S. HRG. 100-479

COVERAGE OF PRESCRIPTION DRUGS UNDER MEDICARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

JUNE 18, 1987

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COVERAGE OF PRESCRIPTION DRUGS UNDER MEDICARE

THURSDAY, JUNE 18, 1987

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

The subcommittee met, pursuant to notice, at 9 a.m. in room SD-215, Dirksen Senate Office Building, the Honorable George Mitchell, chairman, presiding.

Present: Senators Bentsen, Mitchell, Baucus, Pryor, Rockefeller, Chafee, Heinz, and Durenberger.

[The press release announcing the hearing and the prepared statements of Senators Mitchell, Moynihan, Pryor and Chafee follow:]

[Press Release No. H-53, June 11, 1987]

FINANCE SUBCOMMITTEE ON HEALTH TO HOLD HEARINGS ON COVERAGE OF PRESCRIPTION DRUGS AND MENTAL HEALTH SERVICES UNDER MEDICARE

WASHINGTON, DC.—Senator George J. Mitchell (D., Maine), Chairman, announced Thursday that the Subcommittee on Health of the Senate Finance Committee will hold hearings on coverage of prescription drugs and coverage of mental health services under the Medicare program. Chairman Mitchell stated that the purpose of the hearings is to examine the feasibility of various options for including coverage of these items and services under Medicare.

The principles to be examined with respect to prescription drug coverage include the nature of the coverage (catastrophic or basic), the scope of the coverage (including any limits on the types of drugs that might be covered), the use of deductibles, coinsurance, and other cost sharing, the administration of the benefit, reimbursement, quality assurance, cost and utilization control, and the financing of the benefit.

The principles to be examined with respect to mental health services include the nature of any changes in coverage (catastrophic or basic), changes in the types of services that are subject to the current coverage limits, and the financing of any benefit expansion.

The hearings will be held on Thursday, June 18, 1987 in Room SD-215 of the Dirksen Senate Office Building. The hearing on coverage of prescription drugs will begin at 9:00 a.m., and the hearing on mental health services will begin at 11:00 a.m.

OPENING STATEMENT OF SEN GEORGE J. MITCHELL

SUBCOMMITTEE ON HEALTH

SENATE FINANCE COMMITTEE

HEARING ON MEDICARE PRESCRIPTION DRUG BENEFIT

JUNE 18, 1987

Welcome to this hearing of the Health subcommittee of the Senate Finance Committee. Our purpose today is to receive testimony related to catastrophic out of pocket expenses of the elderly that result from payment for prescription drugs.

The Senate Finance Committee, by a 19 to 0 vote, reported to the Senate a bill that is designed to reduce catastrophic out of pocket costs resulting from acute illness. Even in its present form, the bill represents one of the most important changes in Medicare since its inception over 20 years ago. However if Medicare is to serve as a comprehensive insurance program for older Americans, there are still some major gaps that must be closed. The cost of prescription drugs is one such gap.

For those older persons with out of pocket costs between $500 and $2000 per year, acute hospital expenses account for about 15% of total out of pocket expenses. By comparison the cost of prescription drugs account for over 25% and co-insurance and balance billing for physician services account for nearly 40% of the total. As I have repeatedly noted in the past, for those with out of pocket expenses exceeding $2000 per year, the major category, accounting for over 80% of the total, is the expense associated with long term care.

Thus, if one defines catastrophic medical care costs as out of pocket expenses which exceed 20% of income, the majority of the problem with prescription drugs falls on those with incomes below $10,000 per year. While all but two states cover, through their Medicaid programs, the cost of prescription drugs, differing eligibility requirements result in coverage for less than two-thirds of the elderly poor. Private insurance coverage for prescription drugs is not widespread and its cost may be too high for those in low income groups.

- more -

While such statistics are important in defining the problem, they do not make clear the actual burden imposed on those low income elderly who require high cost prescription drugs. A significant number of such persons are reported to go without needed medications because of their inability to pay for the prescription. Others are forced to choose between prescription drugs and essential food or shelter.

While the need is apparent, the solution is not. In 1972, the Senate Finance Committee, under the leadership of Sen Long, reported out of committee a provision creating a Medicare prescription drug benefit. The proposed benefit was not very different from those that have been advanced by members of the 100th Congress. The provision was not adopted largely because of concerns about how to control the utilization and costs of such a benefit. These concerns still exist, along with those about how to provide equitable but cost effective reimbursement for the pharmacist or pharmaceutical manufacturer, and those about the complexity of administration of such a benefit.

Our major task today is not to determine that a need exists for a drug benefit. The need is there; it has been well described in previous hearings before this and other Congressional committees. Rather our purpose is to gain information that may allow us to establish a benefit that meets the need of those who suffer the greatest burden, does not retard the development of new discoveries in the field, and does not further accelerate the rate of increase of drug costs. This is indeed a major task, but one which we must accomplish if we are to legislate responsibly.

