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MEDICARE DRUG CARD: DELIVERING SAVINGS FOR PARTICIPATING BENEFICIARIES

HEARING

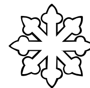
BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

JUNE 8, 2004



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MEDICARE DRUG CARD: DELIVERING SAVINGS FOR PARTICIPATING BENEFICIARIES

TUESDAY, JUNE 8, 2004

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

The hearing was convened, pursuant to notice, at 10:07 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Also present: Senators Snowe, Thomas, Santorum, Frist, Bunning, Daschle, Breaux, Conrad, Graham, Bingaman, and Lincoln.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Good morning, everybody. Thank you for being patient. I took about 5 minutes to establish seniority down at the Judiciary Committee so I can go down there and ask some questions of the Attorney General later on this morning, so that is why I am late. Please excuse me for being late.

Today's hearing is on the Medicare-approved drug discount card, and that program just got under way within the last week. I think it is very important, then, for this committee to learn more about its early implementation, the significance of it, and particularly the significance of it for the health of low-income beneficiaries.

Today's witnesses will offer an array of perspectives on the card program, and we appreciate your taking time to be with the committee.

I would especially welcome Dr. McClellan, who is making his first appearance before the committee in his new role as Administrator.

I would also like to welcome my fellow Iowan, Kris Gross, who does a superb job in our State heading the State Health Insurance Information Program, with the acronym of SHIIP, for short. They are a tremendously helpful resource for beneficiaries.

Kris and/or her staff participated in 41 town meetings that I have had specifically on the subject of Medicare since January 1 in my State, and I thank her for that cooperation because it was very helpful in explaining the program to our seniors.

I know that we are all well versed in the basic mechanics of the drug card program, so I will not spend any time going through those. The program offers beneficiaries immediate relief on their drug costs prior to the start of the voluntary drug benefit in 2006.

The drug card is an important first step in filling a void for many of the Nation's seniors and disabled, a void that has prevented them from getting life-saving and life-improving prescription drugs.

While the program's creation was a bipartisan effort, over the past few months, we have, in fact, heard an awful lot of criticism about the program, even though it just started a week ago.

The drug discount card program has been the target of a deliberate campaign to discredit it and confuse seniors about how it works. This effort is driven and coordinated by those who oppose the Medicare Modernization Act, not because of policy, but because of politics.

This kind of politically motivated subterfuge disappoints me. It is a disservice to the millions of older Americans and millions of people who are disabled who can benefit, and will benefit, from the Medicare-approved discount card.

I am not alone in this view. Just last week, we had the Centrist Policy Network writing this: "Democrats are the opposition party in the Congress and they are supposed to raise questions, but discouraging seniors from enrolling in the Medicare drug discount card is too much."

The average Martian would be justifiably perplexed about why the Democratic leadership wants to repeal a program that does no one harm, might actually help quite a few people, and offers a significant benefit to low-income seniors.

I would especially think that this would be satisfying to those who say that too many seniors have to choose between drugs and food, and nobody should have to make that choice. This program, then, will help them avoid having to make that choice.

Through this program, Medicare beneficiaries have access to discounts on their prescription drugs, and low-income beneficiaries can get $1,200 in direct assistance between now and the end of the program.

Now we may hear additional criticism this morning, but the point of this hearing is, (1) to clear the air, and (2) to provide objective information, because that is what seniors and people with disabilities deserve.

In particular, I want to commend the Access to Benefits Coalition, who will be here and we will hear from today during our second panel. The ABC, as it is called, is made up of organizations who have put politics aside to make sure that beneficiaries, particularly those with low incomes, get the assistance that they deserve.

Many of these organizations did not support the passage of the original bill, but they have agreed to put that aside, move on, and now, in fact, help seniors and those with disabilities obtain these benefits.

I believe that these organizations should be commended, and I do commend them for stepping forward to work together to help beneficiaries learn about the lower prices that they can get through their drug cards.

I have done some checking into discounts that these cards offer beneficiaries, and here is what I found. A hypothetical beneficiary living in Waterloo, Iowa with an income of $12,000 a year who

takes Celebrex, Norvast, and Zocor would pay around $7,300 at her local pharmacy from now until the end of 2005.

The beneficiary gets her prescriptions filled at the local pharmacy because she trusts and knows that pharmacist. Like many, she does not want to order drugs through the mail. She can save over $1,300—that is 20 percent—off of her three medications by using the discount card.

The $1,300, by itself, is a pretty big savings. But she also qualifies for transitional assistance, so she will not pay an enrollment fee, if there is one. In addition, she will receive additional assistance from drug manufacturers when she signs up for the drug card.

Beneficiaries who qualify for transitional assistance can automatically get these additional manufacturer discounts upon enrollment in the card. The Medicare drug card has dramatically simplified these benefits by making them available through one card.

I hope the card sponsors will work with as many drug manufacturers as possible so that low-income beneficiaries have access to all of these discounts.

So when she combines the $1,200 in transitional assistance with the additional manufacturer assistance offered through her card, she will save $6,300, a 90 percent savings. That is 90 percent. That is pretty hefty, real savings.

To those who say this discount card program provides no real benefits, my only conclusion is that they are the ones who are confused.

I will be the first to admit that some issues have surfaced that need to be worked out, but that is not unusual with a new program. Medicare itself experienced start-up problems 38 years ago.

In commenting on the implementation efforts then, Bob Ball, former Commissioner of Social Security, said, "To a remarkable degree, opponents as well as supporters of Medicare tried hard to be helpful." For the sake of beneficiaries, we should heed his words and work in that spirit today.

More recently, we have the State Children's Health Insurance Program. It faced some challenges when it started up. Only 982,000 recipients, less than 20 percent of the enrollment goal of 5 million set by the Clinton administration, enrolled in the SCHIP program during the first year.

In the first 5 weeks that beneficiaries have been able to enroll in the Medicare-approved discount card program, CMS succeeded in enrolling nearly 40 percent of the 7.4 million eligible. That is a pretty good start after 5 weeks.

I think we all agree that it was a good thing we did not give up on Medicare, or SCHIP, for that matter, in their early stages. I know that you, Dr. McClellan, will comment on our efforts to address some of these early implementation issues.

I am also looking forward to hearing from other witnesses on that point. I, for one, am proud of our bipartisan accomplishments in delivering real relief for our beneficiaries.

Senator Baucus and Senator Breaux were instrumental in achieving that accomplishment. Now it is time to put politics aside and give the card program a chance to work. Our Nation's Medi-

care beneficiaries, who can clearly benefit, simply deserve nothing less.

Since Senator Baucus is not here, did Senator Breaux or Senator Conrad wish to make a statement? Oh. We always give courtesy to the Leaders, if you have to go someplace else.

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

Senator FRIST. Thank you, Mr. Chairman. I will just briefly comment, and then I do ask that my entire statement be made a part of the record.

The CHAIRMAN. It will be made a part of the record.

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

Senator FRIST. I do want to thank you for holding today's hearing to examine the new Medicare discount drug card program. This is the first step, and indeed a very important first step, under the Medicare Modernization Act to provide seniors relief from the high prescription drug costs which we know they face.

For the first time, seniors will be able to get discounts through the Medicare cards. And this program has been under way for exactly 1 week, or just 7 days, yet even at this early date the cards are well on their way, I think, to being a huge success for seniors, many of whom struggle each day to pay for the prescription drugs that they need, that they deserve, and that can literally change their lives.

Chairman Grassley, Senator Baucus, and the other members of this committee have worked hard on the new Medicare law. They deserve credit for their determination to see that seniors could begin to see this benefit almost immediately, that is, just several months after the bill was signed into law.

We have all realized all along that it would take some time to fully implement the new Medicare benefit, and that is why so many of us wanted this quicker, more immediate benefit under way, which is, and which I believe, as people learn more about it, will be increasingly accepted by seniors and the public at large.

I do think that President Bush and the administration should be applauded for getting the discount program up and running just 6 months after the President signed the Medicare Modernization Act. Secretary Thompson and his team at the Department of Health and Human Services deserve a great deal of credit for their efforts to educate seniors.

It is an enormous, enormous undertaking. There will be stumbles along the way, there will be mistakes along the way, there will be misunderstandings along the way, and there will, no doubt, because of the magnitude of this program, be some confusion. That is true of any new government program, and I do not think it is any more or any less here.

It is not surprising that a program that is just 7 days old has not reached full enrollment. It is not surprising that some would be unaware about details of the program, and some confused by details of a program that has been available for but 7 days.

What is both surprising and disappointing to me, is the fact that there are some intent on deliberately confusing the public and scar-

ing and frightening seniors. We need to realize that this only hurts the very people that we, through this very positive government program, are trying to help.

I am deeply troubled by reports like the one issued by the Kaiser Family Foundation last week that found "seniors' feelings toward the new Medicare law are being shaped by misinformation and lack of information. It is clear from these groups that seniors are very confused and not yet informed about what is happening to their Medicare."

I know that having the Commissioner with us today will help set the record straight. I look forward to his testimony, and the testimony of other witnesses who will be joining us today.

I look forward to the opportunity that the hearing provides today to learn more about the discount drug card program and how we can all work together to accomplish the goals that I think we all mutually share.

The CHAIRMAN. Thank you, Senator Frist.

Now, Senator Breaux, for a Democrat opening statement.

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

Senator BREAUX. Thank you very much, Mr. Chairman. I am happy to welcome Administrator Mark McClellan to this, his first hearing, as administrator.

The Medicare card was always intended to be a temporary program that was going to be in place until we actually established an actual insurance program. I remember talking about the fact that I was very concerned that we would end up in a situation where we would have a senior walking into their local drugstore with 16 cards and opening their purse and wallet and cards flying all over the place, trying to figure out which card was the appropriate one for them to use.

Now it is not 16 cards, it is over 70 cards. That concern about which one is the best, which one is the most appropriate, which one is most cost-efficient, is a very difficult challenge for the average senior.

I somehow wish we had maybe come up with one card that the companies would have participated in along with the government and worked out a universal Medicare drug card that would have been very easy to understand for the average citizen.

But choices are important. This is about giving them more choices. I am just a little concerned that we now have too many choices and it makes it more difficult to pick the one that is correct.

Now, with regard to the start-up situation, it is interesting. When Medicare was first passed, we had start-up problems. It was not easy for people to understand.

But I think everybody sort of pulled together and said, look, whether I liked the bill or did not like it, we are trying to make it work, and I think they worked together to do that.

I was interested particularly in the statements by the Chairman with regard to the start-up of the SCHIP program. When we started the SCHIP program, health insurance for low-income children, we got less than 20 percent of the enrollment goal met in the first year.

So, the whole first year we only got 20 percent of SCHIP enrolled. Now I think, with the Medicare card, you are talking about approximately 40 percent of the original first-year enrollment goal that you set out. So, that is progress.

And when I hear people saying no one is enrolling, that is not true. It is substantially more enrollment in the Medicare card than we had when we started the SCHIP program at this stage, and that is real progress.

And it is an educational deal. We have to help seniors to the maximum extent possible through senior groups, through AARP, through all of the organizations out there to help them pick the best card for their purposes. I am anxious to see from the Administrator what we are doing in that regard. Thank you.

The CHAIRMAN. Senator Daschle, we give priority to you and Senator Frist if you have an opening statement. Senator Frist gave his already. Go ahead.

OPENING STATEMENT OF HON. TOM DASCHLE, A U.S. SENATOR FROM SOUTH DAKOTA

Senator DASCHLE. Mr. Chairman, thank you very much. I appreciate very much the Chairman holding this hearing today. I think it is an important time, given the fact that the drug card program has just started.

There is a great deal of confusion, and that confusion has been overwhelming, I think, especially to beneficiaries. We keep learning about some of the problems that we were not aware of even as late as a few weeks ago.

Just yesterday, a constituent from South Dakota called my office and reported that she was told now that her food stamps were going to be reduced as a result of receiving the transitional assistance. That is a terrible predicament for someone with an annual income of under $12,600. Take your pick—food or drugs. If her food stamps are reduced, that is just unacceptable.

So the $600 assistance is the best part of this program, but it certainly should not detract from someone receiving food stamps. So, just the latest illustration of the clarification required with regard to the start-up that Senator Breaux has just mentioned. If that is not the case, then our State Department of Human Services does not know.

That is just another example of the failure to communicate essential information related to the program, and I would hope that hearings like this could help clarify that.

But the questions keep mounting. Should I sign up for the card? If so, which card should I choose? Will my pharmacy take it? Does it offer discounts? If those discounts change, what happens to my benefits? What will my drug needs be if the circumstances change? Is it worth the enrollment fee? And on and on.

The enrollment figures reflect, I think, the confusion. Some have signed up. About 500,000, so far, of the 41 million beneficiaries have chosen to sign up for the card. The rest of the only 2.8 million enrolled were enrolled, of course, through their HMOs.

But that is due, I think, in part to the confusion that hearings like this might be able to help clarify. But study after study has shown that these cards are like being offered something on sale

after they have already marked up the price, and that is a concern that many of us have as well.

Have the drug companies already accounted for the discounts and marked up their prices? Hopefully, this hearing can help answer that question.

What we do know is drug prices are out of control. Last year, the prices of the top 30 drugs used by seniors rose by over four times the rate of inflation, just in 1 year. So what we as a Congress can do about it, and what we have done about it so far, is what is a great source of frustration to many seniors.

Last year, the Medicare reform law actually prohibited Medicare from using its bargaining power to get lower prices for beneficiaries, and effectively ensured that Americans cannot take advantage of lower prices available in the world market.

We believe, many of us, that we ought to change both of those things. If we are truly going to benefit seniors in helping to cope with these dramatic prices, then we have got to give our government the same authority to work on behalf of seniors that it has now to work on behalf of veterans.

We ought to say, if we are advocates of a free market system, that the free market ought to be truly free and consumers ought to have the right to go to the sources where they can get the best price, and if Canada is one of those sources, then we ought to embrace it.

This hearing offers us, Mr. Chairman, of course, the opportunity to talk about all of this and much more. We have not had hearings yet on the threatened firing of the Medicare actuary and the concealment of the cost estimates, but I hope that that can be done.

We have not discussed the General Accounting Office findings that CMS broke the law in producing propaganda in the form of video news releases, but I hope that that can be done as well.

I am hopeful that we can do better for Medicare beneficiaries than the paltry drug benefits scheduled to take effect in 2006, but, at the very least, lessons can be learned about what has happened with the discount card, and seniors know that we can do better than this and are demanding that Congress act to make that happen.

But this hearing is a good start, and I appreciate the opportunity that the Chairman has provided the members of the committee to avail ourselves of this chance to get answers to many of these questions.

The CHAIRMAN. Before I go to Dr. McClellan, Senator Conrad asked to make a statement about a piece of legislation he is going to introduce.

Go ahead, Senator Conrad.

OPENING STATEMENT OF HON. KENT CONRAD, A U.S. SENATOR FROM NORTH DAKOTA

Senator CONRAD. Thank you, Mr. Chairman.

I voted for this bill because I thought it was in the best interest of the people I represent. On the other hand, I have just been home 2 of the last 3 weeks, and I really have received a lot of blow-back on the drug discount card.

Before I discuss the problems with the cards, I want to revisit the number of enrolled beneficiaries. According to CMS, there are 15 million people eligible; however, only 500,000 have signed up voluntarily. That is about 1 in 30. There are another 2.4 million, roughly, who have been automatically enrolled. In all, 2.9 million out of 15 million—roughly 20 percent of eligible beneficiaries—have enrolled in the drug discount card program.

The reason for the meager enrollment is simple. Seniors are too confused to choose the card that's best for them. They are confused because there are so many cards. They are confused because they do not see the program as consistent or reliable.

For these reasons, I am introducing legislation today that I call the Drug Discount Card Simplification Act. There are three basic provisions included in my bill.

One, beginning in 2005, the Secretary would be required to reduce the number of approved drug cards per region to three. That would give people choice, but it would simplify the choices, because the thing I heard overwhelmingly from my constituents is, how do you sort through 73 cards?

Second, it would prohibit drug card sponsors from offering discounts that are less than the discounts provided when the Secretary approves them as a participant.

Another thing I heard repeatedly is, you can go into a program, sign up for the card, and then it all changes. The economics of it changes. The discounts change. People feel as though they may be suckered into a program, offered low rates, then the rates change.

Finally, the act I am going to introduce today would protect seniors' access to drugs. The bill would require drug discount card sponsors to continue offering coverage of a drug throughout the duration of a program.

That is a third concern I heard repeatedly. The program could offer drugs that the beneficiary uses, but after the person signs up, the sponsor could drop that drug or that group of drugs. That is another problem that I heard about consistently from my constituents.

So, Mr. Chairman, I thank you for this opportunity. I think all of us who are supporters of this bill have an obligation to try to make it work better, and hopefully what I am offering today will begin a debate on how we improve choices for seniors and how we improve consistency and reliability of the drug discount card program.

The CHAIRMAN. Dr. McClellan, proceed.

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

Dr. MCCLELLAN. Thank you, Mr. Chairman, Senator Breaux, distinguished committee members, and Senators Frist and Daschle. I want to thank you for your strong interest in helping the Medicare-approved drug card program and the transitional assistance program succeed.

Today, 6 months after the legislation creating this program was signed into law, seniors across the Nation who are struggling with drug costs can get overdue assistance as an interim step on the

way to the Medicare prescription drug benefit. It is a real honor and a privilege to be part of this effort and to be with you here today.

Beneficiaries who are struggling with drug costs can use the cards to save 10 to 25 percent or more at neighborhood pharmacies. The card prices are lower than Americans pay, on average, for drugs today, including Americans who get discounts through public or private insurance.

Let me repeat that. Medicare beneficiaries who have been paying some of the highest prices at the drug counter can now get prices for their prescriptions that are significantly less than Americans generally pay, including those who have insurance.

And for beneficiaries who are comfortable with mail order, there are generally savings of 7 to 20 percent or more in comparison with the best discounts available at U.S. Internet pharmacies.

These lower prices come from two sources. First, Medicare beneficiaries can now band together and stick together to use their market clout to negotiate better prices, just as people with public or private insurance have long been able to do.

Second, the availability of information on actual drug prices means that seniors can comparison shop just as they do for other goods and services. We have already seen the effects, as prices on the drug cards have fallen by an average of over 15 percent since the program began.

Even larger savings are possible by combining the new price discounts with other steps, steps that we want to help beneficiaries take. For example, in a study announced yesterday, we found that beneficiaries could reduce their costs for many commonly used drugs by 30 to 70 percent or more by taking advantage of personalized information that we provide on the availability of generic drugs, which are just as safe and effective as brand-name drugs in the United States, and by the large discounts that beneficiaries can get on generics through using their drug cards.

We are working to make it easier as well for beneficiaries to combine these discounts with other sources of savings, including State pharmaceutical assistance programs and manufacturer programs.

The opportunities for savings are even greater for low-income beneficiaries, who can get the additional $600 credit right now, and another $600 next year on any prescription medicine they need.

We have worked with many drug manufacturers—seven so far—to provide wrap-around discounts for these cards, and we are providing new help to beneficiaries in finding out about the State programs and more than 100 manufacturer assistance programs.

In short, millions of beneficiaries who are now struggling to pay for their drugs and pay for other basic necessities can get literally thousands of dollars in help right now, and, as stated in the Medicare Modernization Act, the $600 in transitional assistance will not affect any other Federal benefit.

With this new assistance, our challenge is to make sure that beneficiaries who need help get the facts they need to start saving as soon as possible. The most important fact is that if you do not have good drug coverage now, you should contact us to find out about what the Medicare-approved drug card program can do for you.

It helps to have a little information ready, your zip code, your drugs and dosages, and your income, as well as any special preferences, such as a particular pharmacy you like, or if you want a low-fee card or a no-feed card. You can get this assistance by calling us any time at 1–800–MEDICARE. We have taken many steps to reduce the time it takes to get the facts you need.

We are getting more than 100,000 calls a day, but wait times are generally now just a few minutes. A call to find out about what the drug card program means for you, you personally, usually takes less than 15 minutes.

Or, you or a friend or family member can go to *www.medicare.gov,* and we have taken steps to make the website easier to use, like including new ways to provide information about non-oral medicines, and to focus on the cards that are best for you very quickly. We are getting hundreds of thousands of hits a day on the website.

We will tell you about how you can save, including information about State and manufacturer programs either on the phone or online, or with a personalized brochure that we can send out to you.

After you find a card that gets you real savings, enrolling involves just filling out a standard, two-page form, or calling the 800 number for the card. If you apply for the $600 in transitional assistance, there is a single standard form available that covers both the card and the extra transitional assistance.

This is a voluntary program with no deadlines or late fees, and it does not take away any of the other benefits you may have. Many beneficiaries have already found that the cards can pay for themselves in just the first month or two, and they do not want to leave this new money on the table. Over 3 million beneficiaries have already enrolled.

We are not stopping there. In addition to substantial outreach and enrollment efforts, CMS has already undertaken in the past few months further steps to help beneficiaries take advantage of these new opportunities, especially low-income beneficiaries who can get thousands of dollars' worth of assistance.

We are very pleased with our recently announced partnership with the more than 70 organizations that make up the Access to Benefits Coalition to get low-income beneficiaries into this program and into the related State and manufacturer programs.

We are also working with a growing number of States, and we will soon auto-enroll hundreds of thousands of beneficiaries of State pharmaceutical assistance programs in the Medicare transitional assistance, and we are also increasing funding for State health insurance assistance plans by 69 percent this year, with further increases coming next year.

SHIPs can provide the special face-to-face help that many beneficiaries prefer, and that beneficiaries with cognitive impairments, language barriers, or other barriers to enrollment may require.

We are working with the SHIPs, with our regional offices, and other local partners to identify and spread the proven best practices for helping beneficiaries find out about the card program, the best ways to overcome any confusion about what the program means for them, and how they can get the most out of it right away.

Again, to learn more about this program, all that beneficiaries need to do is pick up the phone and call 1–800–MEDICARE 24/7, or visit us online at *www.medicare.gov,* or contact the local office of their State health insurance assistance program to obtain face-to-face help.

I want to thank you all again for your interest in, and your support for, the successful implementation of this program, and I would be happy to answer any questions you all may have.

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

The CHAIRMAN. Well, thank you very much. I have three issues to bring up, four questions, I think. It will probably take long answers, though. We will have five-minute rounds, since there are so many members here.

There has been a lot of discussion on the importance of preventing fraud and abuse within the new discount drug program. What is CMS specifically doing to prevent fraud and abuse within the discount card program, and how is CMS coordinating its efforts with your own Office of Inspector General or the HHS Office of Inspector General?

Dr. MCCLELLAN. Mr. Chairman, I want to start by thanking you, particularly, for your interest in making sure we get out ahead of the opportunities for fraud and abuse in the new Medicare Modernization Act.

Any time a new government program comes along, there are those who would take advantage of people who most need help by committing fraud or causing beneficiaries to lose their money improperly.

We have been looking around the country for any examples of card fraud. We have seen a few dozen examples of isolated cases. We started a coordinated approach to dealing with these cases with the Office of the Inspector General, and the OIG is now investigating several cases where beneficiaries actually lost money.

I am pleased to say that we have not seen widespread fraud, and that we have seen beneficiaries contacting us or contacting their local law enforcement offices when they get an improper submission of information, when they get a cold call, when someone comes to their door claiming to sell Medicare benefits. These should not happen. They are not allowed under the card.

They do not happen with the legitimate card sponsors. Beneficiaries are calling. I think that is a testament to the fact that we have tried really hard to get the word out about what beneficiaries should look for.

They should not get cold calls. They should not have people coming to their door proposing to sell them or provide them with Medicare benefits. They should not give out their personal information in any of these circumstances, and they should contact us. That is what is happening.

We expect to build on this new partnership with OIG in other aspects of MMA implementation to make sure that there are not any undue cases of fraud and to make sure that beneficiaries are protected.

The CHAIRMAN. Let us look at the implementation challenges that you face with this new legislation. Since the Medicare and

Medicaid program were created 38 years ago, your agency has implemented major legislative changes, and I just think of two recently. One would be the Children's Health Insurance Program, the other one, the Balanced Budget Act.

What unique implementation challenges does the Medicare drug discount card program present, and how is the agency addressing them?

Dr. McCLELLAN. Well, there are some new challenges here. We had set up a new program. This is a new line of business for Medicare, for providing assistance with prescription drug costs.

This is the first time we have done it on a large-scale basis in the 39-year history of the program. So, this is a new type of business for us. We had to get our staffing and support in place.

We had to set up a mechanism for contracting with the card sponsors and go through that process, and make sure the card sponsors met all of our requirements. We had to set up new programs for outreach to beneficiaries and education for them.

There is an unprecedented amount of information available now, information on 60,000 drugs at 70,000 pharmacies, where now beneficiaries can get actual price information.

So, we have taken a lot of steps to try to make that information available in a way that beneficiaries can use it and we have gotten a lot of feedback in this process in just the few months that we have been working on this program about how we can do even better. I would be happy to talk about those steps further as this hearing progresses.

The CHAIRMAN. Well, you have heard some reports. Give us some examples of how you might be dealing with some of these bumps in the road. Not every one of them, of course, but just——

Dr. McCLELLAN. Well, for example, in the initial days of the program we had a completely unprecedented number of phone calls, over 400,000 on the first day that the drug cards were available, and that is more phone calls than the phone company could handle. Nobody had ever seen anything like that.

We responded to that not only by further increasing our staffing and professional customer service support with the drug card, we also took a lot of steps, based on the feedback that we got from beneficiaries, from advocacy groups, and from our customer service representatives themselves, to make it easier to get through and use the phone assistance that we provide.

For example, we now have some menus on our phone call-in so that people can get ready with the information that they need to give us, so they can get some of their questions answered without even talking to a customer service representative. We have also taken steps to better support our customer service representatives, so the time required for people to get the help they need has gone down.

As I said, it is now usually no more than a few minutes' wait to get through to a customer service representative, and less than 15 minutes to go through your personal information and how you can get the most out of this program.

The CHAIRMAN. I think you just now answered my third question as well, so I will go on then to the next person, Senator Breaux.

Then it would be Senators Conrad, Frist, Bunning, and Daschle, in that order.

Senator Daschle, go ahead.

Senator DASCHLE. Mark, thank you for coming.

Dr. MCCLELLAN. Thank you.

Senator DASCHLE. We appreciate your many challenges and what you are trying to do to address them.

Dr. MCCLELLAN. Thank you.

Senator DASCHLE. Could you address the concern raised by my South Dakotan yesterday with regard to eligibility for food stamps and whether or not that discount in some way ought to be counted under the law against her eligibility? Is that something we could clarify immediately?

Dr. MCCLELLAN. Yes, Senator. Let me clarify that right now. The Medicare Modernization Act states that these new benefits, especially benefits for low-income beneficiaries, cannot take away any existing Federal benefits that our low-income beneficiaries already enjoy.

In fact, one of the main points of our new interaction with the Access to Benefits Coalition is to help beneficiaries like yours in South Dakota that may not only need and qualify for assistance under the drug card, but may also qualify for assistance under many other Federal programs.

We just heard how the enrollment levels for many of these Federal programs for the people they are intended to benefit are lower than they should be. In many programs, it is only 50 percent or less. Food stamps is a good example of a program where many people who are eligible do not take advantage of it.

Part of the outreach that we are doing with groups like the Access to Benefits Coalition will help people enroll in all of these kinds of Federal assistance programs to get more help, not only thousands of dollars in new help with their drug costs, but also additional help from other existing Federal programs that people often do not take advantage of.

Senator DASCHLE. So the bottom line is what for this constituent?

Dr. MCCLELLAN. The bottom line is that your constituent should enroll in a drug card. They should also enroll in the food stamp program and they should get broader help as a result, with not only their drug costs, but with other basic necessities that they are struggling to pay for today.

Senator DASCHLE. But I guess the question from her vantage point is, if she has got an income under $12,600 and she is now being told that if she takes this benefit it will be deducted from her eligibility for food stamps, is that an inaccurate interpretation on her part?

Dr. MCCLELLAN. Eligibility for the drug card and the eligibility for food stamps are both based on income. If your beneficiary qualifies based on their income level, then they participate in both programs.

Again, I would go back to the explicit provision in the Medicare Modernization Act that these new benefits for assistance with drug costs do not take away any existing Federal benefits.

Senator DASCHLE. Well, the Department of Social Services says that her expenses have been reduced, so her food stamp allotment will be reduced. Is that not a correct interpretation from the Department of Social Services?

Dr. MCCLELLAN. Senator, we would be happy to follow up with your staff afterwards. This is an additional benefit on top of other low-income assistance available to seniors, and the intent is to provide even more assistance to low-income seniors, in this case, with their drug costs.

That beneficiary can get, literally, thousands of dollars in help, with the $600 credit, with the wrap-around assistance from many drug manufacturers, with additional discounts available. I am certain she will be better off as a result, especially if she has any prescription drug expenditures.

Senator DASCHLE. Well, I think there are two issues here. One, is the question of eligibility, and I think you have clarified that, that that should not be viewed as a reduction of her expenses, so she should not have been penalized with regard to food stamps.

But I think the second issue relates to the confusion, apparently, in States with regard to how it is calculated for food stamps or for other benefits, and that is an issue of clarification not with beneficiaries, but with State officials.

I think it may be helpful to avoid this kind of confusion in the future, to see if we cannot send as clear a message about eligibility for other programs so that these kinds of interpretations do not occur. Would you not agree?

Dr. MCCLELLAN. I agree, Senator. We would be delighted to work with you to take further steps to make sure that States are getting the right information out about this program. It does not have to be confusing.

As we have just heard, any time a new Federal benefit starts there are going to be a lot of questions that not only beneficiaries have, but States, advocates, and others have.

Anything you can do to help let us know when there is a potential source of confusion so that we can resolve it and get help to those low-income beneficiaries, we really appreciate.

Senator DASCHLE. Well, there are a lot of other questions, but, Mr. Chairman, thank you very much.

The CHAIRMAN. Thank you.

Senator Frist, do you want to go ahead? Otherwise I should go back to Senator Breaux.

Senator FRIST. I will just ask one quick question. I have seen your written statement and you address some of it. But it is another one of the issues that has some confusion, and the press has picked up on it, and that is the card monitoring.

The individual cards are allowed to shift their prices and adjust their prices, and there is a fear that you are locked into a card and that card's prices may switch, and that may not be the best card for you in the future.

If you could just share with us what the ongoing monitoring is, and how do you address this sort of bait-and-switch attitude?

Dr. MCCLELLAN. Senator, we have heard this concern from beneficiaries about bait-and-switch. It is a very real concern they have,

and that is why I want to make sure that we are addressing it effectively.

Just to be clear, card prices, the discounted prices, can go down any time. We have seen them go down across the board as there has been competition around the transparency of posting all these prices. Cards want to catch up and get down to that lowest level, and that is what we are seeing.

As for raising prices, however, to have any significant increase in price, it needs to be related to an increase in cost that the cards actually incur. The cost for these cards, basically, are their costs for acquiring the drugs, and the cost for setting up and supporting beneficiaries and using the program.

We are going to have a contractor in place shortly. In the meantime, we are monitoring it ourselves to see if there are any unusual increases in prices from any of the card sponsors. And if and when we see that, we will follow up with the card sponsors.

If we see any kind of significant activity or patterns of activity, we have remedies available to us. We can take civil actions against the card, imposing fines up to $10,000 in individual instances, and we can even kick the card out of the program.

Most importantly, though, by making this information on pricing available, we will be letting seniors, the public, advocacy groups and consumer organizations know about cards that engage in these behaviors, and they will not get beneficiaries back next year, and they will not get beneficiaries back for the drug benefit.

So, through the combination of monitoring and vigilant enforcement, plus just making this information available so that beneficiaries can choose cards that give them consistently good deals, we are going to stay on top of this issue.

Senator FRIST. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Breaux? I am going to go down to Judiciary for a short period of time, and Senator Thomas is taking over.

Senator BREAUX. Thank you, Mr. Chairman. Thank you, Mark, for your testimony.

Are the discounts real to the consumers or have we seen instances where companies have increased the retail price of the drugs by 10 to 15 percent to offset any discount they would be getting out of the card? Have you all been monitoring that to make sure that that is not happening, or is it happening? Can you elaborate on that, please?

Dr. MCCLELLAN. As I said, once the discounts are in place they cannot go up on the cards unless costs go up. We have seen the prices actually going down significantly.

We went back and looked, Senator, at the prices that are available on the cards now, the discounted prices, versus the prices that were being charged a year and a half ago, back in the beginning of 2003 before this card program was anywhere close to coming into existence.

What we are finding, is that the card prices now are always substantially lower, anywhere from 9 to 30 percent or more lower than those list prices that the beneficiaries were paying a year and a half ago.

So any way you cut it, whether you look at prices that people were paying just before, prices a year and a half ago, prices that all Americans are paying today, even with discounts, seniors can do better than average with these drug cards.

Senator BREAUX. Elaborate for the record. You pointed out that prices can go down, but they cannot go up. I mean, are you talking about the private prices offered by companies who participate in a discount card cannot be increased under the program?

Dr. MCCLELLAN. Unless there is a cost increase. They cannot engage in bait-and-switch. They cannot just get people to sign up for their cards and then jack up the prices. They have to have a cost justification for any significant increase in price, and we are monitoring for that.

Senator BREAUX. I take it there is a difference in the amount of discount that is available percentage-wise between generics and brand-name drugs as well.

Dr. MCCLELLAN. There is. We are seeing some very large discounts on generic drugs, discounts of 30 to 60 percent or more, compared to the prices for generic drugs that people are actually paying.

People, when they buy drugs today, often get discounts either through a card provided by the pharmacy or through their health insurance plan that negotiates discounts on their behalf.

The prices that we are seeing for generic drugs are substantially lower than those actual drugstore prices that people have been getting for generics, 30 to 60 percent or more.

Senator BREAUX. To what do you attribute the difference percentage-wise? I know the generics are cheaper than brand, but why is the discount larger percentage-wise, do you think?

Dr. MCCLELLAN. Well, I think it is an example of what could happen when you let people band together and get lower prices. Generic drugs are available now in more than half of our categories of drugs.

We have got 209 classes of drugs where discounts are required to be provided, and there are generic drugs in more than half of them, 55 percent plus. We are also making information available to people about where they can get the best prices for their generic drugs.

Generics were made by lots of different manufacturers, so I think the manufacturers know that they have got to offer a very good price or they are not going to attract beneficiaries to their generics. It is a great way to save in this program.

Senator BREAUX. My final point is, I think we probably got off to a rocky start, but that is not unexpected when you are starting an entirely new program for millions of citizens in this country.

But I was thinking, when Senator Conrad was here, if he had a chart listing all the cards and all the things that you go through, it would probably cover up the entire Senate Finance Committee behind us, trying to see all the choices that seniors have.

I mean, how do we attempt to simplify this for the average 75-year-old senior out there saying, all right which card is best for me? I am a big believer in choices, but when you have so many, it just seems like it is so incredibly complicated for the average senior out there to make the right decision.

Some of them, I think, are scared of having to make that decision, so they back away and say I am not going to do anything because I do not know what to do.

Dr. McCLELLAN. Yes. We certainly do not want that to happen, because there are real savings in this program for many beneficiaries that are paying high prices today. I can understand how people focus in on all the choices that are out there, how it can seem confusing.

But it does not have to be confusing, especially with some of the improvements that we have made in our 800 number and on our website. People can focus on just the one or two cards that are best for their own needs.

What we need them to tell us is what medicines they are on, and also what particular pharmacy they want to use, and we will get them to a card that covers their drugs the best and that allows them to get their medicines in the way that they prefer.

Senator BREAUX. So if a senior contacts the Medicare office, either through the Internet, which a lot of them do not use, or through a telephone call, a 1–800 number, or their children help them to do this, they supply a list of the medications that mom or dad happens to be on, or they are on. You all can do a recommendation for that geographic area of which cards would best suit that individual?

Dr. McCLELLAN. That is right. And some seniors like to go through all the details. They want to see the best 5 or 10 cards and sort through it themselves and make their own decision. Others just want to know, look, tell me the one that offers the best discounts for me at the pharmacy that I want to use for the drugs I want to use.

Senator BREAUX. You all can do that?

Dr. McCLELLAN. We can just focus in on that one particular plan for them.

Senator BREAUX. All right. Thank you.

Senator THOMAS. Thank you.

Just for your information, I am told that they may be testing the cannons here soon, so it is not a pharmaceutical drug blowing up if you hear something.

Dr. McCLELLAN. I will not take it personally.

Senator THOMAS. Senator Bunning?

Senator BUNNING. Thank you.

Mark, I think one of the most critical portions of the law is the low-income beneficiary. They know about the drug card and the annual $600 savings that is available. Please explain for everybody on the committee and for anyone that is listening precisely what CMS is doing to reach out to these people.

Dr. McCLELLAN. A very good question, Senator. It is an absolute priority to get, literally, thousands of dollars in new help to these low-income beneficiaries so they do not have to struggle with the cost of drugs versus the cost of other basic necessities like food.

In addition to mailings that we have sent out through the Social Security Administration, through the Medicare program, in addition to advertising that we are still launching on the air waves now, on television and radio, it is a proven way to reach people that may be hard to reach, do not read the mail or do not partici-

pate in a lot of other outside groups. We are taking some new targeted steps to get directly to these types of individuals.

Our regional offices around the country have engaged in some specific outreach efforts with faith-based organizations, local churches, and with other community service organizations.

One of these groups is actually working with a Neighborhood Watch program. We are trying to collect some of these ideas about what works best to get the information out and to help people enroll.

In addition, we have increased our funding for the State health insurance assistance plans, and you will be hearing from one of those plans a little bit later this morning.

Many beneficiaries do need personalized help in figuring out how they can get the benefits and get the savings from this program, and the SHIPs, as they like to say, that is what they are designed to do. They are designed to provide face-to-face help with beneficiaries who may not be able to negotiate the website, or even give us a call on their own.

Then, finally, we started a new partnership with the Access to Benefits Coalition. It is a group that now includes over 70 organizations with extensive experience in working with seniors, working with, particularly, low-income Americans to make sure they can get the most out of the government programs that are available.

This diverse set of organizations includes faith-based groups, it includes groups like the National Council on Aging that is coordinating the efforts, AARP, minority organizations, you name it, they are going to help us get to the specific communities and the specific neighborhoods where we need to sign people up and to help them walk through the process so that we can overcome those barriers that new programs always face in getting help to those who need it the most.

Senator BUNNING. All right.

Some of the prior questions have been about the many cards that are available, and that there are too many to choose from and they are confusing to seniors.

How in the world are we going to work our way through that to the point where a senior can come in and say, gee, this is the right one, if they call you and they get the information and they say, trust the CMS to give us the right facts about what discount card works for me best in my area.

Dr. MCCLELLAN. Seniors have heard a lot about this program, maybe read some about it in the papers and have heard different things on different sides, and there is a lot of misinformation out there.

The best thing they can do to find out about their own personal needs and what the program can do for them is call us up, and if they do not want to go through their information over the phone, if they feel like they need face-to-face help, we will refer them to a State health insurance assistance program, as I just described, or we can go through things on the phone with them and just with their information on their drugs, information on their income, information on where they live, and if they have special preferences for a particular pharmacy or a particular card, we can help them zero in on the one-card option or just a few card options that are

best for them and turn all that information that may help lots of other beneficiaries in lots of other circumstances, but is not best for this particular person, turn all that information into something that is most relevant to them, that can offer them real savings.

What we are seeing now, is people can then compare what they are actually paying for their medicines now, which they know very well if they are struggling with their drug costs, to what they can pay under one of the best cards for their needs. Usually those savings are enough to pay for the card in the first month or two.

Again, it is free for low-income beneficiaries. So, by waiting, they may end up leaving a lot of money on the table and not taking a card that can pay for itself just in the first month or two.

We want to keep doing everything we can to help them figure out exactly what the card program means for them. We are going to keep working with our partners to help do that as well, so they can make the comparison themselves.

All they need to know is, what are they paying now and how much can they save under the cards? If it is not close—and it is not close in a lot of cases, and there are big savings—then they can go ahead and sign up and start getting those savings right now.

Senator BUNNING. With the largest change in the Medicare program since its inception, I am going to ask you, what is the most important thing you want to leave us with, and the American people, today about the new law?

Dr. MCCLELLAN. Well, I think the main thing about the new law is that help is available now. And because our seniors have very diverse circumstances, different medical needs, some of them not even struggling with drug costs because they have got good coverage now, we want to make sure that we help each individual senior as best as possible.

So, for seniors that are struggling, there are real savings available on the card and it is worth checking it out, and we want to make it as simple as possible for them to do so, at 1–800–MEDICARE, through their local State health insurance plan, through *www.medicare.gov,* and it is worth doing because there are real savings there.

Senator BUNNING. Thank you very much.

Senator THOMAS. Thank you, Doctor.

A Wyoming newspaper had, I think, a general concern that people have. This lady who we are talking about had talked to a friend of hers who had $100 worth of prescriptions and she only paid $20, so she was all excited. So she went to get hers filled, and it was $80, and she only saved $10. Now, I guess, what, different drugs are not covered under the card? This is confusing.

Dr. MCCLELLAN. Well, different cards have different formularies. The way that cards get savings, is they negotiate better prices on certain drugs and they bring lots of seniors together to buy those drugs, and that is why they can get the lower prices.

That is why I think it is important to have choices available, so that people with different medical needs can sign up for the card that is best for those needs. And, as I just said, the best way to get information about which card can get real savings for you is to call us at 1–800–MEDICARE and walk through how to get the most savings.

Senator THOMAS. So, different cards have different deals on different drugs.

Dr. MCCLELLAN. That is right, because different seniors have different needs. There is no one-size-fits-all drug formulary that can work for all of the seniors in this country. The cards do generally offer savings, many of them very broadly.

So I think in this case, both of the people that you mentioned, both the beneficiary that contacted us and got the card that was best suited for them that saved $80 a month, and the beneficiary saving $10 a month, they are both saving over what they are paying now.

They are both going to be able to pay for their card in the first few months. But you can definitely get more savings by matching up your needs with the card that offers the best deal.

Senator THOMAS. I see. That is interesting. I guess I did not understand that your needs, the kind of prescriptions you take, might have to do with which card you buy then.

Dr. MCCLELLAN. It can, depending on the formulary and the drugs that are covered.

Senator THOMAS. I see.

Dr. MCCLELLAN. That is why, again, we do not want to have just one formulary that everybody has to go on, because it may not be a very good fit for many of our seniors. We will help them match up with the card that can give them the best help.

Senator THOMAS. We hear a lot of suggestion that Medicare ought to do the same thing as the VA does and bargain. How do you react to that?

Dr. MCCLELLAN. Well, I think that is the same kind of issue. The VA is a great deal for many beneficiaries who are eligible, but it is a government-run health care program that has a government-run formulary that has some significant restrictions on it.

It does not include Lipitor, it does not include Celebrex, it does not include Prevacid, Nexium, Kozar, Vioxx, and so on, and so on. For many beneficiaries, they may want to get those drugs.

The VA can negotiate some lower prices, but so can the drug cards that may be better-suited to the needs of individual beneficiaries. So I think the idea of having a formulary and the idea of getting lower prices through negotiation is a good one. I just want to make sure that seniors can get in with a group that can negotiate the best prices on the drugs that they actually need.

Senator THOMAS. Yes. As we move into the 206 changing program, do you see it being a little broader so that you do not have to determine what you are using in order to decide which card you might want?

Dr. MCCLELLAN. Senator, many of the cards today do offer very broad ranges of discounts. They have so-called open formularies. If people want to get a card that provides at least some help across the board, they can do so.

Sometimes the cards that focus in on particular drugs in a class—and the drug benefit, and health insurance, work the same way—can get bigger discounts by steering people to particular drugs.

I think what we would like to do is give people the option, so if they want to get very broad coverage they can do that. If they are

happy with a particularly narrower pharmacy because it drives hard bargains on particular drugs, we want them to be able to do that as well.

Senator THOMAS. That is interesting. I do not think I have ever heard anyone who is confused know that there is a relationship between the drugs they take and the card they get.

Dr. MCCLELLAN. That is right. It is also important to point out, though, that there are many cards available that offer big discounts.

What we have seen over the last few weeks, is the cards get more competitive. The prices have come down. They have especially come down on the cards that started out higher.

So, there are a lot of cards that offer savings, but you do not need to spend too much time distinguishing between, for example, the very best card or the third or the fourth best.

They will all help you save money. But it is worth calling us and letting us know about your needs, and we can help steer you to the ones that are likely to be best for those needs.

Senator THOMAS. Thank you very much.

Senator Bingaman?

Senator BINGAMAN. Thank you very much.

