatments here.

There is one other aspect of this, and it is quite complicated. It relates to the whole question of exchange rates. When my staff talked about that I said, well, no, it cannot be that big a deal. But we went back and did a case study.

We said, suppose, Mr. Chairman, you were the marketing manager of a drug company and you decided that you wanted to be able to sell the product at the same price everywhere in the world, and you did it in 1991.

You said, all right. We are going to bring this product to market and it is going to be for one dollar a pill in the U.S., in Canada,

in Mexico, in the U.K., and in Germany. If you did that in 1991 and everything else stayed the same, here is the impact of exchange rates that it would have had.

It still cost one dollar in the United States, it cost $1.10 in the U.K., but it cost 83 cents in Germany, it would cost 77 cents in Canada, and it would cost 33 cents in Mexico, solely because of the exchange rate changes.

So, clearly, it is a difficult issue. It is a difficult political issue. I believe the best thing that Congress can do to address that is to provide group buying power for our senior citizens through the private sector and allow them to be able to have the same kinds of discounts that those that are currently in HMOs or in the Federal Employees Health Benefit Program have.

The key is drug coverage, and that is why we are encouraging you to proceed with the Breaux-Frist bill in your committee.

The CHAIRMAN. Now, you said Canada has price controls. Does that mean we should not adopt price controls?

Mr. HOLMER. Certainly that is one possible answer to the problem. You have heard all of my arguments before with respect to price controls. Actually, we have a chart that I would like to be able to share with you again; Senator Moynihan, you liked this the last time that I was here.

What this chart shows is the increase in research and development expenditures that occurred over the course of the last two decades. This was the percent increase. Normally you will see that percentage bumping along at the 12–14 percent range, but you will see a big drop-off. You cannot see the numbers from there, but the big drop-off occurred in 1994 and 1995.

I wonder what happened about that time that might have caused there to be a reduction in research and development? It was the time when you had Clinton health care and when there was very serious talk about price controls being imposed on the American pharmaceutical industry.

It is patients that are going to be harmed if you have price controls because of the adverse impact it will inevitably have with respect to research and development by our companies.

The CHAIRMAN. Let me ask you this, Ms. Briceland-Betts. Do these answers satisfy you?

Ms. BRICELAND-BETTS. When we talked to the pharmaceutical companies over a year ago, the pharmaceutical companies told us it was research and development. I think once beneficiaries started saying, why do we have to foot the bill for all research and development, we are now beginning to hear some other kinds of things.

I think that, while OWL has not taken a formal position on it, that the idea of group buying power certainly is one that needs to be explored, but it is not the complete answer to this issue.

The CHAIRMAN. Let me ask both you, Mr. Holmer and Mr. Kahn. Last year, Senator Moynihan and I wrote a letter to your industries asking you to work together and with other interested parties to reach some sort of a consensus on a rational, efficient, high-quality prescription drug benefit for Medicare.

Have you reached any consensus that you can share with the committee?

Mr. HOLMER. I will jump in, then turn it over to Chip. You may assume from our respective testimony that there is no agreement at all, and that would be a misimpression. Let me just tick off the things where it seems to me we do have agreement.

I think we agree that there should not be price controls. I think we agree that there should be choices for beneficiaries in the marketplace. There should be access for all to the kind of plan that you have put together. There should be flexibility in benefit design.

There should, of course, be adequate funding. There should be special help for those in need. There should be integrated health care budgeting, that is, considering medicines at the same time you consider doctors and physicians.

Mr. Kahn, I do not want to put words in your mouth, but based on the conversations that we have had and with others, my sense is that we do have agreement on some of those core items.

Mr. KAHN. I think Alan did a good job of outlining the principles that we agree on.

The CHAIRMAN. Could I interrupt there, because time is running out. Periodically we get proposals from the administration, but they just tough a number of points and it is not a comprehensive, well-reasoned thought.

What we are asking for, what our letter was intended to secure, is a rational, efficient, high-quality prescription drug benefit. So I know in developing it is important to go through and agree on various aspects, but what we want is your recommendation as to a comprehensive plan.

Mr. KAHN. Mr. Chairman, I think we got as far as we could under the circumstances. But the trouble is, we do separate——

Senator MOYNIHAN. But you have not written us to tell us that.

Mr. KAHN. My understanding is that——

Senator MOYNIHAN. We wrote you. [Laughter.]

Mr. KAHN. I wrote back and outlined the principles.

Mr. HOLMER. Senator Moynihan, I believe what happened, and if I am mistaken I apologize to you. You all did write to us, we were grateful for that. Karen Ignagni, from the American Association of Health Plans, convened a meeting.

I believe Karen assumed the responsibility for communicating back to you on behalf of the group, and I know this has been communicated as well orally to your staffs about the conversation that previously occurred.

Mr. KAHN. I sent a letter, I know.

Senator MOYNIHAN. Let us get back to the question of Canadian prices.

Mr. HOLMER. We take your letters very seriously, I just want to assure you of that.

Mr. KAHN. I think that actually we agree with the pharmaceutical industry on the issue of price controls. I guess where we have a problem, is that when we talk about any kind of individual insurance product we are talking about a product whose rates are regulated right now by the States.

This is a product that we are talking about here that would be heavily regulated. We are just concerned that it is not something that we can provide to consumers in a workable way, considering the constraints we are under. That is why HIAA suggested ways

of dealing with the drug cost problem for seniors outside of insurance.

The CHAIRMAN. Let me turn to you a minute now, Alan. My time is running out. But the National Governors Association recently adopted a policy stating that, if Congress decides to expand prescription drug coverage to seniors, it should not shift that responsibility or its cost to the States.

Now, given that cautionary note, does your association have any reason to believe that States would choose to participate in an optional State-based delivery system?

Mr. LEVIN. Mr. Chairman, as I said in my remarks earlier, 15 States are currently providing a prescription assistance program to their citizens that are at the 200 percent or below level today, number one.

Number two, 18 other States are contemplating the same. We are not asking to shift this burden. We are not asking the Federal Government to shift this burden. In fact, we are asking the Federal Government to help share the burden, with roughly 74 percent of the cost of these programs.

So I do not believe that there would be a problem with the States that are involved. In fact, I think they would welcome the involvement here.

Mr. CHAIRMAN, if I could just add one thing on the prior discussion that you had with Mr. Holmer. I would defy this committee to find a single-source drug—meaning a drug that is not available generically today—that was introduced in 1991 that would still cost one dollar, that has not had at least 5 to 10 different price increases over the last 9 years. We see price increases every six to 8 months coming to our stores, number one.

Number two, I would also remind this committee that the net profit of pharmaceutical companies today, on average, is 17.2 percent, and that is after taxes. That is with 20 percent spending on research and development. The net profit of our industry, on average, is 2.4 percent. We do not have any research and development, but to be quite frank with you, we do not have any fluff, either.

So I just think I could remind the committee of that. We are not asking for price controls, however, there can be cost management.

The CHAIRMAN. Mr. Holmer wanted to make a comment.

Mr. HOLMER. If I could just respond on the question of price increases. There is often great confusion about this.

In 1999, pharmaceutical expenditures went up 19 percent in the United States. A 19 percent increase. Of that 19 percent, 11 percent was because of increases in volume. We ought to be pleased with that because that means patients are now getting medicines that they were not getting before. Four percentage points was a result of shift from older, less effective, less expensive medicines to newer, more innovative, more expensive medicines.

And 4 percent was a result of price increases. When you look at the level of price increases that has occurred over the course of the last 5 or 6 years. I would disagree with the commentary made by Mr. Levin. Those percentage increases were in the 1 percent, 2 percent, or 3 percent range.

The big increase that you see in pharmaceutical expenditures is because of the shift to the newer, better medicines and because of the increases in volume.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Yes, sir. It is getting towards 1:00 and we have kept our audience and our panelists a long while, so I shall be brief.

Mr. Holmer, I do not think you completely answered Mr. Levin, but that is all right. You said there were price increases.

Mr. LEVIN. Yes, sir.

Senator MOYNIHAN. You said there was an increase in the amount of expenditure. Those are two different things.

Why do you not get that data for us? It is very important.

Mr. HOLMER. I would be pleased.

Senator MOYNIHAN. And, sir, could you help review the data?

Mr. LEVIN. Absolutely.

Senator MOYNIHAN. Yes. And Ms. Briceland-Betts and Mr. Kahn. This is something we ought to be clear about.

I would like to say to Mr. Holmer over there, that you had better get that Canadian story a little straighter. I mean, this is becoming part of our mythology, that Americans rush to the Canadian border, are crossing the bridges at Ogdensburg to get their medicines cheap on the other side, and it must be some terrible conspiracy, to set prices differently here.

An economist would say that your research and development is your fixed cost, and once you have met that you will sell in other markets at just marginal return. It is just, in volume, we will produce some profit and therefore you have the difference in prices.

Let us be open about this and tell us about Canadian price controls. We are not your enemy here, we are friends. I would like to say here and now, whoever produced Celebrex is a friend of mine, for arthritis. [Laughter.]

That table you produced in Attachment 4 on R&D expenditures is pretty impressive. It says, in 1995 R&D abroad has really not moved, and it has doubled in the United States. We now have about 90 percent of all R&D outlays. That surprises me.

Mr. HOLMER. And again, this is the R&D by the American-based companies.

Senator MOYNIHAN. Yes.

Mr. HOLMER. In terms of what they do. But what you will find, is when you talk to a CEO of a pharmaceutical company, be it in the United States or in Europe, there are not any Canadian pharmaceutical companies, which goes to the question of innovation.

But when you talk to them about, where do you want to be able to establish your new investment, your new R&D, your new plants, your new sales force, it is the United States because we have got the environment here that nurtures innovation.

Senator MOYNIHAN. Well, that would seem to be the case. But the more we hear about the numbers, the better we will feel about it. I think I can speak for the Chairman: price controls are not something we want. They would be something we would very much not want. But, do not think they are not possible. We vote around here.

Mr. HOLMER. And Senator, if I could just put a seed in your head, and it goes back to the work that you and I were involved with when I was Deputy U.S. Trade Representative and we worked so hard on the U.S.-Canada Free Trade Agreement.

Senator MOYNIHAN. Right.

Mr. HOLMER. We do not like the fact that there are price controls at the Federal level or at the provincial level in Canada. We do not like the fact that there are price controls or profit controls in Europe.

If there was a way for us to work with you collaboratively in terms of trying to address those foreign countries that do have price controls that have an adverse impact, both on our industry and also potentially with respect to patients, we would love to have a chance to be able to work with you on that.

Senator MOYNIHAN. We will think about it. Welcome. Thank you all.

The CHAIRMAN. Senator Breaux?

Senator BREAUX. Thank you very much, Mr. Chairman. I thank the panel members for their testimony. It has been very helpful.

I have always been impressed by the arguments of some that it is easier to get drugs in other countries at a cheaper price. I know people in my area have taken trips down to Mexico. I mean, you can get cheaper drugs in Mexico. You can get cheaper open heart surgery in Mexico, but I am not sure I would want to go down there to get that.

But I saw a study once that indicated that, when you are looking at the amount that Mexican citizens, Mr. Holmer, pay for their prescription drugs in their country, that they, in fact, pay a higher percentage of their disposable income for their medicine than we do in this country as a percentage of our disposable income.

So it is a real big difference when someone with an income for a U.S. citizen goes down to a very poor country and buys drugs. Is that a function of the marketplace, as the reason why they are less expensive down there? You sell them what you think the market will bear, and the same thing is true in this country?

Mr. HOLMER. That is the case with respect to Mexico. I think they have a substantially lower standard of living there than exists in the United States. While the companies make their own individual decisions about pricing practices, for the most part if you were to say, we will take it at the U.S. price and sell that in Mexico, there would be very few buyers for that product in Mexico and, therefore, the standard of living does have an effect.

I would like to submit for the record the chart that you referred to which shows, in terms of the number of hours worked, as I recall it is about maybe 1 or 2 hours, on average, for U.S. and Canadian patients, but it is more like 8 hours worked for a Mexican patient to be able to get a similar product because they have a much lower standard of living.

Senator BREAUX. Well, I would like to have that for the record.

[The information appears on page 142 of the appendix.]

Senator BREAUX. I take it that that same type of targeting, I guess, Mr. Levin, is also at the retail level as well because I saw a study once on the different prices that retail drug stores, for instance, charge for the same product in the same areas.

In the New Orleans metropolitan area as an example, the retail price of Zocar, among about 12 retail stores in the area for the same number of 30 tablets, ranged from $95 to $137, a 44 percent difference among the retail outlets.

On the drug Narvosec, there is an example of 30 tablets, the same size, prices range from $56 to $84, a 50 percent difference. Is that just targeting your prices to the availability of the consumer, I guess?

Mr. LEVIN. I do not believe that is the case, Senator.

Senator BAUCUS. Why would there be such a discrepancy in the same area for the same product that they bought at the same price?

Mr. LEVIN. I cannot answer that for you, Senator, to be quite frank with you. In my company, we have one price for everyone and it is across the board.

Senator BREAUX. Regardless of the geographic area.

Mr. LEVIN. Regardless of the geographic area. But I will tell you this, I do not believe you can isolate several products. I think you have to look at the whole, Senator.

Senator BREAUX. I could give you a whole bunch.

Mr. LEVIN. No, no. I understand that. But what I am trying to say to you is, there are well over 2,500 drugs that we sell in the pharmacy. I can honestly tell you——

Senator BREAUX. I will bet you a dollar to a donut that the difference is about the same on all of them.

Mr. LEVIN. Well, not on a geographic basis, to be honest with you, Senator.

Senator BREAUX. Well, your company does not do that.

Mr. LEVIN. Well, no, we do not, to be quite frank with you, Senator.

Senator BREAUX. All right.

Mr. LEVIN. But what I can tell you is, that if you look at the gross profit today and what it was 5 years ago, our gross profit 5 years ago was in the average of around 28 percent. Today, it hovers at 19 percent.

We still have a cost for each prescription, regardless of whether we are filling a prescription that the ingredients only cost us a dime or costs us $100. It still costs us well over $6 to fill every prescription.

Senator BREAUX. I do not want to debate that.

Mr. LEVIN. No, I understand that, Senator.

Senator BREAUX. It is not that big of a point. But there are vast differences among drug stores when they buy at the same price from the manufacturer, to what they retail to their consumers among some drug stores. Yours has a uniform price, I take it, nationally.

Mr. LEVIN. Yes, sir.

Senator BREAUX. Mr. Holmer, Senator Jeffords brought up the question of direct-to-consumer advertising. I was reading in Health Affairs an article that has the premise, I guess, that the explosion in drug advertising to consumers—as an example, companies spent $905 million in direct-to-consumer advertising in 1999 in the first half of last year, which is a 43 percent increase over spending a year earlier.

Their thesis is that this explosion in direct-to-consumer drug advertising is changing the physician-patient relationship, and they would argue that the clinical quality of care is harmed by direct-to-consumer advertising.

What is the position of the industry on that? I take it is not FDA regulated.

Mr. HOLMER. I am sorry?

Senator BREAUX. I take it it is not FDA regulated. When I watch an ad, when Bob Dole tells me to buy a certain product, I sort of have to assume it works. [Laughter.] But FDA does not pre-screen your ads before they go on television. The principle is that the clinical quality of care is harmed by the advertising.

Mr. HOLMER. Right.

Senator BREAUX. What is the industry's response to that?

Mr. HOLMER. I think the industry's response is the opposite of that. While there is no pre-screening by the FDA, the FDA does review those ads and if there are problems they are in touch with the company directly.

I think the most important aspect of this is that direct-to-consumer advertising really helps empower patients with information so they can have more informed conversations with their doctors.

Let me just give you some news from a Prevention magazine study that was done last year. They found that 76 percent of Americans believe direct-to-consumer ads helped them become more involved in their health care. That is a good thing.

They estimate that 25 million Americans saw a direct-to-consumer ad and, as a result of seeing that ad, they went and had a conversation with their physician about a condition they had not previously spoken to the physician about.

We have a major problem in this country with respect to under-treatment and under-diagnosis of disease; six million Americans have diabetes and do not know it. One-third of the people who have depression never seek treatment for it.

Senator BREAUX. I understand. You make a point that it is a better-informed consumer. I guess the other side would be, the consumers do not really have the medical ability to determine which drug is the best for their particular problem.

Mr. HOLMER. Absolutely. The physician still has the prescribing pen and he can indicate yes or no and have a conversation. But the consumer, the patient, will be more informed.

Senator BREAUX. Thank you.

Mr. Kahn, your message comes through loud and clear that you all do not want to be in the business of insuring prescription drugs. I guess, one of the things I have seen in the studies indicated that about 79 percent of the prescription drugs that are sold in this country are covered by insurance in various plans, not just for Medicare. So the insurance industry is already, in a very big way, covering prescription drugs for consumers as part of an overall health package.

I can buy insurance in New Orleans to make sure I do not get hit in the head by a coconut during Mardi Gras. I mean, literally. I have seen the policies. [Laughter.] That is a whole other story.

But you can buy insurance for just about everything that you could ever think of possibly happening. I am concerned that, when

you talk about high-option policies for prescription drugs, that somehow this great industry you represent says we do not want to have any part of it. Would it make it any more receptive to the industry if the ideas of a drug-only insurance policy would be exempted from State regulation?

Mr. KAHN. First, I think it would help, but there are still going to be rules, guaranteed renewability, which you are going to want to have at the Federal level if you did not have it at the State level. But I think that the issue you raised, the chance of you being hit in the head by a coconut is great if you are watching "Zulu," but it is not something you can have any certainty about.

Whereas, if you have heart disease, or you have arthritis, or you have diabetes and you are a certain age—or any age, actually, you can pretty well project for a given year what your expenses are going to be. That makes it much more difficult to write insurance.

Also, it is true that most Americans, non-elderly Americans, have some kind of drug coverage. But if we look at drug coverage today, first, it is all part of a package. It is not individual. It is not isolated out there.

If you look at drug coverage, as great and as important as drugs are, for any CEO of any of the companies that I work for, it is their current sore thumb. The 19 percent, for whatever reason that Alan is talking about drug costs going up, are really causing problems for keeping premiums for employed Americans affordable.

So we are talking about the problem area, and we have got tools, and they are formularies and we have got tiering of co-payments. But with all due respect to one of the previous witnesses, one of the big complaints that we hear from consumers is that they do not like the tiering, they are not happy with the co-payments on drugs.

I know, myself, I have got to pay $25 for a particular drug that I take regularly instead of $5 because it fits in the highest tier, and I am dissident about it.

So it is one of the issues that is causing insurance companies general problems with consumers. I guess when you look at the areas of coverage we could get into, this is one that experience in other areas is telling insurance companies is a big problem. We would like you to find a different way to solve it.

Senator BREAUX. I would just close with a comment. I think that all of the plans that I have seen do not mandate that anyone in the insurance industry get involved with the business of offering these proposals for coverage of prescription drugs.

I think that the industry is bright enough, and smart enough, and sophisticated enough, and has a history of being able to insure things, that if we set out a proposal that would allow companies to do this, that you will have takers. You will have companies participating.

If we offer the right to insure for prescription drugs, there will be companies that will step up to the table and figure out a way to do it that keeps them in business and makes a profit, yet provides insurance for something that is so important.

We heard the same arguments when we started Medicare, really, when it was going to be difficult to figure out how much doctors cost, or hospital beds cost. Insurance has done a great job of covering those things.

Now medical science says prescription drugs are more important than a hospital bed. I bet we that are going to be able to figure out a way to cover it as well in a profitable way.

Thank you.

The CHAIRMAN. Thank you, Senator Breaux.

Let me express my appreciation to the panel. I apologize for the lateness of the hour, but we had a vote first thing this morning. I think this has been an excellent panel, and we appreciate your contributions.

Senator MOYNIHAN. Very much.

The CHAIRMAN. The committee is in recess.

[Whereupon, at 1:07 p.m., the hearing was recessed.]

PRESCRIPTION DRUG BENEFIT IN THE MEDICARE PROGRAM

WEDNESDAY, MARCH 29, 2000

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:36 a.m., in room SD–215, Dirksen Senate Office Building, Hon. William V. Roth, Jr. (chairman of the committee) presiding.

Also present: Senators Hatch, Jeffords, Mack, Moynihan, Baucus, Rockefeller, Breaux, Graham, Kerrey, and Robb.

OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will please be in order.

We are very happy to have such a distinguished panel before us. This is our second hearing on the inclusion of prescription drugs in the Medicare program. We are particularly pleased to take testimony from several of our colleagues, as well as a representative of the administration.

These witnesses are joined by the common thread of having authored Medicare reform on drug coverage plans that have been in the public arena for consideration for several months.

We will then conclude with expert testimony drawn from States and the private sector on lessons in designing and administering a major drug benefit. These witnesses will build upon the testimony provided last week by GAO.

That testimony indicated, in part, that Medicare could experience virtually a doubling of its administrative work load if a drug benefit is enacted and it requires the agency to manage a variety of new functions.

With that, I am pleased to turn to Senator Moynihan.

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK

Senator MOYNIHAN. And we are looking forward, Mr. Chairman, to our expert panel of colleagues, followed by another panel of experts. I see Senator Kennedy, who has been at this for so very long, and so honorably and so well.

My dear colleague, Senator Wyden, will not be able to speak just because there is no room, but Senator Snowe will speak for him. Let the games begin.

The CHAIRMAN. We will start with the rule, ladies first, and call upon Senator Snowe.

STATEMENT OF HON. OLYMPIA J. SNOWE, A U.S. SENATOR FROM MAINE, ACCOMPANIED BY HON. RON WYDEN, A U.S. SENATOR FROM OREGON

Senator SNOWE. Thank you, Mr. Chairman. I appreciate this opportunity to allow all of us to be able to testify on what is one of the most significant issues, I think, facing our senior citizens in this country.

I am pleased that Senator Wyden and I could be here today to address the legislation that we have introduced on a bipartisan basis called the Seniors Prescription Insurance Coverage Equity Act, known as SPICE.

I want to commend you, Senator Roth, as Chairman of this committee, Senator Moynihan, and members of the Senate Finance Committee for the herculean efforts that you have engaged in over the years in preserving the quality and the integrity of the Medicare program, as well as the program's long-term solvency.

I am pleased to be here with so many distinguished colleagues to discuss this issue here today. I think that the number of approaches that are on the table underscore the fact that it is not a question of whether something should be done on prescription drugs, it is a question of how and when to best address this issue.

I think in 1998 there was a telling statistic that showed that the most significant increase in health care categories was the increase in prescription drug costs. In fact, in 1998 it was 15.4 percent.

Consider the burden that is placed on senior citizens, particularly those who are over 65 who pay half the costs associated with their prescription drug costs as opposed to those seniors who are under 65 who pay less than a third.

So I guess it should come as no surprise then, according to a recent study in the latest addition of the Health Affairs, the average senior citizens now pays more than $1,100 every year on medications. The latest HCFA estimate shows that 31 percent of all Medicare beneficiaries are without drug coverage, or 13 out of 40 million Americans. So you can see why this becomes a very, very difficult problem and why it requires a solution.

Well, who are these seniors? According to testimony that was presented to your committee last week, it is those people caught in the middle—those who are neither wealthy enough to afford their own coverage, nor poor enough to qualify for Medicaid.

As Jennifer O'Sullivan, the CRS specialist, testified before this committee, the lowest levels of coverage were for persons between 100 percent and 200 percent of poverty. These people are the least likely to have employer-based coverage, Medicaid coverage, or their own money.

Medicaid, obviously, is not the answer. According to the Urban Institute in 1996, 63 percent of beneficiaries eligible for qualified Medicare beneficiary protections—that is, those people who are under the Federal poverty level—actually receive those protections, whereas only 10 percent who were eligible for the specified low-income Medicare beneficiary protections are receiving that coverage.

In addition, only 16 States in the country, including my State of Maine, have a specific drug assistance program.

So then you take a look at Medigap. Three out of the 10 Medigap supplemental insurance plans provide for prescription drugs. Yet, only 14 percent of those people who are purchasing one of the 10 standardized plans even purchases one of the three that includes prescription drugs. Well, why? Because they have high co-payments, as well as high deductibles.

Senator Wyden and I looked at all of the statistics and where we are today, to decide what path do we want to take with respect to providing coverage. We looked at the traditional approach of including it in the Medicare program and decided that, given the complications, and the solvency questions for the short and the long term, that it would behoove us to set up a structure outside the Medicare program. At the same time we would preserve the most important strength of the Medicare program, and that is universal coverage. We happen to believe that anyone who is eligible for Medicare should be able to choose and participate in a prescription drug benefit program.

In addition, we thought that structuring our program outside of Medicare would maximize our choices and minimize the cost. In other words, we do not want to create another layer of bureaucracy.

We know that HCFA really dictates, I think, the choices in health care when it comes to our seniors. But in today's medicine we are seeing more innovation, more creativity, and I happen to think that we have to respond that way when it comes to developing a prescription drug program.

We know that an open-ended entitlement can be very costly, in addition to which it certainly could discourage flexibility in innovation. That is why we decided to structure a program on something that we are all familiar with as members of Congress, and that is the Federal Employees Health Benefit Plan. So we decided to create a program that is structured on competition and choice, and similar to the Federal Employees Health Benefit Program, we would design an independent board that would report to the Secretary of Health and Human Services.

The board would determine the criteria, issue it to the private insurers. They then, in turn, can develop different plans based on formularies, multi-tiered formularies, the specific needs of consumers—in this case, senior citizens. Some may use more of certain types of drugs than others—so that we have more competition and more choices available to senior citizens.

In addition, just like in the Federal Employees Health Benefit Plans, anybody would be able to choose from an array of plans. We would subsidize the premium. Beneficiaries at or below one hundred and fifty percent of poverty level would be fully subsidized. The subsidy would be phased down for beneficiaries between 150 and 175 percent of the Federal poverty level. The subsidy would be phased down to 25 percent, for those at 175 percent of poverty level and above.

The SPICE board would disseminate the information about the type of plan and what would be offered. They would oversee it in that respect. People could pick and choose. They could decide to

add to their Medigap plan, or the Megigap+Choice plan, depending on their needs.

We think that this will offer a great deal of incentive to the private insurance companies by opening up a potential pool of 39 to 40 million Medicare beneficiaries by offering specific plans that could attract and retain enrollees.

So the arguments that some have said here before the committee last week, that somehow companies will not insure for prescription drugs because so many people need them, simply does not hold water.

As Alan Holmer of the Pharmaceutical Research and Manufacturers Association of America provided you last week, the industry already insures everything from sports accidents to the weather on the day of your daughter's wedding. So it is clear that our proposal has the possibility of attracting a wide pool of consumers.

Recognizing my time, Mr. Chairman, I will close with this. I would hope that we would be able to work together in a bipartisan fashion to develop a system that is not one-size-fits-all, and that we should not make the perfect the enemy of the good. We ought to be able to do something, whether it is within the Medicare program or without, and it should not be predicated on Medicare reform if that cannot happen this year.

Thank you.

The CHAIRMAN. Thank you, Senator Snowe.

[The prepared statement of Senator Snowe appears in the appendix.]

The CHAIRMAN. Senator Kennedy, it is a pleasure to have you here.

STATEMENT OF HON. EDWARD M. KENNEDY, A U.S. SENATOR FROM MASSACHUSETTS

Senator KENNEDY. Thank you very much, Mr. Chairman. I thank the committee for letting us appear before the committee.

Let us look at the drug crisis facing seniors today. Coverage is going down, the costs are going up. The bars on this chart indicate, of 36 million American seniors, 12 million have no coverage, and 11 million have employer-sponsored coverage. Medicare HMO coverage, 3 million have it. I will come back to that. Medigap, about 4 million. The only seniors with reliable coverage are the 4 million seniors with Medicaid.

This is what is happening. We have no coverage for 12 million seniors. Of the 11 million with employer-sponsored coverage, we have seen, from 1994 to 1997, close to a 30-percent decline in coverage; that has gone down more rapidly in the last year, and is expected to decline again this year.

For those that have coverage through Medicare HMOs, this is what is happening now; 325,000 seniors have been dropped in the last year. They have been dropped in my own State of Massachusetts, in New England, throughout the New England States. So you have a significant drop in drug coverage for the seniors in Medicare HMOs.

Even in the HMOs that are left, you see that 75 percent now will limit drug coverage to less than $1,000 this year, an increase of 100 percent since 1998.

Seniors that are left in Medicare HMOs are finding that their drug coverage is being limited; 32 percent of all Medicare HMOs now have a limitation of $500. So, even for this group, you are finding that prescription drug coverage is really an empty promise.

Look at what is happening in Medigap. As this committee knows, you have to apply for Medigap immediately when you are eligible, or you are not able to enroll in Medigap plans that cover prescription drugs.

Look at the cost of Medigap. It is getting prohibitive for senior citizens, and they know that, Mr. Chairman.

So what we have, is the number of people with coverage is going down rapidly in every sector of the health care system. Coverage is going down rapidly. And look what is happening to the cost of these prescription drugs. This is against a background of a CPI that has ranged from 2.5 percent, to 3 percent, to 1.76 percent, 1.67 percent, up to 2.7 percent. So these figures, the percentage increase in the cost of prescription drugs, are going right up through the roof. Coverage is going down dramatically and increasingly so and costs are going right up through the roof. We believe that what we need to include in a meaningful prescription drug benefit is coverage for all, basic and catastrophic coverage, and coverage that is affordable; affordable to the individual, and affordable to the government as well. That is what our plan is basically all about.

People can ask, well, why are we looking at affordability for all? The basic reason for affordability of all is that 78 percent of all seniors have incomes below $25,000.

Our particular program has a $25 premium. The premium is going to be subsidized by the overall general fund, and that will lead to participation. We will find that the wealthiest individuals will actually be contributing under this proposal.

We believe you have to have universal coverage or you are going to have adverse coverage and selection, resulting in a program that is not really beneficial. I know you have had testimony on that particular issue.

Finally, Mr. Chairman, you see here what is happening for several major diseases that affect the elderly. You talk about 150 percent of poverty. That is about $12,000. Even those individuals at 150 percent of poverty, $12,000, you find out what percent of their pre-tax income is being spent now for prescription drugs, and it is absolutely out of sight.

Even for those seniors at 300 percent of poverty, almost $24,000—there are many prescription drugs, even at that level, that are virtually unaffordable for our seniors.

So, Mr. Chairman, we think we need to have acceptance of the concept of universality, we need affordability for the Federal Government as well as for individuals, and it must be dependable for members of the senior community so that they have protection.

When Medicare was enacted, it didn't include prescription drugs. Medicare stated, we are going to give the assurance to every senior citizen that they are going to be able to enjoy their final golden years in peace, security, and dignity with regards to their health care. We are finding now the great hole in that kind of protection is in the prescription drug area. We have no alternative but to act, and hopefully we will act in this session.

Senator Rockefeller and I have introduced legislation to try to address this. I am less interested in what the particular deductible is, how the benefit is phased in over a period of time; these are all matters that can be worked out by this committee. You know how to do this. What we ought to do is take action this year through Medicare, not through Medicaid coverage, which would be only for the poor.

I thank the Chair.

The CHAIRMAN. Thank you, Senator Kennedy.

[The prepared statement of Senator Kennedy appears in the appendix.]

The CHAIRMAN. It is now my pleasure to call on Senator Frist.

STATEMENT OF HON. BILL FRIST, M.D., A U.S. SENATOR FROM TENNESSEE

Senator FRIST. Thank you, Mr. Chairman. I think we need to focus on a number of questions. I think the case has been made, both in your previous hearings as well as today from what we have heard so far, and I am sure will be stressed again and again, that drug coverage today in Medicare is necessary if we truly are to guarantee health security. Health security in the 1960's was hospitals and physicians.

We are pretty much at the debate today for prescription drug coverage where, as many of you are aware, back in the early 1960's were hospitals and physician services. The great breakthroughs in medicine, the evolution of health care, the evolution of science simply means that prescription drugs now have become equally, if not in many ways more, important than those basic two tools we had before of hospitals, hospital beds, surgery, and the physicians delivering their care. So I view this exactly where we were back in the early 1960's with the same opportunity.

At that point in time, many of you responded, and the U.S. Congress did, with a plan that set a platform for 30 years that worked beautifully. As a physician, I was able to participate in that and it has worked, I think, very, very well.

Now we recognize that as not sustainable, and we have the opportunity to develop a plan for the next 30 years. The grass roots support that we have for prescription drug coverage for our seniors gives us that opportunity, just as you did in the early 1960's, to come back and set a platform for true Medicare modernization, or reform, capturing the necessity, I believe, of including prescription drugs in Medicare today.

There are five questions I think you are going to have to answer, and we are going to have to answer as a Congress. Number one, how strongly linked should this drug benefit plan aspect be to overall Medicare reform? You have got to decide that.

If you recognize the traditional Medicare, delivered in the traditional way, is not going to be sustainable long term, I would encourage you to link whatever we do in drug coverage today to true Medicare reform.

Number two, how targeted? Should it be universal care prescription drug coverage? I think all of us would like to see that, but in truth, given the realities today, in some way you are going to have to target it.

I argue for universality for many of the same reasons that Senator Kennedy does. I think, realistically, what we can accomplish over the next year is not universal coverage. The money is not going to be there. I do not think the political will is going to ultimately be there, so there has got to be some targeting. What we need to do is figure out how to target, but, I would argue, expand that to more universal coverage.

Who should administer the drug benefit? It is critical, it is key. It is a question that you will have to answer. Who will supervise the administration of that benefit? How much should we pay for it, and who bears financial risk? Again, that is another layer of sophistication, but I think it is increasingly important.

Again, looking at the charts that Senator Kennedy just showed, these have the potential for being runaway costs with no handle, no control, and yes we can cap and put a pool of money in, but in some way we have got to capture what we know, whether it is multi-tier pricing, incentive for cost restrainment, increased use of generic drugs with appropriate incentive, some way that has got to be captured. Thus, I would argue against just giving a 50 percent co-payment and setting a certain cap. Those are the basic questions I believe that we do have to answer.

I strongly believe, and I will keep coming back to this, that any consideration of taking a drug benefit program cannot be totally freestanding today, recognizing the realities of health care security for our seniors. In some way you have got to be able to link the two.

It is hard, because the knee-jerk response is going to be to put a freestanding plan out there that is not integrated, but overall health care today is moving not towards more fragmentation, so we should not institutionalize that, but we should actually take this prescription drug plan, whatever we do, and incorporate it in larger reform, probably recognizing you cannot achieve major overhaul reform all at once just today, but to set that template out there for the next three to four years so that whatever package you do put into place, it is inextricably linked to major reform.

The principles that I would put forth, is that, number one, all of us must recognize, I think, the new drug benefit cannot and should not be modeled on Medicare's traditional, outdated approach to health insurance. It worked well for the past 30 years, but this is the year 2000. Looking ahead, there is absolutely, absolutely no way that a traditional approach is going to work.

Number two, it should be voluntary. Again, we should not force seniors to give up something that they have today or to pay more for something they have today. Third, price controls simply will not work.

The Breaux-Frist template is a good one. It is a good one in terms of long-term reform, the competitive premium support model, but also the concept of having a new Medicare board who supervises these new benefits, oversee a system in which beneficiaries have ongoing choice.

The plans that are put forward are based on an actuarial value of $800. Why is that important? None of the other plans do that, so it is important to understand that. Basically, the supervisory board would say, if you are going to come to the table and play in

our FEHBP-type model, you have to offer $800 of actuarial value. We do not specify specific co-payments, or deductibles, or stop-loss. All of those are at the table.

That is important because we do not have the answer on how to restrain costs in spending long term. We know what they are from the charts, but we do not know today. We do know the private sector is innovating, is being somewhat successful in terms of their innovation. So whatever system we put into place, we need to be able to capture that as we learn it long term.

Therefore, if you put a 50 percent co-payment in there, that is not going to capture it. If you put a $200 deductible, we will just come back next year and say it is $210. That is not going to capture the cost containment potential that is in the private sector.

We can come back, if we have time for questions, and I will elaborate, because my time is out. But the actuarial value of the benefit is absolutely critical to capture the innovation in health care delivery services, the cost containment, competition on quality, under the supervision of a Medicare board, not HCFA.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Frist.

[The prepared statement of Senator Frist appears in the appendix.]

The CHAIRMAN. Now it is a pleasure to call on Mr. Bilirakis. Mike, it is great to have you here.

STATEMENT OF HON. MICHAEL BILIRAKIS, A U.S. REPRESENTATIVE FROM FLORIDA

Congressman BILIRAKIS. Thank you, Mr. Chairman. I thank the members of the committee for inviting me. As you all know, our Health and Environment Subcommittee is holding similar hearings in the House, and I appreciate this opportunity.

Mr. Chairman and members of the committee, and certainly my fellow Floridians, in considering this complicated issue I have been guided by two simple principles.

They are, that no beneficiary should have to choose between buying groceries and filling a prescription, as Senator Kennedy shared with us, but also that we should help the poorest and the sickest beneficiaries obtain the medicines they need today, and I mean now, not 2 or 3 years from now.

I represent one of the oldest Congressional districts in the country, and like all of you, I hear regularly from constituents who are concerned about access to affordable prescription drugs.

The members of the National Bipartisan Medicare Commission spent many hours wrestling with this question, and we failed to make a consensus recommendation to the Congress because of this specific issue.

We have all heard the numbers; roughly two-thirds of Medicare beneficiaries have some form of prescription drug coverage, but one-third have no coverage at all. Given the vital role of pharmaceuticals in modern medicine, we have to improve Medicare by reforming it to include a prescription drug benefit.

But until we have comprehensive reform—and that is the point—common sense dictates that we focus first on helping those who

lack any coverage, while we continue working to expand access to affordable prescription drugs for all beneficiaries.

It is also clear that, absent fundamental reform, a major expansion of Medicare spending on prescription drugs would seriously threaten the solvency of this vital program.

Therefore, if we are unable to reach agreement on legislation to reform Medicare, I believe we have to act this year to help the poorest and the sickest beneficiaries outside of the scope of Medicare, obtain prescription drugs.

This is a first step, but a necessary one. I do not think that these vulnerable individuals should have to wait two, three, or 4 years for the assistance that they need.

Let me explain why I feel so strongly about this point. In 1994, I joined then-Congressman Roy Rowland in proposing a targeted, bipartisan solution to reform our Nation's health care system.

Our plan included critical provisions to help individuals with preexisting conditions obtain coverage and to allow workers to keep their health insurance when they change jobs. Unfortunately, the President took an all-or-nothing approach to health care reform, which resulted in the enactment of nothing.

Sadly, individuals in need of care were thereby forced to wait an additional 2 years until these same insurance reforms were enacted into law in 1996 with strong bipartisan support. I say we must not repeat that mistake. In my mind, it is unconscionable to make the neediest beneficiaries wait for prescription drugs while we continue to debate the larger issues involved in Medicare reform.

Joined by Democratic Congressman Colin Peterson of Minnesota, I have introduced legislation to address this concern. Our bill, H.R. 2925, is a first step—and I emphasize that, a first step only, Senator Kennedy—in providing coverage to those in need. It would provide Federal support for State prescription drug assistance programs serving low-income beneficiaries.

It would also establish a Federal stop-loss protection against high annual drug costs for beneficiaries who obtain up front coverage. Equally important, it would not raise beneficiaries' Medicare premiums, increase Medicare spending, or jeopardize the program's solvency.

States that choose to participate would receive enhanced Federal matching funds to cover individuals whose income is at or below 150 percent of the Federal poverty level. Federal funds would be available to States at the regular Medicaid matching rate to serve individuals whose income is between 150 and 200 percent of poverty.

Under our stop-loss plan, the Federal Government would protect beneficiaries who obtain qualifying, up front coverage from paying more than $1,500 annually in out-of-pocket costs for prescription drugs. Seniors would continue to receive prescription drug benefits through a market of competing private sector plans with no increase in their Medicare premiums.

To date, gentlemen and ladies, 18 States have authorized or implemented pharmaceutical assistance programs. According to the National Conference of State Legislatures, prescription drug proposals are a top priority for consideration in a majority of the States' legislatures.

Working in partnership, we can build on these State initiatives. That is, the whole point. They are already in place, so we can build on these State initiatives to help beneficiaries in greatest need.

In addition, I was pleased to learn that the President's budget proposed to set aside $35 billion over 10 years for a policy that provides for protections against catastrophic drug costs. I obviously share his view on the need for a stop-loss protection, and I hope we can work productively in that area.

I might add also, Mr. Chairman, that this is the same concept as SCHIP. That is a voluntary program, and this would be a voluntary program. All of the States have opted to join in the SCHIP program.

I believe we have a moral obligation to act now, I emphasize, to help the poorest and sickest obtain the medicines they need. If Congress and the President are unable to reach agreement on a broader Medicare reform, I would urge members of this committee, at a minimum, to help the neediest beneficiaries this year. Our Nation's poorest and sickest seniors should not be forced to wait any longer for prescription drug assistance.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Bilirakis.

[The prepared statement of Congressman Bilirakis appears in the appendix.]

The CHAIRMAN. Now we turn to Mr. Hash.

STATEMENT OF MICHAEL HASH, DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION (HCFA), WASHINGTON, DC

Mr. HASH. Thank you, Mr. Chairman, Senator Moynihan, and other distinguished members of the committee. Thank you for inviting me here today to discuss the need and the administration's proposal for prescription drug coverage for Medicare beneficiaries.

This committee will, of course, be a focal point of the debate around this important issue and it is a privilege to be before you today to provide the administration's perspective and to join with this distinguished panel of members of Congress who have been so key in advancing the debate on this important issue.

Mr. Chairman, we must act now to ensure that all beneficiaries have an affordable prescription drug benefit option. Pharmaceuticals are as essential to modern medicine today as hospital care was when Medicare was enacted in 1965.

We have an extraordinary opportunity here to address this shortcoming in the context of additional necessary reforms to make the program more effective, more modern, and more adequately financed.

Lack of prescription drug coverage among many senior citizens and people with disabilities today is a real threat to their health and to their quality of life. Three out of five seniors and disabled people lack dependable coverage. Only half of the beneficiaries have year-round, 12-month drug coverage and, as has already been mentioned, one-third of all Medicare beneficiaries have no coverage at all.

Further, they must pay the highest prices for drugs of any other group in the country today out of their own pockets. The result, is

that many go without medicines they need to keep them healthy, to keep them out of the hospital, and to keep them living longer, healthier lives.

Drug coverage is not just a problem for the poor. More than half of beneficiaries who lack coverage have incomes above 150 percent of the Federal poverty line and fully 40 percent of those who lack coverage have incomes up to 200 percent of the Federal poverty line. Millions more have insurance that is expensive, inefficient, and highly unreliable.

Even those with most types of coverage are finding that it costs more and more and covers less. Co-payments, deductibles, and premiums are all up and coverage is often disappearing altogether as former employers drop retiree coverage, and Medigap coverage is not available.

Clearly, all beneficiaries need access to an affordable prescription drug option. The President has identified several key principles that a Medicare drug benefit must meet. First, must be a voluntary benefit, accessible to all beneficiaries. Second, must be affordable to the beneficiaries and to the program.

Third, must be competitive and have efficient administration. Fourth, it must ensure access to needed medications and encourage high-quality care. Last, it must be done in the context of broader Medicare reform.

The President's plan meets these principles. Under his plan, beneficiaries will have access to an optional prescription drug benefit through either the traditional Medicare program or managed care plans. Those with retiree coverage can retain it and employers would, in fact, be given new financial incentives to encourage the retention of retiree plans.

Third, premiums will be affordable with extra assistance for those with low incomes. Fourth, there will be no price controls or new bureaucracy. Instead, the new benefit will be offered through private pharmacy benefit managers who can effectively negotiate fair prices. All qualified pharmacies would be allowed to participate in this program.

Beneficiaries can get all of the drugs that are prescribed by their physicians from private pharmacy benefit managers who meet minimum quality standards, and there would be, as was noted, appropriate catastrophic protection for those with large drug expenditures.

Finally, the President's budget includes the prescription drug benefit as part of a comprehensive plan to modernize Medicare, make it more efficient and competitive, and extend its financial solvency.

We believe that this plan is the best of all public and private proposals on the table. It maximizes the purchasing power of a public program by combining it with private sector management and experience.

We have a broad, bipartisan consensus that we must act now to establish a Medicare drug benefit. We have an historic opportunity provided by the growing budget surplus.

We have an obligation to keep our commitment to meet the needs of the seniors and people with disabilities who depend on Medicare, and this can only be done by making a voluntary, afford-

able, and competitive drug benefit available to all beneficiaries in the context of Medicare reform.

Mr. Chairman, we look forward to working with you and other members of the committee on this critical issue. I want to thank you again for holding this hearing. I would be happy to respond to any questions that you and other members may have.

[The prepared statement of Mr. Hash appears in the appendix.]

The CHAIRMAN. Thank you, Mr. Hash.

I would like to ask the panel, what recommendation would you make to this committee regarding what is the best and most realistic goal we should attempt this year?

Senator FRIST. Mr. Chairman, I would be happy to respond. Or do you want to go in order?

The CHAIRMAN. Senator Frist.

Senator FRIST. Mr. Chairman, I think, realistically, something can be accomplished this year in terms of prescription drugs. I think if you go down the list, or the list that I have put forward, I think that we need to answer the question, who is going to supervise this? That can be decided this year.

I would argue for a Medicare board. With all respect to HCFA, 100,000 pages of regulations, multiple people having to check off, I just do not think they are the appropriate people as we look to the future to be managing what I view will be the long-term reform program in Medicare. So I would basically say a Medicare board could be established this year to supervise this proposal.

Number two, the population itself. I think it is going to be very difficult this year to have universal coverage, for lots of different reasons, whether it is money, policy, or politics.

I think a targeted population that will be most close to the people who need it the most in terms of whether or not they can afford it, you can look in the SLIMB, QUIMB populations to identify a group, but I think it absolutely must be linked, long-term, to a concept like Breaux-Frist, with universal access, and I would argue for an element of universal subsidy.

The third, in terms of the benefit package, this year you could pass a benefit package that is actuarily based, which I would argue is an important component to that.

Fourth, I would argue that demonstration projects should be set up consistent with Breaux-Frist long-term because I believe, ultimately, it is inevitable that that is where Medicare will be.

Senator SNOWE. Mr. Chairman.

The CHAIRMAN. Senator Snowe.

Senator SNOWE. Thank you. In response to your question, this was basically one of the reasons why Senator Wyden and I took the approach that we did, because we recognized there are real considerations about the long-term solvency of the Medicare program, and that any prescription drug program, I know, similar to what Senator Breaux and Senator Frist have introduced, will be predicated on reform. That may or may not be possible this year, but obviously time is dwindling.

Our opportunities for addressing reform are becoming less and less this year. If it happens, that is fine. But in the meantime, we have to decide whether or not we are prepared, as a Congress, to address this issue here and now. That is why we took the SPICE

structure we did outside of Medicare. SPICE and Medicare reform are not mutually exclusive. SPICE can be part of reform eventually.

I think that we have to make a down payment on the prescription drug benefit program now, and that is why, to set up a benefit on a known structure that we are all familiar with, offering competition and choice, and not creating an overall bureaucracy that ultimately does jeopardize the financial condition of the Medicare program, and all the over-arching comprehensive issues that we need to address with respect to reform, is best.

So I think that this is a good, strong first step that could be merged with Medicare reform ultimately when and if Congress decides to tackle that issue.

Senator WYDEN. Mr. Chairman.

The CHAIRMAN. Senator Wyden.

Senator WYDEN. Thank you, Mr. Chairman. I think what Senator Snowe has said, is we want to jump-start Medicare reform in a way that is consistent with the long-term needs of this country and this program, it seems to me, in addition to the down payment.

What we need to do, is make sure that there is a plan that gives the older people bargaining power in the private sector marketplace to make medicine more affordable. Senator Kennedy is absolutely right when he talks about this affordability crisis.

In effect, the low-income senior in this country gets shellacked twice. In effect, the revolution in medicine has bypassed Medicare because Medicare does not cover these drugs that help lower blood pressure and cholesterol, all of the revolutionary changes in medicine.

But, second, in addition to not covering these services, when an older person walks into a pharmacy without coverage, in effect, because they do not have bargaining power, they are subsidizing those who are a part of a big health plan.

So if you have a big health plan and you have workers that are 35 or 40, their plan goes out and negotiations, because they have bargaining power, a good deal for those members.

That is what we need to set in place for older people in this session, the down payment, the beginning of the dollars that are needed to serve those who desperately need this coverage, but second, to give them real bargaining power so we can do more to make these drugs affordable.

The way that is done is key, because if you do not do it right the costs will just be shifted onto the backs of other individuals, and that is why we take the proposal we do.

Senator KENNEDY. Mr. Chairman, very quickly. I think I agree with those that think that we can make an important down payment this year. The President has introduced legislation which is a phase-in, and I think that is understandable. It can be phased in over a period of time, given the amount of resources we have.

While we meet here today, the Budget Committee is getting ready to make recommendations on funds for prescription drug coverage. The recommendations that will come out are going to be for $20 billion that may be used by the appropriate committee, which would be this committee, after Medicare reform.

This, I think, would be a major step backwards. The budget had $100 billion over 10 years. This budget is talking about $20 billion over 5 years, and that is only after there is comprehensive Medicare reform.

I join my colleagues in saying that we are going to be faced with this recommendation. That decision is being made not by this committee where so many members have tried to do something about prescription drug coverage, but it will be made, I think, to the detriment of the seniors of this country.

We should make sure that the budget report is going to provide for an affordable, universal program that can be phased in and give some hope to senior citizens. We ought to do that now.

We cannot lock ourselves into a program, as I believe the Budget Committee is going to recommend, that is going to put this off for a period of time, when so many of our seniors are going to suffer.

The CHAIRMAN. Mr. Bilirakis.

Congressman BILIRAKIS. Senator, just 10 seconds. Fall-back. That is my recommendation. We have got to have something on the table that we can fall back to if we, in fact, cannot do what we all want, which is comprehensive Medicare reform that would include universal prescription drug coverage.

If we fail to do that, then I think we are really letting down the good people because we do not have that many legislative days left in this Congress. If we do not have a fall-back, whether it be our legislation or whether it be somebody else's. We need a fall-back. Thank you.

Senator SNOWE. Mr. Chairman, may I just respond to what Senator Kennedy said?

The CHAIRMAN. Yes. Very briefly, please.

Senator SNOWE. Yes, very briefly. I recognize what he is saying and I think that it is a concern of ours. Both Senator Wyden and I also serve on the Budget Committee and will be addressing this issue. We do believe Congress should move forward on a prescription drug benefit, if in fact the Senate Finance Committee cannot report out a Medicare reform package by July 15, we want to provide a down payment of $20 billion in the first 3 years for a new benefit, and in 2004, 2005, another $20 billion for this benefit should be predicated on reform.

The CHAIRMAN. Mr. Hash.

Mr. HASH. Mr. Chairman, on behalf of the administration, I would say we do want to move ahead now and take advantage of what I said in my opening statement, which is this historic opportunity with a rising budget surplus to, in fact, make the commitment now to develop a universal, voluntary prescription drug benefit option for Medicare beneficiaries in this Congress, in this session, in the context of making appropriate reforms that addressed the solvency of the Medicare program over the long term and modernize the program as the President has otherwise proposed.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Mr. Chairman, I yielded my time to Senator Wyden, unbeknownst to him, because of the pressures we are under. So, I would just make one comment, which I hope the panel will agree with.

We have been considering all these matters, and the one thing we are particularly, I think, as a committee, concerned with is seeing that we do not directly or indirectly impose price controls. We are in a moment of great creativity in the pharmaceutical world, and it is to be encouraged.

All of these increased costs represent not just additional health care costs, they are substitute costs. If you are not in the hospital, you may be taking a pill, which is, on balance, better. I am sure you all agree on that. Thank you.

Thank you, Mr. Chairman.

Senator KENNEDY. Can I just mention, in complete support with what Senator Moynihan has said, we understand you have 10 cents out of every dollar now used for pharmaceuticals. It has gone up to about 11 cents.

I agree with the Senator that we are going to have to look at the health dollar as we go through in the next 5 or 7 years; prescription drugs will probably rise to 20 cents. But you are going to hopefully see the corresponding savings, as Senator Moynihan has pointed out, due to less hospitalization.

If you get a breakthrough for Alzheimer's disease in the biotech area, you empty half of the nursing home beds in my State of Massachusetts. I think, in the next four to 5 years, we are going to see that.

Even though it will be more costly, necessitating a catastrophic benefit and, even though only about 10 percent of the elderly would be affected, many of our seniors are hoping and looking forward to these breakthroughs, and we ought to give them a degree of hope.

Senator MOYNIHAN. Can I just say, we have seen that—I am sure Dr. Frist would agree—with Zantac and such, and ulcer operations. They have been reduced substantially.

Senator FRIST. Yes. Everybody knows, but it is dramatic. I was trained to do stomach operations on ulcer disease, and now with that one medicine, many people get all the way through their surgical residency never seeing that same stomach operation. I am not that old; it was not that long ago. [Laughter.]

The CHAIRMAN. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman.

Just one point here, following on Senator Kennedy's point. I think, and you know much better than I, Senator, I think the State of New York did a study in subsidizing prescription drug costs and correlating that against what the overall health care cost was for the New York plan and found out that, on a net basis, it saves money to subsidize and help provide drugs compared with on the treatment side. The dollars are there to demonstrate that very point.

I, first, thank all of you. You all are experts. You have obviously thought long and hard about this, and your contributions are terrific, all of you.

At an earlier hearing, I had felt that, because we should do something this year, maybe all we could do was something through Medicaid for low-income seniors, Medicare benefits, but through Medicaid.

I have modified my thinking, that we have got to do a lot more than that. There is no doubt, we can do it this year. There is no

question about it. I believe that the coverage should be universal. American seniors understand Medicare. They understand the current system and it is a basic American principle, universality. There should be a universal plan.

I am open to some kind of income adjustments here. I am very open to that. That is on the table. But I also, frankly, think we need catastrophic coverage. If we are going to do what, as Senator Kennedy said, we all know is right—namely, American seniors want the comfort and deserve the comfort and knowledge that they are going to be somewhat covered by these huge drug costs, whether it is catastrophic or non-catastrophic—obviously, we have got to address the stop-loss problem here in some way.

Now, I am a little concerned about a separate board. Sometimes the grass is always greener. We are all very concerned about the hundreds of thousands of pages that HCFA foists upon all of us. Not us particularly, but the medical profession, hospitals, providers, and so forth. We all hear it when we are home.

I am just wondering though, sometimes the devil you know is better than the devil you do not know. Maybe we can work with HCFA, I do not know. It is an open question. I am a little nervous about immediately jumping toward something else rather than working with the current Medicare structure.

Now, I do believe there is an opportunity and opening here for stop-loss coverage. When I introduced my bill last year, predicated on an on-budget surplus of only about $900 billion over 10 years, the last estimate was $1.3 trillion on budget surplus, my guess is, with the mid-session review, it is going to be even more than that. The administration only begins its stop-loss after 2005, if I understand it correctly.

So let me ask you, Mr. Hash. Assuming we had some more money to help our seniors, which I think we need and I strongly agree with efforts to get a budget resolution that addresses this a little more forthrightly, can you give us some sense of what some catastrophic provisions might be? Because I firmly believe we have got to work together.

I am thinking about introducing a bill which is universal and has stop-loss coverage. It may be phased, but just so we can get some kind of solution this year and bipartisanly get this thing done.

Mr. HASH. Senator Baucus, we certainly agree with you on that. As you know, the President has set aside this reserve fund of $35 billion over the next 10 years for that purpose. We are anxious to work with the Congress to consider a number of design options associated with catastrophic coverage. It would not necessarily, for example, have to be immediate 100 percent coverage as soon as you go across a threshold, it could be graduated.

There are a variety of different ways in which private plans have modeled and identified catastrophic coverage and we would like to work with you and to find the most appropriate model to make sure that the coverage really is the most adequate for those individuals who have those extraordinarily high costs of prescription drugs.

Senator BAUCUS. It just seems to me, if we provide a prescription drug benefit, which we very much should do, we also have to pro-

vide for catastrophic, and begin the same year. It does not make sense to put off catastrophic coverage to the year 2006.

I just do not think that makes any sense whatsoever. I think that they should begin, maybe phased, but begin as soon as possible, and I would say next year. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Next, we have Senator Breaux.

Senator BREAUX. Thank you very much, Mr. Chairman. Thank our distinguished panel members for their contribution.

Mr. Chairman, I would observe that this is the fourteenth hearing that this committee has had in this Congress on the question of Medicare reform. This is the second hearing this year on the question of prescription drugs.

I take it we have one additional hearing on HCFA oversight. I think that clearly indicates the importance, Mr. Chairman, that you put, along with Senator Moynihan and other members, on the whole question of Medicare reform.

I would suggest and encourage that, at some point, we have got to quit hearing and start writing. I think that, after 14 hearings, that we have heard just about everything we are going to hear from just about everybody who wants to tell us what they think we ought to do.

At some point, we have to start making tough, difficult political decisions on what we are going to produce this year. We have a very, very narrow window of opportunity. It would be tragic if we do not move forward with actively marking up a bill.

It would be tragic and a lost opportunity if the only thing, I would add, that we do in this Congress with regard to Medicare is add a prescription drug reform package without also addressing the question of reform and how we pay for it.

This is a program that spent $7 billion last year more than we took in. If we talk about simply adding more benefits to the program, we will have done to Medicare what we did to Social Security last week. Instead of reforming it, we made it easier for more people to get more benefits by removing the earnings cap. That truly is a laudable position, I am all for it, I voted for it, but it was a missed opportunity in not also doing something to reform that program. We should not miss this opportunity with Medicare in this Congress.