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STATEMENT BY DANIEL PATRICK MOYNIHAN ON INCLUSION OF AZT IN DRUG BENEFIT PROVIDED IN CATASTROPHIC INSURANCE BILL

Mr. Chairman:

I am pleased to comment today on the feasability of including a drug benefit in S. 1127, a catastrophic insurance bill. Such a provision is no doubt necessary -- the costs of prescription drugs can often be the source of impoverishment for Medicare recipients, second only to hospitalization costs. But we are here today to decide this, to decide in what way we will finance this provision and which types of drugs should be included therein.

One of the drugs which should not be overlooked is AZT. Although we normally view catastrophic illness as one which afflicts the elderly, AIDS is one catastrophic illness that is robbing many Americans of the most productive years of their lives. Although AZT cannot speed recovery from AIDS, it can, like many other prescription drugs, prolong an individual's life. It is my earnest hope that AZT be included in any prescription drug provision which is incorporated into this catastrophic healthcare insurance bill.

But my colleagues may wonder how AIDS patients, usually recipients of Medicaid, will qualify for Medicare coverage. Futhermore, whether in fact they should qualify for such coverage.

On the first day of the 100th Congress, I introduced a bill to facilitate the availability of Medicare coverage on the

basis of a disability for those affected with AIDS. Currently, there is a 24-month waiting period for disabled individuals before receiving Medicare benefits. This waiting period was established to ensure that only those who were truly disabled, enough so that they recevie benefits for a full 2 years, would be eligible for additional health care coverage.

The AIDS patient simply cannot wait 24 months to receive thsi coverage. The average life expectancy of an AIDS patients, from the date of diagnosis, is between 11.2 and 13 months. Sadly enough, there is no hope that AIDS patients will overcome their disability, hence there is no reason to delay granting them Medicare coverage. These individuals have worked and contributed to society -- by removing the current waiting period for Medicare coverage, we are simply giving AIDS patients the health care coverage they have earned and are in need of right now.

Some may say that we need not incorporate AZT into a prescription drug provision because the Medicaid system covers the cost of the drug. Well, this drug costs $10,000 per year per pateint. Just recently the Senate allocated an emergency fund of $30 million for AZT so that those patients currently enrolled in clinical trials of the drug could receive it even after those trials have ended. But this is only a one-time allocation. What are we to do after this money runs out? We must provide some longer term coverage of this drug and if we will have Medicare pay for prescription drugs for all other catastrophic illnesses, we should have it pay for this one.

OPENING STATEMENT

HONORABLE DAVID PRYOR

MEDICARE COVERAGE OF PRESCRIPTION DRUGS AND MENTAL HEALTH CARE

June 18, 1987

Mr. Chairman, I'd like to commend you for the scheduling of hearings today to examine prescription drug and mental health care coverage under the Medicare program. Although this Committee has completed its formal action on a catastrophic health care package, there are a number of outstanding issues which we agreed to examine prior to floor consideration of the package. Among these issues are the mental health care benefit under Medicare and prescription drug coverage.

Clearly both of these issues deserve our close scrutiny. The mental health care benefit under Medicare has remained the same since 1965. Several of my colleagues on this committee are to be commended for their efforts to encourage reexamination of this benefit in the context of catastrophic health care coverage.

I have received an unprecedented number of letters this year regarding the catastrophic health care package, and by far prescription drugs is the single most mentioned and requested benefit. However, many of my constituents have also expressed concerns about the deficit, and have urged that benefits not be expanded to the point where our deficit difficulties are

increased. The basic catastrophic package which the Finance Committee has reported has been designed to pay for itself through an increase in the part B premium. The prospect of expanding coverage to include outpatient prescription drugs raises a number of very serious issues:

What level of annual prescription drug costs for an elderly individual is actually catastrophic in nature?

--How accurate are the cost estimates we've been provided?

--Is the public aware of the increased coverage costs to beneficiaries such a benefit will require?

--How accurately can we estimate costs of this benefit in future years, particularly in light of the rapid inflation rates in the prescription drug area?

--How do we keep administrative costs of such a complex program within a manageable range?

--If we can finally develop an affordable and manageable benefit, how many individuals will it really help? How many senior citizens will end up with increased out of pocket health care costs as a result?

These are all very serious questions, and I look forward to hearing the discussion today on this important issue, as well as to working with my colleagues on this Committee in this area.

STATEMENT BY
SENATOR JOHN H. CHAFEE
AT
HEARING ON
MEDICARE COVERAGE OF PRESCRIPTION DRUGS
JUNE 18, 1987

MR. CHAIRMAN, I AM PLEASED THAT YOU HAVE AGREED TO ACT QUICKLY TO HOLD THIS HEARING. DURING CONSIDERATION OF THE CATASTROPHIC BILL, I JOINED MY COLLEAGUE FROM PENNSYLVANIA IN OFFERING AN AMENDMENT DESIGNED TO ASSIST MEDICARE BENEFICIARIES WHO HAVE HIGH PRESCRIPTION DRUG EXPENSES.