Mark, thank you for being here. I am concerned, as you are, that there is a lot of money being left on the table. In my State, there are literally tens of thousands of people eligible for this $600 initial credit toward their drug cost and they are not taking advantage of it. These are low-income beneficiaries I am talking about.

My understanding is that 83 percent of the people who have signed up for this discount program, this transitional assistance, have been automatically enrolled.

As I understand it, what this is, is essentially their health maintenance organization decides, this is the one we are going to participate in, and they send them a notice and say, here is your card.

You are eligible, here is your card, start using it. These State assistance programs that you have referred to several times, they are essentially, you have issued guidelines telling them they can do the same thing.

Dr. MCCLELLAN. That is right.

Senator BINGAMAN. That is great for those seven States that have those programs. My State is not one of them. There are 43 States that do not have those programs.

We had written a letter to you. First, Senator Lincoln and I wrote a letter a couple of months ago, back in April, urging that you use the authority that you have in the new law to automatically enroll all eligible Medicare Savings Program, or MSP, beneficiaries—these are the QMB and SLMB and the QI–1 individuals, to just get real specific about it—and automatically enroll them in this transitional assistance program, thus making these individuals automatically eligible for the $600-per-year in low-income discount assistance, without requiring that they do anything else.

Now, it seems to me that is sort of a no-brainer. It seems to me that would make this benefit available right away to an awful lot of these low-income beneficiaries who stand to benefit very substantially from this transitional assistance program.

I am just wondering. We are doing another letter today. I think we have 28 or 29 Senators that are signing this one to Secretary Thompson urging the same thing, that you look at going ahead and automatically enrolling these low-income individuals who are participating in these Federal programs.

What is you reaction? Does this not make sense? Is there something that I am missing here?

Dr. McCLELLAN. Senator, we are definitely looking into this, and I strongly appreciate your interest in making sure as many low-income beneficiaries as possible get the literally billions of dollars in new help that is available right now with their drug costs.

That is why we have started auto-enrollment, as we mentioned, for the State pharmaceutical assistance programs. There will be more than seven States, I think, that end up participating in that.

It takes a little bit of time for the States to gear up, and we are trying to help them along in that process as quickly as possible. We are also doing a lot more, as I have already talked about, to try to help beneficiaries find out about the program and enroll individually.

We have had hundreds of thousands of low-income beneficiaries do that already. There are hundreds of thousands more in the process, and we have got new steps to try to reach more of them.

We are looking into this idea of auto-enrollment of the Medicare savings program beneficiaries. I think the reason for doing that, you have laid out very eloquently. There are some practical concerns that arise.

We need to make sure the States can work with us on this. They need to have so-called deeming authority, as we have had to work through with the States that are doing auto-enrollment for their SPAP, for their State pharmaceutical assistance program, beneficiaries.

We need to make sure that the States are willing and able to participate in this effort. We need to find a way to address the fact that some of these SLMB and QMB beneficiaries have coverage through other means.

We are working through all of those issues now. There have been a lot of good ideas put forth by the Access to Benefits Coalition, by your staffs, and others. So, we are definitely interested in pursuing this, and I will look forward to following up with you on it.

Senator BINGAMAN. Well, I am encouraged by your response, because I do think that this is one way, instead of just saying we have got this amazing effort to educate people about what they can come in and sign up for, or can sign up for, this would be a way to just send them a card and say, next time you buy a prescription drug, take this card in and you have got $600 of credit by virtue of having the card, plus you get a discount. It just seems to me a no-brainer as a way to get this benefit to the people we were intending to benefit as part of this low-income thing.

Dr. McCLELLAN. That is right. It is true that low-income beneficiaries, in general, whichever card they sign up for, are likely to save money if they do not have drug coverage now. If we can steer them to the best cards, they can potentially save even more.

But the first order of business is to try to get them enrolled, so we will try to work with you on this. We are especially interested

in hearing from the States at this point about whether and how they think they could do this, would it be too burdensome or too hard for them to do it in the short term. But we are definitely looking into this issue, and I appreciate your interest in it.

Senator BINGAMAN. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Yes. Thank you, Senator Bingaman.

Next, is Senator Graham, I believe, and then Senator Snowe, then Senator Lincoln.

Senator GRAHAM. Mr. Chairman, I would like to ask that an opening statement that I had prepared be entered into the record.

The CHAIRMAN. Yes, it will be.

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

Senator GRAHAM. This opening statement is a little bit of a broken record, because, again, it asks for a series of issues that we have developed over the past months of problems within the Medicare Modernization and Improvement Act be the subject of a public hearing by this committee.

I have been asking that we do this before Memorial Day. That date having passed, I would now ask that we do it prior to the Fourth of July recess, and particularly because there has been another issue raised to the list of concerns about this program.

In the Chairman's opening statement, this observation is made: "The drug discount card program has been the target of a deliberate campaign to discredit it and confuse seniors about how it works. This effort is driven and coordinated by those who oppose the Medicare Modernization Act, not because of policy, but because of politics."

Then the statement goes on to quote the Centrist Policy Network, which states that "Democrats have been discouraging seniors from enrolling in the Medicare drug card."

Dr. McClellan, have any of the questions that have been asked by Republicans or Democrats this morning constituted discouragement for seniors to enroll in the discount card?

Dr. MCCLELLAN. I think this hearing has had a very constructive tone of figuring out how we can get the most benefits out of this program. The fact is, though, there is a lot of misinformation out there. Some seniors think that they can lose benefits if they sign up for the cards. That is not true.

Some seniors think that the prices are higher than they were a month ago, or 3 months ago. That is not true. Some seniors think that they cannot get real discounts if they do not have drug coverage now. That is generally not true. In general, the prices are lower than Internet pharmacies and the like.

Senator GRAHAM. The question could be answered yes or no. Have any of the questions that have been asked by Republican or Democratic members of the Finance Committee to you this morning been a discouragement to seniors to sign up for the discount drug cards? Yes or no?

Dr. MCCLELLAN. Well, I think the questions, yes, can be an encouragement. But, again, the misinformation came up here, where some people were thinking that they could lose their food stamps by signing up for this program. That is just wrong.

Senator GRAHAM. Was it inappropriate for Senator Daschle to ask the question?

Dr. MCCLELLAN. I think it is appropriate to have a discussion about the best way to get the most out of this program.

Senator GRAHAM. So I am going to ask you a third time a question, if you can answer.

Dr. MCCLELLAN. Yes. Yes. Yes. Yes. Yes.

Senator GRAHAM. Have any of the questions that have been asked of you by either Republicans or Democrats, in your judgment, been inappropriate and constitute a discouragement to seniors to sign up for the discount card plan, and if they are, which were those questions?

Dr. MCCLELLAN. No. And I hope we can overcome this misinformation.

Senator GRAHAM. All right. That is fine.

Now, let me ask you the second question. That is, the statement has been made that there is a coordinated campaign to discourage seniors from signing up, and apparently that the Democrats are a part of that coordinated effort.

Do you have any evidence to support that statement?

Dr. MCCLELLAN. Well, I know there is a lot of misinformation out there, and I know that the Kaiser Foundation——

Senator GRAHAM. No, that is not the question. I know there is——

Dr. MCCLELLAN. [Continuing]. Says that there has been misinformation in advertising and advocacy about the program.

Senator GRAHAM. Could you give some specific examples of a coordinated campaign to discourage seniors from signing up for this program?

Dr. MCCLELLAN. Well, we have heard from seniors who have said that, for example, in a Families USA video, they hear from Walter Cronkite. We have heard seniors say, look, Walter Cronkite does not like this, I am not going to sign up for it. That kind of thing is happening now, and I want to make sure that people have accurate information.

My focus is on doing all we can to get accurate information out, since there is this misinformation out there, not on tracking down who, what, or where the misinformation came from. Our goal needs to be to inform seniors and educate them properly about this program.

Senator GRAHAM. Well, apparently the Centrist Policy Network has gotten some information that Democrats are a part of this coordinated campaign. Do you have any evidence to that effect?

Dr. MCCLELLAN. I would suggest you talk to the Centrist organization that is very concerned about that issue.

Senator GRAHAM. No. You are the manager of this program. Do you have any evidence that such a coordinated effort——

Dr. MCCLELLAN. Senator, no. My job is not to investigate the politics. My job is to get the facts out to beneficiaries.

Senator GRAHAM. I guess that is a no.

Dr. MCCLELLAN. No.

Senator GRAHAM. Let me ask another question about investigation. You are the head of the Medicare program. Most of the people who have been involved in the issues that I discuss in my opening

statement, particularly the issues of the withholding of information relative to the cost of this legislation which has now even reached the point of a possible criminal investigation, in violation of the law which provides that executive agencies and their officers do not have the right to prevent or prohibit their officers or employees from presenting information to the U.S. Congress, a serious series of charges.

Have you done an internal investigation to determine what you think has occurred, and if you have, what has been your conclusion?

Dr. MCCLELLAN. Well, Senator, two points. One, there is an internal investigation going on now by the Office of Inspector General, and I am waiting to hear. They are taking an objective and thorough look at this, and I am waiting to hear what they have to say and what their recommendations are.

Second, I have not waited to be clear about something else. As you know, I have been in this job for about two months and I have been clear from the start that we are going to have transparency with Congress, that we are going to share results of finished analyses that members of Congress request and that are relevant to further policy deliberations. So, we are going to have transparency going forward.

Senator GRAHAM. So you are not, as the leader of the organization, conducting an internal investigation, but the Inspector General is?

Dr. MCCLELLAN. The Office of Inspector General is.

Senator GRAHAM. When do you expect that report to be completed?

Dr. MCCLELLAN. You would have to ask the Office of Inspector General. I know they want to do this thoroughly and properly.

Senator GRAHAM. Could you ask that question and let us know in writing when you expect that report?

Dr. MCCLELLAN. All right. I suspect they may not be able to give an exact date. The investigation will be done when it is done.

Senator GRAHAM. Can they give it, say, within 30 days, plus or minus?

Dr. MCCLELLAN. All right. I will try to find out.

Senator GRAHAM. Thank you.

[The response appears in the appendix on page 95.]

The CHAIRMAN. Thank you, Senator Graham.

Now, Senator Snowe?

Senator SNOWE. Thank you, Mr. Chairman.

Obviously, there is a lot of concern about the fact that the prescription discount card got off to a very rocky start. It further suggests what the implications are for the future and whether or not lessons have been learned in this process, and visualizing what is going to happen in 2006, and whether or not we are going to be able to implement that benefit smoothly, let alone to ensure that the benefits are not negated because of soaring price increases in medications.

First of all, I would like to have you address that question because it really is going to be one of the major issues for the future. I am very concerned. If we cannot get this drug card off the ground efficiently and effectively, I hesitate to think about the future when

we are talking about the overall program that is ultimately going to benefit 43 million people, supposedly.

So, I think we have to look at that. Frankly, I think we should require some reporting from you on that score in response to how you do intend to do it so that it is not complicating, deterring seniors from signing up for the program.

The price increases in medications—again, it is transparency. I am not entirely clear what the transparency is when it comes to pricing that the card sponsors are supposed to be offering. How do we know? I mean, you know it intermittently, regularly, consistently, weekly?

Dr. MCCLELLAN. Yes.

Senator SNOWE. Because I think it is important. We need to know that, whether or not these price increases, dramatic price increases, are negating, ultimately, the benefit of these discounts.

Dr. MCCLELLAN. We know far more transparently than ever before what the prices that seniors are actually paying are under this program. The card sponsors update their prices weekly. So far, we have seen prices go down, in general. And as I have said before, price increases are not allowed in this program unless it is related to an increase in cost.

Not only that, because there is now actual price information available on what seniors can pay at virtually every pharmacy in the United States, we have got a much better way to monitor exactly what is going on with prices and to encourage exactly that kind of transparency that you were just speaking about.

As I said before, we have used this information to go back and look and compare prices available today to prices in the beginning of 2003 before this program ever started, the list prices that seniors were paying, and the prices today are substantially lower, 9 to 30 percent or more.

Senator SNOWE. For what, the top?

Dr. MCCLELLAN. For the brand-name drugs.

Senator SNOWE. For the brand-name.

Dr. MCCLELLAN. For the generic drugs, the savings are even more substantial, 30 to 60 percent or more lower. And with the transparency that we have in place now, I think it will be a lot easier to monitor what is going on with drug prices.

Senator SNOWE. They are lower than at what point in 2003?

Dr. MCCLELLAN. January, 2003.

Senator SNOWE. So any of the price increases that occurred during that period of time——

Dr. MCCLELLAN. This is a comparison of the retail prices that seniors would be paying then versus the discounted prices that they are paying now. And we will get you more information on this, since I know you are very interested in it.

Senator SNOWE. I think we need to know that, frankly.

Dr. MCCLELLAN. Yes.

Senator SNOWE. If it is erratic, consistent, is it the most commonly used, selected cards, for example?

Dr. MCCLELLAN. That is right. And the other thing that I think this kind of information helps provide, is letting seniors know about other alternatives. For example, some of the biggest price increases have occurred on drugs where there are now generic

versions available, drugs like Prilosec, where if seniors know about it, they can switch to a generic version, in some cases even an over the counter version, that is much cheaper than the brand name ever was. So, that kind of information, in addition to the actual retail price information, is very useful.

Senator SNOWE. Well, what is the turnaround when these prices are not on track and they cannot justify the increase of the price that they are requiring for a particular drug? I mean, is it monthly or weekly? Do you monitor it?

Dr. MCCLELLAN. Anyone and everyone can monitor these prices. They are published. The final prices that seniors can actually pay with the cards are available now and they will be available for the duration of this program.

Senator SNOWE. So, what action do you take, and when do you take it? That is the question here.

Dr. MCCLELLAN. We monitor as well, and if there are any unusual increases that are not related to cost, then we have sanctions available under the card program. I think that they are going to be——

Senator SNOWE. When do they submit that data to you? I am just trying to figure out when this all happens.

Dr. MCCLELLAN. They submit price information to us weekly, and the card sponsors know the terms of the contract that they enter into with us about offering discounts, and about the circumstances when price increases are allowed under the program, and we monitor that.

We have a monitoring program in place. We are actually hiring a contractor to make sure it is done regularly and accurately. And it is not going to be just us. I think there are going to be a lot of other outside groups that are going to be keeping a close eye on the prices in this program to see what happens.

Senator SNOWE. Are you satisfied currently with this process?

Dr. MCCLELLAN. What we have seen, Senator, is especially for seniors that do not have good coverage now and have been paying some of the highest prices in the world, they can generally get significant savings on brand-name drugs, even larger savings on generics, and on Internet drugs.

My main goal right now is to help seniors with their drug costs. Seniors who look into this program can generally find that the cards will pay for themselves in the first month or two if they do not have good drug coverage now.

Senator SNOWE. Would the Secretary having negotiating authority not be better leverage?

Dr. MCCLELLAN. Well, that is a very good question. I know it is an issue that you feel strongly about. As you know, CBO has looked into this issue and does not see any additional savings.

Negotiation requires being able to move people to particular drugs. The VA can get good prices for their beneficiaries because they have a specific formulary. Not all the drugs that many seniors like to use are on that formulary.

I think we have already seen that we can get prices down through negotiated discounts through drug manufacturers through the card program already. I think we can build on that while giving seniors options about exactly which drugs they want those prices

negotiated on so they can get drugs that best meet their needs. I am sure we are going to continue talking about this in the months ahead.

Senator SNOWE. We will. Thank you.

The CHAIRMAN. Before Senator Lincoln asks questions, I know you have been at the table a long time, but I was hoping I could get you to stay and hear the second panel, or at least part of it.

Dr. MCCLELLAN. I will try to stay for a bit of it. I do have another engagement at noon.

The CHAIRMAN. All right.

Senator Lincoln?

Senator LINCOLN. Thank you, Mr. Chairman.

And thank you, Dr. McClellan.

Dr. MCCLELLAN. Thank you, Senator.

Senator LINCOLN. We are very grateful that you are willing to be here today. This is the first Finance hearing regarding the implementation of the Medicare bill, and we are getting lots of questions from our constituents. We appreciate your dialogue and look forward to working with you to work through this bill.

Dr. MCCLELLAN. Thank you.

Senator LINCOLN. I have several questions. One, actually, just on top of what Senator Snowe brought up in terms of the transparency. You mentioned that transparency is good for competition.

I guess if that is the case, as we move forward into 2006 and looking for competition to make sure prices are good, would it also mean that making the Medicaid best price public would be a good tool in terms of being able to bring transparency in helping to——

Dr. MCCLELLAN. That is a good question. I am not sure it is going to be real helpful for Medicare beneficiaries because, as you know, under the Medicare Modernization Act, the prices that seniors can get negotiated for their drugs are exempt from the Medicare best pricing statute.

That is one reason that CBO thought that seniors would be getting about $20 billion plus in additional savings. So, I am not sure that will help with Medicare beneficiaries, in particular.

I think we have learned a lot already about the value of having actual price information available, and that is something that we want to work to incorporate in the full drug benefit as well. Giving seniors information allows them to comparison shop. We have already seen it bring down prices on the drug cards.

Senator LINCOLN. Well, we might be willing to look at the possibility of the Medicaid best pricing as a transparency tool.

Dr. MCCLELLAN. We are going to be looking at a lot of issues with implementation of the drug benefit. We expect to have the proposed regulations for the drug benefit available soon, this summer, and look forward to discussing with you and with all other members who are interested in this program succeeding as to how we can do that as effectively as possible.

Senator LINCOLN. We all think that transparency is good for competition. I think much of what you defend in this bill as being positive depends on competition.

Dr. MCCLELLAN. Right.

Senator LINCOLN. So, hopefully we will look at those possibilities.

I also want to align myself with Senator Bingaman. We have written to you about States like ours that do not have State drug assistance plans, that do not have the Medicare+Choice plans or the Medicare Advantage plans. I understand you have auto-enrolled these beneficiaries.

I guess my question to you is, is there any logic in not automatically enrolling the QMBs, the SLMBs, and the QI–1s?

Dr. MCCLELLAN. There are a number of potential issues that need to be addressed and that we are thinking through how to best address, and we appreciate your input into that process. One is the statutory authority. The States have the so-called deeming authority to presumptively enroll people.

Senator LINCOLN. They have the deeming authority through their State programs, right?

Dr. MCCLELLAN. Right.

Senator LINCOLN. They have worked that out.

Dr. MCCLELLAN. And some States have deeming authority defined in different ways. For example, a couple of States, like New York, had to actually pass a special act of the legislature to get the deeming authority for the automatic enrollment in their State pharmaceutical assistance plan.

Senator LINCOLN. Well, clearly you have worked that out with them.

Dr. MCCLELLAN. In that case, we did. Another issue is whether the States are going to be able to take on this burden of helping us out with the automatic enrollment, and we would like to hear from the States about that.

Senator LINCOLN. Have you approached them?

Dr. MCCLELLAN. We have started these discussions. We are also hearing from a lot of advocacy organizations that are well connected with the State programs about whether and how this can best be done.

Senator LINCOLN. Do you keep records on those groups, those QMBs and SLMBs? I mean, I know it is administered through the State Medicaid.

Dr. MCCLELLAN. Yes. We do have some information on them. They are administered through the States. Another related obstacle is that we do not have information on whether or not these beneficiaries already have drug coverage, so we need to find some way to address that. Remember, the low-income assistance is for people who are on their own now and do not have good coverage when it comes to prescription drugs.

Senator LINCOLN. But a lot of those Medicaid programs through the States—I know I had a gentleman call my office just last week, and he is covered by only three drugs a month. Our Medicaid program limits him to three drugs, but he is on eight. Because he has Medicaid coverage, he is not eligible for the discount card or the $600. I mean, there are some problems there, too.

Dr. MCCLELLAN. That is right. And we would certainly like to help as many beneficiaries as we can. A lot of beneficiaries in many States do have more comprehensive coverage.

Even for a beneficiary like that, if he is having trouble with drugs and some of them are not covered, we can put him in touch with manufacturer programs that may be helpful as well.

And that is something else that we are working on improving with the Access to Benefits Coalition, too, is helping them find other sources of savings or generic drug alternatives, or things like that.

Senator LINCOLN. Well, you have obviously overcome the challenges in States that have the State programs, working with them to have that automatic enrollment.

Dr. MCCLELLAN. That is right.

Senator LINCOLN. And I would encourage you to work with the other States that do not have that.

Dr. MCCLELLAN. And we are learning a lot from that auto-enrollment process. It is ongoing now. It is going to get hundreds of thousands of low-income beneficiaries automatically enrolled. So, we will keep learning from this process.

Senator LINCOLN. I do not know. Maybe I am just way too basic here. But you sending a card out to those that you have on record as QMBs and SLMBs, and giving them a number and saying can you please call, you are going to be automatically enrolled—because you just said, if you have got constituents that are concerned or have questions, to be sure and call you all.

We have had a lot of them have been calling and they have not been able to get through. But, I mean, if they got a specific card from you all that said we have already enrolled you, just give us a call and we will make sure the card is appropriate for you.

Dr. MCCLELLAN. If we were going to make auto-enrollment work, we would like it to be as simple as you just described. The question is, how do we work through the details of getting from here to there? That is going to take some input from the States, from advocacy groups, from others, and we are looking into that right now.

Senator LINCOLN. Good. Well, I would encourage that the other States that you have not worked with yet, I hope you will. I hope you will take notice of where the auto-enrollees are already in existence in States.

Mr. Chairman, I have got some other questions. May I submit those for the record?

The CHAIRMAN. And I am going to submit questions for the record.

Senator LINCOLN. All right. Thank you.

Thank you, Dr. McClellan.

Dr. MCCLELLAN. Thank you.

[The questions and responses to them appear in the appendix.]

The CHAIRMAN. Before you go, I would like to ask for clarification. Does this 3 million enrollment number reflect beneficiaries in the seven States that can automatically enroll?

Dr. MCCLELLAN. No, it does not. We expect, in those seven States, another 400,000 beneficiaries with low incomes to be added in. Those are not included in the numbers, the 3 million plus that are enrolled in the cards already. Even beyond those seven States, there are some additional States that are working with us to try to get the numbers up further.

For example, States like Ohio are sending out, basically, completed forms to their beneficiaries so the beneficiary just has to sign it and send it back in. It is not quite auto-enrollment, but it is another step to try to make it even easier for low-income bene-

ficiaries to sign up. A lot of that is going on now too that will add further to the numbers.

The CHAIRMAN. All right. So it will be much higher than 3 million?

Dr. MCCLELLAN. Yes.

The CHAIRMAN. Thank you very much.

I am going to call our second panel. I have already introduced my constituent, Kris Gross, who has been very helpful in the 41 Medicare meetings I have had around Iowa. She represents the Iowa SHIIP program.

Will the second panel please come as I am calling you?

Our second witness, Mark Merritt, is president of the Pharmaceutical Care Management Association. He has participated in some of the highest profile health care policy debates and is well known.

Then we have Dr. James Firman, chairman of the Access to Benefits Coalition. I have already spoken about that coalition and congratulated them on the efforts that they are making to see that everybody can get benefits from this program. He has also written several books and articles on the issue of aging, so he is very expert in this area.

Then we have Robert Hayes, president and general counsel of the Medicare Rights Center in New York. This organization helps older adults and individuals with disabilities get high-quality, affordable health care through education and outreach.

Our final witness, Tom Snedden, is the director of the Pennsylvania Pharmaceutical Assistance Contract for the Elderly, and that is a PACE program. The Pennsylvania PACE program is a State-funded prescription drug benefit for qualified older Pennsylvanians funded exclusively by the State lottery fund. It is the largest State pharmacy assistance program of its kind, I think, with 230,000 enrollees.

Kris, would you go first, please?

STATEMENT OF KRIS GROSS, DIRECTOR, IOWA SENIOR HEALTH INSURANCE PROGRAM, DES MOINES, IA

Ms. GROSS. Thank you, Chairman Grassley.

I am here representing the 54 State health insurance assistance programs, or SHIPs, and I appreciate the opportunity to share with you the role SHIPs play in relation to the Medicare-approved drug discount cards, and some of our experience to date.

First, I would like to give you a brief description of the State health insurance assistance programs. In 1992, the then-Health Care Financing Administration, which is now CMS, offered States funding for the SHIPs.

Some of the SHIPs existed prior to that time and receive additional funding from States and other grants. We are housed in State Departments of Aging, Insurance, and in one State, the Medicare Quality Improvement Organization. Our services are free, confidential, and objective.

We are charged with helping all Medicare beneficiaries by providing information and counseling with problems and questions related to Medicare, Medicare advantage plans, health insurance that supplements Medicare, long-term care insurance, Medicaid claims,

and prescription drug assistance, which now includes the Medicare-approved drug discount cards.

As Dr. McClellan mentioned, the heart of the SHIPs is the one-to-one, face-to-face assistance and counseling provided to our clients and their communities. This is offered primarily through volunteers, many of whom are peers to the people that they counsel.

CMS can provide awareness and information through its many resources at the national level, but SHIPs provide the local face. We are there to help people understand their options so they can make the best possible decision.

An important role for SHIPs is assisting clients with the Medicare-approved drug discount card price comparisons. A Kaiser Family Foundation pollster, Mollyann Brown, found that only 31 percent of seniors have used the Web.

SHIPs are taking client prescription information and running the web-based comparison on the Medicare website if a client does not have access to a computer. Clients who need counseling related to the price-comparison information they received then meet with our volunteer counselors.

Let me share with you some of our experience. Depending on the situation, clients can receive many pages of information with their price comparison. We ran a comparison for an individual taking four drugs, living in Des Moines, and for the pharmacies within 3 miles of her zip code. If she chose to view all the discount cards offered, she would have received over 30 pages of information.

In visiting with the SHIPs directors from across the country, we have universally found that a majority of the clients who do not access the Medicare website on their own need one-to-one assistance to examine all these options before they make a decision about the drug cards.

In some cases, beneficiaries even find it difficult to provide us with their prescription information needed to run the price comparison of the cards.

One woman who called into our Iowa 800 number and asked for help could not find the dosage on her pill bottle. One-to-one assistance is critical to helping beneficiaries get the most from this program.

The $600 low-income credit is the focus of most of our outreach efforts and partnering. Some of our partners include organizations serving individuals with disabilities, public health nurses, community action, energy assistance programs, State Medicaid agencies, low-income housing, the medical community, churches, and organizations serving Latinos, Asian-Pacific, and other ethnic populations.

When beneficiaries find out about the $600 assistance, they are very grateful. One caller to our office told me personally that the $600 credit sounded too good to be true. The $600 represents an amazing opportunity for low-income beneficiaries.

We have had close to 1,000 people call our office who are eligible for the $600 credit. They are typically taking 8 to 10 drugs and are desperate for help.

We are mailing them their price comparison and then they are asking a counselor to meet with them to sort through their options.

Our SHIP counselors are prepared to provide this important assistance.

Some beneficiaries have found that the drug cards can provide significant savings on their drugs without the $600 assistance even factored in. One client is going to save $45 on a $90 prescription each month.

Along with the savings on the other drugs she takes, her annual savings will amount to $700–$900 per year, depending on her choice of local pharmacy versus mail-order.

Some have found, however, that the discounts they are already getting from other discount cards, pharmacy programs, pharmaceutical company assistance programs, or their insurance offer comparable or better savings.

It is taking careful review of the Medicare price comparison information to determine if enrollment in a card will be beneficial for each individual.

Community education has been, and will continue to be, essential. People are confused by the discount card versus the drug benefit. They do not know about the $600 low-income credit. They need to know how to get information about the cards, the formularies, and so on.

SHIPs have been conducting literally thousands of community education events, and we are continually asked to give those presentations.

Our experience with the Medicare-approved drug discount card indicates that a huge challenge lies ahead next year, when we will need to help beneficiaries with the even more critical decision related to the Medicare drug benefit.

It will be important for this committee, the Congress, CMS, and the SHIPs to learn from the challenges beneficiaries face with the discount cards so that we can best meet their information and decision needs next year.

We are grateful that Congress provided CMS with $1 billion in funding for administrative costs, and some of those funds support beneficiary education and outreach, including those conducted by the SHIPs.

We are hopeful that in subsequent years Congress will continue to provide adequate funding for these activities. Adequate funding will be crucial to everyone's efforts to help beneficiaries understand their choices and to make decisions that best meet their coverage needs.

In closing, the SHIPs want to thank CMS and the Congress, and especially you, Senator Grassley, Senator Baucus, and Senator Bingaman, for the interest you have taken in the work that SHIPs do, and for doing what you have done to secure additional funding for SHIPs.

To the members of this committee, thank you for your extraordinary efforts on behalf of beneficiaries, and particularly the low income. Millions of beneficiaries should be thanking you for your leadership on these issues. Thank you.

The CHAIRMAN. Thank you very much.

I forgot to say that if any of you have longer statements, longer than your 5 minutes, we will include those longer statements in the record as you submit them.

[The prepared statement of Ms. Gross appears in the appendix.]

The CHAIRMAN. Mr. Merritt?

STATEMENT OF MARK MERRITT, PRESIDENT, PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION, WASHINGTON, DC

Mr. MERRITT. Thank you. Good morning, Chairman Grassley and Senator Lincoln. My name is Mark Merritt. I am president and CEO of the Pharmaceutical Care Management Association, PCMA.

PCMA is a national trade association for America's pharmacy benefit managers. I am pleased to be here today to update you on the important role that PBMs are playing to make the new Medicare drug discount card program a success for beneficiaries.

PCMA's member companies are participating in the program by sponsoring their own drug cards, in partnership with dozens of Medicare Advantage health plans.

Although we are only 1 week into the new program, enrollment is continuing at a brisk pace and we see several positive signs that point to the program's ultimate success.

This is what we have already seen and learned. First, we know the discounts are real. Based on a survey of PCMA member companies, we estimate that seniors will receive discounts averaging 17 percent for brand-name drugs and 35 percent for generics, when compared to prices paid by cash-paying customers. These data are in keeping with CMS's own data and other independent sources.

Further, according to CMS, card sponsors are passing over 90 percent of the rebates and discounts they receive from drug makers and retailers onto seniors who are enrolled in the program.

This shows the competition spurred by retail price transparency is working to deliver savings for beneficiaries, and it demonstrates the transparency requirements included in the new law, while working to benefit seniors as Congress intended.

The savings are even greater for low-income beneficiaries. Under this program, a needy senior has access to drug card discounts and $1,200 over the two-year life of the program.

In addition to this program, there are discounts provided directly by drug makers. When combined, these savings can mean a senior can slash his or her total prescription drug bill by 60 percent or more, and from the data we saw from Mark McClellan, even more than that.

We have also learned that market competition is helping to drive discounts even deeper. PCMA's own review of price changes since the Medicare price website went live shows that, for a basket of commonly prescribed brand-name drugs received through the mail service option, the average reduction in prices for the top five cards was 13 percent cheaper than the prices originally listed on the website in early May. That is important progress that really should not be minimized.

Third, this program is providing seniors with maximized choice. Seniors have access to virtually all classes of outpatient drugs at discounted rates. Moreover, they have an important new mail service pharmacy option, which adds further cost savings, quality improvements, safety protections, and convenience, and it furthers

the goal of making sure that the right card goes to the right person, according to their particular and individual needs.

Fourth, PCMA member companies are working hard to inform seniors about the new options available to them and are using a variety of methods to help raise awareness about the program, including TV, radio, and newspaper advertisements, information mailers, marketing of tens of thousands of neighborhood and chain drugstore pharmacies across the country, educational outreach to physicians, outreach through seniors groups, community-based organizations, faith-based groups, and other civic groups as well.

Another important educational tool has been what has been discussed broadly here already, the Medicare price comparison website, which is helping seniors to find the drugs that meet their individual needs. In addition, this website is promoting vertical and horizontal competition which is helping to drive down drug prices.

In the coming months, we will continue to work hard to conduct outreach and enroll beneficiaries, because we believe in the program and the tangible value it represents to Medicare beneficiaries.

On behalf of PCMA member companies, thank you for the opportunity to testify today. I will look forward to answering any questions you might have.

The CHAIRMAN. Thank you very much.

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

The CHAIRMAN. Now, Mr. Firman?

STATEMENT OF JAMES B. FIRMAN, CHAIR, ACCESS TO BENEFITS COALITION, AND PRESIDENT AND CEO, NATIONAL COUNCIL ON THE AGING, WASHINGTON, DC

Mr. FIRMAN. Good morning, Senator Grassley and Senator Lincoln. I am James Firman, president and CEO of the National Council on Aging, the Nation's first organization formed to represent America's seniors and those who serve them.

I also serve as the chair of the newly-formed Access to Benefits Coalition, a public/private partnership of 75 diverse organizations dedicated to ensuring that lower-income beneficiaries know about and enroll in the new Medicare prescription drug benefit, and all other available resources for saving money on prescription drugs.

Enactment of the new Medicare law is the single most important opportunity to help low-income Medicare beneficiaries that has emerged in the past 40 years. Of immediate significance is the fact that Medicare group discount cards include $600 transitional assistance this year and next year for those with annual incomes below 135 percent of poverty.

However, to achieve the law's full potential, we must maximize enrollment in the transitional assistance program, as well as in other savings programs offered by States and private pharmaceutical companies.

However, in recent years, various agencies, organizations and foundations have tried to identify and enroll low-income beneficiaries in a wide variety of public and private programs, with only mixed results.

While current government efforts to reach many low-income beneficiaries are to be commended, there also needs to be complementary, coordinated initiatives that go deeper into the community to find and educate consumers and their families and to help them actually enroll in the benefits for which they are eligible.

In response to these challenges and opportunities, the National Council on Aging and 75 other national nonprofit organizations have founded the Access to Benefits Coalition. ABC members share an interest in helping to connect lower-income Medicare beneficiaries to all the public and private prescription savings programs available to them.

The coalition represents a diverse group of senior, disability, faith-based, minority, provider, consumer, and advocacy organizations, and is growing on a weekly basis. The organization has exceptional reach and trust among Medicare beneficiaries, and we are uniquely positioned to counsel and help navigate them through the process. We are now working to organize and support State and local ABC coalitions across the country.

The coalition's short-term objective is both ambitious and clear, to ensure that by the end of 2005 at least 5.5 million low-income Medicare beneficiaries get the $600 annual credit, as well as other public and private benefits that can save them money. This is about 700,000 people more than the government has set as its objective. However, we believe, by working together, we can, and must, do more.

The ABC also has a longer-term objective, which is to ensure that at least 8 million low-income beneficiaries enroll in the low-income Part D program by the end of 2008; 5.5 in 2005, 8 million in 2008.

The coalition applauds the Department of Health and Human Services for its recent commitment to provide $4.6 million to support community-based education enrollment efforts targeted to lower-income beneficiaries.

We are also pleased that the Corporation for National Service has recently approved 15 VISTA volunteer slots to assist our efforts, and we hope they will follow with more.

We expect to be able to announce next week more precisely how these and additional private sector resources will be made available in communities throughout the country.

We are also pleased to announce today that the Access to Benefits Coalition has launched a new website, *accesstobenefits.org*, which has a variety of tools to help people, older people, their consumers, their family members, and professionals to educate and enroll lower-income beneficiaries in prescription savings programs.

Thousands of coalition members' staff and volunteers will be trained and supported to serve as individual counselors and navigators and to help lower-income beneficiaries and their families use the new tool.

There are several tools. First of all, there are 51 State prescription guides with detailed information on a wide range of Federal, State, and private prescription programs. I have heard several Senators ask here today, what should I tell the people in my State? How do I give them the best advice?

Well, one resource is to go to *accesstobenefits.org* and click on the guide for your State, which will give you the best information we have about how these various programs interact, as well as some easy-to-use tools to help people figure out what they are eligible for.

Second, the website includes an enrollment center, the first of its kind, with hundreds of prescription drug savings enrollment forms all in one place—public programs, State programs, private programs, discount cards—and many of those forms are fillable online.

Third, you will find a "Promising Practices in Outreach Enrollment" section, which provides information on the most important lessons learned until now about the best ways to find, reach and enroll low-income beneficiaries in various public programs.

The ABC site also links to NCOA's award-winning BenefitsCheckupRx decision tool. We are developing an enhanced version of this tool to facilitate the decision making and to answer the kinds of questions that you are hearing from each of your constituents. What combination of programs will save me the most money?

This enhanced version will be available later in July and will tell people the combination of Medicare benefits, State pharmacy programs, manufacturers' discount cards, and other cards that will save them money, and we would show them how much money they can save. The tool will also assist people to actually complete the application form with as many programs as they decide to apply for while online.

It is very important to remember that most Medicare beneficiaries who enroll in the credit program can save a lot more than $1,200 over the next 18 months. This is because of commendable actions by States and several pharmaceutical manufacturers to offer wrap-around programs to the Medicare card.

Those people who take multiple medications and who have incomes below 135 percent of poverty could save from 40 to 90 percent on their medication if they choose the card with the right wrap-around.

The Access to Benefits Coalition is calling on all Medicare-approved discount card sponsors to pledge to make their best effort to include all the manufacturers' prescription savings programs in their cards when the $600 is exhausted.

This will make it easier for consumers. If they know that they take a card that has all the wrap-around, they know they will get the free benefits from Merck, J&J, and Novartis, and Wyatt-Ayerth, and other companies as well.

Our goal is to get at least one-half of the Medicare-approved discount card sponsors to sign this pledge within the next 30 days. Five card sponsors have already agreed to sign the pledge.

Although the ABC is not a political organization, we are not involved in whether the Medicare law is a good law or a bad law, or how it should be changed, we believe there are a number of ways in which enrollment and the $600 credit can be improved.

We are pleased that CMS agreed to the development and use of a standardized enrollment form and to allow for automatic enrollment in the $600 credit for State pharmacy assistance programs.

The coalition also supports automatically enrolling current Medicare savings program recipients in the $600 credit, and we will be talking with CMS officials very soon to provide specific recommendations.

I would also like to encourage each State to look for other opportunities, either for auto-enrollment, or at least wholesale marketing of the transitional assistance program.

In each State, you have programs now for low-income beneficiaries, perhaps for energy assistance or housing, or other forms. Most of these people will be eligible for the transitional assistance benefits as well, and we can figure out more efficient ways to reach them.

In conclusion, the Access to Benefits Coalition is firmly committed to working with a broad range of partners to take full advantage of this opportunity to provide much-needed assistance to this vulnerable, hard-to-reach population.

By working closely together on these initiatives, we can significantly improve the quality of life of millions of Medicare beneficiaries who need help in paying for their medication.

Thank you.

The CHAIRMAN. Thank you, Mr. Firman.

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

The CHAIRMAN. Now, Mr. Hayes?

STATEMENT OF ROBERT HAYES, PRESIDENT AND GENERAL COUNSEL, MEDICARE RIGHTS CENTER, NEW YORK, NY

Mr. HAYES. Thank you, Mr. Chairman. Good morning, Senator Breaux.

We appreciate this opportunity to bring to the committee the real-life experiences of the men and women with Medicare who are grappling with the opportunities and with the challenges of the new Medicare discount card program.

From the trenches in which we work, Mr. Chairman, the unaffordability of prescription medicine is, and remains, a national emergency. So it is within that reality that we approach the Medicare discount card program, and it is the needs of the men and women who cannot afford medicines they need that we bring to you.

For many years, this committee, this Congress, our Nation have been numbed by the overwhelming data documenting the human hardship, the needless pain, the lost lives caused by the unaffordability of prescription medicine. But it is not just data.

Mr. Chairman, I cannot shake from my memory the elderly woman who tearfully told me that she lies to her husband whenever her doctor gives her a prescription.

If she told him about the prescription, she said, her husband would insist that she fill it. She wants him to keep taking his heart medication, and she knows they cannot afford another medication. That is an obscenity in America in the 21st century, and I know that we agree on that and appreciate that that is why we are here today.

I will take just 2 minutes, Mr. Chairman, to outline what consumers are experiencing in the wake of the Medicare discount card

roll-out. This evidence has already been widely reported and seems fairly well established. One, the men and women who turn to us for help are in a state of high anxiety. They are confused, frustrated, or angry, or all three.

Two. Most people with Medicare will receive little, if any, benefit from the Medicare discount card program. This is not a political statement and it is not a point in dispute. As you know, CMS itself is aiming to enroll about 7 million people, 17 percent of the people with Medicare in the discount card program over the next 18 months.

Three. Some people, those with low incomes, those without any drug coverage, and those who learn about and sign up for the Medicare discount card program, will be able to afford medicine thanks to the Medicare discount card program's transitional assistance.

This is far too important a point to lose. It is true that in many ways we are critics of a complex program because, in our view, it would take much less, at much less cost, with many more people to be helped if we were able to negotiate fair drug prices with the pharmaceutical industry.

Yet some Americans will have improved health and a better life once they enroll in the discount program's transitional assistance. We join with groups like the National Council on Aging, and other groups more critical of the Medicare Modernization Act, in meeting our responsibility to help enroll as many people as possible and to push this administration to make enrollment as feasible as possible.

So how can that be done? First, recognize that websites and voice-automated phone systems, even when they work, are a sliver of the solution. We know that despite hearings like this, news coverage, tens of millions of dollars of advertising, many people—maybe even most people with Medicare—do not even know yet about the discount cards.

Education enrollment, like the kind Ms. Gross does in Iowa, on the retail level will be critically important in order to bring this transitional assistance to people with Medicare.

For today's discount card enrollment, we believe the single most useful step is to assist people to access the $1,200 transitional assistance through the automatic enrollment that Dr. McClellan indicated CMS is considering.

That alone could bring a million very low-income Americans into the discount program. We think that is a humanitarian act and we think it is a prudent political act.

It is not premature, in our view, to look ahead, as Senator Snowe suggested, to 2006. As currently designed, we fear that the Part D Medicare drug benefit will be so complex to navigate, that today's drug card program will look like child's play.

If the 2006 Medicare drug benefit is to be both a humanitarian and a political victory, we ask Congress and the administration to revamp the structure of the benefit with three words in mind: simplify, simplify, simplify.

To that end, Mr. Chairman, I conclude with six points of modest reform for the 2006 drug benefit: (1) automatically enroll all eligible persons in the low-income drug benefit; (2) remove the assets

test, which represents the leading barrier to enrollment in low-income programs across the country; (3) require the use of simplified application procedures and allow self-certification of income and assets; (4) streamline the renewal process; (5) increase SHIP funding, again, as Ms. Gross pointed out, so that eligible persons can get help cutting through the red tape and receive benefits; and lastly, Mr. Chairman, (6) federalize enrollment not just in the low-income drug program, but also in the Medicare savings programs. Those steps, we believe, will make a reality true drug assistance to low-income Americans in 2006. Thank you.

The CHAIRMAN. Thank you, Mr. Hayes.

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

The CHAIRMAN. Now, Mr. Snedden?

STATEMENT OF TOM SNEDDEN, DIRECTOR, PENNSYLVANIA'S PHARMACEUTICAL ASSISTANCE CONTRACT FOR THE ELDERLY, HARRISBURG, PA

Mr. SNEDDEN. Senator Grassley, thank you. Senator Breaux, good morning.

I was asked to tell you a little bit today about how the Pennsylvania Pharmaceutical Assistance Contract for the Elderly is managing the benefit from the discount card and how our enrollees in our program are benefitting as well.

To do that, I think it helps to put some things into context. First, Pennsylvania is one of 22 States across the country that provide catastrophic or comprehensive prescription medication benefits to qualified State residents. These programs have a collective enrollment of 1.8 million people and have many similarities in terms of their qualifying criteria and benefit structure.

As a result, we have actually been working in concert for the last year and a half to provide what we consider to be salient input into the development of the new Medicare legislation and the development of the regulations for the programs that emanate from the legislation.

Just with respect to PACE, PACE has been around for 20 years. It is currently serving an enrollment of 280,000 older Pennsylvanians, costing roughly a half a billion per year in State funds. We had a projected enrollment of 335,000 by early 2005.

The eligibility criteria for the program is relatively simple: 65 years of age or older, State resident, limited income, cannot be enrolled in the Medicaid drug benefit in Pennsylvania, and there is no asset test.

Most importantly, the average PACE cardholder is a 79-year-old widowed individual with four or five maintenance medications that they are needing, less than a tenth grade education, and living alone in a private residence. These people generally have high anxiety and concerns about their health care, and in particular, their prescription drug coverage.

With respect to the discount cards, Pennsylvania has, with the help of the Congress and with the help of CMS, been able to find a way to benefit both the program and its enrollees from largely the $600 transitional assistance that is provided in the discount card benefit.

Of those 280,000 people currently in the PACE program, 151,000 actually meet the eligibility criteria for the transitional assistance benefit. We, working through our pharmacy benefit administrator, Forrest Hill, have been automatically enrolling 110,000 of those people in PACE into the transitional assistance benefit. As of early this week, in fact, CMS had approved 100,000 of those enrollees.