There are some who would only suggest we subsidize poor people. There are some who would suggest that, no, we should subsidize everybody in the program. There is a distinct difference in the question of whether we provide universal coverage for Medicare beneficiaries versus universal subsidies.

The Breaux-Frist bill is universal coverage and universal subsidies. But if that is not possible, I would ask the question of the panelists, what about a move towards prescription drugs which would be universal coverage?

Everybody in Medicare would get prescription drugs under the Medicare program, but for the poorest of the poor, there would be a subsidy, a 100 percent subsidy, and you could pick the number. Two hundred percent of poverty gives us 19 million more people that do not have prescription drugs today.

Then you would say to those who have catastrophic losses, pick the number: $4,000 a year, $3,000 a year, or some number, and say we are going to subsidize their prescription drugs because they need help.

But for everybody else who is not in their category, they will have universal coverage through a Medicare program but it will not be subsidized, although CRS testified that being able to participate in that program through volume purchasing gives them a better price.

So if we cannot do universal subsidies for everybody, what are your comments on a program that would provide universal coverage for everybody, subsidize the poorest of the poor, subsidize those who have a catastrophic loss, and everybody else has access through the Medicare program.

Senator WYDEN. Senator, I would just say, first, that Lee Iacocca should not pay the same for his Medicare as would an elderly widow who makes $19,000 a year and has a huge prescription drug bill. I think there is a clear consensus in the Congress on that point.

I do think that universal coverage, in addition to the question of bargaining power, is right at the heart of this debate, because if we do not get everybody under the tent, I think we will then run the risk of what happened with catastrophic care, where one group of seniors is seen as being pitted against another.

I happen to think the kind of approach you are talking about with catastrophic care is very attractive, and we ought to take a look at it on a bipartisan basis.

Senator KENNEDY. Could I say, Mr. Chairman, I have a great respect for all of the members here, but I know that Senator Breaux has been wrestling with this and for Medicare reform, and I think be deserves great credit for forcing the Congress to face up to these issues.

The appeal, obviously, that this has, is even those that are not getting help and assistance, would probably get the drugs at a lower price.

I think you do come back, since it is a voluntary program, and if you are not going to have a heavy subsidy and are going to keep the premium at about $25 a month, then you are going to have about 75 percent of revenue that is going to be from the Federal Government.

Once you move the premium to 50 percent, or even above that, you are going to get adverse selection. What I think you want to try in shaping any program, is to avoid adverse selection.

That, I think, would be a concern that I would have, but I think, from what I have heard from the members here, there is a desire to move ahead this year. I think how we work the phasing in is really less important than getting drug coverage that is of significance and importance and basically universal in nature.

Senator BREAUX. Thank you.

The CHAIRMAN. Next, we have Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman.

I would like to go back to a question that was asked earlier. That is, what would be your priority of things to do now relative to moving forward on prescription medication?

I would have to say, my answer to that question would be to be certain that the budget resolution that we are going to adopt provides enough space over the next five years to deal with prescription medication, because if we do not, we will have shut off the resources that are going to be necessary.

So I would like to ask, and for purposes of brevity would suggest, first, a number, and second, in 15 words or less, any modification or conditionality to that number. What would you like to have in the budget resolution that we are going to be adopting in the next few days as it relates to prescription medication over the next 5 years?

Senator SNOWE. I would be glad to respond, since we will be heading to the Senate Budget Committee on this very issue, and Senator Wyden and I have been working on this approach.

I would say, that without undercutting Medicare reform—in the event that it can happen this year—we need to provide $20 billion in the first 3 years on a new prescription drug benefit. In 2004 and 2005, the benefit would be predicated on initiating reforms. We want $40 billion over the next five years.

We would not take action on this prescription drug benefit program unless the Senate Finance Committee could not report out a bill on a benefit by July 15.

I do have concerns with the current budget resolution because it is all up front in terms of Medicare reform. I am not sure that that is possible this year, and we should not defer action on this issue.

Senator WYDEN. Senator, if I could just add one sentence to that. It has got to be $40 billion on prescription drugs in order to launch this, because we are having some discussion about whether this will be $40 billion for all the health care accounts. As you know, we are having problems in home health and nursing homes. So we are talking about $40 billion as it relates to prescription drugs.

Congressman BILIRAKIS. The figure, Senator, that we are working with in the House is $40 billion. But we can talk about all the money in the world, but until we get it done, in writing, and get it passed, and get it out there to the people that count, it is just merely rhetoric.

This is why I feel so very strongly, that if we think we can do what we all want now, fine, let us do it. But if we do not think it is doable, look at what we ran into as far as the Medicare Commission was concerned, an awful lot of politics, quite frankly. So, let us do something now that will blend into the overall reforming of Medicare.

Senator GRAHAM. Doctor.

Senator FRIST. I support the $20 billion mark. But the key component, and what none of us have stressed very much in our conversation, is what the reform means. Prescription drugs have revolutionized health care in this country, but the reality check is, we are spending $200 billion on Medicare and it is going bankrupt.

Those same seniors are spending $35 billion on prescription drugs right now, with nothing, no new government program. Thirty-five billion dollars. We are spending $200 billion on Medicare today, and you are taking $35 billion of expenditures, and in a lot of the proposals, saying, let us just dump it in Medicare.

Now, if that is the approach, it is going to take a lot more than $20 billion. If you even want to cover 50 percent, because remember, it is growing at 18 percent a year, it is $35 billion, which many people want to say, let us jump start it and add it on.

$200 billion here. You are jump starting $35 billion. Say you are paying half of that. That is not very much, but half of that. And let us say you are going to be growing that at 15 to 18 percent a year, without reform.

That is why we can concentrate on the figure and say, $20 billion is not enough, I want $100 billion, I want $120 billion. The reality of this is, if we are obligated to seniors and individuals with disabilities and their health are security, the figure is kind of important.

What is ultimately most important, is the reform. Now, the reform—we have not had the budget debate. Is the reform what I would argue for basically a vision, like Breaux-Frist, could be some other plan, longer term, and insert prescription drugs in? I would argue the most important part of reform is to have some element of cost containment because of the growth at 18 percent a year.

If you have prescription drugs, I would say the actuarily-based $800 gives you the most flexibility to have three-tier pricing, the sort of incentives—and not necessarily that—that are in the private sector, and that is where modernization is critical—critical—if we are doing a service long term.

So when we go to the debate on the budget, I will support the Chairman's mark of $20 billion. I would say, two types of reform: cost containment, quality assurance-type reform in the prescription benefit, long-term reform of a premium support, premium competitive model where you are injecting true competition in overall Medicare reform.

Let me just close and say that, of the premium competitive model of Breaux-Frist, a big model, not just on prescription drugs, overall savings are going to probably be—we do not know for sure—about 1 percent a year over the long term, compounded. If we are going to see that sort of savings, $20 billion is clearly sufficient, if we are talking about that sort of reform.

Senator GRAHAM. I wonder if Mr. Hash could respond.

Mr. HASH. Yes, sir. Senator, I want to underscore what Senator Wyden said.

Senator GRAHAM. What I was looking for was a number and 15 words of commentary on that number.

Mr. HASH. Yes, sir. We have looked at the House resolution of $40 billion, and if it is applied to the drug benefit it would adequately finance the President's proposal.

Senator GRAHAM. Mr. Chairman, I would just say that, if we have a Medicare reform requirement, I think the two most important reforms in Medicare are, (a) to move it from being an acute care program to a prevention program, and (b) to change it from being a program that focuses on death shortly after retirement to a program that focuses on the aging process.

Those, to me, are the two most fundamental reforms that we need to make. Both of those, I think, require a prescription medication benefit in order to be effective.

The CHAIRMAN. Just let me make one observation with respect to the $40 billion figure for Medicare and drugs. My question is, why have a number at all? We do not know what the ultimate proposal will cost, and why not include medicine and drugs with the online debt reduction pool? That is pretty much what we did last year.

Senator WYDEN. Mr. Chairman, in fact, 54 Senators voted for the Snowe-Wyden amendment last year that does exactly what you are talking about, so I think what you are saying is yet another opportunity for common ground.

The CHAIRMAN. Yes. I did write the Budget Committee to that effect, as a matter of fact.

Next, I would call on Senator Hatch.

Senator HATCH. Well, thank you, Mr. Chairman. As we tackle the issues surrounding whether to add outpatient prescription drugs to Medicare's benefit package, we need to address what I believe are some of the fundamental issues that have caused problems for the Medicare program for years.

Specifically, I mean the management of Medicare's benefit package. Right now, it literally takes an act of Congress to secure a benefit in the Medicare program. My friend and colleague on the committee, John Breaux, has referred to the Finance Committee as the Medicare board of directors, and he is not too far off in that view, I do not think.

I share his views, because I think much of what we do regarding benefits should be done either by the Health Care Financing Administration or some other entity. That is why I like the establishment of a Medicare board, as proposed by the Breaux-Frist legislation.

Clearly, the management of a new drug benefit would require considerable flexibility in responding to the rapidly-evolving drug market. I just do not think that HCFA, as currently structured, can handle that job, but I am willing to be convinced otherwise.

I was hoping Senator Frist would be here, but let me ask you, Mr. Hash, if you would comment in more detail why you believe the President's proposal, which basically relies on pharmacy benefit managers, or PBMs, to administer the benefit—will work better than the structure under Breaux-Frist. If anyone else would like to comment on the Administration's proposal, I would like to hear that as well. Of course, I would not mind hearing from my colleague, Senator Breaux, as well on this issue, if he would like.

It seems to me that the administration's approach is modeled on the existing structure of Medicare, where in HCFA, has jurisdiction over the PBMs just as they currently have jurisdiction over Medicare contractors who administer Medicare policy.

Now, I do not want to get into this issue now, but many of my providers in Utah are having considerable difficulty dealing with the Medicare contractor in my State, as you may know. As I said, I do not think the existing administrative structure is something on which we should model the drug benefit program. So I would appreciate your thoughts. You wanted to comment first, Senator Wyden?

Senator WYDEN. Were you asking about the PBMs?

Senator HATCH. Yes. Mr. Hash. Then if Senator Breaux has any comments, I would like to hear his, or any of the rest of you. I do not mean to ignore anybody.

Senator WYDEN. Senator, every day in the health insurance field, private insurance companies and PBMs work together with respect to delivering the benefits that are available.

What we are trying to do in our legislation, is ensure that that continues to stay as a private marketplace kind of function because we think that gives seniors bargaining power. Some medicine will be more affordable and will not cause cost shifting onto other groups.

What has been the concern about the administration's approach to using these PBMs, is that in some instances that kind of approach with a PBM is, in effect, like using the government, the Health Care Financing Administration, to sweep aside the other choices and then eliminate the competition and leading to the kind of thing that Senator Moynihan talked about, the rate regulation and the one size fits all.

So I think, if we work together and build on what happens today with PBMs and private insurance, we will get this right and we will continue to offer choices in the private marketplace, but we will not have turned the PBM issue into another government program that would clobber some of the innovation that Senator Moynihan has correctly stressed.

Mr. HASH. If I may, Senator Hatch. One of the reasons the President's proposal is designed the way it is, is that it makes a very sharp distinction between the way in which we contract for the claims processing activities that you were referring to and how we would contract with PBMs.

In fact, under our proposal, most of the work—the payment of claims, the establishment of formularies, the negotiation of drug prices, the management of the utilization of the benefit—all would be done under private contract with a PBM, a pharmacy benefit manager.

As Senator Wyden just said, that is the model that virtually every private health plan that offers drug benefits offers through pharmacy benefit managers under the same kinds of terms and conditions that the President's plan envisions for this drug benefit.

Senator HATCH. Thank you.

Senator BREAUX. I would just comment to Senator Hatch. The problem here, is if you just take a PBM and put it under the authority of HCFA, HCFA will continue to do what HCFA does very well, and that is, fix prices.

I mean, you have to do more than just give HCFA the authority to go contract with PBM to deliver pharmaceuticals and still have HCFA setting the price of the pharmaceuticals.

That is why a board is suggested, so that you would have the pharmaceutical benefit managers competing against each other, not give them a monopoly, and have real competition instead of having them respond to HCFA. When HCFA is trying to encourage competition, like through Medicare+Choice, the results are very clear and they are not very pretty.

Mr. HASH. May I respond, Senator Hatch?

Senator HATCH. Sure.

Mr. HASH. I would just say that there is nothing in the President's proposal that authorizes or gives the administration or the Health Care Financing Administration the authority to set prices, and we are not seeking such authority.

Senator HATCH. Senator Breaux.

Senator BREAUX. When you put PBMs under HCFA, HCFA is going to regulate what they do, when they do it, how they do it, and how much they charge for doing what they do.

Senator HATCH. As a practical matter, that is what happens. That is what you are saying.

If I could, Congressman Bilirakis, welcome to the committee. I have such respect for you. I just want to ask you, why do you believe your bill is the best approach for low-income seniors and how can we ensure that these people are covered?

Congressman BILIRAKIS. Well, sir, it would be voluntary. It is modeled after the SCHIP program, which is relatively successful. There are some States that are not doing as good a job at that as maybe they can do. But it is not something that is expanding Medicare to cover Medicare beneficiaries. Rather, it would be under the Public Health Service Act, outside of the scope of Medicare.

18 States are already doing it—basically 14 or 15 are doing it, the other 3 or 4 others have authorized it and it is in the process of being formulated. It is the emphasis of State legislatures, and Florida right now is working on a drug assistance program. We feel that approximately 60 to 65 percent of the seniors who are not now covered under some sort of drug program would be covered under this and it would really cut down the number who are uninsured.

Senator HATCH. Thanks, Mike. Appreciate having your comments.

The CHAIRMAN. Senator Mack.

Senator MACK. Thank you, Mr. Chairman. I wish that Senator Frist were still here, because I thought that his comments with respect to the cost, and reform, and trying to relate modernization reform and prescription drugs into a comprehensive plan is right on target.

As much as I believe, and most of you know how involved I have been in medical research over these past 12 years, that to deny prescription drug coverage in today's times is almost ludicrous.

But I think almost equally ludicrous would be to move forward with a commitment to a $40 billion expenditure without going through reforming the system. We are going to end up subsidizing the old system. I think you have made this point over the past year and a half. In essence, we are going to end up subsidizing the old system.

I was struck by Senator Kennedy's comment, that if we find a cure for Alzheimer's, that 50 percent of the patients in nursing homes would no longer be there. But guess what? I suspect we would have a tremendous amount of pressure not to reduce the reimbursement that flows to those institutions.

So what we are going to end up with if we do not do this at the same time, is subsidizing the old system, not making any attempts to modernize it, and accepting the responsibility of a new program. I would make the case that probably everybody has under-esti-

mated what the cost of that new prescription drug really is going to be.

So I wish he were here. I think that his comments were really right on target. I see I have provoked some interest on the part of the panel, so let me let them respond to it.

Senator WYDEN. Only to let you know that we feel in our legislation we include every single one of the major elements you need for long-term Medicare reform. We have ability to pay, we have marketplace forces, we expand choices, we use bargaining power not through government, not through the Health Care Financing Administration, but through the private sector. There is somehow this notion that if you do prescription drugs before you did Medicare reform, it is sort of like having dessert without eating your vegetables, and the like.

We want it understood that we are not interested in throwing money at an old, inefficiency-rewarding kind of system, but that we are committed to including in our efforts with prescription drugs every single one of the key elements of what you need for long-term Medicare reform.

Senator SNOWE. Mr. Chairman, in response to your points, I understand exactly what you are saying. But in terms of subsidizing the old system, that is why we really positioned our approach outside of the Medicare system. Our plan would would enhance competition and the incentive among private insurers—who will have a large risk pool—to design plans that work, even with a catastrophic coverage option.

If we are talking about adverse selection issues, they could develop plans to address short-term and long-term health care problems. That could be a variety of plans offered to seniors who may not be sick, but may need the catastrophic and the long term options. They may not rely on prescriptions at that moment, but realize that may be possible in the future.

So that is why we designed this system specifically out of Medicare. I am concerned about the way the administration has stretched their program, because I think we are going to get back into the same old problems of the past. It is going to be very restrictive. There is not going to be any latitude for innovation and the kind of savings that can be achieved to design a very attractive plan.

That is why we based our plan on universal coverage, having a universal subsidy, but also taking advantage of the free enterprise system, developing a plan that will be very attractive in creating a prescription drug benefit plan without impinging on the Medicare program and what might happen.

I would prefer to integrate all of this, too, but I do not see that possible. Maybe something will change, but I do not think we should put that on the backs of seniors this year, if we cannot follow through on reform.

Senator MACK. Let me follow through with a question to Mr. Hash. It is not clear to me how the administration intends to encourage firms that already provide prescription drug benefits to retirees if the President's plan is enacted. Aside from the tax subsidy issue, why should an employer continue to do this if a Federal program will supplant it?

Mr. HASH. Senator Mack, that is an excellent question, and that is why the President's proposal actually has in a program of paying assistance to employers who are offering drug benefit coverage as a part of their retiree benefits. Coverage that is equal to or better than the Medicare coverage package would be available for us to actually provide two-thirds of the Federal subsidy to the employer.

Actually, the CBO has taken a look at this and has estimated that about 75 percent of seniors who have retiree coverage with drug benefit protection would want to retain that coverage, and we think the subsidy program that is built into the President's plan would, in fact, assist them and actually reduce employer cost with respect to prescription drug coverage.

Senator MACK. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Mack.

Senator Robb.

Senator ROBB. Thank you, Mr. Chairman. I will be very brief, because I know that our colleagues that are at the table have other commitments, as do we, and we have another panel coming before us in just a moment.

First, let me thank them for their efforts in addressing a very challenging topic for the country. Obviously, with the number of different approaches, there is no easy, single solution. I appreciate the folks who continue to work hard and try to work through some of these difficulties that we are very good at propounding, but not always good at providing a solution.

I would say that I am on the side of those who believe that any benefit should be universal, that it needs to be affordable. I think the universal component is one we ought to continue to work on on age, not income. I agree that we need to have some modernization or reform if we are talking about, to use Senator Wyden's term, the dessert before the vegetables.

How we bring all these pieces together, is certainly a challenge. There is an element that my friend from Florida on this side of the panel has discussed with some of us, changing from the concept of prepayment to insurance in terms of how we design a particular program, which I think has particular appeal as well.

I would ask just one general question so that we can get on to the next panel. There was a discussion here at the end about PBMs. There is some question as to, if we go in this direction, whether there should be a single PBM or multiple PBMs, different approaches to this.

Would anybody like to take that just as a generic question?

Senator WYDEN. Senator, I think you are asking an important question. Clearly, if you are talking about, say, rural North Dakota, or rural Montana, or rural Oregon, a place where there are not a lot of health choices right now, I think it is very appropriate that we have a single PBM or a kind of national safety net carrier, because we need to make sure that these policies are accessible everywhere.

But what we are concerned about with respect to PBMs, is just making sure that in the many communities where there are choices, where there are options, that we do not structure this PBM concept so as to sweep aside the opportunity to let a lot of flowers bloom and have a lot of choices for seniors in Virginia so that there

is competition. In a sense, that also will minimize disruption to the program and we are all concerned about that.

I mean, the way we envisage it, if you have private health insurance, the government would pick up the prescription drug portion of your private health insurance bill. If you do not have private insurance coverage, in effect, with a phone, a mailbox, and a pharmacy, you could get access to coverage as well and that ought to minimize disruption to people.

Senator ROBB. Mr. Hash.

Mr. HASH. If I may, Senator Robb. The President's proposal, as you may know, does require that there be one pharmacy benefit manager company in each geographical area, and he does that for several reasons. First, as I indicated earlier, that is typically the way in which private health plans actually contract with PBMs to cover their subscribers or enrollees. There is one PBM that does it. Seniors, probably, in their working lives who had coverage, they would be used to that kind of model.

Second, if we went to a situation where there were multiple PBMs, I think the problem for the beneficiaries might be the criteria that they want to use to make choices between them and the extent to which people would design their PBM offerings in ways to attract certain segments of the beneficiary population, sort of to favorably select them on the basis of their health status, you run into more of that in terms of a competitive environment.

Last, I think from the point of view of administering this program, it would be more complicated to, in fact, oversee multiple PBM arrangements where there were different formularies and different benefit packages provided.

I think for those kinds of reasons we want to make sure that we actually bring together a group of beneficiaries in an area and maximize, as Senator Wyden has said over and over again, their bargaining power in the community for those drugs. If there are multiple PBMs, the ability to negotiate effective discounts for seniors will be compromised.

Senator MACK. Congressman Bilirakis, I do not want to deprive you. I have got a couple of seconds left.

Congressman BILIRAKIS. Oh, I do not know that I could add anything to that, sir. I would just really say as sort of a closing statement here, is the fact that, here we are practically in April and we still are not anywhere close to a meeting of the minds on how we are going to reform on a comprehensive basis.

If we really want to do something now for the good people, we have got to have some sort of a fall-back position, whatever it might happen to be, in order to get something accomplished today, this year. Thank you. Thank you, Senator.

Senator ROBB. Thank you very much for staying in the game. March Madness has a tendency to continue to eliminate various proposals, and we may be at the end of the month here in a couple of days and we will suddenly magically appear with a champion.

Congressman BILIRAKIS. And Florida is still in it, as a matter of fact.

Senator ROBB. That is right. Thank you, members of the panel. I thank you, Mr. Chairman.

Senator MOYNIHAN. We thank you all.

Senator SNOWE. Thank you.

Senator JEFFORDS. Thank you all for excellent testimony, I hear.

Our next panel is Mr. Michael Fogarty, chief executive officer of the Oklahoma Health Care Authority, Oklahoma City, OK; and Carol J. McCall, executive vice president for Managed Care and Informatics, Allscripts, Inc., Libertyville, IL; and Marjorie W. Dorr, chief executive officer of Anthem Blue Cross and Blue Shield of Connecticut, North Haven, CT.

Thank you all. We appreciate your attendance and your testimony.

Mr. Fogarty, why don't you proceed?

STATEMENT OF MICHAEL FOGARTY, CHIEF EXECUTIVE OFFICER, OKLAHOMA HEALTH CARE AUTHORITY, OKLAHOMA CITY, OK

Mr. FOGARTY. Thank you, Mr. Chairman.

I must say before I begin, that the last time I was in this room I occupied the chair as a staff person for your former colleague, Senator David Boren from Oklahoma, and I am glad to be back. I left here with no gray hair. I became a Medicaid director, and I will let you draw your own conclusions. [Laughter.]

I am now the chief executive officer of the Oklahoma Health Care Authority, the State Medicaid agency in Oklahoma. It is also my privilege to serve on the executive committee of the National Association of State Medicaid Directors.

While my testimony today reflects Oklahoma experiences and views, I believe it will be representative as well of most State Medicaid programs. The Oklahoma program serves over 400,000 people, about 12 percent of the State's population, with a current annual budget of $1.7 billion.

In the midst of enormous change in our program in recent years, one item has remained stubbornly constant: the upward-spiraling cost of the pharmacy benefit. Since 1997, the average monthly utilization, as measured by the number of prescriptions per month, per beneficiary, increased by 16 percent.

Also, the average cost per prescription increased by more than 29 percent. From 1992 through 1998, the annual pharmacy benefit cost per person increased an average of 13.6 percent per year.

Any plan, Mr. Chairman, to purchase pharmacy benefits, I believe, must address both utilization and price. With regard to utilization, Oklahoma's experience has been one historically based on a three-prescription limit per month, per recipient. Such an arbitrary limitation is obviously easy to administer. It, however, bears no relationship to medically appropriate or effective treatment.

Under drug utilization review, however, a program is designed that is effective not only by reducing in appropriate utilization, but likely achieves even greater savings by avoiding the costs of treatment caused by adverse drug interaction. We plan to enhance our program by providing physicians and pharmacists with useful information for improved decisions based on the practice patterns of their peers.

The necessity for utilization review is driven, at least in part, by our traditional use of multiple dispensing outlets, combined with a freedom of choice policy. We believe there is merit in providing the

benefit through a single entity that would be responsible for coordinating the benefit as well as dispensing the product.

In a related approach, Oklahoma is developing a disease case management program. It will produce savings through improved patient compliance with recommended drug therapy.

Turning to the management of product cost or price, we believe, involves two approaches. First, we attempt to purchase any given product at a reduced or best price. The Federal rebate program is a classic example.

Frankly, Mr. Chairman, we believe it has not produced a good result due to the accompanying mandated open formulary that dramatically increased our program's cost, and at the same time the manufacturers seemingly wasted little time adjusting price to recover the cost of the rebate.

Perhaps the most effective way to achieve savings is to introduce price competition, to design a program so that within specific categories that include drugs with comparable efficacy manufacturers would compete on the basis of price for product inclusion on a closed formulary.

Second, we encourage the use of effective lower-cost products when medically appropriate. Oklahoma's most recent pharmacy benefit initiative focuses on two therapeutic categories of drugs, anti-ulcer and non-steroidal anti-inflammatory drugs. They make up 10 percent of the total pharmacy budget in Oklahoma's Medicaid program.

The design of this program creates two tiers of products within each of the two categories. Those drugs determined to be most cost effective and with comparable efficacy are placed in tier one and are available without prior authorization.

Less cost-effective drugs are placed in tier two, and are available, if authorized, based on specified clinical indications or the patient's previous unsuccessful trial of the tier one product.

As you might imagine, manufacturers have vigorously opposed this initiative. While it is currently in place and producing positive results, its future is, in fact, in jeopardy.

Mr. Chairman, we are acutely aware of the hardships created for adults who are aged and disabled who have incomes marginally above our Medicaid eligibility guidelines and no pharmacy benefit. Their health may dramatically improve when pharmacy benefits are available that are currently beyond their reach. We appreciate your willingness to tackle this difficult issue.

I have described what seems an often frustrating task of managing the growing costs of the Medicaid pharmacy benefits. I am confident that virtually every purchaser of these benefits shares this frustration.

In conclusion, Mr. Chairman, it is critical, I believe, that any Federal plan anticipate ways to effectively deal with this daunting problem. Frankly, it is also imperative that publicly funded programs, State or Federal, be afforded some method of protection from the overwhelming financial and political power of the pharmaceutical manufacturing industry.

I thank you, Mr. Chairman, for the opportunity. I am happy to respond to questions at the appropriate time.

Senator JEFFORDS. Thank you, Mr. Fogarty.

[The prepared statement of Mr. Fogarty appears in the appendix.]

Senator JEFFORDS. Ms. McCall.

STATEMENT OF CAROL J. McCALL, FSA, MAAA, EXECUTIVE VICE PRESIDENT FOR MANAGED CARE AND INFORMATICS, ALLSCRIPTS INC., LIBERTYVILLE, IL

Ms. MCCALL. Good morning, Senator Jeffords and members of the committee. My name is Carol McCall and I am the executive vice president for Managed Care and Informatics with Allscripts.

Prior to working with Allscripts, I served as vice president of pharmacy management with Humana, Inc., a managed care organization that provides pharmacy coverage for approximately 450,000 seniors through the Medicare+Choice program.

I am an actuary and am a fellow of the Society of Actuaries, as well as a member of the American Academy of Actuaries.

This morning, I would like to focus on two frequently discussed alternatives to using PBMs and talk about their differences in being able to achieve a broad set of goals for providing prescription drug coverage to Medicare beneficiaries.

There are two fundamental issues in understanding the role of using PBMs in the Medicare program. First, whether it is possible to use PBMs to provide drug coverage to the Medicare beneficiary population, and second, if it is possible, how they should be used given the goals of the program.

To the first point, I think it is well established that PBMs are very experienced at providing and administering prescription drug coverage for their clients. They build and maintain complex networks of relationships with pharmacies, drug manufacturers, health plans, providers, and patients and can use a variety of mechanisms to encourage cost-effective utilization of prescription drugs.

In interviews with PBM executives, they have gone on record as saying that they are very comfortable that their current infrastructures and technologies are well-suited to the administrative challenges of providing this coverage to the Medicare beneficiary population.

It is the second question that is more to the point. If we believe it is possible to use PBMs, the question is how to do that given the goals of the program. While there are perhaps a large number of goals, some of the more important are to provide broad access to coverage and quality of care, consistency for beneficiaries, choice for beneficiaries, cost containment capabilities, ease of administration, and compatibility of approach with other Medicare reform proposals.

In choosing how to achieve these goals, it is important to consider different approaches to using PBMs as each provides certain advantages. The two primary approaches under discussion in many proposals consider either a single PBM approach where one PBM is selected for a region and has the exclusive rights and responsibilities for providing access to coverage for prescription drug benefits, or a competitive PBM model where more than one PBM is available to beneficiaries in a region. Beneficiaries would choose

which PBM they want, and coverage would be provided through that PBM.

With respect to providing broad access to coverage and quality of care, broad access can be achieved under either approach. One of the fundamental advantages that PBMs provide is their wide network of relationships with pharmacies throughout the United States.

For quality of care, all PBMs, regardless of model, have an important role to play and can have a positive impact on quality. They can make a significant contribution to quality by using their techniques for drug utilization review which checks for possible drug interactions and can reduce adverse reactions associated with taking certain medications or combinations of medicines.

In providing consistency for beneficiaries, consistency would be greater in a single PBM model. For competitive models the consistency between beneficiaries would be less, but its degree would ultimately depend on the amount of flexibility PBMs were allowed. It could be determined, for example, that certain elements of providing coverage are either not flexible or must fit within certain guidelines.

Opposite of providing consistency is providing choice. A competitive model will give more choices to beneficiaries, again, which could be bounded based on the degrees of freedom a PBM will allow.

In general, beneficiaries would choose from different approaches PBMs had for prescription drug access, support services, and cost containment. If a PBM proved to be too restrictive, beneficiaries would likely switch to another PBM at the annual open enrollment.

Single PBMs do not provide that choice and can reduce choice in another way. A single PBM model could give an advantage to bigger PBMs which might reduce the field of bidders.

In terms of providing cost containment capabilities, using the full range of a PBM's cost containment mechanisms is not likely to be as viable in a single PBM model because of the possible political pressures and the lack of choice in such a model.

Competitive models could allow the flexibility to use more of these mechanisms and, because of that, could reduce the overall expenditures associated with providing drug coverage below those in a single PBM approach.

One of the more talked about mechanisms that PBMs use to contain costs is a formulary. It may be more feasible to have formularies in a competitive model than a single PBM model.

Also, even though the consolidated purchasing power in a single PBM model would be larger, the potentially greater drug price discounts may not be sufficient to make up for a loss of rebates that would likely occur if there were no formulary.

Finally, if it is desired to have some PBMs take some of the financial risk for prescription costs, PBMs would want more degrees of freedom in order to manage that risk, which is more likely under a competitive approach, although risk taking is not necessary in a competitive model.

In terms of administration, implementing a single PBM approach is administratively simpler, as the issues surrounding the bidding process are reduced. One of the disadvantages of this initial sim-

plicity, though, is that changing PBMs in this type of model can be disruptive.

Finally, as respects compatibility with other approaches, a competitive model is more compatible with other types of reform being considered for Medicare. I can talk about that more in questions, if you would like me to.

But, in summary, both approaches are capable of providing broad access and enhancing the quality of care. A single PBM model would make consistency for beneficiaries easier to achieve, and a single PBM model is easier to administer.

For the other goals, a single PBM model is not likely to provide the same opportunities with respect to choice for beneficiaries, cost containment, or compatibility with other types of reforms.

The final choice of which approach to pursue is an important one. Before making your choice, Congress should begin with a clear concept of the policy goals and make sure that your choice is consistent with the goals you seek.

I would be pleased to answer any questions about my remarks or my written testimony at the appropriate time. Thank you.

Senator JEFFORDS. Thank you very much.

[The prepared statement of Ms. McCall appears in the appendix.]

Senator JEFFORDS. Ms. Dorr.

STATEMENT OF MARJORIE W. DORR, CHIEF OPERATING OFFICER, ANTHEM BLUE CROSS AND BLUE SHIELD OF CONNECTICUT, NORTH HAVEN, CT

Ms. DORR. Senator Jeffords and members of the committee, I am Majorie Dorr and I am the chief operating officer for Anthem Blue Cross/Blue Shield of Connecticut. Previously, I was the president and director of Anthem Prescription Management, which is a pharmacy benefit management company.

I do thank you for the opportunity to testify on behalf of the Blue Cross/Blue Shield Association in providing pharmacy drug coverage for Medicare beneficiaries.

Congress is now facing the same challenge that confronts Blue Cross plans, which is providing a meaningful level of coverage for prescription drugs while keeping premiums as affordable as possible.

We heard this morning that the cost of prescription drug benefits is high and is escalating, at 15 to 18 percent each year, which is well above other benefit costs. As a result, drugs now account for a growing share of total medical costs and the beneficiaries' premium dollars. Previously, it was below 10 percent and now is rapidly approaching 20 percent of our premium dollars.

Blue Cross/Blue Shield plans employ a range of techniques to keep the drug coverage affordable. Several methods were outlined in my written testimony. In spite of our efforts, however, spending continues to be propelled by a number of market and structural forces over which private insurers have little control. Demographic trends, the rapid flow of new drugs to market, the onslaught of direct-to-consumer advertising, and rising generic drug costs have resulted in higher utilization and growing per-unit drug costs.

At Anthem, we are particularly concerned about the impact the direct-to-consumer advertising has had on utilization and on cost.

A recent study has indicated that the 10 most heavily promoted drugs in 1998 accounted for over one-fifth of the total growth in prescription drug expenditures.

While these ads can improve patients' knowledge on drug options, their impact on utilization and costs is undeniable. It is in this atmosphere of rising prescription drug utilization and cost that Congress is now debating whether or not to add drug coverage to the Medicare program.

We wholeheartedly agree that coverage for prescription drugs is critical to seniors, and we applaud the efforts of the members of this committee to address this issue.

As a first step, we believe Congress and the administration must review all current and pending policies on prescription drugs to assure that they do not exacerbate the rapid rise in prescription drug costs, which does hit the seniors hardest.

For example, Congress has legislation pending right now that would provide patent extensions for certain drugs. A recent study estimates that the extension of these patents could result in additional consumer costs of over $11 billion in the next five years.

Additionally, the House-Senate conferees right now are considering language in the Patient Bill of Rights which would restrict the ability of insurers to manage the cost of drug benefits. These, and similar proposals, must be rejected.

Second, the Blue Cross/Blue Shield Association believes Congress should enact prescription drug coverage as part of an overall Medicare reform. We believe it needs to be integrated. It is simply not prudent to add such an expensive benefit such as prescription drugs until Medicare is on sound financial footing.

However, if lawmakers wish to act now and provide assistance in the interim, we recommend a two-part approach. First, an approach similar to Senator Jeffords' proposal, which is target assistance to the most vulnerable Medicare beneficiaries, those with low incomes, through Federal block grants to States.

We believe that 14 States have already implemented successful programs and 18 others have ones under consideration. This action could be taken quickly and without disrupting the current coverage, bankrupting Medicare, or hindering future Medicare reform.

I have experience with this in Connecticut. Connecticut has a CONPACE program which is very successful. We work collaboratively with the States and the seniors to enroll them in this kind of program which provides drug coverage to those beneficiaries below a certain poverty level.

Second, the Medicare Choice program must be improved. By enhancing and stabilizing funding, more plans are likely to stay in the program and continue to provide drug coverage to seniors at affordable prices. We do appreciate the changes made over the past year by this committee to the Balanced Budget Act. They have been helpful, but more must be done to preserve this program.

We urge Congress to reject attempts to stand-alone programs or to mandate that a drug benefit be added to all Medigap policies. Although appealing on the surface, these proposals simply do not work. They will not make coverage affordable and they will only create a false hope.

In conclusion, expanding prescription drug coverage to seniors is critical, but it must be done in a way that will actually achieve the goal and will not erode or eliminate Medigap coverage, upon which so many current seniors rely on.

Thank you for the opportunity to testify today.

[The prepared statement of Ms. Dorr appears in the appendix.]

Senator JEFFORDS. Well, thank you for your helpful testimony, all three of you.

I am reminded as I sit here of the fact that my family was in the drug store business for 100 years.

Senator MOYNIHAN. Really?

Senator JEFFORDS. Yes. I was the last one to manage it, because the pharmacist at the time, when my aunt had an untimely death, decided he was going to go across the street and open in competition.

So I spent 2 years finding a pharmacist to fill in one day a week, in order to keep it open, and finally sold it to a very fine young man, and it prevailed. But I did learn a lot.

Our recent hearings on medical errors held by the Health Committee, of which I am chairman, has reinforced for me the significance of this relationship and the role that pharmacists can play in reducing medication errors. Could you please give us your opinion on how the plans we have heard about today would affect the pharmacist-patient relationship? Mr. Fogarty, let us start with you and move on down.

Mr. FOGARTY. Let me confess initially, Mr. Chairman, that I am not conversant in those proposals. I did learn a bit about them today. I feel, frankly, inadequate to address that particular question. I would like to invite the other panelists to do that.

Senator MOYNIHAN. Mr. Fogarty, we cannot have that. Just because you do not know anything does not mean you do not testify. [Laughter.]

Mr. FOGARTY. I learned that fact as an employee of this body several years ago. It is often better policy to be honest than to try to make up the answer. Thank you, Chairman.

Senator JEFFORDS. Ms. McCall?

Ms. MCCALL. I will confess to not being completely familiar with the topic, but I will go ahead and testify. In terms of the specifics of each proposal, rather than talking about each one in turn, I think that providing coverage, in general, will enhance the relationship between a beneficiary and the pharmacist, for a couple of reasons.

Number one, just the fact that there would be broader access at all and greater opportunities to have discussions regarding the proper use of medication, especially as respects the potential adverse reactions.

So I think that there are relationships with pharmacists at a number of places. One is at a retail setting, and I think that that can be enhanced, and your own experience long, long ago can give you a flavor for the types of discussions that take place.

But there is also the relationships with pharmacists that are employed by either PBMs or health plans that also play a role in conducting and administering some of the benefits. For example, there

are PBMs that conduct programs that focus on people, and seniors in particular, that take a lot of medications.

So there would be a discussion between that beneficiary and the pharmacist that looks to try to rationalize some of the medications and reduce some of the risk, and they would bring the physician in to that conversation as well if any changes were determined to be possible. But all of that enhances the relationship between the pharmacist and the beneficiaries.

Senator JEFFORDS. Ms. Dorr.

Ms. DORR. I concur with Ms. McCall, that overall coverage for pharmacy will enhance the relationship with the pharmacist and the beneficiary. Currently, seniors do a lot of shopping around because the cost is very expensive, and oftentimes those pharmacists are not talking to each other. So if you have coverage, there is a nice integrated system that will allow then all of the pharmacists to know what kind of coverage the beneficiary is taking.

But I also want to encourage that conversation to occur also with the physician and with the health plan, because when the physician, the health plan, and the pharmacist all are in communication, that is when we can make sure the senior is getting the best coverage possible and the best information possible.

Senator JEFFORDS. Ms. McCall, did you have a further comment?

Ms. MCCALL. One additional comment, and it is not how this coverage might affect the relationship in particular, but the growing trend. There have been projections that the volume increase projected for prescriptions will outpace that of new pharmacists coming into the market by a magnitude of 20 times.

So when you think about the overwhelming——

Senator MOYNIHAN. Excuse me.

Ms. MCCALL. Yes?

Senator MOYNIHAN. Did you say new pharmacists?

Ms. MCCALL. Pharmacists available.

Senator MOYNIHAN. You mean, graduates?

Ms. MCCALL. Yes.

Senator MOYNIHAN. Yes.

Ms. MCCALL. Enable to facilitate and handle those transactions, that they will be outnumbered by a magnitude of 20 just in the prescription volume. What this will do, is put a strain on just the number of transactions that retail pharmacies can, in fact, process and the types of dialogues that I know that pharmacists want to be able to have with the beneficiaries. The amount of time available will become less, so I think that technologies are important to help address that particular problem.

Senator JEFFORDS. Ms. Dorr, do you have anything?

Ms. DORR. No.

Senator JEFFORDS. All right. Fine.

Senior citizens want the freedom to be involved in choices about their health care decisions. At the same time, I am hearing from Vermont seniors that any new program enacted should be straightforward and comprehensible.

As we discuss the increasing competition in every sector of the health care industry, including prescription drugs, how can we help to ensure that all seniors are able to get the help they need in navigating through these programs? Mr. Fogarty.

Mr. FOGARTY. I think, Mr. Chairman, that the key question is the availability of the program at all. If we finally achieved success in overcoming that barrier, then those Medicare beneficiaries that may have that benefit available will need to have the basis to make informed decisions.

But I think, most importantly, the underlying ability to manage the cost of that program is going to enhance the ability of those recipients to do that. They have to be effective benefits and they have to be affordable benefits, and they have to come accompanied with sufficient information for the beneficiary to make those kinds of decisions.

Senator JEFFORDS. Ms. McCall.

Ms. MCCALL. To continue along that same vein, I think there are a couple of ways in which to help that communication occur. Number one, is to set communications standards with respect to, specifically, what needs to be communicated, in what format, when, and how.

Second, depending on the approach that is taken, whether it is single PBM or a competitive model, I would imagine that if it were competitive that service would be one of the differentiators that PBMs would seek to use as a basis of competition, so that I would imagine that there would be a number of mechanisms for seniors to contact whomever their administrator is to help them sort through any uncertainty that there is.

Senator JEFFORDS. Ms. Dorr.

Ms. DORR. We currently do have some nice mechanisms in place that help navigate the seniors through the system. I think the Medigap program is a fine example. A recent poll that we did of our Medigap participants have over 90 percent satisfaction. We are helping them navigate through.

I mentioned in the Connecticut program, the CONPACE program. We help the seniors fill out the applications for this assistance for drug programs that the State helps fund. Those are things that a plan can help do. Certainly the Medicare+Choice.

Again, the reforms that you have helped make to stabilize this program. Still more is needed, but I think the health plans help those seniors navigate through the complexities that surround coverage as they age.

Senator JEFFORDS. My good friend, Senator Moynihan.

Senator MOYNIHAN. Why, thank you, neighbor and friend.

I have a question for Mr. Fogarty and the whole panel, but I am sure he will want to speak to it specifically. We have been trying to get some metrics about this whole subject.

One of the issues is the degree to which the increased pharmacy costs are offset by decreased use of hospital facilities. We began this program in almost another era of medicine, when what you did when someone got sick, is you sent them to the hospital, and they got better or they did not, but we learned not to do any harm.

But you might have heard Senator Frist say that he, as a medical student, specialized in stomach surgery, and that they do not teach that any more. Just this one pill has taken many of those ulcer diseases away and has probably reduced the number of psychoanalysts talking about stressful personalities that produce ulcers, too.It turns out to be a virus.

But do you have any sense of that trade-off, if that is the word for it? I would ask you all, we are getting anecdotal evidence, but we do not have any number.

Mr. FOGARTY. Thank you for the question and the form of it, because if you had asked for empirical data I would have to say, no, I do not have it.

Senator MOYNIHAN. Yes.

Mr. FOGARTY. But do I have a sense of it? Yes, I believe I do have a sense of it.

Senator MOYNIHAN. Yes. Yes.

Mr. FOGARTY. Interestingly, Oklahoma was a late-comer in the Medicaid pharmacy program. We did not implement a pharmacy program in Oklahoma until over 10 years after we had a Medicaid program, so 1976. We were authorized by our legislature to have a program and spend up to $9 million. The program is now $175 million.

The fact of the matter is, and it is true intuitively, I think, to anybody that looks at it, and that is, there are now pharmaceutical products that, because they are available to Medicaid recipients in Oklahoma, avoid the cost of treating diseases that would otherwise result in inpatient care or other alternatives far more expensive than pharmaceutical intervention.

I want to include in my response, something that is very important in today's consideration. Zantac did revolutionize the treatment of stomach illness. Zantac is now available to the Oklahoma Medicaid program at a price of 50 to 60 cents a pill.

What I am asking for, and what we have now implemented in Oklahoma, is the ability to encourage people to continue to use Zantac, frankly, at 50 to 60 cents a pill, which is very effective, rather than going immediately to Prilosec at $3.50 a pill, which is a new, improved product, a wonderful thing.

There are certain conditions that respond to that $3.50 product much better than they responds to Zantac, but the fact of the matter is, if we want—and I recommend to you in a Federal program—the ability to manage that program in a way that provides effective response at the lowest cost, that means if Zantac will do it, let us use Zantac before we move on to a more expensive product.

Senator MOYNIHAN. Ms. McCall, do you find this substitution effect taking place?

Ms. MCCALL. In terms of the phenomenon that was just described?

Senator MOYNIHAN. Yes. Yes.

Ms. MCCALL. Yes. I have found in my experience a lot of desire when new products are launched that there is an overwhelming desire to try the new product. It may be they need all the new indications for a drug.

Probably the most recent example of that, was the introduction of the new Cox 2 drugs. One is call Viox and the other is called Celebrex, and these can be extremely effective in helping people with the pain of arthritis.

There are drugs out there on the market that can do that today, but these are supposed to reduce the incidence of gastrointestinal upset. So some are taking the Prilosec that was just mentioned, and they may not need that, or need that less frequently than a

Cox 2. But the phenomenon happens for a lot of drugs, so there are a lot of instances where there is greater demand for a drug as people want to move up toward the best and greatest.

Senator MOYNIHAN. Ms. Dorr, do you want to respond?

Ms. DORR. I, too, have been searching for that data. As a payor, I can simply tell you the facts that we have from our data, which is, we have had flat inpatient days, not declining. We have had increasing outpatient days, not declining. I have increased pharmacy costs and increased utilization.

Are there specific examples? Yes. And I think these are wonderful examples of where a lot of the pharmacy has helped reduce some of the medical costs. But I can tell you, in the overall aggregate, no. That is because a lot of the new pharmaceuticals are life-enhancing. They are not decreasing the medical costs but they are, indeed, improving the health.

Claritin is a nice example. It is OTC—over the counter—in most of the rest of the country, but not here. But it makes one live their day much more enjoyably than if they were not taking this Claritin. But it is not necessarily, unless you are an acute asthmatic, not decreasing any medical stays as a result and it is a very expensive drug.

Senator MOYNIHAN. I can testify, at age 73, that Celebrex is quite a good thing. It was all right for me. I guess I would not be in a hospital, I would just be unhappy.

Ms. DORR. Right. And that tends to be a lot more of the new drug therapies that are being introduced.

Senator MOYNIHAN. Thank you all. Thank you very much.

Thank you, Mr. Chairman.

Senator JEFFORDS. Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman. Thank the panel as well for their testimony. I appreciate your being with us. A lot of the discussion in the Congress has been in reference to prescription drugs, the fact that we all sort of agreed almost, I guess, to use PBMs to administer delivery of the pharmaceutical drugs, but there has not been a great deal of discussion about what type of PBMs we are going to be utilizing.

There is very little discussion of whether there will be a single PBM in a region, or whether there will be competing PBMs, whether they will have open formularies, or closed formularies, or who is going to decide what drugs go into a formulary, or what are we going to do about adverse risk selection, and all the multitude of questions that come into play dealing with this PBM. Pharmaceutical benefit managers are not, I think, just a panacea for the high cost of drugs. I mean, it is just a mechanism to be able to purchase drugs for people.

So I wanted to ask, and I was really interested in the comment, I think, by Mr. Hash from HCFA, when he argued in support of a single PBM in a region, because multiple PBMs would conceivably give beneficiaries too many choices. I do not know how they rationalize that and balance it with Medicare+Choice, which in effect is giving beneficiaries more choices.

So can I have some discussions about, how do PBMs work? I mean, which ones are best? Do we give a PBM a monopoly to deliver drugs for beneficiaries, or is competition among PBMs a bet-

ter approach? Ms. McCall, you had talked about it, but I do not think you made a recommendation.

Ms. MCCALL. No, I probably did not make one during the testimony. My personal opinion, and to play off of some of the comments earlier today, is that we need broader reform.

I believe that, given some of the reforms being considered for other parts of Medicare, that a competitive approach with respect to PBM models is more consistent with achieving some of the goals that were laid out.

Some of the goals that I mentioned earlier today, I think that, in terms of flexibility that is needed, we have not talked at all about performance guarantees or how to measure a PBM or any risk taking.

Senator BREAUX. If you have competing PBMs in a region, how do you avoid adverse risk selection?

Ms. MCCALL. I think that there are a couple of ways to do that. Adverse risk selection at all, within the program, is separate and distinct from adverse selection between PBMs.

The most important thing is to, first, look at how the program is designed, which is to say, what are the eligibility and enrollment requirements and restrictions, what is the level of the benefit, because it is possible to design benefits that attract people that are healthier, and third, what are the subsidies?

Senator BREAUX. On that question about designing of the program, should Congress design the program? I mean, the Breaux-Frist suggestion is that there would be an $800 actuarial value prescription drug plan, as opposed to just saying exactly what the copayments are, what the deductibles are.

Should Congress design the program and then say, anybody who wants to compete to offer these benefits, can compete to do so? Is that the proper approach to avoid adverse risk selection, or what?

Ms. MCCALL. I think an actuarial value approach is very appealing, and not simply because of my background. But I think it would need to be designed very carefully. There may still need to be in that approach some boundaries within which all types of benefits would have to operate.

The reason, is that $800 of actuarial value could be designed in a myriad of ways, and that is probably, if it were done with complete flexibility with respect to drug class or how something was put together, there would be a lot of fracturing of the risk pool among different players and PBMs. So there would be some sort of framework or foundation below which you may not want to allow players to go, but still give them flexibility.

Senator BREAUX. Recently, the health insurance folks testified that the insurance industry would not be interested in providing insurance for prescription drugs. They do it in the private market, obviously, and they do it in some of the Medigap policies.

With your experience, either one of you, we are not mandating that insurance companies would insure for prescription drugs, we are just offering them the opportunity to do so. If some of them want to do it, I would imagine some of them would.

Do you have any feeling for whether this prescription drug issue, either one of you, is something that would be insurable? I mean,

what is the past experience? Have insurance companies not dealt with prescription drug insurance policies before?

Ms. DORR. We offer drug coverage integrated in with the medical coverage as opposed to a stand-alone drug coverage. So, in theory, could you offer just a stand-alone drug coverage? Of course you can.

Senator BREAUX. Would your company do it?

Ms. DORR. No, we would not offer that because it would turn into what we call in the insurance industry a death spiral, that you start out with a certain rate, anticipating X number of people participating, and then, in particular with pharmacy coverage because it is rising so rapidly, the premium would go up such that the healthy people would drop out, and then the sick people would stay in. The following year, the drug coverage premium would go up even more dramatically. The healthier people of that mix would drop out, and it just becomes a death spiral.

Senator BREAUX. Can I ask one follow-up question? This is really important. We want a voluntary drug program. That is what has happened with Medigap. For the people who offer prescription drug plans, the three of them that do, only the people who need prescription drugs are buying the insurance. Obviously, it costs a great deal.

But suppose you said you give people an up-front choice: I mean, they would have a window when they enroll in the program to sign up for this program. If they did it later, there would be a penalty. So, it would encourage people to take advantage of it immediately, up front. That is what we do with Part B.

Would that not help ensure that everybody gets into the program without having a mandate from Congress?

Ms. DORR. Senator, currently that is the way the program works. There is a choice that all seniors have when they turn 65. They can buy that.

Senator BREAUX. That is what I said, Part B is like that. But, I mean, would that not help with regard to a prescription drug plan?

Ms. DORR. So it is an integrated drug program with the medical program. About 10 to 20 percent of the people select those particular programs that include drug coverage at that point in time, so the people do have that choice right now.

It is an affordability issue that a number of people, the people that do not select those particular coverage, do not select the three programs that do include drug coverage. But we have that in our particular plan. About 20 percent of the seniors do select programs with drug coverage, and they are very happy and satisfied in those programs.

Senator BREAUX. Ms. McCall, do you have a comment on that?

Ms. MCCALL. I agree with what Ms. Dorr said. The anti-selection capabilities are tremendous with a stand-alone program. I think your idea of handling it in a manner similar to Part B, something to that effect would be absolutely necessary.

Part of this is due to the cost of how pharmacy costs differ from other types of costs. I do not know if you have ever heard the 80/20 rule; about 20 percent of the people spend about 80 percent of the dollars, in general. But in pharmacy, that is not the case. It

is about a 55/20 rule. Twenty percent of the people spend about 55 percent of the dollars. So, it is more evenly distributed.

In terms of the cost of a unit of care, it is cheaper. Prescriptions, for as expensive and as overwhelming a burden as they have become for people, the individual prescription itself is much cheaper than a hospital stay and a day in the hospital.

So it is lower cost and higher frequency, so when you turn back to insurance principles and what you really want in order to have an insurable benefit, you want a very low frequency, much higher cost, much less predictable type of occurrence. Then you have the basis for insurance. So we are beginning to kind of toe that line, and other elements to prevent adverse selection are going to be very important.

Senator JEFFORDS. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I want to follow up on what John Breaux was talking about. It is always necessary for me to disagree with John Breaux about something, just as a matter of principle. Whether I do or not, I have to.

He indicated the Medicare+Choice, and then related that to what we are talking about here. One of the things that I would say about Medicare+Choice as opposed to fee-for-service, is that it tends to attract healthier people, and thus, the diminution of the so-called fee-for-service pot for sicker and more frail people.

Now, you get into what we are talking about here and you come up against the question of adverse risk selection. It is confusing, in a sense. I think you, Ms. McCall, just said that 20 percent of people use 50 percent of drugs. That is necessary, and those are probably the kind of people who would be in fee-for-service because they would not be taking plans, or there is that possibility. I would ask any of you to comment on this.

So it is almost a necessary condition. I mean, obviously some people require more prescriptions than others do. That is just the way life works. So how is it that we deal in this whole question of prescription drugs with adverse selection in a way which gives people what they need, but does not sort of violate some principle which means that people that are necessary to all of this functioning properly stay away from it, if you understand the question that I am asking.

Also, Don Nickles says to say hello.

Mr. FOGARTY. Thank you. Thank you.

And I think Medicaid does have something to contribute to that question, if I might, Senator. Obviously, if you have Medicaid in Oklahoma, you have a pharmacy benefit. It is not optional. You are either in the Medicaid program or you are not.

What that means, of course, is that the risk of that cost is spread over the entire population of 400,000, in this particular case. But what perhaps is more important——

Senator ROCKEFELLER. But is it not also true, though, that that is a much more sort of a constant type of group? I mean, they have more consistent points about them, financial and otherwise.

Mr. FOGARTY. I think not. Well, financial, certainly, because they all meet the financial eligibility, so they are, by definition, in the low income status financially.

However, it is an extremely diverse population, including now 260,000 children out of that 400,000, and another 150,000 adults. So it is a very diverse population in both age as well as health status.

But the point I want to make, is Oklahoma also now has 150,000 of those 400,000 in fully capitated managed care plans. Those plans all include—we do not carve out the pharmacy benefit—the pharmacy benefit. Of course, that risk is also spread.

My point is, it works well in Oklahoma. One of the reasons it works well, is because the plans have been given the latitude to manage that component of the benefit package, specifically the pharmacy benefit. But it also works well because it spreads the risk across the entire population.

I would suggest that any—any—federalized proposal that gives options where people who need the program most are going to be incentivized to take it, is by definition going to have a very difficult time dealing with that adverse selection in terms of how to make that program affordable.

I think the closest, perhaps, if you come to it, I heard Senator Breaux mention a Medicare Part B-type approach, where you declare in or out, not based on a need at a given time. For me, that would be the closest I would want to come to a program where you would go in knowing that adverse selection was going to be a tremendous burden in that program.

Senator ROCKEFELLER. Is that it? I would like to hear from you two, if the Chairman will allow it. But does that mean that adverse selection is a given and that we respond to that by assuming that they need the prescription and that, therefore, there has to be more money spent, or are you looking at another mechanism whereby you can get around adverse selection in some way? I mean, in other words, does the adverse selection mean it is going to be more costly and we had just better face up to it?

Mr. FOGARTY. It will clearly be more costly as to those who choose to go into the program, tremendously more costly.

Senator ROCKEFELLER. Right.

Mr. FOGARTY. I think you need to look to a system that will spread that risk among a much broader population.

Senator ROCKEFELLER. But that is the question I am asking. How do you do that? How do you do that?

Ms. MCCALL. If I may. Part of the issue of adverse selection only arises when you have different financiers, number one. So if you set up a program where—excuse my terminology—the government is the bank and the only bank, if you do not get all the enrollees and some of the healthier ones decline to participate in their wisest judgment, instead of spending $1,000 you may spend $900. Now, instead of spending that on 10 people, maybe you are spending it on 1, but you are still only spending $900.

The issue, is when you try to calculate it on a per-participant basis and the participants can go, perhaps, to different places that are funding that. Then it becomes an issue. I only wanted to state that. That is a very important point of differentiation.

To your question of how to handle it if there are different financiers and who has what financial risk, is very important. I would recommend looking to the private insurance industry for health in-

surance for some of those mechanisms because the potential for that exists every single day. Some of the things that are commonly used, we talked a little bit about eligibility and enrollment, and you had mentioned that with respect to Part B. That is very important.

Another one, is what are the benefit levels? Are they designed to try to entice healthier people? For example, for the healthier in the population, most of what they use are generic drugs.

So what if there were a benefit that were designed to try to say, I am going to enhance coverage for generics, I am going to try to provide a catastrophic type of coverage so for those of you who are healthy today, you never know, and in the middle I am going to try to provide more of the benefit of cost and negotiation leveraging, not so much in insurance but just to help in terms of financing that.

Those are just examples of ways to try to design a benefit that could be attractive enough for people that are healthier, as well as provide help for people that are on chronic medications. So, benefit design is absolutely critical.