THERE WAS A GREAT DEAL OF INTEREST ON THE COMMITTEE IN DEVELOPING SOME TYPE OF DRUG BENEFIT, SO WE AGREED TO WORK WITH OTHER CONCERNED MEMBERS IN THE HOPE OF DEVELOPING AN ACCEPTABLE COMMITTEE AMENDMENT TO PROPOSE WHEN THE BILL IS CONSIDERED ON THE FLOOR.

I HOPE THAT THE WITNESSES HERE TODAY WILL BE DISCUSSING SOME POSSIBLE OPTIONS FOR ~~US~~ TO EXPLORE AS WE ATTEMPT TO BUILD A CONSENSUS ON THIS ISSUE IN THE COMMITTEE.

AS ALWAYS, IT SEEMS, THE MOST DIFFICULT QUESTION IS HOW TO FINANCE THE BENEFIT. IF WE AGREE THAT THOSE OVER 65 SHOULD BE RESPONSIBLE FOR FINANCING THE BENEFIT, THEN HOW CAN WE MAKE IT AFFORDABLE?

THEN THERE IS THE QUESTION OF THE SCOPE OF THE BENEFIT. SHOULD ALL PRESCRIPTION DRUGS BE INCLUDED OR SHOULD WE LIMIT THE TYPES OF DRUGS TO BE COVERED. I DO NOT THINK WE CAN LIMIT THE BENEFIT ONLY TO CERTAIN TYPES OF DRUGS.

FINALLY, THERE IS THE ISSUE OF REIMBURSEMENT. SHOULD WE REIMBURSE ACCORDING TO COST OR SHOULD WE DEVELOP SOME UPWARD LIMIT FOR EACH DRUG COVERED?

THESE ISSUES ARE NOT EASILY RESOLVED. HOWEVER, BECAUSE OF THE THE COST OF PRESCRIPTION DRUGS PLACE SUCH AN ENORMOUS FINANCIAL STRAIN ON THE ELDERLY -- ESPECIALLY THOSE WITH MODERATE INCOMES -- I BELIEVE WE MUST ACT THIS YEAR TO MITIGATE SOME OF THE BURDEN.

THOSE AGED 65 AND OLDER REPRESENT ONLY 12 PERCENT OF THE POPULATION, BUT THEY CONSUME 30 PERCENT OF ALL PRESCRIPTION DRUGS. OVER 75 PERCENT OF THE ELDERLY USE PRESCRIPTION DRUGS -- BUT AMONG THOSE WITH CHRONIC HEALTH CONDITIONS THE PROPORTION RISES TO 90 PERCENT. IN 1985, TOTAL PERSONAL HEALTH CARE EXPENDITURES FOR OUTPATIENT DRUGS AMOUNTED TO $28.5 BILLION. OF THIS AMOUNT, $21.7

BILLION WAS PAID DIRECTLY BY THE PATIENT, $4 BILLION WAS PAID BY PRIVATE INSURERS AND $2.7 WAS PAID BY FEDERAL PROGRAMS.

FOR A MEDICARE BENEFICIARY WHO MUST PURCHASE DRUGS IN ORDER TO TREAT AN ILLNESS OR CHRONIC HEALTH CARE PROBLEM, NOT BEING ABLE TO AFFORD THAT TREATMENT CAN BE A TRUE CATASTROPHE -- IT CAN RESULT IN NOT FILLING PRESCRIPTIONS, A LOWERING OF QUALITY OF LIFE AND PREMATURE DEATH. ESPECIALLY FOR THOSE WITH CHRONIC CONDITIONS SUCH AS ARTHRITIS, HIGH BLOOD PRESSURE, ANGINA, HYPERTENSION, HEART CONDITIONS, DIABETES AND ULCERS THE COST OF PRESCRIPTION DRUGS CAN WIPE OUT THEIR DISPOSABLE INCOME.

I STRONGLY BELIEVE THAT ADDING A DRUG BENEFIT IN OUR CATASTROPHIC ILLNESS PROPOSAL WILL GO A LONG WAY TOWARD CREATING A TRUE CATASTROPHIC PROPOSAL. I HOPE THE WITNESSES WE WILL HEAR FROM TODAY WILL HELP US ACHIEVE THAT GOAL.

Senator MITCHELL. Good morning, ladies and gentlemen, and welcome to this hearing of the Health Subcommittee of the Senate Finance Committee. Our purpose today is to receive testimony regarding the catastrophic out-of-pocket expenses of the elderly that result from payments for prescription drugs.

The Senate Finance Committee, by a 19 to zero vote, reported to the Senate a bill that is designed to reduce catastrophic out-of-pocket costs resulting from acute illness. Even in its present form, the bill represents one of the most important changes in Medicare since its inception over 20 years ago.

However, if Medicare is to serve as a comprehensive insurance program for older Americans, there are still some major gaps that must be closed. The cost of prescription drugs is one such gap.

For those older persons with out-of-pocket costs between $500 and $2000 per year, acute hospital expenses account for about 15 percent of their total out-of-pocket expenses. By comparison, the cost of prescription drugs accounts for over 25 percent, and co-insurance and balance-billing for physician services account for nearly 40 percent of the total.