There are another 30,000 or so in PACE who also have coverage with a Medicare HMO in Pennsylvania that is also offering a discount card, and as a result, they cannot be automatically enrolled in PACE.

But, again, through the facilitative efforts of CMS, we have been able to help our State Medicare HMOs automatically enroll those people into their own discount cards.

This discount card savings will accrue largely to the program, but what the program is doing for the eligibles who are in PACE is picking up the co-insurance while they are remaining in the transitional assistance benefit. That is a significant savings to people in the program.

I think the bottom line, as it stands now, for Pennsylvania PACE and the Medicare discount card, is, first and foremost, by automatically enrolling these people in the transitional assistance benefit, we will save $150 million in the period between June 1 of this year and March 31 of 2006. That represents approximately 15 percent of the gross outlays during that period.

Second, the auto-enrollment will also facilitate the participation levels in the Medicare discount card, particularly with respect to the Medicare HMO enrollment of exclusives.

I say that because if the 151,000 people were not automatically enrolled through PACE in the Medicare HMOs, it is very likely that less than a majority of those would ever find their way to signing up for the benefit.

As a result of the experience to date, or I should say the success that we have enjoyed so far with the auto-enrollment, we are hoping that this methodology, in fact, will serve as a template for the 2006 Medicare Part D benefit, much like Mr. Hayes just recommended in his remarks.

Thank you very much. I hope this has helped.

The CHAIRMAN. Thank you very much.

I am going to start with a question for Mr. Hayes. You mention in your testimony about a person that takes four different drugs. You suggested that he would be better off by signing up for assistance from each drug manufacturer, and that no Medicare-approved card would serve him better.

Now, from what I have heard, I find that hard to believe. But could you tell me how you came to that conclusion?

Mr. HAYES. Sure, Senator Grassley. The point in the prepared testimony was to underscore the complexity and the sort of idiosyncratic analysis each person with Medicare really needs in order to make his or her best choices.

Several weeks ago, in a far more contentious legislative hearing before the House Energy and Commerce Committee, a gentleman from Oregon testified that he was, indeed, benefitting from the discount card program, and indicated with respect to the drugs he was

taking he could save about $152 monthly on his needs, which was significant because he had a $16,000 annual income.

At the Medicare Rights Center, frankly, we are more social workers than we are politicians, so I gave my card and suggested to the witness that after the fact we could review his needs.

In fact, one of our social workers went through it and we did find, for the prescription medicines this gentleman was on, he could do far better because he was eligible for various manufacturer pharmacy assistance programs.

That is pretty much Mr. Firman's point, that you really have to dig in deeply to see what will be the best for an individual, because clearly to save an additional $3,000 or $4,000 a year, for a gentleman with a $16,000 annual income, was very significant.

So, it is hard work, and I think Dr. McClellan, Ms. Gross, the SHIPs, and Jim Firman, all of us know that. That really was the point we were trying to make there, not to disparage in any way the Medicare discount cards in and of themselves.

The CHAIRMAN. Well, Dr. McClellan, maybe standing where you are, I would like to have you comment on that. Have many of the card sponsors entered into agreements to offer additional manufacturing assistance when the $600 runs out?

Dr. MCCLELLAN. Yes. The card sponsors are offering wraparound assistance to beneficiaries who qualify for the $600 transitional assistance. As Mr. Hayes mentioned, there are other programs that people can take advantage of in addition to the Medicare cards, however.

One of the things that we are trying to provide, and we are getting more help now from the Access to Benefits Coalition providing, is the details on how they can get the most benefits.

I would caution that a lot of these manufacturer programs do have income limits and they often do not go up to 150 percent of poverty or more, as in this particular example. They may not cover all drugs. For example, this particular beneficiary was taking a generic drug, which I think is probably unlikely to be covered on a manufacturer program.

But the point is that you can, and should, get information on both programs together to find out how you can get the most benefits, and people like this beneficiary are going to be able to save hundreds of dollars through the card.

They may be able to save hundreds of dollars more on top of that by finding out more about these additional programs. That is what we want to do as effectively as possible.

So, we really appreciate the suggestions from people on this panel, from people we have been hearing from around the country who are actually working with beneficiaries who are in a state of anxiety. And, first and foremost what we can do to reduce that anxiety, is to help them reduce their drug costs.

That is why all of these constructive suggestions on putting these programs together, on getting costs down, on getting savings from the drug card, and, where they are available—and I am not sure they are always going to be available; they are available in this particular case, but where available—the manufacturer discounts, which make available lower-cost drugs as well, though probably not zero-cost drugs, are very helpful, too.

So, this is another source of benefits that can be used that can provide lower-cost, though probably not zero-cost drugs, for many beneficiaries. We want them to get help in all of that, and that is what we are taking these steps to do.

Mr. FIRMAN. Senator, may I add one point of clarification?

The CHAIRMAN. Please do.

Mr. FIRMAN. As has been noted, there have been several companies—Merck, Novartis, Johnson & Johnson, Abbott, and Wyeth—which have said that they intend to make their benefits available through the cards. So once you have spent your $600, you will get those medications for free.

Lilly has offered a variation on that and said you can get their medication for $12 a month. However, what has to happen, is that those manufacturers have to negotiate and sign a contract with each card sponsor to make that real.

They are in the process of doing that, which is why the Access to Benefits Coalition has called on these companies to make the pledge, in fact, to sign these contracts so that when a consumer signs up for the $600 benefit, they will get the wrap-arounds automatically as opposed to a situation that Mr. Hayes was describing where they would have to apply individually for the patient assistance program. It comes down to the same issue that Mr. Hayes said about simplify, simplify, simplify. We have got to find ways to make these benefits simple.

It takes time, but we are all working toward that same goal. The bottom line, though, is low-income people can save at least $600 a year, and probably a lot more, so it is worth making the effort.

The CHAIRMAN. Ms. Gross, referring to the Des Moines Register, they featured, June 2, a story about fake drug card marketers targeting the elderly. This reported that a dozen Iowa seniors received unsolicited telephone calls. The callers claimed to provide help in choosing a discount card.

They asked the seniors what medicines they used and then pretended to offer advice. At the end of the call, they asked for credit card information and charged them $99. Have you heard similar reports from other Iowans that you serve with SHIP?

Ms. GROSS. Yes. Those reports actually came into our office and came up at community presentations that our staff were giving around the State, and also through our counselors, where clients came in and sat down and reported this occurring.

A few of the clients actually gave out account information and we worked with them to take care of that. But those reports all came in to our office and were forwarded to the CMS regional office.

The CHAIRMAN. Do you have some advice for people like that, what they should look out for?

Ms. GROSS. Well, first of all, as was mentioned by Dr. McClellan, telemarketing and door-to-door sales are prohibited on the drug discount cards. So, people need to be aware that if they are contacted by those means, they should automatically assume that it is not legitimate.

That was the message that we certainly got out to folks. And, of course, always never giving out your personal account information to anyone that you do not initiate the contact with. I believe the

State, CMS, and others are working with our attorney general's offices and local authorities to get that message out.

The CHAIRMAN. Mr. Merritt, a criticism that we often hear about the drug discount card is how frequently prices can change and that the formulary can change. I would like to have you explain the reasons why the price might change, either to go up or down, and comment on the frequency of formulary changes.

Mr. MERRITT. Sure. Well, each week CMS checks the data to make sure that the drug list is stable and the prices are stable, and so forth. So far, the only movement we have seen in prices has been downward, and that is frankly because competitors have seen other competitors' drug cards' prices and said, hey, we have got to charge less if we want people to sign up for this card.

In terms of prices going up, there are a lot of reasons that we do not believe that would happen, at least in any significant way. First of all, we have a strong track record that the GAO did a report on, "PMBS in the Commercial Marketplace," about a year ago, on about 17, 18 million people. There was no mention of bait-and-switch, rise in prices, dropping drugs, et cetera.

Second, our companies and sponsors have a great incentive to make sure that seniors like, and are satisfied with, this program or else they are not going to sign up for them in the Part D program in 2006.

Third, there are a lot of patient safeguards that CMS already has. They monitor weekly how the drug lists are moving, if drugs are coming off the list, if prices are going up, and so forth, and there are several sanctions that they can perform against sponsors, such as civil penalties, fines, kicking sponsors out of the program, and so forth.

So, there are a lot of incentives that companies have to do this program the right way, but also there are a lot of safeguards for patients, in any case, the CMS has access to.

The CHAIRMAN. All right.

Mr. Firman, referring to your testimony, you described the opportunities, as well as challenges, in identifying and enrolling low-income beneficiaries in the program for which they are eligible.

Why is it hard to reach these populations? Also, what kinds of promising practices in outreach or enrollment do you think would help low-income beneficiaries, particularly in rural areas where I come from, and most of this committee has representatives from rural areas?

Mr. FIRMAN. Well, as has been noted, our track record collectively, the public sector and the private sector, of finding and enrolling people in benefits for which they are eligible has not been very good.

After all these years, more than half the people eligible for food stamps, or almost half eligible for SSI, or more than half that are eligible for QMB/SLMB, do not all get the benefits. If you look at many State programs, participation rates are even worse.

One of the reasons is because we keep doing the same things over and over again, which is one definition of insanity, and we keep getting the same result. Up until now, as we look at the situation, everybody has assessed the challenge as finding the needles in the haystack, finding the low-income people who are eligible,

going out and convincing them that they are eligible for a particular benefit, and signing them up.

Our assessment at the Access to Benefits Coalition, based on what we have seen, is that is really not the challenge. We should not be looking for the needles in the haystack. We should be looking for the piles of needles.

We have identified a pile of one million needles called the Medicare Savings Program. We have identified 400,000 piles of needles called the people in the low-income pharmacy program in four States. We believe there are many more piles of needles in every State.

For example, your State has a home energy assistance program which has income eligibility rules, and most of those people are going to be eligible for this program. People who are eligible for food stamps, by and large, are going to be eligible for the transitional assistance benefit.

In some States, there are programs where the DMV will give you a waiver on your property taxes or your license plate fees if you are below a certain income. So, we believe we need to do smarter strategies, finding people. We have already found them once. Instead of spending the money on finding them again, focus on enrollment, either auto-enrollment, or at least marketing.

Let me give you one example on which I think Pennsylvania is leading the way. Pennsylvania, I am aware, is working with a group called The Foundation to Benefit Our Seniors, which recognized that Pennsylvania has already identified a lot of low-income seniors, but many of those were also eligible for either QMB, SLMB, or State property tax programs.

So, they have worked out with the foundation, working with the State, communicating with, and in a very efficient way, finding and enrolling those people in the benefit. So, there are a lot more opportunities like that and we need to use them.

In answer to your question about rural areas, we need to recognize the specific challenges of finding and reaching people, and we believe that is where there is a unique strength in the affiliates of the Access to Benefits Coalition, the churches, the social service agencies, the extension service, all of the places, the grocery stores to drug stores, where people are anyway.

We have got to take advantage of all of these kinds of things in order to achieve our goal. It is ambitious, but we believe it is doable and we certainly think it is worth the effort.

The CHAIRMAN. Thank you.

Senator Breaux?

Senator BREAUX. I thank the panel. Once again, I thank the Chairman for having this very important hearing. I think the hearing today has cleared up a lot of misconceptions about what is out there and the benefits of the program.

We have all experienced some of the wild statements, that the discount card does not amount to anything and that it is not working. I have had some instances of people suggesting that the seniors do not participate in the program and just boycott it.

I think what we have heard today from Administrator McClellan and from all of you, is that this program has had difficulties in getting started, but we are talking about a program that now has al-

most 3 million people enrolled in it, and I think you are seeing some real discounts.

There is a point that I would like to ask anybody to comment on. Dr. McClellan talked about the recent studies CMS has done indicating that the brand-name drugs are generating between 11 to 18 percent or more below the average price actually paid in neighborhood pharmacies by all Americans, and that for generics, the savings ranged from 37 to 65 percent below the average price actually paid by all Americans. And I think he was talking just about the card then.

If you are using a company card, a Merck card, or an Eli Lilly card, or a Pfizer card, if you are participating with the Medicare card plus the company discount card, plus, if you had the $600 if you are low income, the savings would be substantially greater even than the numbers that Administrator McClellan pointed out.

Can anybody comment on that? Mr. Merritt?

Mr. MERRITT. Yes. First of all, I would agree with that. I think the stubborn fact here is, there are real savings that seniors have now that they did not have before June 1.

Those are added on to by the pharmaceutical cards, they are added on to, particularly people in transitional assistance, as you mentioned. But the reality is, these savings are great and getting better and it is a very good program.

Some of the things that we have been frustrated with, those of us who have been administering these benefits, is when we see kind of apples to oranges comparisons to Canada, VA, and so forth, and there are all kinds of arguments people could discuss about that.

But the reality is very simple. The discounts here are 17 to 35 percent, at minimum, from our industry estimates, and those discounts get greater and greater depending on your particular needs and the cards that you have. I think this program is really on the track to be a great success for seniors.

Senator BREAUX. Thank you.

I notice that some of the companies will give you the company discount card if you are involved in a whole series of different Medicare cards, but some have limited it to only one program.

What is happening out there? Does anybody want to comment on that? Does anybody have any thoughts about that?

Mr. FIRMAN. Most of the companies that have offered the free wrap-arounds have said they want to offer them to all of the cards, and they are in the process of negotiating those contracts. Pfizer has taken a different tack and has said that their program, at least for now, will be only available through the Share card.

But in addition, going back to what Mr. Hayes said earlier, the example I think he provided in his testimony is a person who would not be eligible for the transitional assistance because the person's income is too high, but he would still be eligible for other savings programs from the manufacturers.

This is important because, keeping our eye on 2006 and beyond, we should not forget that there is another significant population of people between 135 and 150 percent of poverty, with assets up to $10,000 for an individual and $20,000 for a couple, who will be eli-

gible for significant savings in 2006, although they are not eligible for them now. We want to find them now as well.

So, consumers need to realize, even if they do not qualify for the transitional assistance benefit now, if their income is as high as $18,000 for an individual and $28,000 for a couple, there are programs that will save them money.

Senator BREAUX. Thank you.

Mr. Merritt, you talked, and it is something I would like you to address, because we heard a lot of statements that one of the big defects in this bill is that we are prohibiting the Federal Government from negotiating the price of drugs, which has been sort of a consistent position for Congress for a long period of time in legislative efforts.

But now you heard, well, the big defect in the bill is that we prohibited the Federal Government from directly negotiating on the price of drugs like we do for VA, and you talked about that a little bit.

Mr. MERRITT. Sure.

Senator BREAUX. I would like you to elaborate on it. Because I have always said, and I think you are saying this as well, that when GAO looked at what was happening with the VA and the government negotiating the price, or the Medicaid State programs directly negotiating the prices with the manufacturers, that, in fact, what PBMs would be able to do presented larger discounts than what the government was able to accomplish.

Can you give me some explanation as to why that would be true if, in fact, it is?

Mr. MERRITT. Sure. PBMs are on the cutting edge of innovation in terms of negotiating discounts with manufacturers and retailers using big-volume purchasing. Often, we have more volume purchasing power than the Federal Government. Some of our companies have 100 million enrollees.

If you look at the VA program, they do it through a lot of restrictions and it is a great program for the people who are in it. But I think it is an inappropriate comparison for what people want out of Medicare.

It means a national formulary. It means only 31 classes of drugs, which are a significant restriction on choice. PBMs and managed care plans often have 50 to 100 classes of drugs. So, you have VA offering something more restrictive than very restrictive managed care plans for the people who are in it.

Also, you have a situation where it is inconvenient. You have 250 VA locations. You have 70,000 retail pharmacies you can go to with this discount card alone. Finally, when you are talking about the VA, you are talking about 1 percent of the drug spend. When you are talking about seniors and Medicare, you are talking about 40 percent of the drug spend.

So if you were to shift the VA program into Medicare, you are talking about major cost shifting to the commercial side of health care, which means an increase in the uninsured, a significant increase in drug prices for non-seniors, and you have just pushed the air down on one part of the balloon and pushed it up somewhere else, so you really have not solved the problem.

So, we think that PBMs offer significant tools, not just preferred drug lists as States use, but a number of other things with pharmacy networks, formulary management, and other tools where we can get the best bargains at the best time for consumers.

That is why GAO has said that, even when States have tried to do direct negotiation, and why CBO said the same thing at the Federal level, we do not think they can do as good a job, and certainly not a better job, than PBMs and the free market can do on their own.

Senator BREAUX. This program has been in effect just for a matter of weeks now. Can any of you give me a recommendation as to what should have been done differently, or is it too early to make that recommendation now because we are right in the midst of this being put together? I mean, is there any recommendation that could say, boy, if you had just done this it would be running much smoother than it is now?

Mr. HAYES. Two quick thoughts, Senator. One, is to actively recognize that we would be taking these automatic enrollment steps that, bit by bit, CMS seems to be adopting. I think we heard today reason to hope that the next step toward automatic enrollment——

Senator BREAUX. And you think that is positive?

Mr. HAYES. That is a very positive step to move in that way. Hindsight says maybe we should have recognized 4 or 5 months ago we were going to be doing that so we could have hit the ground with slightly less of a thud than we got on June 1.

Second, there has been talk about the need and the complexity, even in your example, Senator, of people eventually being able to dig down relatively deeply into the array of programs that might help them. Again, Kris Gross and I, our organization in New York, do this day by day with people.

At this point, there is a promise of resources coming to help that we must make a bit more muscular. I know we have not seen a single penny in increased resources, so we continue to pull volunteers, and stretch and pull them.

But if there was a little more proactive movement that way, I think, without even tinkering with the structure of the programs, we could have gone more quickly.

Senator BREAUX. Well, I appreciate that. I appreciate the work that all of you are doing. I mean, I think every senior organization in the country, regardless of what their position was on the Medicare bill, we are spending literally billions of dollars on providing access to prescription drugs for the 41 million American seniors. I think we all ought to do everything we possibly can to make it work. We can always fight on future changes, but this is where we are today.

I commend all of you and your organizations for trying to help seniors figure out what is available and make it as easy as possible to understand, and aggressively encourage them to participate in something that I think is a very valuable addition to what they had previously.

We could always talk about how to change it and make it better in the future, but while we have what we have, I think it is so important to have people trying to make it work to the best of our ability, and I commend all of you for doing that.

Thank you all on the panel for cooperating with us. You may get questions to respond to in writing. I would appreciate your cooperation on that.

Thank you all very much. Thank you very much, Kris, for coming. We appreciate that.

[Whereupon, at 12:29 p.m., the hearing was concluded.]

APPENDIX

Additional Material Submitted for the Record

Prepared Statement of Hon. Max Baucus

Thank you, Mr. Chairman. This is the first of what I hope will be many Finance Committee hearings on implementation of the 2003 Medicare bill. And, Dr. McClellan, welcome to your first hearing before the Finance Committee since becoming CMS Administrator.

The discount card program was intended to be a temporary, stop-gap measure. It was intended to give Medicare beneficiaries some relief from high and rising prescription drug prices between now and 2006, when the new Part D benefit starts. And it was also intended to ensure that the neediest seniors with low-incomes and no existing coverage receive meaningful assistance during the transition to the Part D benefit.

The discount card program was part of last year's Medicare bill, but it was not a high priority for many in Congress.

Instead, the Administration designed the drug card. The Administration promoted it. And the Administration even published regulations to implement a drug card program before the 2003 Medicare law was enacted. But the courts prevented CMS from implementing its early version of the drug card program without statutory authority.

Congress enacted the drug card based on the Administration's framework. But the Administration's struggles with the drug card have continued.

- The *Medicare.gov* website has often failed to provide correct and consistent information. And about 85 percent of low-income seniors lack internet access.
- Wait times on 1–800–MEDICARE have been long.
- And enrollment in the program has lagged. The vast majority of participants have come from managed care plans—where beneficiaries are automatically enrolled.

But in my view, the main problem—and the root cause of many other problems—is that there are simply too many drug card options.

Some argue that choice is good. Choice is liberating, empowering. I hear this again and again.

I don't oppose choice. I believe in choice.

But I believe in meaningful choice—not choice for the sake of ideology. This drug card program has elevated the ideology of choice over the best interests of Medicare beneficiaries.

The sheer number of discount cards has made the enrollment process daunting, confusing, and downright unattractive to many beneficiaries. Consider that there are 39 national drug discount card options. And in Montana, beneficiaries can choose among 41 cards.

Forty-one cards, valid at different pharmacies.

Forty-one cards, with different enrollment fees.

Forty-one cards, covering different drugs at different prices.

Mr. Chairman, Congress aimed to provide the drug card as a bridge to temporary savings—not a bridge to frustration and confusion.

Most in this room could not sort through so many options on so many different dimensions and feel good about the choice they make.

Indeed, as psychologist Barry Schwartz has pointed out, "Increased choice can lead to a *decrease* in satisfaction. . . . Too many options can result in paralysis, not liberation."

For example, a study on mutual funds found that as the number of funds in a 401(k) plan offered to employees increases, the likelihood that employees will choose

a fund—any fund—goes down. According to the study, for every 10 funds added to an array of options, the participation rate drops 2 percent.

Drug cards are not the same as mutual funds. But a recent study using focus groups confirms these findings. The study found significant apprehension among seniors about investigating and choosing among such a large array of drug card options.

And as a supporter of the 2003 Medicare bill, I am concerned that this paralysis may extend to the actual drug benefit when it is offered in 2006.

The law gives CMS plenty of authority to reject cards. The agency is by no means required to take all comers. But that is apparently what they have done. In fact, they went out of their way to increase the number of participating sponsors—even after they had more than two dozen already signed up.

I am concerned that beneficiaries who don't sign up now for the drug card will be less likely to enroll in the Part D benefit when it becomes available. They may refuse to enter the proverbial Part D drugstore altogether.

I hope that is not the case. While the 2003 Medicare benefit is not perfect, it is a solid start. I was glad it passed, and I remain an ardent supporter of the bill. But the drug card experience so far has not inspired confidence that CMS will be able to implement the Part D benefit successfully.

I would like to be convinced that I am wrong, for the sake of beneficiaries.

Thank you, Mr. Chairman. I look forward to hearing from our witnesses.

Prepared Statement of Hon. Jim Bunning

Thank you, Mr. Chairman.

Last year, Congress finally delivered on a promise we'd been making to seniors for years—we passed the medicare prescription drug bill. This law was probably the biggest change to Medicare since its creation.

Because it will take two years to get the comprehensive drug benefit up and running, we included the discount drug card program, and provided special assistance to low-income beneficiaries. This is a voluntary program, so no one will have to join if they don't want to.

Today's hearing will focus on the implementation of this new program.

Only a week ago, Medicare beneficiaries could begin using their discount cards and seeing a savings on their drug bills.

It is important that we do everything we can to inform beneficiaries who need this benefit the most—those who are low-income and those without other drug coverage—that this card is available to them.

About a quarter of Medicare's beneficiaries currently do not have drug coverage. This number includes about 146,000 beneficiaries in Kentucky. This card wil be a real savings for them.

Low-income beneficiaries will receive additional help with a $600 credit in both 2004 and in 2005 to help them purchase their prescription drugs. No beneficiary who is elegible for this assistance should pass up this money.

CMS estimates that 112,000 Medicare beneficiaries in my State will be eligible to receive this credit.

It is critically important that the federal government, state governments, and all those in the health care community are aware of the low-income benefit and can either help beneficiaries enroll in the program or at least point them in the right direction.

I'm afraid that too many beneficiaries aren't getting a clear message about this new program, and are choosing not to participate.

I have been working to inform the beneficiaries in my State, and know many other groups are as well.

This program is too important for low-income beneficiaries and those without drug coverage to ignore, and every one of us should be trying to reach out to beneficiaries—particularly those with low incomes.

I am pleased we will be taking a look at the discount drug card program today, and I appreciate the time our witnesses have taken to be here today. I look forward to hearing their testimony.

Thank you.

Prepared Statement of James B. Firman

I am James Firman, President and CEO of The National Council on the Aging (NCOA)—the nation's first organization formed to represent America's seniors and

those who serve them. Founded in 1950, NCOA is a national network of organizations and individuals dedicated to improving the health and independence of older persons; increasing their continuing contributions to communities, society and future generations; and building caring communities. Our 3,800 members include senior centers, area agencies on aging, faith-based service agencies, senior housing facilities, employment services, and consumer organizations. NCOA also includes a network of more than 14,000 organizations and leaders from service organizations, academia, business and labor who support our mission and work.

I also chair the newly formed Access to Benefits Coalition (ABC), a public-private partnership of over 70 diverse organizations dedicated to ensuring that lower income beneficiaries know about and can make optimal use of new Medicare prescription drug benefits and all other available resources for saving money on prescription drugs.

I appreciate having the opportunity to participate in today's hearing: *Medicare Drug Discount Card: Delivering Savings for Participating Beneficiaries.* Enactment of the new Medicare law is the single-most important opportunity to help lower income Medicare beneficiaries to have emerged in the past 40 years. Of immediate significance is the fact that Medicare-approved discount cards include a $600 transitional assistance (TA) credit this year and next for those with annual incomes below 135 percent of poverty (this year, $12,569 for singles; $16,862 for couples), regardless of assets. The credit is not available to those with drug coverage from Medicaid, FEHBP, TRICARE for Life or an employer group plan.

SAVINGS FOR LOWER INCOME BENEFICIARIES: OPPORTUNITIES AND CHALLENGES

To achieve the law's full potential, it is imperative to maximize TA enrollment as well as savings from other programs for lower income beneficiaries. We know from experience and research that this population is more likely to have chronic and/or cognitive illnesses and tends to be very difficult to reach, with enrollment goals hard to achieve.

In recent years, government agencies at all levels, voluntary organizations and foundations have been involved in efforts to identify and enroll low-income beneficiaries who are eligible for but not receiving needed benefits from government and private programs. To date, success on this front has been at best inconsistent and uneven.

For example, take-up rates for the Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) programs—for beneficiaries with incomes below 120 percent of poverty—are estimated at only 43 percent. Participation in the Qualified Individual (QI) program—for beneficiaries with incomes between 120 and 135 percent of poverty—is significantly lower. Take-up rates for Food Stamps and the SSI elderly program are estimated to be as low as 54 and 50 percent, respectively. The bottom line is that millions of vulnerable, low-income seniors and younger persons with disabilities are not receiving the assistance they are eligible for. We must do better. We can.

One way to do better is to shift the focus from *benefit-centered* outreach and enrollment to *person-centered* outreach and enrollment. Previous efforts to find people eligible for a specific low-income benefit have been akin to finding needles in a haystack. Each benefit program conducts its own expensive efforts to find low-income individuals and enroll them in a single benefit. The next program that comes along essentially repeats the same process. We believe it makes more sense now to gather together all of the piles of needles that have already been located through various public and private sector initiatives, and enroll those people in a range of different savings programs for which they are eligible.

In order to maximize available savings, most low-income beneficiaries will need to enroll in a Medicare-approved discount card, in the annual $600 credit, AND enroll in additional public and private savings programs in order to afford the prescription drugs they need to maintain their health and improve the quality of their lives. Then, beginning in 2006, low-income beneficiaries will have a different set of options regarding enrollment decisions in the new Medicare Part D benefit which, unlike eligibility for the annual $600 credit, includes an asset test.

There are both short-term and long-term imperatives and opportunities to ensure that as many lower income seniors as possible get the new benefits. In 2004 and 2005, there will be an estimated 7.2 million low-income beneficiaries who will be eligible to receive the $600 credit. However, the Center for Medicare and Medicaid Services (CMS) has estimated that 2.7 million of those eligible will fail to enroll and will forfeit the benefit. An estimated 14.1 million seniors will be eligible for the full low-income benefits which begin in January 2006. These benefits will pay for between 85 percent and almost 100 percent of prescription drug costs. But the Con-

gressional Budget Office estimates that 5.4 million low-income beneficiaries will not receive these benefits in 2013. In our view, it is unacceptable that so many in need will forego these essential savings.

We are pleased that the Congress, including key members of this Committee, share our concerns about the importance of ensuring that vulnerable lower income beneficiaries receive the new Medicare benefits to which they are entitled. Strong, clear report language was included in the Medicare bill on improving outreach to lower income beneficiaries. The language states:

"[T]he Conferees expect that . . . HHS will place a priority on, and make a best and concerted effort to, ensuring that the lower income seniors are aware of the additional benefits available to them and how to enroll. Therefore, the public information campaign should include a program of outreach, information, appropriate mailings, and enrollment assistance with and through appropriate state and federal agencies, including State health insurance counseling and assistance programs, in coordination with other federal programs of assistance to low-income individuals, to maximize enrollment of eligible individuals. In addition, special outreach efforts shall be made for disadvantaged and hard-to-reach populations, including targeted efforts in historically underserved populations, and working with low-income assistance sites and a broad array of public, voluntary, and private community organizations serving Medicare beneficiaries. Materials and information shall be made available in languages other than English, where appropriate." [Joint Explanation Statement of the Committee of Conference, page 432]

We are committed to ensuring that as many lower income Medicare beneficiaries as possible know about and take advantage of the "safety net" provisions of the new law. We view this as an extraordinary and time-sensitive opportunity to organize and mobilize a broad public-private partnership to increase projected beneficiary participation rates.

THE ACCESS TO BENEFITS COALITION

The importance of ensuring that those in greatest need receive the help they are entitled to is underscored by the significant opportunities and challenges inherent in enrolling low-income beneficiaries in the Medicare discount card $600 credit program. While government efforts will reach many low-income beneficiaries, years of experience tell us that there also needs to be complementary, coordinated initiatives that go much deeper into the community in order to educate consumers and their families, help them make informed choices and facilitate their actual enrollment in the new Medicare benefits.

In response to these challenges and opportunities, NCOA and over 70 national non-profit organizations have formed the Access to Benefits Coalition (ABC). ABC members share an interest in helping lower income Medicare beneficiaries (including both those aged 65 and over as well as younger persons with disabilities who qualify) find the public and private prescription savings programs they need to maintain their health and improve the quality of their lives.

Every member organization shares a commitment to helping lower income Medicare beneficiaries connect to new Medicare and other prescription drug benefits, both public and private. The national coalition represents a diverse group of senior, disability, faith-based, minority, provider, consumer, and advocacy organizations, and is growing on a weekly basis. The organizations have unique reach and credibility among Medicare beneficiaries. The current list of ABC members is attached.

The Coalition's short-term objective is as ambitious as it is clear: to ensure that by the end of 2005, at least 5.5 million low-income beneficiaries get the $600 annual credit as well as other public and private benefits that can save them money on their medicines. By the end of 2008, our goal is for at least 8 million low-income beneficiaries to have enrolled in Medicare Part D prescription drug low-income savings programs; and by 2012, for at least 12 million low-income beneficiaries to be receiving these benefits.

The goal of enrolling 5.5 million low-income beneficiaries in 18 months is too important and too ambitious to leave to just government agencies alone. The private sector—voluntary organizations, businesses and philanthropy—must also do their fair share. The Coalition is working with the government to maximize the involvement of the private sector at the national, state and local levels in ways that complement and extend governmental efforts.

The ABC applauds the Department of Health and Human Services for its recent commitment to provide $4.6 million to support community-based education and enrollment efforts targeted to low-income beneficiaries. Funding from the Centers for Medicare and Medicaid Services will provide resources for grassroots efforts in 30 of the largest metropolitan areas, and funding from the Administration on Aging

will target particularly hard-to-reach low-income beneficiaries. The Corporation for National Service has also recently approved 15 VISTA volunteer slots to assist Coalition efforts. We expect to be able to announce some time next week more precisely how these and other resources will be made available to support Coalition efforts. Greater involvement by community coalitions and organizations that work with and are trusted by low-income beneficiaries is a critical complement to other HHS initiatives that have been announced previously.

The Coalition has a Steering Committee and three Working Groups. The Steering Committee includes the AARP, Alzheimer's Association, Easter Seals, and National Alliance for Hispanic Health. The Working Groups are Outreach and Enrollment, Research and Policy, and Communications and Media. ABC is committed to forming local Coalitions in 30 of the largest metropolitan areas, as well as in a number of states that do not include these areas. We will provide grants, training and technical assistance to these state and local Coalitions, which will provide broad and deep grassroots support and mobilization.

In order to be successful, we will be partnering with a broad range of other organizations, including: CMS, AoA, SSA, the Corporation for National Service, and other federal agencies; state and local health insurance counseling programs; state and local governments; health care organizations and systems; the business community, including pharmaceutical and pharmacy companies, PBMs, employers, and media companies; and private foundations.

If we all work together in a coordinated fashion toward common objectives, millions of beneficiaries in need will save thousands of dollars each on their prescription drug bills.

NEW DECISION SUPPORT TOOLS

We are pleased to announce that the Coalition has recently made available—at *www.accesstobenefits.org*—a variety of new web-based tools, which are designed primarily to help ABC members and their affiliates to find, educate and help enroll lower income beneficiaries in prescription savings programs. The use of enhanced decision support tools is a key strategy of the Access to Benefits Coalition. We know that many lower income people with Medicare who could benefit the most from using web-based decision support tools do not have access to the Internet. Therefore, thousands of Coalition members (staff and volunteers) will be trained and supported to serve as intermediaries, and help lower income beneficiaries and their families use these new tools, which include:

- **State Prescription Savings Guides**—The Coalition has prepared 51 easy-to-understand State Prescription Drug Savings Guides with state-specific information. This section of the ABC website provides program descriptions, eligibility and enrollment information for the Medicare-approved discount card program, Medicaid and other state drug discount programs, Veterans' Assistance as well as pharmaceutical company discount card and patient assistance programs. A useful bar graph with comparative income eligibility requirements for various programs is also included.
- **Enrollment Center**—Beneficiary education is not enough; people must actually enroll in the benefits they are eligible for. The ABC website includes hundreds of prescription drug savings program enrollment forms. By selecting a state, the user can view enrollment forms for state pharmacy programs, patient assistance programs and Medicare-approved discount drug cards. Some of the forms are fillable online—meaning that they can be filled out while on a computer and printed. Others can only be viewed on-line, printed out and filled out manually.
- **Promising Practices in Outreach and Enrollment**—This section of the website provides links to summaries of case studies that affect outreach and enrollment across various public benefits. Case studies are summarized by category, including: Cross-Program Collaboration; Outreach to Ethnic Populations; Rural Outreach; Provider Enrollment Activities; and Public-Private Partnerships. While not every strategy reported is directly applicable to initiatives related to the Medicare drug benefit, the parallels are significant enough to be of value in the design process of a campaign directed to lower income Medicare beneficiaries. Each case study includes a link to the longer work from which it was taken; in addition, a fully annotated bibliography of the literature in outreach and enrollment is available. The section also includes summaries of case studies of *in*effective outreach initiatives. The Coalition greatly appreciates the work of Trish Nemore, with the Center for Medicare Advocacy, who put this section of the website together, with the help of an Expert Panel on outreach and enrollment that we convened this past April.

It is also important to note that in June 2001, NCOA launched *www.benefitscheckup.org*, a free, web-based public service to allow seniors, their families, and the community organizations that serve them to quickly and easily determine what benefits are available and how to apply for them. Over 1.2 million seniors and their families have used the service. In January 2003, the website was expanded through BenefitsCheckUpRx to include approximately 260 public and private programs to assist seniors in determining what help they can get to pay for prescription drugs. Users can access a questionnaire specifically tailored to promote access to these Rx benefits. The service is also available in Spanish.

The *www.accesstobenefits.org* website includes a link to BenefitsCheckUpRx. In addition, the coalition is developing an enhanced version of the site, which should be available in late July, to facilitate and simplify decision-making and enrollment in the full range of prescription drug savings programs. The new decision-support tool will help beneficiaries to determine the *individualized combination* of programs that will save them the most money—not only new Medicare benefits, but state pharmaceutical assistance programs, discount card programs that are not Medicare-endorsed, and over 130 private drug manufacturer patient assistance programs.

New Medicare transitional benefits are only one of several important components of the Rx safety net—hundreds of other public and private Rx programs are also available. Most lower income beneficiaries will need to know about and take advantage of several of these programs to be able to afford their medicines.

TRANSITIONAL ASSISTANCE CREDIT WILL DELIVER ADDITIONAL SAVINGS

There is some very good news to report about the $600 credit: most low-income beneficiaries who enroll in the credit program can save a lot more than $600 in 2004 and 2005. This is because of the commendable actions by several pharmaceutical manufacturers to offer savings programs for low-income seniors that "wrap around" the Medicare-approved cards. For example, Merck announced that once a Medicare beneficiary uses up their $600 debit on a Medicare-approved card that person can purchase their Merck medications for the rest of the year for only a dispensing fee. Novartis Pharmaceuticals, Johnson & Johnson, Abbott Laboratories and Wyeth have announced similar programs. Eli Lilly has announced that people who qualify for and enroll in the TA program can purchase any Lilly drug for $12 per month, even when they still have a balance on their card. TogetherRx, which covers more than 170 medications from seven leading manufacturers, will continue to offer savings of 20 percent to 40 percent to people who qualify. Pfizer will continue to offer its medications for $15 per month for those who enroll in its U-Share card.

The bottom line is that low-income beneficiaries who take multiple medications and who have incomes below 135 percent of poverty could save from 40 percent to 90 percent on their medications in 2004 and 2005. Exactly how much an individual will save depends on the specific medications they take, what they are currently paying for them and what the dispensing fees will be at the pharmacy they use.

However, most of these extra benefits will only be realized by consumers if these wrap-around benefits are as broadly available as possible. Therefore, the Access to Benefits Coalition is calling on all the Medicare-approved discount card sponsors to sign a pledge to make their best effort to include all the manufacturers' free or low cost medication programs in their card(s) as a benefit when the $600 credit is exhausted. Our goal is to get at least one-half of the Medicare-approved discount card sponsors to sign this pledge within the next 30 days. We believe this will help provide a "short list" of cards that low-income Medicare beneficiaries should consider for enrollment. In recent days, 5 card sponsors have agreed to sign the pledge: Computer Sciences Corporation (Community CareRx, Criterion Advantage Golden Buckeye (OH) cards), PharmaCare, Pharmacy Care Alliance, UMPC Health Plan (Rx for Less (PA) card), and WellPoint (Precision Discounts card).

RESEARCH AND POLICY ISSUES

Although the activities of the Coalition are not involved with whether the new Medicare law was good or bad, or how it should be changed, we believe there are a number of ways in which implementation of the discount card program, and enrollment in the $600 credit program, can be improved. We were very pleased, for example, that CMS agreed to the development and use of a standard enrollment form and to automatic enrollment in the $600 credit for state pharmaceutical assistance program (SPAP) enrollees.

The ABC is also hopeful that current Medicare Savings Program (MSP) recipients (QMBs, SLMBs, and QI–1s) can be automatically enrolled by CMS in the $600 credit program. Those who do not choose a card on their own by a date specific should be automatically assigned a card, thereby assuring that an estimated 700,000 indi-

viduals can receive significant savings. Members of the Coalition's Research and Policy Working Group will soon be meeting with CMS officials to discuss how this might be accomplished.

The Coalition is interested in getting other federal agencies involved in low-income outreach, such as the Department of Agriculture (which administers the Food Stamps program), the Department of Energy (which administers the Low Income Home Energy Assistance Program), the Department of Housing and Urban Development (which runs various low-income housing programs), and the Department of Labor (which administers programs for lower income older workers). We would also encourage members of Congress to link to our website and look forward to educating staff in State and district offices about Coalition resources and efforts in their areas.

We are also creating a database so that we can locate lower income Medicare beneficiaries and track what savings programs they are enrolled in. We want to use our limited resources as efficiently as possible and find those who have historically been the hardest to reach. Finally, the Coalition is planning to do research next year on lessons learned from Medicare discount card outreach and enrollment efforts, so we can achieve our goals for lower income beneficiaries when new benefits are available in January 2006.

CONCLUSION

Enactment of the new Medicare law is the single-most important opportunity to help low-income Medicare beneficiaries to have emerged in the past 40 years. The Access to Benefits Coalition is firmly committed to working with a broad range of partners to take full advantage of this opportunity to provide much-needed assistance to this vulnerable, hard-to-reach population.

The ABC is a public-private partnership dedicated to ensuring that lower income beneficiaries know about and can make optimal use of new Medicare prescription drug benefits and all other available resources for saving money on prescription drugs. We are working with CMS, AoA and others on funding strategies to provide resources to metropolitan and state coalitions and organizations to educate and enroll lower income beneficiaries. The Coalition has a variety of new and emerging decision-support tools for organizations available on the *www.accesstobenefits.org* website, including State Prescription Savings Guides, an Enrollment Center, and a robust section on Promising Practices in Outreach and Enrollment.

Most low-income seniors who enroll in the Transitional Assistance credit program will save much more than $600 in 2004 and 2005. This is because of state programs and the commendable actions by several pharmaceutical manufacturers to offer savings programs for low-income beneficiaries that "wrap around" the Medicare-approved cards. The Coalition is working with card sponsors to ensure that these additional benefits are widely available.

The Coalition is also working with CMS to try to automatically enroll Medicare Savings Program recipients in the annual $600 credit program.

By working closely together on these initiatives, we can significantly improve the quality of the lives of millions of vulnerable Medicare beneficiaries who need help in paying for their medications.

ABC MEMBER LIST – As of June 3

AARP
ACORN
Allen Chapel A.M.E. Churches
Alliance for Children and Families
Alzheimer's Association
America's Health Insurance Plans
American Association of Homes and Services for the Aging
American Association of People with Disabilities
American Diabetes Association
American Foundation for the Blind
American Geriatrics Society
American Health Care Association
American Hospital Association
American Medical Association
American Pharmacists Association
American Society of Consultant Pharmacists
American Society on Aging
Arthritis Foundation
Association of Jewish Aging Services
B'nai B'rith International
Catholic Charities USA
Catholic Health Association of the United States
Center for Advocacy for the Rights and Interests of the Elderly
Center for Medicare Advocacy
Center for Medicare Education
Easter Seals
Epilepsy Foundation
Fisher Center for Alzheimer's Research Foundation
Last Acts Partnership
Meals on Wheels Association of America
National Academy of Elder Law Attorneys
National Adult Day Services Association
National Alliance for Caregiving
National Alliance for Hispanic Health
National Alliance for the Mentally Ill
National Asian Pacific Center on Aging
National Assembly of Health & Human Services Organizations
National Association for Hispanic Elderly
National Association for Home Care & Hospice
National Association of Area Agencies on Aging
National Association of Chain Drug Stores
National Association of Community Health Centers
National Association of Nutrition and Aging Services Programs
National Association of Professional Geriatric Care Managers
National Association of State Units on Aging
National Center for Assisted Living
National Coalition for Women with Heart Disease
National Consumers League
National Council on the Aging
National Family Caregivers Association
National Health Council
National Hispanic Council on Aging
National Indian Council on Aging Inc.
National Low Income Housing Coalition
National Medical Association
National Mental Health Association
National Multiple Sclerosis Society
National Partnership for Women and Families
National Rural Health Association
National Senior Citizens Law Center
National Urban League
Older Women's League
Paralyzed Veterans of America
Salvation Army USA
Shepherd's Centers of America
60 Plus Association
The Arc
United Cerebral Palsy
United Seniors Association
United Spinal Association
Visiting Nurse Associations of America
Volunteers of America

RESPONSE TO A QUESTION FROM SENATOR GRASSLEY

Question: In your testimony, you stated that a better way to identify low-income Medicare beneficiaries is to use person-centered outreach and enrollment rather than benefit-centered outreach and enrollment. Would you please explain the difference, and why one is more effective than the other?

Answer: Public benefits outreach and enrollment involves three discrete processes:

- Outreach: finding potentially eligible people.
- Decision-support: determining whether the individual is likely to be eligible for the benefit and helping them to decide whether to apply.
- Enrollment: assisting them to fill out and submit the necessary forms and the required documentation.

For the past forty years, virtually all public benefits outreach efforts supported by the federal government, states and private companies have been "benefit-centered", *i.e.,* the efforts were focused on finding low-income individuals, informing them that they may be eligible *for a single benefit,* and encouraging and assisting them to sign up. This approach has been used extensively for outreach on SSI, Food

Stamps, Medicare Savings programs, a variety of state programs as well as the prescription assistance programs offered by private companies (such as the Pfizer Share Card, Lilly Answers, the TogetherRx card, etc.].

There are several major drawbacks to benefit-centered outreach strategies:

1. *Benefit-centered outreach strategies are not very successful.* Data on enrollment in federal and state benefits for low-income seniors shows that participation rates for most programs are less than 50 percent even when outreach efforts have continued for many years. [See Figure 1]

2. *Benefits-centered strategies lead to great redundancies.* A useful analogy for the benefit-centered approach is "looking for needles in a haystack." Each effort begins by trying to find the "needles" through media and community-based outreach, then educate them and assist them to enroll. For each benefits effort, the processes of outreach, decision-support and enrollment are repeated over and over again, from start to finish.