It also may be important to bound the choices of benefits. If you go into an insurance mechanism and you look at what they do when they face a choice, what they call a personal choice environment, they do not want to go into situations where somebody has an extremely richer or extremely leaner benefit. Risk adjustment mechanisms and high-risk pools are two other mechanisms that are considered or used in terms of how to deal with that.

Ms. DORR. Senator Rockefeller, adverse selection——

Senator JEFFORDS. Please be brief.

Senator ROCKEFELLER. The Chairman is about to gavel me.

Ms. DORR. This is why we do not recommend a stand-alone drug plan, is because of this adverse selection and this is very complex, obviously, dealing with the pharmacy, and we do not advise tackling that separate from the overall reform.

That is why we do believe the Federal block grant will address the poorest of the poor so that they can get the drug coverage and not be affected with this adverse selection which will occur with a stand-alone drug benefit.

Senator JEFFORDS. I want to thank you all for excellent and very helpful testimony. I will tell Don Nickles that you performed admirably.

Mr. FOGARTY. Thank you very much.

Senator MOYNIHAN. Ms. McCall, we finally have an economist on the case.

Senator JEFFORDS. Thank you all. I think this committee, I assume, reserves the right for members to submit questions to you if they so please, and I am sure you will respond.

[Whereupon, at 12:53 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. MICHAEL BILIRAKIS

Mr. Chairman and members of the Committee, thank you for inviting me to testify regarding prescription drug coverage for Medicare beneficiaries. My Health and Environment Subcommittee is holding similar hearings in the House, and I appreciate the opportunity to exchange views with you.

In considering this complicated issue, I have been guided by two simple principles: No beneficiary should have to choose between buying groceries and filling a prescription, and we should help the poorest and sickest beneficiaries obtain the medicines they need today.

I represent one of the "oldest" congressional districts in the country. Like all of you, I hear regularly from constituents who are concerned about access to affordable prescription drugs. The members of the National Bipartisan Medicare Commission spent many hours wrestling with this question; we failed to make a consensus recommendation to the Congress because of this specific issue.

We have all heard the numbers: roughly two-thirds of Medicare beneficiaries have some form of prescription drug coverage, but one-third have no coverage at all. Given the vital role of pharmaceuticals in modern medicine, we must improve Medicare by reforming it to include a prescription drug benefit.

In lieu of comprehensive reform, however, common sense dictates that we focus first on helping those who lack any coverage B while we continue working to expand access to affordable prescription drugs for all beneficiaries. It is also clear that absent fundamental reform, a major expansion of Medicare spending on prescription drugs would seriously threaten the solvency of this vital program.

Therefore, if we are unable to reach agreement on legislation to reform Medicare, I believe we must act this year to help the poorest and sickest beneficiaries obtain prescription drugs. This is a first step, but a necessary one. These vulnerable individuals should not have to wait any longer for the assistance they so desperately need.

Let me explain why I feel so strongly about this point. In 1994, I joined then-Congressman Roy Rowland in proposing a targeted, bipartisan solution to reform our nation's health care system. Our plan included critical provisions to help individuals with pre-existing conditions obtain coverage and to allow workers to keep their health insurance when they change jobs.

Unfortunately, the President took an "all or nothing" approach to health care reform B which resulted in the enactment of nothing. Sadly, individuals in need of care were thereby forced to wait an additional two years until these insurance reforms were enacted into law in 1996 B with strong bipartisan support. We must not repeat that mistake.

In my mind, it is unconscionable to make the neediest beneficiaries wait for prescription drugs while we continue to debate the larger issues involved in Medicare reform. Joined by Democratic Congressman Collin Peterson, I have introduced legislation to address this concern.

Our bill, H.R. 2925, is the first step in providing coverage to those in need. It would provide federal support for state prescription drug assistance programs serving low-income beneficiaries. It would also establish a federal "stop-loss" protection against high annual drug costs for beneficiaries who obtain up-front coverage. Equally important, it would not raise beneficiaries' Medicare premiums, increase Medicare spending or jeopardize the program's solvency.

States that choose to participate would receive enhanced federal matching funds to cover individuals whose income is at or below 150 percent of the federal poverty

level. Federal funds would be available to states at the regular Medicaid matching rate to serve individuals whose income is between 150 and 200 percent of poverty.

Under our stop-loss plan, the federal government would protect beneficiaries who obtain qualifying up-front coverage from paying more than $1,500 annually in out-of-pocket costs for prescription drugs. Seniors would continue to receive prescription drug benefits through a market of competing private sector plans, with no increase in their Medicare premiums.

To date, 18 states have authorized or implemented pharmaceutical assistance programs. According to the National Conference of State Legislatures, prescription drug proposals are a top priority for consideration in a majority of the states' legislatures. Working in partnership, we can build on these state initiatives to help beneficiaries in greatest need.

In addition, I was pleased to learn that the President's budget proposes to set aside $35 billion over 10 years for a "policy that provides for protections against catastrophic drug costs." I obviously share his view on the need for a "stop-loss" protection, and I hope we can work productively in this area.

I believe we have a moral obligation to act now to help the poorest and sickest beneficiaries obtain the medicines they need. If Congress and the President are unable to reach agreement on broader Medicare reform, I would urge members of this Committee B at a minimum B to help the neediest beneficiaries this year. Our nation's poorest and sickest beneficiaries should not be forced to wait any longer for prescription drug assistance.

Thank you again for the opportunity to testify. I would be glad to answer any questions.

PREPARED STATEMENT OF DEBORAH BRICELAND-BETTS

Mr. Chairman and distinguished Members of the Committee:

I appreciate your invitation to testify today on the timely issue of developing a prescription drug benefit for Medicare. OWL commends you and the Committee for engaging in the important discussion of updating and strengthening Medicare for the 21st century.

As the Executive Director of OWL, the only national grassroots membership organization dedicated exclusively to the unique concerns of women as they age, I can assure you that our members are fired up about this issue. Many of the healthcare hurdles facing older women have not changed since OWL's 1999 Mother's Day Report, The Face of Medicare is a Woman You Know, and its addendum Medicare: Why Women Care were published. Based on this research, the longtime leadership of OWL on this issue, and our upcoming 2000 Mother's Day Report on this very topic, I am pleased to be able to share with you some concrete suggestions that both would modernize Medicare and truly help those who use the Medicare program the most: older women.

Women are quite literally the face of Medicare. Let me paint you a picture of the typical Medicare recipient. She:

- Is 58% of the Medicare population at age 65 and 71% at age 85; as you know, the fastest growing portion of our population is age 85 plus;
- Managing more than one chronic illness at a time. At age 65, 9 in 10 women have at least one chronic illness; 73% have two or more chronic illnesses;
- Has outlived her spouse, she's divorced or, increasingly, she's never been married; and because she's alone, she is five times more likely to be poor; older women are 75% of the elderly poor;
- And she is paying an average of 22% of her annual income, or about $218 a month, for out-of-pocket health expenses such as prescription drugs and supplemental health insurance. This compares to 17% for male Medicare recipients.

And though she may be living in her own home today, her poor health and the lack of help in managing her daily affairs will probably require her to seek long-term care—paid for by Medicaid—tomorrow.

Because older women are more likely to be poor, they are more likely to face financial barriers to health care and thus spend a greater portion of their income on such costs. Except for those individuals enrolled in managed care programs, Medicare does not cover prescription drugs unless they are used in a hospital or other health care institution. Yet almost eight out of ten women on Medicare use prescription drugs regularly, and thus most pay for these medications out-of-pocket.[1] All told, because of their greater longevity and their tendency towards more chronic illnesses, women on Medicare spend 20% more on prescription drugs than their male counterparts.[2]

We must remember that this financial burden is being placed on women who are, at every age, at a greater risk for poverty than their male counterparts. These disparities are particularly pronounced in old age. Women's retirement income is almost less than half of men's. Women age 65 and over are twice as likely as older women to be poor, with average annual incomes of less than $10,000.[3] Women with incomes of less than $10,000 and no Medicaid spend 53% of their annual income on out-of-pocket health expenses.

But I want to be clear here today. Access to prescriptions drugs is not simply a problem for the poor. While older Americans comprise only 12 percent of the U.S. population, they account for one-third of all prescription drug spending.[4] In fact, after premium payments, prescription drugs account for the single largest component of out-of-pocket spending for non-institutionalized Medicare beneficiaries' age 65 and older.[5] Consequently, many seniors with moderate incomes are also finding that the high cost of prescription drugs are out of their reach; many of them are sacrificing their future financial security and, sadly, even playing a game of Russian roulette with their health as a result. Stories abound of seniors trying to stretch their medications by not taking the required dosages, and in fact some are not taking needed medicines at all.

A new international health care survey of the elderly by the Commonwealth Fund reported 7% of adults ages 65 and over did not even fill a prescription.[6] Why? Because they can't afford them, and there is no comprehensive benefit that provides the medicines they need at a reasonable cost. We even hear of how this financial burden is trickling down through the generations, with working families paying for parents' prescriptions and thus limiting what they can save for their children's education or their own retirement. So I must stress that these catch-22 decisions are not limited to the poor. The barriers are very real for those with moderate incomes, and a simple Medicaid enhancement will therefore not solve the full scope of the problem.

In fact, limiting a Medicare drug benefit to only those with low incomes would exclude many of the people most in need of assistance, including those with modest incomes (135-200% of poverty). Research suggests that beneficiaries at all income levels experience high or very high drug spending and out-of-pocket costs.[7] A means tested program would also exclude those in poor and fair health, or with severe functional limitations, who have incomes or assets too high to qualify for Medicaid coverage. Clearly, then, this is as much an affordability issue as it is a coverage issue.

Ironically, Americans who pay for all or part of their prescriptions out-of-pocket are charged far more than either insurance companies or HMOs. In fact, uninsured seniors often pay twice as much for their prescription drugs than more favored customers, such as those in big HMO plans or the federal government.[8] And those costs are rising. From 1981 to 1999, prescription drug prices increased by 306%, while the Consumer Price Index, on which Social Security's cost-of-living-adjustments are based, rose 99%.[9] Given this lopsided increase, we should not be surprised that the high cost of many prescription drugs are out of reach for many seniors, regardless of income.

This is a universal problem that requires a universal solution. Outpatient prescription drug coverage is one of the last major benefits still excluded form Medicare, and the elderly are the last major insured consumer group without access to prescription drugs as a standard benefit. With the technological revolution that is taking place in the development of safe and effective drug therapies, the absence of such a benefit is a critical barrier to providing comprehensive, effective treatment to our rapidly aging population.

In some cases, prescription drugs can be a substitute for surgery; in others, it can postpone institutionalization. Prescription drug coverage needs to be part of Medicare if the program is to keep up with the latest developments in modern medicine. One in eight seniors cannot afford the cost of prescription drugs.[10] Those individuals not only put their health at risk, but also ultimately cost the Medicare system more in funds through treatments and hospitalizations that might have been avoided by proper medication.

It's also obvious that existing approaches to this issue are not enough. Medigap coverage is limited and spotty, HMO coverage is decreasing and often unreliable, and employer-sponsored coverage is just plain declining. One in every three Americans over age 65 has no prescription drug insurance. Millions more have only limited coverage, which is slipping away as HMOs and company retirement plans cut back or drop altogether their drug benefits.[11]

Frankly, the existing coverage options are inadequate, limited, expensive, and unstable. For instance, a new study by the Commonwealth Fund reports that most Medicare beneficiaries do not have continuous prescription drug coverage. In 1996,

just 53 percent of beneficiaries had prescription drug coverage throughout the year.[12] Thus, while low-income Americans would certainly benefit from a prescription drug benefit, targeting only low-income beneficiaries would leave millions of seniors without affordable, dependable coverage. Now is the time for a Medicare prescription drug benefit—OWL strongly believes that we must work to fix this particular roof while the sunshine of the surplus warms the debate.

Keeping in mind these pictures I've painted for you—both of the typical recipient and the scope of the problem—OWL would like to put forth several suggestions for your consideration as you deliberate the prospects for a Medicare prescription drug benefit package.

OWL strongly believes that prescription drug coverage for seniors is needed to modernize Medicare. Further, such a program is best implemented through a defined benefit package that is voluntary, comprehensive, and universally available to all beneficiaries. Co-payments, premiums and deductibles must be affordable, and benefits should be indexed to inflation to ensure that coverage keeps pace with the cost of prescription drugs. Lastly, adequate stop-loss protections and catastrophic coverage are critical components, and measures must be taken to ensure that a new prescription drug benefit does not put current Medicare benefits at risk.

Let me briefly elaborate on each of these principles.

- The benefit must be universally available to all Medicare beneficiaries, regardless of income.
- The benefit should be voluntary, allowing beneficiaries to keep their current coverage if they choose to do so.—
- The benefit needs to be affordable, with premiums, co-pays and deductibles that are within the reach of all seniors. This is an important element in avoiding the dangers of adverse risk selection. Also, the government contribution towards such a benefit must be sufficient to produce a premium and benefit design that is accessible to low income seniors.
- The benefit should be part of the defined benefit package of a modernized Medicare program.
- The benefit must assure access to medically appropriate drug therapies, including the high-end, cutting edge drugs that many older women need for common chronic illnesses.
- The benefit should be indexed to inflation to ensure that coverage keeps pace with the rising cost of prescription drugs. Further, while OWL has not yet taken a position on this issue, I do believe that drug purchasing strategies that enable the Medicare program to take advantage of the aggregate purchasing power of large numbers of beneficiaries should be explored.

Proposals to increase cost-sharing and deductibles under Medicare would likely discourage many women, for whom out-of-pocket health care expenses are already a hardship, from seeking the health care they need. Proposals to provide a set amount of money to purchase Medicare coverage would unfairly disadvantage women who could not afford the high cost of comprehensive coverage. Further, both approaches could lead to adverse risk selection within the plans, thereby inflating costs and endangering coverage. Frankly, if prescription drug coverage is available but not affordable, it just doesn't work. Medigap is an excellent example of this concept; it's available, but most people don't buy it because they can't pay the bill.

Whenever prescription drug coverage is discussed, there is always an 800-pound gorilla in the room—the issue of price controls. The American consumer is understandably upset that prescription drug costs in the United States are the highest in the world. It seems reasonable that, despite arguments about negatively impacting research and development as well as the potential profit losses for pharmaceutical companies, there is room to explore models that would insure that Americans paid only their fair share for these necessary and beneficial therapies. Truthfully, we all know that this cat is already out of the bag. As representatives of the American people, I know that Congress is struggling to give their constituents an answer to these simple questions: Why do Americans pay more? And, what can be done to reduce this disproportionate burden on American consumers? Any reform measures you adopt should also address these key public concerns.

I respectfully urge that, in undertaking any type of Medicare reform, policy makers must develop a program that reflects this simple fact: women are the face of Medicare. A Medicare prescription drug benefit may be the single most important improvement Congress can enact for America's retirement health. But if the prescription drug benefit you design doesn't work for women, it just doesn't work.

ENDNOTES

[1] Kaiser Family Foundation/Commonwealth Fund, Survey of Medicare Recipients.

[2] National Economic Council, Domestic Policy Council, *Disturbing Truths and Dangerous Trends: The Facts About Medicare Beneficiaries and Prescription Drug Coverage*, July 22, 1999.
[3] "Women and Medicare" Fact Sheet, Kaiser Family Foundation, 1999.
[4] Statement of Beatrice Braun, M.D., Testimony Before the Subcommittee on Health of the House Committee on Ways and Means Hearing on Senior's Access to Prescription Drug Benefits, February 15, 2000.
[5] Statement of Beatrice Braun, M.D., Testimony Before the Subcommittee on Health of the House Committee on Ways and Means Hearing on Senior's Access to Prescription Drug Benefits, February 15, 2000.
[6] Commonwealth Fund
[7] AARP, "How Much are Medicare Beneficiaries Paying Out-of-Pocket for Prescription Drugs?" September 1999.
[8] Prescription Drug Task Force, US House of Representatives, October 28, 1999.
[9] Bureau of Labor Statistics, 1999.
[10] National Committee to Preserve Social Security and Medicare, "America's Quiet Crisis: Prescription Drug Costs for Seniors," 2000.
[11] National Committee to Preserve Social Security and Medicare, "America's Quiet Crisis: Prescription Drug Costs for Seniors," 2000.
[12] Commonwealth Fund, January 2000.

PREPARED STATEMENT OF HON. PAUL COVERDELL

[MARCH 22, 2000]

Mr. Chairman, I appreciate your willingness to hold this hearing to discuss the issues that surround the inclusion of a Medicare prescription drug benefit in the Medicare system. I look forward to working with the Chairman and the distinguished members of this committee to advance the debate over these issues and to carefully explore the best options for modernizing Medicare and securing its future.

When Congress created the Medicare system in 1965 to provide health insurance to the elderly and disabled, it could not have anticipated the modern-day dependence on pharmaceuticals to treat disease. While many blame prescription drugs for the rise in health care costs, truth is that, per dollar spent, drugs offer a better return on health care spending than virtually any other health care option. The use of prescribed drugs as a routine and chronic treatment in meeting the health care needs of older Americans has changed over the last thirty-five years. It is time we lay out a plan to modernize the Medicare system and respond to the changing needs of our elderly population.

Testimony this morning hopefully will illustrate where the need for prescription drug coverage lies. It is important for us to look at the facts when considering a prescription drug benefit. For instance, Medicare beneficiaries already have private or public insurance to supplement their Medicare benefits, and over two-thirds of Medicare beneficiaries already have some type of prescription drug coverage. Admittedly, beneficiaries in higher income brackets tend to have higher levels of drug coverage, persons below poverty level are also often eligible for drug coverage through Medicaid. The lowest level of drug coverage is for seniors and disabled Americans that make between 100% and 200% of poverty.

One of the difficulties in providing a Medicare drug benefit will be providing coverage in a way that does not diminish the benefits older Americans may already have, while extending protection to those who presently have no or very little drug coverage.

The issue of out-of-pocket costs must also be evaluated in our discussions. Whereas beneficiaries in higher income brackets are most likely to have prescription drug coverage, they are also likely to pay nearly one-third of their drug bill out-of-pocket. For instance, the Administration's plan does not cover drug costs after the beneficiary exceeds the maximum allowable expenditure, so the out-of-pocket costs could be very detrimental to seniors.

We all agree that our seniors need help, and we must respond with a responsible solution. But one of our overriding concerns must be ensuring that we do not make the system worse or erode the choice and flexibility seniors deserve with their health coverage. We must also be cautious about proposals such as the Administration's plan which will raise seniors' premium costs, endanger their existing coverage and of course, increase bureaucracy.

Having said this, I look forward to hearing the testimony of the witnesses and having their insight into the complex and often contentious issue of Medicare reform and the need for a prescription drug benefit.

PREPARED STATEMENT OF HON. PAUL COVERDELL

(MARCH 29, 2000)

Mr. Chairman, I appreciate your willingness to hold this follow up hearing to discuss the issues that surround the inclusion of a Medicare prescription drug benefit in the Medicare system. I look forward to working with the Chairman and the distinguished members of this committee to advance the debate on these issues and to carefully explore the best options for modernizing Medicare and securing its future.

According to the Bipartisan Commission on Medicare, not only could the Medicare Trust Fund be bankrupt in the year 2008, but annual Medicare expenditures will climb from $207 billion, in 1998, to as high as $3 trillion by the year 2030. As a result, Medicare spending will become a much larger part of the federal budget, potentially affecting the funding of other important programs such as national defense, justice, health and safety, and environmental protection.

The Commission also reported that as the Medicare system itself faces financial troubles, Medicare beneficiaries will face higher costs. Today, beneficiaries pay nearly 30 percent of their health care costs from their own pockets. In 1995, those costs averaged $2,563 per person to pay for premiums, services and products not covered by Medicare. In the future, out-of-pocket costs are expected to rise.

Last week we heard testimony from experts that illustrated where the need for prescription drug coverage lies. We heard that most Medicare beneficiaries already have private or public insurance to supplement their Medicare benefits, and more than two-thirds of Medicare beneficiaries already have some type of prescription drug coverage. From this we understand that one of the difficulties in providing a Medicare drug benefit will be providing coverage in a way that does not diminish the benefits older Americans may already have, while extending protection to those who presently have little, if any, drug coverage.

We all agree that our seniors need help, and we must respond with a responsible solution. But one of our overriding concerns must be ensuring that we do not make the system worse or erode the choice and flexibility seniors deserve with their health cover age. We must also be cautious about proposals such as the Administration's plan which will raise seniors' premium costs, endanger their existing coverage and of course, increase bureaucracy.

Medicare faces serious challenges brought on by changes in population, treatment and medical costs. Unless fundamental reforms are adopted to make Medicare more efficient and to slow its growth, some combination of tough choices will have to be made to ensure Medicare's long-term solvency. Today, I look forward to hearing the testimony of my colleagues and learning more about their respective proposals to address these issues.

Again, I thank you, Mr. Chairman, and my colleagues for the time and energy you have invested in this issue, and I look forward to your leadership and guidance as we broach this complex and often contentious issue of Medicare reform and the need for a prescription drug benefit."

PREPARED STATEMENT OF MARJORIE DORR

Mr. Chairman and members of the committee, I am Marjorie Dorr, Chief Operating Officer for Anthem Blue Cross and Blue Shield of Connecticut. Prior to becoming COO of Anthem in 1998, I was the CEO, President and Director of Anthem Prescription Management, a Pharmacy Benefit Management Company.

Today, I am testifying on behalf of the Blue Cross and Blue Shield Association, which represents Anthem and 48 other independent Blue Cross and Blue Shield Plans nationwide that together provide health coverage to 74 million Americans. I appreciate the opportunity to testify today on the critical issue of providing Medicare beneficiaries access to prescription drugs.

Blue Cross and Blue Shield Plans have extensive experience in providing prescription drug coverage to both working and retired Americans.

- BCBS Plans offer health coverage to working Americans through a variety of managed care and indemnity products, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point of services (POS) plans. Nearly all of these plans provide prescription drug benefits to their members.
- BCBS Plans underwrite and deliver the government-side Service Benefit Plan under the Federal Employee Health Benefits Program (FEHBP), providing coverage, including prescription drugs, to more than 3.7 million people.

- BCBS Plans collectively are a leader in providing coverage options for older Americans. They provide Medicare+Choice coverage to more than a million Medicare beneficiaries, making them the largest Medicare+Choice provider in the country. Most BCBS Plans provide outpatient prescription drug benefits in their Medicare+Choice package. BCBS Plans are also the largest provider of Medigap and Medicare SELECT coverage, which offer seniors varying levels of protection from Medicare's cost sharing requirements. Three of the ten standardized Medigap packages include outpatient prescription drug coverage.

The challenge facing Congress now is the same one BCBS Plans face every day: how to provide a meaningful level of coverage for prescription drug costs while keeping premiums as affordable as possible.

In my testimony today I will address four areas:

1. Background on the costs of providing prescription drug coverage;
2. Strategies used by BCBS Plans to manage prescription drug benefits;
3. BCBSA recommendations on providing Medicare beneficiaries access to prescription drugs; and,
4. Comments on proposals currently under consideration in the Congress.

I. BACKGROUND ON PRESCRIPTION DRUG COSTS

Prescription drugs have significantly increased Americans' life span and contributed to their improved health status in the 20th century. Recognizing the potential for pharmaceuticals to prevent and treat disease, BCBS Plans offer pharmacy benefits to their members. However, the cost of drug benefits is high and accelerating at rates well above those of other benefit costs. As a result, drugs account for a growing share of BCBS Plans' total medical costs and our members' premium dollars. BCBSA expects these costs to continue to grow rapidly.

- From an annual increase of 8.7 percent in 1993, growth in total prescription drug spending has steadily accelerated to 15.4 percent in 1998. This makes prescription drug expenditures the fastest growing health care spending category over the past three years.
- Between 1993 and 1998 it is estimated that BCBS Plans' aggregate spending on outpatient drugs increased almost 60 percent, from $7.6 billion to $12 billion. Some Plans have experienced even more rapid growth in pharmacy costs. For example, payments made by one BCBS Plan rose by 26 percent just in 1997 and around 25 percent in 1998. For some Plans, payments for prescription drugs now exceed those for inpatient hospitalization.
- Other private insurers have experienced similar increases. In May 1999, the Employee Benefit Research Institute reported that private insurance payments for prescription drugs increased 17.7 percent in 1997, after growing 22.1 percent in 1995 and 18.7 percent in 1996. This growth in prescription drug payments compares with 4 percent or less annual growth in overall private payments for each of these three years. In the broader U.S. private insurance market, analysts estimate that prescription drugs now account for 11 to 14 percent of total medical expenses for most health plans, up from 7 percent just a few years ago.
- Prescription drug costs may be even higher for some health plans, especially those that provide drug benefits to older populations. For example, the Service Benefit Plan under FEHBP, which covers a large number of retired workers, has prescription drug costs that are approaching 30 percent of total benefit costs.

Factors Contributing to Increased Prescription Drug Spending: While BCBS Plans use a range of strategies to manage growing prescription drug costs on behalf of their subscribers, spending is being propelled by a number of market and structural forces over which private insurers have little control. Some of the most important forces are the following:

Demographic Trends

As the U.S. population ages, the number of people at risk for chronic and disabling diseases is rising dramatically. The single largest market for prescription drugs is the aging "baby boom" generation. The drugs used by the middle aged and elderly tend to be expensive and often treat chronic conditions, such as hypertension, high cholesterol, diabetes and arthritis, which require a steady regimen throughout the patient's life.

Rapid Flow of New Drugs to Market

Over the past decade, many new prescription drugs have come to market. One of the most robust measures of the flow of pharmaceutical technology is the annual number of new molecular entities (NMEs) approved by the Food and Drug Adminis-

tration (FDA). NMEs are compounds that have never before been marketed in this country.

Over the course of a generation—from the early 1960s to the mid-1990s—the annual number of new molecular entities (NMEs) receiving FDA approval nearly doubled from an average of 13.7 in the 1960s to 25.6 in the first half of the 1990s. Just in the last decade the number has nearly doubled again.

Some of these new drugs are "breakthrough" products, which treat diseases and conditions that previously lacked effective therapies. Others are differentiated from older drugs by having less prevalent or severe side effects, or easier dosing forms. Physicians tend to adopt such new technology rapidly, and they are often expensive.

The National Institute for Health Care Management (NIHCM), a non-profit research organization based in Washington, D.C., released a report in July 1999 on trends in pharmacy spending. This report, which was prepared by the Barents Group LLC, found that:

- Over the five year period between 1993 and 1998, prescription drug spending rose by $42 billion; $27.6 billion, or 65 percent of this $42 billion increase, was associated with new prescription drugs: that is, those approved by the FDA after 1992.
- By 1998, total spending for new drugs accounted for $30 billion or 32 percent of retail drug expenditures even though they represented just 17 percent of all prescriptions. In some therapeutic categories, new drugs accounted for over half of spending. For example, an estimated 98 percent of the 1998 sales of antihistamines, 68 percent of anti-cholesterol agents, and 51 percent of antidepressants were derived from new drugs.
- In 1998, the average price per prescription of a new drug was $71.49 per prescription, compared with $30.47 for older drugs. For some new drugs, however, the average price per prescription was three to seven times that of the older drug it replaced.

This rapid increase in the number of new, expensive drugs on the market is expected to continue. Over the past two decades, the pharmaceutical industry and the federal government have made massive investments in research and development. And on the horizon, discoveries in genetics are expected to increase exponentially the number of targets for drug intervention in just a few years.

Direct-to-Consumer Advertising of Prescription Drugs

Another factor in increased costs is the greater utilization due to the explosion in direct-to-consumer advertising (DTC). Over the past decade, direct-to-consumer (DTC) advertising expenditures have skyrocketed. In 1991 pharmaceutical companies spent $55 million to promote prescription products directly to consumers. By 1998, outlays on DTC advertising had multiplied over 20 fold to reach $1.3 billion.

Does the advertising work? According to the NIHCM study, the 10 most heavily promoted drugs in 1998 accounted for over a fifth (22 percent) of the total growth in prescription drug expenditures from 1993 to 1998. In total, these 10 drugs had 1998 sales of $11.2 billion—about 12 percent of all retail drug spending.

DTC advertising can promote the public health by encouraging patients with undiagnosed and untreated conditions to discuss prescription drug issues with their doctor. However, it also promotes utilization and increases costs.

Increases in Generic Drug Prices

Generic drugs are the chemical and therapeutic equivalent to brand name drugs. They are not inferior in quality or effectiveness, but are significantly less expensive. While generic drugs are typically used to lower health care spending, the price of generic drugs has begun to rise as a result of consolidation in the industry. In fact, 1999 was the first time since 1992 that there was an increase rather than a decrease in the cost of generic drugs. While not having as great an impact as the other trends we have highlighted (demographic trends, the flow of new drugs or DTC advertising), higher generic drug prices contribute to overall higher prescription drug costs.

II. STRATEGIES FOR MANAGING DRUG COVERAGE

BCBS Plans use a range of programs to deliver pharmacy benefits and ensure that drugs are used in ways that are both clinically appropriate and cost effective. Some BCBS Plans contract with outside prescription benefit managers (PBMs) to perform claims processing, negotiate volume discounts on their behalf, monitor drug interactions and polypharmancy, and oversee the retail and/or mail distribution of drugs to their members. Others provide these management functions in-house, and a few have created their own PBMs. In any case, some of the most important strategies for managing drug benefits are the following:

Encouraging Use of Certain Drugs: BCBS and other health plans have recently increased the use of financial incentives to sensitize beneficiaries to the cost of drugs. As stated in earlier testimony to this committee, increases in cost-sharing have the behavioral effect of lowering the cost of the drug to the insurer and decreasing inappropriate use because of the greater consumer copayment.

Over the past year many plans have implemented tiered-copayment structures in which plan members share the cost of expensive drugs that have safe and effective, but less costly, alternatives. Three-tiered copayments, which classify drugs in three categories with differing levels of copayment, are now prevalent in the insurance industry. For example, one BCBS Plan recently established the copayment structure shown in Table 1.

Of course, while tiered cost-sharing helps control costs in situations where generic drugs or less expensive branded alternatives exist, they have little impact on the spending associated with breakthrough technology.

Table 1.—AN EXAMPLE OF PRESCRIPTION DRUG TIER DEFINITIONS AND COPAYMENTS

Tier 1—Lowest copayment	Tier 2—Second lowest copayment	Tier 3—Highest copayment
All generic drugs	Preferred brand drugs	Non-preferred brand drugs
	Brand name drugs that are clinically effective, cost-effective and meet the needs of most patients..	Brand name drugs that have a generic equivalent or a therapeutic alternative available in Tier 2.
		Brand name drugs not usually used as the first line of treatment.

Promoting Use of Certain Drugs: Some health plans use selective formularies that give certain drugs preferential status. Typically, such status is given to breakthrough drugs and those lacking effective alternatives, and to safe and effective drugs that cost less than other drugs in the same therapeutic class. Drugs not on the preferred list are still covered when medically necessary and when safe and effective alternatives are not available.

Preferred Provider Arrangements with Retail Pharmacies: Health plans also may negotiate discounts by contracting with networks of retail pharmacies to become preferred providers in their geographic area. In general, network pharmacies will provide higher discounts and reduced dispensing fees in exchange for greater exclusivity (i.e., more volume). However, limiting coverage to participating pharmacies may limit beneficiaries' access to pharmacies. Hence, health plans must make a tradeoff between providing their members with convenient access to retail outlets and reducing costs. Some plans offer mail order pharmacies to obtain volume discounts and provide financial incentives (e.g., eliminating front-end deductibles for prescriptions filled by mail) to encourage their members to use them.

Negotiating Discounts: Many BCBS Plans contract with a network of retail pharmacies to provide discounts of 5 percent, 20 percent, or even higher on prescription drug purchases. BCBS Plans use their market share as leverage to receive a better price.

With surveys showing an expected trend of 13 to 17 percent increases in unmanaged pharmacy benefit costs, we hope these cost containment strategies will help to rein in drug costs. Ironically, some policymakers, at both the state and federal level, support proposals that would undermine these cost containment tools. For example, the "Patients' Bill of Rights" legislation that is now in conference contains a provision that could force health plans that have 3-tier co-pay structures to cover non-formulary drugs as preferred drugs. This would absolutely undermine a critical cost containment strategy that offers members preferred co-pays for equally effective drugs with lower prices.

We urge Congress to reject this proposal that will limit the ability of health plans to promote utilization of drugs with the highest value to members. The ability of insurers to manage the skyrocketing costs of prescription drug coverage may mean the difference between employers providing drug benefits to their retired employees or not.

III. BCBSA RECOMMENDATIONS

The Blue Cross and Blue Shield Association believes that providing access to affordable prescription drug coverage for seniors is critical.

As a first step, we believe that Congress and the Administration should review all of their current and future policies on prescription drugs to assure they do not

exacerbate the rapid rise in prescription drug costs—which hits older people hardest since they have the highest utilization of prescription drugs.

For example, Congress has legislation pending (S. 1772/H.R. 1598) that would provide patent extensions for certain drugs. Stephen Schondelmeyer, of the Pharmaceutical Research in Management and Economics (PRIME) Institute, authored a recent study on the incremental costs to consumers of providing patent extensions of up to 3 years to drugs affected by this legislation. The PRIME study estimated that granting Claritin a 3-year patent extension would cost consumers up to $5.3 billion from 2002 to 2007. Americans could expect to pay as much as $11 billion in extra costs for a 3-year extension for all 7 drugs affected by this bill.

Second, the BCBSA supports comprehensive reform of the Medicare program to assure the program will remain financially stable and secure to serve both current and future beneficiaries. In the context of overall reform, the BCBSA believes Congress should provide prescription drug benefits as an integral part of Medicare coverage. When Medicare was created, it provided appropriate coverage for the time. But that was 35 years ago. BCBS Plans have not stayed the same—they have responded to the benefit needs of its customers, advances in medicine, and the increasing challenge to keep coverage affordable. It is time for Medicare to change and we applaud members of this committee for their tireless efforts to reform and improve Medicare.

However, we caution Congress to avoid adding prescription drug coverage to Medicare until the program is reformed so that all current benefits are adequately financed. As described earlier, prescription drug costs are skyrocketing. It simply is not prudent to add such an expensive benefit until Congress can pass comprehensive Medicare reform.

Given that it appears passage of comprehensive Medicare reform is not likely this year, the BCBSA believes Congress should take the following actions if policymakers wish to act in the interim:

1. Target assistance to low-income seniors through federal block grants to states.

Fourteen States already have implemented successful prescription drug assistance programs, and eighteen others have programs under consideration. By building on these programs, the goal of making prescription drugs more affordable to lower-income seniors can be attained without disrupting current coverage, bankrupting Medicare, or hindering future Medicare reform. It also can be done quickly, as most states already have the infrastructure and expertise necessary to implement an assistance program.

- To ensure all states participate in the program, it is vital that the federal government fully fund the program. The federal government has the primary responsibility for funding health care coverage to seniors. This responsibility should not be shifted to the states in the case of prescription drugs.
- Most importantly, this proposal would provide overdue assistance to the most vulnerable seniors. If the federal funds were available to help seniors with incomes below 200 percent of the federal poverty line, then 64 percent of all seniors who currently do not have prescription drug coverage would receive assistance. While this may not be the final solution, it is certainly an important step in the right direction, and it can be accomplished this year.

2. Improve the Medicare+Choice program.

By enhancing and stabilizing funding and providing plans regulatory relief, more plans will likely stay in the program and continue to provide prescription drug coverage to seniors at an affordable price.

- Payments to Medicare+Choice (M+C) plans must keep pace with changes in spending in the government-run fee-for-service program. If payments to private health plans fall significantly below per person spending in the Medicare fee-for-service program—as is currently projected—plans will have difficulty attracting sufficient numbers and types of providers to their networks and in providing the Medicare benefit package. Indeed, the extension of the 2 percent cap for one more year will undoubtedly force more plans to leave the program.
- While adequate payments to health plans are critical, stability and predictability in future year payments are just as important. Blue Cross Blue Shield Plans place a high priority not only on attracting new beneficiaries, but also on keeping them satisfied over the long term. One of the most important ways to retain members is to avoid large increases in premiums and instability in benefits. Therefore, it is essential that payments do not fluctuate unpredictably and significantly from one year to the next.
- Improving the Medicare+Choice program is critical because it is the foundation of any broader private sector based reform. Not only would a continued depar-

ture of plans from the program bode ill for reform, but continued turbulence in the Medicare+Choice program might turn many Medicare beneficiaries against any private-sector based reform.

IV. CONCERNS ABOUT MEDIGAP PROPOSALS

In an effort to help seniors afford the high cost of prescription drugs, some in Congress are proposing to expand coverage of prescription drugs through Medigap: (1) some proposals would create a stand-alone Medigap prescription drug policy; (2) other proposals would mandate prescription drug coverage in all 10 Medigap packages.

Although appealing on the surface, these proposals would not help seniors, as they would make coverage more expensive and unaffordable for many seniors

Stand-alone Prescription Drug Coverage

Proposals allowing seniors to purchase a stand-alone prescription drug policy create a false hope. Insurers would be called on to offer a policy that is expensive and has costs growing at 15 to 20 percent per year. Plus the need for drug coverage is much more predictable than general medical needs, as many seniors with high expenditures are on maintenance drugs.

Insurers know this is a recipe for an insurance policy that will fail. It would start out unaffordable for most, and rapidly lose enrollment as more disappointed seniors found it unaffordable each year.

Medigap companies would not put a product on the market unless it is for the long run. The way to assure a stable benefit that does not increase wildly from year to year is to: 1) make sure it is not a benefit only purchased by those who need it; and, 2) make sure the benefit is not one whose price is likely to increase dramatically year to year.

A stand-alone prescription drug benefit fails both tests. The high cost of prescription drugs would make a drug-only benefit package so expensive that only those who are in immediate need of benefits would initially buy a policy. After that, large annual price increases would result in the healthier people dropping their policy each year, which in turn would lead to even higher prices for those who remained. This spiral would leave many seniors without coverage, and very disillusioned.

Moreover, a stand-alone prescription drug policy actually could raise the cost of existing Medigap drug policies, and further erode existing coverage for prescription drugs. At least one congressional proposal to offer stand-alone prescription drug coverage would close the Medigap plans that currently offer Rx coverage (options H, I, and J) to new enrollment. However, with no new enrollees coming in, costs in the existing H, I and J plans would spiral ever higher. At the same time, existing subscribers would be unlikely to have an option to purchase an affordable stand-alone prescription drug plan, if indeed any is offered at all, given the adverse selection expected.

Mandatory Rx Coverage

Requiring prescription drug coverage in all 10 Medigap packages would raise average Medigap premiums by more than 50 percent for those policies that currently do not include drug benefits. (This assumes that Congress requires the level of benefits currently available in Medigap options H and I: $250 deductible, 50 percent coinsurance up to a total benefit of $1,250.) An American Viewpoint study found that 70 percent of seniors who have Medigap policies would drop their coverage if premiums increased by 50 percent.

The key issue for seniors on prescription drugs is not access but cost. All seniors have the opportunity to purchase Medigap policies with drug coverage when they turn 65, regardless of their health status. However, of those Medicare beneficiaries who do not otherwise have drug coverage (i.e., through an employer-sponsored plan or through a government program such as Medicaid), fewer than 20 percent purchase Medigap policies H, I, or J, which provide drug coverage. Approximately 40 percent choose one of the other seven standard plans—which are relatively affordable because they lack prescription drug coverage—and the rest do not purchase any coverage. Forcing an increase in Medigap premiums by mandating drug coverage in all 10 packages would invariably force many Medicare beneficiaries to drop their Medigap coverage.

This would be unfortunate because most Medigap enrollees are pleased with their coverage. A July 1998 report from the Department of Health and Human Services Inspector General found that 88 percent of beneficiaries are satisfied with their Medigap policies. Beneficiaries like Medigap because the core Medicare package is clearly inadequate compared to coverage in the private sector. Key shortfalls include a limited hospital benefit, no cap on out-of-pocket expenses, and high physician and

outpatient co-insurance requirements. Seniors rely on Medigap policies to fill these shortfalls, and do not want to lose this coverage option.

Expanding prescription drug coverage to seniors is critical. But it must be done in a way that will actually achieve that goal and will not erode or eliminate the Medigap coverage on which so many seniors currently rely.

V. CONCLUSION

Making drug coverage affordable to our customers continues to be one of the most difficult challenges facing BCBS Plans. As the cost of prescription drugs continue to rise at 15-20 percent per year the Plans have developed and implemented a range of techniques to control costs and, thus, maintain the affordability of prescription drug coverage.

As Congress tackles the important issue of expanding prescription drug coverage to seniors, I hope the members of the committee will learn from the vast experience of the BCBS Plans and also consider our calls for caution.

The BCBS Plans stand ready to work with Congress to develop a comprehensive plan to reform Medicare and ensure that seniors have access to meaningful and affordable prescription drug coverage through the next century. Until such a plan can be implemented, BCBSA urges Congress to provide federal block grant funds to states so they can assist those seniors who need the most help in paying their high prescription drug costs.

Thank you again for the opportunity to testify today.

PREPARED STATEMENT OF MIKE FOGARTY

Mr. Chairman, my name is Mike Fogarty. I am the Chief Executive Officer of the Oklahoma Health Care Authority, the designated Medicaid state agency in Oklahoma. It is my privilege to also serve on the Executive Committee of the National Association of State Medicaid Directors. While my testimony today reflects Oklahoma experiences and views, I believe it will be representative of most state Medicaid programs.

The Oklahoma Medicaid program serves over 400,000 enrollees (approximately 12% of the State's population), including 260,000 children and 150,000 adults. The current annual budget is $1.7 billion. Since the Authority's creation in 1994, we have focused our efforts on achieving efficiencies through care and benefit management and on improving benefit quality, access to care, and availability and use of preventive services. By legislative action effective December 1997, Oklahoma extended eligibility to children and pregnant women with family income up to 185% of the Federal Poverty Level. We also initiated an aggressive and highly successful outreach program. The State was aided financially in its efforts to extend benefits to uninsured children by your enactment of Title XXI, the State Child Health Insurance Program, for which we are very grateful.

It is against this backdrop of enormous change—more dramatic change than I have before witnessed in my nearly thirty years of Medicaid experience—that I approach the subject of this hearing. One item that has remained constant is the upward spiraling cost of the pharmacy benefit at a rate far exceeding any other covered benefit. Consideration of some factors contributing to the cost increase and a review of our attempts at addressing it will, hopefully, contribute to the Committee's deliberation on a potential federal pharmacy benefit.

The average monthly expenditure for the Oklahoma Medicaid pharmacy benefit has grown from $8.9 million in State FY1997 to $14.8 million in current State FY2000, an increase of 65%. Three factors contributed to this growth. The previously mentioned eligibility expansion and outreach resulted in a 29% increase in the number of people receiving benefits in that time period. This has obviously contributed to the increase in total program expenditure. During the same three-year period, the average monthly utilization per beneficiary rose by 16%. Also, the average cost per prescription increased from $33.42 to $43.22, an increase of over 29%. These most recent indicators are consistent with longer-term annual increases. Over the period from 1992 through 1998 the annual benefit cost per person increased an average 13.6% per year.

I would note, Mr. Chairman, that the Oklahoma program has had a lower rate of increase in this period than that of the Medicaid program nationwide. A 1999 HCFA study showed the drug payment per Medicaid recipient increased from $307 per year in 1992 to $572 in 1997, an annual rate of growth of 17.2%.

Utilization management of the pharmacy benefit has taken several forms. Oklahoma's program has historically been limited to three prescriptions per month and, with certain exceptions, that limitation remains in effect. Such an arbitrary limita-

tion is certainly easy to administer. It obviously, however, bears no relationship to medically appropriate or effective treatment. We are attempting to move to more treatment centered methods of managing utilization.

The drug utilization review program (DUR), as mandated by OBRA '90, is effective not only by reducing inappropriate utilization, but likely achieves greater savings by avoiding the costs of treatment otherwise caused by adverse drug interactions. We plan to enhance our DUR program by developing a provider-profiling program. The application of this program will compare patterns of prescribing and dispensing activity among physicians and pharmacists and their peers. The program will provide these professionals with useful information for improved decisions based on practice patterns and guidelines.

The necessity for DUR is driven, at least in part, by our traditional use of multiple dispensing outlets combined with the "freedom of choice" policy. There appears to be merit in considering providing a benefit available to the beneficiary from a single entity (of the beneficiary's choosing) that would be responsible for managing the benefit and dispensing the product.

Finally, with respect to utilization management, Oklahoma is pursuing the development and use of a disease/case management program. We believe an effective program will produce savings primarily in the non-pharmacy medical costs of the Medicaid Program through improved patient compliance with their drug therapy.

Attempts to manage the price of the pharmacy benefit are most critical—and most difficult. The issue takes two forms, which are addressed very differently. First, we attempt to purchase a given product at a reduced or "best" price. The current federal rebate program is a classic example.

Frankly, from our perspective it has not produced a good result. Oklahoma had a limited formulary prior to the OBRA '90 mandated open formulary, which dramatically increased our program cost. At the same time, it appears that the pharmaceutical manufacturers wasted little time adjusting pricing to recover the cost of the rebate. Short of direct price controls, perhaps the most effective way to achieve best price savings is to introduce opportunity for price competition. For example, a program designed so that within specified drug categories manufacturers would compete on the basis of price for product inclusion on a closed formulary.

The second form of price management attempts to encourage the use of a lower cost product when medically appropriate. Oklahoma's most recent pharmacy benefit management initiatives included a program directed toward this form of price management. The Preferred Product Initiative focused on two therapeutic categories of drugs, anti-ulcer drugs and non-steroidal anti-inflammatory drugs (NSAIDS). These two categories represented approximately 10% of the entire State FY1999 pharmacy budget. The design of the program was to create two tiers of products in both categories. Those drugs that are determined to be most cost effective and which demonstrated comparable efficacy to other more costly drugs in the category are included in Tier 1. Less cost effective drugs were placed in Tier 2. Tier 1 drugs are available without prior authorization while Tier 2 drugs are available if authorized. Authorization is granted based on specified clinical indications or if the patient had a previous unsuccessful trial of the Tier 1 drug. As you might imagine, pharmaceutical manufacturers have vigorously opposed this initiative. While it is currently in place and producing positive results, it's future is in jeopardy.

Another initiative under development for price management is a State Maximum Allowable Cost (SMAC) program. It is similar to the Health Care Financing Administration's Federal Upper Limit (FUL) program. The program is designed to maximize the cost effectiveness of our generic substitution policy by setting reimbursement amounts for generic products more accurately based on actual acquisition costs of the dispensing pharmacy.

The management of both utilization and price is critical to any publicly funded pharmacy benefit program. We have attempted to respond to the needs of patients, physicians, dispensing pharmacies, and manufacturers. Ultimately, however, we must try to provide a comprehensive, high quality benefit that is financially responsible to the tax paying public that supports it.

In closing, Mr. Chairman, we are acutely aware of the hardships created for those adults who are aged and disabled who have incomes marginally above our Medicaid eligibility guidelines and who have no pharmacy benefit program available to them. They are hardships measurable in human suffering by those whose health could be dramatically improved by use of medication now beyond their financial reach and, no doubt, measurable in financial costs to the Medicare Program when medical conditions require more expensive treatment due to lack of effective pharmaceutical intervention. The Oklahoma Legislature now has under consideration a proposal to extend Medicaid coverage to 10,000 additional adults by increasing financial eligibility to 100% of the Federal Poverty Level—a proposal motivated almost exclusively

to extend pharmacy benefit coverage to those adults. We appreciate your willingness to confront this issue.

As you can tell from my earlier comments, we are frustrated by what seems an impossible task of managing the spiraling costs of pharmacy benefits. I am confident that every State Medicaid agency and virtually every purchaser of pharmacy benefits share our frustration. It is critical that any Federal benefit plan anticipate ways to effectively deal with this daunting problem. Frankly, it is also imperative that publicly funded programs—state or federal, present and future—be afforded some method of protection from the overwhelming financial and political power of the pharmaceutical manufacturing industry.

Thank you for this opportunity.

PREPARED STATEMENT OF HON. BILL FRIST, M.D.

Mr. Chairman and Members of the Committee:

I am pleased the Committee has gathered today to discuss an issue critically important to the health of our nation's seniors and individuals with disabilities—prescription drugs. As you are aware, last November, Senator Breaux and I introduced legislation, S. 1895, along with Senators Kerrey and Hagel, to strengthen and improve the Medicare program and include an outpatient prescription drug benefit.

I. PRESCRIPTION DRUGS ARE CRITICAL TO THE HEALTH OF OUR MEDICARE POPULATION

When Medicare was first enacted in 1965, it was done so as an acute care program with the goal of providing the elderly access to necessary health care services that would otherwise have been unaffordable. Even then, the inclusion of a prescription drug benefit was considered, and it has been considered numerous times since, as prescription drugs become increasingly important in preventing disease and treating illness.

From a clinical perspective, the lack of a prescription drug benefit in 1965 did not hinder the ability to deliver effective health care, as it does today. In 1965, few prescription drugs had clinically significant effects in treating diseases that are common among the elderly population. Today, however, research and development efforts have resulted in an enormous increase in the number of effective drugs available to prevent and treat diseases. One indication of the impact pharmaceuticals have had in the delivery of health care is the roughly $90 billion the United States spent on prescription drugs in 1998, with seniors representing one-third of these expenditures.[1]

II. THE IMPORTANCE OF PRESCRIPTION DRUGS IN THE BROADER CONTEXT OF REFORM

As we address the addition of a prescription drug benefit this year, we must not overlook the problems the Medicare program faces today, nor the critical importance of understanding the link between these problems and the addition of a new benefit. It is the very problems that have plagued Medicare for years—fragmentation of health care delivery and inflexibility—that we may use as examples and lessons learned as we develop a successful prescription drug benefit.

The Breaux-Frist legislation addresses Medicare as a whole by focusing on two key goals: (1) to guarantee health care security with improved benefits and greater choice for beneficiaries and (2) to protect and strengthen the long-term financial viability of the program. To meet these goals, it is critical to understand the current spending, budgetary, and demographic issues that the Medicare program faces. Today, we know that Medicare:

- Will be insolvent in 2015;
- Will continue to consume an increasing share of the federal budget, reaching 25% by 2030;
- Will continue to grow by an average of 6.9% over the next 10 years, doubling spending from $208 billion today to over $400 billion in 2010;
- Relies on general revenues to pay for 36% of total program expenditures and will continue to use an increasing share of general revenues, leaving fewer and fewer federal dollars available to support other federal programs;
- Will experience a reduction in the workforce paying into the program, while at the same time enduring the shift of 77 million baby boomers becoming eligible for Medicare beginning in 2010.

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[1] E. Steinberg et al., "Beyond Survey Data: A Claims-Based Analysis of Drug Use and Spending by the Elderly," *Health Affairs* (Mar/Apr 2000): 198-211.

As we address the need to add a prescription drug benefit, we must recognize the necessity of updating the total benefit package and increasing the flexibility of the program overall. Medicare today is inadequate, covering only 53% of a beneficiary's average health care costs. The benefit package is extremely outdated, covering a limited number of outpatient prescription drugs, providing few preventive services, and limiting access to medical technologies. Most importantly, the Medicare program is too rigid and slow to change. As a physician I am acutely aware of the need to ensure that seniors have access to life-saving drugs and technologies as they come available. Right now, the Medicare program is so heavily micro-managed by the Health Care Financing Administration and the U.S. Congress, with over a hundred thousand pages of regulations, that it is next to impossible to adapt to the rapid advances in medicine and health care delivery we are seeing occur almost daily.

Let me provide a few examples.

1. In 1994, the FDA approved a technology which rapidly increases the healing of bone fractures. This technology is reimbursed by 850 private insurers today, but has yet to be approved by Medicare.
2. Today, private insurance companies recognize the importance of early detection and disease management and cover a wide variety of preventive screening tests. Medicare, however, provides only limited preventive services and still does not cover even some of the most basic and essential preventive screenings, such as cholesterol tests.
3. Even when life-saving diagnostic tests become available, such as a breakthrough prostate cancer-screening test that came on the market in the early 1990s, it takes years before it can be approved. Medicare just recently began reimbursing for prostate screening and only because a new law was passed to allow it.

The very fact that Congress must pass such laws illustrates perfectly the problem with a heavily micro-managed program. The U.S. Congress simply should not be in the business of setting disease-specific or drug-specific health policy. No government program can possibly keep up with the increasingly rapid rate at which new life-saving and life-improving drugs and technologies are brought to the market. Today, more than ever, drug treatments and advances in medicine are the key to providing quality health care.

It is imperative, and I strongly believe, that a prescription drug benefit be addressed as an integrated component of the Medicare program. Such a benefit should maintain the flexibility necessary to ensure beneficiaries are not trapped in a time warp five, ten or fifteen years from now, much like they are today with the current Medicare benefits and antiquated delivery system. Medicine today is advancing more rapidly than any time in history. Many Americans, including a fraction of seniors, who have insurance for an integrated set of health care benefits, have access to the success that prescription drug treatments and medical advancements bring as well as to the affordability of these services. Most Medicare beneficiaries do not.

We would be short sighted and irresponsible to add a stand alone drug benefit without recognizing the role prescription drugs play as part of delivering total, comprehensive quality health care. If that total quality health care is to be effective, affordable and sustainable, it must be integrated. The current antiquated Medicare system is not sustainable, and there is a proven track record of models, such as the Federal Employees Health Benefits Program (FEHBP), the California Public Employees' Retirement System (CalPERS) and others that have been delivering integrated health services and prescription drugs to seniors for years.

III. COVERAGE: THE KEY TO AFFORDABLE PRESCRIPTION DRUGS

The key to providing affordable prescription drugs to seniors is ensuring they have coverage for a prescription drug benefit. That may seem like common sense, but there has been much discussion regarding drug pricing and the availability of drugs at more affordable prices in other countries, such as Canada and Mexico, compared to the United States. Some are even looking to Canadian cost containment policies in making decisions regarding prescription drug coverage for America's seniors. As a physician who has practiced medicine in a socialized health care system, let me share some perspectives that are unique to these kinds of systems.

On average, Canadians must wait 7 months longer than Americans for new medicines to be approved. The average wait for cardiovascular surgery is 23.3 weeks. An MRI (magnetic resonance imaging) has a waiting list of 150 days in Canada, whereas Americans average wait for the same procedure is 3 days. In contrast to a market-based approach to controlling health care costs, as is used here in the United States, Canada relies on government financing and control mechanisms as a cost-

containment method and as a result, access to and reimbursement for pharmaceuticals in Canada is delayed, on average by 1-2 years.[2]

There are ways to make drugs more affordable without stifling innovation and competition. How? By providing coverage. In the United States, 50% of the seniors who have insurance coverage through a private-sector, employer-sponsored or retiree health plan have out of pocket drug expenses for prescription drugs today that are less than $14 per month and 99% have monthly drug expenditures that are less than $100 per month.[3] This is the result of a private-sector model of health care delivery, where disease management programs and flexible cost-sharing are types of tools used to allow seniors to receive the highest quality of health care at the most affordable price. It's not hard to imagine which of the two scenarios—Canada or the U.S. system—our seniors would prefer. That is why the Breaux-Frist legislation is modeled on a system, the Federal Employees Health Benefits Program, that has a proven track record of delivering health care to federal employees, retirees and dependents for 40 years.

IV. THE BREAUX-FRIST MEDICARE REFORM BILL (S. 1895)

The Breaux-Frist Medicare Reform bill guarantees health care security for seniors, while at the same time capturing the innovations of the marketplace and increasing beneficiaries choice of affordable health care options. S. 1895 promotes integrated, high quality, comprehensive health care to meet the individual needs of each beneficiary, increases the flexibility of the Medicare program, and provides beneficiaries timely access to the latest advances in the practice of medicine and delivery of care. S. 1895 offers universal prescription drug coverage, so for the first time, all Medicare beneficiaries will have access to prescription drug coverage through enrollment in an integrated health plan. All beneficiaries will receive a subsidy for drug coverage, and low-income seniors are provided complete coverage at no cost.

S. 1895 establishes a Medicare Board, similar to the role of the Office of Personnel Management under FEHBP, to oversee private and government-sponsored plans offering Medicare benefits and prescription drugs. Plans are allowed the greatest flexibility in benefit design to meet the individual prescription drug needs of each beneficiary. A minimum actuarial value of $800 is established as a floor, with no limit as to the generosity of the value of benefits a plan can offer. In addition, plans have the flexibility to adjust copayments, deductibles, and benefit caps to ensure beneficiaries have a drug benefit that works for them.

If you compare this structure to what is already present in the Medicare HMO market there's not much difference. In Medicare HMO plans, copayments vary, so beneficiaries can choose a plan where they would pay as little as $5 per prescription. Benefits under these plans vary, with some that have a maximum benefit and many that have maximum benefits that only apply to brand name drugs, so that generic drug benefits are unlimited. Almost all offer mail order service, which is especially important for those living in rural areas where there may not be a pharmacy close by. Some manage these benefits internally, others contract out with a pharmacy benefit manager.

My point is that the flexibility incorporated into the Breaux-Frist legislation is the type of flexibility plans need to establish an effective prescription drug benefit and to adjust to changes in the market. It would be a tragedy for the U.S. Congress to mandate coinsurance and other design features that would limit a plans flexibility in offering these benefits. As we have seen in the Medigap market these mandates just lead to increased premiums for beneficiaries.