As I have repeatedly noted in the past, for those with out-of-pocket expenses exceeding $2000 a year, the major category accounting for over 80 percent of the total is the expense associated with long-term care.

Thus, if one defines "catastrophic medical care costs" as out-of-pocket expenses which exceed 20 percent of income, the majority of the problem with prescription drugs falls on those with incomes below $10,000 per year.

While all but two State cover, through their Medicaid programs, the costs of prescription drugs, differing eligibility requirements result in coverage for less than two-thirds of the elderly poor.

Private insurance coverage for prescription drugs is not widespread, and its cost may be too high for those in low income groups.

While such statistics are important in defining the problem, they do not make clear the actual burden imposed on those low-income elderly who require high cost prescription drugs. A significant number of such persons are reported to go without needed medication because of their inability to pay for prescriptions. Others are forced to choose between prescription drugs and essential food or shelter.

While the need is apparent, the solution is not. In 1972, the Senate Finance Committee, under the leadership of Senator Long, reported out of committee a provision creating a Medicare prescription drug benefit. The proposed benefit was not very different from those advanced by members of this, the One Hundredth Congress. The provision was not adopted, largely because of concerns about how to control the utilization and the costs of such a benefit.

These concerns still exist, along with those about how to provide equitable but cost-effective reimbursement for the pharmacist or the pharmaceutical manufacturer, and other concerns about the complexity of administration of the benefit continue.

A major task today is not to determine that a need exists for a drug benefit—the need is there. It has been well-documented and described in previous hearings before this and other congressional

committees. Rather, our purpose is to gain information that will allow us to establish a benefit that meets the need of those who suffer the greatest burden, does not retard the development of new discoveries in the field, and does not further accelerate the rate of increase of drugs costs. This is a major task, but one which we are determined to accomplish, and one which we must accomplish if we are to legislate responsibly.

Before calling on our first witness—and, Senator Graham, you may take the witness stand if you would like—I would like now to call upon my distinguished colleague Senator Heinz of Pennsylvania, who as we all know is one of the recognized leaders in this area and has exhibited great concern for the needs of the elderly Senator Heinz.

Senator HEINZ. Mr. Chairman, thank you for calling this hearing. I suppose it is fair to say it grew out of an amendment that I offered during our markup of the catastrophic coverage bill. That amendment would have provided prescription drug coverage, but there were a number of members of the committee who thought—and I think it was the correct decision—to have a hearing first. And as we decided at that time, subsequent to the hearing we would develop a committee amendment to offer on the floor to provide an appropriate legislative solution to the problem.

As you said, Mr. Chairman, the reason we are having this hearing is not because we need more evidence that there is a problem. The need for prescription drug coverage is not the issue. But what is an issue are the various ways we can handle it and the costs, and paying for the costs, of any such solution.

It is my hope that as challenging as that may be to some, that if there is one legacy that the One Hundredth Congress leaves, it should be our demonstrated willingness not only to tackle but to solve difficult problems head-on. And nowhere is that challenge more vital than in health care.

In terms of the need, which is so well documented, it is also highly quantifiable. In 1987, for example, older Americans will spend over $9 billion on prescription drugs, with millions—literally—of aged individuals paying over $1000 apiece for medication to treat chronic illnesses such as arthritis and hypertension.

It is also a fact that drug costs are escalating two and a half times faster than other consumer prices, and that cost is cited by the elderly as the second most important reason for not filling a prescription.

We might, therefore, ask ourselves, Mr. Chairman, by what twisted process of reasoning any of us can commend ourselves for giant strides in combatting and controlling disease with drugs, if we at the same time deny access to these modern miracles by reason of cost.

One of my constituents from Pittsburgh is typical of millions of older individuals facing large out-of-pocket expenses for drugs. He wrote that his income from Social Security was, and I quote, "devastated by the costs of prescription drugs." His costs averaged $180 per month for the last year, and he knows of "many others whose limited means are similarly being ravaged."

That choice, Mr. Chairman, that you mentioned between having to choose either drugs or adequate nutrition and/or shelter is a

tragic choice that Americans who have been proud and independent all their lives should simply not have to make.

But I do know that there are naysayers on a prescription drug benefit and that they point to several reasons for avoiding coverage.

One of the reasons they say we shouldn't have a benefit is that such a benefit would encourage over-utilization. I must say I became aware, painfully aware, of the emotional and physical agony of seniors suffering drug misuse at a 1983 Aging Committee hearing, and I have two observations to lay before my colleagues on this issue;

The first is that, while over-utilization is a problem, there is also a major problem with over-prescription, which properly drawn legislation might be very helpful in addressing;

And secondly, there is substantial evidence of drug under-utilization because of cost. The result of the latter is unnecessary hospitalizations and even deaths, certainly unwarranted suffering and pain—all have been tied to the failure to take prescription drugs—and the costs associated with unnecessary hospitalization because of the inability to pay for and therefore fill and take prescriptions is a very high-cost indeed.

So, it is a simple equation of need. Subtract essential living costs from a limited fixed income, and very little may remain for medications.