3. *Benefit-centered outreach strategies have very high unit costs.* It typically costs between $40 and $350 per person to find and enroll a low-income person in a single benefit.

4. *It is virtually impossible to enroll large numbers quickly using benefit-centered outreach strategies* because of time and expense involved.

Person-centered outreach and enrollment strategies are based on the fact that low-income persons are likely to be eligible for a variety of federal, state and other benefits, and once the person has been found it is more cost effective to screen them for all benefits and sign them up for any that they want.

The leading example of this person-centered approach with low-income older persons is the BenefitsCheckUp, which was developed by NCOA and made available nationwide in June 2001. More than 1.3 million older persons have been screened and told about all of the benefits for which they are eligible.

There are several important advantages to person-centered outreach strategies:

1. *Person-centered outreach and enrollment strategies eliminate the need for redundant efforts.* With this approach, low-income persons only need to be found and screened once instead of many times.

2. *Person-centered outreach and enrollment strategies are much more cost-effective.* An analysis conducted by The Bridgespan Group, the non-profit arm of Bain Consulting, shows that the BenefitsCheckUp, an example of person-centered outreach, can cost as little as $5 per benefit enrolled versus $40 or more for the best benefits-centered strategies. [See Figure 2] Bridgespan's analysis of the Chicago Department on Aging's BenefitsCheckUp program shows that the person-centered efforts can yield a return-on-investment of 60:1. [See Figure 3]

3. *Person-centered outreach strategies can be taken to scale more easily.* The process of "finding" low-income persons can be much more quick and efficient, because chances are they have already been "found" somewhere, *i.e.,* they may be receiving one benefit (as a result of earlier, benefit-centered outreach efforts) or they may be on a federal, state, county or company list that indicates they are likely to have a low income. In other words, the strategy is not "finding the needles in the haystack" but "finding the piles of needles."

There are many important implications of this approach for public and private efforts to enroll low-income Medicare beneficiaries in the $600 credit in 2004–2005 and in the low-income Part D subsidies in 2006.

1. *Don't look for the needles in the haystack . . . look for the piles of needles.* The most cost-effective way to find people who are eligible for the low-income Medicare benefits is to "look for the piles of needles," *i.e.,* existing lists of low-income Medicare beneficiaries. There are many likely lists available through the federal and state governments as well as private companies. Federal lists include: SSI recipients, Food Stamps recipients, SCSEP enrollees. State lists include: Medicaid recipients, QMB/SLMB/QI enrollees, HEAP recipients, state pharmacy assistance beneficiaries. Company lists include: Enrollees in the Pfizer Share Card, TogetherRx, Glaxo Orange Card, and Lilly Answers. Most utility companies also have lists of low-income people who have difficulty paying their bills. Figure 4 indicates how the enrollees of an NYC-sponsored benefit are also eligible for and not receiving many other important programs.

2. *Decision-support needs to be improved.* Finding low-income people who are likely to be eligible for the new Medicare benefits is not enough . . . we need to also make it possible for them to make good decisions about applying for the benefits. For 33 million Medicare beneficiaries, price compare on *www.medicare.gov* is a very useful tool for deciding about CMS-approved discount cards. However, for approximately 7 million low-income Medicare beneficiaries, it is more important for consumers to choose a card with the best wrap-around assistance and to also enroll in state and manufacturers' programs for which they qualify. In late August 2004, the

Access to Benefits Coalition will make available a new version of NCOA's BenefitsCheckUpRx to facilitate decision-making and enrollment for low-income Medicare beneficiaries in CMS-approved card programs, state pharmacy programs and company patient assistance programs.

3. *Person-centered enrollment assistance can be very cost-effective, but it is not free.* While there are very promising and cost-effective models for person-centered enrollment, most notably the Chicago Department on Aging and the Foundation to Benefit Our Seniors in Philadelphia, these programs also demonstrate that enrollment activities require staff and basic computer and telephone technologies to be effective. It is unrealistic to expect large-scale enrollment without substantial investments by both the public and private sectors.

Figure 1

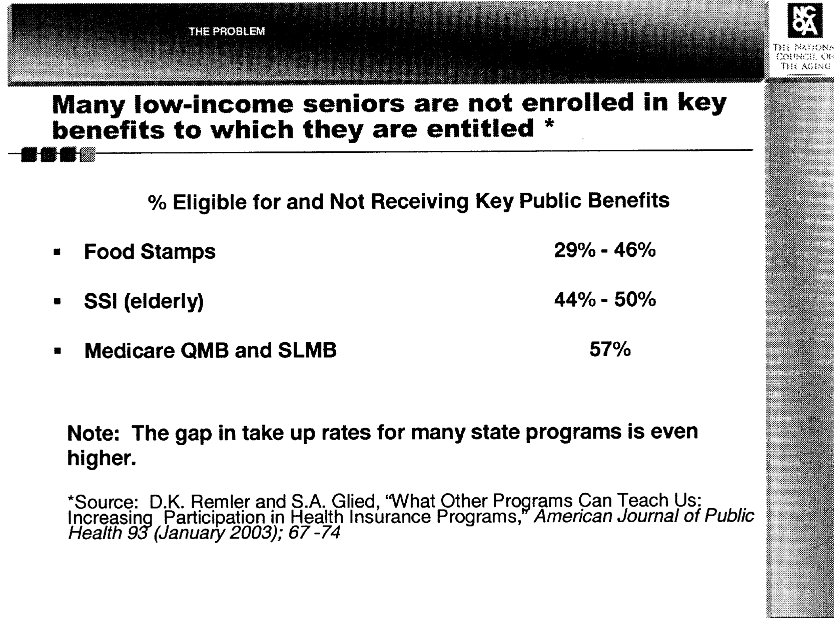

Figure 2

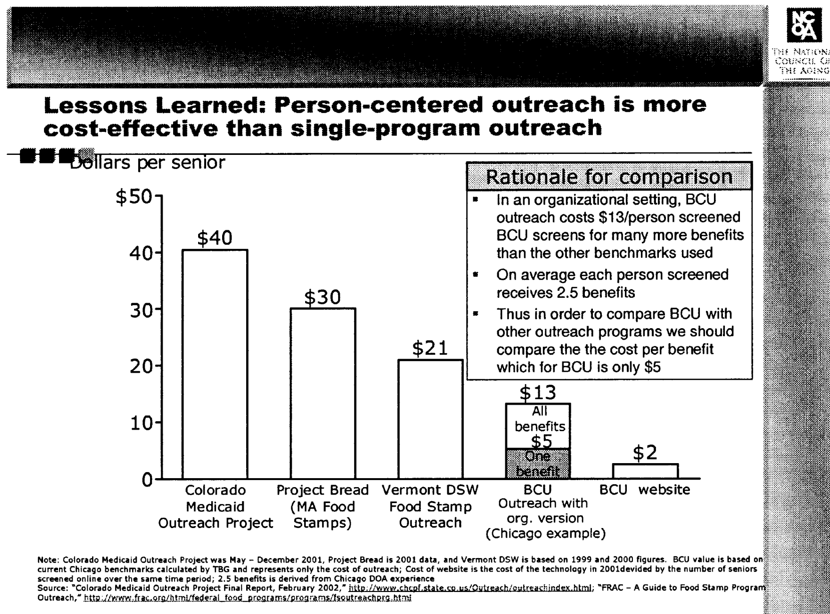

Figure 3

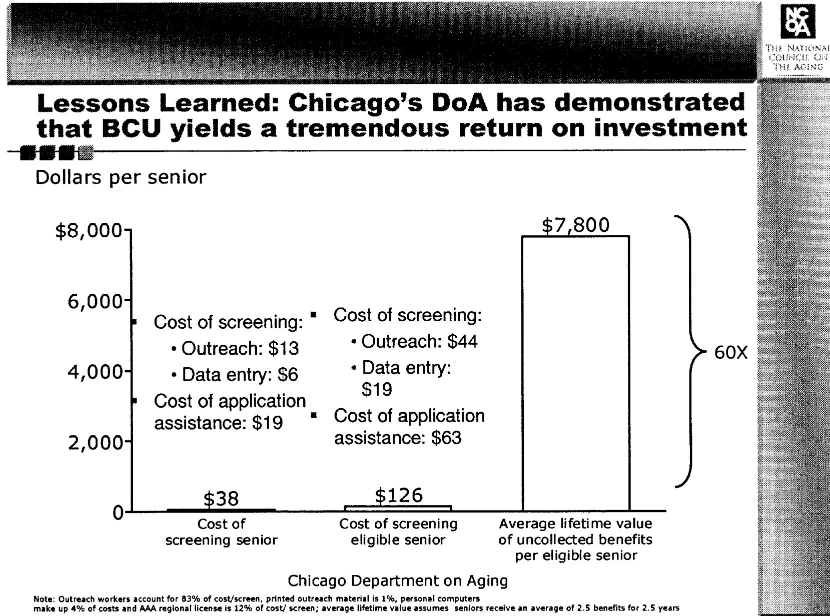

Figure 4

THE NATIONAL COUNCIL ON THE AGING

NYC example of value of person-centered screenings and targeting existing databases

	Total #	%
NYC Residents Found Eligible for Home Energy Assist by BCU	1,115	100%
Programs Currently Received		
• Food Stamps	99	8.9%
• Medicaid	193	17.3%
• SSI	68	6.1%
• All three	27	2.4%
People Eligible for and Not Receiving Key Benefits		
• Food Stamps	635	57.0%
• Medicaid	379	34.0%
• SSI	176	15.8%
• All three	148	13.3%
Other Key Benefits for Which People are Eligible		
• Medicare QMB or SLMB	238	21.4%
• Weatherization	1,012	90.8%
• EPIC	351	31.5%
• SCRIE	630	56.5%

PREPARED STATEMENT OF HON. BILL FRIST

Mr. Chairman, thank you for holding today's hearing to examine the new Medicare Discount Drug Card program. The Medicare discount card is the first step under the Medicare Modernization Act to providing seniors relief from high prescription drug costs.

Seniors now have been able to get discounts through the cards for exactly 1 week—7 days. Even at this early date, the card is well on its way to being a huge success for seniors.

- Since price comparisons were made available to the public 1 month ago on the Medicare Compare website, prices have come down. Prescription drug price transparency is turning out to be a marvelous market tool for controlling drug costs.
- In a study released just yesterday, the Centers for Medicare and Medicaid Services (CMS) found that seniors can save between 46 and 92 percent on many commonly prescribed generic drugs by using the discount card.
- This complements brand-name drug savings of 11–18 percent below the average prices paid by all Americans—with even larger savings available to Medicare beneficiaries through mail order.
- Because seniors with incomes below 135 percent of the federal poverty level will be able to get $1,200 during the next 18 months in addition to these steep discounts, savings will be even more meaningful for lower income seniors. This is a benefit that one of today's witnesses, Mr. Hayes, has called a "pure plus."
- And three million seniors already are enrolled and receiving discounts. This represents about 40 percent of target enrollment—only 1 month after seniors could begin enrolling.

Chairman Grassley, Senator Baucus and the other members of this Committee who worked so hard on the new Medicare law deserve credit for their determination to see that seniors could begin to benefit almost immediately.

We all realized that it would take some time to fully implement the new Medicare drug benefit. That is why many of us wanted to be sure that seniors—many of whom have no help now—had some way to get affordable medicine before the full prescription drug program could take effect.

And, further, it is important to note that we all agreed that the best answer was a low-cost, voluntary, private, competitive, transparent prescription drug discount card program that offered substantial additional assistance for lower income seniors. The interim discount drug card program received strong bipartisan support when it was included in the Senate-passed Medicare bill last year. And the discount card program was supported unanimously by all Senators and members of the House of Representatives who served on the Medicare Conference.

President Bush and his Administration should be applauded for getting the discount card program up and running less than 6 months after the President signed the Medicare Modernization Act into law. Secretary Thompson and his team at the Department of Health and Human Services deserve a great deal of credit for their efforts to educate seniors about this new benefit.

But make no mistake about it, this is an enormous undertaking. There will be mistakes. There will be misunderstandings. And there will no doubt be some confusion. That is true of any new government program. It is not more or less so here.

If we are committed to ensuring that seniors get the benefits they deserve—under both the discount card and the comprehensive prescription drug program—we all must work together. This will require patience, persistence, and cooperation.

Unfortunately, those attributes have been in short supply during the past few weeks. The Administration has had to implement this program against the backdrop of a series of coordinated, partisan attacks designed to discredit the Medicare law, and to scare and confuse seniors.

It is not surprising that a program that is 1-week old would not have reached full enrollment. It is not surprising that some would be confused about, or unaware of, the details of a program available for only 1 week.

But what is both surprising, and disappointing, to me is the fact that some are intent on deliberately confusing the public, and scaring seniors. We need to realize that this only hurts those we are trying to help. I am deeply troubled by a report issued last week by the Kaiser Family Foundation which found that, quote, "seniors' feelings toward the new Medicare law are being shaped by misinformation and lack of information. It is clear from these [focus] groups that seniors are very confused and not yet informed about what is happening to their Medicare."

I know that Commissioner McClellan will help set the record straight today. I look forward to his testimony, and the testimony of the other witnesses who have joined us.

Mr. Chairman, I hope that today's hearing will provide an opportunity to learn the facts about the Discount Drug Card Program, and how we can work together to help seniors get the benefits they need, and deserve.

PREPARED STATEMENT OF HON. BOB GRAHAM

Mr. Chairman, I am going to sound like the proverbial broken record, but I must continue to ask for a Finance hearing on a topic of great importance to the federal budget, the relationship between the Legislative and Executive branches, and the trust of our citizenry: the Administration's $534 billion cost estimate of the Medicare Modernization and Improvement Act (MMA) and the reasons for its late disclosure to Congress.

The hearing we are having this morning is certainly important. However, the discount card is barely up and running—a hearing on the discount card would be even more valuable once we have some real experience with the program to consider.

On the other hand, a hearing on the cost estimate is long overdue.

Mr. Chairman, it has now been more than 4 months—nearly 19 weeks—since I made, along with three other members of this Committee, my first request for a hearing on this topic.

I understand you are planning to have a member meeting on this topic—I look forward to that, and hope it will be soon. However, a closed-door meeting is not sufficient. The subject in question is one of transparency of information. I believe a public hearing on this issue is imperative.

Since my last request, there have been new developments. An April 26 Congressional Research Service (CRS) memorandum reports that, in ordering Chief Actuary Rick Foster not to reveal to Members of Congress cost estimates for the Medicare legislation, his superiors violated the law (including 5 U.S.C. 7211, sections 618 and 620 of P.L. 108–199, 42. U.S.C. 1317, and 5. U.S.C. 2302(b)(8)). According to the memorandum "executive agencies and their officers and employees do not have the right to prevent or prohibit their officers or employees . . . from presenting information to the United States Congress . . . concerning relevant public policy issues".

Surely, with this information, a hearing related to the suppression of the Administration's Medicare cost estimates, with testimony from former CMS Administrator Tom Scully and Presidential aide Doug Badger, is now warranted.

As we all know, the magnitude of the difference in the cost estimates is large—$400 billion v. $535 billion. A difference of this magnitude is disturbing.

However, even more disturbing are the efforts apparently taken by the Administration to keep their higher estimate hidden from Congressional and public scrutiny, and the recent conclusion by the CRS that in the process of keeping that information hidden, laws have been violated.

Mr. Chairman, we have an obligation as Members of this Committee to investigate this deception. We have an obligation to the seniors depending on the drug benefit, and to the taxpayers paying for it, to find the answers to the following questions:

- Who in the Administration knew about the higher cost estimates, and when did they know it?
- What actions were taken, and by whom, to prevent the timely and accurate reporting of information to Congress on the subject of the cost of the Medicare bill?
- Is the Administration seeking to prevent or obstruct Congressional inquiry into this matter?

Mr. Chairman, these are critically important questions.

This Committee needs to find the answers to these questions, as well as to examine closely the numbers—including why 25 percent of the difference in the cost estimates is due to the Administration's higher cost [$46 billion versus CBO's $14 billion] of putting more seniors into managed care.

Medicare managed care has been sold to us as a cost-saver, and now, at least as constructed in the recently-passed legislation, it comes at a *higher* expense than keeping seniors in traditional Medicare.

I question the sense in spending more for each beneficiary enrolled in managed care when we should be looking for ways to reduce costs.

The entire MMA needs examination. While most people think of this bill as "the prescription drug bill", it also covers many other aspects of the Medicare program.

Unfortunately, we have missed an important opportunity to lower Medicare costs overall, thereby freeing up more resources for improvements to the prescription drug benefit, other program improvements, or savings for beneficiaries.

I am referring to Section 302—"Payment for Durable Medical Equipment; Competitive Acquisition of Certain Items and Services."

I had high hopes that we would finally be able to use the experience gained in the Lakeland, Florida and San Antonio demonstrations and move Medicare to a competitive bidding system for durable medical equipment. This would allow us to pay appropriately for wheelchairs—the subject of last month's hearing.

Instead, the poorly drafted section will continue to make it difficult to rein in abuses such as in the case of the motorized wheelchair.

Section 302 does not even begin to be implemented until 2007, and then it is only in 10 of the largest metropolitan statistical areas (MSAs). It is not until 2009 that 80 of the largest MSAs are included.

The purpose of a demonstration project is to determine if an idea makes sense on a larger scale. The Lakeland and San Antonio demonstration projects were a resounding success.

There is no reason to wait another 3 years to begin saving money for the program and taxpayers, or to limit competitive bidding to the very largest MSAs.

Unfortunately, fraud exists in urban and rural America alike, and the taxpayers in all parts of the country deserve an efficiently run program.

Mr. Chairman, immediate and nationwide competitive bidding would improve Part B of the Medicare program.

On the Part A side of the program, we now know that the Hospital Insurance (HI) Trust Fund will reach insolvency 7 years earlier than projected last year.

The HI Trust Fund overwhelmingly is used to reimburse hospitals for inpatient services. As with all sectors of our health care system, hospitals are facing increasing pressures from the ever-exploding costs of prescription drugs.

We could begin to address the financial pressures on the trust fund by allowing Medicare to negotiate the prices of prescription drugs provided in the inpatient setting.

I recently spoke to a gentleman who is the head of the pharmaceutical division of a 4-hospital system. He told me that these hospitals purchase the drugs they dispense in the inpatient setting at the so-called AWP—average wholesale price.

We know from innumerable reports done by the Inspector General of HHS, and from extensive work done by the House Commerce Committee, that the average wholesale price is not average, and isn't even what is paid at wholesale.

It is a phantom price, set by the manufacturers. It is certainly not a negotiated market price.

Pharmaceuticals account for between 5–6 percent of a hospital's operating costs for a year. This puts prescription drugs as one of the largest single expenditures, after salary and benefits.

At a time when the HI trust fund is facing deep financial trouble, and hospitals are struggling with exploding drug costs, why haven't we made available to the hospitals the system that the VA is using to so successfully negotiate drug prices on behalf of veterans?

Mr. Chairman, I had hoped we would have a hearing on this topic before the Memorial Day recess.

I now urge you to hold a hearing before the July 4 recess in order for us to understand the differences between the prescription drug cost estimates, the process by which we learned at such a late date of the Administration's estimate, and measures—such as allowing Medicare to negotiate prices—that could lower the cost of the drug benefit.

Prepared Statement of Hon. Charles E. Grassley

Today's hearing is on the Medicare-approved drug discount card program, which just got under way. I think it is important for the Committee to learn more about its early implementation and significance, particularly for our Nation's low-income Medicare beneficiaries. Today's witnesses will offer an array of perspectives on the card program, and we appreciate your taking the time to be with us. I'd like to welcome Dr. McClellan, who is making his first appearance before the committee in his new role as administrator of the Centers for Medicare and Medicaid Services. I'd also like to welcome my fellow Iowan, Kris Gross, who does a superb job in heading our State Health Insurance Information Program. The SHIIPs are a tremendous resource for beneficiaries.

I know we're all well-versed in the basic mechanics of the drug card program, so I won't spend any time going through them. The program offers beneficiaries immediate relief on their drug costs prior to the start of the voluntary drug benefit in 2006. The drug card is an important first step in filling a void for many of our Nation's seniors and disabled, a void that has prevented them from getting life-saving and life-improving prescription drugs. While the program's creation was a bipartisan effort, over the past few months, we have heard an awful lot of criticism about the program even though it started just a week ago. The drug discount card program has been the target of a deliberate campaign to discredit it and confuse seniors about how it works. This effort is driven and coordinated by those who opposed the Medicare Modernization Act not because of policy, but because of politics. This kind of politically-motivated subterfuge disappoints me. It's a disservice to the millions of older Americans and people with disabilities who can benefit from a Medicare-approved drug discount card.

I'm not alone in this view. Just last week, the Centrist Policy Network wrote, "Democrats are the opposition party in Congress, and they're supposed to raise questions. But discouraging seniors from enrolling in the Medicare drug discounts cards is too much. The average Martian would be justifiably perplexed about why the Democratic leadership wants to repeal a program that does no one harm, might actually help quite a few people, and offers a significant benefit to low-income seniors."

Through this program Medicare beneficiaries have access to discounts on their prescription drugs, and low-income beneficiaries can get $1,200 in direct assistance between now and the end of the program. Now, we may hear additional criticism this morning, but the point of this hearing is to clear the air and to provide objective information, because that is what seniors and people with disabilities deserve. In particular, I want to commend the Access to Benefits Coalition, which we will hear from today during the second panel. The ABC, as it is called, is made up of organizations that have put politics aside to make sure that beneficiaries, particularly those with low incomes, get the assistance they deserve. Many of these organizations did not support the passage of the original bill, but they have agreed to put that aside, move on, and now help seniors obtain these benefits. I believe that these organizations should be commended for stepping forward to work together to help beneficiaries learn about the lower prices they can get through a discount card.

I've done some checking into the discounts these cards can offer beneficiaries, and let me tell you what I found. A beneficiary living in Waterloo, Iowa, with an income of $12,000 a year who takes Celebrex, Norvasc, and Zocor would pay around $7,300 at her local pharmacy from now until the end of 2005. The beneficiary gets her prescriptions filled at the local pharmacy because she knows and trusts the pharmacist. Like many, she does not want to order drugs through the mail. She could save over $1,300—that is 20 percent—off her three medications by using a Medicare discount card. The $1,300 by itself is a pretty big savings. But she also qualifies for the transitional assistance so she won't pay an enrollment fee if there is one. In addition, she will receive additional assistance from drug manufacturers when she signs up for a drug card. Beneficiaries who qualify for transitional assistance can automatically get these additional manufacturers' discounts upon enrollment in a card. The Medicare drug card has dramatically simplified these benefits by making all of them available through one card. I hope that card sponsors will work with as many drug manufacturers as possible so that low-income beneficiaries can access all these discounts.

So, when she combines the $1,200 in transitional assistance with the additional manufacturers' assistance offered through her card, she will save $6,300. That is a 90 percent savings for her. Ninety percent savings. To me that's real savings. And to those who say this discount card program provides no real benefits, my only conclusion is that they are the ones who are confused. I'll be the first to admit that some issues have surfaced that need to be worked out, but that's not unusual with a new program. Medicare itself experienced some start-up issues. In commenting on implementation efforts, Bob Ball, former commissioner of Social Security, said, "To a remarkable degree, opponents as well as supporters [of Medicare] tried hard to be helpful." For the sake of beneficiaries, we should heed his words and work in that spirit today.

More recently, the State Children's Health Insurance Program (S-CHIP) faced some challenges. Only 982,000 recipients—less than 20 percent of the enrollment goal of 5 million set by the Clinton Administration—enrolled in S-CHIP during its first year. In the first 5 weeks that beneficiaries have been able to enroll in the Medicare-approved discount drug card, CMS succeeded in enrolling nearly 40 percent of its goal of 7.4 million. That's a great start after just 5 weeks. I think we'd all agree that it was a good thing we did not give up on Medicare or S-CHIP in

their early stages. I know that Dr. McClellan will comment on efforts to address some of the early implementation issues. I am also looking forward to hearing from our other witnesses and to clearing up some of the misconceptions about the card program. I'm proud of our bipartisan accomplishment in delivering real relief to beneficiaries. Senator Baucus and Senator Breaux were instrumental in achieving that accomplishment. Now it's time to put politics aside and give the card program a chance to work. Our Nation's Medicare beneficiaries—who can clearly benefit—simply deserve nothing less.

PREPARED STATEMENT OF KRIS GROSS

I. INTRODUCTION

Chairman Grassley and members of the Committee, thank you very much for the opportunity to testify on our experience with the Medicare-approved drug discount cards. I am Kris Gross, Director of the Senior Health Insurance Information Program (SHIIP), based in the Iowa Insurance Division, Des Moines, Iowa. I am here today representing the 54 State Health Insurance Assistance Programs or SHIPs.

Since 1992 the Centers for Medicare and Medicaid Services has offered funding for SHIPs to the states. Some SHIPs existed prior to 1990 and some states receive additional funding from their states or other grants. SHIPs are housed in state departments of aging, departments of insurance, and in the Medicare Quality Improvement Organization in one state. SHIPs' services are free, confidential and objective.

Our clients are all Medicare beneficiaries—aged, disabled and those with end stage renal disease. We help the beneficiary, and the people who help beneficiaries—family members, friends, and caregivers. We are charged with helping beneficiaries by providing information, counseling and assistance with problems and questions related to Medicare, Medicare Advantage plans, health insurance that supplements Medicare, long-term care insurance, Medicaid, claims, and prescription drug assistance—now including the Medicare-approved drug discount cards.

The heart of SHIPs is the one-to-one, face-to-face assistance and counseling provided to our clients in their communities. This is offered primarily through volunteers, many of whom are peers to the people they counsel. According to a report from the Office of Inspector General, this makes SHIPs a very cost effective way to serve beneficiaries. There is variation from state to state in how programs are structured, which allows us to best meet the needs of the populations we serve.

II. INDIVIDUAL ASSISTANCE AND THE MEDICARE-APPROVED CARDS

The Medicare-approved drug discount cards give SHIPs the opportunity to do what we do best. The Centers for Medicare and Medicaid Services is providing awareness and information about the Medicare-approved drug discount cards through its many resources at the national level. SHIPs provide the local face—we're there to help people understand their options so they can make the best decision possible.

A Kaiser Family Foundation study released June 3 points to problems in explaining the new law to beneficiaries. Kaiser President Drew Altman said that absent "one-to-one customized assistance to beneficiaries I don't see much chance that this law will achieve its goals."

SHIPs provide the type of one-to-one consultation that is needed. Telephones and the internet are tools to be used, but what is needed by many beneficiaries is face-to-face assistance. As pollster Mollyann Brodie reported only 31 percent of seniors said they had gone online.

The SHIP national network of volunteers is assisting clients with the Medicare-approved drug discount card price comparisons. SHIPS are taking client prescription information and running the comparison on the Medicare web site (*www.medicare.gov*) if the client does not have access to a computer. Clients who need counseling related to the price comparison information they receive then meet with our volunteer counselors.

A good example of a SHIP working to meet the needs of its specific populations is outreach the Washington SHIP has done with the National Asian Pacific Center on Aging. NAPCA held seminars about the drug cards and $600 credit in Chinese, Korean, English, and Vietnamese. Washington SHIP volunteers, working with interpreters, have helped 87 people who were referred from one of these seminars enroll with a card and the $600 credit.

Let me now share with you some of our experience working with the drug cards and clients. Depending on the situation, clients may receive many pages of informa-

tion with their price comparison. We ran a comparison for an individual taking four drugs, living in Des Moines, and for pharmacies within three miles of her zip code. If the individual chose to view all discount cards offered, she would have received over 30 pages of information. In visiting with SHIP directors from across the county, we have universally found that the majority of clients who do not access the Medicare web site on their own, need one-to-one assistance to examine all of their options before they make a decision about the drug cards. In some cases, beneficiaries even find it difficult to provide us with their prescription information needed to run a comparison of cards. One woman who called our 800 number and asked for help couldn't find the dosage on her pill bottle. One-to-one assistance is critical to helping beneficiaries get the most from this program.

Some beneficiaries have found that the drug cards can provide savings on their drugs. One client is going to save $45 on a $90 prescription each month. Along with savings on the other drug she takes her annual savings would amount to $700–900 per year (depending on her choice of local pharmacy versus mail order). Others are finding that discounts they are already getting from other discount cards, pharmacy programs, or their insurance, offer comparable or better savings. We are finding that we must help beneficiaries understand how some of the assistance programs offered by pharmaceutical manufacturers which they currently participate in, are wrapping around the Medicare-approved drug cards. It is important that they not lose this assistance by selecting a card that is not participating with their particular drug manufacturers. It is taking careful review of the Medicare price comparison information to determine if enrollment in a card will be beneficial, and then finding the best card options.

Another important hat the SHIPs will wear for clients is our advocacy hat. If a person has a problem with a card we will assist them in contacting the drug card sponsor or CMS, whichever is appropriate.

III. COMMUNITY EDUCATION

Community education has been, and will continue to be essential. People are confused by the discount card versus the upcoming drug benefit. They don't know about the $600 transitional assistance. They need to know how to get information about the cards, formularies, and so on. SHIPS have been conducting thousands of community education events, and the demand continues to grow.

During the month of May the Pennsylvania SHIP hosted several hundred community seminars on the Medicare-approved drug discount cards. In several states, including my own, SHIPs are being asked to be part of town meetings sponsored by members of Congress. AARP has asked SHIPs to present at events they sponsor, or make counselors available at their events so participants can get a price comparison run and receive counseling.

Recently in Iowa, we have had several reports of telemarketing fraud related to Medicare-approved cards. Not only have we used our community seminars to address this issue, but we have also used our established statewide media network to quickly conduct community education and awareness of fraudulent activity.

Beneficiaries want to learn about the drug cards and get basic questions answered before they make the decision to research specific cards. The SHIPS' expertise, and experience with community education, is allowing us to fill this role in our states.

IV. OUTREACH AND THE $600 TRANSITIONAL ASSISTANCE

The $600 transitional assistance offered as part of the Medicare-approved cards is the focus of most of our outreach efforts and partnering. SHIPs are partnering like never before to make sure beneficiaries who are eligible enroll in this important benefit.

Some of our partners include organizations serving individuals with disabilities, public health nurses, Community Action/Energy Assistance programs, senior centers, Meals on Wheels, state Medicaid agencies, University Extension, low income housing, the medical community, Farm Bureau, caregiver groups, churches, Native American reservations, and organizations serving Latinos, Asian Pacific and other ethnic populations.

When beneficiaries find out about this assistance they are grateful. One caller to our office told me that the $600 assistance sounded too good to be true. The $600 represents an amazing opportunity for low income beneficiaries. We have had close to 1,000 people call our office who are eligible for the $600 assistance. They typically are taking 8 to 10 drugs and are desperate for help. We are mailing them their price comparison, and they are asking a counselor to meet with them and sort through the options.

Many states have state pharmaceutical assistance programs. SHIPS have been active in educating and enrolling individuals in these programs. When CMS offered states the opportunity to automatically enroll their state program participants in the $600 credit SHIPs took action. Many beneficiaries had questions about this option. In a few states, because of the state program design, enrolling in the $600 credit is not a good choice for the beneficiary. SHIPs have been a key part of the education and counseling taking place in these states.

One example of a SHIP's work with a state program is Illinois. It has a Medicaid waiver program called Illinois SeniorCare which serves people 65 and older with incomes up to 200 percent of poverty. However, the under 65 Medicare eligible population is not served by this program and would benefit from the $600 credit. The Illinois SHIP is working with the state Medicaid agency, and other professionals serving this audience, to make sure they know about this benefit and enroll if they want.

The $600 transitional assistance is the true gem of the Medicare-approved drug discount cards and the SHIPs are dedicated to making sure those eligible in our states know about the program and enroll, if appropriate.

V. CHALLENGES

Our experience with the Medicare-approved drug discount cards indicates that a huge challenge lies ahead next year when we will need to help beneficiaries with the even more critical decision related to the Medicare drug benefit. Every Medicare beneficiary (41 million) will need to decide if they want to enroll in the drug benefit. It will be important for the Committee, the Congress, CMS and the SHIPs to learn from the challenges beneficiaries face with the discount cards so that we can best meet their information and decision needs next year.

Not only will beneficiaries have to understand the new benefit, but health insurance decisions will need to be made, and dual eligibles will be transitioned from their current state Medicaid prescription drug benefits to the Medicare benefit. The need for education, counseling and assistance will be much more extensive. SHIPs are uniquely qualified to offer this integrated counseling and want to be prepared for the demands this will put on our programs. The drug cards are stretching our resources to the limits, and we need to begin training more volunteers, expand our staffs and 800 numbers now to be prepared for the drug benefit. The volunteer recruitment and intensive training they need is not a quick process.

We are grateful that Congress provided CMS with $1 billion in funding for administrative costs. Some of these funds will support beneficiary education and outreach activities, including those conducted by the SHIPs. We are hopeful that in subsequent years Congress will continue to provide adequate funding for these activities. Adequate funding will be crucial to everyone's efforts to help beneficiaries understand their choices and to make decisions that best meet their coverage needs.

VI. CONCLUSION

In closing, the SHIPs want to thank CMS and the Congress—and especially you, Senator Grassley, Senator Baucus and Senator Bingaman for the interest you have taken in the work SHIPs do and for the additional funding for SHIPS. And to the members of this Committee, thank you for your extraordinary efforts on behalf of beneficiaries and particularly the low-income. Millions of beneficiaries should be thanking you for your leadership on these issues. The drug cards are just a hint of the work we all have to do in 2005 and 2006. Your continued support and leadership will be critical. Thank you.

RESPONSES TO QUESTIONS FROM SENATOR GRASSLEY

Question 1: As you know, I have held over 40 meetings in Iowa to help inform Medicare beneficiaries about the new Medicare law and its benefits. At all of those meetings, I was fortunate to have either you or a representative from your office there to help inform Iowans about the new Medicare law. I know that we both agree that beneficiaries deserve access to accurate information on this program to make choices that best suit their needs. What other activities is the Iowa SHIIP engaging in to help inform Medicare beneficiaries of the Medicare-approved discount drug card?

Has your office focused any of its efforts on beneficiaries eligible for the transitional assistance benefit? If so, what do you think are the most effective strategies to inform this often hard to reach population?

Answer: The Iowa SHIIP has engaged in many activities to reach all beneficiaries, and in particular those eligible for the $600 credit. We have partnered with our

state Medicaid agency to include an insert with a monthly mailing to QMB program enrollees. In September we will partner with them again to send direct mail information to SLMB program enrollees. We also trained Medicaid field staff about the program and provided them with brochures and posters to share with clients.

Information was provided to public health nurses around the state and they were asked to share information about the $600 credit with their clients.

One of our local SHIIP sites partnered with the low-income energy assistance program and did a direct mail to their Medicare clients about the credit. This resulted in many clients contacting SHIIP for information about the credit and Medicare approved cards. SHIIP then ran PDAP for them and helped them enroll with a card. We plan to replicate this effort in other parts of the state.

We have trained area agency on aging staff on the Medicare-approved drug discount cards and have provided them with intake forms they can give to seniors. The intake forms are sent to the SHIIP state office or AAAs that are SHIIP local sponsor sites for PDAP comparisons to be run.

We have worked with USDA low income housing staff also. They received materials to share with their residents about the credit. We have also presented at many HUD low-income housing units and collected intake forms from the residents. We run PDAP for them and send the information to them. Local counselors are available to meet with any beneficiary who requests additional assistance.

We have used the media extensively and have gotten good coverage. Three of our monthly press packets have focused on the drug cards. Several radio stations and TV stations have done interviews with SHIIP staff and volunteers about the cards. We plan to continue to work with the media to help make beneficiaries aware of the cards and the $600 credit.

Partnering with organizations that reach low income beneficiaries and the use of local media, in particular local radio, have been effective strategies in reaching this important audience.

Question 2: We have heard a lot today about the many improvements that CMS continues to make. I believe one of the wisest investments that CMS has made in the last six months is to increase the SHIIPs' funding levels in 2004 and 2005.

These additional dollars should help SHIIPs educate Medicare beneficiaries on the new Medicare law and the discount drug card. Beyond additional dollars, are there other improvements that the Congress or CMS can make to help SHIIPs in their role as a non-biased informational source for Medicare beneficiaries?

Answer: Including SHIPs as resources (in addition to 1–800–Medicare and *www.medicare.gov*) in all materials released from CMS is important.

CMS is working to keep SHIPs updated on the drug cards and other developments, and also giving us CMS contacts on specific topics and issues. Timely availability of information is critical.

Access to quantities of CMS publications, fact sheets, etc. is also important.

Looking ahead to implementation of the drug benefit, SHIPs need as much advance information and training as possible so that we can have our staff and volunteers trained before our beneficiary outreach, education and counseling activities begin.

Continued access to beneficiary information to help resolve issues is important (*e.g.,* being able to contact Medicare to verify drug card or Part D enrollment). This might occur through expansion of the Unique ID system currently in place.

Question 3: What is the most common question that you hear from Medicare beneficiaries and their families?

How do you typically answer this question?

Answer: There are two questions we are asked most often:

1. Is it worth signing up for a card (will I save anything)?
2. Why is it so confusing?

Our response to the first question is that many people do realize a savings (we might give an example) and the only way to know is to do a comparison of the cards with their drugs. We offer to run PDAP for them if they can't or don't want to do it themselves. We also ask them questions to see if they are eligible for the $600 credit. If they are, we tell them to sign up even if the prices of their drugs aren't reduced. We also explore the drug manufacturers' additional assistance offered by some of the cards.

The second question reflects confusion about the cards in general and understanding the PDAP comparison. People are overwhelmed by the number of cards offered and the number of pages of PDAP printout they may have to go through.

We explain the cards as simply as possible. If the call is to our 800 number we offer them the option of meeting with a volunteer. We offer them ways to limit how much information they have to process with PDAP (*e.g.,* search by pharmacy, five

cards with best prices, etc.). We will walk through their PDAP with them, help them complete the enrollment form and get it sent into the card sponsor.

RESPONSE TO A QUESTION FROM SENATOR BAUCUS

Question: SHIP counselors provide vital assistance to seniors and their families, including assistance with Medicare's latest offering, a drug discount card with 73 different sponsors. With so many choices to navigate, it makes sense that seniors would turn to the Internet for help in making decisions. But as you know, a survey released last week showed that only about a third of seniors—and only 15 percent of low-income seniors—use the Internet. Are those numbers consistent with your experience?

Answer: The percentage of people who contact us who do not have Internet access, or who have it and don't want to try PDAP themselves, is higher than two-thirds of our contacts. The reason for that, we suspect, is that people who have computers and know about *www.medicare.gov* use the website and never contact SHIIP.

Testimony of Robert M. Hayes
President, Medicare Rights Center
Before the United States Senate
Finance Committee
"Medicare Drug Card: Delivering Savings for Participating Beneficiaries"
June 8, 2004

Good morning, Mr. Chairman, Senator Baucus, Committee members. My name is Robert M. Hayes, and I am the President of the Medicare Rights Center. We appreciate the opportunity to bring to this Committee the real life experiences of men and women with Medicare who are grappling with the opportunities, and with the frustrations, of the new Medicare discount drug card program.

The context of today's hearing is important. Drug pricing and discount cards need not be the subject of partisan rancor. The focus must be on the humanitarian life and death crises that older and disabled Americans face because they cannot afford the medicine that their doctors prescribe.

Without doubt, the greatest and gravest unmet need of older and disabled Americans is the unavailability of affordable prescription medicine. From the trenches in which we work, Mr. Chairman, the unaffordability of prescription medicine is a national emergency. It is within that reality that we approach the Medicare discount card program, and it is the needs of men and women who cannot afford needed medicine that we bring to you.

The Medicare Rights Center

The Medicare Rights Center ("MRC") is the largest independent source of Medicare information and assistance in the United States. Founded in 1989, MRC helps older adults and people with disabilities get good affordable health care. Day in and day out we work to assist people with Medicare access needed health care. Tens of thousands of callers use our help-lines annually, and we reach out to assist people with Medicare enroll in programs that can help them.

The Medicare Rights Center is a not-for-profit consumer service organization, with offices in New York, Washington and Baltimore. It is supported by foundation grants, individual donations and contracts with both the public and private sectors. We are consumer driven and independent. We are not supported by the pharmaceutical industry, drug companies, insurance companies or any other special interest group. Our mission is to serve the 41 million men, women and children with Medicare.

Through national and state telephone hotlines, casework and both professional and public education programs, MRC provides direct assistance to people with Medicare from coast to coast. By way of example, MRC currently is providing, in partnership with the American Society on Aging, a series of web-based tele-trainings on the Medicare discount cards to social workers and other professionals across the country. You can access that training at www.asaging.org/medicare/about.cfm.

We are also bringing to counselors and consumers across the country Medicare Interactive, a web-based counseling tool—developed with major support from the United States Department of Commerce—that assists people with Medicare access the health care they need. **Invitation: every Congressional constituent service office that requests it will be provided a password to access Medicare Interactive to assist voters with Medicare problems or questions.** Trust me, your district offices will need it – Medicare is not getting simpler.

MRC also gathers data on the health care needs of the elderly and disabled Americans that we serve. We share that data with researchers, policy makers and the media. Just one of MRC's services, its New York State Health Insurance Assistance Program (SHIP), offers counseling support to one out of every 14 Medicare recipients in the nation. Each year, the Medicare Rights Center receives over 70,000 calls for assistance from people with Medicare. By far, the greatest numbers of callers are seeking help in finding ways to pay for medicines that their doctors have prescribed. Our counselors are trained to assist consumers with complex problems and we complement the basic services offered by the 1-800-MEDICARE hotline operated by the Centers for Medicare and Medicaid Services (CMS). 1-800-MEDICARE is the largest source of referrals to our hotline, and CMS provides about 25 percent of the financial support for the MRC hotline: the rest we raise privately. To date, we have received no new support from CMS, or any other public agency, in the wake of the widespread and desperate demand for information triggered by the Medicare prescription drug discount card program.

Needless Pain, Lost Lives

For many, many years this Committee, this Congress, our nation have been numbed by the overwhelming data documenting the human hardship, the needless pain, the lost lives caused by the unaffordability of prescription medicine. I cannot shake from my memory the elderly woman who tearfully told me that she lies to her husband whenever her doctor gives her a prescription. If she told him about the prescription, she said, her husband would insist that she fill it. She wants him to keep taking his heart medicine, and she knows they could not afford another prescription. That is an obscenity in America in the 21st Century, and I know that is why we are here today.

I will take just a few minutes to outline what consumers are experiencing in the wake of the Medicare discount card roll out. This evidence already has been widely reported and well established.

One, the men and women who turn to us for help are in a state of high anxiety: they are confused or frustrated or angry – or all three.

Two, most people with Medicare will receive little if any benefit from the Medicare discount card program. This is not a political statement and it is not a point in dispute. As you know, CMS itself is aiming to enroll about seven million people, 17 percent of people with Medicare into the discount card program over the next 17 months.

Three, some people –those with low incomes, those without any drug coverage and those who learn about and sign up for the Medicare discount card program – will be able to afford some medicine thanks to the Medicare discount program's transitional assistance. This is far too important a point to lose.

In many ways we are critics of a hopelessly complex and wasteful program because all it would take to help everyone at much less cost is for the government to negotiate fair drug prices with the pharmaceutical industry. Yet some people will have improved health and a better life once they enroll in the discount program's transitional assistance. We join with groups like the National Council on Aging, and other groups more critical of the Medicare Modernization Act, in meeting our responsibility to help enroll as many people as possible, and to push this Administration into making enrollment as feasible as possible.

How can that be done?

First, recognize that web sites and voice automated phone systems are – even when they work – a sliver of a solution. We know that, despite hearings like this, news coverage, tens of millions of dollars in advertising by CMS, most people with Medicare do not even know about the discount cards. Confused and frustrated seniors are among the most knowledgeable.

The need to understand the discount card program is most important for low income people who have the most to gain – $600 annually from transitional assistance. But last week's survey by the Kaiser Family Foundation found that only 15 percent of seniors – that's one in seven – with incomes below $20,000 have ever *used* the internet. Twenty-six million seniors with Medicare have incomes below $20,000.

A "Wild West" Marketplace

Here's how complicated the drug market is for an actual consumer, including the most sophisticated consumers with the best of support. Last month I sat at a witness table like this with Stan Baumhofer, a gentleman from Portland, Oregon, while we were testifying before the Health Subcommittee of the House Energy and Commerce Committee. Mr. Baumhofer testified quite enthusiastically about the savings he would enjoy using his Medicare Approved Drug Discount Card. At the Medicare Rights Center we are really more social workers than political analysts, so I gave Mr. Baumhofer my card and offered our help in reviewing his drug needs as time goes forward. In fact, had Mr. Baumhofer been prudently counseled to look beyond the Medicare approved drug discount cards for help, he would have found much deeper savings.