Today, a senior choosing to enroll in a Medigap plan that includes prescription drug benefits can pay on average $2,500 per year in premiums, plus deductibles, 50% coinsurance, and even Part B premiums. Annually these costs can add up to over $4,000 per year—and that's only providing drug coverage of up to $1,250 annually. Even a supplemental policy that doesn't include drug coverage costs seniors premiums in excess of $1,500 annually (including their Part B premiums).[4] If the FEHBP and CalPERS programs can offer seniors inpatient and outpatient care at no charge, $5 copays for prescription drugs, full preventive services, vision services, durable medical equipment and the like with no coinsurance—and all at about $100-$200 a month—then Medicare can do the same.

The bottom line is S. 1895 does not force seniors into managed care. Instead, it offers seniors a voluntary option of either staying in the current Medicare Fee-for-

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[2] The Lewin Group, *The Impact of the Canadian System On Access to New Medical Technology Including Prescription drugs* (Washington: The Lewin Group, March 7, 2000).

[3] Steinberg et al.

[4] L. Alecxih et al., *Key Issues Affecting Accessibility to Medigap Insurance* (Washington: The Commonwealth Fund, August 1997).

Service program or enrolling in a managed care option, both of which will offer prescription drugs.

Equally important, S. 1895 embodies the very foundation that we must build upon to ensure seniors have a system of health care that works for them. Adding a new outpatient prescription drug benefit to Fee-for-Service Medicare with no solutions to address the long-term financial problems facing the program and no provisions to better integrate health care delivery or increase access to the latest advancements in medicine creates a false promise to Medicare beneficiaries.

The Administration's proposal ignores the need to incorporate flexibility into the design and delivery of the prescription drug benefit as well as all Medicare benefits. Right now two-thirds of our Medicare population spend less than $1,500 a year on drugs and 70% of those have out-of-pocket expenditures of less than $1,000 per year. In addition, 10% spend anywhere from $1,000 to $2,000 per year on prescription drugs and 4% spend in excess of $4,000 annually.[5] Clearly, with a population that varies so drastically, mandating a 50% coinsurance and a maximum benefit does little to help address beneficiaries' individual needs. In addition, the Administration's benefit is delivered in a manner that is similar to the delivery of current Medicare benefits—a system that we know is outdated and is driving the program to bankruptcy. Federal government contracts with pharmacy benefit managers to deliver prescription drugs is no different than how HCFA currently contracts with fiscal intermediaries and carriers today to deliver Part A and B benefits. Why in the world would we mirror a prescription drug benefit after a delivery model that was designed in 1965?

In addition, the inability of the current system to deliver a stand alone prescription drug benefit will inevitably impact the quality of health care delivered and drive up program costs tremendously—at the expense of beneficiaries' health and our nation's Medicare providers—causing further cuts in Medicare reimbursements, increases in beneficiary copayments and deductibles, and reductions in benefits that will be necessary to maintain this type of drug benefit. We owe it to our seniors and individuals with disabilities to take a more responsible and comprehensive approach to strengthen, preserve, and improve our Medicare program and the Breaux-Frist legislation is the first step in that process.

V. CONCLUSION

The overwhelming public support for an outpatient prescription drug benefit gives us a real opportunity to make Medicare better with bipartisan legislation. Seniors absolutely need prescription drug benefits, but adding them without addressing the underlying program will only exacerbate Medicare's financial deficiencies and administrative inefficiencies. A drug benefit that does not address total health care delivery in Medicare, is selling ourselves short, and most importantly placing the health of our nation's seniors and individuals with disabilities at risk.

Medicare must be modernized and put on a sound financial footing to be able to provide seniors with a drug benefit that is an integral part of their health care plan. No system is perfect, and change is always unsettling, but we must move beyond the demagoguery and disinformation campaigns and instead act responsibly and take a step-by-step and carefully thought out bipartisan approach this year to balance the very real need for outpatient prescription drug coverage with the need for meaningful structural reforms. It is time for us to take the necessary steps to reshape Medicare, include a prescription drug benefit, and guarantee health care security for seniors in the decades to come. By doing this, I believe we can truly provide choice and security for our Medicare beneficiaries to ensure their individual health care needs are met, today and well into the future.

PREPARED STATEMENT OF MICHAEL HASH

Chairman Roth, Senator Moynihan, distinguished Committee members, thank you for inviting me to discuss the need, and our proposal, to provide prescription drug coverage for Medicare beneficiaries. This Committee will be a focal point of the debate around this important issue and it is a privilege to be before you today to provide the Administration's perspective.

We must act now to ensure that all beneficiaries have an affordable prescription drug benefit option. Pharmaceuticals are as essential to modern medicine today as hospital care was when Medicare was created. And the President believes that we

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[5] M. Gluck, *A Medicare Prescription Drug Benefit*, Medicare Brief No. 1 (Washington: National Academy of Social Insurance, April 1999).

have an extraordinary opportunity to address this shortcoming in the context of additional necessary reforms to the program that make it more effective, modern, and adequately financed.

Lack of prescription drug coverage among senior citizens and people with disabilities today is similar to the lack of hospital coverage among senior citizens when Medicare was created. Three out of five lack dependable coverage. Only half of beneficiaries have year-round coverage, and one third have no drug coverage at all. They must pay for essential medicines fully out of their own pockets, and are forced to pay full retail prices because they do not get the generous discounts offered to insurers and other large purchasers. The result is that many go without the medicines they need to keep them healthy, out of the hospital, and living longer lives.

Drug coverage is not just a problem for the poor. More than half of beneficiaries who lack coverage have incomes above 150 percent of the federal poverty level and millions more have insurance that is expensive, insufficient, or highly unreliable.

Even those with most types of coverage find it costs more and covers less. Copayments, deductibles and premiums are up. And coverage is often disappearing altogether as former employers drop retiree coverage and Medigap is not available to everyone. Clearly all beneficiaries need access to affordable prescription drug coverage option.

KEY PRINCIPLES

The President has identified key principles that a Medicare drug benefit must meet.

- It must be a voluntary benefit accessible to all beneficiaries. Medicare beneficiaries in both managed care and the traditional program should be assured of an affordable prescription drug option. Since access is a problem for beneficiaries of all incomes, ages, and areas, we must not limit a Medicare benefit to a targeted group. At the same time, those fortunate enough to have good retiree drug benefits should be able to keep them.
- It must be affordable to beneficiaries and the program. We must provide assistance that enables all beneficiaries participate. Otherwise, primarily those with high drug costs would enroll and the benefit would become unaffordable. And beneficiaries must have meaningful protection against excessive out-of-pocket costs.
- It must be competitive and have efficient administration. Beneficiaries must have bargaining power in the market place. And we must integrate the benefit into Medicare but use the private sector to deliver it in a competitive way.
- It must ensure access to needed medications and encourage high-quality care. Beneficiaries must have a defined benefit providing access to the medications that their physicians deem to be medically necessary, and they must have the assurance of minimum quality standards, including protections against medication errors.
- It must be done in the context of broader reform. The drug benefit should be a part of a larger plan to strengthen and modernize Medicare.

The President's plan meets these principles.

- Beneficiaries will have access to an optional drug benefit through either traditional Medicare or Medicare managed care plans. Those with retiree coverage can keep it and employers would be given new financial incentives to encourage the retention of these plans.
- Premiums will be affordable, with extra assistance for those with low-incomes.
- There will be no price controls or new bureaucracy; instead, the new benefit will be offered through private pharmacy benefit managers who can efficiently negotiate fair prices. All qualified pharmacies will be allowed to participate.
- Beneficiaries can get all drugs prescribed by their physicians from private benefit managers who meet minimum quality standards.
- The President's Budget includes the prescription drug benefit as part of a comprehensive plan to make Medicare more efficient and competitive and extend its solvency.

We have broad consensus that we must act now to establish a Medicare drug benefit. We have an historic opportunity provided by the growing budget surplus. We have an obligation to keep our commitment to meet the medical needs of seniors and the disabled. And this can only be done by making a voluntary, affordable, accessible, competitive, efficient, quality drug benefit available to all beneficiaries in the context of Medicare reform.

BACKGROUND

Prescription drugs can prevent, treat, and cure more diseases than ever before, both prolonging and improving the quality of life. Proper use should minimize hospital and nursing home stays, and could in some cases substitute for more expensive care that is already covered by Medicare.

Recognizing that prescription drugs are essential to modern medicine, the private sector now includes outpatient drug coverage as a standard benefit in almost all policies.

Further, all plans in the Federal Employees Health Benefits Program offer a prescription drug benefit. No one would design Medicare today without including coverage for prescription drugs. Prescription drugs are particularly important for seniors and disabled Americans, who often take several drugs to treat multiple conditions. All across the country, Medicare beneficiaries are suffering physical and financial harm because they lack coverage.

Current coverage for prescription drugs for Medicare beneficiaries is incomplete and unreliable. We project that this year more than half of Medicare beneficiaries will use prescription drugs costing $500 or more, and 38 percent will spend more than $1000. Each year, about 85 percent of Medicare beneficiaries fill at least one prescription. Yet one third of beneficiaries have no coverage for drugs at all and, in 1996, half did not have drug coverage for the entire year.

Forty percent of beneficiaries without coverage have incomes above 200 percent of poverty ($16,700 for a single person, $22,500 for a couple), demonstrating that this is not just a low-income problem. All these beneficiaries end up paying more for needed prescriptions because they do not get the discounts commonly offered to insurers and other large purchasers.

This situation is worse for the 10 million Medicare beneficiaries who live in rural areas. Nearly half of these beneficiaries have absolutely no drug coverage. They have less access to employer-based retiree health insurance because of the job structure in rural areas. And three-quarters of rural beneficiaries do not have access to Medicare+Choice plans and the drug coverage that many of these plans provide.

In 1996, about one-third of Medicare beneficiaries had private sector coverage offered by former employers to retirees. However, this coverage is eroding. The number of firms with 500 or more employees offering retiree health coverage dropped from 40 percent in 1994 to 30 percent in 1998, according to the employee benefits research firm Mercer/Foster Higgins (numbers for small firms would be even lower).

The true impact of this trend has not yet been realized, because some employers' decisions to drop coverage apply only to future retirees. Furthermore, a recent survey prepared for the Kaiser Family Foundation reported that 40 percent of large employers would consider cutting back on prescription drug coverage in the next three to five years. As today's workers retire, the population of Medicare beneficiaries with access to retiree coverage is likely to be well below the levels reported in our surveys.

About one in six Medicare beneficiaries today are enrolled in Medicare+Choice plans, most of which include some drug coverage. Although Medicare+Choice plans are only required to provide the traditional Medicare benefit package, the majority of them also provide prescription drugs, which is one reason why they have been popular with Medicare beneficiaries.

Nearly one-third of all beneficiaries, however, lack a Medicare+Choice option because they live in areas where there are no plans. And where plans are available, they have been raising premiums and copayments for drugs, while lowering caps on drug coverage. In 2000, three quarters of plans cap benefit payments for brand-name drugs at or below $1000, and nearly one-third of plans cap this coverage at $500 or less, even though the majority of Medicare beneficiaries use prescription drugs costing $500 or more each year.

About one in eight Medicare beneficiaries have drug coverage through Medicaid. Eligibility for Medicaid, however, is restricted to beneficiaries under 100% of poverty, and the majority of beneficiaries eligible for such coverage—60 percent—are not enrolled in the program. This enrollment problem persists despite increasing outreach efforts to enroll those who are eligible.

Roughly one in ten Medicare beneficiaries obtain drug coverage from a supplemental Medigap plan. Medigap coverage, however, is expensive, and its availability is not guaranteed except right after a beneficiary turns 65.

Costs for these policies are rising rapidly, by 35 percent between 1994 and 1998, according to Consumer Reports, in part because those being covered this way are less healthy than the average beneficiary. The General Accounting Office (GAO) found that almost half of all Medigap insurers implemented substantial increases in 1996 and 1997, with AARP—one of the largest Medigap providers, and the only

one offering a community-rated policy covering prescription drugs—increasing rates by 8.5 percent in 1997, 10.9 percent in 1998, and 9.4 percent in 1999.

The GAO also found that Medigap premiums for plans that include drug coverage vary widely, both within and across States. For example, premiums charged to a 65-year-old beneficiary for the standardized "I" Medigap plan ranged from $991 to $5,943 in 1999. And the average premium for the standardized "H" Medigap plan ranges from $1,174 in Virginia to $2,577 in Georgia.

Furthermore, Medigap premiums increase with age in most States. In some parts of the country, beneficiaries over age 75 are paying more than $100 per month for a plan with drug coverage over and above the premium for a comparable plan without drug coverage. This occurs despite the fact that the maximum annual payment for drug costs in the "H" and "I" plans is only $1250 per year, barely over $100 a month.

THE PRESIDENT'S PLAN

The President has proposed a comprehensive Medicare reform plan that includes a voluntary, affordable, accessible, competitive, efficient, quality drug benefit that will be available to all beneficiaries. The President's plan dedicates over half of the on-budget surplus to Medicare and extends the life of the Medicare Trust Fund to at least 2025. It also improves preventive benefits, enhances competition and use of private sector purchasing tools, helps the uninsured near retirement age buy into Medicare, and strengthens program management and accountability.

The President's drug benefit proposal makes coverage available to all beneficiaries. The hallmark of the Medicare program since its inception has been its social insurance role. Everyone, regardless of income or health status, gets the same basic package of benefits. This is a significant factor in the unwavering support for the program from the American public and must be preserved. All workers pay taxes to support the Medicare program and therefore all beneficiaries should have access to a new drug benefit.

A universal benefit also helps ensure that enrollment is not dominated by those with high drug costs (adverse selection), which would make the benefit unaffordable and unsustainable. And, as I described earlier, lack of drug coverage is not a low-income problem—beneficiaries of all incomes face barriers.

The benefit is completely voluntary. If beneficiaries have what they think is better coverage, they can keep it. And the President's plan includes assistance for employers offering retiree coverage that is at least as good as the Medicare benefit to encourage them to offer and maintain that coverage. This will help to minimize disruptions in parts of the market that are working effectively, and it is a good deal for beneficiaries, employers, and the Medicare program.

We expect that most beneficiaries will choose this new drug option because of its attractiveness, affordability, and stability. For beneficiaries who choose to participate, Medicare will pay half of the monthly premium, with beneficiaries paying an estimated $26 per month in 2003. The independent HCFA Actuary has concluded that at least 50 percent of the premium must be subsidized in order to ensure adequate participation. A lesser subsidy would result in adverse selection and thus an unaffordable and unsustainable benefit.

Premiums will be collected like Medicare Part B premiums, as a deduction from Social Security checks for most beneficiaries who choose to participate. These beneficiary premiums would pay roughly half of program costs. Low-income beneficiaries would receive special assistance. States may elect to place those who now receive drug coverage through Medicaid in the Medicare drug program instead, with Medicaid paying premiums and cost sharing as for other Medicare benefits.

We would expand Medicaid eligibility so that all beneficiaries with incomes up to 135 percent of poverty would receive full assistance for their drug premiums and cost sharing. Beneficiaries with incomes between 135 and 150 percent of poverty would pay a partial, sliding-scale premium based on their income. The Federal government will fully fund States' Medicaid costs for the beneficiaries between 100 and 150 percent of poverty.

Under the President's plan, Medicare will pay half the cost of each prescription, with no deductible. The benefit will cover up to $2,000 of prescription drugs when coverage begins in 2003, and increase to $5,000 by 2009, with a 50 percent beneficiary coinsurance. After that, the dollar amount of the benefit cap will increase each year to keep up with inflation.

For beneficiaries with higher drug costs, they will continue to receive the discounted prices negotiated by the private benefit managers after they exceed the coverage cap. And, to help beneficiaries with the highest drug costs, we are setting aside a reserve of $35 billion over the next 10 years, with funding beginning in

2006. It will be available so that Congress and the Administration can work in collaboration to design protections for those with the greatest need.

Benefit managers, such as pharmacy benefit manager firms and other eligible companies, will administer the prescription drug benefit for beneficiaries in the traditional Medicare program. These entities will bid competitively for regional contracts to provide the service, and we will review and periodically re-compete those contracts to ensure that there is healthy competition. The drug benefit managers—not the government—will negotiate discounted rates with drug manufacturers, similar to standard practice in the private sector. We want to give beneficiaries a fair price that the market can provide without taking any steps toward a statutory fee schedule or price controls. The drug benefit managers will have to meet access and quality standards, such as implementing aggressive drug utilization review and patient counseling programs. And their contracts with the government will include incentives to keep costs and utilization low while assuring a fairly negotiated contractual relationship with participating pharmacists.

Similar to the best private health plans in the nation, virtually all therapeutic classes of drugs will be covered. Each drug benefit manager will be allowed to establish a formulary, or list of covered drugs. They will have to cover off-formulary drugs when a physician certifies that a specific drug that is not on the formulary is medically necessary. Coverage for the handful of drugs that are now covered by Medicare will continue under current rules and will not be included in the new drug benefit package.

And Medicare+Choice plans will benefit from the President's plan. Beneficiaries enrolled in Medicare+Choice plans will receive this optional coverage through those plans, and the plans will use their existing management tools to negotiate prices and formularies. Today, most Medicare+Choice plans offer prescription drug coverage using the excess from payments intended to cover basic Medicare benefits. Under the President's proposal, Medicare+Choice plans in all markets will be paid explicitly for providing a drug benefit—in addition to the payment they receive for current Medicare benefits—so they no longer have to depend on what the rate is in a given area to determine whether they can offer a benefit or how generous it can be.

This will eliminate the extreme regional variation in Medicare+Choice drug coverage when only 23 percent of rural beneficiaries with access to Medicare+Choice have access to prescription drugs, compared to 86 percent of urban beneficiaries. And beneficiaries will not lose their drug coverage if a plan withdraws from their area or if they choose to leave a plan because they will also be able to get drug coverage in the traditional Medicare program. We estimate that plans will receive $54 billion over 10 years to pay for the costs of drug coverage.

Appeals Process

Under the President's plan, few appeals of coverage denials would be likely since pharmacy benefit managers would be required to cover all drugs that a physician prescribes. However, a process for appealing pharmacy benefit manager decisions by beneficiaries would be established similar to the highly effective system that exists for appeals of HMO care denials in the Medicare+Choice program.

Benefit managers would be required to respond within set timeframes, state the reasons for a denial in writing, use denial notice forms that describe beneficiary appeal rights, maintain logs, and periodically report on requests for expedited appeals.

All appeals rejected by benefit managers would be automatically forwarded to an independent appeals contractor for review, and this independent contractor also would be required to act within set timeframes. Beneficiaries would be able to appeal an independent review contractor's decision to Social Security Administration Administrative Law Judges, and appeal those decisions to the Health and Human Services Departmental Appeals Board. Finally, beneficiaries would be able to appeal a Departmental Appeals Board decision in federal district court.

Administrative Workload

The administrative workload on the federal government for the drug benefit proposed by the President also would be relatively minimal, since the vast majority of decisions and day-to-day functions would be handled by the pharmacy benefit managers. The capacity of these benefit managers to process claims instantly has expanded rapidly in recent years, and we have no doubt that this capacity could be readily expanded by 2003 to administer our proposed drug benefit. There would be no need for the type of coverage determination process in the traditional Medicare program because the pharmacy benefit managers would establish their own formularies, and be required to cover off-formulary drugs whenever prescribed by a physician.

The federal role would primarily be in conducting competition for the pharmacy benefit manager contracts, overseeing the contracts, and ensuring a smooth interface with other Medicare programs and data systems. We now have a work group evaluating the most efficient way to meet the relatively limited staff and other resource needs that would be required.

MEETING BASIC PRINCIPLES

In any proposal to provide a prescription drug benefit for Medicare beneficiaries, it is essential that the key principles identified by the President be met.

- It must be a voluntary benefit accessible to all beneficiaries.
- It must be affordable to beneficiaries and the program.
- It must be competitive and efficient.
- It must ensure access to needed medications and encourage high-quality care.

Unfortunately, some of the proposals to establish a Medicare drug benefit fail to meet one or more of these criteria.

Proposals that provide assistance only to low-income beneficiaries fail to help millions of beneficiaries with no or undependable coverage. Most lacking drug coverage have incomes above 150 percent of poverty, and it is increasingly difficult for them to afford the medicines they need as drug prices rise faster than inflation. It also is essential that we maintain the principle that all Medicare benefits are equally available to all beneficiaries. This is a pillar of the program's strength and overwhelming support among the American people.

Proposals with a premium subsidy of only 25 percent would make the benefit unaffordable to many low and middle-income beneficiaries unable to shoulder the remaining 75 percent. As a result, the benefit would attract a disproportionate number of enrollees with high drug costs. That would drive up the price of premiums, which would further discourage those with lower incomes or lower drug costs from enrolling, and in the end result in an unsustainable program. As mentioned above, the independent HCFA actuary has concluded that a subsidy of at least 50 percent is essential to attract a range of enrollees wide enough to maintain an adequate risk pool.

Proposals with continuous or annual open enrollment periods would be especially vulnerable to attracting enrollees with high drug costs because beneficiaries could wait until they had substantial drug costs before enrolling. This would exacerbate adverse selection problems caused by an inadequate premium subsidy.

Proposals that link a drug benefit to a high-option Medicare plan with additional benefits like a stop-loss for out-of-pocket costs for Medicare's basic benefits also are less affordable. Beneficiaries who elect the high option would have to pay not only for drug coverage but also for all the other higher costs of the high option plan that many would not need, want, or be able to afford.

Proposals that fail to establish private sector benefit managers everywhere, and instead merely allow private plans to offer coverage when and where they wish, fail to ensure access for all beneficiaries. The benefit would be available only in regions where Medigap and other private plans step forward to offer it. Medigap insurers have already said they would not find stand-alone drug policies an attractive business proposition and are currently offering drugs less frequently. Medigap plans also have little experience negotiating with drug manufacturers and do not pool the purchasing power of seniors. That could well make the coverage unaffordable for many beneficiaries.

And, finally, proposals that do not include a minimum or specified benefit design cannot ensure access or high-quality care. They would allow insurers offering the coverage to "cherry-pick" by tailoring benefits in a way that would limit the value of the benefit to those with greater prescription drug needs. And they would not ensure that minimal safety protections, such as medication error prevention programs, are in place.

CONCLUSION

The need for a prescription drug benefit in Medicare is clear. The consensus across the political spectrum that it should be added is broad. The principles on which it must be based are strong. The opportunity is before us. The time to act is now. I look forward to working with all of you on this critical issue. I thank you for holding this hearing, and I am happy to answer your questions.

PREPARED STATEMENT OF HON. ORRIN G. HATCH

Mr. Chairman, I want to commend you for holding this important hearing today on prescription drug coverage under the Medicare program. As I travel around the country and meet with senior citizens, it is clear to me that paying for prescription drugs is a matter of concern for most of our seniors. It is my hope that despite the fact that we are in the middle of an election year that this Congress can take constructive actions to help remedy this problem.

I am of the school of thought that the entire Medicare program needs a comprehensive overhaul in order to meet squarely the problems presented by the sheer demographics of our aging population, advances in medical technology and in organization of care providers. We must conduct an honest dialogue with the American public about the nature of the choices we face. All of us have a stake in this debate: working Americans, their children and the retirees of the best generation alike, have a stake in how the Medicare program is financed and structured.

Mr. Chairman, current and future beneficiaries deserve to have a strong and financially sound Medicare program. Whatever actions we take with respect to the coverage of prescription drugs, we need to guarantee that Medicare will always be here for seniors. While my strong preference is to consider the prescription drug coverage issue in the context of overall reform, if the opportunity exists for incremental change, we should take it. However, it must be understood by everyone that there are larger coverage and financing issues that must be addressed in the very near future. Unlike the present administration, the next President will not have the luxury of avoiding these important issues. In the long run, it is the American public that pays the cost of short term political expediency, and that is why I believe it is imperative for Congress to seriously consider this issue this year.

Statement PhRMA

Alan F. Holmer
President and Chief Executive Officer
Pharmaceutical Research and Manufacturers of America

before the

Committee on Finance
United States Senate

March 22, 2000

INTRODUCTION

Mr. Chairman, Senator Moynihan, and other members of the Committee. I'm pleased to be here on behalf of America's innovative pharmaceutical industry to discuss an issue that is vitally important to all of us--prescription drug coverage for seniors and disabled citizens. Across America, 50,000 scientists in our research labs work day and night in hopes of finding the next cure or the next treatment, to allow individuals to live long, healthy, and productive lives (see Attachment 1). On average, it takes 12 to 15 years and $500 million to develop a new drug and bring it to market.

Today, industry has more than 1,000 new medicines in development to treat hundreds of serious illnesses including Alzheimer's and Parkinson's diseases, cancer, stroke, arthritis, and depression. We are confident that, in time, we will find the cures for these and other conditions that are so prevalent among our aging population (see Attachment 2).

The 21st Century brings even greater promise. As the human genome is mapped, many new targets for pharmaceutical innovation will be identified. Currently about 500 targets for drug interventions are known. This figure is expected to increase to 3,000 to 10,000 drug targets in the near future. When these new cures and treatments are brought to market, we want to ensure that seniors have access to them--without discouraging the discovery and development of new medicines.

In our discussions, I hope that we all can begin by agreeing on at least four key points:

First, expanded drug coverage for seniors will happen. At some point in the not-too-distant future, a Congress will pass, and a President will sign, legislation to expand drug coverage for Medicare beneficiaries. It's going to happen, and the

pharmaceutical industry wants to be part of the solution. Most Medicare beneficiaries have prescription drug coverage either through their (or their spouse's) current or former employer, a Medicare supplemental insurance (or Medigap) policy, a Medicare+Choice plan, or by qualifying for Medicaid or other governmental programs. But many of those who do not receive the coverage they need through these mechanisms require additional assistance.

Second, expanded drug coverage for seniors will be a positive development. Prescription drugs are increasingly the most effective and cost-effective therapy with which to treat diseases or conditions. Some Medicare beneficiaries are in need of prescription drug coverage and our medicines provide extraordinary value to them.

Third, as we expand drug coverage for seniors, we must sustain the American pharmaceutical industry's worldwide leadership. The industry has developed new medicines that benefit all patients--young and old--and we do not want to harm the environment in the U.S. that has allowed our industry to thrive. In the1990s alone, 370 prescription drugs, biologics, and vaccines developed by industry were approved for patients' use with a physician's prescription. Almost half of all new medicines in the world are discovered by the U.S. industry (see Attachment 3). We are the world's leader in pharmaceutical research and development (see Attachment 4).

As we work together to expand access to prescription drug coverage, we must remember that Medicare beneficiaries want access to new medicines because they were invented.

Finally, we need to always remember to put the interests of patients first. In an environment where we discuss 10-year forecasts, adverse selection, risk pools, and premium calculations, it is sometimes difficult to remember that the real focus must always be on patients. In moving forward, we must always focus on what type of expanded Medicare drug coverage will be best for patients, their children, and their grandchildren--who need access to medicines, but who also need the discovery of medicines that today exist only in our dreams.

SUPPORT COMPREHENSIVE MEDICARE REFORM

The pharmaceutical industry strongly supports strengthening and modernizing Medicare, including expanding Medicare coverage of prescription medicines (see Attachment 5). We believe that today's Medicare structure does not effectively meet the health care needs of today's seniors and disabled citizens. Medicare beneficiaries need high-quality health care, and prescription medicines often offer the most effective therapy for them.

We believe that the best way to expand prescription drug coverage for Medicare beneficiaries is through comprehensive Medicare reform. The current program is based on a 1960s-style, one-size-fits-all model that relies on centralized price controls and

complex regulations. The result is a program that is confusing for patients and providers, difficult to administer, and inadequate to meet the health care needs of the 21st century.

In his Fiscal Year 2001 budget, the President proposed several initiatives to "reform" the Medicare program. However, these policy modifications do not modernize Medicare because they would not change the fundamental structure of the Medicare program nor increase the long-term financial stability of the program. Rather, they would simply institute new centralized payment policies and regulatory authorities.

Likewise, the Administration offered a new prescription drug benefit that it claimed would rely on private market forces to foster competition. But this plan would offer a one-size-fits-all benefit design and would simply use private entities to administer the program, as they do currently for hospitals, physicians, and other services.

The Administration claims that its proposal contains no price controls and ensures patients' access to medicines. But we believe that price controls and limits on access to medicine would be the inevitable outcome of any HCFA-administered plan.

We believe that seniors deserve more choices than the "yes" or "no" that characterizes the Administration's plan. We agree with Sen. Breaux who said that the "competition" the Administration's plan would provide is a "distant second cousin" to real competition. Allowing private entities to 1) bear the risk, 2) offer a variety of plans, and 3) compete for customers based on quality and cost, would ensure real competition.

Indeed, a reformed Medicare program would use the power of the marketplace to foster competition among private plans, resulting in more choices of high quality for Medicare beneficiaries. Seniors and disabled Americans could then select a plan that meets their individual needs. With this market-based approach, the Medicare program would evolve to reflect changes in the medical marketplace. The right reforms would expand prescription drug access for all, provide special assistance to those in need, and deliver high-quality care.

We do not need to look far for a model that incorporates many good design elements—the Federal Employees Health Benefits Program (FEHBP). Each year, Members of Congress, 9 million Federal employees (and retirees), and their families choose a comprehensive health insurance plan from the wide range offered by different kinds of competing private entities. These plans provide both quality care and good value. Most Federal employees enroll in preferred provider organizations (PPOs); others enroll in health maintenance organizations (HMOs). Almost all Federal employees are very satisfied with their health care.

Some Medicare beneficiaries already receive their coverage from a private entity, rather than remaining in traditional fee-for-service Medicare. Beneficiaries who choose a Medicare+Choice plan often find that they have lower out-of-pocket costs,

better coordination of care, and receive extra benefits--including prescription drug coverage. Nationwide, 16 percent of Medicare beneficiaries choose this option. However, participation in Medicare+Choice varies by geographic area--often reflecting trends in the under-65 market. For example, in parts of northern California, nearly half of the beneficiaries receive their Medicare benefit from a private plan. In other parts of the country, especially rural areas, beneficiaries have only one option--traditional Medicare. Today, nearly two-thirds of beneficiaries have access to a Medicare+Choice plan that includes some form of prescription drug coverage. A modernized Medicare program would foster competition among plans and provide even more private plan options for all beneficiaries that include prescription drugs.

Senators Breaux, Frist, Kerrey, and Hagel recognize the importance of fundamental reform of the Medicare program and introduced the Medicare Preservation and Improvement Act (S. 1895). This bill represents a commitment to making Medicare financially sound and more responsive to the needs of seniors by using a market-based approach. Under this plan, all health plans would compete to enroll Medicare beneficiaries. Consumer choice would drive plans to provide better--and more cost-effective--health care.

America's innovative pharmaceutical manufacturers recognize that modernizing Medicare to increase prescription drug coverage, while preserving and protecting these vulnerable populations, is as complex as it is important. We are committed to comprehensive Medicare reform with private sector delivery, and pledge to work with Congress to achieve this goal.

INCREMENTAL MEASURES TO INCREASE ACCESS

If the Congress decides to pursue interim measures pending longer term comprehensive reform, PhRMA would support efforts to increase access to prescription drug coverage, so long as they would improve, rather than impede, opportunities for future comprehensive reform.

We are encouraged by the Seniors Prescription Insurance Coverage Equity Act (SPICE) (S. 1480) introduced by Sens. Snowe and Wyden. This bill would provide beneficiaries with access to prescription drugs by subsidizing the purchase of a supplemental policy, enrollment in a Medicare+Choice plan, or through an employer-provided group health plan. It provides opportunities for private market competition and more choices.

With respect to the delivery system for any proposal, policy makers need to ask:

- Should the drug benefit be delivered by the government or the private sector?
- Should the benefit be a single, one-size-fits-all program, or should seniors and disabled beneficiaries have a range of choices?

We believe several principles are key components of any interim proposal. As Congress continues to grapple with this complex issue, we will support proposals consistent with these key principles:

- All beneficiaries would have the ability to enroll in a private insurance coverage plan of their choosing, ranging from private fee-for-service to HMOs and various private-sector options in between.
- Federal subsidies would help low-income beneficiaries afford coverage.
- Plans would provide coverage for beneficiaries with high pharmaceutical expenditures.
- Beneficiaries would have access to all medicines.
- Plans should be overseen by a new, independent government entity.
- The new program would be consistent with, and a step toward, needed comprehensive modernization of the Medicare program.
- Coverage would be offered through competing, private insurance or health plans that rely on marketplace competition to control costs and improve quality.

Government price controls are unacceptable to the industry, because they would inevitably harm our ability to bring new medicines to patients. We urge you to say "no" to price controls in any form, not direct price controls, not indirect price controls, not by design, not by accident, not by stealth, not by baby steps.

A PRIVATE INSURANCE INCREMENTAL APPROACH

The pharmaceutical industry believes that if Congress decides to provide an incremental prescription drug benefit, the best approach would be to provide seniors access to private insurance products. This approach would fit easily into the current marketplace, since well over 150 million people get their drug coverage through private entities. In delivering drug coverage, these private entities would do more than simply pay the claims. **They could provide disease management programs, drug utilization review, patient education, and help to reduce medical errors.** We in the research-based pharmaceutical industry believe that seniors and disabled beneficiaries would benefit greatly by having access to these private insurance products, with the government providing subsidies for those in need.

Skeptics point to complex issues, such as "adverse selection," and claim that a private insurance program will not work. Adverse selection can occur because individuals purchase insurance only when it is in their best interest. If an individual could purchase insurance at <u>any</u> time, it would be perfectly rational for them to wait until

they were sick. Consequently, insurers often place limits on when individuals can purchase insurance and under what conditions.

Recognizing that adverse selection is an important issue, we asked the experts for assistance. We turned to leading actuarial and economic firms including Milliman and Robertson, Abt Associates, and Towers-Perrin and commissioned analyses (see Attachments 6, 7, and 8). These actuaries and economists note that a private prescription drug insurance program can work if designed properly. They also note that adverse selection is "one of the most difficult issues in designing any insurance program involving individual choice." Actuaries and economists have several tools to minimize the impact on adverse selection. These include:

- Limiting election opportunities for enrollment;
- Providing low-income subsidies for premiums and deductibles;
- Establishing a high-risk pool for enrollees with very high expenditures;
- Requiring up-front cost sharing, such as an annual deductible; and
- Allowing insurers to negotiate with manufacturers and distribution networks to reduce costs.

We believe that a properly designed prescription drug insurance benefit would attract many Medicare purchasers and many private market sellers. Why are we so confident? In the market today, there are private health insurance policies for cancer, sports accidents, emergency room visits, pregnancy complications, and campers. There are private insurance products for goats, carriage rides, and the weather on the day of your daughter's wedding (see Attachment 9). We believe that there are similar opportunities for private-market solutions to increase access to prescription drug coverage for the elderly and disabled Americans.

CONCLUSION

In my testimony today, I've tried to highlight the pharmaceutical industry's support for expanded drug coverage for seniors--done the correct way.

Some say that this issue is life or death for the pharmaceutical industry, America's premier high-technology industry. After the debate is over, and the dust settles, we will still have a pharmaceutical industry, but depending on what you do, the industry could be profoundly different, and the results for patients could be demonstrably less.

As the debate unfolds, I hope you'll remember the millions of Americans, like my children, waiting impatiently for new cures and treatments. We can provide quality health care for seniors and the disabled, including better prescription drug coverage, but we need to do it the correct way. If we do it the wrong way, the industry and the patients we serve will undoubtedly suffer the consequences.

ATTACHMENT 1

THE RESEARCH-BASED PHARMACEUTICAL INDUSTRY: FACTS AT A GLANCE

A Strong Commitment to Research and Development

- This year, research-based pharmaceutical companies will invest $26.4 billion in research and development (R&D) on innovative new medicines. This represents an increase of 10.1 percent over research spending in 1999. Since 1980, research-based companies have multiplied their R&D investment 13-fold.
- Domestic R&D is expected to increase by nearly 12 percent in 2000.
- R&D conducted abroad by U.S. based companies will grow only 1.2 percent - a clear sign that the American system nurtures innovation and discovery.
- Over the past two decades, the percentage of sales allocated to pharmaceutical R&D has increased from 11.9 percent in 1980 to approximately 20.3 percent in 2000, higher than virtually any other industry. The average for all U.S. industries is less than four percent.
- Approximately 36 percent of pharmaceutical R&D conducted by companies worldwide is performed in the United States, followed by Japan with 19 percent.
- This U.S. industry investment is very efficient. Of 152 major global drugs developed between 1975 and 1994, 45 percent are of U.S. origin.

Drug Discovery and Development Are High-Risk

- During the 1990s, the average time it took to discover, test and develop a single new drug increased to nearly 15 years. This was almost twice the development time in the 1960s.
- Of every 5,000-10,000 compounds tested, only five enter human clinical trials, and only one is approved by the FDA for sale in the U.S. Of every 10 medicines in the market, on average, only three generate revenues that meet or exceed average R&D costs.
- The Boston Consulting Group estimates that the pre-tax cost of developing a drug introduced in 1990 was $500 million, including the cost of research failures and interest over the period of investment.

Medicines in Development

- The research-based pharmaceutical industry currently has more than 1,000 new medicines in development to treat hundreds of serious diseases.

  - There are currently 369 biotech medicines in the pipeline to combat over 200 diseases. Nearly half the medicines - 175 - are for cancer, the second leading killer of Americans. Biotechnology and new technological tools have revolutionized cancer research.

  - Among these drugs and biologics in development are promising new treatments for cancer, heart disease, Alzheimer's, AIDS, diabetes, multiple sclerosis, Parkinson's, stroke, rheumatoid arthritis, and depression.

The Value of Medicines

- The estimated life expectancy of an American born in 1920 was 54 years. By 1965, life expectancy had increased to 70 years. The average American born today can expect to live more than 76 years, and life expectancy has risen dramatically for all age groups. Every five years since 1965, roughly one additional year has been added to life expectancy at birth. These improvements in life expectancy are due advances in medicine and our improved ability to prevent and treat disease:

  - Antibiotics and vaccines have virtually wiped out such diseases as diptheria, syphilis, whooping cough, measles and polio in the U.S.

  - The influenza epidemic of 1918 killed more people than all the battles fought during the First World War. Since that time, medicines have helped reduce the combined U.S. death rate from influenza and pneumonia by 85 percent.

  - Over the past 30 years, innovative medicines have helped reduce deaths from heart disease and stroke by half, enabling 4 million Americans to live longer, better lives.

  - Since 1965, drugs have helped cut emphysema deaths by 57 percent and ulcer deaths by 72 percent.

- In a year-long disease-management program for about 1,100 patients with congestive heart failure run by Humana Hospitals, pharmacy costs increased by 60 percent, while hospital costs (the largest component of U.S. health care spending) declined 78 percent. The net savings were $9.3 million.

- A National Institutes of Health (NIH) study showed that while it initially costs more to treat stroke patients with a clot-busting drug, the expense is more than offset by

reduced hospital rehabilitation and nursing home costs. Treatment with the clot-buster costs an additional $1,700 per patient, but reduced hospital rehabilitation and nursing home costs result in net savings of more than $4,000 per patient.

- According to a study published in the *New England Journal of Medicine*, the use of ACE inhibitor drugs for patients with congestive heart failure reduced mortality by 16 percent, avoiding $9,000 in hospital costs per patient over a three-year period. Considering the numbers of people at risk for congestive heart failure, additional use of ACE inhibitors could potentially save $2 billion annually.

- According to a study conducted at the University of Maryland Medical Center, patients treated with beta-blockers following a heart attack were up to 40 percent less likely to die in the two-year period following the heart attack than the patients that did not receive the drugs. According to another study, use of beta-blockers resulted in an annual cost savings of up to $3 billion in preventing second heart attacks and up to $237 million in treating angina.

  - Unfortunately, a study published in the *Journal of the American Medical Association* found that only half the people who could be helped by these medicines are getting them.

- Estrogen-replacement therapy can help aging women avoid osteoporosis and crippling hip fractures, a major cause of nursing home admissions. Estrogen-replacement therapy costs approximately $3,000 for 15 years of treatment, while a hip fracture costs an estimated $41,000.

- The combination of two drugs, at a cost of about $140 can eradicate the bacterial cause of most ulcers. Ulcer surgery costs upward of $28,000.

Attachment 2

Prevalence, Cost, and Medicines in Development for Selected Major Diseases in the United States

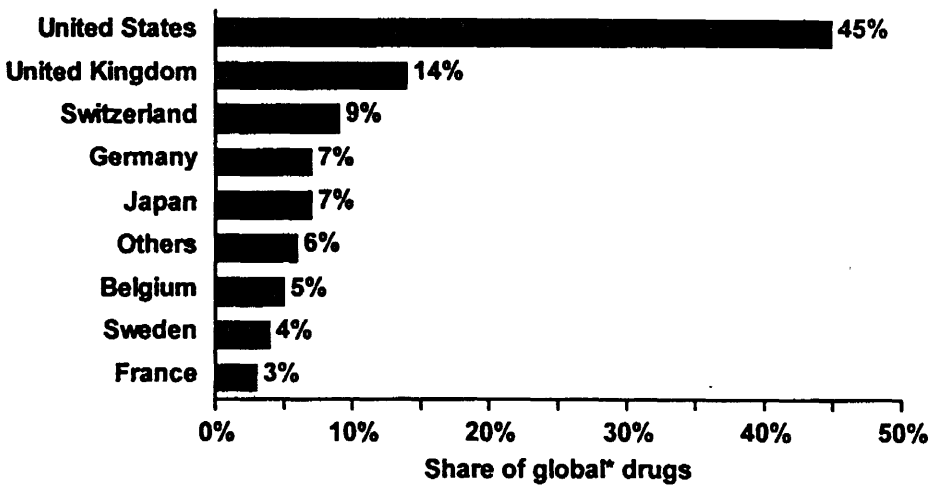
Uncured Disease	Approximate Prevalence	Approximate Annual Economic Cost ($billions)	Number of Medicines in Development*	Source
Alzheimer's Disease	4,000,000	$100.0	23	National Institute on Aging
Arthritis	40,000,000	$54.6	28	Arthritis Foundation
Asthma	14,000,000	$6.2	17	National Heart Lung and Blood Institute
Cancer	8,000,000	$107.0	316	American Cancer Society
Congestive Heart Failure	4,900,000	$20.2	17	American Heart Association
Coronary Heart Disease	13,900,000	$95.6	38	American Heart Association
Depression	17,600,000	$53.0	17	National Institute on Mental Health
Diabetes	15,700,000	$98.2	19	National Institute of Diabetes
Hypertensive Disease	50,000,000	$31.7	10	American Heart Association
Osteoporosis	10,000,000	$13.8	24	National Osteoporosis Foundation
Schizophrenia	1,500,000	$23.0	12	National Institute of Mental Health
Stroke	4,000,000	$43.3	22	American Heart Association

*PhRMA data.

Source: Compiled by PhRMA, 2000.

Attachment 3

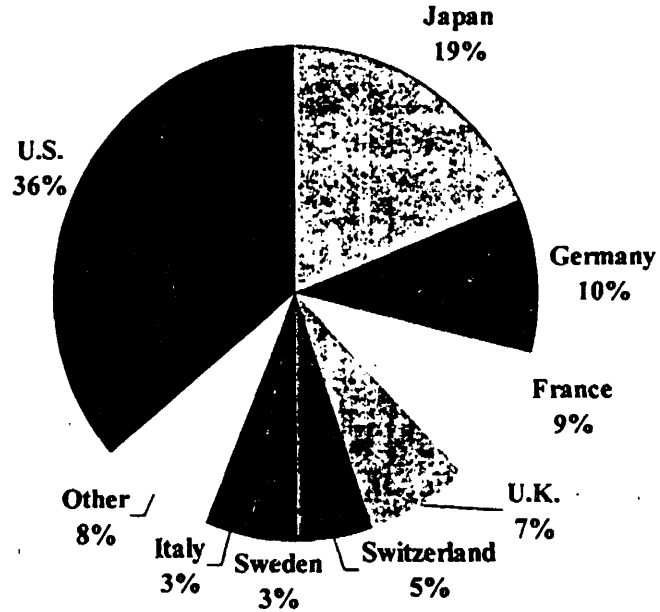
Development of 152 Global* Drugs by Country of Origin, 1975–1994



Global drugs: Launched in U.S., Japan, France, Germany, U.K., Italy and Switzerland.

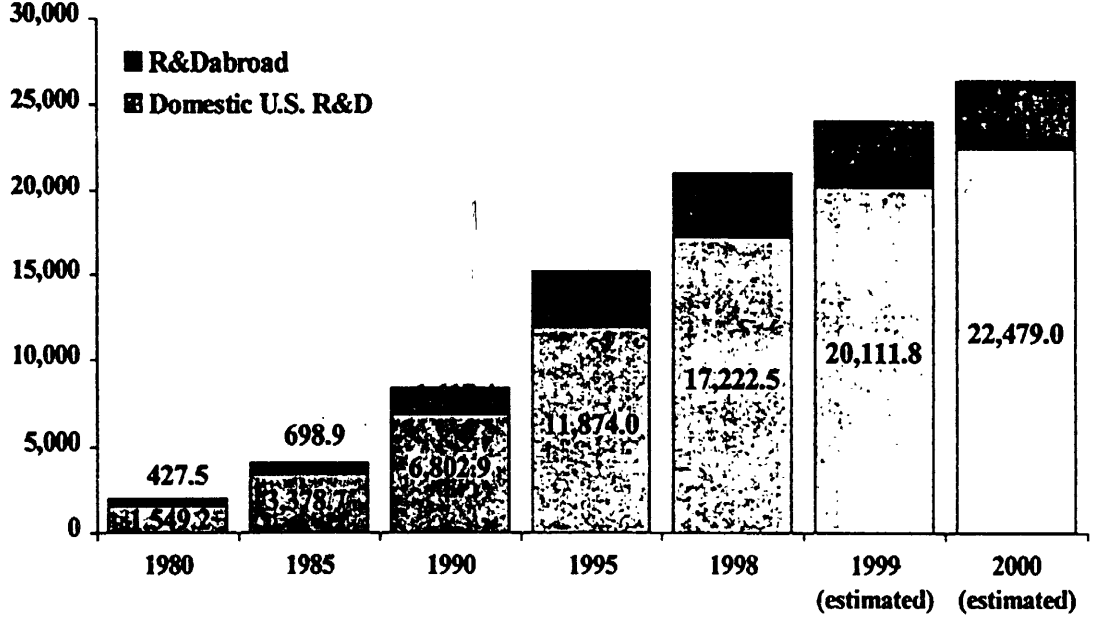
Source: Barral, P.E., 20 Years of Pharmaceutical Research Results Throughout the World, Rhone-Poulenc Rorer Foundation, 1996.

Company-Financed Pharmaceutical Research & Development by Location, 1997



Source: Centre for Medicines Research, U.K., 1999.

R&D Expenditures, Research-Based Pharmaceutical Companies 1980-2000



Source: PhRMA Annual Survey, 2000.

Attachment 5

Statement PhRMA

PhRMA Medicare Prescription Drug Position

The Pharmaceutical Research and Manufacturers of America (PhRMA) supports pharmaceutical coverage for Medicare beneficiaries. We believe that the best way to provide pharmaceutical coverage to Medicare beneficiaries is through comprehensive modernization of the Medicare program to provide beneficiaries a choice of health plans that would also provide drug coverage. If such modernization does not occur this year, PhRMA would support federal legislation that would provide all seniors with access to pharmaceutical insurance coverage, wherever they live and no matter how sick they are.

Such a proposal would have the following elements:

1. All beneficiaries would have the ability to enroll in a pharmaceutical coverage plan of their choosing.
2. Federal government subsidies would help low-income beneficiaries afford coverage.
3. Coverage would be offered through competing, private insurance plans that rely on marketplace competition to control costs and improve quality.
4. Plans would provide coverage for beneficiaries with high pharmaceutical expenditures.
5. Beneficiaries would have access to all medicines.
6. Plans would be overseen by a new, independent government entity.
7. This new program would be consistent with, and step toward, needed comprehensive modernization of the Medicare program.

Several existing proposals embody these elements in whole or part. We offer our assistance and support in advancing the goal of enhanced pharmaceutical coverage this year.

January 17, 2000

Attachment 6

MILLIMAN & ROBERTSON, INC.
Actuaries & Consultants

Stephen M. Cigich, F.S.A. | Suite 400, 15800 Bluemound Road, Brookfield, Wisconsin 53005-6069 Telephone: 262/784-2250 Fax: 262/784-4116 | Wendell Milliman, F.S.A. (1976-) Stuart A. Robertson, F.S.A. Chairman Emeritus

Design Elements in a Private Medicare Insurance Program for Prescription Drugs
Issue Brief

A private prescription drug insurance program for Medicare enrollees could be viable if certain design elements are in place. The purpose of this issue brief is to identify those critical design elements and parameters. This brief is designed for an audience familiar with: 1) the Medicare program, 2) currently available prescription drug insurance options (e.g. Medicare supplemental policies and the Medicare+Choice program), as well as 3) a basic understanding of risk and the operation of the insurance industry.

The Pharmaceutical Research and Manufacturers of America has retained Stephen M. Cigich, F.S.A., M.A.A.A. of Milliman & Robertson, Inc. to prepare this issue brief. This brief is based on actuarial modeling and analysis regarding the impact of adverse selection, and reflects the author's actuarial judgment and opinion.

BACKGROUND

Private insurers would consider many issues in determining whether to participate in a prescription drug insurance program for Medicare enrollees. Issues include parameters placed on program design elements such as: the general program design (premium structure and cost sharing), pharmacy network structure, prescription drug interventions and formulary usage, pricing for future estimated utilization and cost trends, enrollment rules, existing prescription drug programs, regulatory oversight, and government subsidy mechanisms. Additionally, insurers would need to consider the possibility of future legislative changes that may have adverse effects.

Private insurers would also need to address one of the most difficult issues in designing any insurance program involving individual choice — adverse selection. This is especially true for a stand-alone prescription drug program for Medicare enrollees. However, a carefully designed program that includes the features outlined in this paper could substantially control the effects of adverse selection.

ADVERSE SELECTION - DEFINED

Adverse selection arises when potential enrollees purchase private insurance only when they believe it is in their financial interest to do so. Most people can estimate their near-term future prescription drug spending with reasonable accuracy. Barring an unforeseen change in health, a person can determine if they benefit from enrolling in a private plan based on a review of their recent prescription drug spending. This determination becomes less clear if a person must consider the need for coverage over their remaining lifetime.

Adverse selection can be measured as the increase in the per capita cost of the population electing the private plan to the per capita cost of all of those who were eligible to elect the private plan. For example, we project the average per capita drug spending, ignoring managed care discounts, in calendar year 2000 to be $1,243 per person for all current aged enrollees. However, the distribution in average annual drug costs by quartile is striking: $55, $459, $1,182, and $3,277. If all current aged enrollees join the plan (i.e., election rate equals 100%), the average drug spending would also be $1,243 and adverse selection would be 0%. At the other extreme, if only the 25% with the highest annual drug spending ($3,277) enrolled, then adverse selection would be 164% [=($3,277-$1,243)/$1,243].

Under a private insurance program, the initial first-year offering to all current enrollees creates the biggest potential for adverse selection impact. The fact that there are approximately 37 million people in this category magnifies the potential impact of misestimating adverse selection.

DESIGN ELEMENTS TO CONTROL ADVERSE SELECTION

Adverse selection is dynamic. The higher the average private insurance plan cost, the greater the impact of adverse selection as people with lower prescription expenses elect not to join. Consequently, program features designed to keep costs low will help in controlling adverse selection. These elements include:

Limited One-time Election Opportunity - A limited one-time election opportunity would encourage Medicare recipients to consider factors beyond the near-term in making their election decision, resulting in higher enrollment levels and reduced adverse selection.

Catastrophic Benefit Design Emphasis - A benefit design that emphasizes catastrophic protection (providing full coverage when the enrollees' calendar year prescription expenses exceed a threshold level) introduces an important protection against adverse selection. A catastrophic benefit not only protects enrollees against an uncertain future financial event; it changes their frame of reference from enrolling in a plan to obtain coverage for incidental expenses to enrolling in the plan to obtain coverage for expenses that they potentially may not be able to afford. A catastrophic benefit would necessitate up-front cost sharing features, such as annual deductibles, to help keep the premiums low.

Management Techniques - Allowing insurers to establish contractual relationships with pharmaceutical manufacturers and distribution networks would lessen product costs and thus premiums. Formularies and utilization management programs would also control expenditures.

Low-Income Subsidy - Subsidies for both premiums and deductibles for low-income enrollees would encourage their enrollment. Thus, low-income subsidies are an effective way to enroll a significant number of potential enrollees with a broad range of prescription drug costs into the program, thus reducing the level of adverse selection.

High-Risk Pool and Subsidy - A subsidized high-risk pool would allow insurers to segregate the highest users of prescription drugs from their community rate pool. By eliminating the excess cost of these individuals, the community rate level supporting all other enrollees falls. Additionally, the level of claims variance in the insurers' community rate pool falls as well. Lower claims variance provides a greater level of stability and predictability to insurance company pricing.

AN ILLUSTRATION OF A PRIVATE INSURANCE OPTION

The following is an illustration of a private insurance option for prescription drugs that incorporates these elements:

- All current Medicare enrollees (Initial Eligibles) and future Medicare enrollees (Future Eligibles) would be offered a one-time, limited opportunity to buy prescription drug insurance from private insurers on a guaranteed issue, community rated basis.

- A one-time, 6-month enrollment window would be established whereby Eligibles would be allowed to enroll on a guaranteed issue, community-rated basis. Eligibles who did not enroll during the enrollment window would apply for coverage later, but would be subject to insurance company underwriting requirements.

- Premium subsidies would be offered to individuals with incomes below a certain percentage of the poverty level. Eligibles at or below a defined income threshold would have their entire premium and any benefit deductibles paid by the government. Subsidies would be graduated so that Eligibles above a certain income level would receive no subsidy.

- High risk pools would be established to mitigate the impact the highest users of prescription drugs would have on the insurers' community rates. The government would publicly fund benefit expenditures for these high-risk individuals in excess of the community rate.

- Benefit management methods such as participating pharmacy networks, formularies, and utilization management would be permitted.

- The benefit would be designed to emphasize catastrophic protection while keeping the community premium rate reasonably low.

Attachment 7

Addressing Issues for Private Sector Provision of Drug Insurance

Marian V. Wrobel, Ph.D., and David Kidder, Ph.D.
Abt Associates, Inc.
March, 2000

Introduction

Prescription drugs play an essential role in the treatment of disease, but providing these therapies may be costly and may impose financial burdens on the people who require them. Drug costs represent a growing share of total medical costs largely due to the growing importance of prescription medications in the treatment of disease and the increased use of these drugs.

Many individuals, including Medicare beneficiaries, would like to purchase insurance against *all* medical costs including drug costs; however, at present, fee-for-service Medicare does not include a drug benefit, and Medicare beneficiaries have only limited access to drug benefits from other sources. Three of the ten standard Medicare supplemental insurance policies include some drug coverage, but these benefits are capped at $1,250 or $3,000 per year and this insurance is expensive, relative both to its actuarial value and to many potential buyers' incomes. Some beneficiaries have access to drug benefits via Medicare+Choice plans, but these plans are not available in all areas and may not appeal to all beneficiaries. Some beneficianes have employer-provided retiree health insurance that includes drug benefits. Approximately one-third of seniors report having no drug coverage at all.

There are strong arguments for policy reforms that would increase Medicare beneficiaries' access to drug insurance and that would subsidize some of the costs of that insurance. Some evidence exists that a lack of drug coverage reduces access to essential drugs among the sickest patients and results in increased use of expensive institutional services, which *are* covered by Medicare and funded publicly.

The Pharmaceutical Research and Manufacturers of America (PhRMA) has retained Abt Associates to assess the viability of allowing the private sector to offer drug insurance for voluntary purchase by Medicare beneficiaries and enabling insurers to retain significant flexibility regarding how those benefits are designed. Private sector products could take various forms. A combination of government policies, presented below, could help to make the products affordable and to foster the success of these markets.

Advantages of Flexible, Privately-Provided Drug Benefits

Flexible, privately-provided drug benefits offer several potential advantages relative to their publicly-provided counterparts. Market competition would provide incentives for insurers to offer the best possible product at the best possible price: purchasers, voting with their pocketbooks, determine the design and generosity of their benefit. The private sector is free to adopt state-of-the-art utilization management techniques to the extent that purchasers are willing to accept them in return for the resulting reductions in premiums or cost-sharing. The private sector is also free to *negotiate* drug discounts with manufacturers: this is in contrast to government drug benefit programs which typically *mandate* drug discounts. Flexible, private benefits also allow ongoing innovation in areas such as the design of benefits, the techniques used to control costs, and special services for members: they enable Medicare beneficiaries to enjoy the same advantages as individuals with private insurance.

Adverse Selection: The Problem and Solutions

Any voluntary health insurance program faces the problem of adverse selection. At any given premium, individuals are most likely to purchase insurance if they expect their health costs (net of cost-sharing) to exceed the premium. This drives premiums higher, potentially creating a "death spiral" and provoking market collapse. Drug benefits may be particularly vulnerable to adverse selection, first because individuals can predict their expected drug costs more accurately than other components of their health expenditures, and second because the insurance policies under discussion will primarily be purchased by individuals, rather than groups. (Groups present less risk than individuals.) Also, the problem of adverse selection may discourage insurers from entering a newly opened market because the first market entrant is likely to attract the individuals with the greatest need for insurance, i.e. the highest expected costs.

Adverse selection may be exacerbated by flexible benefits. Flexible benefits further divide the market as each would-be purchaser selects the plan under which he would benefit the most. At the same time, insurers may try to structure benefits in such a way as to attract only low-cost or low-risk enrollees, that is, they will seek to avoid individuals with high expected expenditures, the very people in greatest need of drug insurance. This phenomenon is frequently referred to as "cherry-picking."