I might emphasize again, if Medicare does cover prescription drugs in some way, shape, or form as we propose here, we can better monitor use, we can help the pharmacist, we can help the doctor, and therefore protect both against over- and under-utilization.

Mr. Chairman, I want to just close with one other point, their being other subjects we will get into in the course of this hearing. I just want to illustrate what can happen under our peculiar system of paying for health care.

Two people, who we will call Mrs. A and Mrs. G, both suffered from terminal cancer and had essentially the same treatment regimen. This is a printout of some of the costs, and most especially a number of the drug costs for this treatment regimen.

They were both treated, as a matter of fact in the Washington, DC metropolitan area. The difference in their care was that Mrs. G received chemotherapy in a local hospital, because Medicare would pay only in the hospital; while Mrs. A was treated in her home with chemotherapy under a private plan. And what is the difference in cost?

The difference in cost is nearly twice. Mrs. G, who was treated in the hospital for the same disease, with the same chemotherapy, her bills, which Medicare paid, were $1900. Mrs. A, who was treated in her home for the same disease with the same drugs or chemicals, her costs paid by private insurance was $1100.

Mr. Chairman, we have a health care system that is costly now—costly, so much so that some people can't afford absolutely vital life-saving drugs, and costly to the taxpayers in ways that make no sense at all. I am confident that through this hearing, Mr. Chairman, and with your leadership, we can write a prescription drug bill that does the job on all counts.

I thank you, Mr. Chairman.

Senator MITCHELL. Thank you, Senator Heinz.

Senator Durenberger?

Senator DURENBERGER. Mr. Chairman, let me, too, thank you for holding this hearing, and thank you not only for the opportunity you offer all of us who have worked on this issue but on behalf of the literally tens of thousands of vulnerable people out there who suffer real deprivation because of the lack of coverage of prescription drugs under Medicare.

While I visit in my home State, I often hear the stories of personal misery, much of it suffered silently by elderly people who can't afford the medications they need, or who are giving up the satisfaction of other health needs in order to satisfy the high cost of the need for medication.

Worthington, Minnesota, which is a small city in the southwestern part of the State, is typical. On my last trip through there, a little grandmother introduced herself as Marguerite Morris. She told me that she lives on a Social Security check of $400 a month, and yet the very beat of her heart depends on her spending one-fourth of that amount, $100 a month, for 3 drugs including one called Lanoxin, which is designed to prevent a killer heart attack from an irregular heartbeat called erythmia, which many elderly people have.

Mrs. Morris manages to pay for the drug because to do otherwise would mean death; but the price she pays is to go without many of life's other necessities. Other sick or disabled elderly people go without the drugs that make the difference between life and death or which greatly affect the quality of their life, through pain-control and other means.

So, I think we all feel a special urgency. We feel it, too, because in rural parts of our State the elderly are such a large part of our population.

No one who is old or disabled should have to go without needed medication because they lack the means to pay for them. Fortunately, most States cover drugs for Medicaid enrollees, and eight of our States have additional programs for low-income elderly. There is a ninth, I understand, New York, which has enacted a program which goes into effect next January.

So, whatever else we do as a nation, we ought to facilitate the expansion of these kinds of programs.

I am not at all certain that the best approach is to add a benefit under Medicare for everybody over the age of 65, particularly if it is done with a huge annual deductible which will still leave low and moderate income elderly exposed.

Rather, since we are talking about a multi-billion dollar program, we ought to design it and the new benefit very carefully. Medicare enrollees who have moderate to high incomes, plus being the ones who have the access to private health plan coverage, are not in this same kind of need. But we must recognize that, in an aging population with many chronic illnesses, prescription drugs can be life-saving and life-enhancing; so, no one should be without them when needed.

Therefore, Mr. Chairman, we must provide coverage with a limited copayment for low-income people, limiting coverage to drugs available by prescription only.

Financing for these programs should be compassionate, but realistic, and must not add to our national burden of debt. It should be built around affordable public and private insurance programs which reflect the needs of people at various income levels.

Mr. Chairman, I can't stress enough the importance of the subject of these hearings today. The needs that I hear most frequently and emphatically expressed are for nursing home coverage, prescription drugs, and adequate mental health care. Today we are discussing two of the three, moving towards some form of solution.

Senator MITCHELL. Thank you very much, Senator Durenberger.

Senator Chafee?

Senator CHAFEE. Thank you very much, Mr. Chairman. I want to commend you for moving so swiftly on these hearings. As you recall, this came as a result of the deliberations and the comments that were made when we were making-up the catastrophic bill, and the promise was made by Senator Bentsen that those of us, including of course yourself, who are so deeply concerned about prescription drugs for the elderly would have a chance to present a floor amendment to the catastrophic bill. And now, this is the first effort in that direction, and I want to thank you very much and assure you of my cooperation, because I am deeply concerned about it.

Thank you.

Senator MITCHELL. Thank you, Senator Chafee.

Our first witness today is our distinguished colleague from Florida, the former Governor of that State and, given the significance of its elderly population, someone with a keen interest in all matters relating to the elderly. We welcome Senator Graham. We look forward to hearing from him.