If you look at Table A attached to this testimony, you will see the results of our analysis showing that Mr. Baumhofer could save over $2,700 more using existing drug assistance programs than he could using the best Medicare approved discount card for his prescription drug needs. Of course Mr. Baumhofer is correct in appreciating the value of the discount card that, he said, would save him $1,750 a year. But when existing drug programs can save him over $4,500 annually, he needs to know that as well. After all, those savings are over 25 percent of his $16,000 annual income.

The point of Mr. Baumhofer's tale is not to diminish the value of any program that helps a single person afford a single prescription. And of course we intend no criticism of the House members who assisted Mr. Baumhofer in his testimony. Our own experts at the Medicare Rights Center are struggling mightily to assist people in the best way possible.

The point of this analysis is to show just how complex the prescription drug marketplace has become, how Byzantine the process of finding discounts can be, and how utterly helpless the savviest of consumers – including those assisted by the best intentioned professionals – become in the face of layer upon layer of pricing changes, discount programs and assistance programs. This is not a marketplace where willing buyers meet willing sellers to establish price. It's the Wild West, and the consumer is without ammunition.

The Baumhofer tale also raises another interesting point: if the Administration could use its influence with the pharmaceutical industry to maintain its patient assistance programs, would it not better serve the American public to promote these assistance programs and enroll eligible Americans in them? As the chart shows, Mr. Baumhofer is far better served by assistance programs than by any Medicare approved card. And all people eligible for

transitional assistance are eligible for each of the major drug companies' assistance programs.

No Surprise

Absolutely no one should be surprised that very few people have signed up for Medicare-approved discount cards to date. The program's structure is hopelessly complex, and for most people the benefit is meager. Permit me to spend a moment reviewing the structure of the program.

The design of the discount benefit, and even worse the design of the 2006 Part D drug benefit, draws all the wrong lessons from decades of experience with existing income-tested programs, especially the Medicare Savings Programs known by their acronyms QMB, SLMB and QI-1. It is well established that the design of the enrollment process for any public benefit will determine whether more than a small percentage of eligible individuals enroll in and benefit from the program.

"A Dirty Secret"

It is a dirty secret to most of the American people that the design of most low-income programs excludes about half of the people eligible for the benefit. It's common knowledge to all of us experts. But when political leaders speak of the safety net for poor Americans – be it in health care, housing, food – they only rarely acknowledge that half the people in need go unassisted. Tragically, in many ways the people in greatest need – that is those least aware of government programs that can help and least able to navigate bureaucratic hurdles to assistance – most frequently lose out. We thank Senator Bingaman and other members of this Committee who have been leaders in working aggressively to correct this.

The good news is that if we want full enrollment in public benefit programs, we know how to do it. Since 1966, enrollment in the voluntary Part B Medicare program has hovered between 95 and 97 percent. Automatic enrollment, with voluntary opt-out is the simple but magic solution.

Please review Table B which compares Medicare Part B enrollment with the take-up rates for Medicare Savings Programs, which require people to apply, in various states. In North Dakota, only one in four people are receiving the assistance to which they are entitled. Even in the relatively high enrollment states of Senator Lott, Senator Frist, Senator Grassley and Senator Snowe (Mississippi, Tennessee, Iowa and Maine, respectively), where enrollment is above 70 percent, thousands of poor people are going without needed health care because of their inability to enroll in Medicare Savings Programs. Senator Baucus, the story in Montana pretty much tracks national data – only about half of the people eligible for assistance receive it.

For today's discount card enrollment effort, here's a modest prescription: The single most useful step to assist people access the $1200 transitional benefit -- as it is now designed -- is to require automatic enrollment of anyone who has established eligibility through an existing program, principally the Medicare Savings Programs. That alone could bring nearly a million very low income Americans into the discount card program. It is a humanitarian act, and it is a prudent political act. It will do what the Administration repeatedly says it wants to do: help bring affordable prescription drugs now to the neediest men and women with Medicare.

We understand, but hardly appreciate, that there is a debate within the Administration about the wisdom of automatic enrollment. We have heard from some in the Administration that auto-enrollment would undermine the voluntary nature of the drug card. To that, from the perspective of the real world, we say, "Come on." Neither the White House nor the Internal Revenue Service forced Americans to jump through hoops to claim their tax refunds two summers ago. The checks were just mailed to you. People with Medicare eligible for the $1200 in transitional assistance should be treated similarly.

While there are a million Americans who will benefit from automatic enrollment in transitional assistance, there are an additional 18 million people with Medicare who have incomes under $20,000 a year who will not be helped by automatic enrollment and who remain largely without assistance in affording the medicines their doctors prescribe. The push to enroll eligible Americans in transitional assistance is a noble one. But that push cannot obscure the reality that many, many medically needy Americans will be unable to afford prescription drugs until this Congress requires the federal government to bargain for best prices with the major pharmaceutical companies.

The CMS Website and 1- 800-MEDICARE

I won't speak about the difficulties of the CMS web site or the 800-MEDICARE phone line now; we have quietly provided CMS with a good deal of feedback since late last month, and we will continue to do so as partners in the effort to maximize consumer understanding of the discount card program.

We recognize that CMS is trying, but CMS – just like people with Medicare -- has been dealt a cruel hand by the structure of this discount card program. At the end of the day, a reasonably informed choice for most people with Medicare will be impossible. It is wasteful to spend tens of millions of tax dollars in futile attempts to explain nuanced choices involving scores of plans offering hundreds of medical products and services. Rather than offering multiple card choices with scant benefits, a useful drug assistance program would provide a truly meaningful benefit with multiple medication and pharmacy choices. The

structure of the discount program, and we expect the 2006 benefit as currently designed, does not work and no magic by a CMS webmaster can change that.

It is not premature to look ahead to 2006. As currently designed, we fear that the Part D Medicare drug benefit will be so complex to navigate that today's drug card program will look like child's play. If the 2006 Medicare drug benefit is to be both a humanitarian and political victory, Congress and the Administration must revamp the structure of the benefit with three words in mind: simplify, simplify, simplify.

To that end, I will conclude with six points of essential reform so that the 2006 drug benefit can meet its stated purpose – to assist the neediest older Americans secure medicine that they can afford.

- **Automatically enroll all eligible persons in the low-income drug benefit.** The MMA already provides that full benefit Medicaid recipients be enrolled in the low-income subsidy and a prescription drug plan if they fail to enroll themselves. Persons can then opt-out of the program so the benefit is still voluntary. Likewise, automatic enrollment procedures should be applied to all state pharmacy assistance program and Medicare Savings Programs recipients. (CMS has permitted states to automatically enroll state pharmacy assistance recipients in transitional assistance and is now considering extending automatic enrollment to Medicare Savings Programs enrollees.)

Automatic enrollment procedures, such as those used for Medicare Part B, are the best way to maximize enrollment in health insurance programs.[1] Persons automatically receive Part B when they turn 65 and sign up for Social Security[2] unless they affirmatively decline Part B enrollment. As a result, Part B has a 95.5 percent participation rate. In contrast, national participation in the Medicare Savings Programs stands at about 50 percent because persons must affirmatively apply for benefits.[3] This is despite fifteen years of efforts by the federal government, states, and community organizations to increase awareness of the programs and to ease application and eligibility requirements.

- **Remove the asset tests, which represent a leading barrier to enrollment in low-income programs.** The onerous task of verifying the worth of certain items (including burial accounts, life insurance policies,

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[1] Dahlia K. Remler and Sherry A. Glied, "What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs." *American Journal of Public Health,* January 2003.

[2] Persons who qualify for Medicare based on a disability are automatically enrolled in Part B when they sign up for Medicare after r two year waiting period.

[3]. In 2001, CMS found that 40.5 percent of those eligible for the QMB and SLMB programs were not enrolled. Actuarial Research Corporation, *Dual Eligible Buy-In Status*, prepared for the Centers for Medicare and Medicaid Services, May 2001. Nationally, only about 145,000 (10%) of the estimated 1.4 million eligible individuals are enrolled in the QI-1 program. 68 Fed. Reg. 50792 (Aug. 22, 2003).

bank accounts, and vehicles) prevents many eligible older Americans and Americans with disabilities from completing applications for the Medicare Savings Programs. [4] Additionally, people who would qualify for the low-income assistance programs based on income, but not assets, are hardly well-off. The median value of assets for persons with incomes between 100 and 135 percent of poverty is 8,000.[5]

- **Require the use of simplified application procedures and allow self-certification of income and assets**. Cumbersome enrollment processes represent a leading barrier to participation in low-income assistance programs. In particular, face-to-face interviews and income and asset verifications pose insurmountable hurdles for many older people, especially those with low literacy, limited English-speaking skills, and cognitive impairments. [6] Simplified enrollment should include easy-to-complete mail-in and online application forms, prohibit requirements for in-person interviews, allow applicants to self declare the value of their income, and minimize verifications for assets. CMS should also use presumptive eligibility to allow persons who appear to be eligible to apply in pharmacies and doctor's offices and receive benefits immediately. Persons are more likely to enroll in benefits if they can access them immediately.

- **Streamline the renewal process.** Burdensome renewal procedures, like complicated enrollment procedures, can undermine participation in low-income assistance programs.[7] Easing renewal requirements also makes sense because most persons with Medicare have fixed incomes, and most persons remain eligible for the programs from year to year.[8] Streamlined renewal should involve:

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[4] Kim Glaun, *Medicaid Programs to Assist Low-Income Medicare Beneficiaries: Medicare Savings Programs: Case Study Findings* (Washington, Kaiser Commission on Medicaid and the Uninsured, December 2002) [Hereafter *Glaun Medicare Savings Programs*]

[5] Laura Summer and Lee Thompson, *How Asset Tests Block Low-Income Medicare Beneficiaries from Needed Benefits* (Commonwealth Fund, May 2004) [Hereafter: *Summer Asset Tests*]. About 30 percent of persons with incomes at or below poverty are disqualified for the Qualified Medicare Beneficiary Program because they have a modest life insurance policy or vehicle valued at more than $4,500. Seventy-five percent of these persons have assets that exceed the life insurance limit by $8,500 or less. *Id.*[

[6] *Glaun Medicare Savings Programs.*

[9] Glaun *Medicare Savings Programs;* Michael J. Perry, Susan Kannel, and Adrianne Dulio, *Barriers to Medicaid Enrollment for Seniors:Findings From 10 Focus Groups With Low-Income Seniors* (Washington, the Kaiser Commission on Medicaid and the Uninsured, January 2002).

[8] See *Summer Asset Tests*; Susan Haber, et. al, Evaluation of Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) Programs (commissioned by the Centers for Medicare and Medicaid Services, October 2003) [Hereafter *Haber Evaluation of QMB*]

- Yearly, rather than quarterly or semi-annual renewals and
- Passive renewal procedures whereby states send enrolled individuals a recertification form with all of their eligibility information filled in and ask them to return the form only if some of their information is incorrect. Persons who do not return the form would be automatically retained in the program.

- **Increase SHIP funding so eligible persons can cut through the red tape and receive benefits.** Even when application processes are simplified, many older persons and persons with disabilities need personalized assistance to complete the application process.[9] Moreover, a recent study commissioned by CMS identifies personalized assistance as a key factor in getting persons enrolled in the Medicare Savings Programs.[10] SHIPs are uniquely equipped to provide this personalized help.[11]
- **Federalize enrollment in the low income drug benefit and the Medicare Savings Programs.** The MMA requires that Medicaid offices and the Social Security Administration determine eligibility for the new low income drug benefit. The Medicare Savings Programs are now administered by Medicaid offices. But applying through Medicaid offices presents multiple obstacles, including Byzantine documentation requirements, traveling to often inaccessible offices, and long waits for service once persons get arrive.[12] Federalizing both administration of the low-income drug benefit and the Medicare Savings Programs would improve participation in both programs because Social Security is generally more user-friendly and accessible for older persons and persons with disabilities. Also, having enrollment administered by one agency will promote accountability and reduce confusion.

These modest steps, even standing alone, can play a significant role in fulfilling the legislative purpose behind the MMA creation of the Part D drug benefit.

In sum, the discount cards will do some people some important good, but the discount cards are leaving the overwhelming majority of people with Medicare without help and angry. There are lessons to be learned from the frustrations of this spring:

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[9] *See* Glaun *Medicare Savings Programs*
[10] *Haber Evaluation of QMB*
[11] In a 2002 report on the effectiveness of SHIPs, the Health and Human Services Office of Inspector General (HHS OIG) wrote, "The SHIPs are uniquely positioned to provide personal locally-oriented counseling and assistance services with trained counselors who often have similar backgrounds, cultures, and experiences as the beneficiaries they serve." HHS OIG, February 2002.
[12] Medicare Rights Center, A*n Investigative Report on Medicare Savings Programs in New York City: Local Involvement in Federal Programs Impedes Access for People with Low Incomes*, December 2001.

- humanitarian and political goals converge when a drug benefit provides meaningful relief in a structure that most people with Medicare can understand;
- if there is the will, there are straight forward ways to increase substantially enrollment in low income benefit programs; and
- until the federal government is willing to use its market power to drive down drug prices for all Americans, most people with Medicare will not see a drug benefit that provides them with what they need – the ability to afford the medicines that their doctors prescribe.

TABLE A

Prescription Drug Cost Comparison for Stan Baumhofer
Portland, OR
Annual Income: $16,000
All prices are for a month's supply

	Current[13]	Retail[14]	Medicare-Approved Card[15]	Manufacturer Pharm. Asst
Lipitor[16]		$105.73	$97.01	$0[17]
Lisinopril[18]		$45.16	$19.23	$0[19]
Plavix[20]		$127.34	$112.97	$0[21]
Toprol xl[22]		$26.87	$21.39	$6.00[23]
Total Costs	$403.31	$305.10	$250.60[24]	$6.00
Total Savings[25]		$98.00	$152.71	**$397.31**

We found that Mr. Baumhofer could get his drugs for just $6 if he took advantage of the drug companies' assistance programs. In contrast, he would pay $250.60 using the best of the Medicare-approved drug discount card programs.

[13] This is the amount, according to Mr. Baumhofer's May 20, 2004 testimony to the House Energy and Commerce Committee, that he spent for his prescription drugs without a Medicare-approved drug discount card or other assistance. His testimony did not include the prices for individual drugs.
[14] Prices on June 2, 2004 including a 10% senior discount available at Bowman's Hillsdale Pharmacy, 6256 SW Capitol Hwy Portland, OR 97201.
[15] Using Envision Rx Plus Medicare-Approved Drug Discount Card at Bowman's Hillsdale Pharmacy
[16] 20 MG 30 TABS
[17] Pfizer Connection to Care (Annual income cap is $16,000 (single)).
[18] 30 MG 30 TABS
[19] Merck Patient Assistance Program. Merck produces Prinivil, which is the trade name for the generic drug Lisinopril. Mr. Baumhofer could receive Prinivil, in place of Lisinopril, for no cost. (Annual income cap is $18,000 (single))
[20] 75 MG 30 TABS
[21] Bristol-Myers Squibb Patient Assistance Program. Bristol-Myers has not set down the qualifications for its Patient Assistance Program in writing. However, in a personal conversation with Medicare Rights Center staff on June 2, 2004, a Bristol-Myers Squibb representative indicated that based upon her experience with similar applications, Mr. Baumhofer would qualify to receive Plavix for free through the company's patient assistance program.
[22] 50 MG 30 TABS
[23] AstraZeneca Together Rx Program (Annual income cap is $28,000 (single)). See: Freudenheim, Milt and Robert Pear. "Drug Discounts Beginning Tuesday, but Sign-Ups Lag." *New York Times* 1 June 2004.
[24] See Mr. Baumhofer's testimony.
[25] Total savings are calculated in comparison to Mr. Baumhofer's current prescription drug cost expenditure.

TABLE B

Enrollment Rates in the Medicare Savings Programs* After More Than A Decade

Program	Take-up rate**	Enrollment	Steps to facilitate participation: Liberalized asset requirements***	Self-certification of assets and income allowed	Mail-in applications
Part B Medicare	95.5%	Automatic with application for Social Security Retirement Benefits or Medicare; individuals may opt out	N/A	N/A	N/A
Mississippi Medicare Savings Programs	84%	Individuals must apply for benefits	Yes (Disregard all assets)	No	Yes
Tennessee Medicare Savings Programs	77%	Individuals must apply for benefits	Yes (Liberalized procedures for counting assets)	Yes	Yes
Iowa Medicare Savings Programs	71%	Individuals must apply for benefits	No	No	No
Maine Medicare Savings Programs	71%	Individuals must apply for benefits	Yes (Disregard savings of $8,000 (single)/$12,000 couple)	No	Yes
Connecticut Medicare Savings Programs	64%	Individuals must apply for benefits	Yes (Disregard all assets for QI1s)	Yes	Yes
Louisiana Medicare Savings Programs	60%	Individuals must apply for benefits	Yes (Increased limits for burial accounts, life insurance to $10,000)	Yes	Yes
New Mexico Medicare Savings Programs	56%	Individuals must apply for benefits	No	Yes	Yes
Arizona Medicare Savings Programs	47%****	Individuals must apply for benefits	Yes (Disregard all assets)	No	Yes
Montana Medicare Savings Programs	47%	Individuals must apply for benefits	No	No	Yes
North Dakota Medicare Savings Programs	26%	Individuals must apply for benefits	No	No	Yes

* The Medicare Savings Programs (MSPs), which Congress enacted in 1988 and expanded in the 1990s, include: the Qualified Medicare Beneficiary (QMB) Program for persons with incomes at or below the Federal Poverty Limit (FPL), the Specified Low Income Beneficiary (SLMB) Program for persons with incomes at or below 120 percent of FPL, and the Qualifying Individual (QI-1) Program for persons with incomes at or below 135 percent of FPL. The assets limits for all of the programs are $4,000 for a single person and $6,000 for a couple.

**The take-up rate is the percentage of eligible individuals enrolled in the program. Part B take-up rate from "Dahlia K. Remler and Sherry A. Glied, "What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs." *American Journal of Public Health,* January 2003 . State MSP take-up rates from 2001 figures in Susan Haber, et. al., "Evaluation of Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) Programs," Volume 1 (Commissioned by the Centers for Medicare and Medicaid Services, October 2003). Estimates do not include QI-1.

*** Medicare Savings Programs employ the SSI methodology for counting assets, but states can adopt more liberal rules.

****From 1999-2001 Arizona MSPs experienced a 4% increase in enrollment after instituting practices to promote enrollment, while the national mean increase was 2%.

RESPONSE TO A QUESTION FROM SENATOR GRASSLEY

Question: Another service the Medicare Rights Center provides to beneficiaries is the HIICAP hotline. HIICAP, the New York SHIP, provides free, confidential, accurate and unbiased health insurance information, counseling and assistance. Given your public opposition to the Medicare drug discount card program, do you try to discourage New York's beneficiaries from enrolling?

Answer: First, it is necessary to correct a misstatement in your question. The Medicare Rights Center has never been in "public opposition to the Medicare drug discount card program." As I said at the Senate Finance Committee hearing, and as we have said repeatedly both publicly and privately, some people will be able to afford desperately needed medications as a result of the program—particularly because of the Transitional Assistance that provides up to $600 a year towards the

cost of prescription drugs to people with very low incomes and no drug coverage. That is why we are working to assist people with Medicare enroll in a Medicare-approved discount card when it will help them afford medicine that they need.

The Medicare Rights Center, in all its activities, from policy to education to client service, is committed to providing people with Medicare with objective assessments of all their options for prescription drug savings. These include not just the Medicare-approved drug discount cards, but also state pharmacy assistance programs, pharmaceutical manufacturer assistance and discount programs, internet pharmacies (both domestic and Canadian), Veterans Administration benefits, other existing drug discount cards and Medicare Advantage plans.

The volunteers who staff our hotlines are trained to provide comprehensive counseling on the full breadth of options for prescription drug savings. It is a very difficult task. We applaud the programmers of the *www.medicare.gov* website, who also attempt to inform visitors of many ways to save—going beyond the often meager savings of the Medicare approved discount cards.

There has never been a more important time for supporting the volunteers of State Health Insurance Assistance Programs (SHIPs). With the introduction of the Medicare-approved drug discount cards and, soon, other changes to Medicare, people now more than ever need access to the personal, confidential services that SHIPs are uniquely qualified to provide. The Medicare-approved drug discount cards are not a panacea but a new option, good for some and inappropriate for others; trained SHIP volunteers can help people make the hard choices. A modest SHIP funding increase from $12.5 million to $21.1 million in FY 2004 was welcome; far more is necessary to allow people with Medicare access to the basic information they need to make informed decisions. SHIP funding at this year's level is equal to about 50 cents for each of the 41 million Americans with Medicare.

We thank you and the Finance Committee for your continuing efforts in moving our national policy to the point when Americans will no longer go without the medicine they need because they cannot afford it.

RESPONSE TO A QUESTION FROM SENATOR BAUCUS

Question: Many seniors turn to the Medicare Rights Center for help in navigating Medicare's complexities, the latest of which is a drug discount card with 73 different offerings. Given that only about a third of the seniors—and only 15 percent of low-income seniors—use the Internet, many Medicare beneficiaries receive information through 1–800–MEDICARE, and many seniors also call the Medicare Rights Center for assistance. Can you share some examples of what seniors have experienced with 1–800–MEDICARE?

Answer: Experiences with 1–800–MEDICARE have been mixed.

In some cases, people with Medicare have been satisfied with the service on 1–800–MEDICARE. Composed, well-trained operators nimbly navigated the several scripts on their computers to find the right text to read, verbatim, to the confused callers on the other end of the line. Of course, callers are forced to press numerous buttons and wait, sometimes as long as 15 minutes, before speaking to an operator.

Unfortunately, the operator a caller finally reaches after figuring out the right buttons to push and waiting is not always so helpful. Consider these four actual calls, made within the last month:

1. A caller asked for the number of the New York State Health Insurance Assistance Program (SHIP) hotline. The operator responded that she was in Florida, and suggested that the caller use a phone book.
2. A caller asked how long the Medicare drug discount program will run. The operator responded that the cards will work for 18 months, and that after that, card companies would have the option of extending the cards for another 18 months, into 2007. Remarking that the program might even run until 2009 if it works well, the operator also noted that people could continue receiving an annual $600 subsidy as long as the program continued.
3. A caller asked what drug savings options were available for someone living in New York State. The operator responded that she was only aware of one possibility, EPIC, and did not mention (or seem to know of) any other options.
4. A caller asked for help in comparing Medicare drug discount cards with EPIC. The operator referred the caller to the Social Security Administration.

Although its operators are not always familiar with the many options for drug savings, the 1–800–MEDICARE hotline has, to its credit, grown less-biased as the new discount card program has developed. As late as May, 1–800–MEDICARE callers would have to utter "Medicare Improvement" and endure an ode to the new Medicare law before gaining access to a counselor. Now, they need only say, "Drug Card."

As operators of our own telephone hotline for people with Medicare, we appreciate the importance of well-trained human counselors in assisting older Americans and people with disabilities. Indeed, Internet access is extremely limited among older Americans—as few as 22 percent have it, according to the Pew Internet and American Life Project.

We appreciate the efforts of the Centers for Medicare and Medicaid Services for their continued efforts to train counselors to serve on their 1–800–MEDICARE hotline.

PREPARED STATEMENT OF HON. MARK MCCLELLAN

Chairman Grassley, Senator Baucus, distinguished Committee members, thank you for inviting me here to discuss the Medicare-Approved Drug Discount Card and the Transitional Assistance Program, which was enacted into law on December 8, 2003, as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Today, we reached the six-month mark since the legislation was enacted. In that time, CMS has worked diligently to meet the short deadline we had to implement the drug card and transitional assistance program by June 1st—and we have done so. We issued an interim final regulation and guidance, we implemented new contracting and oversight mechanisms for card sponsors, we set up new information and outreach systems that provide a new level of price transparency and price shopping for prescription drugs, and we are working every day to make the drug card program even better.

As a result, we are no longer just talking about the need to do something about high drug prices for Medicare beneficiaries—for the first time ever, Medicare is starting to provide real help and real savings with drug costs, ahead of the full drug benefit in 2006. Drug card sponsors began marketing and enrollment efforts on May 3, as scheduled, and last week, beneficiaries began realizing significant saving on their drug purchases. To date, around three million Medicare beneficiaries have enrolled in one of the various card programs.

As we meet today, Medicare beneficiaries are enrolling in and using Medicare-approved drug cards to get some immediate assistance with their drug costs. Seniors are already seeing significant savings not only off the high retail prices that they have long had to pay; in general, they are now able to pay prices below the average paid by all Americans, including Americans with price discounts through private or public prescription drug coverage. And with the new transparency and competition, prices offered under card programs have fallen since CMS first began posting pricing data. As a result, beneficiaries who are struggling with drug costs can generally recoup the cost of enrollment within one or two months—and many cards have a low annual enrollment fee, or none at all, so that not signing up for a card means leaving money on the table. And while any Medicare beneficiary who is struggling with drug costs is eligible to sign up, regardless of their income, the savings are even greater for low-income beneficiaries. Low-income beneficiaries without good coverage who are struggling with paying for their drugs on the one hand and paying for other basic necessities on the other, out of a fixed Social Security check, can get up to thousands of dollars in assistance through this program—including a $600 annual credit on the discount card and substantial additional discounts on many brand-name and generic prescription drugs.

HOW BENEFICIARIES CAN TAKE ADVANTAGE OF THIS PROGRAM

We are working hard to help beneficiaries get accurate information that they can use about whether the drug card program is worth it for them, and how they can get the most out of it. Beneficiaries need to know, first, that there are real savings available through the program at their neighborhood pharmacies and by mail-order; second, there are a few specific steps that they can take to find out how much the drug card program can help them—and the most important step may be contacting us at 1–800–MEDICARE to get the personalized information they need; and third, once they have found a good fit with a card and they want to start saving, enrolling just involves a phone call or filling out a two-page enrollment form.

Retail savings

Medicare beneficiaries who are struggling with their drug costs—particularly those without good coverage today—need to know that the drug discount cards can provide real savings on their medications. Currently, many seniors are able to get some discounts off list retail prices through a variety of pharmacy discount cards. But the Medicare-approved cards also require manufacturer discounts that are passed on to beneficiaries, and so larger savings are generally possible. In fact, re-

cent studies show that the prices on brand-name drugs available through the cards are 11 to 18 percent or more below the average prices actually paid in neighborhood pharmacies by all Americans—including Americans who receive discounts on their drug prices through their public or private insurance plans.

Generic savings

Potential savings from generics are even greater. A new study just released by CMS shows that the savings on generic drugs range from 37 to 65 percent below the average prices actually paid by all Americans. Generic drugs are just as safe and effective as the brand-name drugs when they are approved by FDA, they are available in 55 percent of the 209 categories of drugs included in the drug cards, they account for a majority of prescriptions in the United States today, they generally cost about 70 percent less than brand-name drugs to begin with, and now they are even less expensive at neighborhood pharmacies for Medicare beneficiaries.

Mail order savings

Finally, the drug cards offer real savings on mail-order prescriptions. Prescriptions available by mail-order and on the Internet from licensed U.S. pharmacies are generally less expensive because they are available less quickly, in higher volumes, and without face-to-face assistance and advice from a pharmacist. For seniors who prefer such prescriptions—and the latest evidence suggests about 1 in 5 seniors buys drugs by mail—the Medicare-approved drug discount cards also compare favorably to mail-order prices available from safe Internet drug sources. For example, a recent study found savings of 5 to 20 percent or more on mail-order prices for brand-name drugs through Medicare-approved cards in comparison to such Internet sources as *drugstore.com* and *costco.com.*

Low-income savings

Finding out about the drug card program and enrolling is especially urgent for the 7 million low-income Medicare beneficiaries who do not have drug coverage today, and who can get major relief from their drug costs through the Medicare-approved drug card program. CMS has recently completed analysis of the savings low-income beneficiaries (incomes below 135 percent of the federal poverty line, or FPL) who are eligible for $600 in transitional assistance and, in many cases, additional manufacturer discounts on drug prices, can expect to see under the drug card program. Our results indicate that our illustrative low-income beneficiaries can save 29–77 percent over the next 7-month period through the end of 2004 compared to national average retail prices for "baskets" of commonly used brand name drugs when both discounts and $600 in transitional assistance are taken into account. In addition, our analysis indicates that low-income beneficiaries can save 39 percent to over 96 percent on individual brand name drugs that are commonly used by the Medicare population when both the discount and transitional assistance are taken into account. Five of the nine brand name drugs we examined had savings of over 90 percent when including the transitional assistance.

Furthermore, this analysis does not reflect the special pricing arrangements some manufacturers have with certain discount cards after the $600 in transitional assistance is spent. These additional sources of savings may provide thousands of dollars in further help this year and next for low-income beneficiaries. As an illustration, based on our analysis, one example beneficiary's savings increased from 58.4 percent with the drug card alone to 88 percent with the added special manufacturer offerings.

And low-income beneficiaries should keep in mind that the program is completely free: they do not pay the annual enrollment fee, and they can begin using the $600 transitional assistance on any prescription medication they need as soon as they get their card.

Taking all of this evidence on savings together, it's clear that Medicare beneficiaries who are struggling with drug costs today can generally save 10 to 25 percent or more compared to what they would otherwise spend, just by using the cards. That's why it's important for beneficiaries who are struggling today, particularly those without good drug coverage, to find out about how they can get the most out of this program. There are no deadlines or late fees for enrollment in this voluntary program, but savings will start as soon as the cards are put to work. Medicare beneficiaries' market clout is finally being used in their favor when it comes to drug purchases, and we would urge beneficiaries to take advantage of this opportunity to save.

Specific steps—how you can find out what the drug card program means for you

After all they may have heard about the general features of the drug card program, many beneficiaries may wonder what exactly it means for them. Can it help

them meet their prescription drug needs at a lower cost? Anyone who is eligible for Medicare who does not already have drug coverage through Medicaid is eligible for the card program. This is a voluntary program that does not affect any other benefits you may receive. So, if you're already on Medicaid, you don't need to do anything. If you get your Medicare benefits through a Medicare Advantage plan, you probably have some drug benefits already, and you generally also have access to a special card associated with your plan (in many cases, you've already received a drug card). And if you have comprehensive coverage through an employer retirement plan or some other source, you may not need a card, but you may want to check on any additional savings. But it's probably worth finding out the facts about what the drug card program means for you, especially if you don't have good coverage for all of your drug needs today. This includes, obviously, people who don't have any coverage or full coverage. It also includes most people with drug coverage through Medigap, because their coverage is usually capped and it often provides insubstantial price discounts. And of course, it's especially true for low-income beneficiaries without good coverage, who stand to save thousands of dollars through the drug card program.

If you decide to look into what the drug card program can do for you, the best way to start is usually to contact Medicare to get the personalized facts based on your needs. While you can get the facts by using a computer to visit us on-line at *www.medicare.gov,* you don't have to go anywhere near a computer to take advantage of this new program. You can call us 24-7 at 1–800–MEDICARE and talk to a trained customer service representative who can answer your questions and provide you with personalized information as well. When you contact us, you need to be ready with a few pieces of information about your particular needs, since Medicare beneficiaries have very diverse drug needs and preferences about how they get their medicines. You should be ready with your zip code, your drugs and dosages (which can be found on their prescription labels), and your monthly income, if you have limited means. If you have any other special preferences about your medicines, you can tell us about those as well—for example, whether you have a preferred pharmacy, whether you want a low-fee or no-fee card, whether you want to find out whether a particular card that you've heard about is a good deal for you, and whether you're interested in additional savings through mail-order or generic drugs.

Whether you call us at 1–800–MEDICARE or go to *www.medicare.gov* on the Internet, you can use the specific information on actual discounted drug prices that Medicare provides in this program to answer the most important thing you need to know: how much can the drug cards save for you, at your neighborhood pharmacy or whatever means you most prefer to get your medicines. And in addition to talking with us about it, you can get a personalized brochure in the mail that lets you read about additional details on the savings at your leisure.

In addition to information on Medicare approved prescription drug discount cards, our customer service representatives at 1–800–MEDICARE and the *www.medicare.gov* website can provide additional help if you have limited means—not only about the details of what you can save with the drug card discounts and the $600 credit, this year and next, and the additional low-income discounts, but also about Medicaid, state pharmacy assistance programs, and over a hundred manufacturer discount programs. Some of these programs provide assistance for beneficiaries with family incomes up to nearly 300 percent of the poverty line.

Right now, it usually takes just a few minutes at most to talk to a customer service representative at 1–800–MEDICARE, and even at peak times the maximum wait times have generally been less than 10 minutes. It then takes less than 14 minutes on average to speak with a customer service representative to get the personalized information you need to find out about how much you can save.

Finally, we know that many of our beneficiaries need even more personalized assistance. Face-to-face personal help is available through the local offices of the State Health Insurance Assistance Programs, and through other organizations that have extensive experience with assisting low-income seniors.

How to enroll

This is a voluntary program, so it's up to you whether to sign up. After you get the facts about what the program means for you, there are a couple of ways to enroll in a card. One way is to fill out a two-page enrollment form and mail it in to the card you choose. You can get this form from the drug card sponsor of your choice, it's included in the personalized brochure you can get from 1–800–MEDICARE, it's available through *www.medicare.gov,* or it's available through local SHIP offices and many seniors' organizations. The other way to enroll is to call the 1–800 customer service number for the card you choose. When you contact us for your personalized information on the drug card program, we will give you the specific address or

phone number of the card sponsor you select. If you want to apply for the $600 in transitional assistance, there's a similar two-page form. You will generally receive your card in the mail in a matter of days, and the discounts start the month after you sign up.

The bottom line for Medicare beneficiaries

There are real savings on drug costs available through Medicare-approved drug discount cards. If you are struggling with drug costs, it's probably worth getting the facts about what the drug card program means for you—and it's definitely worth getting the facts now if you have limited means. So many cards offer significant savings that the important step right now is simply to get enrolled. The easiest way to do this is to call 1–800–MEDICARE or to go to *www.medicare.gov,* and when you do, be ready with your zip code, your drugs and doses (from the prescription labels), and your income (if you have a limited income). We'll tell you about what your drugs will cost on the cards that are the best fit for your needs, and if you're interested, we'll tell you about more ways to save. We'll send you a personalized brochure to go over at your leisure. And we'll give you the two-page enrollment form, and the 1–800 number to call, if you decide to enroll.

It's also important to know that there's no deadline for signing up and no late enrollment penalties. However, if you're struggling with drug costs, it's also important not to leave the money you can save through this new program on the table for too long. I've talked with many beneficiaries who have been struggling with drug costs for years, who are finding that the cards pay for themselves in the first month or two, and who are taking the steps I just described to start saving right now.

BENEFICIARY ACCESS IMPROVEMENTS

As you all know, in the few months since MMA was signed into law, CMS took the drug card program—the first of its kind to be offered through Medicare—from concept to reality. Implementing the drug card in such a short period of time presented many challenges for the Agency, including issuing regulations, qualifying card programs, and developing the technical platforms to support enrollment, eligibility determinations, and providing the American public with unprecedented transparency about prescription drug pricing. In spite of substantial progress we have made in just six months and the fact that beneficiaries are seeing savings, we recognize that there have been some operational problems. However, we are identifying and correcting these problems and, with each passing day, improving the efficiency of this program.

The initial phase of a major new program is clearly a time of learning, and what we have seen is that millions of seniors and people with disabilities are very interested in learning about the best ways to save on their drugs. During the first few days of May, we averaged 400,000 calls to 1–800–MEDICARE each day. We received more than 3.8 million calls during the entire month of May. This is an extraordinary call volume, particularly when you consider that we had 5.6 million calls in all of 2003. Responding to this volume of calls was a significant challenge to our high customer service standards in Medicare. Even with this unprecedented level of interest, we are committed at 1–800–MEDICARE to provide service that reliably gets customers the help they need in a matter of minutes.

We have worked quickly to improve the program and we will continue to do so as we identify problems. At 1–800–MEDICARE, we greatly increased the number of customer service operators from several hundred to 3,000 as of last week, and we expect to maintain this number of trained representatives to handle the unprecedented number of callers in a timely and effective manner. We have also taken steps to reduce the time that our customers have to take when they call, by adding voice messages that can help callers to be better prepared when they reach a customer service representative. We have also provided self-service information in our interactive voice response system so that callers can get information to address their questions without needing to speak with a customer service representative. And, we have also developed additional tools to help our customer service representatives use "best practices" to work more efficiently—reducing our call handle time significantly and allowing our representatives to serve more callers more quickly. As a result, we are achieving much better support results—the kind of results our beneficiaries deserve and expect. We are tracking our call center wait times and call times, and we are reaching the balance we want between calls and caller support. Callers are now waiting between two and eleven minutes to have their call answered, and processing times, once they have been answered, average 14 minutes to discuss options with the customer service representative.

We are committed to getting people with Medicare the information they need to get the most out of the drug cards, and that starts with personalized facts now

available at 1–800–MEDICARE or *www.medicare.gov.* To help callers and web visitors who have trouble matching up their medicines with the discount information, we have added a "drug lookup" feature to the website to assist with the spelling of their drug names and we are expanding our drug entry list—a growing "dictionary" of drug names that now covers an extremely broad range of drugs. We have also provided instructions to users that they can "add another drug" if they do not find their drug on our initial drug entry screens. We also are providing special tips for entering information on inhaled and topical medicines on the website. Of course, if you don't want to do these steps yourself, you can just call us—our customer service representatives have been trained to help with all of these specialized needs as well.

We are committed to continuing improvements to our customer support based on feedback from all of our users. And that's why we appreciate the unprecedented level of interest and feedback we are receiving from beneficiaries and others in the first days of this new program. We will continue to refine and improve our 1–800 number and our website by using feedback from all interested parties, including the suggestions we have received from Members of Congress.

GETTING RELIEF TO LOW-INCOME BENEFICIARIES

One of the many important messages I want to convey today is the tremendous help the drug card will provide for low-income beneficiaries. Medicare beneficiaries are eligible to enroll in the drug card of their choosing, unless they have drug coverage through Medicaid. If beneficiaries receive help with prescription drug costs through other sources—retiree insurance, Medigap coverage, or health plan benefits, they don't have to enroll if they don't want to—the program is completely voluntary. However, beneficiaries with limited incomes, and without drug coverage, unquestionably can get much needed financial assistance. More than 7 million beneficiaries with incomes below $1,047 a month ($12,569 a year) for single people or less than $1,405 a month ($16,862 a year) for couples who do not have drug coverage may qualify for the $600 drug credit as early as this month and an additional $600 again in January of next year. The discounts from the cards combined with the $600 credit available now and again in January, and substantial additional manufacturer discounts specifically targeted at low-income individuals make this an exceptional program for low-income people with Medicare—our most vulnerable beneficiaries. We want to make sure that everyone who qualifies for the $600 credit gets it, and we want to do so much more quickly than has been the case when other new federal low-income assistance programs began. So we are taking some unprecedented steps.

First, we are conducting new kinds of beneficiary outreach. We have worked closely with our partners at the Social Security Administration (SSA) to send letters to millions of low-income beneficiaries who are potentially eligible for the $600 credit. We are using broadcast advertising campaigns in English and Spanish—proven tools for reaching difficult-to-reach populations.

Second, we have set up an "auto-enrollment" program that states can use to automatically enroll beneficiaries currently in state pharmaceutical assistance programs (SPAPs) into the Medicare-approved drug discount card program. Based on the state's income determination, these beneficiaries are likely to be eligible for the $600 credit, and because of the additional assistance provided through the state program, the beneficiary is likely to get the most savings through the card sponsor, or sponsors, that contract with the state. Auto-enrollment can benefit both Medicare beneficiaries and the states. Medicare and the states want low-income beneficiaries to get the additional $600 credit, and auto-enrollment is one way to increase the number of people who take advantage of the program. In addition, the $600 contribution from Medicare frees up additional money for states to finance their own drug assistance programs.

We are working with states to automatically enroll their SPAP members into a Medicare-approved drug card and obtain the $600 credit so there is no loss in coverage or confusion for the beneficiaries. Several conditions must be met for auto-enrollment to occur for SPAP beneficiaries. In accordance with state law, states must have the authority to act as the beneficiary's authorized representative. In addition, the auto-enrollment process must allow a beneficiary the option to decline being enrolled in a Medicare-approved card before the actual automatic enrollment takes place. And, because auto-enrollment is a state option, states must choose to provide auto-enrollment. States that have agreed to automatically enroll Medicare beneficiaries thus far include Connecticut, Maine, Massachusetts, Michigan, New Jersey, New York, and Pennsylvania. CMS is currently in the process of auto-enrolling 393,000 individuals from these states.

Ohio and Rhode Island are facilitating enrollment by mailing out pre-filled enrollment forms to beneficiaries participating in their state pharmacy assistance plans. The beneficiaries need only sign the form and send it back to be enrolled, as the state will take care of submitting those signed forms. Approximately 65,000 individuals will be receiving these forms. A number of other states are also considering auto-enrollment, which could result in 35,000 more individuals receiving a discount card. We will continue to work with states to facilitate this process.

Third, we have started a new partnership with leading non-profit organizations with the specific goal of informing and enrolling low-income seniors. In particular, on May 27, CMS announced that we are making $4.6 million available to organize and fund community-based organizations to help inform and enroll seniors who qualify for the $600 transitional assistance. We are committed to working together in a complementary fashion with the Access to Benefits Coalition, a group of 68 diverse, national non-profit organizations, all of which are committed to assisting low-income Medicare beneficiaries to find significant savings on their prescription drugs. The Coalition's short-term objective is to ensure that by the end of 2005, at least 5.5 million low-income beneficiaries get the $600 annual transitional assistance benefit now available to them as well as other public and private benefits that can save them money. These organizations have extensive experience and credibility with the low-income beneficiary population and CMS believes that this grant will produce real results in terms of getting the benefit to seniors who are most in need. We also believe that outreach efforts for the drug card will be beneficial as we move toward enrollment for the drug benefit in 2006, which will need to reach even more beneficiaries. CMS is also working with the Administration on Aging and the Indian Health Service to reach out to their constituencies, to make sure they sign up for the program.

Finally, we are taking additional steps to help all beneficiaries find out about the drug card program and enroll if they choose to do so. We recently announced unprecedented new funding for state health insurance assistance programs (SHIPs). The SHIPs provide one-on-one assistance to Medicare beneficiaries through volunteer counselors who are trained by CMS. Among other things, these volunteers can help Medicare beneficiaries learn about, and enroll in a drug discount card of their choosing. Last year we awarded $12.5 million in grants to the SHIPs. This year, we are increasing that amount by 69 percent, to $21.1 million. And next year we are proposing an even larger increase, to $31.7 million. Based on our initial experience with the SHIP counseling and outreach activities, we are identifying best practices for informing and assisting beneficiaries in determining how they can get the most out of the drug card program, and then enrolling in a card if they choose to do so. In addition, especially through our regional offices, we are working with community organizations to make sure these beneficiaries are aware of the substantial savings and assistance now available to them through the drug card program. These community organizations include such entities as the American Library Association, the National Association for Hispanic Elderly in Philadelphia, Pennsylvania, the Asian Counseling and Referral Services, Takoma, Washington, the National Asian Pacific Center on Aging in King County, Washington and the Nevada Beneficiary Coalition.

Further, CMS has established a standard enrollment form that all card sponsors must accept to make it even easier to sign up for a discount drug card as well as the $600 credit. This form will also be used by State Health Insurance Assistance Programs (SHIPs), and other partners and community-based organizations that assist beneficiaries with their health care decisions. This standard form has been widely downloaded from the Internet (at *http://www.cms.hhs.gov/discountdrugs/forms/*), and is included in the personalized brochures mailed to beneficiaries who call 1–800–MEDICARE.

SAVINGS THROUGH PRICE SHOPPING AND NEGOTIATING POWER

The Medicare-approved drug discount cards give beneficiaries new savings for two main reasons. First, just as Americans with public and private drug coverage have long done, beneficiaries can join together and stick together to negotiate better prices on their medicines. Unlike other discount programs generally available to Medicare beneficiaries, the Medicare drug cards require negotiated discounts from drug manufacturers that are passed on to beneficiaries. Beneficiaries will get lower prices for their drug purchases because they will be able to pool their purchasing clout to leverage discounts from drug makers.