Adverse selection, however, can be substantially controlled by policies that 1) raise the total level of enrollment, 2) promote risk-neutral enrollment, and 3) keep premiums down. Subsidies to low-income buyers or to all buyers, possibly via favorable tax treatment, raise total enrollment and, by extension, lower the risk level in the enrolled pool. Such subsidies also extend access to individuals who might otherwise find drug insurance unaffordable. In order to minimize "crowding out," subsidies should probably be available to beneficiaries

regardless of whether their drug insurance comes from a former employer, a Medicare+Choice plan, a supplemental insurance program, or another insurance product.

To promote risk-neutral enrollment, insurers might be offered some latitude for underwriting. For example, all beneficiaries might be given a six-month enrollment window with guaranteed issue, with insurers able to impose reasonable restrictions after that. (This is the existing policy for Medicare supplemental insurance, and there are similar enrollment incentives in Medicare Part B.) To encourage significant enrollment, insured individuals should probably be guaranteed the ability to renew their policies annually at community rates following initial enrollment.

A high-risk pool or assigned-risk pool could also keep premiums down and mitigate the effects of adverse selection on the drug insurance market. Reinsurance, that covers a substantial share of any individual's annual drug expenditure in excess of a very high threshold, is an alternate policy with a similar impact. Such policies also soften insurers' incentives to engage in cherry-picking.

Reasonable standards for benefits is also a way to curb cherry-picking as well as to guarantee the quality of the products available. Benefits might be regulated along such dimensions as basis of premium and a requirement to cover at least some drugs in each of a set of standard therapeutic categories while leaving insurers latitude regarding formularies, utilization review, discounts, cost-sharing, pharmacy networks, and premiums. Reasonable requirements regarding when insurers could enter and exit this market and what populations must be served by participating insurers also "level the playing field," allowing markets to develop, and ultimately serve the interests of both potential insurers and potential purchasers.

Information/Protection for Purchasers

While adverse selection is the key issue for health insurance markets, concern is often expressed that individuals do not have sufficient knowledge of the different plans available to them to make well-informed decisions. The solution to this problem would entail helping Medicare enrollees select among competing plans, by requiring insurers to submit uniform information about the benefits they offer in clear, concise language. Third parties might also offer prudent purchaser information to help beneficiaries understand tradeoffs and make informed choices. Individuals eligible for coverage under the Federal Employees Benefits Program receive this kind of assistance today. The federal Office of Personnel Management requires that plans submit certain standard information that it compiles in a plan comparison book. Similarly, Washington Consumer Checkbook (a private consumer organization) publishes a more extensive annual guide to available plans for federal workers residing in or near Washington, DC.

Conclusion

In summary, there are strong arguments for extending Medicare beneficiaries' access to drug benefits. While all options should be discussed and explored, there are some clear advantages to a system in which the private sector offers a range of different competing plans and beneficiaries are free to choose among them. Such an approach would offer Medicare beneficiaries the opportunity to select the product that best suits their needs at a competitive price. The Medicare population would benefit from the ongoing innovation taking place in the national drug benefit market. The problems of adverse selection and, to a lesser extent, information/protection for purchasers certainly pose threats to the development and success of this market but these problems can be substantially controlled via a combination of policies. Such policies might include subsidies for low-income purchasers, favorable tax treatment, risk pools or reinsurance, reasonable regulation, and some latitude for underwriting, following an open enrollment period.

Attachment 8

MANAGING RISK FOR A MEDICARE PRESCRIPTION DRUG BENEFIT

BY DALE A. RAYMAN, F.S.A., M.A.A.A., M.H.A

The author is a healthcare actuary in Towers Perrin's national pharmacy practice.

INTRODUCTION

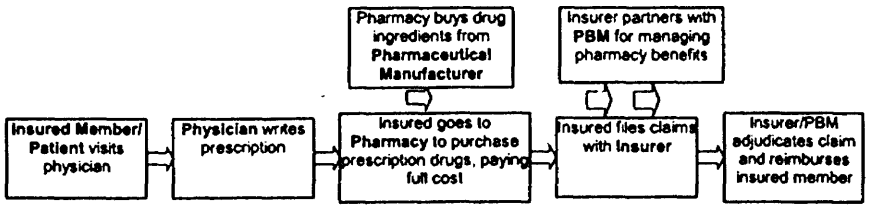
A variety of proposals have been offered in Congress to increase access to prescription drugs for Medicare enrollees. Some believe that the pharmacy issue should be addressed only as part of comprehensive Medicare reform. Others, however, believe that comprehensive Medicare reform may take years to develop and implement, and believe that many seniors may be better served by an incremental approach that addresses the lack of access to prescription drugs with more immediacy.

This paper examines one aspect of an incremental approach by demonstrating how generally accepted actuarial techniques can be used to manage the risk of a prescription drug benefit offered through insurance companies. We believe these techniques can permit insurance companies to offer seniors financial security against high drug costs, and promote access to effective health care, while avoiding unnecessary or excessive utilization that can result from adverse selection.

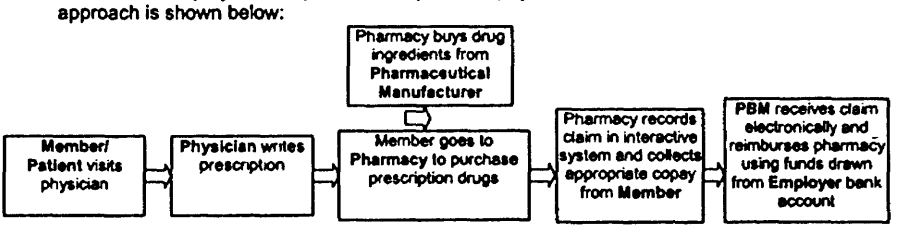
FUNDAMENTALS OF PRESCRIPTION DRUG BENEFITS

Before designing and pricing a health insurance product, an actuary usually seeks to answer several basic questions: how will health care services be approved and delivered, how much will services cost and what are the key drivers of utilization and cost. Taking a holistic approach enables the actuary to understand how the risk can be managed and thus improves the ability to predict cost and price the product appropriately (i.e., competitively yet sufficiently). This is a key step in risk management. To frame our discussion, we must understand the major stakeholders and the mechanics of delivery for a prescription drug benefit.

The diagram below shows one example of how an insured patient obtains prescription drugs. Major stakeholders, shown in bold font, include the insured member (i.e., patient), physician, pharmacist, pharmaceutical manufacturer, insurer and pharmaceutical benefit manager (PBM).



In many large companies that self-fund their benefits (i.e., do not purchase insurance), a PBM administers the pharmacy benefit directly and reimburses the pharmacy once the covered employee or dependent has paid a copayment or coinsurance. This approach is shown below:



The actuary must also understand the key cost components and what is driving increases in these costs. Key cost components for a managed pharmacy program are shown below:

[(Ingredient Cost + Dispensing Fee – Copay + Admin Fee) * Utilization]
– Rebates + Drug-related Problems + Therapeutic Failures

The administrative fee paid to the PBM or insurer generally covers the cost of on-line systems, electronic edits, customer service, pharmacy network contracting and maintenance, eligibility updates, communications, physician prescribing profiling and education, and drug utilization review. (A detailed discussion of these features is beyond the scope of this paper.)

The actuary is also interested in both short- and long-term cost trends. Drug expenditures have increased between 14.4 and 18.8 percent annually over the past three years and are expected to continue this level of increase over the next couple of

years. The three major components of prescription drug expenditures are: utilization, new products and elements, and price.

According to IMS Health, the main factors contributing to prescription drug spending in 1999 were non-price factors, including increased volume of prescriptions, record sales of new products, and the changing mix of available products being used. Of the 18.8 percent increase in drug expenditures (1999), 4.2 percent resulted from increased prices for existing drugs. The remaining growth was due to increased volume (10.8 percent) and new product introductions (3.8 percent).

Drug mix within a therapeutic class can change drastically as new, expensive but very effective drugs enter the market. Treatment thresholds are also lowered as these new drugs prove effective for larger groups of patients than in the past. And new drugs are being discovered to treat diseases for which no drug treatment was historically available.

With this basic understanding of prescription drug benefits, we can now begin to examine the risk management process.

FUNDAMENTALS OF RISK CONTROL

The objective of risk control is to reduce the frequency, severity or unpredictability of losses. There are numerous approaches to risk control e.g., risk avoidance, loss prevention, risk/loss reduction, risk separation, risk combination and contractual transfer of risk. In this paper we assume that most of the risk for prescription drug costs has been transferred to an insurer by purchasing insurance for a predetermined price (i.e., premium). The insurance company seeks to control or manage the risk using loss prevention and loss reduction techniques.

A key aspect of insurance is the pooling or spreading of risk. By pooling the risk for a large number of purchasers, the insurance company can improve the predictability of the average loss. By pooling risks, policyholders who have higher-than-expected losses are offset by those with lower-than-expected losses. The larger the pool, the better the predictability.

The improved predictability of large risk pools allows the actuary to establish reasonable premiums. Premium development is a critical function for insurers and involves determining a reasonable, yet sufficient, price for accepting the risk. In a competitive market, the insurer's rates must be attractive relative to the perceived value obtained by the purchaser.

In the premium development process, the actuary must consider factors that will have an impact on the risk, either positive or negative. The actuary must also estimate the

probability of these factors occurring. For example, an insurer could reduce the risk of over-utilization of hospital services by implementing an inpatient pre-admission certification program. The actuary would reduce the basic premium to reflect the expected reduction in hospital utilization due to this program.

ADVERSE SELECTION

Many factors can increase the level of risk for the insurer. One of the most significant of these is adverse selection. Adverse selection is defined as the tendency of purchasers, when given a choice of benefits, to choose the plan that will produce the greatest return to them for the price. When individuals are given choice, they will gravitate to the option that provides what they perceive as the best value for the amount they spend.

Although seniors cannot precisely predict their prescription drug needs for an upcoming year, they often have a good idea of whether these needs will be high or low. For example, a senior with a complicated heart condition and diabetes is likely to need far more prescription drugs than a senior who has no chronic conditions and exercises regularly.

When an insurer increases health insurance premiums to cover adverse selection, those in good health are likely to drop coverage, thus causing the average cost to increase for remaining members. If premiums are increased once again, the healthiest of the remaining members will also drop coverage. This creates an assessment spiral whereby premiums reach such a high level that only members with the worst health status remain.

In designing an insurance product, actuaries view the benefit cost as being composed of utilization multiplied by unit cost. For example, the cost for a prescription drug benefit would be equal to the number of prescriptions filled multiplied by the average cost per prescription. In applying risk management approaches, actuaries consider the impact that each will have on utilization, unit cost or both. Adverse selection is a key factor affecting utilization.

ACTUARIAL APPROACHES FOR MANAGING RISK

This section examines several risk management approaches used by actuaries in designing health care products. These techniques are used to prevent or reduce losses and to ensure the long-term viability of the product.

Law of large numbers – A key risk management approach is the spreading of risk using risk pools. Insurers understand that the average claims cost is significantly more predictable for larger groups of covered lives than for smaller groups since there is a

greater probability of obtaining an average cross-section of risks. This approach is essential for managing the risk of a Medicare prescription drug benefit. Policies that motivate a larger number of Medicare beneficiaries to choose a private insurance product will help to maintain a stable insurance market.

Premium sharing – Insurers typically require employers to contribute to the cost of group health insurance. The larger the percentage of cost contributed by the employer, the greater the participation, thereby reducing adverse selection. One of the most obvious ways to reduce adverse selection for a prescription drug benefit for Medicare beneficiaries is to have the federal government subsidize the cost for many seniors. This could be accomplished through direct payments to health insurers (e.g., similar to Medicare + Choice plans), tax credits or tax deductions. If individuals receive a substantial government subsidy (e.g., 25 percent or more of the cost), participation will be significantly greater than for a benefit that is wholly paid for by the beneficiary.

Risk-sharing – Insurers recognize that accepting 100 percent of the risk may eliminate any motivation that insured members have of helping control the risk. If, however, the insurer assumes 80 percent of the risk while members continue to pay 20 percent of the cost out of their own pockets, the member has significantly more motivation to control utilization and shop around for the best price. Risk-sharing has been used historically to control risk in health insurance and is applicable for prescription drug benefits as well. Many prescription drug plans use fixed copayments rather than percentage coinsurance so that members who must use high-cost drugs do not shoulder an inordinate burden. Copayments can also vary to provide incentives for patients to follow the most cost-effective drug therapies (e.g., generic, preferred brand, non-preferred brand).

Benefit design – Risk-sharing is one only aspect of benefit design. In addition to copayments and coinsurance, benefit provisions can also include deductibles, maximum benefit limits, internal limits, exclusions, coordination of benefits (see below), mandatory pre-certification for non-emergency high-cost care, and other cost-control incentives. The potential for adverse selection with respect to prescription drug benefits requires careful benefit design.

Individual underwriting and substandard premiums – The purpose of individual underwriting is to determine whether potential members are good or bad risks for the insurance company. Individual underwriting protects the insurer from providing coverage to a disproportionate number of unhealthy members. The worst risks are often declined coverage. Other potential members in bad health may be charged a substandard premium (i.e., a rate greater than the standard premium level). Individual underwriting can be performed using a short- or long-form questionnaire or by a physical examination by a physician.

Pre-existing condition limitations – Some health insurance policies exclude treatment for conditions that were treated during some time prior to coverage (e.g., six months). Pre-existing condition limitations generally expire after coverage has been in effect for twelve months. The Medicare program does not currently include any pre-existing condition limitations.

High Risk Pools – Individual underwriting, substandard premiums and pre-existing condition limitations are all aimed at ensuring that insurers enroll a fair cross-section of risks. An alternative approach would be to establish high-risk pools to pick up risk that exceeds certain thresholds. These pools are essentially a reinsurance mechanism and could operate in several ways. One approach, commonly used in the auto insurance industry, is to have all insurers pay a certain premium to the pool for each of their enrolled lives. The pool would then pick up excess claims for any insured. For example, the government could fund a pool to cover the risk of prescription drug claims in excess of a certain threshold per individual per year.

Eligibility requirements – Health insurers often establish eligibility provisions to reduce the potential for adverse selection. For example, employees covered in a group health plan may need to be actively at work on the effective date of their insurance. This ensures that individuals are sufficiently healthy to be engaged in gainful employment. For those not actively at work, the effective date is deferred until they return to work. Similarly, the Medicare program charges higher premiums for seniors opt out of Medicare Part B upon initial eligibility and then choose to enroll at a later date.

Closed election periods – Requiring members to enroll only during a fixed election period each year, rather than having the opportunity to change benefits at any time, reduces adverse selection. A private insurance prescription drug program for Medicare beneficiaries should limit the frequency with which enrollees can change coverage. In addition, adverse selection could also be reduced by requiring seniors who opt out of coverage to wait at least two years before re-enrolling or to pay a premium surcharge (e.g., 10 percent) during the first two years after re-enrollment.

Coordination of benefits – Insurers typically coordinate coverage with other insurance or government-sponsored coverage such that benefits are reduced if another payor is primary. Coordination of benefits (COB) provisions would continue to be an effective way for insurers to ensure that seniors are not reimbursed for more than the costs they incur. COB would also provide some cost savings for insurers.

Premium development – Careful premium development with appropriately established risk margins is another approach for controlling risk. For example, tiered rating might apply for benefits that vary significantly with age or certain other factors (e.g., whether a senior is a smoker or a non-smoker). Durational rating might be applied to reflect expected select and ultimate claims costs.

Links to other coverage – To reduce adverse selection, some health insurers have packaged together various benefits. For example, packaging vision benefits with medical benefits avoids the high adverse selection that results when only those who need glasses or contact lenses purchase vision coverage. Medicare + Choice plans are likely to combine prescription drug options with medical options to reduce adverse selection. An integrated approach to managing the health care of seniors is significantly more effective than a fragmented approach and can produce significant savings over the long term.

Risk-adjusted premiums – Risk adjusters are designed to provide higher payments to those insurers who enroll individuals who are more likely to have higher costs. For example, HCFA has proposed reimbursing Medicare + Choice plans on a risk-adjusted basis that would pay more to plans that enroll individuals with diagnoses that are projected to produce higher medical costs. Risk-adjusted premium subsidies from the federal government for prescription drug coverage would be one solution for ensuring that insurance companies that enroll a high proportion of high-cost seniors for the same average premium as competing insurers do not bear an unfair burden.

Reducing the number of options – Giving potential enrollees a choice among benefits, options or financial terms can lead to adverse selection. High benefit users will tend to choose options that provide more generous coverage whereas low benefit users will choose low-cost, less generous coverage. Insurers can reduce adverse selection by reducing the number of options. The number of prescription drug options for seniors can be limited (much like Medigap plan options) thereby reducing chances of adverse selection and facilitating comparisons among companies. Alternatively, an independent Board could be established to certify that plans meet certain minimum criteria. This would reduce the variability among plan designs and also the potential for adverse selection.

Marketing rules – Although Medicare + Choice plans are offered though the private market, the government has instituted uniform rules that level the playing field for competitors. These rules not only prevent discriminatory marketing but also ensure that all competitors have a fair chance of enrolling an average cross-section of risks. Similar rules could be considered for prescription drug plans to reduce opportunities for "cherry picking."

SOME FINAL WORDS

The actuarial design features described above are used to improve an insurer's ability to manage risk. Given the potential for adverse selection among insurers and the

importance of ensuring the long-term viability of a private market Medicare prescription drug program, these techniques should be carefully considered. Good and accurate data can also help to reduce insurance costs. The impact of each approach used should be continuously monitored to measure its value.

This paper has briefly described some approaches that insurance companies can use to control risk for prescription drug benefit coverage. While designing a market-based prescription drug benefit would require careful design, there are private-market solutions that work.

TYPES OF INSURANCE

There are many varying types of insurance coverage available in the United States. Coverage can range from the typical health and auto insurance, to the more unusual, including insurance for a dancer's legs or a doctor's hands. If a client is willing to pay, there are few limits to the types of insurance coverage available.

Listed below are a number of insurance products ranging from health to weather conditions.

Health Insurance

- Critical Illness Insurance
  Cancer, heart disease, etc.
- Critical Security Insurance
  For those suffering from a critical illness
- Children's Insurance
- College Students' Health Insurance
- Emergency Room Insurance
- Catastrophic Disability Insurance
- Infertility Coverage
- Pregnancy Complication Insurance
- Hospital Indemnity Insurance
  Covers hospital confinement and ICU
- Campers Accident & Sickness Insurance
- "Specified Diseases" Insurance
  E.G. stroke, diabetes, HIV
- Pre-Schooler Accident Insurance
- Sports Accident Insurance
- Psychiatric Insurance
- "Natural Health Supplemental Insurance"
  Covers acupuncture, homeopathy, Oriental medicine, nutritional counseling, biofeedback, colon therapy, etc.

Horse Related Insurance

- All Breeds
  National and International)/All Disciplines
- Animal Mortality*
  National and International
  **(Horses, Mules, Donkeys, Dogs, Ostrich, Sheep, Pigs, Goats, Llamas, Exotics, to name a few.)*
- Associations
- Auto
- Barns
- Barrel Racing
- Bed and Breakfasts (Inns)
- Blacksmiths
- Boarding
- Boats
- Breeding
- Business Packages
- Care, Custody and Control
- Carriage Rides
- Clinics
- Combined Training
- Commercial Farm Auto
- Commercial Horse Liability
- Commercial Packages
- Cutting
- Dairy Farms
- Draft Horses
- Dressage
- Drill Teams
- Driving
- Dude Ranches
- English
- Equine Dentists
- Equitation
- Eventing
- Farm Machinery
- Farms
- Farriers
- Flood
- Fox Hunters

TYPES OF INSURANCE

- Gaited Horses
- Gymkhanas
- Harness Horses
- Hay Rides
- Horse Haulers
- Horse Owners
  Private Liability
- Horse Shows
- Horse Trailers and Vans
- Hunters
- Instructors Liability
- Jumping Horses
- Leased Horses
- Liability, Commercial and Personal
- Livestock
- Major Medical
- Marinas
- Miniature Horses
- Mounted Troops
- Orchards
- Personal Auto
- Personal Liability
- Personal Umbrella
- Pleasure Animals
- Ponies
- Pony Party Liability
- Race Horses
- Race Horse Liability
- Reining Horses
- Restaurants and Taverns
- Riding Lessons
- Riding Stables - Public and Private
- Roping
- Saddle Shops
- Saddleseat
- Sales Barns
- Shipping
  Both International and National
- Sleigh Rides
- Sport Horses
- Sports Accident Coverage
- Stables
  Public and Private
- Steeplechasers
- Stock Horses
- Student Accident Coverage
- Tack Shops
- Tack and Equipment
- Team Penning
- Three Day Eventing
- Trail Rides
- Trailers
- Transport
  National and International
- Trotters
- Truckers
- Truckers General Liability
- Vans
- Vaulting
- Vet Clinics
- Veterinarians
- Vineyards
- Workers Compensation

Weather Insurance

(covering hurricane, typhoon, rain, snow, wind, hail, etc.)

- ***Special Events***: Fairs, Festivals, Airshows, Fourth of July, Chambers of Commerce, Parties, Weddings, Fireworks, Parades, Fundraisers, Company Outings, Conventions, Carnivals, Picnics, Hospitality, Theatrical Productions
- ***Concerts***: Amphitheater, Promoters, Venues, Concessions, Sheds/Shacks
- ***Sports***: Racing, Football, Baseball, Mud Racing, Basketball, etc.
- ***Entertainment***: Commercials, TV Shows, Film/Video Productions, Photo Shoots, Advertising
- ***Promotions***: Car Dealers, Jewelry Stores, etc.

TYPES OF INSURANCE

- ***Agricultural***: Fruit/Vegetable growers, Packers, Canneries, Juicers, etc.

- ***Snow Removal***: Municipal, Towns, School Districts, Airports, Universities, etc.

- ***Weather Sensitive Business***: Resorts, Country Clubs, Florists, Ski Resorts, Utilities, Flea Markets, etc.

Marine Insurance

- Private Pleasure Craft
- Boat Dealers

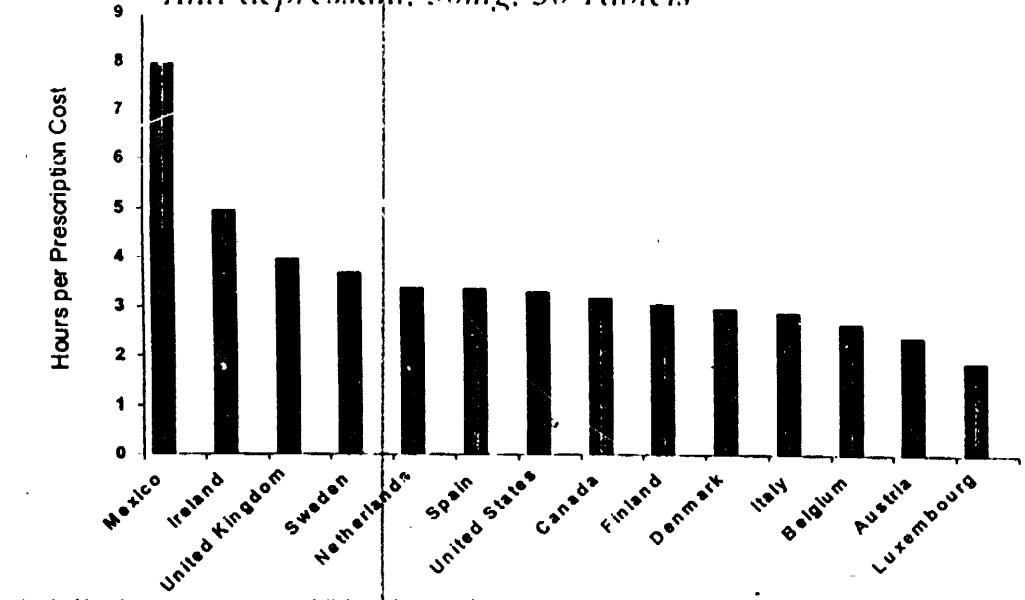
- Piers, Wharves, and Docks
- Charterers Legal Liability

- Marina Operators
- Passenger Vessels

Hours of Work Needed to Buy Medicine

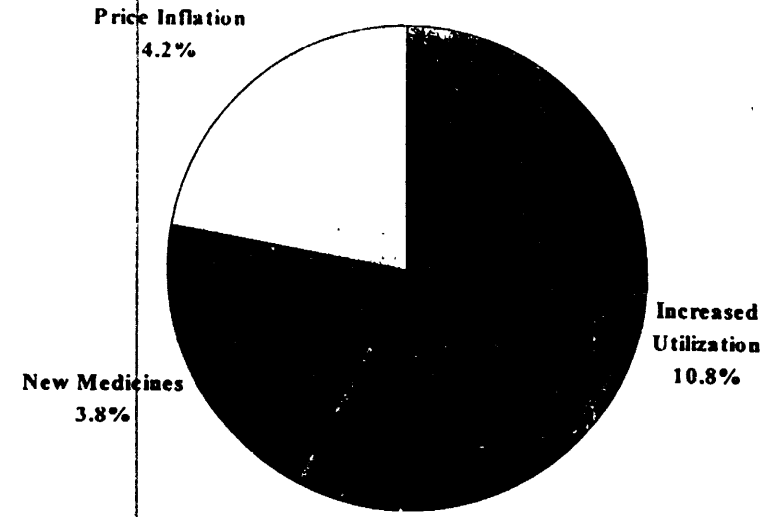
Americans & Canadians Work Almost Same Number of Hours to Purchase Medicines

Anti-depressant, 50mg, 30 Tablets



(Implied hourly income is per capita GDP divided by 2000 hours)

Drug Expenditures Increased 18.8 Percent in 1999



Source: IMS Health, Retail and Provider Perspective, 2000.

RESPONSES TO QUESTIONS FROM SENATOR COVERDELL

Question 1 from Senator Coverdell to Alan Holmer: When we talk about adding a prescription drug benefit to Medicare, I think we all agree that we want to help seniors in the best way possible—and to do so at the lowest possible cost. One of the issues we need to look at in this regard is how do we structure out-of-pocket costs in any drug benefit. How are out-of-pocket costs dealt with in the current Medicare system and how can we address these costs in any reform efforts?

Question 2 from Senator Coverdell to Alan Holmer: Has anyone on the panel looked at this question of how to structure out-of-pocket costs? Would any of you care to comment on whether significant savings are available in this area without unduly burdening the patient with high out-of-pocket costs?

Response: Under the current Medicare program, beneficiaries are required to pay out-of-pocket in several ways for services and items covered by Medicare. Part A covers inpatient hospital, skilled nursing home and hospice services. Part B covers outpatient health care services and items. Part A has a deductible of $776 and Part B has a separate deductible of $100. Beneficiary cost-sharing requirements vary widely by type of service, according to complex formulas. For example, after paying the $776 Part A deductible, beneficiaries pay no copayments for the first 60 days of an inpatient hospital stay. However, if they have a very long hospital stay, they pay $194 per day for days 61-90, $388 per day for days 91-150, and then may use additional "lifetime reserve day." For most physician services, beneficiaries pay 20 percent of a fee schedule amount. However, if their doctor is not "participating" in the Medicare program, they pay a higher amount. The Medicare program does not cover catastrophic costs.

Most private plans that participate in the Medicare+Choice program have a single deductible, rather than separate deductibles for inpatient and outpatient services. In addition, copayments are generally easier to understand. More importantly, the private plans may changes the copayments to reflect changes in the market, so long as the entire basket of services is equivalent to, or greater than, the fee-for-service benefits.

The National Bipartisan Commission on the Future of Medicare discussed many ways to reform the Medicare program. In particular, there was considerable support for allowing beneficiaries to enroll in any of several different private plans that would cover at least the benefits covered currently under Medicare. A fundamental part of this reform was to allow plans to vary cost sharing, subject to approval of a new administrative board. PhRMA believes that seniors should be protected from excessive costs by providing stop loss protection; allowing plans to innovate enhances beneficiary choices and increases the likelihood that each beneficiary will have their needs met. It also allows the benefit design to respond to market changes more quickly. Virtually all Medicare experts agree that today's Medicare benefit does not reflect the current delivery system. By allowing flexibility in the copayment design-subject to appropriate plan oversight-balances the needs of beneficiaries and plans.

Question 3 from Senator Coverdell for Alan Holmer: How can we deal with the issue of adverse selection, where only beneficiaries who need Rx coverage will purchase it, thus causing the premiums to increase?—(target the Administration's proposal.)

Response: Adverse selection can occur because individuals purchase insurance only when it is in their best interest. For example, if an individual could purchase health insurance at any time, it would be perfectly rational for them to wait until they were sick. Consequently, insurers often place limits on when and under what conditions individuals can purchase insurance.

Leading actuarial and economic consulting firms note that adverse selection is "one of the most difficult issues in designing any insurance program involving individual choice." They also point to several tools to minimize the impact on adverse selection. These include:

- Limiting election opportunities for enrollment;
- Providing low-income subsidies for premiums and deductibles;
- Establishing a high-risk pool for enrollees with very high expenditures;
- Requiring up-front cost sharing, such as an annual deductible; and
- Allowing insurers to negotiate with manufacturers and distribution networks to reduce costs.

(See attached analyses by Milliman and Robertson, Tower-Perrin and Abt Associates.)

The Administration's Plan. The Administration's plan does not include a specific proposal for high-risk enrollees. Rather, it includes a so-called "Catastrophic Reserve Fund." The specific purposes for which these funds would be spent is not

provided, leaving an important element of the program open to speculation as to its ultimate effectiveness in meeting the costs of high-risk beneficiaries.

RESPONSES TO QUESTIONS FROM SENATOR JEFFORDS

Question 1 from Senator Jeffords for Alan Holmer: You testified that the benefits of using private insurance models and private-sector entities to provide prescription drug coverage is that the entities can provide disease management, drug utilization review, and patient education, and can reduce medical errors. How many PBMs have this type of program in place, and can they perform these programs without the help of pharmacists in the community setting? What role do pharmacists play in performing these services now?"

Response: Managed care organizations use a variety of methods to provide integrated health care with the goal of cost-effective, error-free drug prescribing, dispensing, and use. While exact data are not available on the number of managed care organizations or pharmacy benefits management companies (PBMs) with disease management, utilization review and patient education programs, market demands by cost conscious purchasers have encouraged many to develop, pilot test or initiate disease management programs. These have typically focused on such chronic conditions as asthma, depression, diabetes and gastrointestinal disorders. Some companies are also developing enhanced outcomes reporting capabilities and innovative disease management and patient education initiatives to improve the quality and cost effectiveness of drug therapies. Effective communication with community-based pharmacists, physicians and consumers is essential to the success of these activities.

Drug counseling by retail pharmacists remains the most basic form of disease management. This communication has been enhanced by the computer-based information provided by managed care organizations and PBMs. In addition, some entities reimburse retail pharmacists for certain cognitive services they provide in connection with drug utilization review, patient counseling, contacting the physician to modify medication dosage or drug, etc.

Question 2 from Senator Jeffords for Alan Holmer: One area of great concern to me is Direct-to-Consumer (DTC) advertising. It is reported that the DTC in the pharmaceutical industry will top $2 billion this year. Some argue that DTC is one-sided, and I am concerned that DTC is fundamentally changing the nature of the doctor-patient relationship with possible adverse effects. It appears that DTC, much of it for "lifestyle" products such as hair loss or nail fungus, is also driving up insurance premiums for all Americans. None of us wants to hamper R&D, although I wish it were spread more appropriately to all countries, but how do you explain spending billions on DTC, much of it for lifestyle-type products? Don't consumers ultimately pay this $2 billion for advertising through higher prices and higher premiums?

Response: PhRMA also does not want to hamper R&D. Moreover, we do not believe that DTC advertising impinges on R&D spending. Last year, the pharmaceutical industry, according to just-released information from IMS Health, spent $1.8 billion on DTC advertising, or less than one percent of total revenue, $124.8 billion. At the same time, the pharmaceutical industry devoted $24.0 billion to R&D, more than 20 percent of revenue. (This year the industry is spending $26.4 billion on R&D.)

The idea of "lifestyle" medicines is controversial; all medicines relate to life and the quality of life. In any ovent, advertising includes advertisements for prescription medicines used to treat high cholesterol, ulcers, asthma, allergies, depression, diabetes and other diseases that no one would characterize as unimportant.

Advertising informs consumers about a treatment of which they might otherwise have been unaware. The manufacturer of a medicine to treat genital herpes, for example, employs DTC advertising to inform sufferers with this disease that treatment is available. In the quarter after this medicine's introduction, 34 percent of physicians indicated more patients had inquired about treatment options for this condition, a condition many thought untreatable. Of patients who called the manufacturer's hotline about the new medicine, 49 percent had scheduled an appointment with their physician within three months after seeing the ad. Among those who saw their doctor, only 51percent received a prescription, some for other medicines, reflecting the fact that doctors retain the appropriate discretion to determine the best treatment for their patients. Still, many of those patients who did see the advertisement were new patients.

Patients increasingly benefit from becoming more knowledgeable and more involved in their own health care. Armed with information, patients have become active participants with health care professionals in managing their own care—and

they have become savvy consumers. Rather than simply saying "Yes, doctor," patients today are asking questions, evaluating information, and making choices.

The sources of user-accessible information about health care have increased exponentially. Some 50 consumer magazines focusing on health care hit the news stands every month. Just about every television station in the country has a physician dispensing medical news. Internet users can surf literally tens of thousands of sites dedicated to various health care topics. The Physician's Desk Reference, or "PDR," once confined to doctors' offices, is now available in a consumer edition at pharmacy counters.

Direct-to-consumer advertising enhances consumer knowledge about diseases and treatments. It also fosters competition among products, which can lead to improved quality and lower prices for consumers. Most direct-to-consumer advertising can improve public health. It helps start a dialogue between patients doctors. Often, this dialogue will not result in the doctor prescribing the drug that the patient has asked. But it will prompt a discussion that may lead to better understanding and treatment of the patient's condition.

A 1999 study by Prevention Magazine found that 76 percent of consumers surveyed feel that DTC advertising "allows people to be more involved with their health. "Further, the study found that such advertising is an extremely effective means of promoting both the public health and prescription medicines, and concluded that the benefits of DTC advertising could go far beyond simply selling prescription medicines: these advertisements may play a very real role in enhancing the public health.

The research determined that pharmaceutical advertising has helped foster patient-physician dialogue where none had previously existed and, more importantly, improved that dialogue as patients came prepared, armed with information from websites, brochures and 800 telephone numbers. In fact, the survey found that direct-to-consumer advertising prompted an estimated 24 million Americans to talk to their doctors about a medical condition or illness they had never discussed with a physician before. In other words, millions of people who had previously suffered in silence were encouraged to seek help.

Consumers are actively seeking information about their health and about medicines. Pharmaceutical companies are a prime source of such information. Patients have the right to ask for information about the treatments available, and the companies that develop those treatments have a right to communicate information about these problems and about health problems to patients. Information included in direct-to-consumer ads should be accurate, direct and user-friendly.

PREPARED STATEMENT OF EDWIN C. HUSTEAD

Thank you for the opportunity to address the Senate Finance Committee on the design of prescription drug coverage for Medicare beneficiaries. I am a Senior Vice President with the Hay Group, an international human resources consulting firm and have headed the team of actuarial consultants to the Congressional Research Service for over fifteen years.

I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries and was Chief Actuary of the Office of the Personnel Management (OPM) for eight years ending in 1980. My duties as Chief Actuary of OPM included negotiation of the design and cost of benefits under the Federal Employees Health Benefits Program (FEHBP).

I will focus on considerations in the design of a prescription drug benefit with particular emphasis on how private sector experience might be adapted to best meet the needs of Medicare beneficiaries at the lowest cost. My comments will specifically refer to the Administration's proposal for a separate prescription drug program as a new Part D and the Breaux/Frist proposal (S. 1895) for competing health plans.

The primary points that I will cover are:

- The design of prescription drug coverage in private sector employer-provided health plans.
- How that design might apply, or not apply, to Medicare.
- How the two Medicare proposals deal with risk sharing. That is the degree to which the plan and the beneficiary share risk.
- How the two Medicare proposals deal with potential adverse selection. That is the potential for high-cost beneficiaries to select certain plans and, therefore, drive up the costs of those plans.

The information in my testimony on private sector health plans is drawn from the 1999 Hay Benefits Report. The Hay Benefits report is based on an annual survey of the benefits design of over 1,000 medium to large private sector employers in the

United States. The survey results are often used, by the Congressional Research Service and other clients, to determine the cost and relative benefits value of health benefits plans.

BENEFIT DESIGN IN THE PRIVATE SECTOR

Almost all private sector employer plans provide prescription drug coverage for employees. The most common design, used by three-fourths of plans in our survey, is a prescription drug card approach that requires the employee to pay a fixed amount (for instance $10) for each prescription. Plans that continue coverage into retirement typically use the same benefit design for both annuitants and employees.

The drug card approach has become popular in the private sector because of its convenience to the employee, the employees' up front understanding of their per prescription cost, low administrative cost, and inducement to employees to select the lowest cost prescription drugs.

A disadvantage of the drug card approach, from the insurer's point of view, is that the fixed dollar payment is not related to the cost of the prescription. For example, a $10 copayment is half of the cost of a $20 prescription but only 10 percent of the cost of a $100 prescription. Employees are less sensitive to the cost of the most expensive prescription drugs when their cost is the same for any prescription drug.

A disadvantage from the patient's perspective is that there is no limit to the employee copayments but each copayment is relatively small so the total out-of-pocket payment is limited. For example, Poisal and Chulis (2000) report that Medicare beneficiaries in the poorest health category average 38 prescriptions a year that would be a $380 copayment for a $10 per prescription drug card.

Many drug card plans have a three-tier structure with the lowest copayment for generic prescription, the next highest for brand name prescription drugs on the formulary and the highest copayment for brand name prescription drugs that are not on the formulary. Drug card plans will often include mail order prescription drugs as a fourth option. A typical copayment structure is $5 for a generic or mail-order prescription, $10 for a brand name formulary prescription drug, or $20 for a brand name prescription drug that is not on the formulary.

The largest FEHBP plan, Blue Cross/Blue Shield, uses a variation of the drug card plan that charges a copayment as a percent of the prescription drug cost and the copayments are applied against the stop-loss limit.

Fifteen percent of employers cover prescription drugs under the same coinsurance/deductible provisions that apply to most other medical expenses. A typical design is for the employee to pay 20 percent of medical expenses, including prescription drugs, after a $250 deductible. Most employers have a maximum stop-loss provision in these types of plans typically limiting all copayments for prescription drugs and most other medical expenses to between $2,000 and $3,000 a year.

The other ten percent of employers cover prescription drugs through a separate plan with its own coinsurance and deductible. These plans rarely have a stop-loss limit.

COST CONTROLS

Employers, and their insurers, have reacted to the acceleration in prescription drug costs in recent years by increasing the cost controls on the prescription drug benefits. A common approach is to use a formulary that is a list of prescription drugs preferred by the plan because of their lower cost. The employer, insurer, or pharmaceutical benefit management organization (PBM) will have negotiated discounts on many of the formulary prescriptions with the pharmaceutical companies.

Formularies can be of a "closed" type where the health plan will only pay for the prescription drugs on the formulary list or an "open" type that encourages, but does not require, the employee and the physician to select prescription drugs that are on the formulary. The primary tool used to encourage the use of prescription drugs on an open formulary is to charge the employee a lower copayment for those prescription drugs. In addition, PBMs have developed sophisticated computerized system to let the physician and the pharmacist know when a prescription is not on a formulary and to suggest use of a lower cost prescription drugs that are on the formulary.

Another common approach is to encourage use of the least expensive prescription drugs by educating the employees and physicians through written communications or in meetings. Prescription drug costs can also be minimized through restrictions on the days of medication that can be filled with each prescription and restrictions on the frequency of refills.

And, even more than with other health benefits, prescription drug costs charged to the health plan can be reduced through shifting more of the payments to the em-

ployee. Increases in copayments have both the immediate effect of shifting cost to the employee and a second-level behavioral effect of lowering the cost and use of services because of the greater employee copayment. Our experience with employer plans as well as studies such as those by Greenlick and Dansky (1968) and Smith and Garner (1974) have shown that prescription drug copayments have one of the largest second-level behavioral effects.

For example, consider an employee who would be expected to purchase $200 in prescription drugs if there was no employee copayment. If the plan adds a copayment of $20, the Hay premium models would predict that the total prescription drugs purchased would decline to $180 because of the induced lower demand. Since the employee would pay $20 of the $180, the health plans would pay the remaining $160—a savings of $40.

APPLICATION TO MEDICARE

Private sector employers are convinced that the drug card design and cost control approaches are effective in providing prescription drug benefits at the lowest possible cost and highest perceived value to the employee. However, prescription drug design and cost control measures that have been shown to be effective in the private sector may not work as well in Medicare.

One major difference is the type and intensity of prescription drugs used by employees and their families compared to Medicare beneficiaries. A cost-sharing design that is appropriate for employees and their families may not be as effective for Medicare beneficiaries with a much different prescription drug expenditure pattern.

A second difference is that in the private sector the entire health plan, including the prescription drug plan, is under the direct control of the employer. The employer can work closely with insurers and PBMs to achieve the best plan and cost control design within the overall health plan. The two Medicare proposals being considered spread the cost control among a number of entities and permit a wide range of options with different designs.

A third difference is that an employer has direct and immediate communication with the employees and can both explain complex changes in benefit design and address questions on a one-to-one basis. The logistics of communicating with Medicare beneficiaries are much different. Thorough communication of changes in Medicare benefit design can only be achieved through the mail and Medicare beneficiaries cannot have their questions addressed by going down the hall to the human resources department.

A final difference is the political reality of making changes in the Medicare program. Most proposals, including the two under consideration, begin with the assumption that, whatever else is offered, beneficiaries must be able to choose the current Medicare benefits with beneficiary payments that are close to those of the current program. Employers can, and often have, totally restructured their programs to introduce more effective cost controls and benefit designs. For example, many employers simply discarded their traditional fee-for-service plans when they moved to preferred provider networks. Employees have had to live with the fact that their physicians may no longer have been accessible through their health plan after the plan change.

WHO BEARS THE RISK

A major question in the design of insurance plans is the assignment of risk. Traditional insurance provides a safety net in the event of an unexpected financial loss such as death, disability, or major illness. Minor predictable expenses are typically paid by the insured through a deductible with major expenses largely, or fully, covered by the health plan. As I noted, most employer plans limit employee copayments for many categories of benefits to a specific amount such as $1,000 or $2,000 a year.

From the beneficiary's perspective, the traditional approach of the health plan paying more for the largest risks is not consistent for all types of health benefits. Dental plans, for instance, usually pay more for smaller predictable expenses than for larger unpredictable expenses and dental and mental illness benefits are rarely included in the stop-loss provisions.

The traditional risk sharing approach has the disadvantage of concentrating payments among fewer employees than, for example, the drug card approach which provides at least some payment each year to most employees.

The Administration and Breaux/Frist proposals take very different approaches to the assignment of risk. The Administration proposal specifies the copayment structure while Breaux/Frist permits any reasonable design that has prescription drug benefits with and actuarial value of at least $800 a year. Specification of the plan

benefits, as in the Administration plan, is closer to private sector practice than Breaux/Frist.

The Administration's plan will pay half of the prescription drug costs up to a maximum annual expenditure. The maximum will grade up from $2,000 in 2003 to $5,000 in 2009 (a maximum plan payment of $2,500 a year) and be indexed to inflation after 2009. The Administration estimates that the $5,000 in 2009 will cover all of the expenses for 90 percent of beneficiaries.

The Administration plan is similar to the private sector drug card approach but, as in FEHBP, the beneficiary pays a percentage of the cost rather than a flat dollar amount. An important difference, however, is that the Administration plan does not pay for any of the cost after the beneficiary exceeds the maximum benefit level. Private sector plans pay for any necessary prescription drug and the FEHBP Blue Cross/Blue Shield not only pays for all necessary prescriptions but includes those payments in determining the stop-loss on copayments.

Plans offered under Breaux/Frist are free to select any reasonable design as long as the value is at least $800 a year. The result will undoubtedly be that Medicare beneficiaries will be offered each of the major plan designs. Competition should eventually determine which, if any, of the plan designs is best for the Medicare population.

MANAGEMENT OF THE PLANS

The separate prescription drug plan under the Administration proposal would be administered by one entity, such as a PBM, in each regional area. The entity would be selected through competitive bids. These entities could not use closed formularies but are free to propose other cost saving approaches including open formularies. However, without differential copayments, it is unlikely that open formularies could achieve significant savings.

Breaux/Frist would permit a wide variety of plans to operate. These plans would be free to use cost controls including closed formularies. Prescription drugs would be included in the total health benefits package offered to the beneficiary.

Exclusion of the closed formulary approach under the Administration proposal is tied to the fact that only one plan design will be permitted with only one managing entity in each area. Politically, Medicare proposals probably cannot force beneficiaries to select from a closed formulary. Since Breaux/Frist permits a wide variety of plans, beneficiaries will be free to choose between plans with and without closed formularies.

POTENTIAL ADVERSE SELECTION

Insurers carefully design benefits, premiums, and screen applicants to avoid "adverse selection." Adverse selection is the tendency of people with the highest risk to choose an insurance plan more frequently than those with the lowest risk. For example, life insurers use various strategies to attract the healthiest lives and/or exclude the least healthy lives. Insurers who are less successful at avoiding adverse selection will have to raise their premiums higher than their competitors.

Adverse selection often leads to a recurring cycle of higher premium increases. In the first year of adverse selection, a small tilt toward higher cost participants results in a premium that is somewhat greater than that of competing plans. In the succeeding years, the adverse selection worsens as more of the healthier participants select a competing plan.

In the extreme case, an insurance plan that is subject to adverse selection can become so expensive that it no longer is competitive in the marketplace. This was the case with the Aetna option that was once a popular component of FEHBP. The Aetna plan became caught in the adverse selection cycle and eventually became so expensive compared to other options that Aetna withdrew from the program.

Adverse selection has also been a factor in the lack of popularity of the Medigap policies that include prescription drugs. The added cost for these options is much greater than the actuarial value of the prescription drug benefits offered because participants with the highest prescription drug costs select these plans. As a result, only about 15 percent of Medigap participants select options with prescription drug coverage.

A self-standing prescription drug plan would face severe adverse selection if beneficiaries could elect into or out of the plan each year. The adverse selection would, in turn, drive up the cost of the plan and further limit participation. Eventually the plan would only be purchased by beneficiaries with the highest expected expense with a premium that would be much higher than the average prescription drug cost of most beneficiaries.

The Administration proposal avoids the adverse selection problem by only giving a once in a lifetime choice to join or reject the prescription drug option. HCFA actuaries project that this restriction will result in purchase by enough of the population to avoid adverse selection.

The threat of adverse selection is not as great under Breaux/Frist, as it would be under a self-standing prescription drug plan, because the prescription drug coverage is part of the overall high option package. As in FEHBP, beneficiaries will be asked to consider the cost and benefits of the plan as a whole. However, it is likely that the gap between the standard and high option premiums under Breaux/Frist would exceed the actuarial value of the difference in benefits because of at least some level of anti-selection. Beneficiaries with high expected medical expenses will tend to choose the high option plans.

CONCLUDING REMARKS

My testimony has summarized the prevalent private sector approach that is to use a prescription drug card plan with a wide range of cost controls. While this approach has worked well in the private sector there are major differences between private sector employee health plans and Medicare that must be considered in designing Medicare.

Private sector employers closely control all aspects of their health plan design and administration. Employers have often totally restructured their plans to achieve savings goals. In the process, prior plan design is often no longer available to the employee. The political requirement to include something like current Medicare as an option limit the savings and control over the program that is available to a private sector employer.

Both the Administration and Breaux/Frist proposals are well designed and bring an important missing benefit to Medicare. Their main difference is in the design of the benefit and premium structure. The Administration proposal specifies the benefits and provides for administration by one entity in each region. Breaux/Frist specifies the cost of the benefit and permits any qualifying entity to offer a plan.

The Administration proposal stops paying part of the cost of prescription drugs after the maximum benefit limit. This is counter to the usual approach of sharing risks on all expenses, especially major expenses, which is found in the private sector plans. Breaux/Frist does not specify plan design so there would probably be plans offered with a variety of risk sharing arrangements including those that pay more of the smaller bills and those that pay more of the larger bills.

One of the major cost control methods in the private sector is use of formularies. It would not be good design to force Medicare beneficiaries into a closed formulary but the new benefits could encourage use of an open formulary through variable copayments. The Administration design does not use variable copayments. Breaux/Frist does not specify the formulary approach so there would probably be plans with both closed and open formularies and copayment differentials to encourage use of the latter.

Both proposals offer the beneficiaries a choice of (1) selecting a prescription drug plan, or an option including a plan, or (2) not selecting the prescription drug option. That choice could result in adverse selection that would raise the cost of prescription drug coverage to a level that is not competitive. The Administration plan avoids that problem by not allowing a beneficiary to revisit the choice. There would be adverse selection against the high options under Breaux/Frist. The severity of the adverse selection will depend on the plan design and pricing of the high options.

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STATEMENT OF SENATOR JAMES M. JEFFORDS
HEARING OF THE
U.S. SENATE COMMITTEE ON FINANCE
ON
INCLUSION OF A PRESCRIPTION DRUG BENEFIT IN THE MEDICARE PROGRAM
March 22, 2000

Thank you, Mr. Chairman, for holding this very important hearing today. I commend your leadership on this issue and your commitment to reforming Medicare in order to implement a prescription drug benefit and save the program from bankruptcy.

I would like to take this opportunity to reiterate my personal commitment to securing a meaningful prescription drug benefit in the Medicare program. I continue to hear from Vermonters that the high cost of prescription drugs is the most pressing problem facing them today. They agree with me that it doesn't make sense for Medicare to cover surgeries and hospital care, but not the prescriptions that could prevent hospital stays.

Like you, Mr. Chairman, I want to reform Medicare this year, and I will continue to work as hard as I can to see that it happens. But even if we can't achieve full Medicare reform this year, I think we need to do something now to help the most vulnerable beneficiaries -- low-income seniors who don't have other prescription drug coverage. I have introduced several bills to do just that: S. 1462 would allow Americans to import prescription drugs from Canada for their personal use, but would make sure that the Food and Drug Administration (FDA) has adequate authority to ensure that the drugs that are imported are safe; S. 1725 would provide prescription drug insurance for low-income seniors; and S. 1942 would provide Federal funds for State pharmacy assistance programs and medications management programs. Each of these proposals would address an important issue that Vermonters have told me needs to be addressed. I am working hard on each one of them and hoping to redraft them soon in order to address some concerns raised by a few of my colleagues.

In particular, I am considering ways to expand the scope of the Pharmaceutical Aid for Older Americans Act (S. 1942). Not only could this bill be expanded to cover millions of low-income Medicare beneficiaries, but, in light of the recent Institute of Medicine (IOM) report on medical errors, I think it is important to continue to emphasize the need to assist States in promoting the safe use of medicines through medications management programs. My bill would do just that.

Let me be clear, however, that I view these bills as stopgap approaches. It is imperative that we reform the Medicare system, and implement a broad drug benefit in the context of such reform, in order to transform the current, inefficient system into a system that offers more integrated, higher quality care for Medicare beneficiaries.

Mr. Chairman, thank you again for holding this important hearing, and I look forward to continuing to work with you and the rest of the Members of this Committee to ensure that a Medicare drug benefit is enacted into law as soon as possible.

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PREPARED STATEMENT OF CHARLES N. KAHN III

INTRODUCTION

Mr. Chairman, distinguished members of the Committee, I am Charles N. Kahn III, President of the Health Insurance Association of America (HIAA). Before joining HIAA, I devoted a significant portion of my professional life to working on Medicare policy as a staff member for a former member of this Committee and as Staff Director to the House Ways and Means Subcommittee on Health. In particular, I played a major role in the enactment, and subsequent repeal, of the Medicare Catastrophic Act and the enactment of the Balanced Budget Act of 1997.

HIAA is the nation's most prominent trade association representing the private health care system. Its 290 members provide health, long-term care, dental, disability, and supplemental coverage to more than 123 million Americans. We represent companies offering a broad range of insurance products to our nation's seniors, including long-term care insurance, Medicare+Choice, Medicare Select, and Medicare Supplemental plans.

I am very pleased to be here today to speak with you about how best to increase access to affordable prescription drugs for our nation's seniors.

SENIORS SHOULD HAVE EXPANDED ACCESS TO NEEDED PHARMACEUTICALS

Clearly, pharmaceuticals have become a critical component of modern medicine. Prescription drugs play a crucial role in improving the lives and health of many patients, and new research breakthroughs in the coming years are likely to bring even greater improvements. With older Americans becoming an ever-increasing percentage of the overall United States population, the need for more medicines for this sector of the population is becoming equally urgent. There is continuing emphasis on new pharmaceuticals to treat diseases typically associated with aging. Over 600 new medicines to treat or prevent heart disease, stroke, cancer, and other debilitating diseases are currently under development. Medicines that already are available have played a central role in helping to cut death rates for chronic and acute conditions, allowing patients to lead longer, healthier lives. For example, over the past three decades, the death rate from atherosclerosis has declined 74 percent and deaths from ischemic heart disease have declined 62 percent, both due to the advent of beta blockers and ACE inhibitors. During this same period, death rates resulting from emphysema dropped 57 percent due to new treatments involving anti-inflammatories and bronchodilators.

These advances have not come without their price. Rapid cost increases are putting prescription drugs out of reach for many of our nation's seniors. Because of both increased utilization and cost, prescription drug spending has outpaced all other major categories of health spending over the past few years. For example, while hospital and physician services expenditures increased between 3 and 5 percent annually from 1995 through 1999, prescription drug expenditures have increased at triple the rate, averaging between 10 and 14 percent. According to projections by the Health Care Financing Administration, prescription drug spending will grow at about 11 percent a year until 2008, more than double the rate of spending on hospital and physician services.

About two-thirds of seniors have some type of insurance coverage for pharmaceuticals—either through employer-sponsored retiree health plans, private Medicare+Choice plans, Medicaid, or, in limited instances, individual Medicare Supplemental (Medigap) policies. But this coverage may be limited, and it is likely to decline over time as cost pressures mount for employers, insurers, and individual consumers. For example, recent surveys indicate that employers are contemplating several changes to their retiree health care plans over the next several years, including increasing premiums and cost-sharing (81 percent of respondents to a 1999 Hewitt Associates survey sponsored by the Kaiser Family Foundation) and cutting back on prescription drug coverage (40 percent).

Also, unrealistically low government payments to Medicare+Choice plans is having the effect of reducing drug coverage for many seniors enrolled in these plans. Increases in per capita payments on behalf of beneficiaries enrolled in Medicare+Choice plans from 1997 to 2003 are projected to be less than half of the expected increases during the same period for those individuals in the Medicare fee-for-service program. In fact, the President's Fiscal Year 2000 budget included projected five-year medical cost increases of 27 percent for the original Medicare fee-for-service program and 50 percent increases for the Federal Employee Health Benefit Program, while Medicare+Choice payment increases during the same period will be held to less than 10 percent in many counties.

In addition, most seniors live on fixed incomes and their purchasing power will continue to erode over time as drug expenditures increase more rapidly than their real income. In terms of current dollars, seniors' income has increased very little over the past ten years. From 1989 to 1998, the median income of households with a family head 65 years of age or older increased from $20,719 to $21, 589. This represents an increase in real income of less than 5 percent over the entire decade.

HIAA shares the concerns of many public voices today, including many of the leaders on this Committee, calling for measures to help seniors better afford prescription drugs. We stand ready to work with members of Congress from both parties, and with the Administration, to help make prescription drug coverage a reality for all of our nation's seniors.

While we all know that seniors need help, some of the proposals under consideration would fall short of the goal. In addition, the possible effects of any new policy proposal must be carefully examined to ensure that unintended consequences do not erode the private coverage options that beneficiaries rely on today to meet their health care needs. In fact, we are extremely troubled that some of the proposals before Congress would do just that.

Some of the proposals we have examined that rely on "stand-alone" drug-only insurance policies simply would not work in practice; their proponents have, quite simply, promoted a fiction by ignoring the realities of the insurance market and basing their supporting analyses on unrealistic assumptions. Others have proposed to assure seniors drug coverage by mandating that private health plans—either Medigap or Medicare+Choice, or both—provide enhanced coverage for pharmaceuticals. While this option has the virtue of being virtually cost-free from a federal budgetary standpoint, it would be far from inexpensive for seniors who, according to our estimates, would experience premium increases for Medigap products of between 50 and 100 percent. It also would result in many seniors dropping the supplemental coverage they depend upon, creating a whole new set of political problems. Seniors in rural areas, in particular, rely heavily on Medigap coverage to help them meet their health care needs. My concern about these two policy options can be summed up in two statements:

- First, designing a theoretical drug coverage model through legislative language does not guarantee that private insurers will develop that product in the market.
- Second, if coverage that consumers cannot afford is mandated, the result will be unsustainable premium increases, limited choice, and reduced coverage.

It is simply not good policy (or politics) for Congress, as well intentioned as it may be, to enact legislation that will result in seniors not being able to purchase today's extremely popular and very successful Medigap coverage.