STATEMENT OF HON. BOB GRAHAM, U.S. SENATOR FROM FLORIDA

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

I have very much enjoyed and benefited from the opening statements that have been made, because I think they framed the basic question, and that is a recognition of the appropriateness of prescription medication as part of the Medicare program, but a groping as to how to incorporate that goal within philosophical and economic standards that would be appropriate.

Since the beginning of the Medicare system, Congress has been debating the question of the inclusion of prescription medication. It is appropriate for this Congress, now nearly three decades after the creation of the program, to provide for prescription medication.

I suggest that the place to start is to provide medication for chronic diseases. The arguments are compelling:

One, prescription medication is a major and often an unaffordable expense for older Americans.

Two, largely because of this cost, many older Americans with chronic health problems do not take their prescribed medication.

Three, failure to take prescription medicines is a significant contributor to subsequent major illnesses which could have been controlled or prevented.

The relationship of these three factors has been recognized by both public and private health care programs, and a report, to which the Chairman alluded, prepared by the Finance Committee in 1972 stated: "Coverage of only those drugs which are important for the treatment of chronic illness among the elderly, and which usually are required on a continuing or recurring basis, would concentrate the protection provided by a drug program where it is most needed."

The report went on to say: "Particular consideration should be given to providing coverage at the outset, mainly for those prescription drugs which are most likely to be essential in the treatment of serious long-term illness."

Those recommendations, valid in 1972, are valid in 1987.

The barrier to this sensible, preventive health measure in 1972, and the same barrier we confront today, is twofold: philosophic and economic.

Philosophically, the Federal Government has embraced a crisis orientation. Our involvement has been generally limited to intervention after major illness—kidney dialysis rather than generic hypertension medication, intervention over prevention.

Economically, the Federal Government has shied away from a potential avalanche of unanticipated costs which could result from an unlimited free prescription medication program.

Those barriers, Mr. Chairman, are without merit.

A limited number of common prescription medications for widespread, chronic conditions of poor health in older Americans can be dispensed with fiscal controls. A small monthly fee for users in combination with an annual deductible would offset the initial cost of the program. The astronomical sums of money required to care for victims of debilitating catastrophic illness could be sharply reduced by a nationwide program under Medicare of affordable, prescribed preventive medication.

For example, the hypertension medication costs between $300 and $600 per year, per patient. A stroke or kidney failure, two common developments of unchecked hypertension, can cost $15,000 a year for basic nursing home care, or as much as $30,000 a year for kidney dialysis.

All of this does not attempt to factor in the improved quality of life for the well, older American or the productivity and independence which can needlessly fall victim to a disabling disease.

Prevention is cheaper and more humane than intervention in catastrophic illness.

I would suggest the following: One, a joint Medicare client program in which the older American, through a combination of a $100-per-year deductible, a 5 percent copayment on specific prescriptions, and a voluntary monthly premium of $4.00, in combination with the Federal Government, would pay for a limited group of prescription medications for common chronic conditions. Those conditions covered would be determined, as suggested by the 1972 report, by addressing the widespread high-risk illnesses for older people: hypertension, respiratory and cardiovascular diseases, dia-

betes, arthritis. All of those can be crippling, disabling, even life-threatening if they are not treated. When controlled by medication, people with those conditions can lead normal lives.

The essential elements of the recommendation which I present today, Mr. Chairman, are an orientation towards prevention, the establishment of priorities of those diseases which will be treated through prescription medication funded by Medicare, the establishment of priorities through a prescription drug formulary, and the shared costs between the client and Medicare.

I would like to submit to the committee and for the record the 1972 Report of the Committee on Finance, which takes up the question of a prescription medication benefit, and a copy of the bill which has been submitted with a proposal for a voluntary, preventive medication benefit under the Medicare program.

Thank you, Mr. Chairman.

[The report and a copy of the bill follows:]

Calendar No. 1175

92d Congress, 2d Session - - - - - - Senate Report No. 92-1230

SOCIAL SECURITY AMENDMENTS OF 1972

REPORT

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

TO ACCOMPANY

H.R. 1

TO AMEND THE SOCIAL SECURITY ACT, AND FOR OTHER PURPOSES

(Together With Additional Views)

COMMITTEE ON FINANCE
UNITED STATES SENATE
RUSSELL B. LONG, *Chairman*

SEPTEMBER 26 (legislative day, SEPTEMBER 25), 1972

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78-178 O WASHINGTON : 1972

necessary care on an outpatient rather than inpatient basis could operate to reduce need for new construction of costly hospital facilities. Hospital bed need would be further reduced by reductions in lengths of hospital stay and avoidance of admission for unnecessary or avoidable hospitalization.

To be effective, the PSRO provisions will require full and forthright implementation. Equivocation, hesitance, and half-hearted compliance will negate the intended results from delegation, with appropriate public interest safeguards, of primary responsibility for professional review to nongovernmental physicians. For these reasons, the committee expects that the Inspector General for Health Administration (whose office is established under another amendment) will give special attention to monitoring and observing the establishment and operation of the PSRO's to assure conformance and compliance with congressional intent.