Second, for the first time, beneficiaries can get accurate information on actual drug prices at their neighborhood pharmacies and by mail-order, for card options, so that they can comparison-shop. Today, beneficiaries comparison-shop for many

things in their daily lives, comparing the price and quality of a product or a service. But Medicare beneficiaries with and without prescription drug coverage often find it difficult to find the best prices on prescription drugs, especially at neighborhood pharmacies. Now, even after a beneficiary receives the card, they can use the information available from Medicare to determine which pharmacy in their card's network is assuring the best price during any given week. That's changing with the new Medicare Price Compare tool that makes actual drug prices available to beneficiaries, their advisers, and all Americans through 1–800–MEDICARE and *www.medicare.gov.*

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

Through the new website, beneficiaries for the first time in the Medicare program will have access to prices for approximately 60,000 drug products (including the particular dosages and packaging beneficiaries might prefer) sold at nearly 75,000 pharmacies around the country—all turned into information they can use to get the best bargains on the drugs they need.

Seniors, who until this time have not been able to use their potential group buying power for prescription drugs, now have more power than ever to get lower prices—and we are seeing these drug savings in the card program already. By combining unprecedented transparency of prescription drug prices with individualized assistance and educational resources, we are working to use modern technology to provide the medicines Medicare beneficiaries need at a lower cost. Transparent prices for Medicare-approved cards give beneficiaries important information to help them choose the best card to address their needs.

CMS is currently working on a tool for the website that will allow a person to look up a clinical condition, like high cholesterol, and see average prices for Lipitor as well as for other therapeutic alternative cholesterol-lowering agents like Zocor and Crestor—options that may be worth discussing with their doctor if they are less expensive and clinically appropriate. In addition, patients also get information on generic alternatives, which are just as safe and effective as the brand-name versions when approved by the FDA.

We are working with card sponsors to ensure that the prices they have submitted to us for posting on the website are prices they can assure to beneficiaries at the included participating pharmacies. Based on our work with card sponsors, we believe the information now on the website reflects just that, though many card sponsors may be able to provide even larger discounts in many cases. We have also taken new steps to make sure that Medicare and the HHS Office of the Inspector General can take effective enforcement actions against cards that don't live up to their promises. But in the meantime, we remain committed to our requirement that beneficiaries must pay no more than the discounted price listed by Medicare.

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

REAL SAVINGS FOR BENEFICIARIES—EXAMPLES

I have already described the substantial and growing evidence that the drug cards allow beneficiaries who are struggling with drug costs to get help now—to reduce those costs by 10 to 25 percent or more, and by much more in the case of lower-income beneficiaries. Some case study examples can further illustrate the level of potential savings, which are consistent with the savings that many beneficiaries are obtaining right now.

CMS' May 6, 2004 study gives data for the following real-life examples:

- A person taking Celebrex (osteoarthritis), Zocor (high cholesterol), Paxil (depression), and Norvasc (hypertension) on average pays $363.60 each month for these drugs at a retail pharmacy according to the IMS Health data. A Medicare beneficiary taking these medications who lives in Portland, Oregon could enroll in a Medicare-approved drug discount card and pay $295.85—an 18.6 percent savings over what a typical person would pay. That is a savings of $67.75 every month or $813.00 a year.
- A person taking Coumadin (anti-coagulant), Vioxx (osteoarthritis), and Fosamax (osteoporosis), on average pays $187.47 per month for these drugs at a retail pharmacy. A Medicare beneficiary taking these medicines residing in Arlington, Virginia, could enroll in a Medicare-approved discount card and save about 17 percent. This beneficiary could save $31.24 per month, or $374.88 per year, over what the typical American would pay.
- The discount cards are offering lower prices on generic drugs as well. For example, a person taking furosemide could enroll in a Medicare-endorsed drug discount card in Albuquerque, New Mexico and save nearly 54 percent on the cost of furosemide. A person residing in Little Rock, Arkansas, taking metformin could save about 77 percent. So, in addition to the savings achieved by using generics, the discount cards further lower the cost of generic drugs. Beneficiaries who choose to use mail order pharmacies can also save significant amounts, even when compared to prices available from on-line retailers such as *Costco.com* and *drugstore.com.* CMS data indicate savings as high as 24 percent in this case.

We are continuing to analyze the data on Price Compare, and we have generally seen the discounted prices decline as more sponsors have come online. CMS analysts also used the data from the FDA analysis of national average retail prices to illustrate potential savings for low-income Medicare beneficiaries in a number of geographic areas. In all of these cases, Medicare would pay the annual enrollment fee, if any. For example:

- A person taking Prinivil (hypertension), Glucophage (diabetes) and Lasix (congestive heart failure) would expect to pay $913.50 over a 7-month period. A low-income Medicare beneficiary in Orange County, California could enroll in a Medicare-approved drug discount card and save 77 percent over the 7 months. The savings include a discount of 11.3 percent and $600 of transitional assistance.
- A typical person taking Enalapril, a generic medication for hypertension, might expect to pay $170.10 over 7 months for this medicine. A beneficiary residing in Louisville, Kentucky with income over 100 percent FPL but no more than 135 percent FPL could enroll in a Medicare-approved discount drug card and save about 95 percent over 7 months, including savings from the discount and the transitional assistance. The beneficiary would have several hundred dollars to roll over for use, if necessary, in 2005.
- An individual taking Celebrex for osteoarthritis might expect to pay $636.30 over a 7-month period. A beneficiary with income at or below 100 percent FPL residing in Portland, Oregon could enroll in a Medicare-approved drug discount card and save over 95 percent over 7 months, a savings of over $609.

The figures above are for model beneficiaries that CMS used in setting up its studies. However, CMS has also received information on some real-life individuals who are already realizing substantial savings by using their discount cards.

- A senior from Louisville, Kentucky taking Toprol, Ranitidine, Lipitor, Androderm patch, Glipizide, Metformin and Lisinopril will save $2,774.28 annually, and because they are eligible for the $600.00 low-income subsidy, this senior will save $3,374.28 annually.
- A senior from Phoenix, Arizona taking Zoloft, Digitek, Diovan, Lipitor, Norvasc, Miacalcin, Coreg, Coumadin and Dilantin will save $3,252.36, and because they are eligible for the $600.00 low-income subsidy, this senior will save $3,852.36 annually.
- A senior from Fresno, California taking Aciphex, Advair, Xanax, Combivent, Albuterol, Neurotonin, Paxil, Darvocet, Permarin, Triamcinolone and Mobic will

save $4,682.16, and because they are eligible for the $600.00 low-income subsidy, this senior will save $5,282.16 annually.

- A senior from Louisville, Kentucky taking Celebrex, Flonase, Norvasc, Zyprexa, Plavix and Enulose will save $4,092.96, and because they are eligible for the $600.00 low-income subsidy, this senior will save a total of $4,692.96 annually.
- A senior from Tulsa, Oklahoma taking Hydrochlorothiazide, Prevacid, Neurontin, Nortriptyline, Ranitidine and Toprol XL will save $2,112.48, and because they are eligible for the $600.00 low-income subsidy, this senior will save $2,712.48 annually.

The dollars these seniors are saving are substantial, particularly when compared to their income levels. These cards are making a significant difference in their lives by providing them with financial relief from very difficult circumstances.

As examples like these illustrate, beneficiaries who look into the program find that Medicare-approved drug discount cards are providing significantly lower drug prices and real help compared to what they have to pay for their drugs today. These initial price comparisons demonstrate that signing up for a Medicare-approved drug discount card means that seniors need no longer have to pay the highest prices for their drugs, or anything close to retail list prices, and that they can start to get real help with their drug costs. Again, the important step for beneficiaries at this point is simply to sign up so that they do not miss out on savings that can be realized as soon as they have their card. This assistance is an important step toward the additional help coming with the full Medicare drug benefit in 2006.

CARD MONITORING

While prices have generally been declining on the drug cards since Price Compare started a month ago, with average price declines of around 15 percent during this period, CMS remains vigilant in overseeing the program and working with outside groups to protect beneficiaries from cards that might try to "bait and switch," by posting a given price and then inappropriately raising it at a future time. CMS also is monitoring changes in overall drug prices and identifying programs that stray from the expected changes in prices. Drug card sponsors have to report to CMS if price increases exceed any corresponding increase in their sponsors' costs, such as costs of administering the drug card program or changes in the discounts, rebates, or other price concessions received from a drug maker or pharmacy. A CMS contractor will be building a relational database that includes the weekly pricing files from the exclusive and general card sponsors from May 2004–January 1, 2006. The contractor will review all pricing data submitted at the National Drug Code (NDC) level, for prices significantly higher or lower than the standard price for the nation and/or region. This will be accomplished by comparing the prices to national and/or regional benchmarks such as First DataBank and Medispan pricing data, and the established Federal Upper Limit for non-innovator multi-source generic medications. Outliers must be reported to CMS weekly, and in addition, the contractor will monitor price increases from week to week to determine which price increases are greater than one and/or two standard deviation units above the mean price increase for all sponsors per NDC. If a price increase is reported the contractor will verify if the sponsor submitted documentation to justify the price increase and report whether or not the price increase is justified based on federal regulation and guidance. This information will be reported to CMS via the Performance Monitoring Tool (PMT) on a weekly basis. We'll also engage in other activities to ensure that card sponsors are charging the advertised enrollment fees and following other federal guidelines.

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

Because the Medicare-approved programs are competing for beneficiaries, the card programs have a real incentive to negotiate and pass on savings in the form of the lowest possible prices for the drugs that their beneficiaries need. In a discount program like this one, the only way that cards can generate any revenues is by providing attractive prices on the drugs that beneficiaries want, so that beneficiaries use the cards to fill their prescriptions. The cards need to offer savings and service, and we're going to be taking steps like these to make sure beneficiaries get both. Thus, to succeed in holding onto its beneficiaries, and in building up its client base

for when their drug benefit becomes available in 2006, a card must offer consistently good deals and consistently reliable service to beneficiaries.

CONTINUED EDUCATION AND OUTREACH

In addition to Price Compare and the personalized drug card information services provided through 1–800–MEDICARE, CMS has a number of education and outreach efforts underway. In particular, CMS has prepared customer service representatives at 1–800–MEDICARE with up-to-date information on the drug card, as well as other CMS programs, and training on using the Price Compare website. As I mentioned earlier in my testimony, we are getting unprecedented volume at our 800 number and on the website. Our call volume statistics show that 1–800–MEDICARE received nearly 407,000 calls on May 3, the day drug card enrollment commenced—quadruple the last highest call record—and another 328,000 on the subsequent day. And during the first week of May, CMS received more than 10 times the regular call volume, with 1.6 million calls to 1–800–MEDICARE and more than 7 million Internet visits. Based on our analysis, we estimate 1–800–MEDICARE will receive 12.8 million calls in FY 2004. This compares to an FY 2003 call volume of approximately 5.6 million calls. To handle this increased volume and attend to beneficiaries in a timely manner, we have increased the number of customer service representatives at the Medicare call centers, bringing the total to 3,000. Enhancements are also being implemented in Medicare's Price Compare services based on feedback from beneficiaries, customer service operators, and advocates, to reduce the time for each beneficiary visit. For example, *www.medicare.gov* now has a new, easily visible link making the Price Compare database easier to find, and as noted above, the "drug dictionary" of drugs included on Price Compare is being expanded. We will continue to take user feedback to improve and refine these systems to assure beneficiaries get the most up-to-date and easy-to-use information as possible.

CMS also has a number of publications designed for beneficiaries that explain changes in the Medicare program. For example, CMS has published a small pamphlet with an overview of the drug card program and an introduction to the discount cards and the $600 low-income assistance, as well as a larger booklet with more detailed information about eligibility and enrollment. This larger booklet, the Guide to Choosing a Medicare-Approved Drug Discount Card, also includes a sample enrollment form and a step-by-step guide to comparing and choosing a discount card. The "Guide" is currently available in English, Spanish, Braille and audio-tape (English). We have also prepared a simple document giving the very basics needed to signing up for a discount card. I have appended a copy of this flyer to my testimony so that you can see how truly easy it is to sign up for one of these cards.

CMS is also preparing a booklet specific to the needs of beneficiaries in long-term care facilities. This booklet will give information that they, their family members, or caregivers can use to access drug discounts available to them through pharmacies catering specifically to patients in their situation.

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

CMS has produced a variety of products geared toward educating physicians, pharmacists, and providers who often have one-on-one relationships with beneficiaries, to help them assist their patients in drug card enrollment decisions. The products include brochures, articles, and journal ads in major medical publications including the *New England Journal of Medicine* and the *Journal of the American Pharmacists Association.* For states, (including territories and the District of Columbia), and stakeholders, CMS will sponsor a variety of listening sessions and open door forums to make the latest drug card developments available nationwide. For example, we hosted in-person trainings at the Drug Card Kickoff Conference on April 7–8 and the National SHIP Conference on May 24–25, where CMS staff provided technical assistance and support. We will continue to work with our partners to give beneficiaries the personalized information they need to make an informed decision about the voluntary drug card, and to begin lowering their drug bills now. By following the steps I've outlined above, beneficiaries can get the facts they need to get the most out of this program, and to start saving, in a matter of minutes.

CONCLUSION

The Medicare-approved drug discount card program provides an unprecedented opportunity for beneficiaries to band together to get lower negotiated prices, and to find the best deals through large-scale public reporting of prescription drug prices.

On June 1, 2004, this voluntary card program began providing assistance by lowering prescription drug costs for Medicare beneficiaries as an interim step until the new Medicare drug benefit takes effect on January 1, 2006. We recognize the special importance of the discount card program coupled with the low-income credit to lower-income beneficiaries, who have had to struggle with drug costs and the costs of other basic necessities for too long. But all this is starting to change now. Thank you again for this opportunity. I look forward to answering any questions you might have.

RESPONSE TO A QUESTION FROM SENATOR GRAHAM

Question: Could you ask that question and let us know in writing when you expect that report?

Answer: The HHS Office of Inspector General (OIG) released that report July 6, 2004.

RESPONSE TO A QUESTION FROM SENATOR GRASSLEY

Question: There is quite a bit of background noise surrounding the Medicare-approved drug discount card program. We are even hearing reports that scam artists are using this opportunity to exploit and prey upon older Americans and people with disabilities that stand to benefit from the program. What are you doing to minimize confusion and ensure that Medicare beneficiaries have clear, accurate information to make an informed choice about the discount drug card that will be of most help?

Answer: In the months since the passage of the Medicare Modernization Act, CMS has moved with unprecedented speed to get the discount drug card program up and running. With an undertaking of such magnitude, there is going to be a learning curve, as we find out what works and what does not. Despite the inevitable bumps in the road, we are making progress, and I am very pleased with where we stand. When drug card sponsors began marketing their cards May 3, we did recommend to beneficiaries that they take time to make their decision, as detailed information about the drug prices for all cards was not yet available. More information was added throughout the month, and since the end of May the CMS's message to people with Medicare, particularly those with low incomes and without prescription drug coverage, is to take advantage of real savings on their prescription medicines by signing up for the Medicare-approved drug discount cards. Enrollment in the drug card can be a simple process. As we have emphasized in our educational materials provided to beneficiaries, as well as in materials to those counseling beneficiaries, help is available 24 hours a day, 7 days a week by calling 1–800–MEDICARE. When beneficiaries call, they just need to know their zip code and information on the drugs they take. If they think their level of income qualifies them for the $600 annual credit, they can provide that information as well. Beneficiaries can also get information on the subset of cards that most interest them. For example, they can tell the representative at 1–800–MEDICARE other preferences they may have, such as their preferred pharmacy or whether they are interested in low-cost or no-cost cards. The program also provides 7 million low-income beneficiaries with additional discounts and a $600 credit this year and next year on their drug card. These features add complexity to the management of the program, but we have structured the program to allow qualifying seniors to access the benefit as simply as possible. Please be advised that CMS is making every effort to ensure that eligible Medicare beneficiaries are able to access the $600 transitional assistance. The Social Security Administration has sent letters to Medicare beneficiaries with incomes estimated to be at or below 135 percent of the federal poverty level providing guidance regarding how to select a drug card and apply for the $600 credit. Also, CMS has allowed SPAPs to auto-enroll their membership into the transitional assistance program for the $600 credit. Currently, seven states are taking advantage of this auto-enrollment option. These states include Connecticut, Maine, Massachusetts, Michigan, New Jersey, New York, and Pennsylvania. Further, CMS is partnering with leading non-profit organizations, such as Access to Benefits Coalition, to educate low-income beneficiaries on the drug card program. The Coalition's objective is to enroll at least 5.5 million low-income beneficiaries for the $600 credit by the end of 2005. CMS has also provided additional funding to State Health Insurance Assistance Programs (SHIPs) to provide one-on-one assistance with the drug card and transitional assistance enrollment. The CMS remains vigilant in overseeing the program and working with outside groups to protect beneficiaries. CMS has taken several steps in order to oversee and prosecute fraud under the program. CMS has several means of educating our beneficiaries on how to identify fraudulent activities under this program. This is accomplished through media and 1–800–MEDICARE scripts informing beneficiaries on actions they may take if they feel threatened by a caller or door-to-door

salesman who may be falsely advertising a drug card program. Beneficiaries have also been advised to contact local authorities and/or the Office of Inspector General (OIG) fraud hotline (800–HHS–TIPS) to report fraudulent activities.

RESPONSES TO QUESTIONS FROM SENATOR BAUCUS

Question 1: To date, over 70 Medicare discount cards are available to Medicare beneficiaries enrolled in the traditional fee-for-service program. Having so many discount card options has caused significant confusion and frustration among seniors. Why did the Administration approve 73 card sponsors? Did CMS turn down any card sponsors, or were all applicants accepted?

Answer: Because the Medicare-approved drug card sponsors are competing for beneficiaries, they have a real incentive to negotiate and pass on savings in the form of the lowest possible prices for the drugs that their beneficiaries need. In a discount program like this one, the best way for cards to generate revenue is by providing attractive prices on the drugs that beneficiaries want, so that beneficiaries use the cards to fill their prescriptions. In addition, providing a number of card programs enables beneficiaries to have choices based on the drugs they need and the pharmacies that are closest to them. The cards need to offer savings and service, and we will be monitoring card programs to make sure beneficiaries get both. Thus, to succeed in holding onto its enrollees, and in building up its client base for when the drug benefit becomes available in 2006, a card must offer consistently good deals and consistently reliable service to beneficiaries.

Most applicants were accepted as drug card sponsors. Only a few were not accepted as they did not meet the requirements as specified in the solicitation.

Question 2: Five of the discount cards are not engaged in marketing and enrollment activities. Why were these cards approved to participate in the drug card program? Did CMS know in advance that these sponsors did not plan to be active?

Answer: These cards were approved to participate in the drug card program because they met the requirements as specified in the solicitation. CMS did not know in advance that these sponsors did not plan to be active. They became inactive as a result of technical issues with their card programs.

Question 3: CMS expected 7.3 million Medicare beneficiaries to enroll in the drug card in 2004. To date, only about 2.9 million have enrolled, and over 80 percent of those enrolled have been signed up automatically through a managed care plan. Of the 7.3 million expected enrollees, how many did CMS anticipate would come from traditional Medicare?

Answer: Currently, (as of August 1, 2004) 4 million individuals are enrolled in the drug card. In our impact analysis we did not estimate the number of enrollees that would come from traditional Medicare. We only estimated the number of low-income and non-low-income enrollees that would enroll in the card.

Question 4: Do you think enrollment in the drug card program would be higher if the number of options were limited, say, to a handful of manageable options?

Answer: We do not believe that this would be the case. As for why we chose to have numerous card programs, see Answer to Question 1 under Senator Baucus.

Question 5: It was recently reported that a significant portion of the potential savings from the Medicare drug cards has been wiped out in the last year by drug price inflation. Can you comment on that assertion? If true, what can CMS do to prevent further erosion of savings?

Answer: Pharmaceutical prices have been rising at a steeper rate than overall inflation for a number of years now, even before the Medicare prescription drug discount card program was even conceived. Currently, beneficiaries without any coverage pay out of pocket at the going rate, which may fluctuate up and down. Card sponsors negotiate specific discounts off of that going rate, known as the average wholesale price (AWP) and pass them on to beneficiaries. Although the AWP may float up and down in response to labor and ingredient price changes, the discounts negotiated by the card sponsors cannot change, unless the sponsor can demonstrate to CMS that they have good cause to do so. Absent the card, beneficiaries would always be paying the going price. The cards insulate them from having to pay that full price.

Question 6: How do the discounts available through the Medicare-endorsed drug cards compare to discounts that are available through non-Medicare discount cards? The Medicare discounts appear to be 10–15 percent of brand-name drugs. Is this significantly better than the rate of discount for other, commercially available discount cards?

Answer: Despite other non-Medicare discount cards being available, consumers, especially Medicare beneficiaries, are still in need of greater discounts on prescription drugs. In the drug card program, we utilize the power of the marketplace to

negotiate lower prices. The program is allowing beneficiaries without good drug coverage to band together to negotiate lower prices from drug manufacturers, similarly to individuals when they enroll in public and private insurance plans. Also, by listing drug prices on the Price Compare website, drug cards are competing with each other to give beneficiaries the best prices. The discounts available through the Medicare-approved drug cards allow enrollees many choices and therefore the flexibility to choose a card that best fits their individual needs while receiving significant discounts.

Because the Medicare-approved drug discount card programs are competing for beneficiaries, they have a real incentive to negotiate and pass on savings in the form of the lowest possible prices for the drugs that their beneficiaries need. In a discount program like this one, the only way that cards can generate any revenue is by providing attractive prices on the drugs that beneficiaries want, so that beneficiaries use the cards to fill their prescriptions. The cards need to offer savings and service, and we're going to be taking steps like these to make sure beneficiaries get both. Thus, to succeed in holding onto its beneficiaries, and in building up its client base for when the drug benefit becomes available in 2006, a card must offer consistently good deals and consistently reliable service to beneficiaries.

In recent months, we have conducted studies that show evidence of the drug card providing significant savings especially for low-income beneficiaries:

- Between 11 to 18 percent off the retail prices that the average Americans pays, and even greater discounts of 30 to 60 percent or more on generics;
- More than 20 percent in many cases for mail-order drugs—these savings are 7 to 24 percent lower than prices at popular U.S. Internet pharmacies; and
- From 32 to 86 percent over the national average retail pharmacy prices on brand-name drugs, for low-income beneficiaries using drug cards with the best prices, the $600 transitional assistance, and the additional manufacturer discounts.

Question 7: CMS has long stated that the drug card will allow seniors' buying power to be harnessed, pooled into an entity to command large discounts from drug manufacturers. Given the scant enrollment so far—combined with the vast number of card options available—do you think this premise is still valid? Would the discounts the cards are able to provide be greater if CMS had restricted the number of card sponsors and selected sponsors in part by their ability to secure discounts?

Answer: Under the Medicare prescription drug discount card program, we have seen consistent discounts off of prices available to all Americans on brand and generic drugs. Our data indicate that prices have fallen since the inception of the program, and we anticipate that the competition among card programs will continue to put downward pressure on these prices. Also, see answer to Question 6 above.

Question 8: The law does not require drug card sponsors to provide a minimum discount to beneficiaries. Instead, the statute says, "Each drug card sponsor offering an endorsed discount card program shall pass on to beneficiaries negotiated prices on covered discount card drugs, including discounts negotiated with pharmacies and manufacturers." What percent of card sponsor savings from drug manufacturers are passed along to beneficiaries? Is CMS satisfied that card sponsors are fully and accurately reporting discount, rebate and other pricing information?

Answer: CMS is monitoring drug prices including the amount of discounts and rebates that are being passed onto enrollees. While specific numbers are not available at this time on the percentage of card sponsor savings from drug manufacturers that are passed along to beneficiaries, numerous studies have demonstrated real savings for beneficiaries. In recent months, we have conducted studies that show evidence of the drug card providing significant savings especially for low-income beneficiaries:

- Between 11 to 18 percent off the retail prices that the average Americans pays, and even greater discounts of 30 to 60 percent or more on generics;
- More than 20 percent in many cases for mail-order drugs—these savings are 7 to 24 percent lower than prices at popular U.S. Internet pharmacies; and
- From 32 to 86 percent over the national average retail pharmacy prices on brand-name drugs, for low-income beneficiaries using drug cards with the best prices, the $600 transitional assistance, and the additional manufacturer discounts.

Question 9: What lessons has CMS learned from the implementation of the discount card program that can be applied to its efforts to implement the Part D drug benefit in 2006?

Answer: The discount card program has offered us many lessons to prepare CMS for the implementation of the drug benefit in 2006. Specifically, we have refined the process for beneficiary outreach to ensure they know about and are able to choose and enroll in a drug card that is best for them. We have strengthened our relation-

ships with community organizations in an effort to educate and help to enroll beneficiaries in the drug card program. We believe this experience will be invaluable as we begin outreach to beneficiaries on the drug benefit. In addition, we have become familiar with the operations of the drug industry and how to design a program for seniors that will provide savings on prescription drugs. As we develop the drug benefit, we look forward to working with you.

Question 10: Secretary Thompson has been quoted as saying that the $600 low-income assistance is "too good a deal to leave this money on the table." While true, it seems that many seniors eligible for the low-income subsidies are not enrolled. The Medicare law gives the Administration discretion to allow automatic enrollment of certain low-income beneficiaries, including beneficiaries enrolled in Medicare Savings Programs, into the Medicare discount card program, and thus the $600 transitional assistance. Are there any new developments regarding whether the Administration plans to allow automatic enrollment?

Answer: CMS is still auto-enrolling individuals in SPAP programs and Medicare Advantage (MA) programs. We think auto-enrollment is a very efficient and effective way to ensure that beneficiaries who can benefit from this program will be enrolled. We are examining the possibility of building off of our auto-enrollment experience to facilitate enrollment for certain low-income people with Medicare.

Question 11: During the month of May, beneficiaries faced very long wait times to talk to a representative on 1–800–MEDICARE. Wouldn't you agree that these waiting times were predictable, given the media deluge and mass mailings associated with the card program? Shouldn't CMS have expected a significant increase in call volume and expanded the number of call representatives before the month of May to avoid problems?

Answer: The initial days of operation for this new program were extraordinarily busy times for us. During the first few days of May, we averaged 400,000 calls to 1–800–MEDICARE each day. This is an extraordinary call volume for one week, particularly when you consider that we had 6 million calls the ENTIRE YEAR of 2003. Because we did expect a large call volume, we prepared by expanding the number of call representatives. However, we do not believe that we could have predicted such an unprecedented call volume as occurred. Because of the unprecedented volume, many callers could not get through, some calls were dropped, and many beneficiaries could not get the information they needed in a timely way—all of which are unacceptable under our high customer service standards in Medicare. We have staffed up and now have 3,000 customer service representatives, and we continue to look for the best ways to get the information people want to them in a timely and effectively manner.

Question 12: How did CMS award the contract for establishing the comparative website? Was this a competitively bid contract?

Answer: The contract was not competitively bid. The contract was awarded in accordance with Federal Acquisition Regulations.

Question 13: The price comparison database on *medicare.gov* has been lauded as a great tool to help seniors pick the drug card that is right for them. However, there have been complaints that the site is cumbersome and confusing, and that the information on the website is inconsistent with information given over the phone. Has CMS sought any feedback from seniors who have tried to use the site? What efforts will CMS make to improve the usefulness and user-friendliness of the site?

Answer: We have received much positive feedback from people with Medicare at various Town Hall meetings across the country and through on-line site surveys about how helpful the website has been in helping them choose a drug card. CMS has made several enhancements to the website. For example, some of the steps we have taken include adding information on manufacturer wrap around programs and links to enrollment forms, reorganizing the site to make it more user friendly, including a worksheet to help compare drug costs among cards, and making the information on "What you will need to get started" more prominent on the PDAP home page. And we continue to make enhancements weekly based on feedback.

Question 14: There have been reports that 20 of the 73 drug card sponsors have a history of health care fraud at either the state or federal level. Can you explain why these companies were considered eligible to participate in this program and what precautions, if any, CMS has taken to protect beneficiaries who enroll in their drug card programs?

Answer: We continue to fervently monitor drug card sponsors for fraud. It is important to note that an allegation of fraud is not sufficient to deny an entity the opportunity to contract with CMS. CMS has taken steps to protect beneficiaries from unethical card sponsors through its application review and contracting processes. CMS conducted its review of each applicant's business integrity in a manner consistent with regular DHHS contracting standards. Generally, those standards

prohibit CMS from contracting with entities listed on the Office of the Inspector General's exclusion list or the General Accounting Office's debarment list. CMS made certain that none of the applicants or their key subcontractors appeared on either of those lists. As part of their application for the Medicare endorsement, potential card sponsors were required to submit a description of any past or pending legal action concerning health care and/or allegations of fraud, misconduct, or malfeasance within the last three years. CMS reviewed that information, as well as relevant databases to determine whether a sponsor had been subject to a criminal conviction or civil judgment related to health care fraud. Contracts with sponsors include provisions that require CMS to be given notice by sponsors when they have reason to believe they are under investigation by a government agency or financial institution on a matter relating to health care fraud. The contract also requires a card sponsor to notify CMS when it has been the subject of a criminal conviction or civil judgment on a matter relating to fraudulent activities or is sanctioned by any federal program involving health care. Finally, the contract authorizes CMS to terminate immediately the approval of any card sponsor upon the card sponsor's debarment or suspension from any federal program.

Question 15: There have been multiple reports of fraudulent activities surrounding the roll-out of the drug card. For example, seniors report receiving calls from card "sponsors" asking for personal financial information. Additionally, CMS has recently asserted that the agency, together with the OIG, will be monitoring drug prices to make sure that card sponsors are not raising prices without cause and that discounts are passed on. But at the same time, OIG's budget is flat-funded, and CMS does not propose giving the OIG any funding from the $1.0 billion in the Medicare bill. Why not?

Answer: We do not believe that the MMA appropriation gives us the authority to use the $1.0 billion for work done by OIG. It is appropriated solely for CMS implementation activities. We support increased funding for OIG, but we need to work on a different source for that funding.

Question 16: Chairman Grassley and I wrote to Secretary Thompson in January of this year, asking for a detailed plan for the spending of the $1 billion appropriated to CMS for implementation of the Medicare prescription drug bill. In the same letter, we asked that at least $25 million of the $1 billion be dedicated to funding the Office of Inspector General's program integrity efforts. It seemed to us that $25 million was an excellent investment to preserve $400 billion. We have never received a response to our letter. My staff was told that a detailed plan for spending the $1 billion would be finalized after you were confirmed as Administrator. No such plan or budget has been made available. Moreover, I understand that the Inspector General's office has not received an additional dollar to begin to undertake new program integrity efforts. In fact, they are losing positions. Can you please reassure us and explain why, under these circumstances, we should not be concerned about CMS' ability to run this new program? When will CMS submit to Congress a detailed spending plan of the $1.0 billion?

Answer: We are now reviewing our original estimates for the $1 billion spending plan as we enter into fiscal year 2005. I have directed staff to review our needs and align funds with the priorities we have set to fully implement the provisions of the Act in the most cost effective and efficient way to administer the new law with the funds available. As we have done in the past, CMS will be happy to brief the committee on our updated plans and answer any questions.

I'd like to provide you with the most recent information related to CMS' Medicare Prescription Drug Discount Card spending.

As of September 2, 2004 CMS has expended $138.5 million to implement the drug card program. This spending represents all activities related to the program, which include education and outreach, information technology, research, and other contracts. CMS will expend additional money in fiscal year (FY) 2005 for monitoring activities, appeals, and comparison website. The amounts for each major function are:

Drug Card Spending (in millions)	
Education and Outreach	$ 108.0
Information Technology	21.5
Research	2.1
Contracts	5.9
Administration	1.0
Total	**$138.5**

Our implementation strategy has included several steps in order to oversee and prosecute fraud under the program. CMS continues to work closely with the Office of Inspector General, other law enforcement agencies and our contractors to monitor and oversee the drug card program and our other new program expansions. We are also educating our beneficiaries on how to identify fraudulent activities under this program. This is accomplished through media and 1–800–MEDICARE scripts informing beneficiaries on actions they may take if they feel threatened by a caller or door-to-door salesman who may be falsely advertising a drug card program. Beneficiaries have also been advised to contact local authorities and/or the Office of Inspector General (OIG) fraud hotline (800–HHS–TIPS) to report fraudulent activities.

As we have done in the past, CMS will be happy to brief the committee on our updated plan and answer any questions.

Question 17: I understand that CMS has completed writing the proposed rules to implement Title I and Title II of the Medicare bill and that these regulations have been sent to OMB and the White House for clearance before publication. When can Congress expect to see the proposed rules? Some have expressed concern that the Administration may purposely delay publication of the proposed rule until after the November election. Or that the administration will soon publish a broad policy outline of the provisions, but without significant detail—and then publish an interim final rule with more detail following the election. A delay in publication of the rules, or an attempt to play games with the publication of regulations, would be extremely unfortunate and would negatively affect implementation of the bill. Detailed regulations should be published as soon as possible to ensure that the federal government and all stakeholders are prepared for January 1, 2006. Is there any truth to these rumors?

Answer: We anticipate the final regulations being published early 2005. The proposed regulations are available on the CMS website and the regulations have been published in the *Federal Register.* There will be a comment period of 60 days after the publication date until October 4, 2004. Information on where comments should be sent is also included in the *Federal Register.*

RESPONSES TO QUESTIONS FROM SENATOR DASCHLE

Question 1: At last week's hearing, we discussed the issue of whether beneficiaries could have their food stamps reduced as a result of the discount program. At the hearing, you assured me this was not the case. Since the hearing, the Department of Agriculture has reversed its position that would have allowed food stamp benefits to be reduced and issued a revised policy, but we have not yet seen the details. How will the new policy work?

Answer: OMB issued guidance to all federal agencies that administer programs that may be affected by the drug card transitional assistance. Programs like food stamps, subsidized housing and home heating assistance are based on a person's income and assets, and an additional $600 credit available to someone might preclude them from eligibility in such a program or could affect the amount of the benefit they receive until the $600 is exhausted. Under the new law, Medicaid benefits may not be delayed or disapproved because a beneficiary has a discount drug card that may yield savings on medical expenses. Any discount received and any portion of the $600 credit used must be treated as if the person had actually spent the money out of their own pockets when being evaluated for state "medically needy" program eligibility, CMS' guidance to states says. Also, no portion of the $600 credit can be

counted as an asset or resource for purposes of Medicaid eligibility. That means that a Medicare beneficiary who has a discount card and is receiving the credit and later applies for Medicaid benefits, does *not* have to spend the credit before Medicaid will be awarded or pay for prescription drugs. Because the policy is effective as of June 1, 2004, states will be instructed to reopen cases that may have been decided before the guidance was issued.

Question 2: In addition to the low-income beneficiaries who are enrolling through their state programs, I have heard that some Medicare beneficiaries have applied for the transitional assistance but have not yet received confirmation that they qualify and have not received their cards. Is this the case? If so, how many such beneficiaries are there? Given the low overall enrollment in the card program, what is the reason for this delay? What are you doing to ensure their applications are expedited? Have delays in receipt of cards been typical? What is the average wait time between submitting applications for transitional assistance and receiving a card?

Answer: There have been isolated incidents where beneficiaries were delayed in receiving their Medicare-approved discounts cards. However, there are no specific numbers on this issue. Each of these complaints was investigated by CMS staff, and the highest priority is placed on assisting these beneficiaries to receive their cards in an expedited manner. In many cases, sponsors provided beneficiaries temporary ID numbers over the telephone that the beneficiary would use at the pharmacy at the point of sale. In many cases, sponsors were asked to send beneficiaries their cards through overnight delivery. CMS monitors these complaints, and, to the extent there is a pattern of deficiency with any specific card sponsor, corrective action steps are taken against that sponsor to resolve the problem. Every effort is taken to ensure beneficiaries receive their cards in an expedited manner and to have cards in beneficiaries' hands on their effective dates, on the first day of the following month in which the application is received by the sponsor. However, due to unavoidable processing timeframes, which include the receipt and processing of the application, and receipt of CMS eligibility confirmation, there may be a slight delay in providing the card to the beneficiary prior to the effective date, particularly for those beneficiaries who apply near the end of the month. However, most sponsors appear to be providing beneficiaries cards within reasonable timeframes.

Question 3: You have indicated that you are compiling data on enrollment in the drug card program by state. Please provide any state-specific data you have for South Dakota.

Answer: As of August 1, 2004, about 4 million beneficiaries are currently enrolled in the drug card program. State-specific drug card enrollment data are not available as of yet but we plan to release this information soon.

Question 4: The General Accounting Office recently concluded that the video news releases your agency produced on the Medicare reform law, the prescription drug benefit, and the drug card program violated the law. What plans do you have to rectify that situation?

Answer: The video news release is no longer being used. Should we choose to use this type of communication tool in the future we will ensure that attributions are clear and complete.

RESPONSES TO QUESTIONS FROM SENATOR ROCKEFELLER

Question 1: According to the West Virginia Bureau of Senior Services, seniors that attempt to use 1–800–MEDICARE to obtain information about the discount cards are experiencing extremely long wait times, being disconnected, and having to deal with poorly trained operators. What is CMS doing to improve the availability of trained professionals to address seniors' questions and concerns about the discount card program?

Answer: CMS has approximately 3,000 customer service representatives (CSRs) available to answer 1–800–MEDICARE inquiries. The CSRs have been trained on 1–800–MEDICARE inquiries and each week refresher training is conducted at the 1–800–MEDICARE call centers. In addition, the 1–800–MEDICARE contractor conducts quality assurance/quality call monitoring on every CSR each month. Due to a telecommunications failure on August 21, 2004, some callers to 1–800–MEDICARE experienced a wait time to speak with a customer service representative. The 1–800–MEDICARE contractor worked with the telecommunications provider to quickly identify and correct the failure. With the exception of this incidence, callers to 1–800–MEDICARE are not currently experiencing wait times to speak with a customer service representative. The average time to handle a call is about 10 minutes and 30 seconds.

Question 2: How do the discounts available through the Medicare-endorsed drug cards compare to discounts that are available through non-Medicare endorsed dis-

count cards, such as West Virginia's Golden Mountaineer Card? Are seniors able to use either the hotline or website to compare the prices of Medicare-approved cards to non-Medicare approved cards available in their states?

Answer: CMS studies did not compare discounts available through the Medicare-approved drug cards with discounts available through the non-Medicare drug cards. However, an individual can have one Medicare-approved card along with as many non-Medicare cards as he/she wishes and use whichever card will provide the best discount on a specific prescription.

The 1–800–MEDICARE hotline and the price comparison website only allow for comparisons for Medicare-approved discount drug cards. However, an individual can compare prices of drugs they will get with non-Medicare approved cards—obtained from other sources such as information that drug card entity has released—with prices of drugs on Medicare-approved drug cards obtained from the website and the hotline.

Question 3: What type of outreach is CMS using to reach low-income beneficiaries who are eligible for transitional assistance?

Answer: A number of mailings have been completed. These include a mailing from the Social Security Administration of approximately 19 million notices about the availability of the $600 transitional assistance to low-income beneficiaries. These notices were sent in English and Spanish and provide information on enrollment in the drug card program along with 1–800–MEDICARE and *www.medicare.gov* information. CMS has mailed a bi-fold mailing introducing the Medicare Approved Drug Discount Cards to 35.5 million households. Copies in English and Spanish have been shipped to partners and the American Library Association for distribution to local libraries. We are working with the United Way to electronically distribute to its member organizations. In addition to these mailings, English and Spanish versions of "The Facts about Medicare Approved Drug Discount Cards" have been posted on the website. A 36-page booklet entitled, "Guide to Choosing a Medicare-Approved Drug Discount Card Booklet," in English, Spanish, Braille, Audiotape, and Large Print versions, has also been posted on the website and is available, by request, to those calling 1–800–MEDICARE. In addition to these, Secretary Thompson has begun an initiative that will target enrolling low-income seniors and persons with disabilities in the Medicare-approved drug discount card program. To help in the enrollment effort, HHS is making an additional $4.6 million available to organize and fund community-based organizations to help low-income beneficiaries learn about the drug card program and how to enroll. These funds are in addition to the $21 million previously made available to the State Health Insurance Assistance Programs (SHIPs), which provide one-on-one assistance to Medicare beneficiaries through trained volunteer counselors who are provided training from CMS.

Question 4: Families USA released a report last week, which states that the prices of the 30 brand-name drugs most often used by seniors increased by 6.5 percent last year. That increase negates much of the potential savings that seniors have been promised under the Medicare drug discount cards. What is CMS doing to prevent further erosion of savings for seniors?

Answer: Pharmaceutical prices have been rising at a steeper rate than overall inflation for a number of years now, even before the Medicare prescription drug discount card program was even conceived. Currently, beneficiaries without any coverage pay out of pocket at whatever the going rate is, which may fluctuate up and down. Card sponsors negotiate specific discounts off of that going rate, known as the average wholesale price (AWP) and pass them on to beneficiaries. Although the AWP may float up and down in response to labor and ingredient price changes, the discounts negotiated by the card sponsors cannot change, unless the sponsor can demonstrate to CMS that they have good cause to do so. Absent the card, beneficiaries would always be paying the going price. The cards insulate them from having to pay that full price.

Question 5: Drug card sponsors are allowed to change the drugs they cover and the discounts they offer on a weekly basis. This could have a dramatic effect on seniors who depend on specific drugs or who were expecting a specific discount when they signed up for a particular card. Why are seniors locked into a particular card for a year, when card sponsors can change what they are offering from week to week?

Answer: The Medicare-approved drug card is a fundamental change in Medicare; for the first time Medicare beneficiaries can band together and use their purchasing clout to secure low prices on drugs. Drug card sponsors need to enroll lots of beneficiaries so they can secure the best discounts for their enrollees. Furthermore, they are working to build a customer base so they will be in a competitive position when the drug benefit begins in 2006. As a result, sponsors have little incentive and we do not anticipate that sponsors will raise prices or stop offering drugs (*i.e.,* change

their formularies) as this would cause sponsors to lose business now and in 2006. Further, all drug card sponsors are required to cover at least one drug in the 209 classes of covered drugs so that a Medicare beneficiary will always have access to a medication for most medical conditions. After choosing a drug card, Medicare beneficiaries may switch their drug card during the enrollment period of November 15–December 31, 2004. So, they are only locked in for part of 2004. Also, many card sponsors will have open formularies, which means that beneficiaries will have access to any drug. Drug card sponsors should provide this information in their initial enrollment packages to beneficiaries. Finally, beneficiaries should remember that there are many cards with low fees, or no fee at all, so we hope the cost to them is minimal.

Question 6: There have been reports that 20 of the 73 drug card sponsors have a history of health care fraud at either the state or federal level. Can you explain why these companies were considered eligible to participate in this program given their history of fraudulent activity?

Answer: We continue to fervently monitor drug card sponsors for fraud. It is important to note that an allegation of fraud is not sufficient to deny an entity the opportunity to contract with CMS. CMS has taken steps to protect beneficiaries from unethical card sponsors through its application review and contracting processes. CMS conducted its review of each applicant's business integrity in a manner consistent with regular DHHS contracting standards. Generally, those standards prohibit CMS from contracting with entities listed on the Office of the Inspector General's exclusion list or the General Accounting Office's debarment list. CMS made certain that none of the applicants or their key subcontractors appeared on either of those lists. As part of their application for the Medicare endorsement, potential card sponsors were required to submit a description of any past or pending legal action concerning health care and/or allegations of fraud, misconduct, or malfeasance within the last three years. CMS reviewed that information, as well as relevant databases to determine whether a sponsor had been subject to a criminal conviction or civil judgment related to health care fraud. Contracts with sponsors include provisions that require CMS to be given notice by sponsors when they have reason to believe they are under investigation by a government agency or financial institution on a matter relating to health care fraud. The contract also requires card sponsors to notify CMS when it has been the subject of a criminal conviction or civil judgment on a matter relating to fraudulent activities or is sanctioned by any federal program involving health care. Finally, the contract authorizes CMS to terminate immediately the approval of any card sponsor upon the card sponsor's debarment or suspension from any federal program.

Responses to Questions From Senator Lincoln

Question 1: In Arkansas, Medicaid has a limited drug benefit for the poorest of the poor. Three prescriptions a month are covered for someone making less than $9,300 a year with assets less than $2,000.

An elderly gentleman called my office the other day and said he is on Medicaid, but it is covering only three of the eight prescription drugs he needs. Yet, because he has Medicaid coverage, he isn't eligible for the drug discount card or the $600 in transitional assistance. However, beneficiaries who have prescription drug coverage through a Medicare-Advantage plan are eligible for the drug discount card and the transitional assistance. I understand that CMS is supposed to make recommendations for changes in the drug discount card program as of today. Would you recommend the $600 be coordinated with Medicaid, just as it is coordinated with Medicare Advantage? Arkansas has no Medicare Advantage plans, but has many poor seniors on Medicaid who would greatly benefit from an extra $600 a year in drug assistance, given that the Medicaid drug coverage is so limited.