HIAA HAS DEVELOPED A SOLUTION TO HELP ALL SENIORS

Before I elaborate on these concerns, let me first make clear that HIAA believes strongly that the status quo is unacceptable. Reforms clearly are needed to expand access to prescription drugs for the nation's seniors. My belief is that the most rational and responsible way to accomplish this is in the context of overall Medicare reform and restructuring. HIAA agrees with many members of this Committee that broad reforms are necessary and that a sustainable long-term solution to providing affordable drug coverage for seniors is best accomplished in the context of securing Medicare for the baby boom generation—and beyond.

However, we also recognize that significant steps can be taken in the short term to provide relief to seniors. Last year, HIAA's Board of Directors approved a three-pronged proposal developed by our member companies that would help seniors better afford prescription drugs. The HIAA program would: (1) help lower-income seniors through a federal block grant to expand drug assistance programs; (2) provide a tax credit to help offset out-of-pocket drug costs for all other seniors; and (3) ensure fair payments to private Medicare+Choice plans that are struggling to provide prescription drug coverage for seniors despite unrealistically low government payments that will not keep pace with medical inflation and the projected increases in drug costs.

Thirteen states already have drug coverage programs for low-income seniors; several more are considering such programs in the current legislative session. We believe a federal block grant, with no requirement for state matching funds, would give needy seniors additional support in these states and encourage other states to adopt such programs. Each state would receive a per-capita payment sufficient to cover the equivalent of drug coverage with a $1,500 annual maximum for eligible beneficiaries. States would have considerable flexibility under our approach, and could use the funds to expand existing drug assistance programs or create new ones.

We estimate that about 10 million lower-income seniors would be eligible for this subsidy.

The HIAA program also would provide a tax credit to offset out-of-pocket prescription drug expenses for those seniors who file tax returns. A single Medicare beneficiary with income above about 200 percent of poverty (about $16,300) would have be eligible for a tax credit worth up to $1,000 a year, after incurring $500 in out-of-pocket expenses. A couple with an income above approximately 250 percent of poverty (about $28,000) could access a tax credit worth up to $1,500 per year after they jointly paid $500 in out-of-pocket drug expenses. The value of this credit would grow over time to keep pace with inflation. We estimate that nearly 22 million beneficiaries would be eligible for this federal tax credit.

Finally, the HIAA proposal includes a number of measures to assure that seniors choosing to enroll in Medicare+Choice plans are not disadvantaged by unrealistically low government reimbursements. As members of this Committee know, the vast majority of Medicare+Choice plans provide some coverage for prescription drugs and this has proven to be a very popular benefit for seniors. However, inequitable government payments are undermining the Medicare+Choice program and harming seniors who depend on these plans for their health coverage. In effect, the growing disparity between payments to Medicare+Choice plans and per-capita payments for seniors enrolled in traditional Medicare fee-for-service disadvantages the former, forcing them to shoulder an increasing out-of-pocket burden for prescription drugs.

The Balanced Budget Act of 1997 (BBA) reduced payments to Medicare+Choice plans by $22 billion over five years and the Health Care Financing Administration (HCFA) plans to reduce payments by another $9.7 billion through "risk adjustment." The Balanced Budget Refinement Act of 1999 restored less than $1 billion of the cuts made through the BBA. Clearly, additional steps are needed: (1) HCFA should be required to implement risk adjustment in a budget neutral manner and the current phase-in should be halted at its current 10 percent level; (2) HCFA should not expand encounter data collection beyond the hospital inpatient setting and should replace the planned universal encounter data-based risk adjustment scheme with a less burdensome approach; and (3) Medicare+Choice payments should be linked more closely to local medical inflation trends.

The HIAA proposal represents an immediate and workable step that will provide meaningful relief for seniors, while avoiding the disruption and confusion for beneficiaries that surely would result were Congress to make changes in seniors' private benefit options before addressing needed changes in the underlying Medicare program. Equally important, it would not foreclose the integration of drug coverage into broader Medicare reform.

The remainder of my testimony today will focus primarily on the reasons why we believe that relying entirely on private insurance models as a way to provide drug coverage to seniors is unsound—particularly without significantly restructuring Medicare. First, I will outline HIAA's concerns with stand-alone "drug-only" insurance plans for seniors. I will then elaborate on why we so strongly oppose drug coverage mandates on private insurance products.

WHY A "DRUG-ONLY" BENEFIT IS AN EMPTY PROMISE FOR SENIORS

Some have proposed that most seniors' drug coverage needs could be met by authorizing the creation of several new private insurance coverage options. Theoretically, these "drug-only" policies would be offered either as stand-alone policies, or sold in conjunction with existing Medigap coverage.

Developing a legislative prototype based on a set of theoretical constructs does not guarantee that the market will respond by creating a private insurance product. Creating a new form of insurance is not easy. As with any new product, start-up efforts are costly and time-consuming. Adding to the difficulty is that such insurance policies would have to meet existing (and possibly new) state and federal requirements before they could be sold. Thus, before making its entry into the marketplace, a "drug-only" policy would have to clear a multitude of economic and regulatory hurdles. Our members have told us that it is unlikely to do so.

Economic Barriers and Adverse Selection Problems

Insurance carriers attempting to bring this type of product to market would face many barriers, including the costs of development, marketing, and administration. Premiums for the policy would have to reflect these costs. Adding to these administrative expenses is the inherent difficulty of developing a sustainable premium structure for a benefit that is so widely used and for which costs are rising so dramatically.

Volatility in pharmaceutical cost trends also will make a stand-alone "drug-only" policy difficult to price. While there has been relative stability in the rate of increase of hospital and physician costs during the past two decades, pharmaceutical costs have been more difficult to predict. In March 1999, for example, HCFA estimated that prescription drug expenditures would reach $171 billion by 2007. Just six months later, in September, HCFA was forced to revise these projections and now predicts that prescription drug spending will reach $223 billion by 2007, a 30 percent increase over the previous estimate. Since the Administration first offered its Medicare drug benefit proposal just last year, it has had to revise cost estimates for the program upward by more than 30 percent due largely to greater-than-expected increases in the costs of prescription drugs.

For many reasons, "drug-only" policies would be very expensive to administer. Adding to the economic liabilities of these policies, therefore, are the expense margin limitations insurance carriers must meet under Omnibus Budget Reconciliation Act of 1990 (OBRA), which are likely to be too small to support separate administration of drug benefits.

The most difficult factor driving up premiums, however, will be "adverse selection." Adverse selection occurs because those who expect to receive the most in benefits from the policy will purchase it immediately, while those who expect to have few claims will forgo purchasing it. When people with low drug costs choose not to enroll in coverage while those with high costs do enroll, insurance carriers are forced to charge higher premiums to all policyholders. The more opportunities there are for enrollment, the greater the risk of adverse selection.

Adverse selection would be a very real problem for this type of product. Projections indicate that one-third of seniors (even if all had coverage for outpatient prescription drugs) will have drug costs under $250 in the year 2000, with the average cost estimated at $68. These seniors are unlikely to purchase any type of private drug coverage, given that the additional premium for such a policy would be at least 10 times higher than their average annual drug costs. Of the two-thirds who might buy the coverage, many would be doing little more than dollar trading. Some may actually end up much worse off: a person with $500 of drug expenses could have premium, deductible, and coinsurance costs equal to over 200 percent of the actual costs of drugs. Consequently, many seniors are not likely to purchase the product, resulting in further premium increases for those that do.

Limiting the sale of these policies to the first six months of Medicare eligibility would help in theory only, given legislators' demonstrated proclivity to expand on "guaranteed issue." The Clinton Administration's Medicare drug coverage proposal seeks to avoid adverse selection by limiting enrollment in a government-provided drug coverage plan to the first six months when beneficiaries initially become eligible for Medicare. While this type of rule theoretically helps, the concept seldom works in practice because legislators and regulators expand guaranteed issue opportunities over time in response to political pressure. For example, the "first time" guaranteed issue rule originally in place for Medigap policies has been greatly expanded over time—both through new federal rules in the Balanced Budget Act of 1997 (BBA) and through state law expansions.

Regulatory Hurdles

Even if such insurance policies were economically feasible, they would face significant regulatory barriers. The National Association of Insurance Commissioners (NAIC) would likely have to develop standards for the new policies; state regulators would have to approve the products before they could be sold, as well as scrutinize their initial rates and any proposed rate increases. Even relatively straightforward product changes based on proven design formulas can take several years to progress from the design stage through the regulatory approval process and, finally, to market.

Because insurers would be required to renew coverage for all policyholders (as they are required to do with Medigap products), policies could not be cancelled if new alternatives were authorized by subsequent legislation or regulations. This would exacerbate adverse selection problems for these plans, since people with the greatest drug needs would retain them while others may seek out less costly alternatives. It also would dampen interest in offering the product in the first place, as insurers would be locked into offering these policies once they were issued.

Guaranteed renewability also would exacerbate pricing problems for these "drug-only" products. While many in Congress have said that they oppose government price controls for pharmaceuticals, private insurers offering "drug-only" coverage are sure to face premium price restrictions on their products at the state level (all states have adopted either rate bands, modified community rating, or full community rating for Medigap as well as medical insurance coverage options available to non-sen-

iors). Even when proposed premium increases are consistent with state law parameters, state regulators are likely to be resistant to the magnitude of increase it would likely take to sustain a "drug-only" insurance policy as drug prices grow over time.

If the NAIC did standardize these policies, as some have proposed, it could impose unworkable limitations on insurers. If insurance carriers were prevented from adjusting co-payments and deductibles as drug costs continue to skyrocket, effective cost management would not be possible without significant premium increases over time. On the other hand, allowing needed flexibility would destroy the standardization of Medigap that Congress and the NAIC have worked so hard to achieve during the past decade.

High-Deductible Options Introduce Additional Practical Limitations

Various suggestions have been made to render these policies economically viable. One suggestion that flies in the face of historical reality is to design the policies with very high deductibles—a feature that has never been popular with seniors. Comprehensive high-deductible Medicare+Choice medical savings account plans authorized under the Balanced Budget Act of 1997 (BBA) are not available because no company believes it can develop sufficient market size to make it worth the effort. It is also notable that the high-deductible Medigap policies with drug coverage authorized under the BBA have not gained market acceptance, largely out of the knowledge that this product would not be attractive to a large enough block of seniors to make it viable. Primary carriers have not entered this market and, as far as we are able to determine, only a handful of these policies, if any, have been sold. The most common reasons for this cited by insurers are: (1) lack of consumer demand; (2) consumer confusion; and (3) unworkable system change requirements and regulatory barriers (e.g., states will not approve policy forms for 2000 or 2001 because of the federal government's delay in publishing allowable deductible levels). The $1,500 deductible in those BBA Medigap policies is considerably lower than some of the deductible levels proposed by advocates of the new drug-only policies.

In short, a "drug-only" policy is an empty promise: it may sound good, but it cannot succeed in the real world.

A DRUG MANDATE ALSO IS A BAD IDEA

Another bad idea is mandating drug coverage for Medicare+Choice plans or Medicare supplemental insurance. (More than 20 million Medicare beneficiaries have Medigap coverage, with about 9 million policies purchased individually and 11 million through the group market.)

HIAA is strongly opposed to proposals that would require Medicare supplemental insurance or Medicare+Choice plans to cover the costs of outpatient prescription drugs without the addition of prescription drug coverage as a Medicare covered benefit. The growing cost of pharmaceuticals would force plans with mandated drug coverage to raise premiums or enrollee cost-sharing or reduce other benefits, all of which would be counterproductive as seniors dropped their supplemental or Medicare+Choice coverage. Mandated drug coverage also could lead to overly-restrictive government restrictions on private plans, such as prohibitions on the use of formularies or mandating certain levels of coinsurance.

Today's Medigap marketplace is convenient and flexible, offering many choices to seniors. Of the 10 standard Medigap policies (A through J) sold, three (H, I, and J) provide varying levels of coverage for outpatient prescription drugs. Largely because of the increased costs of the policies with drug coverage, only a relatively small number of seniors have chosen to enroll in them. Of the 9.5 million Medicare beneficiaries with individually purchased Medigap policies, HIAA estimates that only 1.3 million have drug coverage through the standardized H, I, or J plans.

Several studies show that adding a drug benefit to Medigap plans that currently do not include such coverage would increase premiums dramatically. Seniors who today have chosen to purchase Medigap policies that do not provide a drug benefit would end up paying $600 more a year (assuming a $250 deductible for the policy), according to HIAA estimates.

And if Congress were to require more comprehensive drug coverage, those premiums could double. According to a May 1999 study by HIAA and the Blue Cross Blue Shield Association, requiring that all Medigap plans include coverage for outpatient prescription drugs would raise Medigap premiums by roughly $1,200 per year, an increase of over 100 percent.

Premium increases of 50 to 100 percent would result in many seniors dropping their Medigap coverage, leaving them without protection against the high out-of-pocket costs of the hospital and physician services not covered by Medicare. More-

over, increases of this magnitude would discourage employers (who are also purchasers of supplemental coverage) from offering such a benefit at all.

It is doubtful, then, that requiring all Medigap policies to include a drug benefit would be popular with seniors—who would experience diminished choice of policies, higher prices, and in some cases, loss of coverage.

CONCLUSION

The plight of seniors who are struggling to make ends meet and are finding it difficult to pay for medicine is very real. But the immediacy of the problem should not lead to short-term fixes that would do much more harm than good. We believe Congress should step back and examine a broad range of proposals—such as financial support for low-income seniors, tax credits, and fair payments to Medicare+Choice plans, most of which offer drug benefits. We believe there are workable solutions that can meet the needs of our seniors without undermining the coverage they currently rely upon. HIAA stands ready to work with the members of this Committee, and all in Congress and the Administration, to ensure that all seniors to have access to affordable prescription drugs.

PREPARED STATEMENT OF HON. EDWARD M. KENNEDY

Thank you Chairman Roth, Senator Moynihan, and members of the Committee for the opportunity to testify on this very important issue. Senator Rockefeller, Congressman Stark, Congressman Waxman, Congressman Dingell and I introduced the Access to Rx Medications in Medicare Act to deal with this urgent challenge. Our bill received strong support from most organizations representing senior citizens, and from many other groups who agree with the importance of prescription drug coverage under Medicare. With the permission of the Chair, I will submit those letters for the hearing record.

Since that bill was introduced, a number of additional proposals have been put on the table. My testimony today will focus on the general principles that should guide Medicare prescription drug legislation rather than the specifics of our legislation.

The need for action is as clear as it is urgent. Too many elderly Americans today must choose between food on the table and the medicine they need to stay healthy or to treat their illnesses. Too many seniors take half the pills their doctor prescribes, or don't even fill needed prescriptions—because they cannot afford the high cost of prescription drugs. Too many seniors are paying twice as much as they should for the drugs they need, because they are forced to pay full price, while almost everyone with a private insurance policy benefits from negotiated discounts. Too many seniors are ending up hospitalized—at immense costs to Medicare—because they aren't receiving the drugs they need at all, or can't afford to take them correctly. Pharmaceutical products are increasingly the source of miracle cures for a host of dread diseases, but senior citizens are being left out and left behind because Congress fails to act.

Senior citizens today face a crisis-a crisis that will only worsen if we fail to act. Coverage is going down, and costs are going up.

Opponents of covering prescription drug coverage under Medicare often cite the fact that two-thirds of the elderly have some drug coverage today. That still leaves twelve million elderly and disabled without a dime's worth of protection. According to a recent survey by the Commonwealth Fund, only half the elderly actually have coverage throughout the year. But even more ominous is that, except for the very poor on Medicaid, no senior citizen has adequate, reliable, affordable coverage.

Eleven million senior citizens have prescription drug coverage through an employer's retirement plan. That coverage has usually been reasonably comprehensive and affordable—but it is also drying up. In the four years 1994-1997, the number of firms offering retirement coverage dropped 25%. In the last two years, it dropped another 13%. Certainly, employees who are 50 or 55 today cannot count on receiving employer coverage when they retire.

In addition, three million senior citizens have prescription drug coverage through a Medicare HMO. That coverage is usually affordable, but it is increasingly unreliable and inadequate.

Finally, four million senior citizens have coverage through a private medigap plan—but that coverage is very expensive, and the protection is often inadequate.

At the same time that coverage is declining, the cost of drugs is soaring. Overall inflation is very low, but prescription drug costs have been going up at double digit rates for the last four years and show no signs of slowing down.

It is clearly time to act.

There are three basic principles that any prescription drug proposal should meet.
It must be cover all senior citizens.
It must provide both basic coverage and catastrophic coverage.
It must be affordable, for senior citizens and the government alike.

COVERAGE FOR ALL

Medicare and Social Security are the two most successful federal social programs ever enacted. One of the reasons that they are so popular and effective is that they are universal programs. Everyone—rich and poor alike—contributes during their working years. Everyone benefits during their retirement years. That model must be preserved for a Medicare prescription drug benefit. Additional help can and should be provided for the low income elderly, but the benefit must be one in which government and senior citizens share in the cost at all income levels. Senior citizens want Medicare, not welfare.

As a practical matter, a program targeted on the low income elderly won't meet the need. The vast majority of the elderly are of moderate means, and a program restricted to the low income elderly will still leave millions of senior citizens without affordable medical care. Fifty-seven percent of seniors have incomes below $15,000 a year and 78% have incomes below $25,000. Only 7% have incomes above $50,000 a year. The older senior citizens are, the more likely they are in poor health—and the more likely they have a very limited income to meet their health needs.

Physicians at Harvard Medical School recently analyzed typical medical profiles of elderly citizens needing substantial prescription drug therapies. The annual costs ranged from $2,400 a year to $26,500. Some proposals under consideration would provide coverage only for those with incomes below 135% of the poverty level. People at 150% of poverty have an annual income of $12,000 a year. They cannot possibly afford costs in this range without extreme hardship. Inevitably, they would be forced to go without needed care.

Even those at 200% of poverty—far beyond the range proposed in the plans limited to the low income—have an annual income of only $16,000. Even a $2,400 bill—the low end of the range of these conditions—would be spending more on drug costs than on food, on clothing, or on other essentials such as heat and light and water.

For all of these reasons, including all senior citizens is the right prescription for prescription drug coverage under Medicare.

BASIC AND CATASTROPHIC COVERAGE

The second major issue is the need for Medicare to cover both basic prescription drug expenses and catastrophic expenses. The basic coverage will meet the needs of senior citizens with moderate drug costs, and catastrophic coverage to protect those who need very expensive drugs.

A drug bill of $200 or $100 or even $50 a month is a heavy burden for most senior citizens. They deserve help in meeting these expenses. A program that asks them to pay premiums and receive no basic benefits is not defensible. That is why a basic benefit is critical.

But a basic benefit alone will not help those who need drugs costing thousands of dollars a year. Increasingly, many of the miracle biotech drugs that are coming on the market have price tags at those levels. Often, they save money for the system overall, by reducing the need for costly hospital and physician care. But senior citizens will not be able to afford these medications unless Medicare includes a catastrophic stop-loss protection. I am especially pleased that President Clinton has recognized this need in his new budget.

AFFORDABILITY

The third and final basic issue is affordability. Premiums under the new program must be affordable for senior citizens. Special help needs to be provided for the low income elderly, but the government should share in the premium cost for all of the elderly.

Affordability also has another meaning, however. Millions of Americans with private insurance coverage pay much less for prescription drugs than senior citizens pay. Citizens of foreign countries often pay a small fraction of the American price. Government agencies like the Veterans Administration receive large discounts. Private purchasers who buy in bulk—such as HMO's, insurance companies, and large corporations—all receive substantial discounts.

Any Medicare prescription drug program should be set up to provide the benefits of bulk purchasing to senior citizens. Any program we are likely to enact will still leave senior citizens responsible for paying a significant proportion of the costs of

the drugs they buy. They deserve to pay that proportion based on a fair price, and taxpayers deserve a fair price, too.

I am not a supporter of price controls. I recognize the importance of adequate revenues and generous profit opportunities for the pharmaceutical and biotech companies that are creating the miracle cures of the future. I do not believe that a Medicare drug program should necessarily pay the lowest price that any drug is available. But Medicare—and senior citizens are entitled to a fair price—the same fair price that is given to other large purchasers of pharmaceutical products. The elderly are willing to pay their fair share—but today they are paying far more than their fair share—and that is unacceptable.

Few if any issues facing this Congress are more important than giving the nation's senior citizens the health security they have been promised.

Medicare is a specific contract between the people and their government. It says, "Work hard, pay into the trust fund during your working years, and you will have health security in your retirement years." Today's elderly kept their part of the bargain. They fought in World War II and Korea. They got up every morning, went to work, played by the rules, raised their families. Their hard work laid the foundation for the prosperity our country enjoys today. But our country's promise to them is being broken today and every day, because Medicare does not cover prescription drugs.

Mr. Chairman and members of the committee, it is time to honor that promise. This Congress owes it to senior citizens, and their children, and their grandchildren to pass a Medicare prescription drug benefit. The promise of Medicare will not be fulfilled until Medicare protects senior citizens against the high cost of prescription drugs in the same way that it protects them against the high cost of hospital and doctor care. I urge this Committee to act, and act promptly, to meet this pressing need.

PREPARED STATEMENT OF ALAN B. LEVIN

I. INTRODUCTION

Mr. Chairman and Members of the Committee, I am Alan B. Levin, President, Chairman and Chief Executive Officer of Happy Harry's, Inc., a 43-store chain pharmacy company headquartered in the state of Delaware. I am here in my capacity as an owner of a regional chain pharmacy, as well as Acting Chairman of the National Association of Chain Drug Stores (NACDS).

NACDS membership consists of 143 retail chain community pharmacy companies operating over 31,000 community pharmacies, including more than 19,000 traditional chain drug stores, 7,000 supermarket pharmacies and 5,000 mass merchant pharmacies.

Collectively, chain community pharmacy comprises the largest component of pharmacy practice with over 94,000 pharmacists. Chain operated community retail pharmacies fill over 60 percent of the 3 billion prescriptions dispensed annually in the United States. Our industry's annual sales total over $160 billion including prescription drugs and over-the-counter (OTC) medications.

Mr. Chairman, NACDS supports expanding prescription drug coverage to all Medicare beneficiaries as part of comprehensive Medicare reform. However, we do not believe that sufficient time remains in this year's Congressional session for Medicare reform to be enacted. Nor do we believe that a consensus has developed at this time on the best reform model.

However, millions of low-income seniors need help right now in obtaining their prescription medications. They cannot wait for the enactment of Medicare reform, which could take several years to happen. It is for this reason that NACDS, as well as other national pharmacy and consumer groups, are supporting an approach called SenioRx Gold.

SenioRx Gold would assure that low-income older Americans have access to their vital prescription medications. Data indicate that low-income seniors are most in need of prescription drug coverage. For example:

- Beneficiaries with the highest out-of-pocket prescription drug costs are those with modest incomes—135 to 200 percent of poverty—not those with low or high incomes.
- The majority of Medicare beneficiaries without prescription drug coverage—61 percent—have incomes below 200 percent of poverty. The percentage is highest for that income category between 100 and 150 percent of poverty—almost 39 percent of beneficiaries in this income bracket do not have prescription drug coverage.

Given these statistics, we believe low-income seniors with immediate prescription drug needs should not be caught in the political crossfire of an election year. Doing something now for these seniors is a reasonable, responsible, and necessary interim public health step that both Republicans and Democrats can embrace. In fact, an approach similar to SenioRx Gold has already been introduced by a bipartisan group of Members of the House of Representatives. Other state-based approaches have also been introduced by Senator Jeffords and Senator Baucus.

II. WHAT DOES SENIORX GOLD DO?

SenioRx Gold would fill an immediate need to provide prescription drug coverage to millions of low-income seniors. This would give policymakers time to determine the best way to reform the Medicare program, as well as the best structure for a new comprehensive drug benefit for the Medicare population. Here's what SenioRx Gold would do:

- *Provides Federal Allotments to States:* SenioRx Gold is a temporary, voluntary 5-year program of Federal allotments to the states to provide prescription drug coverage to low-income seniors below 200 percent of poverty (about $16,488 for individuals, and $22,128 for couples)—those Medicare beneficiaries that need prescription drug coverage most.

We estimate that our proposal would provide incentives to states to cover all 7.3 million individuals below 200 percent of poverty without prescription drug coverage, or 61 percent of all Medicare beneficiaries without prescription drug coverage.

- *Builds Upon Existing State-Based Programs:* The program would build upon the 15 programs that have already been developed by states—including the states of Delaware, Vermont, and New York—to provide prescription drug coverage to low-income Medicare beneficiaries without prescription drug coverage.

Moreover, we estimate that about 73 percent of seniors live in states that currently have or are considering establishing state-based pharmaceutical assistance programs. SenioRx Gold would help states that have recognized the need to provide relief to this needy population.

- *Assures State Flexibility:* Under SenioRx Gold, states would have flexibility to develop and manage their state-based pharmaceutical assistance program. They could use the Medicaid infrastructure, establish their own separate state-based program, or use other mechanisms to provide prescription drug coverage. States would have to provide comprehensive prescription drug coverage, with no premiums or deductibles. There would be no annual out-of-pocket cap on prescription drug coverage.
- *Provides Important Medication Therapy Management Services:* Data indicate that the elderly comprise 12 percent of the population, but use 35 percent of all prescriptions. About 80 percent of retirees take at least one prescription drug every day. The average individual over 65 takes about 19 prescriptions each year, anywhere from two to three times that of the average individual under 65.

Given these statistics, it is easy to see why seniors are more at risk for potential medication-related problems. To address this important public health issue, SenioRx Gold also includes important pharmacy-based medication therapy management services.

These services will help assure that prescription drugs are used appropriately by those seniors who are most at risk for potential complications from drug therapy. These services include disease management, case management, and medication refill reminder programs—all of which have been documented to improve the use of medications in older Americans.

In the wake of the recent Institute of Medicine (IOM) report on the need to continue to find ways to improve medication use, we believe that any new Medicare prescription drug benefit should provide coverage and payment for pharmacy-based medication therapy management.

- *Incorporates Efficiencies in Prescription Program Delivery:* To assure that the program's funds are used appropriately, SenioRx Gold would encourage states to incorporate efficiencies into their SenioRx Gold prescription drug benefit programs. For example, states would be encouraged to use online prescriptions claims processing and adopt the use of standard pharmacy benefit cards.

We estimate that the total cost of SenioRx Gold to be about $41 billion over the 5-year life of the program—2001-2005. About three-fourths of this amount—or about $30 billion—would be paid by the Federal government to the states in the form of Federal allotments. States would collectively have to match these funds with about $11 billion over 5 years to receive these monies.

III. WHAT ARE THE BENEFITS OF SENIORX GOLD?

Mr. Chairman, several proposals are being considered that would expand prescription drug coverage by creating insurance-based "drugs only" Medigap policies, or contracting the administration of the benefit to private sector entities, such as PBMs. Some of these proposals are being offered as a "first step" or "down payment" on comprehensive Medicare reform. However, NACDS questions how we can make a down payment on a reform model that may not have yet been developed?

We believe that too many questions remain about what long-term Medicare reform will look like, and whether or how these prescription drug proposals will fit into the new Medicare reform model. For that reason, we believe that SenioRx Gold is a better approach for both low-income seniors and all Medicare beneficiaries for the following reasons:

- *SenioRx Gold would provide better prescription drug coverage to those up to 200 percent of poverty:* Compared with the many proposals that have already been introduced, SenioRx Gold is a more comprehensive benefit for those seniors without prescription drug coverage. For individuals with incomes up to 200 percent of poverty, SenioRx Gold would require no premium, no annual deductible, and lower copay amounts than other prescription drug benefit proposals.

  For example, some plans require an annual $500 prescription drug deductible, while others would impose a 50 percent prescription copay, even for some Medicare beneficiaries below 200 percent of poverty. Moreover, SenioRx Gold has no annual cap on prescription drug coverage, while many proposals cap annual prescription drug coverage.
- *SenioRx Gold would cover up to 61 percent of those Medicare beneficiaries without prescription drug coverage:* About 12 million—or 31 percent of the 39 million Medicare beneficiaries—do not have any form of Medicare prescription drug coverage. SenioRx Gold would provide incentives to states to provide drug coverage to 7.3 million of the estimated 12 million Medicare beneficiaries—or 61 percent—of those Medicare beneficiaries without coverage.
- *SenioRx Gold would not "crowd out" many Medicare beneficiaries with existing prescription drug insurance coverage:* New data indicate that 69 percent of Medicare beneficiaries—primarily middle and upper income seniors—already have some form of prescription drug insurance coverage. Past experience with the Medicare Catastrophic Coverage Act (MCCA) of 1988 tells us that many seniors want to retain their existing private-based prescription drug coverage, or are reluctant to purchase coverage that they do not need.

SenioRx Gold would minimize the extent to which a new broad-based Medicare prescription drug benefit would "crowd out" those with existing private-sector coverage, such as employer-based retiree prescription drug coverage, or force seniors to purchase coverage they may not want.

SenioRx Gold does not attempt to cover everyone without prescription drug coverage. Some seniors may have the resources to purchase their medications out of pocket, or don't have high enough annual drug expenditures to justify prescription drug coverage. For example, approximately 2.4 million—or roughly half of the 4.7 million beneficiaries that would not be covered by SenioRx Gold—have incomes above 300 percent of poverty. Moreover, data indicate that nearly 1.4 million of these 4.7 million uncovered Medicare beneficiaries did not use any prescription drugs in 1998, or have such low drug use that they would not likely benefit from a new comprehensive prescription drug benefit. Thus, SenioRx Gold targets the problem without creating additional problems.

And Mr. Chairman, your support of the repeal of the earned income limitation on Social Security could potentially provide millions of our nation's seniors with an incentive to remain in the workforce and earn additional income—including for the purchase of health care services. This could reduce the immediacy of addressing prescription drug coverage for many higher income seniors who currently have no coverage.

- *SenioRx Gold would not "break" the Medicare entitlement and would not impede "reform efforts":* Concerns have been expressed that any new prescription drug benefit program for seniors not "break" the Medicare entitlement. NACDS recognizes the political and policy importance of this argument. That is why SenioRx Gold was not structured to be part of the Medicare program.

Rather, it is a program of Federal allotments to the states to help them provide coverage to low-income seniors without prescription drug coverage. The program can be administered outside of the Medicare program, while the discussions continue on how to provide comprehensive prescription drug coverage within a reformed Medicare program.

Moreover, because the program would "sunset" within 5 years, significant momentum would still exist to reform the Medicare program. While we believe that prescription drug coverage is one of the factors driving Medicare reform, there are clearly more fundamental structural and financing issues that will soon have to be resolved in order for the program to remain viable. SenioRx Gold clearly does not impede the long process of comprehensive Medicare reform.

- *SenioRx Gold could be implemented quickly to help provide immediate prescription drug relief to needy seniors:* Millions of low-income Medicare beneficiaries need help with their prescription drug expenses now. However, some proposals that have been offered would not implement a new Medicare prescription drug benefit for at least three years—2003 at the earliest—even if enacted this year. Others might take longer, given that Medicare reform is unlikely until at least 2001.

  Under SenioRx Gold, states could use their existing Medicaid infrastructure to develop their own state-based pharmaceutical assistance programs for seniors. Other states might want to develop a program separate and apart from the Medicaid structure. We believe that states may have the ability and flexibility to respond quicker than the Federal government to address this situation.
- *SenioRx Gold would avoid the political and policy problems of "drugs only" insurance policies:* Seniors would have greater certainty of their prescription drug coverage under SenioRx Gold as compared with "insurance-based" approaches. We do not want to give seniors the unfulfilled promise of prescription drug insurance coverage if the market cannot respond to the demand for such a product.

For example, the ability of insurers to develop—and the ability of seniors to afford—"drugs only" insurance policies remain a serious and important policy question. A recent GAO study reinforced the prohibitive cost of current Medigap policies that include prescription drugs. As a result, only 9 percent of all Medicare beneficiaries purchase these Medigap policies, and the benefits provided are universally recognized as being inadequate.

Creating "drugs only" insurance policies as a solution to the Medicare prescription drug coverage issue will undoubtedly result in the same "adverse selection" effects that we have seen in the current Medigap market. This will create the uncontrollable spiral of increasing premiums and decreasing enrollments that will lead to unfulfilled promises for our nation's seniors.

Moreover, even if these policies were viable, it would take time for the insurance commissioners to develop consensus on the standards for these policies. Time is not on the side of low-income seniors who need immediate prescription drug coverage.

IV. WHAT ARE CONCERNS WITH OTHER MEDICARE PRESCRIPTION DRUG COVERAGE PROPOSALS?

Several approaches would contract the administration of the Medicare prescription drug benefit to private sector entities, most notable pharmaceutical benefit managers (PBMs). We have several concerns wit the use of such an approach in the Medicare population. We believe—for the following reasons—that more analysis is needed regarding the effect of these approaches on Medicare beneficiaries, community retail pharmacies, and other providers.

How will pharmaceutical expenditures be managed?

Over the last few years, there has been a significant increase in pharmaceutical expenditures in public and private health care programs.

Indeed, recent data indicate that prescription drug spending increased faster than any health care category during the past three years. Indications are that these increases are being driven by a combination of factors, including increased use of prescription medications due to managed care coverage, manufacturer direct to consumer advertising, and the higher prices of new drugs coming to the market.

Several recent reports indicate that "competition" in the pharmaceutical manufacturer marketplace has done little to manage pharmaceutical expenditures, especially in the wake of extensive new manufacturer direct-to-consumer advertising of prescription medications. For example, the Federal Employee Health Benefits Program (FEHBP) program—which is often considered the model for Medicare reform—experienced annual double-digit increases in prescription drug expenditures over the last several years, 22 percent for 1998 alone.

We draw your attention to the comment recently made by Office of Personnel Management (OPM) Director Janice LaChance. In announcing significant health premium increases for the 2000 FEHBP plan year—a significant percentage of which was to account for escalating prescription drug costs—she said that "it is

clear that competition in the marketplace has not effectively slowed the growth in FEHBP premiums."

She went on to say, "we must consider new and bold approaches so we can continue providing affordable, high-quality health care to our employees, retirees, and their families." In response to the challenges faced by OPM, the President's FY 2001 budget proposed that OPM consolidate its purchasing power in order to obtain better prices and lower premiums for the 9 million employees and retirees in its health care programs.

Because of increasing pharmaceutical costs and insufficient Medicare payments, many Medicare+Choice plans have either eliminated or reduced their pharmaceutical benefits. The same "private-sector entities" that manage the FEHBP program, Medicare+Choice, and employer-based prescription drug benefit plans would also be used by Medicare.

If these plans have had difficulty managing the pharmaceutical expenditures for a population that is healthier and use fewer prescription drugs that the Medicare population. How will these plans be able to manage expenditures in the Medicare population, given that seniors use more prescription drugs than the populations in these plans?

We also urge you to consider data from a recent report on the ability of pharmaceutical benefit managers (PBMs) to manage pharmaceutical product costs. The study found that the average manufacturer rebate per prescription to a PBM was $0.96 in 1997, down from $1.04 per prescription in 1996. With an average prescription price of $38, the rebate from the manufacturer only represents 3 percent savings from the manufacturers.

How would capitated payment mechanisms work?

Some proposals would shift "full financial risk" to the private sector entity managing the prescription drug benefit. Under these approaches, a plan would receive a fixed or capitated amount to provide all the beneficiaries' prescription drug needs, regardless of the cost of those drugs, or the number of drugs being taken. These "full financial risk" capitation approaches have significant potential negative implications for quality of care.

That is because providers are placed at risk for the cost of purchasing and dispensing drug products and providing pharmacy services, over which they have no control. For example, to stay below the reimbursement "cap," drugs that are less expensive but less effective may be provided to the patient.

Because of the unpredictability in prescription drug utilization, there are few private-sector prescription drug benefit programs that are partially capitated, and we are not aware of any with full capitation for older Americans.

Making matters worse, it has become increasingly more difficult to control utilization in the wake of manufacturer direct to consumer advertising, which has increased from $100 million for about 10 drugs in 1990 to about $2 billion for more than 100 drugs in 1999.

How will medication therapy management programs be provided?

Several Medicare proposals would require that pharmacy-based "medication therapy management" or pharmacy services be provided to Medicare beneficiaries. For example, we applaud Senator Jeffords for including medication therapy management services in the Pharmaceutical Aid for Older Americans Act (S. 1942), which would create state-based programs for the provision of prescription drugs and medication therapy management services. Medication therapy management services include disease state management, medication compliance programs, and drug use review. These programs have been documented to improve prescription use, reduce medication errors, and save money.

Community retail pharmacy believes that the provision of medication therapy management services is an important part of a Medicare pharmaceutical benefit. Pharmaceuticals are potent technologies, with significant benefits if used correctly. As prescription medication therapy becomes more potent and complex, the need for these services will only increase.

Many private sector entities do not currently incorporate these programs into their benefit packages. Pharmacists are usually paid for dispensing pharmaceuticals only, not for the important activities involved in helping to manage the appropriate use of pharmaceuticals by patients.

Under SenioRx Gold, however, states would design and structure medication therapy management programs for seniors most at risk for potential medication-related problems. Based on other models currently in use in various public and private sector programs, the programs might pay pharmacists a flat fee per month to help manage a beneficiary's drug therapy.

Alternatively, they could pay pharmacists based upon the time and resources involved in providing the services. We want to work with the states to determine what works best for the state and the patients.

We also believe that pharmacy-based medication therapy management services should be included in the standard benefits package of any final Medicare prescription drug program that is developed under Medicare reform.

Why would policymakers want to put price controls on retail pharmacies?

Some proposals mandate a price cap that a pharmacist can charge an individual once the prescription benefit limit is reached. That is, the pharmacist could charge no more than the reimbursement price set by the PBM, even after the benefit cap is reached. This is a form of direct price controls on pharmacy providers.

Moreover, once the beneficiary's benefit cap is reached, the pharmaceutical manufacturer is no longer obligated to provide any discount or rebate to the private sector entity for the prescription product. Therefore, the responsibility for the entire prescription "discount" falls on the shoulder of the retail pharmacy provider.

We believe that these approaches are unfair to pharmacy providers, and should be eliminated from any final Medicare prescription drug benefit plan. Because the net profitability of retail pharmacies is about 2 percent, focusing pharmaceutical cost containment efforts on pharmacists is misguided, and threatens the highly-efficient, highly-competitive pharmacy services infrastructure.

V. CONCLUSION

Mr. Chairman, let me summarize by saying that NACDS appreciates the opportunity to present our views on this important issue. We are not arguing against providing comprehensive Medicare prescription drug coverage.

We believe that such coverage should be and will be achieved over time through comprehensive Medicare reform. However, we are concerned about developing prescription drug approaches this year that may hold empty promises for our nation's seniors.

In recent Congressional testimony given on this issue, an AARP Board Member said "it would be an error for the Congress to rush to judgment on any reform option before policymakers and the public understood the proposed changes and their anticipated effect on beneficiaries, providers, and the Medicare program in general." She also said "the approach of providing low income drug assistance outside of the Medicare program deserves further review."

In the event that Medicare reform does not happen this year, NACDS believes that an interim approach is an appropriate and needed policy response. That is why we believe that SenioRx Gold is the best approach to provide prescription drug coverage as soon as possible to as many low-income seniors as possible.

We point further to the recent statement made by Linda Golodner, President of the National Consumers' League, the nation's oldest and largest consumer organization, who said SenioRx Gold "is an important stop-gap measure to help those most in need. Senior citizens who are poor, want and should be given some relief now."

We believe that the recent edition of Health Affairs provided some instructive policy conclusions for Federal lawmakers regarding this issue. The respected editor of the publication, John Igelhart, M.D., said that "studies indicate that, given the Medicare program's limited financial resources, government assistance should be targeted to those beneficiaries most in need." He went on to say that the studies in the journal provided evidence that there is a "core group of elderly—those that are poor and those who have chronic illnesses—who have the greatest need for a drug benefit."

We agree with his assessment, and look forward to working with Members of Congress and the Administration in crafting both short term and long term solutions that provide a meaningful, responsible prescription drug benefit for Medicare beneficiaries that includes pharmacy-based medication therapy management services. Thank you.

RESPONSES TO QUESTIONS FROM SENATOR COVERDELL

Question: When we talk about adding a prescription drug benefit to Medicare, I think we all agree that we want to help seniors in the best way possible—and to do so at the lowest cost possible. One of the issues we need to look at in this regard is how do we structure out of pocket costs in any drug benefit. How are out-of-pocket costs dealt with in the current Medicare system and how can we address these costs in any reform efforts?

Answer: Medicare beneficiaries currently pay different cost sharing amounts for health care services depending upon which part of the Medicare program pays for

the service. For example, under Part A, which pays for most institutional-based health care services (such as hospitals and SNF care) there is an annual hospital "spell of illness" deductible of $786. (This is waived in certain cases where a repeat hospitalization is needed within a limited period of time after the original hospitalization.)

Under Part B, which pays for outpatient services, there is a $100 annual deductible and a 20 percent cost sharing for approved Medicare charges. These cost sharing amounts also apply to the few prescription drugs that are currently provided under Part B (e.g. immunosuppressive, oral cancer drugs)

Many Medicare beneficiaries have supplemental insurance coverage—with is either provided through an employer or a privately-purchased Medigap plan—that can pay for many of these cost sharing amounts. Data indicate, however, that these supplemental coverage plans may actually encourage the overutilization of health care services because they significantly reduce or eliminate the out-of-pocket costs for the beneficiary.

Alternatively, these cost sharing amounts may impede low-income Medicare beneficiaries access to health care services because they may not have supplemental coverage, and may not have the means to afford the cost sharing.

Some Medicare reform proposals would eliminate the separate Medicare deductibles and have a combined annual deductible of anywhere from $300 to $400. This would reduce the cost sharing burdens for those beneficiaries with significant medical expenses and hospitalizations. On the other hand, it would increase cost sharing burdens for those Medicare beneficiaries that only use limited services, such as an occasional physician visit.

Question: Has anyone on the panel looked at this question of how to structure out of pocket costs? Would any of you care to comment on whether significant savings are available in this area without unduly burdening the patient with high out of pocket costs?

Answer: Medicare beneficiaries with annual incomes between 135 and 200 percent of poverty currently pay the highest out-of-pocket costs for prescription drugs. That is because data indicate that this income group has the least coverage for prescription drugs.

Appropriate cost sharing should be included in any Medicare prescription drug benefit. However, the cost sharing amounts should be structured so that appropriate prescription drug usage—not overutilization or underutilization—is encouraged. Cost sharing should be nominal for low-income Medicare beneficiaries because of their limited disposable incomes.

For example, beneficiaries should pay an appropriately-indexed annual deductible and a percentage of the prescription cost. Current private-sector cost sharing per prescription is usually about 15 to 20 percent of the cost of the prescription. Use of a percentage copay will also encourage the appropriate use of lower-cost generic drugs.

Copays should not be waived to encourage beneficiaries to use mail order pharmacy providers instead of local retail pharmacies. In reality, this is no more than a cost shift to the beneficiary. In 1996, in an attempt to reduce pharmaceutical costs, the Federal Employees Health Benefits Program (FEHBP) waived its mail order copay, while maintaining its retail prescription copay. This resulted in significant prescription utilization increases in the mail order program, and actually increased overall program expenditures. We strongly discourage these types of policies in the Medicare program.

Some private-sector prescription drug plans are now instituting "tiered copayment" systems. Under these systems, consumers are charged the lowest copay for a generic drug (first tier), the next highest copay for a formulary-covered preferred drug (second tier), and much higher copay for non-preferred drugs (third tier). This approach is used to encourage the use of the most cost-effective drugs within a particular class. Exceptions are made to the more-expensive third tier copay if a particular prescription drug covered in the second tier is not appropriate for the consumer.

These copay approaches do not necessarily have an impact on rapidly-escalating manufacturers' charges for prescription drugs—they simply shift more of the program's cost burdens to beneficiaries.

Answer: How can we deal with the issue of adverse selection, where only beneficiaries who need Rx coverage will purchase it, thus causing the premiums to increase?—(target the Administration's proposal)

We have concerns about the workability of insurance-based models and other voluntary approaches to provide prescription drug coverage to Medicare beneficiaries. We think that the experience with the Medicare Catastrophic Coverage Act of 1988 should give pause to policymakers as they attempt to provide prescription drug cov-

erage to those that do not have such coverage. That is because it is important to not displace the private-sector prescription drug coverage that many beneficiaries already have.

Seniors would have greater certainty of their prescription drug coverage—and the issue of "adverse selection" would be eliminated—under an approach which provided annual Federal allotments to the states on a short-term basis as compared with "insurance-based" approaches. We do not want to give seniors the unfulfilled promise of prescription drug insurance coverage if the market cannot respond to the demand for such a product.

For example, the ability of insurers to develop—and the ability of seniors to afford—"drugs only" insurance policies remain a serious and important policy question. A recent GAO study reinforced the prohibitive cost of current Medigap policies that include prescription drugs. As a result, only 9 percent of all Medicare beneficiaries purchase these Medigap policies, and the benefits provided are universally recognized as being inadequate. Creating "drugs only" insurance policies as a solution to the Medicare prescription drug coverage issue will undoubtedly result in the same "adverse selection" effects that we have seen in the current Medigap market. This will create the uncontrollable spiral of increasing premiums and decreasing enrollments that will lead to unfulfilled promises for our nation's seniors. Moreover, even if these policies were viable, it would take time for the insurance commissioners to develop consensus on the standards for these policies.

In conclusion, significant potential exists for "adverse selection" under current Medicare prescription drug proposals. For this reason, we urge that Congress act this year to provide prescription drug coverage to low-income Medicare beneficiaries by giving Federal allotments to the states. This will serve as a "sop-gap" measure until more study can be done on the best way to provide prescription drug coverage under a reformed Medicare program, and to avoid adverse selection.

Response to Questions to Alan Levin
from Senator James Jeffords
Senate Finance Committee Hearing - March 22, 2000
April 12, 2000

Mr. Levin, it was noted at the hearing that different pharmacies might charge different prices for the same prescription, even within the same geographic region. Can you explain the reasons for these prescription price variances?

Senator Jeffords, as you might imagine, we are concerned about the study of retail prescription prices that was mentioned at the hearing. The study found that different pharmacies charge different prices for prescription drugs within the same geographic region.

NACDS has analyzed this study, which was done by a Washington, D.C. firm called InContext. The study's conclusions are dubious, and highly suspect, given that there are serious questions about how this survey was done. For example, it is impossible to determine how the sample of pharmacies was drawn. Moreover, several of the pharmacies in the survey are no longer owned by the pharmacy chains indicated in the survey, raising questions about the validity of all the data that were collected. Finally, there is no indication of who sponsored or paid for the study. We respectfully ask that the attached letter sent to InContext be included in the hearing record. The letter seeks more information about how the survey was conducted.

Like any other highly-competitive retail industry, it would be natural to find that the prescription prices charged by retail pharmacies might vary. These variations reflect the differences in operating costs that pharmacies in each of these metropolitan areas might incur. For example, there are differences in wages, rent, insurance costs, utility costs, and other variable factors depending upon where the store is located, even within the same metropolitan areas.

Because of these factors, similar price variations would be found in the same geographic area for other non-health items sold at the retail level. Price variations would also exist for health-related items and services, such as physicians' charges, lab charges, medical equipment charges, and even hospital visits.

Moreover, it is unfair to draw conclusions about retail pharmacy's pricing policies by isolating and surveying prices for one or two particular prescription drugs. At this time, almost 90 percent of all retail prescription prices are covered by insurance plans. The reimbursement rates for these prescriptions are set by the insurance company, not the pharmacy. Therefore, only about 10-11 percent of all prescriptions provided by retail pharmacies are paid for by cash. These prices are set by the highly-competitive retail pharmacy marketplace.

According to the recent pharmaceutical pricing report released by the Administration, "Pharmacies employ a variety of pricing strategies when determining the markup for their sales to cash-paying customers. For example, they may set a lower markup for maintenance medications and a higher markup for acute medications, or they may routinely discount certain commonly-used medications as "loss leaders" in order to attract cash customers who will they buy other medications or merchandise.
The bottom line is that the average retail pharmacy operates at a net profit of about 2 percent. Over 90 percent of our business in paid for by insurance-set rates, and the remaining 10 percent cash prescription business is set by a highly-competitive

marketplace.

Mr. Holmer testified that private-sector entities would provide more than just prescription drug coverage to seniors; that is, they would do more than just pay claims - they could provide disease management, drug utilization review, and patient education, and could help reduce medical errors. Do you agree with this statement? How many PBMs have this type of program in place? How can they perform these programs without the help of pharmacists? Aren't pharmacists doing these programs now?

Senator Jeffords, we are somewhat perplexed by Mr. Holmer's statements that private-sector entities would be providing these pharmacy-based services. Insurers and PBMs are not generally known for their training and expertise in this area. Pharmacies have been, are, and will continue to provide these important medication-related services. Congress recognized the contributions that pharmacy providers make to improving medication use and reducing the incidence of medication errors long before PBMs were even in existence.

That is, OBRA 90 assured that Medicaid recipients would have access to the important community pharmacy based prescription counseling and medication management services. Most states have since adopted these OBRA 90 requirements for all consumers in the state, not just Medicaid recipients.

PBMs are not health care providers; they function more or less as claims processors that have, over the years, added some basic prescription drug benefit management functions to their package of services. It is the community pharmacy providers with whom the PBMs contract that provide the various patient-oriented services, not the PBM. PBMs do not provide patient counseling; the pharmacist performs this service. The same is true of disease management. PBMs may help pharmacists perform these functions by providing some data to them about other prescription medications that the patient might be taking, but it is the pharmacist that makes the ultimate professional judgement about how to interpret and use the data in providing services to the patient.

Despite their claims to the contrary, we have concerns that PBMs may emphasize cost containment at the expense of providing quality patient care services in any new Medicare prescription drug benefit. A recent survey of PBMs found that only 37 percent offer disease management programs as part of their benefits package. We are interested in working with you to assure that any Medicare prescription drug benefit include comprehensive pharmacy-based medication therapy management services to assure that prescription drugs are used appropriately in the Medicare population.

I have introduced a bill that would establish programs of medication therapy management to help improve the use of prescription medications for seniors. What services do pharmacists now perform that help to improve prescription medication use? How would these services impact on patient care and the practice of pharmacy?

Senator Jeffords, we commend you for introducing the Pharmaceutical Assistance for Older Americans Act, which includes a program of medication therapy management for older Americans covered under the individual programs.

Pharmacists are uniquely qualified to play an important role in medication therapy management, helping to assure the appropriate use of medications, and the avoidance of medication-related errors. Pharmacists receive, at a minimum, 5 to 6 years of training and education in such subject areas as pharmacology, disease management, and therapeutics.

Medication therapy management services consist of a comprehensive range of programs and services delivered by the pharmacist that help assure that patients take their medications appropriately, and as prescribed by their physician. At a minimum, these pharmacy-based medication therapy management standards should include disease state management, medication compliance programs, and comprehensive drug use review. The program may be structured so that it targets those patients most at risk for adverse reactions, such as those taking multiple or complex medications.

The current pharmaceutical distribution system undervalues the contributions made by pharmacist medication therapy management to the health care system. This is because the system provides payment to pharmacists for dispensing pharmaceuticals products, *rather* than paying for both the product *as well as* the activities involved in managing the appropriate use of pharmaceuticals in patients.

Community retail pharmacy believes that the provision of medication therapy management services - and the accompanying payment for these services - is as important as providing the drug product itself as part of a pharmaceutical benefit. Pharmaceuticals have the potential to result in a significant amount of benefit if used correctly, and the potential for harm if used incorrectly. As prescription medication therapy becomes more potent and complex, the need for these services will significantly increase.

Precedent already exists in Federal health care programs for the use of medication therapy management:

- In 1987, long-term care facilities receiving Medicaid payments were required to conduct drug regimen review (DRR) for nursing home residents. This was done in response to the need to improve the use of medications in nursing home residents, who are often taking multiple chronic medications to treat serious medical conditions.
- In 1993, Medicaid programs were required to adopt a comprehensive program of drug use review (DUR) for Medicaid recipients to assure that prescription medications are used correctly, and to reduce the incidence of adverse drug reactions.

While we believe that your bill is an excellent start, policymakers should consider developing incentives for health plans to incorporate pharmacy-based medication therapy management programs into Medicaid, Medicare, and FEHBP - as well as payment for these services. Evidence suggests that these programs save money by avoiding drug-related medication problems, reducing the need for hospital stays and other medical services.

April 13, 2000

William Lilley, III
InContext, Inc.
1615 L Street, N.W.
Suite 650
Washington, D.C. 20036

Dear Mr. Lilley:

On behalf of the National Association of Chain Drug Stores (NACDS), I am writing to ask that you provide important information regarding how your firm developed the ***"Point of Sale Prescription Drug Survey."*** This survey, which has been circulating among Congressional policymakers, is misleading at best, and creates distortions about the community retail pharmacy marketplace.

NACDS membership consists of 145 retail chain community pharmacy companies operating over 31,000 community pharmacies. Collectively, chain community pharmacy comprises the largest component of pharmacy practice with over 94,000 pharmacists. The chain community pharmacy industry is comprised of more than 19,000 traditional chain drug stores, 7,000 supermarket pharmacies and 5,000 mass merchant pharmacies. Chain operated community retail pharmacies fill over 60 percent of 3 billion prescriptions dispensed annually in the United States.

Because the survey contains little information about how it was conducted, it is extremely difficult to judge the validity of the conclusions. In that regard, we would appreciate if you could address the following concerns and provide us with the following information:

1. **Survey Sample Undefined:** No methodology is indicated for how pharmacy sample was selected and drawn. For each metropolitan area in which you surveyed pharmacies, can you tell us how these pharmacies were selected? Was a representative sample of chain and independent pharmacies chosen? What was your source for the list of the pharmacies?

2. **Market Areas Too Large:** In many cases, the "market areas" used in the studies were as large as hundreds of square miles in size. Traditionally, retail-based price surveys are conducted within much smaller market areas because of the wide variations that exist across large areas in variable costs such as rent, labor, utilities, and other factors. Why did the survey use such large market areas? How are other traditional retail price surveys conducted? Can you identify other retail surveys that use such large market areas? Were any of the data collected adjusted to reflect the differences in operating costs that pharmacies in different parts of each of these metropolitan areas might incur?

3. **Samples are Inconsistent:** While the study says that "50 retail drug outlets were surveyed," it is unclear why there are only 40 pharmacy prices reported for the Seattle region, 43 for the San Jose region, 12 for the Washington, D.C. region, and over 80 reported for the Detroit region. Why are some regions undersampled and other regions oversampled?

4. **Prescription Taxes not Considered:** Did you account for the fact that some states

charge taxes on prescription drug sales, making the costs of these prescriptions higher in some regions than other regions of the country?

5. **Survey Methodology Undefined:** What survey methodology did you use for the study? For example, did you do a phone survey or an in-store shoppers' survey? How was the survey instrument developed and tested for reliability and validity? Can you provide us with a copy of the survey instrument? It was not attached as part of the study results.

6. **No Study Timeframe Indicated:** Manufacturers frequently increase prices to pharmacies for prescription drugs. For that reason, it is very important to indicate the exact time frame over which the survey was conducted. To assess how current the data are, what is the exact time period and year during which the survey was conducted for each metropolitan area (e.g. May 1-May 31, 1999)?

7. **Questionable Pharmacies Included:** Several pharmacies included in the study no longer operate under the names that you have included in the study. For example, Revco stores were purchased by CVS several years ago, yet you list a Revco store in the St. Louis study. The "Shelley Forman Enterprises" pharmacy that you list in the Philadelphia market is now owned by Eckerd. This leads us to conclude that your other data may also be outdated, and therefore meaningless to the survey. Why are these pharmacies not listed under their current ownership name? Do you believe that questions about the validity of the store names raises questions about the other data that were collected for this study?

8. **Source of Pricing Data Not Indicated:** From what source were the pricing data obtained? Were they obtained from the same data source in each area? When the pricing information was obtained from the pharmacy, was the respondent asked to provide the "cash price," the "price to senior citizens" or the pharmacy's "third party" prescription price? Senior citizens often receive a 10 percent discount on their prescriptions. Often times, pharmacies will quote one or the other price, or both. Were the responses recorded consistent with the question that was being asked?

9. **Several Pharmacies have "No Employees":** According to your survey results, several pharmacies are recorded as having "no employees," while other chain-based pharmacies are recorded as having the exact same number of employees. What was the purpose of including these data in the survey, and how were they obtained? Given that the survey was unable to correctly report the name of several pharmacies, should we put the same faith in these employee numbers, as well as the prescription pricing numbers?

10. **Data Order are Inconsistent:** The data in the tables appear to be presented in no particular order. For example, data collected from pharmacies in Ann Arbor are listed both at the top of the table and the bottom. For comparative purposes, it would have been more helpful to examine pricing data collected within the same geographic area - perhaps arranged by contiguous zip codes - rather than presenting the data in haphazard fashion. Can you explain why these data were reported in this manner?

11. **Pharmacies' Competitive Marketplace Ignored:** In some cases, the price quoted by the pharmacy may be *below* the pharmacy's costs of purchasing and providing the prescription. That is, the highly competitive nature of the retail pharmacy marketplace may require that pharmacists sell some products below costs, especially high-volume movers such as Norvasc and Zocor, for which there might be significant

competition. Pharmacies often will match the price offered by other pharmacies to assure that they retain or attract new patients to their pharmacies. Did you consider these factors when constructing your survey? If all the results of this survey found that pharmacies charged the same or very similar prices, would you conclude that pharmacies were engaging in anti-competitive behavior?

12. **Pharmacy Services not Considered:** Did you ask the pharmacies if the price they quoted reflected the charges for the additional patient care services that pharmacies provide, such as counseling and medication management?