Coverage of Certain Maintenance Drugs Under Medicare

(Sec. 215 of the bill)

BACKGROUND

The committee added an amendment to the House bill which would provide coverage of certain maintenance drugs under part A of medicare. Medicare presently covers the cost of drugs given to an inpatient in a hospital or extended care facility, but does not, however, pay for prescription drugs on an outpatient basis.

Beneficiaries and others have frequently indicated the lack of coverage for outpatient drugs as the most significant gap in the medicare benefit structure. Prescription drug expenses account for a large part of the health expenses of older people. More important, perhaps, than the fact that drugs represent a large out-of-pocket expense for the elderly is that this expense is distributed unevenly among the elderly. Those with chronic illnesses such as heart or respiratory diseases are often faced with recurring drug expenses and many of these drugs are critical to the survival of these chronically ill patients. As a result, the elderly with chronic illnesses have, on the average, prescription drug expenditures nearly three times as high as those without chronic illnesses.

The committee believes that an outpatient prescription drug benefit is the most important and logical benefit addition to the Medicare program. However, the committee was quite concerned with the cost and administrative problems associated with proposals to cover all outpatient prescription drugs under medicare. Covering all drugs for the aged and disabled, with a $1 copayment, was estimated by the Social Security Administration to cost about $2.6 billion. In addition, the administrative burden of covering all drugs would be enormous since the program would have to deal with millions of small prescriptions, and the utilization controls to assure that prescriptions reimbursed under medicare were reasonable and necessary and used only by beneficiaries, would be quite cumbersome.

In studying the problems posed with respect to establishing an outpatient drugs benefit, the committee concluded that the problems could in large part be surmounted by an approach which focused on provid-

ing specified drugs which are necessary for the treatment of the most common crippling or life-threatening chronic diseases of the elderly. This approach would have four advantages: (1) It would result in the medicare dollar being targeted toward patients with chronic diseases who need drugs on a continuing basis for a lengthy period of time; (2) it would substantially simplify administration of a drugs benefit; (3) it would incorporate almost self-policing utilization controls at a relatively low administrative cost, since the program would involve only a relatively small number of drug entities and the necessity for these drugs would be comparatively easy to establish; and (4) this approach would substantially lower the cost of providing a drugs benefit. The cost of the amendment is estimated at $740 million for the first full year beginning July 1, 1973.

The committee approach is consistent with the recommendation of the Task Force on Drugs of the Department of Health, Education, and Welfare. The Task Force, in accordance with the Social Security Amendments of 1967, undertook many months of study concerning the appropriateness and possible methods of covering drugs under medicare. In their final report, issued in February 1969, the Task Force stated:

> "Available data on drug use by the elderly support the hypothesis that coverage of only those drugs which are important for the treatment of chronic illness among the elderly, and which usually are required on a continuing or recurring basis, would concentrate the protection provided by a drug program where it is most clearly needed."

After reviewing the relative advantages of this approach, the Task Force recommended:

> "In order to achieve maximum benefits with whatever funds may be available, and to give maximum help to those of the elderly whose drug needs are the most burdensome, the Task Force finds that particular consideration should be given to providing coverage at the outset mainly for those prescription drugs which are most likely to be essential in the treatment of serious long-term illness."

The committee commends the Task Force for its exhaustive and definitive efforts and agrees with its recommendation.

Summary of Committee Amendment

Basically, the committee amendment would cover specific drugs necessary for the treatment of the many crippling or life-threatening diseases of the elderly with the beneficiary subject to a copayment of $1 per prescription.

The chronic illnesses covered under the amendment were carefully chosen. The Task Force on Prescription Drugs issued a voluminous study containing extensive data with respect to drug utilization among the elderly. The table below, taken from the Task Force report, lists the more common chronic illnesses of the elderly, in order of the number of prescriptions related to each condition.

DESCENDING ORDER FOR NUMBER OF PRESCRIPTIONS USED IN TREATMENT OF ILLNESSES AMONG THE AGED

[Excluding mental conditions, gastrointestinal disorders, chronic skin diseases and anemia]

Diagnosed Conditions	Number of Rx's in thousands
Heart	46,512
High blood pressure	19,681
Arthritis and rheumatism	17,343
Genito-urinary conditions	9,127
Diabetes	8,085
Colds, coughs, throat conditions and influenza [1]	7,504
Other disorders of circulatory system	4,776
Injuries and adverse reactions [1]	4,000
Neoplasm	3,701
Eye	3,683
Emphysema	2,766
Asthma and hay fever	2,547
Other respiratory conditions	2,415
Sinus and bronchial conditions	2,138
Ear	2,113
Pneumonia	1,531
Thyroid	1,491

[1] Not included in amendment because of generally short-term nature of condition and need for prescriptions.