Answer: Unfortunately, by statute, individuals with Medicaid outpatient prescription drug coverage are not eligible for the $600 in transitional assistance.

Question 2: Dr. McClellan, despite partisan differences over the new Medicare law, I think both Democrats and Republicans agree that the most useful aspect of the drug card program is the $600 in transitional assistance in 2004 and 2005 for low-income seniors.

A couple weeks ago when you testified before the House Energy and Commerce Committee, you said that automatic enrollment of beneficiaries in the Medicare Savings Programs "may be something we can work out if it turns out the other mechanisms don't work." What are these other mechanisms, and when will you determine if they've worked or not?

Six months from now on December 31, 2004, beneficiaries will lose access to $600 in transitional assistance that they can never get back. You obviously recognize that

automatic-enrollment is an effective way to get beneficiaries the $600 in assistance because you have allowed beneficiaries in Medicare Advantage and state pharmaceutical assistance programs to automatically-enroll. In fact, CMS says that 83 percent of those who have enrolled in a drug card to date are Medicare Advantage members who were automatically enrolled. Doesn't it make sense to automatically-enroll the 700,000 beneficiaries in Medicare Savings Programs because we already know they qualify?

It seems that auto-enrollment is an effective tool, but beneficiaries in Arkansas are left out because we don't have Medicare Advantage plans, nor do we have a state pharmaceutical assistance program. We do, however, have tens of thousands of low-income seniors enrolled in Medicaid's Medicare Savings Programs (QMBs and SLMBs). *You have the authority to automatically enroll them.* This population of seniors and people with disabilities is often very sick, and may have cognitive and mental illnesses that make it hard to talk on the phone or use the Internet. Will you automatically enroll them, and if so, when?

Answer: We appreciate your interest in enrolling the MSP population, and agree that we need to do all we can to ensure that eligible beneficiaries are enrolled as quickly as possible so they can obtain the drug coverage they need. We are currently in the process of reviewing how to build off our experience and work with states to facilitate the enrollment of MSP beneficiaries.

Question 3: Do you know where the auto-enrollees are located? If you don't know for sure, could you guess?

Answer: Connecticut, Maine, Michigan, New Jersey, New York, Pennsylvania and Massachusetts have auto-enrolled low-income beneficiaries. In addition, Ohio and Rhode Island are helping beneficiaries enroll in a drug discount card by sending pre-filled out applications for the drug card to expedite the process for enrolling for these individuals.

PREPARED STATEMENT OF MARK MERRITT

I. Introduction

Good morning Chairman Grassley, Ranking Member Senator Baucus, and Members of the Committee. I am Mark Merritt, President and CEO of the Pharmaceutical Care Management Association (PCMA). I am pleased to be here today to discuss the role pharmacy benefit managers are playing to make the Medicare drug discount card program a success for senior and disabled beneficiaries.

PCMA is the national association representing America's pharmacy benefit managers (PBMs). PCMA represents both independent, stand-alone PBMs and health plans' PBM subsidiaries. Together, PCMA member companies administer prescription drug plans that provide access to safe, effective, and affordable prescription drugs for more than 200 million Americans in private and public health care programs. PCMA appreciates the opportunity to testify before the Senate Finance Committee regarding the recently enacted Medicare prescription drug discount card program. I applaud you, Chairman Grassley, Ranking Member, Senator Baucus and all the other committee Members who worked so hard to bring the promise of more affordable medicines to millions of America's seniors and disabled beneficiaries.

The bipartisan Medicare Modernization Act (MMA) provides a historic opportunity for the private sector to work in partnership with government to make prescription drugs more affordable to our nation's elderly and disabled, particularly those most in need. PCMA and its member companies have long supported efforts to provide Medicare beneficiaries with the benefit of drug discounts made available through competitive price negotiation and quality drug management services. We believe PBMs will play a pivotal role in the overall success of the drug discount card program and many of our member companies have made a considerable investment to that end.

Today, I would like to focus my testimony on four key areas:

- How vertical and horizontal competition among drug card sponsors, retail pharmacies, and drug manufacturers is driving down drug prices and providing savings and value to beneficiaries, particularly those with low incomes;

- How PBM-sponsored drug cards are providing beneficiaries with more than just discounts on drugs, but also valuable care management services that can lead to additional cost savings and enhance the quality of care for seniors and the disabled;

- Highlight steps PBMs have taken to prepare for the launch of the discount card; and

- The challenges and opportunities we see in educating seniors and the disabled about the drug card program's benefits.

II. Competition Works to Benefit Consumers

The Medicare drug discount card program is providing seniors and the disabled with a maximum choice of medications and flexibility in how and where they get their medications filled. Beneficiaries have access to virtually all classes of outpatient drugs available by prescription at discounted rates. Moreover, they have been provided an important new option: the mail-service pharmacy option, which adds further cost-savings, quality and safety protections, and convenience. This freedom of choice and flexibility for seniors and the disabled is what drives card sponsors to compete for their business and is critical to the government's effort to make prescription drugs more affordable.

Preliminary estimates by the Centers for Medicare & Medicaid Services (CMS) indicate that as many as 2.87 million eligible beneficiaries have enrolled in the program, with the majority being automatically enrolled by managed care plans. It is still too soon to tell how many seniors will ultimately enroll in the drug card program or how deep the savings will be for beneficiaries. That said, PCMA member companies believe that enrollment is continuing at a brisk pace and that there are several positive signs that point to the program's long-term success.

The Discounts are Real. There is ample evidence to suggest that the discounts provided to beneficiaries participating in the program are meaningful and making a difference. The savings are real, particularly for the estimated over 4 million Medicare beneficiaries who qualify for the $600 transitional assistance. Low-income seniors who can now avail themselves of PBMs' cost-management tools can make their $1200 subsidy go even further because PBMs can help them stretch those dollars.

- Based on a survey of PCMA member companies conducted prior to the launch of the card program, PCMA estimates that seniors with the Medicare drug card will see discounts averaging 17 percent for brand-name drugs and 35 percent for generics, compared to consumers paying retail pharmacy prices with no prescription drug coverage. These data are in keeping with CMS' own data which shows that drug cards are offering savings of up to 18 percent on brand name drugs and 30 to 60 percent on generics.

- Furthermore, according to CMS preliminary estimates, card sponsors are passing over 90 percent of the discounts they receive on to seniors participating in the program. This shows that competition is working to deliver savings for seniors, and it proves that the rebate and discount disclosure requirements included in the MMA are working to benefit beneficiaries as Congress intended.[1]

- Savings are even greater for low-income beneficiaries who need the help the most. Take, for example, a hypothetical 66 year-old man living in Brooklyn, NY, with high cholesterol, high blood pressure, diabetes, and impotence. His drug needs can be met with a combination of two brand-name drugs and two generics. Without the Medicare discount card, he could get these drugs through AARP's drug program (available to all AARP members at an average discount of 16 percent off retail) for $195 per-month at retail and $182 per-month through mail order. With the Medicare card, the $600 dollar subsidy, and additional discounts offered directly by drug manufacturers for low-income

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[1] "Medicare Rx Card Sponsors Are Passing On 'More than 90%' of Discounts," The Pink Sheet, May 24, 2004.

seniors, he can get the same drugs for $71 per month retail and $60 per month mail order. This is an overall savings of 63 percent and 67 percent respectively.[2]

Competition Among Card Sponsors Yields Further Discounts. Since the first publication of drug prices offered by the different card programs in early May, there has been considerable competition among card sponsors to provide the most affordable drugs. PCMA's own internal analysis of price changes from May 11 through June 1 shows the following:

- Overall, for a large basket of commonly prescribed drugs[3] with no generics yet available, prices declined for retail -- and particularly mail service -- in the three weeks they were monitored.

- The following chart compares the top five drug discount cards offering the best mail service (90-day supply) prices for this basket of brand-name drugs.

Card Sponsor[4]	5/11/04	6/01/04	*Difference ($)	Difference (%)
Card #1	$1697.27	$1559.41	$137.86	-8 %
Card #2	$1829.21	$1661.15	$168.06	-9%
Card #3	$2082.04	$1673.14	$408.90	-20%
Card #4	$2094.03	$1829.21	$264.82	-13%
Card #5	$2215.35	$1829.21	$386.14	-17%

- As this chart shows, the average reduction to already discounted prices for the top 5 cards over the three week period was 13 percent.

- It is also worth noting that not only did prices decline within each of the top 5 slots during the three week period, but that the price differential between the Card #1 and Card #5 was also halved during this time. On 5/11/04, the difference in price between Card #1

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[2] Joe Antos, "The Truth About the Medicare Drug Discount Card," American Enterprise Institute, May 27, 2004. Statistics are based on a 7-month cost estimate (May - December 2004) of price information available on May 3 at www.medicare.gov and assumption of use of the $600 subsidy available to low income seniors on June 1.

[3] The following drugs and their strengths were included in this basket of drugs: Cozaar (100mg) for angina; Viagra (50mg) for impotence; Lipitor (40mg) for high cholesterol; Fosamax (40mg) for osteoporosis; Celebrex (200mg) for arthritis; Nexium (20mg) for gastric reflux disease; Lexapro (10mg) for anxiety; and Norvasc (5mg) for high blood pressure.

[4] Note that the top five drug cards on 5/11/04 may not necessarily be the same top five cards on 6/01/04.

and Card #5 was $518. On 6/01/04, the difference was $269. This shows that card sponsors jockeying for a spot in the top five made even more significant reductions in prices in order to compete.

Direct Government Purchasing Schemes Offer a False Hope of More Access, Affordability. Some have proposed reopening the Medicare law to permit the federal government to negotiate directly with drug manufacturers and purchase prescription drugs on seniors' behalf, similar to the Veterans' Administration (VA). However, there is considerable evidence to suggest that direct negotiation of drug prices by the federal government may actually *limit* seniors' access to prescriptions and will not necessarily yield the savings predicted by proponents. First, to replicate the VA model would mean adoption of a national formulary, something Members of this Committee fought hard to avoid during negotiations on the Medicare drug benefit. The VA formulary restricts access to prescription drugs to 31 classes. In contrast, most commercial plans offer a much broader selection of therapeutic classes. Moreover, an August 2000 US General Accounting Office (GAO) report concluded that if the federal government was to provide other purchasers access to the VA's government-mandated discounts, those discounts will disappear as drug manufacturers raise the wholesale price of their drugs to make up for the loss in revenue.[5] Finally, in January 2003, the GAO has reported that PBMs have been able to get better discounts than some state Medicaid programs. In a review of five state Medicaid programs, the GAO found that Medicaid was only getting an 11 percent discount off of cash-paying retail prices versus PBMs' 18 percent discount.[6]

PBMs are Better Able to Deliver Value to Seniors. Because PBMs are neither retail pharmacies nor drug manufacturers, they are generally able to achieve discounts at both ends of the pharmaceutical chain—from the manufacturer and from the retail pharmacy. PBMs are uniquely capable in securing these discounts, managing pharmacy care, and delivering savings to consumers. PBMs are able to achieve these important goals because PBMs represent significant volume in their customer base; are able to leverage inherent efficiencies in their electronic claims

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[5] US General Accounting Office, "Prescription Drugs: Expanding Access to Federal Prices Could Cause Other Price Changes," GAO/HEHS-00-118. August 2000.

[6] US General Accounting Office, "Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees and Pharmacies," GAO-03-196, January 2003, p. 10.

processing technology; are able to provide a mail-service pharmacy option; and because of their commitment to the use of generic drugs where appropriate and available.

That PBMs deliver value to their current customers in both private industry and government is well documented. In its 2003 report, the GAO found that PBMs contributed to an 18 percent reduction in the average price for brand-name drugs for, among others, Members of Congress and their staffs in the Federal Employees Health Benefit Program (FEHBP). This, in turn, caused a total annual reduction in drug spending of between 3 and 9 percent for FEHBP plans.[7]

One area that PBMs can provide unmatched value for seniors is through the mail-service pharmacy option. Mail-service pharmacies typically fill prescriptions for maintenance medications; i.e., prescriptions that are used on a continuing basis for individuals managing complex or chronic illnesses. For seniors with limited mobility or disabled beneficiaries living in rural or urban under-served areas, the mail-service pharmacy option can be a vital lifeline to maintaining their health and well-being. Plan designs often allow consumers to obtain a 90-day supply of medication instead of the usual 30- or 60-day scripts that are filled by retail pharmacies. Consumers save money as well by paying only one co-payment for the 90-day supply of medication filled by a mail-service pharmacy, rather than the three separate co-payments required for 30-day supplies filled at a retail pharmacy. A 2002 industry survey of 14,000 mail-service pharmacy consumers found that more than 95 percent were satisfied with the condition of the drugs they received; the accuracy of the drugs that were delivered; with the professionalism of customer service; and the cost savings provided by mail-service pharmacies.

These savings would not be possible without the right market conditions. One such condition is keeping the terms of a contract confidential. Competition for market share drives drug manufacturers to negotiate discounts and rebates with PBMs. It is competition for retail customers that drives retail pharmacies to negotiate discounts with PBMs. If efforts to force disclosure of proprietary contract pricing information are successful, drug manufacturers will have little incentive to negotiate deeper discounts because they will know the competition got a better deal. Last year during the Medicare prescription drug debate, Congress considered – and

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7 *Ibid*, p. 4.

ultimately rejected – a proposal that would have undermined the competitive marketplace under the guise of "transparency" and "disclosure." The Congressional Budget Office estimated that the proposal would have cost the Medicare program $40 billion over ten years because PBMs' ability to drive discounts for beneficiaries would be undermined.[8] Moreover, as already noted, such public disclosure is not necessary. CMS is already utilizing the transparency requirements in the new law and has found that PBMs and other card sponsors are passing more than 90 percent of the discounts they secure on prescription drugs on to beneficiaries in the drug card program.

III. PBM Drug Discount Card Benefits Provide Quality Protections

Seniors need ***more*** than just discounted drugs. We believe that the funded drug benefit that will be made available in 2006 will go a long way towards meeting those needs. In the interim, however, our focus should not solely be on the cost of drugs. We must also look at how those drugs are being utilized and if they are being used safely and appropriately.

Here again, PBMs have and will continue to prove their value. When a senior enrolls in a Medicare-approved PBM drug discount card, he or she is not only receiving discounts, he or she is getting the benefit of certain care management services PBMs provide to help ensure good health outcomes. We expect that when the fully funded drug benefit begins in 2006, seniors and the disabled will have access to the full range of tools and techniques that PBMs rely upon to improve drug safety and quality. Preserving PBMs' proven tools and techniques should be a top priority as policymakers work to implement the new Medicare drug benefit.

One of the most important functions PBMs perform is drug utilization review. Consider: one in four seniors sees four or more physicians; however nearly one in 10 seniors was prescribed medications by six or more different doctors in 2002. One in three seniors used four or more different pharmacies and one in seven seniors used five or more pharmacies to fill prescriptions in 2002.[9] As these data suggest, it can be difficult for any one physician or pharmacist to know all the drugs a senior is taking at one time. PBMs, however, are able to keep a patient's

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[8] Congressional Budget Office, "Cost Estimate of HR 1, Medicare Prescription Drug and Modernization Act, and S 1, Prescription Drug and Medicare Improvement Act of 2003," July 22, 2003

[9] Medco Health Solutions, 2003 Drug Trend Report

prescription drug history in one central file, with appropriate privacy protections. When a senior enrolls in a PBM-sponsored drug discount card, that senior receives the added protection of having their drug utilization continuously monitored for dangerous interactions and/or for under- or over-medicating. A real-time alert will be sent from the PBM to the pharmacy if a potentially dangerous drug interaction is about to take place.

IV. PBMs Will Play Pivotal Role in Drug Card's Success for Beneficiaries

As already noted, PBMs have a proven track record in bringing high quality, affordable medicines to beneficiaries in public programs and to the under-65 population with prescription drug coverage provided by employers, Taft-Hartley trustee plans, state and federal-employee benefit plans, and health plans. Now the Medicare drug discount card program has challenged PBMs to step up to the plate and prove their value to millions of Medicare beneficiaries, particularly those with low incomes, who today pay full retail prices for their prescription drugs. PBMs are meeting this challenge.

Since the Medicare Modernization Act was signed into law last December, PCMA member companies have worked countless hours and spent millions of dollars to develop and market their drug cards. This effort includes 1) submitting proposals for drug cards to CMS for approval; 2) once approved, working with CMS on marketing, disclosure, compliance and drug price submission requirements; 3) engaging in new contract negotiations with network pharmacies and drug manufacturers for thousands of drugs covered by the program; and 4) rolling out the new cards through marketing and enrollment campaigns which have required sponsors to increase call center staff by up to 15 percent.

The information reporting requirements alone are staggering. These requirements include not only providing a complete inventory of covered drugs, but also a weekly updated list of the retail and mail-service pricing for each dosage of each drug. In addition, each card sponsor must provide a list of the retail pharmacies where seniors can go to get their drugs. Furthermore, each card sponsor is required to inform CMS the extent to which negotiated price concessions with manufacturers are being passed on to beneficiaries through pharmacies. If adequate discounts are not being passed on, or card sponsors attempt to "bait and switch" beneficiaries by luring

them with artificially low drug prices only to raise those prices once they have enrolled, CMS has broad auditing authority – backed by tough sanctions and civil monetary penalties – to protect beneficiaries.

Some critics' assertion that drug card sponsors will game the system are unfounded. The flexibility included in the MMA with regard to drug pricing and drug lists stands primarily to benefit Medicare beneficiaries.

- In the commercial marketplace, prescription drugs are rarely, if ever, removed from a formulary during a contract period unless the FDA determines a drug to be unsafe. With respect to the drug discount card program, we do not anticipate a drug being withdrawn from a list unless the FDA determines it to be unsafe.
- To the extent that there are changes to the drug list in the discount card program, they are likely to occur because a drug card sponsor is adding a new brand name or generic drug to the drug list. Adding a drug to the drug list would presumably further drive down drug prices because of increased competition within a therapeutic class.
- If a drug manufacturer *does* raise the price of a drug, the card sponsor must submit pricing changes to CMS, with supporting rationale. In reviewing price increases, CMS has the authority to impose penalties or expel a card sponsor from the program if they deem the price increase to be excessive or unwarranted. Given the potential penalties, it is unlikely that card sponsors will raise drug prices without compelling data.

V. Consumer Education Is Greatest Challenge and Opportunity Going Forward

Without a doubt, the greatest challenge to making the drug card a success for beneficiaries is informing them about how to enroll and to choose the drug card that best meets their needs and provides the maximum benefit. The www.medicare.gov website is a crucial tool -- the near and long-term benefits of making available retail pricing on thousands of drugs cannot be overstated.

Of course, seniors need to be able to rely on the accuracy of the information. There have been a few kinks in the system since the website was launched over a month ago, but CMS is working collaboratively with Medicare drug card sponsors to make the information better and more usable for seniors and the disabled. CMS should be commended for its effort in this endeavor.

In many ways, the Medicare price comparison web site lets the genie out of the bottle. Not only are retail drug prices available on one site, but information about the availability of generics and home delivery of medicines may provide seniors with new options they previously did not know existed. This information is helping to provide greater savings and enhanced convenience for seniors and provides all consumers – not just seniors – with a valuable tool for understanding and gauging competing drug prices. As a result, we expect consumers to demand more information so that they may make more informed choices. The Medicare price comparison website may well become the engine that drives quality and sparks greater transparency throughout the entire health system.

VI. Conclusion

PCMA and its member companies stand committed to do what we can to ensure the Medicare Modernization Act makes good on its promise to deliver more affordable prescription drugs to our nation's elderly and disabled, particularly those most in need. While the Medicare drug discount card program was conceived as an interim first step in this effort, we believe the program holds the potential to change the way beneficiaries access and use prescription drugs and may well have ramifications beyond the life of the program and into other parts of the system.

In time, we expect to learn more about the lessons these experiences will provide as we prepare for 2006. PCMA and its member companies will continue to work hard to conduct outreach and enroll beneficiaries in the drug card program because we believe in the tangible value it represents to Medicare beneficiaries.

Mr. Chairman and Members of the Committee, thank you for the opportunity to testify today and I look forward to answering any questions you might have.

RESPONSES TO QUESTIONS FROM SENATOR GRASSLEY

Question 1: As you mentioned in your testimony, Pharmaceutical Benefit Managers (PBMs) administer prescription drug plans for more than 200 million Americans, including Members of this Committee who have a Federal Employee Health Benefits Plan. Would you please explain how a PBM works?

Answer: Many purchasers—including health plans, self-insured employers, union-sponsored plans, federal and state employee benefit programs, and state Medicaid programs—rely upon PBMs to make prescription drugs more affordable and accessible to consumers.

PBMs are the one entity in the drug supply chain dedicated to lowering the price of prescription drugs. PBMs evolved from claims administration and mail-service pharmacies to pharmaceutical administrators and care managers. Today, most PBMs offer a range of sophisticated administrative and clinically based services that enable them to manage drug spending for their clients by enhancing price competition and increasing the cost-effectiveness of the medications covered under client health plans.

PBMs do not directly handle prescription medication (other then through their mail-service pharmacies). Instead, they aggregate the buying clout of millions of enrollees through their client health plans, enabling plan sponsors and individuals to

obtain lower prices for their prescription drugs through price discounts from retail pharmacies, discounts and rebates from manufacturers of pharmaceuticals, and the efficiencies of mail-service pharmacies. Held accountable by clients for their ability to control drug spending, PBMs also provide purchasers with clinically-based services designed to improve the safety and quality of pharmacy benefits. The following is a list of tools and techniques PBMs use:

Strategies and tools

PBMs manage pharmacy networks by recruiting and credentialing pharmacies, negotiating discounts from pharmacies for drug ingredients and dispensing services, monitoring pharmacies for quality and customer service, auditing pharmacy records, and providing technical support to pharmacies and pharmacists. Most PBMs establish a network of retail pharmacies with a broad geographic range.

Formularies

A formulary is a list of prescription drugs approved for coverage under a client's pharmacy benefits plan. It is up to the client to ultimately decide on the exact formulary that will be used in conjunction with its benefits plan as well as the techniques that will be applied to encourage formulary compliance. The primary considerations in the development of a formulary are safety and clinical appropriateness. PBMs use panels of independent experts, called Pharmacy and Therapeutics (P&T) Committees, to develop their formularies. P&T Committees meet routinely to review the drugs available in each therapeutic class. In cases where there are therapeutically equivalent drugs, the PBM will evaluate the most cost-effective alternative, which will be recommended for placement on a client's preferred drug list; enrollees may be given incentives under the client's plan design to choose the preferred drug over more costly alternatives.

Generic substitution

It has been well-documented that generic substitution saves money and provides equally beneficial therapeutic value to equivalent brand names. PBMs help pharmacies recognize opportunities to dispense generic alternatives through real-time electronic messaging. The ultimate authority for the medication prescribed for a patient rests with the physician or other appropriately licensed prescriber.

Mail-service pharmacies

Almost all PBMs offer a mail-service pharmacy. Such pharmacies primarily dispense prescriptions for medications that are used on a continuing basis for long-term illnesses or conditions. These pharmacies also provide many of the other services provided by full-service retail pharmacies, such as consumer counseling and physician information by licensed pharmacists.

Drug utilization review (DUR)

PBMs perform DUR at the point of sale and sometimes will also conduct retrospective DUR. Real-time computer link-ups between the pharmacy and the PBM inform the pharmacist almost instantly whether there are any DUR concerns before dispensing the medication. This is particularly useful in detecting harmful drug interactions, where one drug prescribed may react negatively to another drug currently taken by that patient. Retrospective DUR is conducted to detect patterns of inappropriate prescription and utilization.

Disease and therapeutic drug management

PBMs provide disease management functions, where teams of professionals work with providers and patients with chronic disease to provide them with self-management tools, and education materials. These strategies have been proven effective and, according to a recent study in the Archives of Internal Medicine, therapeutic drug management served to increase the rate of achieving therapeutic goals for patients from 74 percent to 89 percent.

Electronic claims processing

Processing pharmacy benefit claims is a core activity of PBMs. About 98 percent of pharmacy benefit claims are processed electronically, thus eliminating most of the need for paper claims and retrospective adjudication. This real-time electronic interchange also allows for the PBM to interact with the pharmacist for quality and cost management interventions.

Clinical prior authorization

Clinical prior authorization, a requirement for prior approval by the PBM of a drug before it can be dispensed by a pharmacy, is intended to assure the appro-

priateness and suitability of the prescribed medication for the specific individual, as well as to control costs. It is used for only a small number of drugs.

Rebates

In addition to negotiating discounts with pharmacy networks, PBMs obtain discounts on brand name drugs for their clients through arrangements with wholesalers and through manufacturer purchase and rebate agreements. PBMs use various techniques, such as placement on a preferred drug list, to affect market share and sales volume, and obtain better discounts, including rebates.

In conclusion, PBMs have made significant investments in the technology necessary to process pharmacy claims and have developed considerable expertise in developing techniques that produce value in the pharmaceutical component of the health delivery system. Bringing to bear the sizable buying clout of an aggregate of thousands and sometimes millions of enrollees, PBMs at their most basic are able to negotiate price discounts from retail pharmacies and wholesalers and rebates from manufacturers. In recent years, PBMs have offered a range of services that move them beyond the pharmaceutical benefit cost management into broader clinical management.

Follow-up to Question 1: Do PBMs contract with companies that make lower-cost generic drugs?

Answer: Yes, PBMs contract with many generic drug manufacturers and provide access to a wide range of generic alternatives to more expensive brand name drugs. In fact, larger PBMs with generic-based programs have increased generic use to 45 percent to 49 percent of their managed prescriptions.

The reason is that PBMs use generic-based programs which quickly move market share from brand name to generic as soon as a generic comes on the market. A program's features may include lower copayments for generic use and even lower copayments still for generics purchased through mail order; offering physicians generic drug samples; and educating pharmacists and select patients as soon as a generic comes onto the market. The result of these programs is that the switch to generics is much faster with PBM-administered prescription drug plans.

Typically, a generic can save a patient on the order of 40 percent to 60 percent below the cost of a brand name drug.

Question 2: What internal checks and safeguards do the companies you represent have in place to ensure that Medicare beneficiaries are able to access the discounted, advertised prescription drug prices at the pharmacy counter?

Answer: When a PBM negotiates for a discounted price on a given drug with a manufacturer, the discounted rate is conveyed to their retail pharmacy networks. The pharmacy that participates in that specific card program agrees to provide the drugs at the given discounted rate. When a beneficiary comes into a pharmacy that accepts the card, the pharmacy processes the claim at the discounted rate under that card program.

In addition, PBMs and pharmacies have very sophisticated interconnected claims processing systems that provide this information accurately, at the point of dispensing.

PBMs monitor and communicate with their network pharmacies and points of dispensing very closely to make sure the discounted rates that are set by the card program are the prices seniors pay at the pharmacy.

RESPONSES TO QUESTIONS FROM SENATOR BAUCUS

Question: As the President of the leading trade association for many, if not most, of the drug discount card sponsors, why do you think that enrollment in the cards is not as strong as many had anticipated?

Answer: The card program has only been up and running for less than a month, and at last count has enrolled 3.7 million seniors, about 50 percent of what CMS projected for 2004. 50,000 beneficiaries are enrolling per day. These numbers will increase through the continuing outreach and education efforts, along with the fact that more and more seniors will realize they can get significant savings on their prescription drugs with a card.

Question: Do you agree with the statement that seniors are overwhelmed by the complexity of the program and by the number of card options available?

Answer: See last response at bottom.

Question: Would having fewer choices—for example, limiting the number of drug card sponsors to 3 or 5—encourage greater enrollment?

Answer: We think maximum choice, which currently exists in the program, among a number of card sponsors benefits seniors by lowering the drug prices even further as the cards compete among themselves to attract enrollees. In fact, what we have

seen is prices continue to fall due to competition among many cards, competition among manufacturers who want to ensure their prices are lower than their competitors offerings, and among pharmacies who also want to ensure beneficiaries select their services.

Question: In your opinion, what could be done to ease the complexity and ease seniors' concerns?

Answer: The card program is still in its infancy, and through educational and outreach activities conducted by CMS, card sponsors, consumer groups, and others, any concern seniors have will be alleviated when they realize they can save 17 to 35 percent on their drug costs.

RESPONSES OF TOM SNEDDEN TO QUESTIONS FROM SENATOR GRASSLEY

Question 1: Do enrollees in the PACE program and the Medicare discount drug card transitional assistance program have a cost-sharing requirement?

Answer: Some 110,000 PACE cardholders enrolled in the First Health/PACE Medicare drug discount card with the transitional assistance will not have a cost-share requirement while they are using the $600 credit. Their copayments and co-insurances will be covered until the credit is exhausted.

However, an additional 30,000 PACE cardholders enrolled in a managed care plan that is offering a Medicare drug discount card cannot be enrolled in the First Health/PACE Medicare drug discount card. They must enroll in the managed care plan's Medicare discount card if they want a card. In this instance, the individuals will have to pay copayments and/or coinsurances, according to the managed care plan's requirements.

Question 1a: How do you plan to address the issue of utilization control?

Answer: PACE uses a comprehensive set of mandatory point-of-sale pharmacy edits to effectively manage enrollment utilization. PACE cardholders with a Medicare drug discount card will only be able to obtain a one-month supply of medications at a time, and the pharmacy reimbursement system will not permit an early refill. In addition, reimbursement will not be permitted on medications that may be contraindicated, prescribed off-label, or clinically inappropriate for the enrollee.

Question 1b: What assurance does Pennsylvania have that this type of arrangement will be sustainable?

Answer: The pharmacy reimbursement system is a real-time, on-line system, in which utilization review edits are activated at the point of service and are mandatory. In addition, PACE is working very closely with the pharmacy community to ensure that they know the proper billing procedures for the Medicare drug discount card.

Question 1c: Is there a formulary to help to contain cost and utilization of drugs?

Answer: PACE has an open formulary but effectively controls utilization through a comprehensive set of mandatory point-of-sale edits and step therapy protocols.

Question 2: I understand that the state of Pennsylvania worked with a particular drug card sponsor to create a discount drug card program that coordinated with its PACE program. How has working directly with one particular drug card sponsor facilitated Pennsylvania's ability to utilize auto-enrollment?

Answer: By utilizing the pharmacy benefit administrator for the PACE program, First Health Services, as the Medicare drug card sponsor for PACE cardholders, we were able to ensure that the enrollment in the drug discount card program was relatively simple, optimal and transparent to our cardholders. We already had available to us the individual's demographic and income information and did not have to require them to complete a separate application form for the program. And, we are also able to best manage the claims data to ensure that the provider community experiences minimal inconvenience and optimal service levels.

Question 2a: Are you able to tell who does and does not have other drug coverage?

Answer: Yes, the PACE program receives other prescription coverage information from various sources: Medicare Managed Care Plans, self-declaration from applicants, and data exchanges with Medicaid and the state's Retired Employee Health Program.

Question 2b: What in your state law permitted you to auto-enroll beneficiaries? Does this make you unique from other states?

Answer: When an applicant signs the enrollment form, they attest that the information provided is true and correct and that they have read the Certification and Authorization statements on the back of the form. Provision D of the Certification and Authorization states the applicant must "hereby assign to the Commonwealth of Pennsylvania, in the event of duplicate or overpayment, any right to drug benefits which I may be entitled under any other plan of government assistance or insurance

from any for-profit third party insurer." This language permits PACE to obtain any government benefits to which the applicant is entitled.

We are not unique from other states. New York and New Jersey, to name a few, have also conducted auto enrollment for their beneficiaries.

RESPONSES TO QUESTIONS FROM SENATOR BAUCUS

Question 1: As the Director of Pennsylvania's PACE program, you may have extensive experience in running a prescription drug program for low-income Medicare beneficiaries. Based on your observations about the demographics and characteristics of this group of seniors, what is the best way to ensure that low-income Medicare beneficiaries sign up for the $600 transitional assistance, and, when the time comes, best take advantage of the Part D benefit?

Answer: Auto-enrollment! When the State Pharmacy Assistance Programs (SPAPs) were authorized to conduct auto-enrollment into the Medicare drug discount card, it eliminated significant barriers, such as requiring the beneficiaries to complete an application form.

Question 2: What is the best way to communicate with these beneficiaries?

Answer: It has been our experience in the Pennsylvania PACE program that any type of communication with the population we serve can be somewhat difficult and confusing for the beneficiaries. In most cases, it is more beneficial to communicate with the caregivers, physicians or pharmacists.

Question 3: What are some of the challenges in helping them adapt to changes in a program, and what is the best way to communicate program changes with them?

Answer: The largest challenge is to communicate in a way that the individuals understand the message you are trying to convey. The population we serve, on average, has a tenth grade education level. Although we often think our message is simple and clear, it may not be understandable for them. Direct communication should be kept to a minimum in an effort to reduce beneficiary consternation and anxiety.

COMMUNICATIONS

Statement for the hearing record

Mary R. Grealy
President
Healthcare Leadership Council

Hearing on
"Medicare Drug Card:
Delivering Savings for Participating Beneficiaries"

Senate Finance Committee

The Healthcare Leadership Council appreciates this opportunity to provide its views on the Medicare prescription drug discount card program, and wishes to commend the Senate Finance Committee for its continuing leadership in building a stronger Medicare program.

The HLC represents providers and innovators from all sectors of American health care. Our membership is comprised of chief executives of leading companies and institutions from across the health spectrum.

Since its inception, HLC has been dedicated to advancing a health care system that provides affordable, high-quality care in a patient-centered environment. We are committed to accessible medicines, technologies and treatments that can help people lead longer, more active and fulfilling lives. Consistent with this philosophy, we have long supported improvements to the Medicare program to give beneficiaries greater access to the high-quality preventive care that can bring greater health and enrichment for the disabled and the elderly.

The Medicare prescription drug discount card program is the first step – an important interim step – toward that goal. The Healthcare Leadership Council is involved in helping seniors to better understand the discount cards and the application process, and we have also undertaken research to fully comprehend what the discount cards will mean to Medicare beneficiaries in terms of cost savings. We will be sharing the preliminary results of that research within this statement.

Background

When Congress passed, and President Bush signed into law, the "Medicare Modernization Act of 2003," it represented a major advancement on behalf of millions of older and disabled Americans. With this legislation, Medicare is beginning to make a critical transformation into a 21st century health care program that makes prescription drugs, preventive care and diagnostic care more accessible to its beneficiaries.

In 2006, Medicare will, for the first time, offer a prescription drug benefit, a benefit that will substantially reduce beneficiaries' out-of-pocket costs for prescription drugs. Realizing, though, that it will take time to put this benefit into effect, and that Medicare beneficiaries should begin to reap savings immediately, Congress wisely created the discount drug card program. This is an important interim step intended to give beneficiaries assistance right now, lasting until the full Medicare prescription drug benefit takes effect on January 1, 2006.

The structure of the discount card program enables participating seniors to have the power of consumer choice and the fruits of competition. With 73 vendors involved in the discount card program, beneficiaries have the opportunity to select the card that gives them the greatest savings on the specific prescription drugs they are using. And with the card vendors able to see, on the Centers for Medicare and Medicaid Services website, the discounted prices their competitors are offering, we have an environment

in which market competition can bring lower prices and greater value to Medicare beneficiaries.

Seniors and disabled Americans are currently applying for their drug discount cards. Some media attention has been focused on the difficulties some seniors are having in negotiating the CMS website to gather comparative data on cards and prices. We support the efforts of CMS and Administrator Mark McClellan to correct problems on the site and to make it as user-friendly as possible. It should be pointed out, though, that individuals who are having difficulty with the CMS website or are simply not comfortable with the Internet can and should call 1-800-MEDICARE to receive personalized assistance with their discount drug card inquiries. It should be noted that CMS has recently added even more customer service representatives to their 800 line, which should make it easier for callers to get through.

As well, there are numerous public and private organizations, such as the State Health Insurance Assistance Programs, that are working with seniors to provide guidance and to ensure that they are able to register for the right discount card.

The Healthcare Leadership Council is also working with senior centers throughout the country to provide information about the discount cards, and we're making a special effort to reach those low-income seniors who qualify for the $600 annual subsidy in addition to their drug discount cards.

The Lewin Group study on discount card savings

How much money can Medicare beneficiaries save on their prescriptions by using the drug discount cards? That is a question the Healthcare Leadership Council is seeking to answer and, in so doing, give seniors a comprehensive sense of how the discount cards can affect their personal finances and their health care.

To answer this question, we have worked with The Lewin Group, a nationally-respected economic analysis firm that specializes in health and human services research and consulting. In structuring the Lewin study, we wanted to make it as relevant as possible to the everyday lives of the Medicare beneficiaries who will be using the discount cards. So, our analysis is focused upon 150 of the drugs that are most frequently used by senior citizens. We are looking at the difference between what a cash purchaser would pay for those drugs at a retail pharmacy and what someone would pay when using the Medicare discount card. We are also taking a look at the impact of the drug card for beneficiaries with chronic health conditions, using multiple medications. In this case, Lewin is analyzing the total cost for the drug regimen for beneficiaries using the discount card and also for those using the discount card plus the $600 low-income credit.

We should note that our retail price data is based on a national database of prescription drug utilization data compiled by Verispan. Verispan considered one of the 12 months of price data, running through March of this year, to establish the average retail price for a customer without any insurance or discounts. We should also emphasize that, in

conducting this research, we have chosen to err on the conservative side. If anything, this study underestimates, rather than overestimates, the average savings for discount card users. Our estimates are for people who do not currently benefit from an existing discount card or state pharmaceutical assistance program.

Second, we want to stress that these results are preliminary in nature. Our study is ongoing. And, in fact, just as Dr. McClellan has noted publicly that the discount card prices are moving downward as a result of price transparency and competition, our finalized study, to be released later this month, may show even greater average savings than we are witnessing thus far.

The Lewin study findings can be found on the Healthcare Leadership Council's website, www.hlc.org.

Answering the question regarding how much a beneficiary can save overall, we worked from the premise that beneficiaries are likely to choose a discount card based upon the best savings for the drugs they take today. Looking at the 150 most frequently used drugs, we are finding that the best available prices on those drugs represent a weighted average savings of more than 20 percent in many states. (See attachment, Table 1)

Let's look at some specific examples. We're finding a weighted average savings of 27 percent in Florida, 26 percent in Louisiana, 25 percent in Illinois, 23 percent in New York, 21 percent in California and 19 percent in Michigan. We believe these estimates of savings are representative and that many beneficiaries will receive savings of similar magnitude.

In fact, it should also be pointed out that we are seeing very little in the way of geographic disparities in the discounted prices. The best price offered for a single drug rarely varies across markets. For example, the lowest available price for a best-selling brand name hypertension drug varies by less than one dollar across 20 zip codes and was offered by the same card sponsor in 18 of the 20 zip codes. This is a very positive finding. We're seeing that, regardless of the state or region in which a beneficiary lives, they will still receive the best price available nationally from the discount drug cards. (See attachment, Figure 1)

We have found, as well, that the savings are considerable for beneficiaries who have chronic disease conditions and are utilizing multiple drugs. Those savings are then significantly increased in cases in which the beneficiary is also using the $600 low-income credit for prescription purchases.

Here are some examples from our findings. A senior citizen taking the most frequently used combination of drugs for hypertension – a calcium blocker, an ACE inhibitor and thiazides – would pay an average retail price of $956.78 over the course of a year. With the drug card, that beneficiary will save $243.50, a savings of 25 percent. Add in the low-income credit, and the total savings increases to $843.50, or 88 percent off of the retail price.

In another hypothetical example, a beneficiary taking the most common combination of drugs for diabetes would spend $3,099.23 during the year if paying retail prices. With the discount card that provides the best price on those drugs, that person will save $753.59 – a 24 percent savings. With the low income credit included, the savings increase to $1,353.59, a 44 percent total discount from the retail price. Savings for each of the drug regimens identified in our study were estimated by collecting prices for the specific prescribed drugs using a single card at a single pharmacy. (See attachment, Table 3)

On the subject of low-income seniors, there is another fact that needs to be discussed that doesn't receive the visibility that it should. Several of the major pharmaceutical companies have already announced that they will make drugs available at minimal or no cost to those beneficiaries who exhaust their $600 transitional assistance before the year is out. That is in addition to the many company-sponsored patient assistance programs that are already providing medicines at no cost to people of limited means.

This study, as noted earlier, is a work in progress. We are going to continue to monitor and analyze the prices that are available on the CMS website with the intent of producing a final report later this month that gives a complete, accurate and comprehensive view of the savings Medicare beneficiaries can experience by using the Medicare drug discount cards.

And, in the meantime, the Healthcare Leadership Council will be continuing its efforts, working with seniors throughout the country to provide information and assistance so that all of those who can benefit from this program are able to do so.

We believe strongly that the Medicare drug discount card program is an important interim step, prior to the implementation of the prescription drug benefit in 2006. We believe, as well, that private organizations like ours and public institutions and officials should be working together to educate seniors on this interim assistance, to urge them to contact CMS for comparative information on the discount cards, and to encourage them to apply for a financial benefit that can bring considerable relief to those who need it the most. Thank you for your leadership on this issue, and we look forward to working with you to continue to improve America's Medicare program.