13. **Manufacturers Charge Significantly Higher Prices in U.S. compared with Canada:** Your survey attempts to illustrate price discrepancies among U.S. pharmacies for the same prescriptions. However, more importantly, it points out the significant discrepancies in manufacturer prescription prices between the U.S. and Canada. How do you explain these significant price discrepancies? Does the fact that drug manufacturers charge Canadians much lower prices for prescription drugs than U.S. citizens contribute to this disparity?

14. **Study Sponsorship not Indicated:** You do not indicate who sponsored or paid for the study. This is an important question for policymakers, as they determine the relative value of the data and the conclusions in the context of the study sponsor's self-serving interests.

We would appreciate as timely a response to these questions as possible, as we want to better understand how this survey was constructed. Thank you very much.

Sincerely,

S. Lawrence Kocot
Senior Vice President and General Counsel

Cc: Rep. Dennis Hastert
Senator John Breaux
Rep. Bill Thomas
Rep. John Dingell
Rep. Richard Gephardt

UNITED STATES SENATE
COMMITTEE ON FINANCE

Providing Prescription Drug Coverage Through Medicare

The Role of Pharmacy Benefit Managers

March 29, 2000

Testimony of Carol J. McCall, MAAA, FSA
Executive Vice President, Managed Care, Allscripts

Good morning Chairman Roth and members of the Committee. My name is Carol McCall and I am the Executive Vice President for Managed Care with Allscripts. Allscripts is a Chicago based company that helps provide electronic prescribing and medication management solutions to physicians. Prior to working with Allscripts, I served as Vice President for Pharmacy Management with Humana, Inc., a managed care organization that provides pharmacy coverage for approximately 450,000 seniors through the Medicare+Choice program.

I am a fellow of the Society of Actuaries and a member of the American Academy of Actuaries. I also serve as a member of the Academy's Medicare Reform Task Force that is studying a number of issues involving proposed changes to Medicare. Among the changes under study is adding a prescription drug benefit to the current Medicare coverage. I would like to note that although I am a member of the American Academy of Actuaries' Medicare Reform Task Force, I am testifying today in my private capacity and not on behalf of the Academy.

Prescription drug costs represent a significant part of health care expenses, and those costs have been rapidly rising over the past few years. The cost of prescription drugs can have a major impact on seniors, many of whom are on fixed incomes. Since Medicare is the primary source of health insurance coverage for seniors (almost 98 percent of the population in this country age 65 years or older is covered by Medicare), one possible approach to this issue is to expand the current Medicare coverage to include some level of payment for prescription drugs.

I was asked to provide information about pharmacy benefit management companies and how they operate in the private sector. The first part of my testimony will focus on the ways in which pharmacy benefit managers work with their clients (usually employers or insurance companies) to manage pharmacy benefits. In addition, I will discuss how pharmacy benefit managers might be used to administer prescription drug coverage for Medicare beneficiaries.

Pharmacy Benefit Managers

Pharmacy benefit managers (PBMs) are fiscal intermediaries that administer pharmacy benefits for employers, health insurers and health maintenance organizations (HMOs). PBMs rely on a complex network of relationships with pharmacies, drug manufacturers, health plans, providers and patients and use a variety of mechanisms to encourage cost effective utilization of prescription drugs. Some PBMs are independent, while others are owned by retail pharmacies, drug manufacturers and health insurers or managed care companies. In addition, a number of HMOs administer prescription coverage in a manner similar to PBMs for their employer clients.

According to a recent Kaiser Family Foundation report, PBMs administer 71% of the prescription drug purchases at retail pharmacies covered by a private third-party payer.[1] The current market is fairly concentrated, with three PBMs managing approximately 45% of the market and no other PBM with more than 4% of that market. The degree of concentration,

[1] Henry J. Kaiser Family Foundation, *The Role of PBMs in Managing Drug Costs: Implications for a Medicare Drug Benefit*, January 2000.

however, is less in many areas of the country than might appear from these figures. A number of smaller PBMs have very high proportions of some local markets[2].

PBMs use a variety of mechanisms to help encourage more appropriate utilization of medications and control costs, including:

- Establishing retail relationships and discounted pharmacy pricing
- Designing and implementing prescription drug formularies
- Establishing relationships with manufacturers and negotiating rebates
- Encouraging generic and therapeutic substitution of drugs where appropriate
- Conducting drug utilization review
- Using prior authorization for certain medications
- Providing mail order capabilities

These mechanisms can have a substantial impact on the overall cost of providing prescription drug coverage. There are, however, a number of other factors that can affect the cost of a prescription program, such as:

- Benefit levels, including applicable deductibles, copayments, coinsurance and patient cost sharing maximums.
- The exclusion or coverage of certain drugs or drug classes by the health plan (as opposed to the PBM), such as "lifestyle" drugs or certain injectable drugs that are physician-administered
- Age and sex distribution of the individuals enrolled in the health plan.
- Disease management programs, which can prove very successful in improving health and lowering overall healthcare costs, but can also increase the amount of spending on prescription drugs.
- Other benefits offered by the health plan, which may attract either healthier or less healthy individuals to enroll in the plan.
- Other sources of prescription coverage.

These factors are not typically controlled by the pharmacy benefit manager. Because of this lack of control, PBMs are usually reluctant to assume full financial risk for prescription drug coverage. However, some PBMs may assume partial risk through risk corridors or performance guarantees.

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[2] One particular PBM has only 1.4% national market share but has 37% market share within the state of Wisconsin, per discussions with their executive management.

Pharmacy Networks

One of the fundamental advantages that PBMs provide is their wide network of relationships with pharmacies throughout the United States. PBMs typically negotiate reimbursement rates for drugs that can be substantially below the pharmacy's usual and customary charges. The reimbursement rates are generally structured in one of two ways. The first is a percentage discount off of the average wholesale price, plus a fee for dispensing the drug. The second method, which is typically used for generic drugs, calculates the pharmacy payment as a dispensing fee plus a preset amount from a fee schedule.

PBMs may also establish performance-based pharmacy networks. These are smaller networks of pharmacies with which they have negotiated a lower level of reimbursement. In these types of arrangements, PBMs may negotiate incentive-based arrangements with pharmacies. In this case, the payment to the pharmacy varies based on the performance of certain activities or the level of certain measures (such as increasing formulary compliance or generic dispensing).

Generic and Therapeutic Substitution

One of the keys to controlling costs is to encourage, where appropriate, the substitution of generic drugs for brand name prescriptions or substitution of a prescription with it therapeutic equivalent[3]. Increasing the use of generics can have a dramatic impact on costs. The cost of generic drugs, before taking any cost sharing differences into account, is approximately one fourth that of brand drugs, after PBM discounts. Using this simple relationship (assuming a starting rate of 40% of prescriptions being generic), a 1% increase in generic usage could decrease total costs by slightly more than 1%.

There are many ways to promote the use of generics. In many instances, PBMs use their relationships with pharmacies by offering them an incentive to for increase generic dispensing. Other methods involve benefit design and use higher copays or coinsurance for brand drugs to incent beneficiaries to use generics. Some plans require mandatory generic substitution[4].

For therapeutic substitution, a number of different programs can be classified under this category but all of them seek to do the same thing -- in instances where a different, less expensive drug is a therapeutic substitute -- to work with the physician and see whether a substitution is possible in that particular instance.

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[3] Generic drugs are bioequivalent drug products that are pharmaceutically equivalent products (same drug/dosage/form) with similar bioavailability (same amount of medication is delivered to the body over the same time). Therapeutic equivalents, while not bioequivalent, are drug products that are considered to have the same clinical effects and safety profile when given to patients as another drug. For example aspirin and ibuprofen are considered therapeutic equivalents.

[4] With this mechanism, it is possible to allow beneficiaries to still purchase the brand name drug. Here, they would pay the difference in cost between the brand and generic so the final cost to the plan is as though the generic had been dispensed.

Unlike generic substitution, where the drugs are of the same chemical composition, these programs focus on drugs that are within the same class but not bioequivalent. In these instances, physician permission is required in order to make any change. Formularies are commonly used mechanisms that rely on the ability to substitute therapeutically within a class.

Drug Formularies

Formularies are lists of preferred medications, and they are a mechanism to encourage the use of less costly drugs. Typically, the pharmacy benefit manager creates a list of preferred drugs within a drug class for which they have negotiated lower pricing with manufacturers. The amount of the discount or rebate depends on the particular incentives used for formulary compliance and on how many different drugs are preferred within each of the therapeutic classes.

Formularies can be classified and administered as either "open," "closed," or "incentive." In open formularies, prescriptions that are not on the list of preferred drugs are still covered. Such formularies have little impact on the types of prescriptions dispensed, and rebates from manufacturers are typically the lowest in open formularies. In these instances, PBMs often create programs designed to work with pharmacies and physicians to encourage the use of preferred medications.

In closed formularies, non-preferred medications are not covered unless the prescribing physician certifies that there is a medical exception that meets criteria set by the PBM or the health plan. Such arrangements can generate the highest levels of formulary compliance and rebates, but can also be administratively burdensome. They also have the potential to create access to care issues if the prescription is not written for the preferred medication the first time and the process to determine exceptions is cumbersome or time consuming.

In an incentive formulary, the patient is given certain benefits or penalties depending on whether the drug is included on the formulary. For example, the benefit may have the highest copayment for non-preferred drugs, a middle-level copayment for preferred brand drugs and the lowest copayment for a generic drug.

Pharmacy benefit managers generally rely on pharmacy and therapeutics ("P&T") committees of medical experts to determine which drugs will be included on the formulary. The committee relies on available clinical evidence to determine if there are drugs that do not represent unique clinical advantages over alternative therapies or are considered to be therapeutic equivalents. The net price after rebate available from the manufacturer may play an important role in determining the final list of preferred drugs on the formulary. Formularies should be changed periodically to reflect new drugs being introduced on the market, updated clinical information, drug indications and different rebates available due to competition between pharmaceutical manufacturers.

Relationships with Manufacturers

PBMs may develop relationships with manufacturers that provide lower pricing (through rebates) when a particular drug is on the formulary. The level of rebates will vary by

manufacturer and prescription drug. In general, the level of the rebates increases if the PBM achieves a greater market share for a drug within a defined class of prescriptions with similar therapeutic effects.

Rebates are not available on all drugs. Rebates are usually not provided or they may be minimal for landmark or breakthrough drugs since they generally will have to be included in most formularies because no other comparable drug is available. Generic versions of multiple source drugs also have minimal rebates. Rebates may be paid for brand-name equivalent drugs after they first lose patent protection, but after a period of time the dollar volume of the rebate decreases as the market share of the generic version increases.

In the end, it is the combination of formulary design, benefit design features and other incentive mechanisms that drive formulary compliance. Because formulary compliance in turn affects the level of rebates, it has a significant impact on overall cost of prescription drug coverage.

Mail Order

Many PBMs provide mail order capabilities to their clients and use them as another means for controlling costs. Mail order benefits are most often used for medications for chronic illnesses where there are a number of refills available[5]. In these instances, the first prescription is usually filled at a retail pharmacy, and the refills are sent to a mail order facility. Most mail order prescriptions are for 60 to 90 day supplies of prescription drugs.

The costs of providing medications through mail order are usually lower than providing the same medications in a retail setting (assuming no difference in benefits), because:

- Mail order pharmacies buy their drugs at a lower cost[6]
- Mail order facilities may have greater operational efficiencies because of where the facilities can be located and how the prescriptions are filled. Many mail order houses are fully automated and some make extensive use of robotics to fill prescriptions.
- There are instances in which mail order can be used to increase generic and formulary compliance. If the refill is not needed immediately, there is more time to have necessary discussions with physicians and patients regarding switching the medication.

In order to provide incentives to beneficiaries to order their prescriptions by mail, health plans have sometimes made the benefits richer, frequently by giving up a copayment (a 90 day supply in a retail setting would cost a beneficiary three copayments, i.e., reducing the out-of-pocket cost to the individual covered by the PBM)[7].

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[5] Mail order *can* be used for acute medications, but because of the time required to fill the prescription and get it to the beneficiary, it rarely is.

[6] Mail order pharmacies actually buy their drugs in a different class of trade than retail stores. This can then be passed along in the form of lower discounts and dispensing fees.

[7] Some states have laws that prohibit plans from enhancing benefits in such a manner.

Many PBMs operate their own mail order facilities, although not all have this capacity. Pharmacy benefit managers that do not have a mail order facility can contract with third party vendors to provide mail order services. In addition, some of the larger retail pharmacy chains have mail order facilities.

Drug Management Mechanisms

There are other mechanisms PBMs can use to help contain costs, which are summarized below. In looking at the details, you will see that there are differences in how and why one mechanism is used over another. However, all of them use clinical criteria to look at whether the particular prescription drug is appropriate for the medical condition.[8] If the clinical criteria are not met, the drug is usually not covered.

These tools can be very important in containing costs, especially when new, high-demand drugs are introduced (such as when they are clinically intended for a small population but are being prescribed to a much larger one). One possible problem is that these mechanisms involve interrupting the claims adjudication process to assess the criteria. While such mechanisms can help contain costs, they can be disruptive for physicians and beneficiaries. There is also less consistency *between* PBMs in terms of the list of drugs being reviewed and the clinical criteria they use to evaluate them.

Mechanism	Used For	Issues
Prior Authorization (PA)	Used to check medical appropriateness of the drug for the condition. Used when drugs: • Are inherently dangerous. • Have the possibility of severe drug interactions. • Exhibit high use for what should be considered a niche therapy[9] • Are extremely expensive.	The emerging need for PA (due to the pace of niche therapy development) may conflict with: • The success of "direct to consumer" advertising, • Consumer demand, and • Legislative environment
Maximum Dispensing Limit (MDL)	Used to manage the quantity of pills that are dispensed. MDLs used to: • Check appropriateness of prescriptions for ages and quantities outside FDA indications. • Prevent stockpiling of "as needed" drugs. • Find outliers for quantity.	As drugs become more sophisticated for "as needed use," expect greater use of MDLs.

[8] The PBM's P&T committee set the clinical criteria for these evaluations.

[9] This happens as a direct result of direct-to-consumer advertising and other manufacturer promotion campaigns. Drugs that are meant for a fairly small population of people with particular conditions are marketed and prescribed to a much broader population.

Step Therapies	Used to check the medical appropriateness of using a "first-line" versus a "second-line" drug.[10] Used when: • Readily available alternative therapies are available. • System can check whether alternatives have been tried before requiring review, or • System allows a drug for a certain duration before needing review (duration corresponds to FDA indications).	Requires sophisticated adjudication systems to work well. Works better with: • Physician-targeted edits • "Gold card" capability for certain providers, such as specialists.

Using PBMs in the Medicare Program

If prescription drug coverage is provided through the Medicare program, consideration should be given to allowing PBMs to participate. Many important design features will depend on the approach the program taken when utilizing PBMs. The two approaches most commonly considered in current proposals are:

- A single-PBM approach, where one PBM is selected for a region and has the exclusive rights and responsibilities for providing access to coverage for pharmacy benefits

- A competitive PBM approach, where more than one PBM is available to beneficiaries in a region. Beneficiaries would choose which PBM they want, and coverage would be provided through that PBM.[11]

For various elements of program design, there are specific considerations, each with advantages and disadvantages depending on the approach used. At a high level, single-PBM and competitive PBM models have distinct differences.[12]

Single PBM Approach

- This approach is administratively simpler because PBMs compete only for the regional contract and not the beneficiaries within a region. The issues surrounding competitive bidding and providing benefits through multiple entities are eliminated.[13]

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[10] As much as 7%-8% of prescription drug cost increases are attributed to the use of newer, more intense and expensive therapies ("second line" drugs) for the same condition as in the past.

[11] While our discussion generally refers to PBMs, it should be understood that this includes health plans that offer the same or similar capabilities as a PBM. To the extent they meet the requirements to bid, HMOs could be allowed to provide this coverage.

[12] For a full discussion of the various issues, see: American Academy of Actuaries, *Providing Prescription Drug Coverage to Medicare Beneficiaries*, April 2000.

[13] The issues associated with conducting competitive bids are beyond the scope of this testimony. For a more complete discussion, see: American Academy of Actuaries, *Using Private Sector Competition Strategies*, March 2000. Many of the issues are the same with respect to bidding criteria, calculating reference premiums, etc.

- Implementing such a program could happen more quickly due to combined administrative simplicity and the fact that the technological challenges would be fewer.[14]

- Mass purchasing power for the PBM would be very large. It is possible that greater pharmacy discounts could be achieved than are typically available today by concentrating this power with a few large purchasers. It is unclear, however, whether this would be sufficient to make up for a loss of rebates that would likely occur in a single-PBM model (more on this topic below).

- Using a single PBM would reduce adverse selection *among* PBMs and the need for a mechanism that could adjust for this. It does not necessarily reduce the overall incidence of adverse selection, though, as that is primarily created through the combined interaction of:

  - Program eligibility and enrollment policies,

  - Benefit levels and concomitant premiums, and

  - Premium subsidy levels.

- Using a single-PBM model now could severely restrict the ability to introduce competitive PBM models in the future, as early winners (i.e., the PBMs which are awarded Medicare contracts) would have a clear advantage.

- This model gives an advantage to bigger PBMs, which could reduce the field of bidders. Some PBMs, while they have limited national market share, have tremendous market share at a more regional level.

- For a single-PBM model, one of the most important questions is whether such an approach could use a formulary. An explicit formulary (whether incentive based or closed) could be extremely difficult in a single-PBM model:

  - There would be pressure to have a single national formulary so that all beneficiaries had the same coverage and benefits regardless of where they lived.

  - If there were a national formulary, there would need to be a fairly extensive operational capability to provide exceptions to people for whom the drugs were not clinically appropriate. This would still surface in a competitive model but less so, as beneficiaries would have a choice between formularies.

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[14] PBM executives are comfortable that their existing infrastructure and technologies are directly applicable to providing pharmacy coverage to the Medicare population. See Henry J. Kaiser Family Foundation, *The Role of PBMs in Managing Drug Costs: Implications for a Medicare Drug Benefit*, January 2000.

- In this model, the national P&T committee would likely be making decisions about which drugs would be on the formulary. In such a situation, the process of selecting the drugs would be subject to severe political pressures.

- It would be difficult for the different regional PBMs to agree on what the national formulary should be. Each has different manufacturer relationships and picking something different than what they currently have would either be extremely disruptive to their existing clients (i.e. if they changed their formulary to match) or would not leverage their existing relationships. This could mean that the savings opportunities from using formularies could go down.

- The inability to use a formulary may increase costs above what they would otherwise be. Even if PBMs had more concentrated purchasing power, without a formulary, any additional purchasing power is unlikely be sufficient to make up for this loss. Manufacturers and retail stores have different economic models and inherent profit margins, with margins being much higher for manufacturers. With no formularies, the average rebates that would be forgone are potentially higher than the additional discounts that could be negotiated. In this instance, price controls may be the only method for regaining the cost advantage.

- Because a PBM would have a monopoly within a region, they would have fewer incentives to compete on the basis of service provided to beneficiaries. While always important, these incentives become more important as the program increases the use of PBM-type mechanisms for controlling costs. To the extent cost saving mechanisms are extensively used in a single-PBM model, additional monitoring of services would need to be implemented. If they are not used, however, the PBM's ability to help contain drug costs would be materially compromised.

- Changing PBMs (either at the time the contract is over or if there are performance or service issues) can be extremely disruptive, with the risks being more than administrative disruption and dissatisfaction. Pharmacy coverage has distinct characteristics that make changing its administration quite challenging, and a poor transition of such a large beneficiary population to another PBM creates the potential for adverse impacts on people's health.[15]

Competitive PBM Approach

In addition to the distinctions between the two models summarized in the above discussion, there are some specific points that can be made regarding a competitive PBM approach:

- A competitive model allows more flexibility in overall program design. To the extent it allows great use of traditional PBM mechanisms for controlling costs, it could reduce the

[15] It is an extremely high volume transaction as well as being on-line. If a large-scale transition were not to go well, the affects would immediate as well as massive. Also, improper adjudication of a pharmacy claim can create access to care issues. If claims will not process and beneficiaries are unable to pay out of pocket, they can end up having to walk away without their medications, which can create adverse health events for some people.

overall expenditures associated with providing pharmacy coverage over those available in a single-PBM approach.

- By allowing competing PBMs (or other competing health plans), Medicare beneficiaries could be allowed to choose from different approaches to pharmacy cost containment. If a PBM proved to be too restrictive, beneficiaries would likely switch to another PBM at the annual open enrollment period.

- This approach is more administratively complex and would take longer to implement. In particular, this approach requires deciding and clarifying:

  - The overall policy and process for conducting competitive bids

  - The bases on which PBMs can compete for beneficiaries; (i.e. which program elements should be the same across all PBMs and which can be used as the basis for competition)

  - How communication with beneficiaries will occur. The communication mechanisms and challenges are more complex in this approach

- A benefit of the greater administrative complexity of a competitive PBM approach is that the knowledge gained from implementing it would be applicable to introducing competitive bidding for other elements of Medicare. The problems with competitive bidding for pharmacy coverage would be similar to those encountered for Parts A and B of Medicare, but the order of magnitude is much smaller, in part, because:

  - Many PBMs have (or can create) broad networks which reduces the complexity of having to bid an extremely large number of small regions

  - PBMs, by definition, operate in a consolidated and competitive market, using similar or identical operating standards and many of the same techniques for managing costs. This makes it easier to create, bid and measure the evaluation criteria for qualifying entities

  - Costs, while they do vary by geographic region due to differences in prescribing patterns, are more uniform across than other health care costs since the underlying cost structures are more consistent. This makes creating and evaluating reference premium bids more straightforward

- A competitive PBM model would be more aligned with other competitive models for Medicare whereas a single-PBM approach would be more difficult to integrate. A health plan's programs or administration could conflict with those of a single-PBM but plans would have more opportunities to negotiate such terms with a competitive PBM that was operating in the region.

- For a competitive PBM approach, it may be more feasible to have formularies. In this instance, the questions specific to this model are:

- Whether formularies would be required in this approach or whether they would be optional, making them a feature upon which PBMs compete.

- Whether PBMs would be allowed to enhance benefits in order to differentiate formulary from non-formulary drugs. If not, then the only other true formulary approach is for a closed formulary model, which may be less acceptable.

- Whether a medical exceptions process is needed if beneficiaries can access non-formulary prescriptions directly (albeit for a higher cost).

- How a national P&T committee would monitor the activities of the PBMs. In this model, the final drug decisions would be made by the PBM but they would need to conform to the rules set out by the national P&T committee.

Risk Sharing by PBMs

In designing the overall program, it will be important to decide whether the intent is to put PBMs at financial risk in some way for their role in controlling costs. There are different ways to do this. One would be to use performance guarantees based on certain metrics. These would measure the PBMs against specific metrics (e.g. measuring generic index[16] or formulary compliance) and have them put a certain amount of money at risk for their performance (such as a portion of their administrative fees and rebates, if any). Another would be to hold PBMs responsible for a portion of the actual drug costs, such as would happen if they were to enhance the benefits in a competitive model approach. Depending on the particular goal, many of the features of the program could be affected. In general:

- PBMs would be extremely unlikely to take financial risk for *all* of pharmacy costs

- Performance guarantees may be the best way, in a single-PBM approach, to hold the PBMs accountable for their performance.

- The more financial risk a PBM takes on, the more degrees of freedom (in terms of program flexibility) they would need in order to manage that risk. This means that that a more likely approach when considering partial risk sharing would be a competitive PBM model

- A model where PBMs took partial financial risk for pharmacy costs could require a risk adjustment mechanism to adjust for risk differences between PBMs and what was assumed in any reference premium pricing.

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[16] A generic index measures what percent of total opportunities to dispense generic were actually taken. This measure is better at reflecting generic performance than a flat generic dispensing target because a) generic dispensing is seasonal and b) the extent of generic dispensing opportunities change as drugs fall off patent.

Conclusion

Pharmacy benefit managers can play a major role in the integration of prescription drug coverage into the Medicare program and use their existing infrastructures, technologies and relationships to help control drug costs. Given the potential cost of providing a prescription drug benefit under Medicare, these program changes should be carefully thought out. It is also important to give the government and the pharmacy benefits managers the maximum amount of flexibility in designing the prescription drug program. Fundamental issues will need to be decided which will impact other aspects of how the program is set up. These include whether a single or multiple PBM contract will be used, the nature and extent of a drug formulary and the extent to which various cost containment mechanisms will be used and structured.

United States General Accounting Office

GAO

Testimony

Before the Committee on Finance, U.S. Senate

For Release on Delivery
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PRESCRIPTION DRUG BENEFITS

Applying Private Sector Management Methods to Medicare

Statement of William J. Scanlon, Director
Health Financing and Public Health Issues
Health, Education, and Human Services Division

GAO/T-HEHS-00-84

Mr. Chairman and Members of the Committee:

I am pleased to be here as you discuss issues related to a potential Medicare outpatient prescription drug benefit. In previous hearings before this and other committees, GAO has addressed considerations for adding a prescription drug benefit to Medicare, in light of the fiscal imbalance of the Medicare program and the need to implement major reforms to ensure the sustainability of the program. Today, you asked us to provide information on the methods used by private insurers, managed care plans, and employers to control their prescription drug expenditures, and the applicability of those approaches to Medicare. My remarks will focus first, on the factors contributing to the rise in prescription drug spending and the impact of the rise in spending on Medicare beneficiaries, particularly those without coverage. Next, I will outline the methods private insurers, including those offering Medicare+Choice managed care products to Medicare beneficiaries, have developed to manage these rising costs. Finally, I will discuss whether and how Medicare can adapt these methods to control spending, should an outpatient prescription drug benefit be added to Medicare.

In summary, private insurers, managed care plans, and employers have tried to manage the high and rising costs of prescription drugs by adopting cost and utilization control techniques. In many cases, insurers and managed care plans contract with a pharmacy benefit management company (PBM) to develop and implement these strategies. If a prescription drug benefit were added to the Medicare program, the federal government would face similar cost pressures and would need to employ methods to control spending. The experience gained in the private sector can provide useful insights into options for managing a possible Medicare benefit. However, the unique responsibilities and characteristics of the Medicare program raise a number of issues and introduce questions about applying private sector tools to the traditional Medicare fee-for-service program and the appropriate roles of the Health Care Financing Administration (HCFA) and other entities, such as PBMs, in managing a drug benefit. In adapting these cost and utilization management techniques, it is important to keep in mind that: (1) strategies involving coverage restrictions impose an obligation to provide beneficiaries with adequate information about the benefit; (2) the size of the Medicare program and the need for transparency in its actions may reduce the effectiveness of some cost-control techniques; (3) using private sector entities to implement a drug benefit introduces concerns related to beneficiary equity and concentrating market power; and (4) private sector management tools require a capacity to process and scrutinize a large number of claims more quickly than is typical of the traditional Medicare program.

RISING DRUG SPENDING ELEVATES BENEFICIARY ACCESS CONCERNS AND THE IMPORTANCE OF COST CONTROLS

Extensive research and development over the past 10 years has led to the introduction of new, more expensive drug therapies—including improvements upon existing drug therapies and drugs that treat diseases more effectively—which have contributed to the increase both in prescription drug use and drug spending. For example, new drug treatments for arthritis and depression have therapeutic advantages over older medications, but they are also more expensive than the drugs they replace. Biotechnological advances and a growing knowledge of the human immune

system are significantly shaping the discovery, design, and production of drugs. As a result of these innovations, the importance of prescription drugs to health care delivery has grown.

Rise in Prescription Drug Spending Caused by Many Factors

Prescription drug expenditures have grown significantly in the past 5 years, both in total and as a share of all health care expenditures. From 1993 to 1998, prescription drug spending rose an average of 12.4 percent a year, compared to a 5 percent annual growth rate for overall health care expenditures. Consequently, drug spending comprised a larger share of total health care spending by 1998—rising from 5.6 percent to 7.9 percent. Total drug expenditures have been driven up by both greater use of drugs and the substitution of higher-priced new drugs for lower-priced existing drugs.

Several factors have contributed to rising expenditures--more third-party coverage of drugs, the introduction of new drug therapies, and more aggressive marketing by manufacturers through direct-to-consumer advertising. The increase in prescription drug coverage provided by private insurance is a likely contributor to the rise in utilization because insured consumers are shielded from the direct costs of prescription drugs. In 1988, private health insurers paid almost a third of all prescription drug expenditures. By 1998, that share had risen to more than a half. The development of new, more expensive drug therapies—including new drugs that replace old drugs and new drugs that treat disease more effectively—also contributed to the drug spending growth by driving up the volume of drugs used as well as the average price of medications. Advertising pitched to consumers is also a likely contributor to the increased utilization of prescription drugs. Between March 1998 and March 1999, the pharmaceutical industry's spending on advertising grew 16 percent, to $1.5 billion. A 1999 study found that the 10 drugs most heavily advertised to consumers in 1998 accounted for about 22 percent of the total increase in drug spending between 1993 and 1998.[1]

Medicare Beneficiary Drug Coverage and Utilization

Elderly individuals, with their greater prevalence of chronic conditions, represent a disproportionate share of drug spending. On average, in 1996, Medicare beneficiaries had estimated annual drug spending of about $674 per person,[2] compared to an estimated $156 per person for the nonelderly population.[3] A more recent estimate projected that 20 percent of Medicare beneficiaries would have drug costs of $1,500 or more in 1999, a substantial sum for

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[1] Barents Group LLC for the National Institute for Health Care Management Research and Educational Foundation, *Factors Affecting the Growth of Prescription Drug Expenditures* (July 9, 1999), p. iii.

[2] GAO calculation based on J.A. Poisal and G.S. Chulis, "Medicare Beneficiaries And Drug Coverage," *Health Affairs* (Mar./Apr. 2000), p. 252.

[3] Agency for Health Care Policy and Research Center for Cost and Financing Studies, National Medical Expenditure Survey data, "Trends in Personal Health Care Expenditures, Health Insurance, and Payment Sources, Community-Based Population, 1996-2005" http://www.meps.ahrq.gov/nmes/papers/trends/96-05(c).pdf (Aug. 1998), p. 9 (cited Mar. 16, 2000).

those lacking some form of insurance to subsidize their drug purchases.[4] In 1996, beneficiaries who had no drug coverage and were in poor health had estimated mean annual drug expenditures that were $591 lower than beneficiaries with similar health status who had drug coverage.[5] This indicates that the lack of prescription drug coverage may cause access problems, particularly for those in poor health.

Although the Medicare benefit package, largely designed in 1965, provides virtually no outpatient drug coverage, more than two-thirds of Medicare beneficiaries had at least some prescription drug coverage in 1996. Almost one-third of beneficiaries had employer-sponsored health coverage, as retirees, that included drug benefits. About 17 percent of Medicare beneficiaries had coverage because they chose to enroll in a Medicare+Choice plan or purchase a Medigap policy with such coverage. About 10 percent of beneficiaries received coverage through Medicaid.

The rising cost of prescription drug benefits has driven employers, insurers, and managed care plans to adopt new approaches that limit total drug coverage or increase enrollees' out-of-pocket costs. Although employer-sponsored health plans provide drug coverage to the largest segment of the Medicare population with coverage, there are signs that this could be eroding. Fewer employers are offering health benefits to retirees eligible for Medicare and those that continue to offer coverage are asking retirees to pay a larger share of costs. In addition, the drug benefits offered by Medicare+Choice plans have become less generous. Many plans restructured their benefits in 2000, increasing enrollees' out-of-pocket costs and limiting their total drug coverage.

PRIVATE-SECTOR TECHNIQUES FOR CONTROLLING DRUG EXPENDITURES

During this recent period of rising prescription drug spending, insurers and HMOs have adopted a variety of techniques to control enrollee utilization and the prices they pay for drugs. Many insurers and HMOs contract with PBMs to develop and implement these cost control techniques and to perform other activities related to managing the drug benefit. Direct negotiations with drug manufacturers yield lower prices through manufacturer rebate agreements. Because rebates generally depend on the volume of the products purchased, employers or HMOs use techniques to concentrate their enrollees' drug purchases to be able to use market power to maximize rebates. This is accomplished through the use of a formulary. Cost-control techniques also extend to the drug distribution network, with emphasis on negotiating reimbursement rates and dispensing fees with pharmacies and encouraging the use of mail-order pharmacies to lower distribution costs. Insurers or PBMs also perform other functions to manage a drug benefit, control spending, and ensure quality of care such as monitoring drug use when the pharmacist is filling the prescription to enable the substitution of lower-priced products or to identify possible adverse drug reactions. They also use claims data to monitor patterns of patient use, physician prescribing practices, and pharmacy dispensing practices.

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[4] M.E. Gluck, "National Academy of Social Insurance Medicare Brief: A Medicare Prescription Drug Benefit," http://www.nasi.org/Medicare.medbr1.htm (Apr. 1999), p. 8 (cited Apr. 22, 1999).

[5] GAO calculation based on J.A. Poisal and G.S. Chulis, "Medicare Beneficiaries And Drug Coverage," *Health Affairs* (Mar./Apr. 2000), p. 252.

PBMs originated as claims processors and mail-order or managed care pharmacies. Today, they provide a wide range of services—such as claims processing, formulary management, and pharmacy network development—to HMOs, insurance carriers, Blue Cross Blue Shield plans, plans that cover federal and state employees, and union members. According to the Pharmacy Care Management Association, the PBM industry's trade association, PBMs manage about 1.8 billion prescriptions annually, or about 70 percent of all prescriptions dispensed to ambulatory care patients. According to a recent estimate, PBMs are responsible for managing the drug benefits for about 71 percent of the 194 million people with third party pharmacy coverage.[6] There are more than 140 PBMs, which range in size, scope, and services provided. Some administer prescription drug benefits nationwide; others focus on serving clients in particular regions of the country.

PBMs and insurers negotiate rebates from drug manufacturers and thus lower the net prices they pay for drugs. According to a 1996 study, manufacturers' rebates averaged 5 to 6 percent of total drug costs.[7] This average masks what may be considerable variation across products. The negotiated rebate is typically dependent on the purchasing power of the PBM or insurer, the availability of several brand-named drugs in a therapeutic class, and assurances of a particular level of utilization of the product.

Insurers or PBMs employ various strategies to channel drug utilization to products for which they have rebate agreements that are based on market share. Generally, this js done by using a formulary, a list of prescription drugs, grouped by therapeutic class, that a health plan or insurer prefers and may encourage physicians to prescribe and beneficiaries to use. A particular product may be included on the formulary because of its medical value or because of a favorable price negotiated with the manufacturer. The inclusion of a particular drug on a formulary can affect its utilization, which can increase the level of manufacturer discounts or rebates, and lower a drug's net cost.

Formularies are structured and implemented to steer drug choice when therapeutically equivalent options are available. Closed formularies, which restrict insurance coverage to only selected drugs and require enrollees to pay the full cost of nonformulary drugs, may be the most effective in channeling utilization. However, closed formularies have faced resistance from beneficiaries and providers because they can lead to higher enrollee costs or restrict access to certain medicines. As a result, more insurers are moving to incentive-based formularies that offer enrollees lower copayments for the preferred product or generic drugs. The insurer continues to cover drugs that are not on the formulary, but the beneficiary faces a higher copayment. A third type, open formularies, is often referred to as "voluntary" because physicians and beneficiaries may be informed about preferred drugs, but beneficiaries pay no more for using nonformulary drugs. Formularies that provide the strongest financial incentives to beneficiaries to choose one product over another offer more cost control potential. They can be used to steer utilization to

[6] Testimony of Jeff Sanders, Senior Vice President, Value Development, PCS Health Systems, Inc., before the Senate Committee on Finance, June 23, 1999. http://www.senate.gov/~finance/6-23san1.htm

[7] A. Cook, T. Kornfield, and M. Gold, Mathematica Policy Research, Inc. for The Henry J. Kaiser Family Foundation, *The Role of PBMs in Managing Drug Costs: Implications for a Medicare Drug Benefit* (January 2000), p. 20.

lower-priced products, including generics, and concentrate market share to elicit the best prices or largest rebates on particular products. In doing so, however, they may produce dissatisfaction among consumers, who have to pay more out-of-pocket for nonformulary drugs, and physicians, who believe formularies restrict their prescribing practices.

PBMs and private insurers have also targeted drug distribution costs as an area for cost savings. 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. PBMs attempt to enhance their leverage with retail pharmacies by limiting the size of the pharmacy network. Restricting the number of pharmacies in the network can benefit participating pharmacies by increasing each one's market share, and as a result, make them more willing to provide larger discounts on the prescriptions they fill. Potential savings from this cost-control technique, however, must be balanced with the inconvenience of a limited pharmacy network. PBMs may also operate mail-order pharmacies that allow enrollees to obtain prescriptions by mail. This is a cost-effective way of dispensing drugs, particularly maintenance drugs for chronic health conditions, such as high blood pressure or asthma.

The claims processing capabilities of PBMs enable them to engage in other activities that may help control overall health care expenditures or improve quality of care. For example, drug utilization review (DUR) programs analyze patterns of drug use on a real-time basis when a pharmacist is actually filling a prescription. These programs use databases and computer systems that include a patient's entire drug utilization history for all network and mail-order pharmacies. These systems identify instances in which a drug may be inappropriate for a particular patient given a person's medications or age. Most PBMs use system edits specifically tailored to particular types of beneficiaries, such as people who are 65 years of age or older who may have a difficult time tolerating certain medicines. Such interventions can both improve quality of care and prevent additional health care costs by reducing drug interactions or flagging evidence of inappropriate use, such as early refills. DUR can also be conducted retrospectively, usually on a monthly or quarterly basis, to profile physician prescribing practices, pharmacy dispensing practices, or patient utilization. The results of retrospective DUR programs are used to encourage physicians to prescribe less costly therapeutic alternatives or generics, encourage pharmacies to substitute generics or preferred formulary drugs for more expensive nonformulary drugs, and ensure that some patients are not overutilizing prescription medicines.

APPLYING PRIVATE-SECTOR TECHNIQUES TO A DRUG BENEFIT WITHIN MEDICARE

Private-sector entities have attempted to control the growth of prescription drug expenditures while preserving or enhancing the value of drug coverage for beneficiaries. As you consider methods to manage a potential Medicare benefit, these private sector techniques offer a useful starting point. I would like to discuss four issues to consider in adapting these methods to the unique characteristics of Medicare and its beneficiaries.

- In a competitive model for Medicare--such as exists today with Medicare+Choice or the models envisioned in some reform proposals--cost-containment strategies involving

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restrictions on coverage through formularies or pharmacy networks impose an obligation to adequately inform beneficiaries about plan policies.

- Adaptation of PBM techniques within the traditional fee-for-service Medicare program could be difficult given its size and the need for transparency in its actions.
- Contracting with private-sector entities to administer a drug benefit for traditional Medicare using cost and utilization controls would raise other challenges.
- The efforts of PBMs to control expenditures involve a capacity to scrutinize claims more effectively and quickly than is typical of Medicare today.

Medicare Beneficiaries' Experiences With Drug Benefit Management In Medicare HMOs

The efforts of PBMs to control costs through the use of formularies and restricted pharmacy networks can affect beneficiaries' access to the drugs they need, their out-of-pocket costs, and the overall value of the benefit. When beneficiaries have a choice of health plans with drug coverage, it is imperative that they have sufficient information to select the plan that best suits their needs. Our work on the Medicare+Choice program has demonstrated that attention and vigilance are required to ensure beneficiaries can make such informed choices.

Our previous work has identified a number of factors that make it difficult for beneficiaries to determine which Medicare+Choice plan best meets their needs. In some cases, detailed information about plans' benefits and out-of-pocket fees is provided only after a beneficiary enrolls in a plan. In other cases, detailed information may be available before enrollment from plan sales agents and member literature, but beneficiaries may find it difficult to compare available options because plans present the information in different formats and use different terms to describe covered benefits. The lack of comparative information can be particularly problematic when evaluating plans' drug benefits, because many design characteristics determine the true value of the drug coverage.

Comparing plans' drug benefits can be difficult because formulary types and management techniques differ considerably, affecting the benefit. A beneficiary may not be aware of formulary changes until they are at the pharmacy counter. Aggressive formulary management may control spending, but beneficiaries need to be aware of how it may affect their access to a particular medicine and the prescribing practices of their physicians. Such issues present even greater challenges in the management of a drug benefit for the entire Medicare population.

Adding a Drug Benefit to the Traditional Medicare Program Raises Issues About the Feasibility of Applying PBM Techniques

It may be difficult for the traditional fee-for-service Medicare program to administer a drug benefit using private-sector management techniques such as formularies. Traditional Medicare has generally established administrative prices for services such as physician or hospital care and then processed and paid claims with few utilization controls. Adopting some of the techniques used by private plans and insurers might have the potential for better cost-control. However,

adapting those techniques to deal with the unique characteristics and size of the Medicare program raises many questions. Because the traditional Medicare program may be unable to operate with the flexibility that PBMs have in the private sector, it may rely on other pricing strategies to try to exact lower prices from manufacturers, such as the Medicaid rebate agreements.

Having a formulary would enhance Medicare's ability to control costs by enabling it to negotiate significantly discounted prices with manufacturers by promising to deliver a larger market share for a manufacturer's product. Yet, implementing a formulary and other utilization controls could prove difficult for Medicare. Determining whether a drug should be on the formulary and which drugs should be preferred, typically involves clinical evaluations based on a drug's safety and effectiveness, and decisions on whether several drugs are therapeutically equivalent. A pharmacy and therapeutics committee within the health plan or a PBM may make these decisions. Plans and PBMs currently make formulary determinations privately—something that would not be tolerable for Medicare, which must have transparent policies that are determined openly. Given the stakes involved in a drug being selected as preferred on a Medicare formulary, one can imagine the intensive efforts to offer input to and scrutinize the selection process. In addition, once the formulary is in place it may be difficult to steer utilization or withstand pressure to allow access to non-formulary drugs, especially in the fee-for-service environment, where it may be hard to influence prescribing practices.

If Medicare covered all drugs in a therapeutic class on the same terms, beneficiaries may not be influenced toward particular drugs and thus manufacturers would have no incentive to offer deep discounts. Without a promised share of the Medicare market, manufacturers may determine they could reap greater returns from charging higher prices and concentrating marketing efforts on physicians and consumers to influence prescribing patterns.

If Medicare cannot effectively operate a formulary, it may have to rely instead on administratively determined prices. These could be similar to the manufacturer rebates received by the Medicaid program, which is currently the largest government payer for outpatient prescription drugs, comprising about 17 percent of national expenditures on outpatient drugs. Since the enactment of the Omnibus Budget Reconciliation Act of 1990 (OBRA), drug manufacturers are required to provide rebates to state Medicaid programs on outpatient drugs based on the "lowest" or "best" prices they charged other purchasers. In return for the rebates, state Medicaid programs maintain open formularies that permit reimbursement for all drugs. Although states have received billions of dollars in rebates from drug manufacturers since OBRA's enactment, state Medicaid directors have expressed concerns about the rebate program. The principal concern involves OBRA's requirement for open formularies, which limits the utilization controls Medicaid programs can use at a time when prescription drug expenditures are increasing rapidly.

Contracting with PBMs Presents Other Challenges for Medicare

Using PBMs or other similar entities to administer a Medicare drug benefit could potentially mitigate some of the likely difficulties that the program would face in attempting to apply private

sector strategies. But such an arrangement raises additional questions about how private sector techniques could be applied within Medicare. PBMs could potentially face some of the same difficulties mentioned previously—namely, their usual cost and utilization management tools may be blunted in the Medicare context due to the scrutiny their policies may face. Moreover, the decision to use a single or multiple PBMs for the entire country or one or multiple PBMs per region has the potential to affect the ability of the PBM or PBMs to control the cost of a Medicare drug benefit and to alter the value of the benefit available to different beneficiaries.

A single PBM contractor administering a Medicare drug benefit would likely be subject to the same level of scrutiny as a government entity. Such scrutiny may compromise the flexibility PBMs typically have used to generate savings. An alternative would be to grant flexibility to multiple PBMs that are responsible only for a share of the market. Contracting with multiple PBMs, though, raises other issues. If each PBM had exclusive responsibility for a geographic area, beneficiaries who want certain drugs could be advantaged or disadvantaged merely because they live in a particular area. This kind of geographic variability may be difficult for Medicare to sustain. While it is true that such variability exists in the Medicare+Choice program, individuals enrolled in a Medicare+Choice plan have chosen to enroll and accept the terms of the benefit. For beneficiaries in traditional Medicare, their regional PBM may be their only drug coverage option. To reduce variation, Medicare could, like some private-sector purchasers, specify core benefit characteristics or maintain clinical control over formulary decisions instead of delegating those decisions to the PBMs. However, without the ability to create and manage a formulary, PBMs would have less flexibility to use techniques that have been integral to their efforts to maximize price discounts and control overall costs.

If multiple PBMs operate in each area, beneficiaries would choose one to administer their drug benefit. PBMs would compete for consumers directly, unlike the private-sector where they normally compete for contracts with insurers or other purchasers. With multiple PBMs, issues would arise regarding informing beneficiaries about the differences in each PBM's policies, monitoring the PBMs' marketing and recruitment strategies, and accounting for differences in health status of beneficiaries using each PBM. Having more than one PBM in an area may also dilute the market power of each PBM, because they would individually control fewer beneficiaries and need to be concerned about retaining beneficiaries. Having PBMs compete for beneficiaries may create an incentive for the PBM to have less stringent formularies, if all beneficiaries are subject to the same cost-sharing requirements regardless of the PBM they use.

The competitiveness of a bidding process for contracts to administer a Medicare drug benefit would depend, in part on, the size of the region for which PBMs compete. One recent study showed that the PBM industry is competitive, but that it is dominated by a few large companies.[8] If a contract were awarded for the entire country or a few large regions, these large companies may have an advantage. Large regional contracts would concentrate Medicare's market power in these few firms, giving them more leverage to negotiate with manufacturers. If PBMs competed for smaller areas, more regional PBMs may bid to provide services in their region. Awarding more contracts that cover fewer beneficiaries may encourage participation by a greater number

[8] A. Cook, T. Kornfield, and M. Gold, Mathematica Policy Research, Inc., for The Henry J. Kaiser Family Foundation, *The Role of PBMs in Managing Drug Costs: Implications for a Medicare Drug Benefit* (January 2000), p. 41.

of PBMs, but may also dilute the overall market power associated with providing a drug benefit to Medicare beneficiaries. It may also be more burdensome to administer more PBM contracts.

Drug Benefit Administrative Functions
are Unlike Traditional Medicare Activities

PBMs' ability to administer formulary policy and impose other utilization controls involves a capacity to process and scrutinize claims that is very different from traditional Medicare's handling of claims for other services. For example, PBMs have the ability to provide on-line, real-time drug utilization reviews. These serve as a quality- and cost-control function by supplying information to pharmacists regarding such things as whether a drug is appropriate for a person based on his or her age, medical conditions, and other medications, as well as whether the drug is covered on the formulary, and what copayments will apply. Currently, Medicare does not typically manage utilization of services in this fashion. It does not have the capacity to conduct real-time review of most services. Instead, Medicare pays claims after services have been delivered. In the current Medicare program, analysis of utilization patterns for individual services or providers is only possible after all claims have been submitted and assembled. Nevertheless, Medicare's administrative costs historically have been extremely low, averaging about 2 percent of the cost of the services themselves.[9]

Duplicating the type of controls PBMs have exercised over private-sector drug benefits will likely involve devoting a larger share of total expenditures to administration than is currently expended in the traditional Medicare program. The magnitude of the increase is difficult to estimate. Much depends on what services PBMs are asked to provide and how much of the Medicare drug benefit each PBM will administer. Even if the dimensions of the PBM's or contractor's role are specified, estimating the likely costs remains problematic. A Medicare drug benefit will be a large-scale endeavor. The number of prescriptions for Medicare beneficiaries could easily approach the current number of claims for all other services combined or about 900 million annually. It is unclear how much PBMs or others would have to increase current capacity or instead use more of the capacity already built into their information and claims processing systems--a consideration that could significantly affect the administrative costs that may be incurred.

CONCLUDING OBSERVATIONS

There is growing consensus that Medicare needs to change its benefit structure to include outpatient prescription drug coverage. Yet such an undertaking has substantial consequences for the cost of the program. In fact, one recent study suggests that such an expansion would add between 7.2 and 10 percent annually to Medicare outlays.[10] The structure of such a new benefit—whom it would cover and the extent of its coverage—is an important determinant of the added cost. This is why, in previous hearings, the GAO has emphasized the need to make prescription drugs more affordable to beneficiaries who lack coverage by expanding access to group rates, extending discounts associated with group purchasing, and targeting government

[9] Medicare: HCFA Faces Challenges to Control Improper Payments, (GAO/T-HEHS-00-74,Mar. 9, 2000).
[10] Gluck, p. 8.

subsidies for those most in need. To the extent that this is accomplished through expanding Medicare's benefit package, cost-control methods need to be incorporated into the management of the benefit. The private sector has developed and refined techniques, which have been implemented in some Medicare+Choice plans and private health plans, to control prescription drug costs. Applying these techniques to the larger Medicare population will require adaptations that may diminish their effectiveness.

The challenge in adding prescription drug coverage to the Medicare program will be in designing and implementing drug coverage to minimize the financial implications for Medicare while maximizing the positive effect of such coverage on Medicare beneficiaries. Most importantly, this benefit expansion must be consistent with efforts to ensure the long-run sustainability of Medicare so that the program does not consume an unreasonable share of our productive resources and does not encroach on other public programs or private sector activities. Private sector tools for controlling drug expenditures provide options for controlling drug expenditures. However, how to apply these tools effectively to a Medicare drug benefit presents a number of challenges and requires careful consideration of the nature and magnitude of the Medicare program.

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Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other Committee Members may have.

GAO CONTACTS AND ACKNOWLEDGEMENTS

For future contacts regarding this testimony, please call William J. Scanlon, Director, Health Financing and Public Health Issues, at (202) 512-7114 or John C. Hansen, Assistant Director, Health Financing and Public Health Issues, at (202) 512-7105. Other individuals who made key contributions include Laura A. Dummit, Kathryn E. Linehan, and Myrna Pérez.

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United States General Accounting Office
Washington, DC 20548

Health, Education, and
Human Services Division

March 29, 2000

The Honorable William V. Roth, Jr.
Chairman
Committee on Finance
United States Senate

Subject: Medicare: Administrative Costs Associated with a Potential Prescription Drug Benefit

Dear Mr. Chairman:

During our recent testimony before the Committee, Prescription Drug Benefits: Applying Private Sector Management Methods to Medicare (GAO/T-HEHS-00-84, March 22, 2000), you asked us to provide you with preliminary information on the potential administrative costs of a Medicare outpatient prescription drug benefit. This correspondence responds to your request.

To develop this information, we contacted representatives of the Health Care Financing Administration (HCFA), the Congressional Budget Office (CBO), and two large pharmacy benefit management companies (PBM) that manage prescription drug benefits for many health plans. We also reviewed actuarial studies concerning the design of a Medicare prescription drug benefit.

According to a HCFA official, in fiscal year 1998, HCFA spent about $1.74 billion for fiscal intermediary and carrier contracts to provide administrative services related to the traditional Medicare program. This includes about $760 million for processing almost 860 million Part A and Part B claims, about $545 million for program integrity activities, and about $277 million for beneficiary and provider services.

There are no estimates of the cost of administering a Medicare prescription drug benefit. Although HCFA has developed a list of the functions required to administer a prescription drug benefit, it has not estimated the associated costs. PBMs provided estimates of the range of fees they typically charge large health plans for basic administrative services. The PBMs we contacted report that they typically charge from $.25 to $.50 per prescription for these services. Depending on the design of a Medicare drug benefit, the number of prescriptions or claims could approach 820 million a year.

The enclosure describes the functions involved in the administration of a drug benefit and information available on their cost. We will continue to work to gather information on potential costs of these functions to assist you in your deliberations regarding a Medicare drug benefit.

If you have any questions about this correspondence, please call me at (202) 512-7114 or John Hansen at (202) 512-7105.

Sincerely yours,

William J. Scanlon
Director, Health Financing and
Public Health Issues

Enclosure

ENCLOSURE ENCLOSURE

ADMINISTRATIVE COSTS ASSOCIATED WITH A MEDICARE PRESCRIPTION DRUG BENEFIT

The administrative costs associated with a Medicare prescription drug benefit are contingent on many details of eligibility and benefit design that vary considerably in current legislative proposals. As a result, we describe the general functions that would be required to implement a drug benefit and identify factors that could affect the magnitude of associated costs.

AGENCY FUNCTIONS

Some of the functions needed to administer a Medicare drug benefit are similar to those that are performed to administer Medicare Parts A and B and the Medicare+Choice program. For those functions that are already performed, a Medicare drug benefit would result in an incremental increase in HCFA's workload.

Different decisions could be made about which functions would be performed by the agency and which would be carried out by one or more contractors. The functions listed below are the most likely ones for the agency to perform given current Medicare and private insurer practices.

1. Eligibility and Enrollment: To the extent that a drug benefit is distinct from Medicare Parts A and B or Medicare+Choice, beneficiary eligibility and enrollment would need to be determined before services would be covered. These determinations would be similar to current requirements in the existing program, so any costs would be incremental. Costs could increase somewhat if eligibility was contingent upon the beneficiary maintaining continuous drug coverage either through traditional Medicare or Medicare+Choice. HCFA may also need to develop procedures for enrolling and disenrolling beneficiaries in a drug benefit, just as they do for the Medicare+Choice plans. If beneficiaries in the traditional fee-for-service program have a choice of organizations administering their drug benefit, it will be necessary to enroll them on a periodic basis. The costs of these enrollments would depend on how frequently switches were allowed and the number of beneficiaries switching among benefit administrators.

2. Premiums: The premiums for a Medicare drug benefit could be collected in the same way as Part B premiums, which are deducted from Social Security payments. If there are premium subsidies for low-income beneficiaries, then HCFA would need to determine whether a beneficiary was entitled to a subsidy and calculate the amount of the subsidy for that beneficiary. The costs of these determinations will depend upon the frequency (such as, annually or semi-annually), the required documentation (such as, self-completed applications or tax returns) and the number of persons eligible for subsidies. Costs will also be dependent upon the extent to which processing can be done using an existing administrative structure, such as the network of Social Security offices, and the mechanisms used to collect information such as, by mail, by phone, or through automated transfers of administrative records.

3. Contracting: If one or more contractors were engaged to administer a drug benefit, HCFA would need to choose the contractors by soliciting and awarding bids for the services. Although HCFA has a contracting process in place, the unique requirements associated with administering a drug benefit would mean developing new contractor protocols and standards. Administrative costs would increase in accordance with the additional resources expended to develop those new contractor protocols and standards.

4. Payment: HCFA would have to develop contractor payment methods that would provide incentives for the contractor to minimize its costs and to implement policies to minimize the costs of the drug benefit. To the extent that this involved incentive payments to the contractor, HCFA may need to risk adjust these payments to account for differences in beneficiary drug needs that would affect a contractor's ability to meet incentive targets. Developing the payment approaches could involve research and data collection costs, particularly for a risk adjustment method. Risk adjusting the payments could involve collecting beneficiary health status data and correlating these data with drug benefit costs.

5. Oversight and Evaluation: HCFA would need to implement mechanisms to ensure that the contractors provided the contracted services and met minimum performance standards. These would be similar to contractor oversight functions that HCFA currently performs. The number of contracts, the range of contracted services, and the frequency of the contract competitions would determine the costs of this function.

6. Beneficiary Education: HCFA would need to provide information to Medicare beneficiaries about their rights, benefits, and options as a part of the enrollment process for a prescription drug benefit. This information is currently provided via direct mailings, outreach events, a toll-free call center, and an Internet site, so adding information about a drug benefit would involve incremental costs. To the extent that the drug benefit contractor would send information to beneficiaries or providers (for example, formulary restrictions) this information would need to be reviewed and approved by HCFA. This function would be similar to current reviews of Medicare+Choice benefit information. The incremental costs of this review would depend on the number of contractors and their responsibilities.

CONTRACTOR FUNCTIONS

Employers, health insurers, and HMOs often contract with outside organizations, such as PBMs, to administer their drug benefit and control their drug expenditures. PBMs employ a variety of techniques that are administrative and clinical in nature. They also provide access to the infrastructure necessary to deliver a prescription drug benefit. The federal costs related to reimbursing PBMs for their services in managing a Medicare prescription drug benefit would depend on the services for which the government contracts.

ENCLOSURE ENCLOSURE

The types of services PBMs provide include:

1. Basic Administrative Services: Basic administrative services include services that PBMs are able to provide health plans, most on a real-time computerized basis at the point of dispensing in retail and mail-order pharmacies. These services include:

- coverage determination,
- claims processing,
- concurrent drug utilization review, and
- providing materials that describe PBM services and the pharmacies available to beneficiaries.

2. Infrastructure: PBMs also provide access to other services related to delivering a prescription drug benefit and controlling drug expenditures. These include:

- use of the PBM's standard formulary,
- use of the PBM's retail pharmacy network, and
- use of the PBM's mail-order pharmacy.

PBMs also negotiate rebates with drug manufacturers, and share the rebates with the insurer or HMO. Although the share of these rebates is generally determined in contract negotiations, a typical split would give 80 percent of the rebates to the insurer and 20 percent to the PBM.

3. Additional Services: Other services that PBMs may provide include:

- interventions with physicians to obtain compliance with the use of formulary drugs and generics,
- retrospective drug utilization review,
- prior authorization before certain drugs can be dispensed, and
- profiling physician prescribing practices.

According to two large PBMs, the fees for these services vary widely, would not be included in their basic administrative fee, and may not be on a per prescription basis.