Figure 1. Best Available Price for a Hypertension Drug in 20 Markets

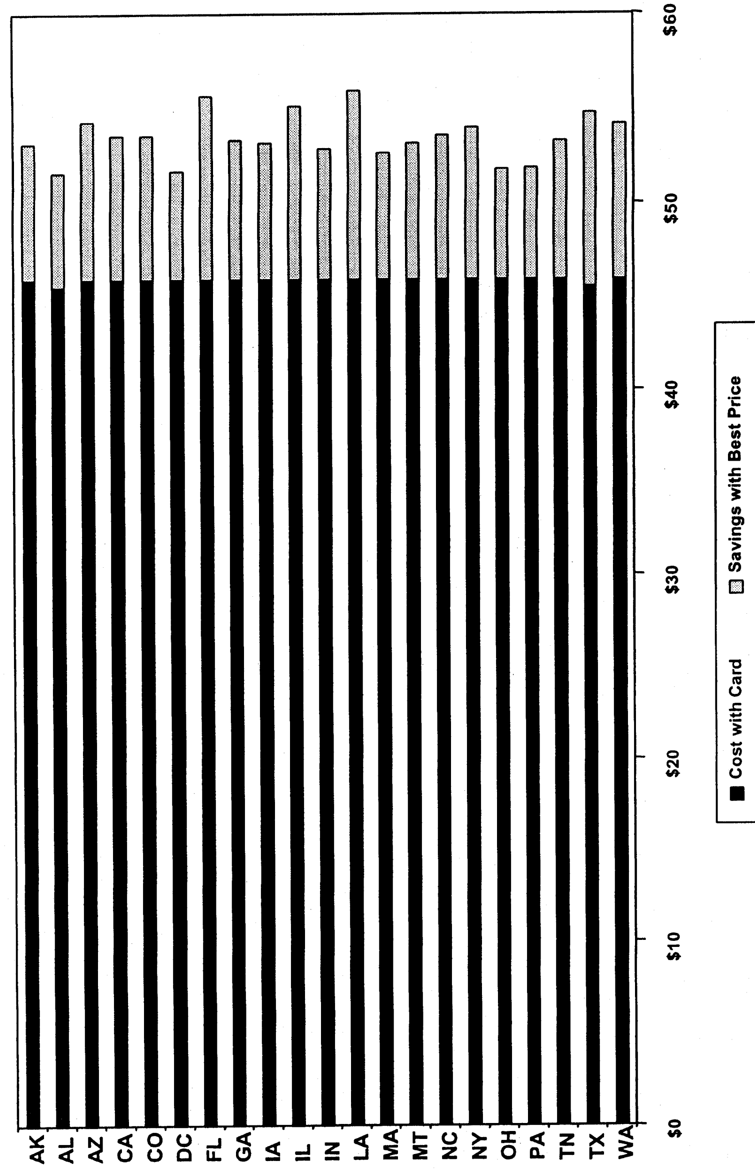


Table 1 – Best Available Price From Any Card Sponsor for Top 150 Drugs

Drug	Therapeutic Class	Used to Treat	Number of Rx Sold to Patients Over 65	Best Price from Available Cards	IL Savings per Rx		AL Savings per Rx		CA Savings per Rx		FL Savings per Rx		LA Savings per Rx		MI Savin Rx
					($)	(%)	($)	(%)	($)	(%)	($)	(%)	($)	(%)	($)
1	Statins	Lipid Lowering Agent	57,169	$66.21	$9.01	12%	$4.29	6%	$6.19	9%	$8.99	12%	$9.55	13%	$4.97
2	Thyroid Synthetics	Thyroid conditions	42,165	$13.76	$2.46	15%	$0.88	6%	$2.73	17%	$3.17	19%	$3.16	19%	$0.61
3	Beta Blockers	High blood pressure	39,411	$3.48	$12.04	78%	$5.19	60%	$6.61	66%	$15.19	81%	$12.72	79%	$8.20
4	ACE Inhibitors	Cardiovascular disease	35,339	$7.36	$17.83	71%	$12.64	63%	$11.79	62%	$21.72	75%	$19.89	73%	$12.01
5	Thiazides	High blood pressure	33,850	$2.77	$3.45	55%	$2.91	51%	$3.27	54%	$3.67	57%	$4.21	60%	$2.03
6	Diuretics	High blood pressure, CHF	33,746	$2.08	$4.29	67%	$3.66	64%	$3.41	62%	$4.94	70%	$5.36	72%	$3.30
7	Calcium Channel Blockers	High blood pressure	29,978	$42.68	$5.64	12%	$3.07	7%	$4.42	9%	$5.84	12%	$6.09	12%	$3.17
8	Anti-depressants	Depression	27,801	$69.99	$14.98	18%	$8.61	11%	$10.74	13%	$14.20	17%	$14.52	17%	$9.43
9	Beta Blockers	High blood pressure	25,267	$19.60	$6.55	25%	$4.87	20%	$5.79	23%	$7.07	27%	$7.27	27%	$4.59
10	Statins	Lipid Lowering Agent	24,035	$101.42	$39.31	28%	$29.75	23%	$34.37	25%	$39.62	28%	$38.66	28%	$31.40
11	Cephalosporins	Anti-infectives	23,750	$23.06	$72.91	76%	$42.47	65%	$44.46	66%	$82.78	78%	$74.50	76%	$46.59
12	Proton Pump Inhibitors	Heartburn, Gastrointestinal	23,382	$110.03	$36.32	25%	$24.89	18%	$31.37	22%	$36.70	25%	$34.38	24%	$28.03
13	Estrogens Oral	Menopause symptoms	22,056	$21.55	$9.06	30%	$7.07	25%	$7.89	27%	$9.20	30%	$9.56	31%	$6.97
14	Corticoids	Anti-inflammatory	21,411	$4.83	$7.90	62%	$9.04	65%	$7.43	61%	$10.18	68%	$9.96	67%	$6.17
15	Biguanides	Diabetes	21,321	$15.61	$23.35	60%	$15.96	51%	$12.84	45%	$27.63	64%	$26.49	63%	$13.44
16	Thyroid Synthetics	Thyroid conditions	21,281	$3.65	$9.88	73%	$8.56	70%	$8.94	71%	$9.72	73%	$10.35	74%	$8.74
17	Sedating Non-Benzodiazepine, Other	Insomnia	21,226	$76.20	$15.58	17%	$7.61	9%	$12.26	14%	$15.42	17%	$14.71	16%	$9.43
18	Anti-Histamines	Allergy	19,519	$59.14	$18.64	24%	$12.38	17%	$16.30	22%	$19.52	25%	$19.64	25%	$13.56
19	Cox-2 Inhibitors	Pain, Inflammation	19,516	$76.79	$14.14	16%	$7.59	9%	$13.30	15%	$15.16	16%	$14.01	15%	$8.85
20	Proton Pump Inhibitors	Heartburn, Gastrointestinal	18,692	$93.99	$49.13	34%	$37.13	28%	$43.48	32%	$49.59	35%	$47.29	33%	$39.42
21	Beta Blockers	High blood pressure	18,465	$4.61	$7.54	62%	$2.92	39%	$3.41	43%	$9.43	67%	$7.68	63%	$3.77
22	Bisphosphonates	Osteoporosis	17,504	$57.43	$14.46	20%	$9.80	15%	$12.24	18%	$14.63	20%	$15.12	21%	$11.06
23	Anti-Histamines	Allergy	17,241	$56.50	$11.88	17%	$6.00	10%	$9.19	14%	$11.97	17%	$11.56	17%	$6.61
24	Leukotriene Agents	Asthma	17,227	$77.18	$18.54	19%	$11.67	13%	$15.16	16%	$19.89	20%	$19.49	20%	$13.08
25	Cox-2 Inhibitors	Pain, Inflammation	17,093	$77.70	$15.74	17%	$8.11	9%	$14.46	16%	$17.50	18%	$15.88	17%	$9.44
26	Anti-depressants	Depression	16,105	$126.99	$62.95	33%	$47.94	27%	$54.26	30%	$63.39	33%	$63.92	33%	$52.47
27	Seizure Treatments	Seizure Disorders	15,938	$111.59	$19.29	15%	$10.39	9%	$15.28	12%	$18.82	14%	$18.40	14%	$11.65
28	Sexual Function Disorder	Erectile Dysfunction	15,207	$269.05	$46.89	15%	$37.27	12%	$36.76	12%	$46.74	15%	$45.51	14%	$26.12
29	Proton Pump Inhibitors	Heartburn, Gastrointestinal	14,028	$72.38	$42.61	37%	$33.76	32%	$38.81	35%	$44.46	38%	$42.57	37%	$35.88
30	Anitplatelets	Reduce risk of stroke	13,789	$112.92	$16.11	12%	$8.67	7%	$14.14	11%	$17.02	13%	$15.72	12%	$9.77
31	Statins	Lipid Lowering Agent	13,312	$110.85	$27.57	20%	$18.08	14%	$21.62	16%	$29.10	21%	$28.97	21%	$20.56
32	New Generation Anti-depressant	Depression	13,165	$4.09	$8.59	68%	$5.33	57%	$5.02	55%	$10.35	72%	$8.93	69%	$7.41
33	Anti-depressants	Depression	13,069	$58.23	$14.71	20%	$8.99	13%	$11.38	16%	$14.70	20%	$14.70	20%	$10.28
34	Quinolones	Anti-infectives	12,608	$262.37	$62.01	19%	$41.07	14%	$53.61	17%	$64.37	20%	$66.11	20%	$41.80
35	ACE Inhibitors	Cardiovascular disease	12,488	$5.70	$20.61	78%	$13.03	70%	$17.19	75%	$23.81	81%	$20.45	78%	$12.48
36	Anti-Arthritics	Pain, Inflammation	12,204	$11.13	$41.92	79%	$16.28	59%	$17.85	62%	$49.80	82%	$38.85	78%	$22.07
37	ACE Inhibitors	Cardiovascular disease	11,427	$33.50	$5.52	14%	$3.42	9%	$3.91	10%	$6.31	16%	$6.30	16%	$3.27
38	ACE Inhibitors	Cardiovascular disease	10,703	$44.32	$10.93	20%	$7.22	14%	$9.22	17%	$11.40	20%	$11.75	21%	$7.13
39	Triazoles	Anti-Fungal	10,671	$251.67	$26.01	9%	$8.05	3%	$20.48	8%	$25.33	9%	$26.35	9%	$11.62
40	Angiotensin II Receptor Blockers	High blood pressure	10,578	$43.70	$7.89	15%	$4.44	9%	$5.90	12%	$8.45	16%	$8.70	17%	$4.99
41	ACE Inhibitors	Cardiovascular disease	10,418	$61.41	$10.36	14%	$5.99	9%	$8.53	12%	$11.57	16%	$11.51	16%	$6.68
42	Sulfonylureas	Diabetes	9,958	$51.50	$4.83	9%	$1.96	4%	$2.53	5%	$5.30	9%	$6.17	11%	$1.19

Table 1 – Best Available Price From Any Card Sponsor for Top 150 Drugs (continued)

Drug	Therapeutic Class	Used to Treat	Number of Rx Sold to Patients Over 65	Best Price from Available Cards	IL Savings per Rx		AL Savings per Rx		CA Savings per Rx		FL Savings per Rx		LA Savings per Rx		MI Saving[s per] Rx
					($)	(%)	($)	(%)	($)	(%)	($)	(%)	($)	(%)	($)
43	Calcium Channel Blockers	High blood pressure	9,439	$8.67	$22.40	72%	$12.35	59%	$11.68	57%	$30.01	78%	$25.63	75%	$17.73
44	Cox-2 Inhibitors	Pain, Inflammation	9,210	$78.00	$21.85	22%	$13.04	14%	$21.95	22%	$21.70	22%	$19.20	20%	$14.01
45	Tetracyclines	Anti-infectives	9,147	$8.81	$50.24	85%	$25.94	75%	$32.52	79%	$58.93	87%	$51.14	85%	$27.27
46	Sulfonylureas	Diabetes	8,815	$6.07	$6.87	53%	$4.62	43%	$4.85	44%	$8.47	58%	$8.33	58%	$3.93
47	Gout Specifics	Gout, certain kidney stones	8,507	$5.68	$8.87	61%	$4.21	43%	$5.33	48%	$11.51	67%	$10.11	64%	$5.72
48	Central Act Alone/Comb (alpha agonist)	High blood pressure	8,486	$5.27	$10.27	66%	$7.47	59%	$6.98	57%	$10.88	67%	$10.50	67%	$6.87
49	Angiotensin II Receptor Blockers	High blood pressure	8,280	$40.38	$9.77	19%	$6.25	13%	$8.46	17%	$10.21	20%	$10.30	20%	$6.71
50	Insulin Sensitizers	Diabetes	8,272	$134.53	$33.35	20%	$22.22	14%	$27.96	17%	$35.52	21%	$32.30	19%	$25.33
51	Angiotensin II Receptor Blockers	High blood pressure	8,074	$13.62	$47.03	78%	$43.01	76%	$44.90	77%	$47.79	78%	$47.82	78%	$43.77
52	Insulin Sensitizers	Diabetes	7,916	$73.39	$15.45	17%	$9.58	12%	$12.79	15%	$16.19	18%	$15.56	17%	$10.90
53	Quinolones	Anti-infectives	7,897	$306.98	$52.80	15%	$27.48	8%	$37.51	11%	$50.74	14%	$54.68	15%	$27.69
54	Anti-Psychotics	Phsychiatric Disorders	7,894	$173.63	$42.25	20%	$26.42	13%	$34.60	17%	$39.94	19%	$37.88	18%	$28.55
55	Anticoagulants	Blood Clot prevention	7,827	$21.91	$5.04	19%	$4.06	16%	$4.31	16%	$5.20	19%	$5.87	21%	$3.82
56	ACE Inhibitors	Cardiovascular disease	7,664	$11.40	$20.56	64%	$12.62	53%	$13.51	54%	$23.91	68%	$21.81	66%	$13.04
57	Proton Pump Inhibitors	Heartburn, Gastrointestinal	7,405	$112.30	$28.03	20%	$15.74	12%	$20.35	15%	$28.87	20%	$28.22	20%	$18.26
58	ACE Inhibitors	Cardiovascular disease	7,115	$31.48	$4.62	13%	$2.87	8%	$3.70	11%	$5.64	15%	$6.71	18%	$2.94
59	Benign Prostate Disease	Prostate Disease	7,092	$52.48	$11.79	18%	$7.20	12%	$9.19	15%	$11.82	18%	$11.83	18%	$7.92
60	Aminopenicillins	Anti-infectives	7,057	$10.41	$16.21	61%	$17.19	62%	$21.48	67%	$19.85	66%	$22.36	68%	$15.50
61	Biguanides	Diabetes	7,049	$47.29	$4.30	8%	$0.91	2%	$2.38	5%	$4.99	10%	$5.13	10%	$1.56
62	Inotropics	heart failure, irregular heart rhythms	6,923	$5.55	$3.26	37%	$3.05	35%	$3.09	36%	$3.14	36%	$3.92	41%	$2.58
63	Codeines	Pain	6,889	$216.23	$60.69	22%	$49.29	19%	$54.62	20%	$63.13	23%	$65.54	23%	$48.74
64	Bone Density Reg, Other	Osteoporosis after menopause	6,480	$66.99	$14.46	18%	$9.85	13%	$12.58	16%	$15.20	18%	$15.18	18%	$11.03
65	Angiotensin II Receptor Blockers	High blood pressure	6,265	$40.12	$9.90	20%	$6.60	14%	$8.50	17%	$10.23	20%	$10.33	20%	$7.36
66	Sulfonylureas	Diabetes	6,260	$27.59	$6.25	18%	$4.16	13%	$5.41	16%	$6.68	19%	$6.79	20%	$4.38
67	Bisphosphonates	Osteoporosis	6,218	$58.81	$16.08	21%	$12.87	18%	$14.02	19%	$16.16	22%	$16.43	22%	$12.99
68	Fibric Acid Derivative	Lipid Lowering Agent	6,193	$82.03	$13.07	14%	$6.66	8%	$9.31	10%	$13.97	15%	$13.21	14%	$7.96
69	Diabetes Orals	Diabetes	6,192	$85.61	$10.10	11%	$5.05	6%	$7.73	8%	$11.91	12%	$11.73	12%	$5.25
70	Antibiotics, Macrolide	Anti-infectives	4,868	$208.87	$46.16	18%	$25.88	11%	$39.82	16%	$43.47	17%	$46.31	18%	$24.99
71	Proton Pump Inhibitors	Heartburn, Gastrointestinal	4,844	$106.33	$35.00	25%	$25.87	20%	$33.14	24%	$34.31	24%	$34.40	24%	$27.86
72	Angiotensin II Receptor Blockers	High blood pressure	4,721	$41.04	$10.59	21%	$7.64	16%	$9.37	19%	$11.97	23%	$11.73	22%	$8.59
73	Alpha-Beta Blockers	High blood pressure	4,687	$90.06	$21.16	19%	$14.42	14%	$17.56	16%	$22.16	20%	$20.71	19%	$16.14
74	Sulfonylureas	Diabetes	4,652	$6.69	$11.66	64%	$6.52	49%	$5.84	47%	$14.35	68%	$13.76	67%	$7.30
75	Antispas Urinary Tract	Bladder conditions, overactive bladder	4,640	$84.49	$10.56	11%	$4.23	5%	$7.48	8%	$11.08	12%	$11.08	12%	$5.40
76	Cephalosporins	Anti-infectives	4,616	$227.25	$58.50	20%	$38.92	15%	$43.05	16%	$62.75	22%	$62.56	22%	$39.73
77	Alpha Blockers	High blood pressure	4,557	$11.03	$31.48	74%	$17.68	62%	$18.47	63%	$34.69	76%	$32.34	75%	$17.51
78	Urinary Tract Anti-Infective, Other	Anti-infective for urinary tract	4,541	$111.78	$33.92	23%	$23.42	17%	$27.99	20%	$35.08	24%	$36.96	25%	$22.64
79	Cholesterol Absorption Inhibitors	Lipid Lowering Agent	4,365	$70.13	$7.32	9%	$1.68	2%	$4.58	6%	$8.00	10%	$7.79	10%	$2.96
80	ACE Inhibitors	Cardiovascular disease	4,322	$36.57	$5.18	12%	$3.07	8%	$3.25	8%	$6.25	15%	$6.43	15%	$3.03
81	Alzheimer's Disease	Alzheimer's Disease	3,482	$131.88	$20.02	13%	$11.57	8%	$17.13	11%	$20.02	13%	$18.24	12%	$12.61
82	Antispas Urinary Tract	Bladder conditions, overactive bladder	3,288	$81.66	$15.69	16%	$9.50	10%	$12.62	13%	$15.42	16%	$15.16	16%	$10.57
83	Anti-Neoplasmic Anti-Estrogens	Breast Cancer	3,111	$40.81	$70.94	63%	$47.77	54%	$54.51	57%	$77.43	65%	$76.13	65%	$56.62
84	Folic Acid Analog	Certain types of cancer, severe psoriasis or	3,109	$40.41	$47.56	54%	$11.89	23%	$13.41	25%	$55.39	58%	$45.82	53%	$22.54

Table 1 – Best Available Price From Any Card Sponsor for Top 150 Drugs (continued)

Drug	Therapeutic Class	Used to Treat	Number of Rx Sold to Patients Over 65	Best Price from Available Cards	IL Savings per Rx		AL Savings per Rx		CA Savings per Rx		FL Savings per Rx		LA Savings per Rx		MI Savin[g] Rx
					($)	(%)	($)	(%)	($)	(%)	($)	(%)	($)	(%)	($)
85	Tetracyclines	Anti-infectives	3,045	$5.30	$6.58	55%	$5.16	49%	$6.62	56%	$8.37	61%	$9.20	63%	$6.03
86	Anti-Arthritics	Pain, Inflammation	2,880	$74.68	$11.21	13%	$5.35	7%	$9.32	11%	$11.76	14%	$10.55	12%	$5.44
87	Quinolones	Anti-infectives	2,869	$253.85	$58.25	19%	$31.87	11%	$41.46	14%	$58.95	19%	$58.94	19%	$32.90
88	Angiotensin II Receptor Blockers	High blood pressure	2,767	$34.18	$14.19	29%	$10.86	24%	$12.92	27%	$14.51	30%	$14.88	30%	$11.80
89	Antibiotics, Macrolide	Anti-infectives	2,728	$228.24	$47.08	17%	$28.56	11%	$35.66	14%	$50.23	18%	$53.62	19%	$29.32
90	Inotropics	heart failure, irregular heart rhythms	2,598	$3.23	$4.69	59%	$5.47	63%	$5.39	63%	$5.62	64%	$7.42	70%	$4.52
91	Angiotensin II Receptor Blockers	High blood pressure	2,482	$49.95	$14.20	22%	$9.95	17%	$12.09	19%	$15.85	24%	$14.60	23%	$10.73
92	Allylamines	Anti-Fungal	2,413	$258.57	$55.82	18%	$16.65	6%	$39.45	13%	$61.03	19%	$38.70	13%	$22.02
93	Benign Prostate Disease	Prostate Disease	2,374	$71.08	$14.61	17%	$8.62	11%	$11.75	14%	$14.06	17%	$14.54	17%	$9.90
94	Gout Specifics	Gout, certain kidney stones	2,254	$7.07	$10.09	59%	$9.56	57%	$9.99	59%	$10.62	60%	$12.10	63%	$9.57
95	Calcium Channel Blockers	High blood pressure	2,184	$57.05	$7.49	12%	$3.13	5%	$2.66	4%	$7.67	12%	$7.67	12%	$4.14
96	Quinolones	Anti-infectives	2,180	$256.40	$47.84	16%	$18.99	7%	$31.41	11%	$50.62	16%	$43.01	14%	$19.15
97	Angiotensin II Receptor Blockers	High blood pressure	2,097	$38.52	$6.02	14%	$2.90	7%	$4.46	10%	$6.41	14%	$6.02	14%	$3.26
98	H2 Antagonists	Heartburn, Gastrointestinal	1,748	$11.38	$120.52	91%	$111.90	91%	$114.47	91%	$119.55	91%	$118.33	91%	$111.23
99	Increased B-Lactam Act	Anti-infectives	1,686	$296.47	$60.02	17%	$28.41	9%	$40.92	12%	$53.80	15%	$52.47	15%	$35.22
100	Biguanides	Diabetes	1,680	$33.01	$44.44	57%	$39.54	54%	$44.73	58%	$45.65	58%	$45.40	58%	$39.56
101	ACE Inhibitors	Cardiovascular disease	1,445	$18.08	$19.61	52%	$16.80	48%	$17.91	50%	$19.49	52%	$20.87	54%	$17.51
102	Hemostatics, Other Oral	Improve Blood Circulation	1,417	$56.42	$56.33	50%	$50.21	47%	$53.99	49%	$56.65	50%	$55.76	50%	$50.54
103	Anti-depressants	Depression	1,404	$37.00	$185.00	83%	$166.85	82%	$173.74	82%	$184.80	83%	$181.78	83%	$171.51
104	Anti-Virals	Viral Infections	1,263	$437.55	$70.09	14%	$25.89	6%	$35.71	8%	$67.36	13%	$62.26	12%	$32.03
105	Quinolones	Anti-infectives	1,137	$216.12	$71.78	25%	$46.38	18%	$61.52	22%	$69.97	24%	$69.38	24%	$46.09
106	Diuretics	High blood pressure, CHF	1,126	$1.75	$9.76	85%	$9.44	84%	$10.00	85%	$9.73	85%	$10.44	86%	$8.95
107	Benzodiazepines	Anxiety	1,116	$106.83	$22.30	17%	$11.19	9%	$18.04	14%	$22.11	17%	$21.57	17%	$11.44
108	Alzheimer's Disease	Alzheimer's Disease	1,100	$133.87	$23.87	15%	$16.38	11%	$22.25	14%	$24.89	16%	$22.76	15%	$17.96
109	Anti-Parkinson Other	Parkinson's Disease	1,092	$70.28	$9.22	12%	$4.98	7%	$7.51	10%	$10.02	12%	$9.77	12%	$5.75
110	Calcium Channel Blockers	High blood pressure	1,048	$64.51	$11.39	15%	$6.64	9%	$9.20	12%	$11.51	15%	$10.28	14%	$7.27
111	Diabetes Orals	Diabetes	950	$126.84	$34.15	21%	$20.92	14%	$27.18	18%	$34.28	21%	$31.50	20%	$25.69
112	Alzheimer's Disease	Alzheimer's Disease	848	$128.16	$29.56	19%	$21.64	14%	$27.01	17%	$28.25	18%	$26.48	17%	$21.36
113	Muscle Relaxant w/o Analg	Muscle Spasms	803	$63.35	$24.42	28%	$14.32	18%	$18.06	22%	$22.80	26%	$23.96	27%	$13.12
114	Diuetics	High blood pressure, CHF	799	$10.53	$8.49	45%	$7.30	41%	$8.40	44%	$8.77	45%	$9.16	47%	$7.04
115	ACE Inhibitors	Cardiovascular disease	762	$25.68	$11.48	31%	$8.52	25%	$9.42	27%	$11.25	30%	$11.48	31%	$8.47
116	Calcium Channel Blockers	High blood pressure	740	$45.23	$4.65	9%	$2.00	4%	$3.22	7%	$4.21	9%	$3.85	8%	$1.82
117	Calcium Channel Blockers	High blood pressure	739	$41.79	$3.53	8%	$3.21	7%	$3.13	7%	$5.18	11%	$5.56	12%	$3.62
118	Syn Non-narcotic non-injectable	Pain	732	$35.63	$105.37	75%	$94.89	73%	$103.11	74%	$104.72	75%	$104.13	75%	$96.07
*119	Propoxyphenes	Pain	716	$15.30	$115.90	88%	$107.15	88%	$113.31	88%	$114.93	88%	$115.03	88%	$102.99
120	Benzodiazepines	Anxiety	596	$71.14	$7.03	9%	$1.26	2%	$4.93	6%	$7.55	10%	$6.10	8%	$0.05
*121	Codeines	Pain	567	$18.88	$198.87	91%	$181.74	91%	$184.58	91%	$200.50	91%	$200.93	91%	$182.34
*122	Beta Blockers	High blood pressure	562	$3.66	$38.90	91%	$35.76	91%	$37.14	91%	$38.62	91%	$38.89	91%	$36.02
123	Calcium Channel Blockers	High blood pressure	555	$38.30	$10.83	22%	$8.52	18%	$9.84	20%	$11.55	23%	$12.16	24%	$8.67
124	Seizure Treatments	Seizure Disorders	502	$56.90	$11.95	17%	$6.45	10%	$7.64	12%	$9.45	14%	$9.85	15%	$7.00
125	ACE Inhibitors	Cardiovascular disease	495	$17.68	$28.12	61%	$24.55	58%	$26.35	60%	$28.31	62%	$27.45	61%	$24.86
126	Beta Blockers	High blood pressure	482	$5.22	$56.79	92%	$52.98	91%	$54.65	91%	$57.15	92%	$57.21	92%	$52.86

Table 1 – Best Available Price From Any Card Sponsor for Top 150 Drugs (continued)

Drug	Therapeutic Class	Used to Treat	Number of Rx Sold to Patients Over 65	Best Price from Available Cards	IL Savings per Rx ($)	IL Savings per Rx (%)	AL Savings per Rx ($)	AL Savings per Rx (%)	CA Savings per Rx ($)	CA Savings per Rx (%)	FL Savings per Rx ($)	FL Savings per Rx (%)	LA Savings per Rx ($)	LA Savings per Rx (%)	MI Saving Rx ($)
127	Alpha Blockers	High blood pressure	460	$19.63	$19.63	50%	$17.46	47%	$17.72	47%	$20.33	51%	$20.01	50%	$16.68
128	Statins	Lipid Lowering Agent	416	$57.31	$27.17	32%	$19.34	25%	$22.68	28%	$27.58	32%	$25.18	31%	$20.71
129	Cephalosporins	Anti-infectives	401	$317.00	$39.11	11%	$2.17	1%	$15.65	5%	$37.51	11%	$27.72	8%	$10.39
130	ACE Inhibitors	Cardiovascular disease	385	$17.47	$20.69	54%	$18.93	52%	$19.23	52%	$20.51	54%	$20.87	54%	$17.60
131	Beta/Alpha-Beta Blockers/Diuretic	High blood pressure	379	$25.75	$19.26	43%	$15.58	38%	$16.78	39%	$20.27	44%	$18.23	41%	$16.47
*132	Anti-Nausea Apti-Dopa Pheno	Nausea, vomiting	372	$26.94	$42.31	61%	$36.18	57%	$40.09	60%	$46.64	63%	$54.49	67%	$27.10
133	Nitrites	Cardiovascular disease	325	$45.95	$18.10	28%	$14.23	24%	$13.76	23%	$18.44	29%	$16.79	27%	$13.84
134	Calcium Channel Blockers	High blood pressure	288	$14.05	$50.96	78%	$47.09	77%	$48.31	77%	$50.58	78%	$50.58	78%	$47.08
135	Alpha Blockers	High blood pressure	282	$47.24	$18.32	28%	$14.85	24%	$15.63	25%	$19.55	29%	$19.13	29%	$15.00
*136	Codeines	Pain	282	$25.58	$56.65	69%	$51.36	67%	$55.37	68%	$59.00	70%	$59.10	70%	$43.02
*137	H2 Antagonists	Heartburn, Gastrointestinal	270	$38.26	$88.53	70%	$79.73	68%	$86.52	69%	$90.45	70%	$85.34	69%	$82.92
*138	ACE Inhibitors	Cardiovascular disease	235	$21.95	$21.61	50%	$18.53	46%	$19.24	47%	$22.33	50%	$21.72	50%	$18.26
*139	Anti-Arthritics	Pain, Inflammation	222	$10.59	$35.23	77%	$27.95	73%	$39.83	79%	$34.63	77%	$33.44	76%	$30.93
*140	Diuetics	High blood pressure, CHF	158	$2.46	$40.99	94%	$38.26	94%	$38.72	94%	$40.47	94%	$40.93	94%	$37.11
*141	Sulfnmd&trimeth w/ cmb	Anti-infectives	149	$12.04	$87.49	88%	$69.12	85%	$84.06	87%	$85.89	88%	$63.85	84%	$74.27
142	Anti-Parkinson L-Dopa	Parkinson's Disease	147	$141.65	$43.18	23%	$35.32	20%	$37.08	21%	$39.45	22%	$44.18	24%	$34.28
*143	Statins	Lipid Lowering Agent	143	$38.46	$42.44	52%	$36.80	49%	$37.77	50%	$42.12	52%	$39.02	50%	$38.29
*144	Anti-Parkinson L-Dopa	Parkinson's Disease	95	$54.46	$64.16	54%	$59.04	52%	$58.54	52%	$61.18	53%	$60.35	53%	$56.13
*145	Cephalosporins	Anti-infectives	89	$41.01	$282.22	87%	$256.71	86%	$262.21	86%	$289.70	88%	$282.90	87%	$252.99
*146	Anti-Arthritics	Pain, Inflammation	69	$11.83	$99.36	89%	$93.28	89%	$95.94	89%	$102.19	90%	$102.88	90%	$92.21
*147	Anti-Nausea Anti-Histamine	Motion Sickness symptoms	67	$7.45	$66.06	90%	$61.24	89%	$67.20	90%	$67.02	90%	$66.38	90%	$59.27
148	Sexual Function Disorder	Erectile Dysfunction	50	$251.70	$107.61	30%	$45.12	15%	$47.46	16%	$74.77	23%	$49.66	16%	$68.59
*149	Sulfnmd&trimeth w/ cmb	Anti-infectives	47	$12.04	$117.79	91%	$107.39	90%	$106.89	90%	$121.87	91%	$116.66	91%	$101.69
150	Anti-Arthritics	Pain, Inflammation	21	$86.24	$25.54	23%	$7.51	8%	$17.68	17%	$27.57	24%	$21.95	20%	$18.67
151	Alzheimer's Disease	Alzheimer's Disease	1	$118.29	$6.44	5%	$6.44	5%	$7.71	6%	$66.90	36%	($56.56)	-92%	$7.71
				Weighted Savings Per Prescription	$20.56	25%	$13.37	18%	$16.09	21%	$21.86	27%	$21.04	26%	$14.13

Note: Drugs marked with an asterisk indicate a possible data problems with prices posted on the CMS website.

Table 2 – Savings for Best Cards, Top 25 Drugs

Drug	Therapeutic Class	Used to Treat	Total Number of Prescriptions for Over-65 Population	Weight	Illinois Retail Price	Card 1	Card 2	Card 3	Median Card
1	Statins	Lipid Lowering Agent	57,170	8.8%	$75.22	$67.71	$66.97	$67.07	$70.94
2	Thyroid Synthetics	Thyroid conditions	42,162	6.5%	$16.22	$15.51	$14.40	$14.93	$16.31
3	Beta Blockers	High blood pressure	39,411	6.1%	$15.52	$4.97	$3.48	$4.95	$6.16
4	ACE Inhibitors	Cardiovascular disease	35,339	5.4%	$25.19	$7.36	$16.00	$15.83	$21.41
5	Thiazides	High blood pressure	33,850	5.2%	$6.22	$3.98	$2.77	$4.36	$6.72
6	Diuretics	High blood pressure, CHF	33,746	5.2%	$6.37	$4.77	$2.08	$3.98	$5.30
7	Calcium Channel Blockers	High blood pressure	29,978	4.6%	$48.32	$44.28	$42.99	$43.60	$46.61
8	Anti-depressants	Depression	27,801	4.3%	$84.97	$74.99	$69.99	$74.36	$78.50
9	Beta Blockers	High blood pressure	25,266	3.9%	$26.15	$21.39	$19.60	$20.92	$22.69
10	Statins	Lipid Lowering Agent	24,035	3.7%	$140.73	$102.42	$101.42	$103.25	$116.95
11	Cephalosporins	Anti-infectives	23,750	3.7%	$95.97	$24.49	$35.97	$57.35	$43.51
12	Proton Pump Inhibitors	Heartburn, Gastrointestinal	23,383	3.6%	$146.35	$110.03	$110.86	$114.20	$130.43
13	Estrogens Oral	Menopause symptoms	22,056	3.4%	$30.61	$25.79	$29.40	$25.30	$26.96
14	Corticoids	Anti-inflammatory	21,411	3.3%	$12.73	$6.29	$7.78	$5.44	$7.26
15	Biguanides	Diabetes	21,321	3.3%	$38.96	$17.74	$17.99	$18.76	$24.84
16	Thyroid Synthetics	Thyroid conditions	21,282	3.3%	$13.53	$11.14	$12.30	$3.65	$10.30
17	Sedating Non-Benzodiazepine, Other	Insomnia	21,225	3.3%	$91.78	$82.86	$79.65	$81.63	$83.61
18	Anti-Histamines	Allergy	19,519	3.0%	$77.78	$59.98	$63.89	$60.68	$60.73
19	Cox-2 Inhibitors	Pain, Inflammation	19,516	3.0%	$90.93	$81.04	$76.79	$80.42	$84.78
20	Proton Pump Inhibitors	Heartburn, Gastrointestinal	18,692	2.9%	$143.12	$106.45	$98.99	$107.30	$110.32
21	Beta Blockers	High blood pressure	18,465	2.8%	$12.15	$5.35	$4.98	$5.13	$5.61
22	Bisphosphonates	Osteoporosis	17,505	2.7%	$71.89	$63.50	$57.43	$63.60	$68.06
23	Anti-Histamines	Allergy	17,241	2.7%	$68.38	$58.04	$61.99	$57.38	$60.90
24	Leukotriene Agents	Asthma	17,227	2.7%	$95.72	$77.68	$83.21	$77.97	$82.57
25	Cox-2 Inhibitors	Pain, Inflammation	17,093	2.6%	$93.44	$78.36	$77.70	$78.65	$83.40
			648,444	100.0%					
	Weighted Average Cost Per Prescription				$56.07	$42.49	$42.55	$43.87	$47.14
	Weighted Average Savings Per Prescription					-$13.58	-$13.52	-$12.20	-$8.93
	Weighted Percent Savings Per Prescription					24.2%	24.1%	21.8%	15.9%

Note: Savings shown are for Illinois, based on data collected May 12 in zip code 60619.

Table 3 – Savings for Low Income Beneficiaries Eligible for $600 Credit, by Disease

		Brand / Generic	Annual Cost Without Discount	Savings with Card ($)	Savings with Card and Credit ($)	Savings with Card (%)	Savings with Card and Credit (%)
Diabetes Combination Therapy I			3,099.23	753.59	1,353.59	24%	44%
Drug A	Sulfonylurea	G					
Drug B	Biguanides	B					
Drug C	Insulin Sensitizers	B					
Diabetes Combination Therapy II			2,209.48	468.53	1,068.53	21%	48%
Drug D	Biguanides	G					
Drug E	Sulfonylurea	B					
Drug F	Insulin Sensitizers	B					
Diabetes with Hyperlipidemia I			3,846.63	825.87	1,425.87	21%	37%
Drug B	Biguanides	B					
Drug C	Insulin Sensitizers	B					
Drug G	HMG-CoA Reductase Inhibitor	B					
Diabetes with Hyperlipidemia II			3,430.75	696.55	1,296.55	20%	38%
Drug E	Sulfonylurea	B					
Drug F	Insulin Sensitizers	B					
Drug H	HMG-CoA Reductase Inhibitor	B					
Diabetes and Hypertension			2,646.56	332.24	932.24	13%	35%
Drug R	ACE Inhibitors	B					
Drug F	Insulin Sensitizers	B					
Drug G	HMG-CoA Reductase Inhibitor	B					
Hypertension Combination Therapy			956.78	243.50	843.50	25%	88%
Drug M	Calcium Blocker	B					
Drug N	ACE Inhibitor	G					
Drug O	Thiazides	G					
Congestive Heart Failure, Hypertension			1,788.46	511.42	1,111.42	29%	62%
Drug O	ACE Inhibitors	G					
Drug P	Alpha-Beta Blockers	B					
Drug Q	Diuretics	B					
Known Coronary Artery Disease			2,637.83	505.91	1,105.91	19%	42%
Drug T	Beta Blockers	B					
Drug R	ACE Inhibitors	B					
Drug U	HMG-CoA Reductase Inhibitor	B					
History of Atrial Fibrillation			429.21	99.69	396.26	23%	92%
Drug V	Inotropics	B					
Drug W	Anticoagulant	B					
Osteoporosis, Osteoarthritis, and Chronic Allergies			3,001.98	509.82	1,109.82	17%	37%
Drug I	Anti-Histamines	B					
Drug J	Cox-2 Inhibitors	B					
Drug K	Bone Density Reg, Other	B					
Multiple Chronic Conditions			5,948.06	1107.14	1,707.14	19%	29%
Drug X	Cox-2 Inhibitors	B					
Drug Y	Bone Density Reg, Other	B					
Drug Z	Proton Pump Inhibitors	B					
Drug AA	Leukotriene Agents	B					
Drug BB	Anti-depressants	B					
Drug CC	Beta Blockers	G					

Note: Preliminary estimates based on savings in Illinois.

A Special Program From Merck & Co., Inc. ("Merck") for Medicare Beneficiaries Receiving Transitional Assistance in the Medicare Discount Card Program

May 2004

About the Special Discount Card Program From Merck

Merck has announced that it will provide its medicines free of charge for low-income Medicare beneficiaries with participating Medicare-endorsed drug discount cards when those beneficiaries have exhausted their $600 annual federal transitional assistance allowance.

Under the Medicare-endorsed drug discount card program, beginning June 1, 2004, Medicare beneficiaries with incomes below $12,569 per year for an individual and $16,862 for a couple are eligible to receive a $600 federal transitional assistance allowance to help cover the cost of medicines purchased with the discount card.

For Medicare beneficiaries enrolled in a participating discount card plan who have exhausted their $600 annual federal transitional assistance allowance, Merck will provide its medicines free of charge to their discount card plan. (The pharmacy may charge a fee consistent with its contractual arrangements with the discount card sponsor. However, Merck will receive no portion of any such fee.) Medicare beneficiaries may also be eligible for this offer if they are enrolled in a participating Medicare health plan (Medicare Plus Choice or Medicare Advantage) and have exhausted their $600 in transitional assistance and any drug coverage provided by their Medicare health plan.

All medicines from Merck will be offered under the special program.* These medicines cover a wide range of therapeutic categories, including cardiovascular disease, osteoporosis, high blood pressure, and arthritis and pain. Only a physician can determine whether a particular medicine is appropriate for an individual Medicare beneficiary. Please note that not all Medicare-endorsed discount card plans will be participating in the Merck program. This program will be available only to beneficiaries whose discount card plan is participating.

For details and additional information, please see the reverse side.

*Excluding vaccines, injectible products, and products from Merck/Schering-Plough.

How Do Medicare Beneficiaries Qualify?

Medicare beneficiaries do not have to apply for the special program from Merck. To automatically qualify, they must simply meet these criteria:

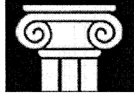
- They must be enrolled in a discount card plan that participates in the special Merck program.
- They must be eligible for and receive federal transitional assistance under the Medicare discount card program.
- They must have exhausted their $600 federal transitional assistance allowance for the year (this can be used for any eligible drugs, not just medicines from Merck).
- If they are enrolled in a participating Medicare health plan, they must also have exhausted any coverage provided under that plan.

Medicare beneficiaries will not have to keep track of their own spending. Participating card sponsors will maintain records of Medicare beneficiaries' spending on medicines that they purchase with the card. Once the $600 transitional allowance is depleted, Merck will provide the medicine to the card sponsor free of charge. Medicare beneficiaries will be responsible only for the pharmacy fees as negotiated by their card sponsor. Participating card sponsors will be responsible for administering the Merck program.

For More Information About the Program and Participating Card Sponsors

We anticipate that nearly all Medicare card sponsors will participate in the Merck program, but some will not be participating. Please contact card sponsors directly to determine if they are participating in this program.

For general information about the Medicare discount card program, transitional assistance eligibility, and Medicare-endorsed card sponsors, please call 1-800-MEDICARE or visit www.medicare.gov.



National Committee to Preserve
Social Security and Medicare

Barbara B. Kennelly, President and CEO
Max Richtman, Executive Vice President

"Mr. Chairman, we believe the problems evident in the discount card program have provided Congress with a unique opportunity to correct the flaws in the new Medicare bill before it goes into effect." Barbara B. Kennelly

STATEMENT FOR THE RECORD
SENATE FINANCE COMMITTEE
MEDICARE DRUG CARD: DELIVERING SAVINGS FOR PARTICIPATING BENEFICIARIES
JUNE 8, 2004

Mr. Chairman and Members of the Committee:

On behalf of the 3.2 million members and supporters of the National Committee to Preserve Social Security and Medicare, we applaud Chairman Grassley and Senator Baucus for holding this hearing today. **We have discovered through many meetings with seniors around the country that they remain confused and skeptical about the new discount card program.** This is unfortunate, because there are some seniors – particularly those who qualify for the low-income benefit – who will clearly benefit from the new discount cards. In our written materials and many meetings, we have urged seniors everywhere to research the cards and determine whether they will benefit from them. We welcome hearings such as this, because we believe they can provide critical information to millions of seniors struggling to understand the new benefit.

Unfortunately, we believe most of the problems with the new cards are inherent in the design of the program and cannot be corrected by the end of 2005. **More importantly, we believe the discount cards are a metaphor for the entire new Medicare law.** Unless the law is re-written, the same fundamental flaws that have made the discount cards so frustrating to seniors today will make the new drug benefit equally disappointing when it becomes effective in 2006, and could undermine public support for the entire Medicare program.

The National Committee to Preserve Social Security and Medicare spent the last six years advocating for a comprehensive, affordable prescription drug benefit offered through the Medicare program, because that is what our seniors have been telling us they need and we believe they deserve. **If Congress had worked directly through Medicare** rather than a system of private providers to provide both the temporary discount card and the permanent drug benefit, **it could have taken advantage of the universal, consistent, inexpensive delivery system that is already inherent in the Medicare program. The result would have been a simple, meaningful benefit to seniors.**

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Unfortunately, that is not what has been implemented through P.L. 108-173. We understand that the wide variety of discount card providers was intended as a service to seniors, to give them the broadest array of card choices. But instead of providing a benefit to seniors, the multitude of options has proved to be extremely confusing, particularly with so few seniors comfortable using the Internet. Allowing sponsors of the cards to change both the drugs covered and the discounts on the drugs weekly was intended to encourage competition between providers, further lowering prices. But experience to date has shown the listed prices can go up as well as down, and even those seniors who research the cards carefully cannot be certain they will end up with the best deal. Meanwhile, **because seniors are only allowed to have one Medicare-approved card at a time, and they are locked into their chosen card until the end of the year, they worry about being forced to stay with a plan that ultimately does not provide them with significant benefits.** This worry can result in paralysis, with seniors preferring not to purchase a card at all rather than risk buying one that does not serve their needs.

This problem will be exacerbated when the permanent benefit begins. We do not know today how many companies will opt to provide the permanent prescription drug benefit in 2006, so it is not clear whether seniors will be faced with a choice between as many providers. Even if the number of options is smaller, however, their choices will be even more complicated than with the discount card. Not only will they be confronted with a confusing array of multiple providers covering different drugs at a variety of prices, in some cases they will also be faced with choosing between managed care companies with completely different menus of standard health services as well.

If they choose wrong in the case of the discount card, their only loss is the price of the card and whatever discounts they might have received with a different card. **But if they pick a health care provider that does not serve their needs once the permanent benefit begins, the financial consequences could be catastrophic**. And unlike the discount card, where taking time to make the right choice does not have adverse consequences, seniors delaying enrollment in the permanent benefit could pay increased premiums for the rest of their lives.

But the most significant problem with the new Medicare law, Mr. Chairman, **is the lack of cost containment.** As you know, most seniors are on relatively fixed incomes, dependent upon Social Security for a significant portion of their income in retirement. They are extremely sensitive to price increases because they rarely have a cushion of disposable income to protect them from the ravages of inflation. They are well aware of the skyrocketing increases in prescription drug costs that have been confirmed in two recent studies. Families USA found prices of the 30 most popular drugs used by seniors increased at four times the rate of general inflation during 2003, and AARP found a 28% increase in a broader list of drugs from 2000 to 2003. Small wonder that seniors are less than impressed by a discount card program that offers reductions of 10 to 25 percent.

CMS has said it intends to monitor the cards to make sure senior discounts are not based on artificially inflated prices, but without a clear definition of what is an acceptable price increase, and considering the issues of artificially inflated prices represented by Average Wholesale Prices, protecting seniors will not be easy. And we are not aware of any federal agency investigating the significant increases prescription drug prices have experienced in recent years, to determine whether those increases were warranted in the first place.

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If the new prescription drug benefit is offered through Medicare, the purchasing power of its 41 million seniors can be harnessed to negotiate for the lowest possible prices, with all the savings passed along directly to seniors. But without effective cost containment, the new prescription drug benefit could well turn out to be an illusion for many seniors, offering limited federal assistance in paying for drugs whose cost keeps skyrocketing unchecked, much as the discount card program appears to many seniors today. And unfortunately, **the drug benefit that looks meager today will only become worse with time.** According to Medicare's own Trustees, **within a few short years seniors will need to have over $8,580 in covered drug costs to trigger the catastrophic coverage.** At that point, seniors will be paying over $6,000 in out-of-pocket costs, in addition to an estimated $730 in annual premiums, and only $2,500 will be picked-up by Medicare.

Many in Congress, including you, Mr. Chairman, have acknowledged the lack of cost containment in the new prescription drug program by advocating for reimportation of drugs from Canada and other countries. **While the National Committee supports reimportation, we believe any relief it offers will be temporary**.

Mr. Chairman, we believe the problems evident in the discount card program have provided Congress with a unique opportunity to correct the flaws in the new Medicare bill before it goes into effect. We urge you to revisit the program while there is still time to make the fundamental changes that will be needed to provide seniors with the kind of access to affordable drugs that they truly require. We look forward to working with you toward this goal as the process continues.

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