The PBMs we contacted told us that they typically charge their customers a fee for basic administrative services that ranges from $.25 to $.50 per prescription. Medicare costs for one or more contractors to help administer a benefit would depend on the terms of the contract with HCFA and the number of claims or prescriptions processed. An analysis of 1996 Medicare Current Beneficiary Survey data indicated that on average, Medicare beneficiaries who had coverage filled about 21

ENCLOSURE ENCLOSURE

prescriptions a year.[1] If a Medicare benefit covers all 39 million beneficiaries, the PBM services could cost from about $205 million to $410 million. If one assumes that the benefit is only for the 12 million beneficiaries without coverage,[2] then the costs could range from about $63 million to $126 million. Alternatively, the CBO estimated that 75 percent of the Medicare population, or about 29 million people, would participate in the drug benefit proposed by the administration, which would yield cost estimates of between $152 million and $305 million.[3]

[1] J. A. Poisal and G.S. Chulis, "Medicare Beneficiaries And Drug Coverage," *Health Affairs* (Mar./Apr. 2000), p. 252.
[2] Based on data from the1996 Medicare Current Beneficiary Survey.
[3] S. Christensen and J. Wagner, " The Costs Of A Medicare Prescription Drug Benefit," *Health Affairs (Mar./Apr.2000), p. 215.*

PREPARED STATEMENT OF HON. BOB SMITH

Mr. Chairman, thank you for the opportunity to share with the Committee my legislation entitled the Voluntary Medicare Prescription Drug Plan Act of 2000, which I will be formally introducing this afternoon.

This bill allow seniors to enroll in a new program under Medicare which provides for prescription drug coverage.

Seniors who join this plan would have a combined Part A and B deductible of $675 which would include all hospital, medical, and drug expenses.

After the deductible is met, seniors would receive 50% coverage of prescription drug costs up to $5,000.

I have spoken to seniors groups and health care providers throughout my state over the last several weeks about this proposal, and I must say, the response has been enthusiastic.

Seniors want a prescription drug benefit. Doctors and nurses understand the importance of providing coverage for seniors because drugs are tremendously expensive in this country.

It would be a victory for seniors and for health care in this country if we could provide this coverage to them.

I have had discussions with many of my colleagues in the Senate who are working on this very issue. We have all heard from our constituents about the importance of prescription drugs.

Senators Breaux and Frist have included prescription drugs in their overall Medicare Reform package. Senator Kennedy, Senators Snow and Wyden, Senator Grams, and Senator Jeffords all have proposed various plans that provide some level of prescription drug coverage in Medicare. Others are also working on this issue.

In a recent Press Conference, President Clinton and Senator Daschle outlined their goals for prescription drug coverage.

Leaving the politics aside, I think the fact that elected leaders from both sides of the isle are looking at this issue of prescription drug coverage is a good thing for seniors.

I have talked with several of my Republican colleagues and it is clear to me that there is overwhelming support for allowing this choice for seniors. The only question is how we can responsibly structure such a program.

But, Mr. Chairman, let me talk about what I heard from seniors in my state—what they are looking for in a prescription drug plan.

First, they are concerned about the solvency of the Medicare program. They want a program that does not add huge new financial burdens to the trust fund or increase the national debt.

Yes, seniors are concerned about the national debt. Just ask them next time you speak to a seniors group.

The President's proposal blows a 168 billion dollar hole in the trust fund, threatening its solvency.

Seniors also don't want new premiums. My plan requires no premium hikes. The President's plan requires a $51 annual premium increase.

The guiding principles of this plan which will likely come as a shock to my Democrat colleagues—are the same principles as the President's and the distinguished Senate Minority Leader's principles for any prescription drug plan.

In addition, I would add three new principles:

One, that the plan be revenue-neutral to preserve and protect the financial integrity of the Medicare Trust Fund;

Two, that the plan does not raise Medicare premiums; and

Three, that full benefits should be provided in 2001, not in 2009, as the President proposes.

My prescription drug plan accomplishes all three of these principles.

Let me briefly explain how my bill works: A senior already enrolled in Medicare part A and B will have the option of choosing my new, voluntary, Prescription Drug Plan which will cover 50% of their prescription drug costs toward the first $5,000 worth of prescription drugs that they purchase.

Medicare Part A has a $776 deductible. Medicare Part B has a $100 deductible—a total of $876. My new plan would create one new deductible of $675 which would apply to all hospital costs, doctor visits, and prescription drug costs.

Once this $675 deductible is met by the Medicare recipient, Medicare will pay 50% of the cost toward the first $5,000 worth of prescription drugs that the senior purchases. However, the senior could not purchase a Medigap plan that would pay for the $675 deductible; this must be paid by the senior.

As a result seniors could save about $550 on their Medigap plans if they traded their current Medigap plan for my new prescription drug plan. Seniors could even use their $550 in savings to help pay the $675 deductible.

But how do you get the cost savings? As my colleagues are aware, according to the National Bipartisan Commission on the Future of Medicare, the federal government pays about $1,400 more per senior if the senior owns a Medigap plan that covers their Part A and B deductible.

This, generally, is because of over-utilization of hospital and doctor visits by the senior.

The savings result because Medicare will not have to pay this $1,400 per person per year out of the Trust Fund.

As I mentioned, all hospital, physician and prescription drug costs would count towards this $675 deductible, and once it was met, the senior would receive regular, above the deductible Medicare coverage.

Or, for those seniors who worked out the numbers, and decided against my plan, they would simply not select it.

I believe that the vast majority of seniors will benefit from this plan—in fact, every senior with a Medigap plan will benefit, and any senior with a prescription drug expenditure of more than $15 a month will benefit. Today, the Medicare Part A and Part B deductible totals $876 which most seniors cover by an average $1,611 Medigap insurance premium.

These estimates, as well as the judgment that this plan is revenue neutral, comes Mr. Guy King, formerly Chief Actuary for the Health Care Financing Administration under President Clinton. I would ask that a letter I just received from Mr. King this morning be included in the Record.

The benefits in this plan are delivered by private competing and regional entities—like Pharmaceutical Benefit Managers. These entities would negotiate with the large drug companies and provide the drugs to Medicare seniors.

Finally, according to the actuaries that reviewed this legislation, there will be no "adverse selection." Both the healthy and the sick will have an incentive to choose this plan.

In conclusion. there are many different methods of providing prescription drug coverage for seniors. I urge my colleagues to look to revenue-neutral methods that fund this benefit by the elimination of waste in the present system. and urge my colleagues to resist the temptation to raise Medicare premiums on the people who can least afford it.

The House's FY2001 budget sets aside S40 billion for prescription drugs, and the Senate is expected to set aside S20 billion. Let's use this money for debt reduction or tax credits for the uninsured rather than providing for prescription drugs when we can use my revenue neutral prescription drug plan instead.

I urge my colleagues to support this bill.

King Associates

Roland (Guy) King, F.S.A., M.A.A.A.
President

March 28, 2000

The Honorable Bob Smith
United States Senate
Washington, D.C. 20510-2903

Dear Senator Smith:

This is in response to your letter of March 9, 2000 asking for my analysis of legislation you intend to introduce in the Senate. The proposed legislation establishes a voluntary prescription drug benefit, the Medicare Prescription Drug Plan, under the Medicare program.

Under the Medicare Prescription Drug Plan, the current Part A and Part B deductibles would be replaced by a single deductible of $675 which would also be applicable to the new prescription drug benefit. The Medicare program would pay fifty percent of the cost of prescription drugs, up to a maximum of $2,500 after satisfaction of the deductible. A beneficiary who chooses the Medicare Prescription Drug Plan would not be allowed to purchase a Medicare supplement policy that fills in the $675 deductible, so special Medicare supplement policies for those who choose the option would be allowed.

The Medicare Prescription Drug Plan would be available, on a voluntary basis, to any Medicare beneficiary not also covered by Medicaid. The possibility of anti-selection is an important consideration for a plan that is available to all Medicare beneficiaries as an option. I believe that the design features of the Medicare Prescription Drug Plan, as outlined in your legislation, minimize the impact of anti-selection.

As you requested, I performed an analysis of the proposed legislation. This analysis is based on Medicare and prescription drug data that I obtained from the Health Care Financing Administration (HCFA). My analysis indicates that the Medicare Prescription Drug Plan, as described above, would be cost-neutral to the Medicare program if it were made available on a voluntary basis to all beneficiaries except those also covered by Medicaid

If you should have any questions regarding my analysis, please don't hesitate to call.

Sincerely,

Guy King

Roland E. (Guy) King, F.S.A., M.A.A.A.

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PREPARED STATEMENT OF HON. OLYMPIA J. SNOWE

Thank you and good morning, Mr. Chairman. I appreciate this opportunity for Senator Wyden and me to address the Committee on the work that we have been doing on our legislation the Seniors Prescription Insurance Coverage Equity Act, or "SPICE."

I also want to commend the leadership of Chairman Roth, Senator Moynihan, and the other members of the Committee who I know have been working hard to improve Medicare and ensure the long-term solvency of the program. As we are all well aware, this is truly a Herculean task.

Finally, let me thank Senators Frist and Kennedy, and Representative Bilirakis for testifying on their bills here today. I think the fact that we have a number of different approaches on the table only underscores the fact that it is no longer a question of should something be done on the issue, but rather what should be done and when.

In my view, a solution to the pressing problem of prescription drug coverage can't come soon enough. In 1998, drug costs grew more than any other category of health care B skyrocketing by 15.4 percent in a single year. And that's a special burden for seniors, who pay half the cost associated with their prescriptions as opposed to those under 65 who pay just a third.

So it should come as no surprise that, according to a study published in the latest edition of Health Affairs, the average senior now spends $1,100 every year on medications. And with the latest HCFA estimates putting the number of seniors without drug coverage at around 31 percent of all Medicare beneficiaries B or about 13 out of nearly 40 million Americans B it's not hard to see why we can no longer wait to provide a solution.

Who are these seniors? They are they people caught in the middle—most of whom are neither wealthy enough to afford their own coverage nor poor enough to qualify for Medicaid. As Jennifer O'Sullivan, CRS specialist, testified before this committee just last Wednesday, in 1996, "The lowest levels of coverage were for persons between 100 percent and 200 percent of poverty. These persons are the least likely to have access to either employer-based coverage or Medicaid."

But even Medicaid is not the answer. According to the Urban Institute, in 1996, 63 percent of beneficiaries eligible for QMB (Qualified Medicare Beneficiary) protections B that is, those under the federal poverty level—actually receive those protections, while only 10 percent of those between 100 and 120 percent of the poverty level—those eligible for SLMB (Specified Low-Income Medicare Beneficiary) protections B are receiving that coverage. And only 16 states—including my home state of Maine—have their own drug assistance programs.

As for Medigap, only 3 out of 10 plans cover prescription drugs. In 1995, only 14.1 percent of people purchasing one of the ten standardized policies purchased one of those three plans. And even they have significant limitations in terms of copayments and deductibles.

Clearly, whatever path we take must provide universal coverage for those who choose to participate. But just as importantly, it must be a package that can garner enough broad-based support to pass into law not next year or the year after but now.

Why did Senator Wyden and I take this approach? When we originally considered a prescription drug program, we wanted to make it part-and-parcel of Medicare. But as our idea developed, we realized that doing so could seriously jeopardize the long-term solvency of the program.

So we purposely designed SPICE outside of Medicare, while at the same incorporating the program's greatest strength—the concept of universal coverage. Every senior in America should have access to prescription drug coverage, regardless of income or where they live. Furthermore, we wanted our program to maximize choice and minimize costs—that meant no new layers of government bureaucracy.

It's no secret that HCFA already has a monopoly on seniors choice in health care. At a time when medicine is at its most flexible and innovative, any plan to cover prescription drugs must be likewise. If history is any guide, the bureaucracy of a new entitlement would only discourage flexibility and innovation. And we know the costs associated with creating a new open-ended entitlement for the Medicare program will likely be prohibitive.

That's why we rely on competition in the marketplace to encourage greater innovation, provide a wider range of options for seniors, and lower costs. If this approach sounds familiar, it should—it's called the Federal Employee Health Benefits Program. And we already know it works.

We establish an independent board, called the SPICE Board, that will have the freedom to work with carriers to create policies that most effectively reflect the

state-of-the-art in medicine. SPICE will allow the use of high-and low-option plans. Plans may or may not use formularies as they see fit—they may even use multi-tiered formularies. At the same time, by having final approval over these plans, the SPICE Board will ensure that Seniors receive the best in consumer protection and that the most appropriate and effective medicines are included in a plan's formulary.

Like FEHBP, anyone enrolled in Medicare will be allowed to choose a privately-offered drug coverage plan that best suits their personal needs. The federal government will subsidize the premiums payable on the plan each senior selects. Benefits are paid on a sliding scale from 25 percent to 100 percent, and participants will remain responsible for any co-pays or deductibles that their plan may have.

The SPICE Board will disseminate information about the various plans. If a senior decides they prefer the coverage they already have, such as their retiree coverage or Medicare+Choice, they can maintain that very same coverage with absolutely no change. It's their choice.

By opening up a potential new customer base of nearly 40 million Americans, insurance companies will have the incentive to design plans that are generous enough, yet inexpensive enough, to attract and retain enrollees. So the argument that companies won't insure for prescription drugs because so many people need them simply doesn't hold water. And that's especially true when you consider the list of insurance policies Alan Holmer of the Pharmaceutical Research and Manufacturers of America provided you last week—the industry will already insure everything from sports accidents to the weather on the day of your daughter's wedding!

In designing any insurance plan, actuaries must always face the issue of "adverse selection." Consequently, they turn to traditional economic constraints such as requiring cost sharing and limiting so-called "first dollar coverage," including catastrophic coverage, allowing insurers to negotiate with manufacturers in order to reduce costs, and establishing a large risk pool. SPICE includes or encourages all these options.

Another point in reducing adverse selection is to ensure the participation of low-income consumers, just as we do by providing enhanced federal assistance for low-income seniors. For those at or below 150 of the federal poverty level B in other words, individuals receiving less than $12,525 per year or couples under $16,875 B 100 percent of the premium will be subsidized. Conversely, for those above 175 percent of the poverty level B individuals over $14,613 per year or couples above $19,688 B 25 percent of the premium would be covered.

Finally, SPICE has the advantage of working with or without Medicare reform—something I've heard time and again is important to seniors, because it means that they don't have to wait for meaningful prescription drug coverage. As I've said, I know members of this committee have spent countless hours and even years wrestling with Medicare reform. And I personally hope we can move forward on this issue sooner rather than later.

But unlike the other plans being discussed, SPICE gives us the best of all possible worlds B a system that can exist outside of Medicare reform, co-exist with a new Medicare regime when it comes, and actually serve as a downpayment on comprehensive reform.

Mr. Chairman, members of the Committee, we all know we need to address this issue. Over the past few months, Senator Wyden and I have received over 6,000 letters and phone calls on this issue alone. Maine seniors tell me their typical prescription drug bills range anywhere from $125 to a whopping $800 a month. I've heard from couples who spend over half of their monthly income on medications . . . I've heard of prices doubling in just six short months . . . I've even heard of one drug that skyrocketed a remarkable 77 percent in a single month.

One woman in Boothbay Harbor wrote to tell me that her doctor prescribed a drug called "Celebrex" for her arthritis. But when the pharmacist informed her it was $215 per hundred pills she, and I quote, "threw away the prescription as I could not afford it."

And a single mother in Fairfield wrote that her parents' prescription costs are almost $400 a month. "Their large medical costs," she wrote, "have reduced their lifestyle to a poverty level . . . My parents are among many elderly who have been forced to choose between high medication costs and other living essentials."

Mr. Chairman, we are honor bound to address this issue in a meaningful way B to work together, to overcome the partisan bickering, and to create a policy that provides real relief for seniors. I believe SPICE provides us with a bi-partisan blueprint to follow, and I appreciate the opportunity to testify here today. I look forward to working with you all and I appreciate your consideration.

I'd be happy to answer any questions you may have.

PREPARED STATEMENT OF JENNIFER O'SULLIVAN

Good morning Mr. Chairman and Members of the Committee. My name is Jennifer O'Sullivan. I am a Specialist in Social Legislation at the Congressional Research Service.

This morning I am going to provide a brief overview of prescription drug coverage for Medicare beneficiaries. I will focus on:

- current coverage of prescription drugs under Medicare;
- surveys of supplemental drug coverage; and
- drug spending by beneficiary income.

The current Medicare program covers drugs when provided in connection with an inpatient stay in a hospital or skilled nursing facility. It also provides coverage for drugs provided by a physician when these drugs cannot be self-administered. However, in general Medicare does not cover outpatient prescription drugs. The two key exceptions are immunosuppressive drugs for a minimum of 3 years following a Medicare-covered organ transplant and certain oral cancer drugs.

Most beneficiaries have private or public insurance coverage to supplement their Medicare benefits. For many, this supplementary coverage includes protection against prescription drug costs. In fact over two-thirds of beneficiaries have some supplementary drug coverage. This coverage can be through a Medicare managed care plan, employer-sponsored retiree health insurance, individually purchased health insurance (known as "Medigap"), Medicaid, or "other" sources such as state sponsored prescription drug programs or Department of Veterans Affairs programs. Figure 1 shows the distribution of drug coverage for Medicare beneficiaries in 1996, the latest year for which we have national data. As can be seen from this figure, the largest single category is persons without coverage. They accounted for about one-third of the total. Persons enrolled in employer-sponsored plans were the largest group with drug coverage.

Figure 1 shows the percentage of beneficiaries with some type of drug coverage. It does not, however, show the extent and depth of coverage, which varies widely. It should also be noted that 1996 may represent a high point. There are indications that coverage may be eroding for certain groups. With this in mind, I'd like to look briefly at the various sources of coverage.

- *Medicare managed care plans.* In the past, many Medicare managed care plans were able to offer prescription drug coverage at little or no cost to beneficiaries. Many of these plans are now increasing costs to beneficiaries by increasing cost-sharing, capping benefits, or, in a few cases, dropping drug coverage.
- *Employer plans.* The percentage of firms offering health insurance to their retirees age 65 and over declined in the late 1980s and early 1990s due to changes in Federal accounting requirements. Subsequently, the percentage of firms offering coverage leveled off. However, very recently there appears to be a new decline. A 1999 study of employee benefits by the Hay Group shows that from 1997 to 1999 there was an 8 percentage point drop (from 55% to 47%) in the number of medium to large firms offering coverage to retirees age 65 and over. For firms with 10,000 or more employees, there was a decline of 6 percentage points (70% to 64%). Virtually all large employers that offer health insurance include outpatient drug coverage. However, many employers with retiree coverage are implementing a number of strategies to cut their drug costs.
- *Medigap.* Beneficiaries purchasing Medigap coverage have a choice of 10 standardized policies labeled A—J. Only 3 of these policies (H, I, and J) offer some prescription drug coverage. All three drug plans impose a $250 deductible and 50% cost-sharing. Plans H and I have a maximum benefit of $1,250 while Plan J has a maximum benefit of $3,000. It is generally believed that only persons who think that they will incur high drug costs actually purchase a Medigap policy with drug benefits. This adverse selection drives up the per capita cost of coverage. A recent estimate shows that the average monthly premium for a 65-year old for a Medigap policy with drug coverage is $164. In many cases, premiums increase significantly as beneficiaries age.
- *Medicaid.* Some low-income aged and disabled Medicare beneficiaries are also eligible for drug coverage under Medicaid. Those entitled to full Medicaid protection have prescription drug coverage. Some groups receive more limited Medicaid benefits. Qualified Medicare Beneficiaries (QMBs) receive Medicaid assistance for Medicare cost-sharing and premium charges. Specified Low-Income Medicare Beneficiaries (SLIMBs) receive Medicaid assistance only for Medicare Part B premiums. QMBs and SLIMBs only receive drug benefits if they are also entitled to full Medicaid coverage.
- *Other Public Sources.* Some beneficiaries may receive coverage through a Department of Defense or Department of Veterans Affairs program. Some bene-

ficiaries also have coverage through a state pharmaceutical assistance program. Fourteen states have implemented pharmacy assistance programs for low-income aged persons not qualified for Medicaid.

There are significant differences both in utilization patterns and expenditures for persons with drug coverage versus those without it. In 1996, the average beneficiary with drug benefits filled 5 more prescriptions than those without coverage (21 versus 16 per person). As would be expected, beneficiaries with coverage also averaged higher overall expenditures. At the same time, out-of-pocket spending was significantly lower for those with coverage compared to those without coverage.

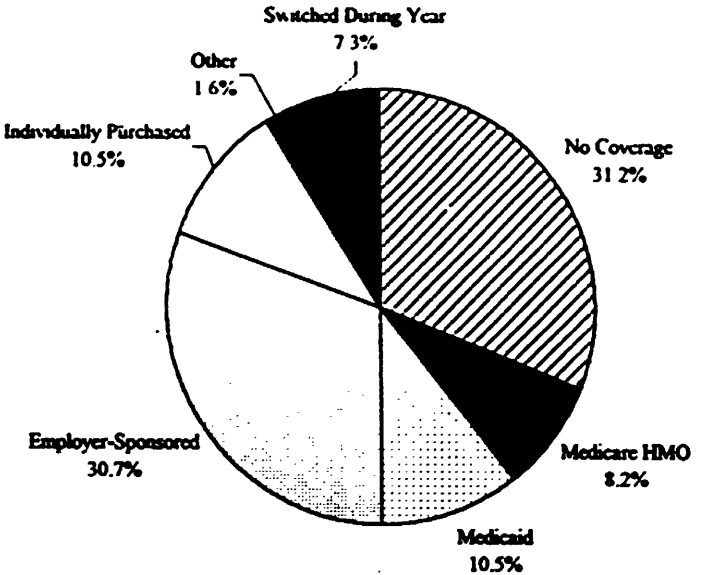
I'd like to turn for a moment to some key findings by income category.

- Figure 2 shows, by income category, the percentage of noninstitutionalized beneficiaries who had drug coverage in 1996. As you can see, persons in higher income brackets tended to have higher levels of drug coverage. This reflects the fact that these persons were more likely to have drug coverage through a former employer. Persons below poverty had coverage levels slightly higher than persons just above poverty. This reflects the fact that many individuals below poverty were eligible for full Medicaid benefits which includes drug benefits. The lowest levels of coverage were for persons between 100% and 200% of poverty. These persons are the least likely to have access to either employer-based coverage or Medicaid.
- Figure 3 shows average annual per capita drug spending by income category. Nationwide, persons without coverage spent $463 per capita in 1996, while those with drug coverage spent $769—nearly two-thirds more. As you can see, higher overall spending appears more closely associated with the presence of drug coverage rather than with income level.
- Overall, beneficiaries pay roughly half of their total drug bill out-of-pocket. Of course, the percentage an individual pays is dependent on whether or not he or she has supplementary coverage. Figure 4 shows average annual out-of-pocket expenditures. Again, persons without drug coverage paid their whole $463 drug bill themselves. Persons with drug coverage paid $253 out-of-pocket or roughly one-third of their total bill. As might be expected from the preceding figure, higher overall out-of-pocket costs are more closely associated with the absence of drug coverage rather than with income level.

In summary, approximately two-thirds of beneficiaries have some coverage for drug costs and one-third do not. Persons in higher income brackets tend to have higher levels of supplementary coverage while the lowest levels are for those between 100% and 200% of poverty. Drug spending is two-thirds higher for those with coverage than for those without. Persons with drug coverage pay roughly one-third of their total bill out-of-pocket. It should be noted that the preceding discussion focuses on averages. There are, of course, wide variations within categories in both the use of drugs and expenditures for these drugs.

Attachment.

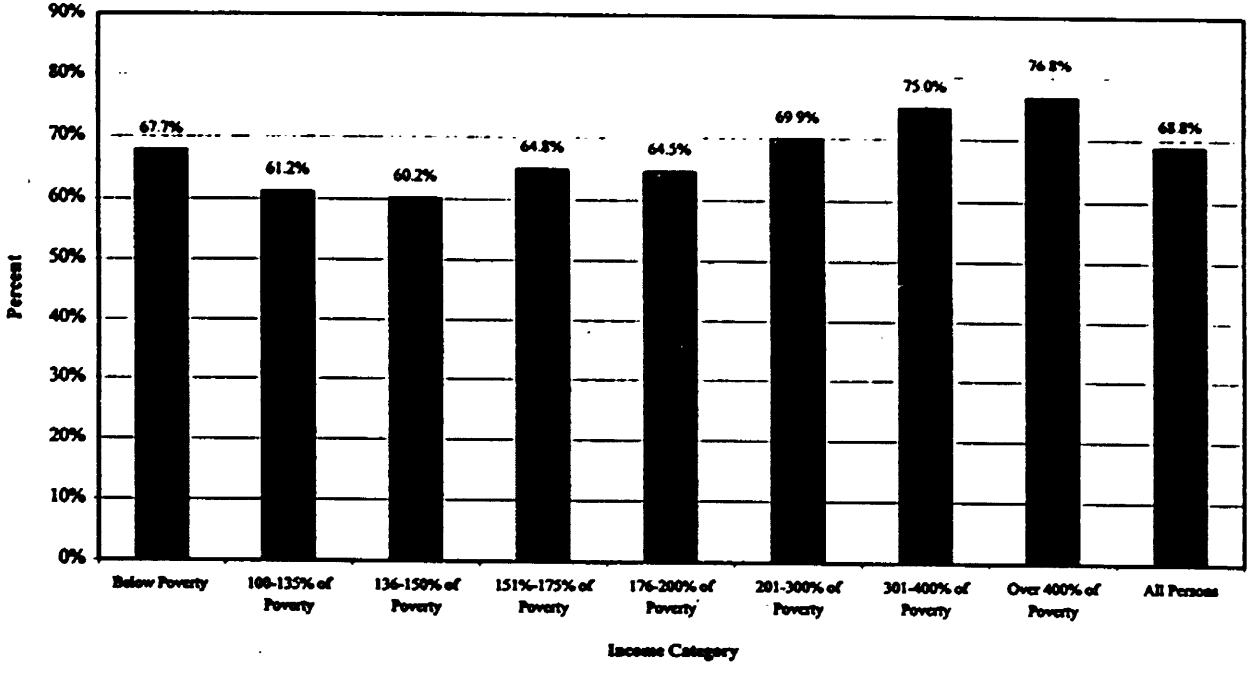
Figure 1. Drug Coverage of Noninstitutionalized Medicare Beneficiaries by Supplemental Insurance Status, 1996



Total with coverage: 68.8%

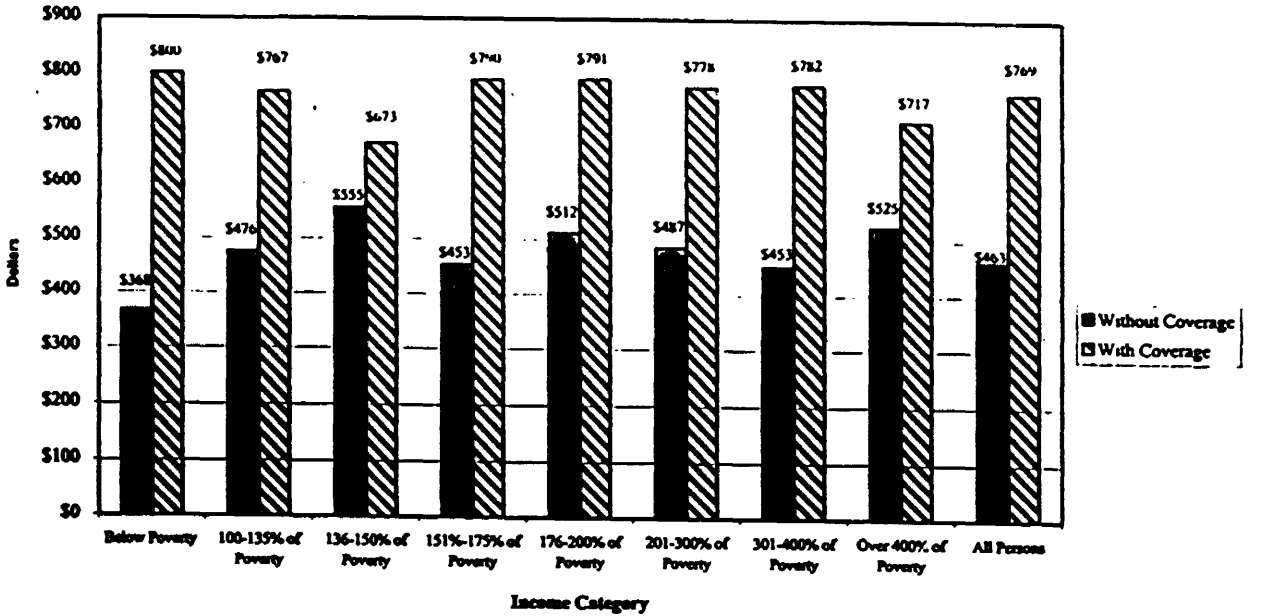
Note: Persons categorized by primary source of supplemental insurance; drug coverage may be from secondary source.
Source : Figure prepared by CRS based on: Poisal and Chulis. Medicare Beneficiaries and Drug Coverage. *Health Affairs*, March/April 2000.

Figure 2. Medicare Beneficiaries with Drug Coverage by Income Category, 1996



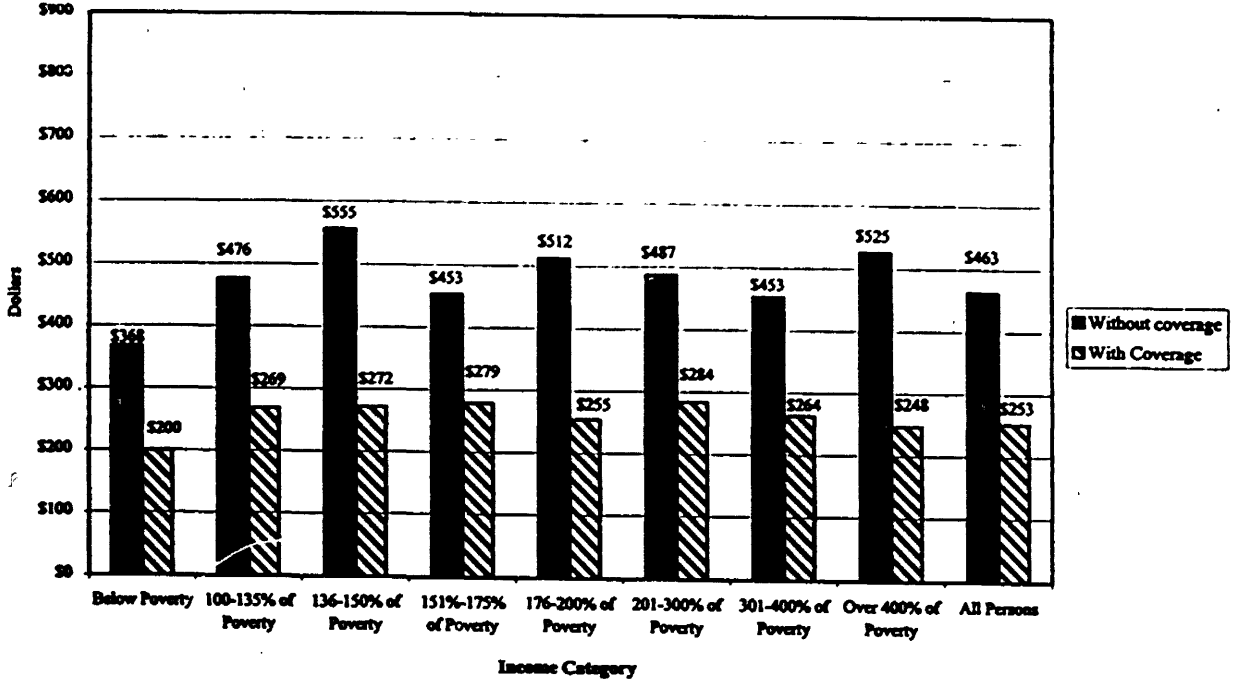
Note: 1996 poverty level for the aged was $7,525 for a single and $9,491 for a couple; the corresponding figures for the disabled were $8,163 and $10,564.
Source : Figure prepared by CRS based on: Poisal and Chulis. Medicare Beneficiaries and Drug Coverage. *Health Affairs*, March/April 2000.

Figure 3. Average Annual Per-Capita Spending for Prescription Drugs for Medicare Beneficiaries by Presence or Absence of Drug Coverage and by Income Category, 1996



Note: 1996 poverty level for the aged was $7,525 for a single and $9,491 for a couple; the corresponding figures for the disabled were $8,163 and $10,564.
Source : Figure prepared by CRS based on: Poisal and Chulis. Medicare Beneficiaries and Drug Coverage. *Health Affairs*, March/April 2000.

Figure 4. Average Annual Out-of-Pocket Spending for Prescription Drugs by Medicare Beneficiaries by Presence or Absence of Drug Coverage and by Income Category, 1996



Note: 1996 poverty level for the aged was $7,525 for a single and $9,491 for a couple; the corresponding figures for the disabled were $8,163 and $10,564.
Source : Figure prepared by CRS based on: Poisal and Chulis. Medicare Beneficiaries and Drug Coverage. *Health Affairs*, March/April 2000.

RESPONSES TO QUESTIONS FROM SENATOR COVERDELL

Questions 1. When we talk about adding a prescription drug benefit to Medicare, I think we all agree that we want to help seniors in the best way possible—and to do so at the lowest possible cost. One of the issues we need to look at in this regard is how do we structure out-of-pocket costs in any drug benefit. How are out-of-pocket costs dealt with in the current Medicare system and how can we address these costs in any reform efforts?

Questions 2. Has anyone on the panel looked at this question of how to structure out-of-pocket costs? Would any of you care to comment on whether significant savings are available in this area without unduly burdening the patient with high out-of-pocket costs?

Answer 1-2: Under the current Medicare program, there are out-of-pocket costs associated with the use of services under both Part A and Part B. Unlike coverage available under typical group insurance plans, there is no upper limit ("catastrophic limit") on the out-of-pocket costs that may be faced by Medicare beneficiaries. However, most beneficiaries have supplementary protection which may pick up some or most of these cost-sharing charges. In these cases, beneficiaries may not be faced with the question of out-of-pocket costs at the point when they use services.

Persons with Medigap have coverage for most or all of their cost-sharing for basic Medicare services. In fact, studies have shown that Medicare expenditures for beneficiaries with Medigap coverage are considerably higher than those for persons with no supplementary protection. This reflects the higher service use among those with supplementary benefits.

Some persons have suggested restructuring standardized Medigap policies to prohibit first dollar coverage. They argue that beneficiaries would be more cost conscious in their use of services, thereby lowering Medicare costs. They further argue that beneficiaries should see a substantial reduction in their Medigap premiums. Other observers note that many beneficiaries are very risk adverse and may not support this approach.

Beneficiaries purchasing Medigap coverage have a choice of 10 standardized policies labeled A—J. Only 3 of these policies (H, I, and J) offer some prescription drug coverage. All three drug plans impose a $250 deductible and 50% cost-sharing. Plans H and I have a maximum benefit of $1,250 while Plan J has a maximum benefit of $3,000. Medicare+Choice plans that offer drug coverage typically have copayment requirements. In 1999, these plans typically had copayments of $5-$10 for generic drugs and $5-$15 for brand name drugs. Information is not available on the extent of cost-sharing imposed under employer plans.

A number of questions would need to be considered in the design of a drug benefit including whether the cost sharing charges, and any catastrophic limit on these charges, would be part of or separate from the basic Medicare package. Another series of questions relates to the interaction of a new drug benefit and any supplementary coverage an individual may have. For example, would a beneficiary be able to obtain private insurance against out-of-pocket drug costs? Some have suggested that some savings could be achieved if beneficiaries were prohibited from purchasing Medigap policies which covered some of these costs.

Another series of questions relates to the size and structure of the cost sharing charges. For example, is there a deductible and how much is that deductible? What level of coinsurance (for example 20% or 50%) is imposed? Is there an out-of-pocket limit? The interaction of these decisions is important and the impact will vary by person. Some argue that a catastrophic limit is particularly important.

Question 3: How can we deal with the issue of adverse selection, where only beneficiaries who need Rx coverage will purchase it, thus causing the premiums to increase?—(target the Administration's proposal.)

Answer 3: The Medicare Part B program has been able to avoid adverse selection because virtually all eligible persons are enrolled. Presumably a new benefit would have to be viewed as sufficiently attractive and sufficiently affordable (from the beneficiary's perspective) to encourage high enrollment. It would also be important to encourage as many persons as possible to enroll at the start of the program. This could be achieved by precluding (or imposing a penalty for) delayed enrollment. It is also important that the program's basic features be fairly easy for beneficiaries to understand. The CBO believes that the President's proposal is attractive enough that most beneficiaries would select Part D.

COMMUNICATIONS

STATEMENT OF THE AMERICAN PHARMACEUTICAL ASSOCIATION

The American Pharmaceutical Association, the national professional society of pharmacists, applauds the attention that Congress, the Administration and other leaders are devoting to the serious problem of increasing seniors' access to medications—one of our most powerful tools in improving health.

The American Pharmaceutical Association (APhA) represents more than 53,000 practicing pharmacists, pharmaceutical scientists and pharmacy students. Many of our members work with seniors every day, and every day must explain that the Medicare program does not include coverage for prescription drugs.

APhA's first preference is for broad Medicare reform that corrects this lack of coverage and simultaneously strengthens Medicare to assure program viability. As many have opined, it is inconceivable that a Medicare drug benefit created today would contain such a significant gap—that a modern health care delivery system would invest so much in diagnosing illness, yet ignore the primary treatment modality of medications used outside the hospital. If, however, such a solution cannot be developed in this Congressional session, APhA strongly supports efforts to expand access to medications for seniors most in need as an interim approach. Such a stopgap measure, building on the experience of State-based senior prescription drug assistance programs, will help seniors while Congress addresses the more difficult problem of Medicare reform and adding coverage for medications and pharmaceutical care. We are pleased to support SenioRxGold, the plan described by Alan Levin, Acting Chairman of the Board for the National Association of Chain Drug Stores, in his statement this morning.

Acknowledging the need to correct the gap (whether in the context of broad reform or within interim approaches to provide short-term assistance to populations most in need) and choosing the mechanism to correct the gap, however, are two very different propositions. Adding a "drug benefit" to Medicare requires more than simply paying for the drug product. Such coverage must include payment not only for the drug product itself, but also include payment for education and training for the consumer to get the most value out of the medication. Without appropriate training and education—a component of broader services known as pharmaceutical care or medication therapy management services—much of the money invested in medication therapy is wasted, wasted because the patient does not get the benefit from improperly used product. For example, what benefit does a patient with asthma receive from an inhaler to manage asthma symptoms, if he uses the inhaler incorrectly?

Pharmaceutical care (medication therapy management services) actively integrates America's 165,000 pharmacists into the patient-care management process, working alongside other providers to ensure that medication therapy is appropriate, safe and effective. Ample evidence shows that a commitment to appropriately reimbursed pharmaceutical care saves lives and dollars throughout the health care system.

Pharmacists are important allies in helping seniors use their medications. The pharmacist is uniquely positioned to reduce the risk of outpatient prescription-medication mistakes among the Medicare population:

- By recognizing and avoiding potential adverse reactions that can arise when a patient is prescribed multiple medications by different providers;
- By identifying and monitoring patients at high-risk of non-compliance because of memory loss, living alone or multiple therapy;
- By observing medication effectiveness, patient tolerance, correct dosing levels and other factors that support physicians in delivering a successful treatment regimen.

An additional component of any expansion of medication access for seniors is the incorporation of administrative simplifications that will ensure an accessible benefit—not more red tape for patients and health care professionals. Incorporating concepts such as a standard identification card and quality clinical support systems will help ensure that seniors not only have access to this benefit for medication and related services in concept, but also have access in reality.

Thank you for the opportunity to provide these comments. We look forward to working with the Committee and all members of Congress on addressing this important issue.

Attachments.

PHARMACEUTICAL CARE: AT THE CORE OF A PATIENT-FOCUSED MEDICARE PRESCRIPTION DRUG BENEFIT

What is pharmaceutical care—and why are medication therapy management services critical to the successful implementation of any Medicare Prescription Drug Benefit?

Pharmaceutical care actively integrates America's 165,000 pharmacists into the patient-care management process, working alongside other providers to ensure that medications are appropriate, safe and effective. Adverse drug events are an avoidable side effect of prescription drug use for 39 million Americans in Medicare. Ample evidence shows that a commitment to appropriately reimbursed pharmaceutical care saves lives and dollars throughout the health care system.

SAVING LIVES—AVOIDING MEDICAL ERRORS

As indicated in The Institute of Medicine report, an estimated 98,000 Americans die every year because of avoidable medical errors. According to a GAO study, one in five—or almost 8 million people in Medicare—are likely to have medication prescribed that could cause them unintended harm.

As the caregiver with extensive drug therapy knowledge, pharmacists are uniquely positioned to reduce the risk of outpatient prescription-medication mistakes among the Medicare population:

- By recognizing and avoiding potential adverse reactions that can arise when a patient is prescribed multiple medications by different providers;
- By identifying and monitoring patients at high-risk of non-compliance because of memory loss, living alone or multiple drug therapies;
- By observing medication effectiveness, patient tolerance, correct dosing levels and other factors that support physicians in delivering a successful treatment regimen.

A HIGH-RETURN INVESTMENT IN PATIENT SAFETY AND QUALITY CARE

Prescription drug-related illness or death costs the U.S. health system between $30-75 billion yearly. Looking at noncompliance alone, patient failure to obtain or renew prescriptions leads to avoidable physician visits and hospital admissions costing an estimated $8.5 billion annually.

Considerable evidence demonstrates that improved patient health and cost-savings follow when pharmacists play an integral role in pharmaceutical care. A 1990 study by the HHS Inspector General concludes, "there is strong evidence that clinical pharmacy services add value to patient care and reduce healthcare utilization costs—Such value includes not only improvements in clinical outcomes and enhanced patient compliance, but also reductions in health care utilization costs associated with adverse drug reactions."

THE EVIDENCE: PHARMACEUTICAL CARE REDUCES MEDICAL ERRORS, PAYS FOR ITSELF IN REDUCED HEALTH COSTS

Pharmacists are moving from behind the counter to play a pivotal role in patient care. Growing evidence shows that the pharmacist, in the appropriately reimbursed role of pharmaceutical caregiver, is able to prevent illness, enhance outcomes and reduce health care costs in the process.

PHARMACEUTICAL CARE HELPS PREVENT MEDICAL ERRORS

According to The Institute of Medicine's 1999 report an estimated 98,000 Americans die each year as a result of medical errors. The evidence clearly shows the pharmacist's role in medical-error reduction:

- Incorporation of a pharmacist on rounds as a member of a medical intensive care unit (ICU) patient-care team resulted in a 66% decrease in the number of

preventable adverse drug events caused by prescribing errors. (Leape LL, et al, JAMA, July 21, 1999)

- In an ambulatory care clinic study, physicians accepted 83% of pharmacist recommendations for drug therapy. In 80% of those cases, "improvement or resolution of a patient's disease state" occurred. (Lobas NH, et al, Am J Hosp Pharm, July 1992.)

PHARMACEUTICAL CARE IMPROVES MEDICAL OUTCOMES FOR THE ELDERLY

- Pharmacists intervening on behalf of elderly patients were able to reduce the number of drugs taken and help them achieve better compliance with their drug regimen. [Lipton HL, and Bird JA, Gerontologist, March 1994].
- Adding a clinical pharmacist to a hospital-based geriatric clinic reduced the number of medications associated with an adverse drug reaction by 42%. [Phillips SL, Carr-Lopez SM. Am J Hosp Pharm May 1990]

PHARMACEUTICAL CARE IMPROVES MEDICATION USE AMONG PATIENTS WITH CHRONIC ILLNESSES

Several programs in chronic disease-management yielded significantly improved patient outcomes and reduced health care costs due to intervention of pharmacists:

- Project Impact (Improve Persistence And Compliance with Therapy), a community pharmacy-based cholesterol-management program, documented how ongoing pharmacist intervention can improve ongoing treatment of high cholesterol. Of the 397 patients continuing in the project for two years, the per-visit medication compliance rate exceeded 90%. Sixty-two percent of the patients had reached their National Cholesterol Education Program (NCEP) lipid goals, largely as a result of their pharmacist's ongoing intervention.
- The Asheville Project, a diabetes-management pilot study undertaken by the City of Asheville, NC, measured patient outcomes before and after a period of pharmacist intervention. One year into the project, 86% of the patients who received pharmacist counseling and medication-management reported a higher quality of life and greater ability to function with their disease. At the beginning of the project 33% of the patients had normal glycosalated hemoglobin levels, one year later, 85% of the patients showed dramatic improvement in their levels.
- Ambulatory patients used significantly fewer health services, saving over $640 a year in health costs per individual, as a result of comprehensive pharmacist counseling. (Borgsdorf LF, et al, Am J Hosp Pharm, March 1994.)

MEDICAID PROVIDES SUCCESSFUL PRECEDENTS FOR PHARMACEUTICAL CARE REIMBURSEMENT

Two State Medicaid programs currently reimburse pharmacists for patient care.

- Mississippi reimburses pharmacists for medication therapy and drug regimen compliance for chronic disease states such as diabetes, asthma, anti-coagulation and high cholesterol. The State Medicaid Plan reimburses pharmacists for up to 12 annual episodes of care to improve the quality of life and health status for patients with these chronic diseases.
- WisMed, Wisconsin's State Medicaid plan, reimburses pharmacists for services related to medication management such as ongoing interaction with the patient to yield improved medical outcomes.

NCL 100 YEARS National Consumers League

NATIONAL CONSUMERS LEAGUE

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PHONE (202) 835-3323 FAX (202) 835-0747 www.nclnet.org

Pharmacy Coalition Media Briefing
Washington, DC, March 10, 2000
Statement of Linda F. Golodner, President
National Consumers League

The National Consumers League is pleased to join our colleagues this morning – those who represent pharmacists – as we combine our efforts to persuade Congress to fill one part of the gap in health care coverage for senior citizens.

We represent citizens from Maine to Alaska, Florida to California who want comprehensive health care reform in this country. And there is no question that all consumers must be provided affordable, quality, health care. But someone who is near the poverty line – a senior citizen who is among the working poor or perhaps the retired poor – cannot wait for politicians and health care institutions and policy makers to debate, to compromise, to delay – again and again – that person must be able to get a prescription filled and be counseled about taking her medicine now.

The proposal that we are supporting today will meet the needs of 60% of low income seniors, and it will build on the experience of 15 states that already have successful senior prescription assistance programs.

It is not the best solution – it will not cover everyone – but it is an important stopgap measure to help those most in need.

An election year is a difficult time to pass comprehensive legislation. We only ask that members of Congress can recognize that the most vulnerable group – senior citizens who are poor – want – and should be given – some relief now.

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STATEMENT OF THE SENIOR CITIZENS LEAGUE (TSCL)

(SUBMITTED BY MICHAEL F. OUELLETTE, DIRECTOR OF LEGISLATIVE AFFAIRS)

Mr. Chairman, The Senior Citizens League (TSCL) appreciates the opportunity to submit testimony to this committee concerning Medicare reform and the provisions of S.1895, a bill to amend the Social Security Act to preserve and improve the Medicare program. Additionally, TSCL appreciates the opportunity to offer a number of insights for consideration and specific recommendations for general application to any Medicare Prescription Drug Benefit passed by Congress that would be both beneficial and accessible by the League's membership.

TSCL is a non profit, issues advocacy organization representing over 1.5 million members and supporters and is dedicated to serving its members by defending and protecting their earned retirement benefits. The League is registered to conduct grassroots fundraising, public education and lobbying activities in nearly every state, and does not solicit nor accept any money from the federal government. As a matter of information, over 443,310 of our members are constituents of members of this committee and are seriously looking for a Medicare Prescription Drug Benefit to be approved by Congress this year.

Although TSCL has formally supported the Administration's Medicare Reform proposal, the League certainly appreciates the efforts of Senators John Breaux (LA) and Bill Frist (TN) to actually be the first to present a proposal in legislation (S. 1895). TSCL is equally grateful to this committee for the decision to hold a hearing on this critically important issue this early in the legislative year.

PRELUDE

Mr. Chairman, the hardships for seniors caused by the increasing cost of prescription drugs has spurred the Congress to include the issue among the highest legislative goals and objectives to be considered during the 2nd Session of the 106th Congress. Prices for the 50 prescription drugs most often used by seniors rose 6.6 percent in 1998— four times faster than the year's 1.6 percent overall inflation rate, according to a recent study. These rising costs are putting medicine out of reach of a growing number of older Americans, particularly the 35 percent of Medicare recipients without prescription drug insurance. Government figures released in July 1999 projected that senior spending on prescription drugs would grow about 11.2 percent annually during 1999 and 2000. Yet industry figures released in September 1999 showed that prescription drug spending increases for 1999 already exceeded that amount; up 12 percent with four months remaining in 1999. Additionally, many Medicare recipients that belong to Health Maintenance Organizations (HMO's) will have to pay three times as much in monthly premiums in 2000 and will find HMO's far less willing to pay for Doctor-prescribed medicines. In sharp reversal of recent trends, no HMO that accepts Medicare patients next year will cover the full cost of a patient's medicine. Sadly, many HMO's across the nation are dropping seniors, who depend on this protection, from coverage at an alarming rate. Particularly hit hard are those seniors residing in rural areas. Faced with the situation just described, many seniors are being forced to travel to Canada or Mexico to purchase prescription medicines at affordable rates. Sadly, when forced to choose between paying for medication or food, older Americans must explore and take advantage of any avenue that provides financial relief, as they must have both to survive.

THE ADMINISTRATION'S MEDICARE REFORM PROPOSAL

In June 1999, President Clinton introduced a plan that would offer a voluntary prescription drug benefit to all Medicare beneficiaries. There would be no deductible and a 50 percent co-payment. Premiums would start at $24 per month in 2002, rising gradually to $44 per month by 2008. The plan would match a beneficiary's drug costs up to $1,000 in 2002, rising to $2,500 by 2008. It would also exclude premiums and co-payments for individuals earning less than $11,000, or couple earning less than $15,000. The Administration estimated this proposed drug benefit would cost $118 billion over ten years. The non-partisan Congressional Budget Office (CBO), however, estimated the cost of the program at $168 billion ($50 billion more).

Although not ideal, TSCL has supported this proposal, as it was the first solid effort to address the prescription drug problem being faced by its members and supporters. The League does not believe that the proposal offers older Americans who have earned a government sponsored benefit, the kind of comprehensive and affordable protection plan that one would reasonably expect would be offered to the older Americans whose efforts during their lifetimes have brought this Country to where it is today.

THE PRESCRIPTION DRUG FAIRNESS ACT OF 1999 (S. 731)

Another proposal that TSCL supports and which drew a substantial amount of support last year is S. 731, introduced by Senators Edward Kennedy (MA) and Tim Johnson (SD). The bill would assure Medicare beneficiaries receive the same reduced drug prices that drug manufacturers currently give their most favored customers, such as the federal government and large HMOs. Estimates are that the most favored prices would cut drug costs by as much as 40 percent. A senior citizen spending $150 a month on prescription drugs could save over $700 annually under the legislation. The appeal of this legislation is the offer of some protection to Medicare prescription drug consumers without huge costs to finance the program. The downside of this proposal is the fear professed by powerful drug lobbies that it creates "price controls" on the industry and would mean less money for research and development, weakening the industry's ability to create new drugs and improve existing ones. Again, TSCL supports the legislation, as it will benefit our members. Ultimately though, TSCL believes that the prescription drug cost situation being faced by older Americans should be solved by the government and not referred to the pharmaceutical industry for resolution.

THE BREAUX-FRIST BIPARTISAN MEDICARE REFORM BILL (S. 1895)

While TSCL has not to date supported S. 1895, we wish to extend our appreciation to both Senators Breaux and Frist for their pro-active efforts to act in an expeditious manner in presenting legislation to significantly reduce the burdens of older Americans and to seek wide public debate on what is referred to as a competitive premium system that was supported by a majority of the Medicare Commission earlier last year. In keeping with our commitment to support any legislative efforts to improve the lives of older Americans by protecting and defending their earned retirement benefits, TSCL should be eager to support S. 1895, but has not done so yet. This can be attributed directly to the overall confusion produced by the legislation. Understanding that experts have crafted the bill, it simply is not readily understandable and is virtually impossible to clearly and succinctly define the bill to our members and supporters so they will be able to understand the impact on their "pocketbooks." The Administration's proposal is understandable as is S. 731 discussed earlier. This committee is urged to consider action to direct the re-crafting of S. 1895 in understandable language so that older Americans, many who have never had access to a prescription drug benefit of any kind, will be able to understand the bill in order to allow them to make an educated decision.

TSCL'S VISION OF A PRESCRIPTION DRUG BENEFIT

Very simply, TSCL will lend its full support and urge the grassroots efforts of its members and supporters to a proposed Medicare prescription drug benefit with the following characteristics:

Universal: Any benefit that becomes law would be the same for all Medicare-eligible beneficiaries to include an age 62-65 and age 55-62 Medicare buy-in options.

Targeted: Provided additional assistance for low-income beneficiaries.

Voluntary: Older Americans participation in a government-sponsored plan would be voluntary and give them the choice of remaining with any current supplemental plan that they currently possess and maintain confidence. Such a condition would generate a need to field a government-sponsored plan that encourages participation by the vast majority of Medicare-beneficiaries.

Affordable: Would require reasonable monthly premiums, cost-sharing or co-pays with an annual likewise reasonable benefit maximum intended to reduce catastrophic out-of-pocket expenses for the most seriously ill beneficiaries.

Responsible: Would discourage irresponsible or over-utilization of the benefit.

Modernizes Medicare: Like other modern insurers, Medicare would use a benefit manager to negotiate lower drug prices.

Partners with the Private Sector: Would provide incentives to employers to develop and retain retiree drug coverage by possibly paying the entire or portion of the retirees' monthly premium.

Understandable: Any plan considered must be clearly understandable by those who make an enrollment decision.

TSCL believes the Administration's proposal meets the majority of the aforementioned preferred characteristics and is one where support is justifiable. However, the League contends that the complexity of S. 1895 is a major shortfall that needs significant improvement.

TSCL believes that the 50 percent cost-sharing requirement of the Clinton proposal should be changed to a $10 co-pay per prescription even if other provisions of the plan were increased. A flat-dollar co-pay requirement would make the plan much more understandable and therefore much easier for older Americans to be able to establish or adjust their monthly prescription drug out-of-pocket costs. Therefore, TSCL recommends to this committee that if the Breaux-Frist plan were to be re-crafted to incorporate this recommended $10 per prescription co-pay, we could support S. 1895 assuming the required monthly premium was affordable. We also highly encourage this committee to debate this issue in a totally bipartisan manner, understanding that that the important question to be answered is not whether older American need a prescription drug benefit, but rather how fast it can be made available. For far too long our parents, friends and neighbors have needed some kind of Medicare Drug Benefit. Now is the time to put aside partisan politics and make the lives of these deserving Older Americans comfortable and dignified.

CONCLUSION

First, TSCL believes that compromise is the key to passing legislation that will provide a prescription drug benefit or option to older Americans. Clearly understanding that putting together a prescription drug benefit that will be acceptable to all parties involved is a monumental task. The fact of the matter is the Breaux-Frist Medicare Reform Plan could very well incorporate many of the proposals made in the Administration's proposal. For instance, what the President plan proposed is very similar to the option under the Breaux-Frist plan called the "high option standard Medicare plan," meaning it covers prescription drugs. Breaux-Frist offers a 100 percent government subsidy for those with incomes under 135 percent and a sliding scale subsidy for those with slightly higher incomes as a "high option standard Medicare plan."

Secondly, it appears that the Breaux-Frist model averts a virtual "show-stopper" situation that may hold up passage of a prescription drug benefit this session by offering some financing mechanisms for the new benefit by incorporating the premium support model. Although this legislation will not solve all of Medicare's financing problems, the fact that it addresses the prescription drug issue within the context of reform is in the opinion of TSCL more responsible than just adding a benefit without reform.

In conclusion, TSCL recommends passage of legislation this year that will give Medicare-eligibles a prescription drug benefit as being the first challenge of this committee. Additionally, TSCL suggests that the insecurity caused by a constant churning of threats to retirement benefits creates an environment of stress that takes a real toll on the health and welfare of older Americans. Seniors simply must be given expanded opportunities to voice their opinions and participate in change instead of living in constant dread and fear of loss. The very fact the Congress and this committee listens to their expressed concerns about those thing that are important and then responds legislatively to meet their needs, means a great deal to older Americans and their families.

Again, TSCL appreciates the opportunity to present a number of views on behalf of its over 1.5 million members and supporters to this committee.

	TSCL Members In State
Senator William V. Roth, Jr., Chairman	3,868
Senator Daniel Patrick Moynihan, Ranking Member	75,229
Senator Paul D. Coverdell	21,679
Senator Charles E. Grassley	22,207
Senator Orrin G. Hatch	7,534
Senator Frank H. Murkowski	1,848
Senator Don Nickles	16,935
Senator Phil Gramm	76,498
Senator Trent Lott	10,521
Senator Jim M. Jeffords	2,688
Senator Connie Mack	102,992
Senator Fred Thompson	20,174
Senator Max Baucus	6,712
Senator John D. Rockefeller IV	11,747
Senator John B. Breaux	16,168
Senator Kent Conrad	5,989

	TSCL Members In State
Senator Bob Graham	102,992
Senator Richard H. Bryan	9,718
Senator J. Robert Kerrey	10,250
Senator Charles S. Robb	20,553
TOTAL	443,310

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