The amendment would cover serious chronic conditions necessitating long-term drug treatment with the exception of mental and nervous conditions, chronic skin disease, anemia, and gastrointestinal disorders. These diagnoses are excepted because many of the drugs used in their treatment (for example, tranquilizers, antacids, antispasmodics, antidiarrheals, vitamins, iron, and skin ointments) are drugs which are also used by many people for general reasons and are, therefore, difficult to confine to appropriate usage by beneficiaries only (for example, they could be acquired for use by nonbeneficiaries) as opposed to drugs such as insulin or digitalis which are almost invariably used only by those who have a specific need for them. In addition, concern has been expressed that coverage of the "major" tranquilizers used in the treatment of mental illnesses might encourage over-prescribing of potent tranquilizers for older people.

The amendment would further limit coverage to only certain drugs used in the treatment of covered conditions. In other words, people with chronic heart disease often use digitalis drugs to strengthen their heartbeat, anticoagulant drugs to reduce the danger of blood clots and other drugs to lower their blood pressure. These types of drugs would be covered under the amendment as they are necessary in the treatment of the heart condition and they are not types of drugs generally used by people without heart conditions. However, other drugs which might be used by those with chronic heart conditions (such as sedatives, tranquilizers and vitamins) would not be covered as they are drugs which are generally less expensive, less critical in treatment and much more difficult to handle administratively, as many patients without chronic heart disease may also utilize these types of medications.

The provision is designed to establish a basis for coverage of drugs capable of administration at reasonable cost. In this form and scope

it is an approach capable of providing significant help and of allowing for orderly future expansion if that were later decided.

It is expected that the Formulary Committee will study the problems related to the question of possible medicare coverage of drugs used in the treatment of mental illness with particular attention to development of means of assuring appropriate usage of such drugs. The Formulary Committee would submit to the Congress, through the Secretary, a report concerning its findings, conclusions and recommendations with respect to this matter.

Eligibility

All persons covered under part A of medicare would be eligible for the new outpatient drugs benefit. Under the provision, the drugs covered are necessary in the treatment of the following conditions:

- Diabetes
- High blood pressure
- Chronic cardiovascular disease
- Chronic respiratory disease
- Chronic kidney disease
- Arthritis and Rheumatism
- Gout
- Tuberculosis
- Glaucoma
- Thyroid disease
- Cancer
- Epilepsy
- Parkinsonism
- Myasthenia gravis

The fact that the patient needs the drug would indicate that he suffers from one of the above illnesses. Thus generally the existence of a specific chronic illness would not have to be established in connection with the application for payment for the prescription.

Benefits

The covered drug therapeutic categories are as follows:

- Andrenocorticoids
- Anti-anginals
- Anti-arrhythmics
- Anti-coagulants
- Anti-convulsants (excluding phenobarbital)
- Anti-hypertensives
- Anti-neoplastics
- Anti-Parkinsonism agents
- Anti-rheumatics
- Bronchodilators
- Cardiotonics
- Cholinesterase inhibitors
- Diuretics
- Gout suppressants
- Hypoglycemics
- Miotics
- Thyroid hormones
- Tuberculostatics

Within these categories, eligible drugs would be those prescription drug entities which are included by dosage form and strength in the Medicare Formulary described below. The amendment would exclude drugs not requiring a physician's prescription (except for insulin), drugs such as antibiotics which are generally used for a short period of time and drugs such as tranquilizers and sedatives which may be used not only by beneficiaries suffering from serious chronic illnesses, but also by many other persons as well. Beneficiaries would incur a $1 copayment obligation for each prescription. They would also be

obliged to pay any charges in excess of the product price component of the reasonable allowances where a higher-priced product of a drug included in the Formulary was prescribed and where the allowances were based upon generally available lower cost products (see "reasonable allowance" below). Payment under this program would not be made for drugs supplied to beneficiaries who are inpatients in a hospital or skilled nursing facility because their drugs are already covered under medicare.

Formulary Committee

To assure rational and professional control over the drugs covered and the cost of the drugs benefit, and to assure that funds are being targeted toward the most necessary drug entities within each covered therapeutic category, a Medicare Formulary would be established.

The Formulary would be compiled by a committee consisting of five members, a majority of whom would be physicians. The members would include the Commissioner of Food and Drugs and four individuals of recognized professional standing and distinction in the fields of medicine, pharmacology or pharmacy who are not otherwise employed by the Federal Government and who do not have a direct or indirect financial interest in the economic aspects of the committee's decisions. Members would be appointed by the Secretary for 5-year staggered terms and would not be eligible to serve continuously for more than two terms. The Chairman would be elected by and from the public members for renewable one-year terms.

It is expected that appointees to the Formulary Committee will have the stature and expertise to assure objective effort and informed decision-making of a level engendering public and professional confidence in their integrity and judgment.

The Formulary Committee would be authorized, with the approval of the Secretary, to engage or contract for such reasonable technical assistance as it determined it might need from time to time to enhance its capacity for judgment concerning inclusion of drugs in the Formulary. This could include utilizing the services of the committees and technical staff of the official compendia (the United States Pharmacopeia and the National Formulary). The committee expects that such contracting would be undertaken on a limited ad hoc basis, and will be used to supplement, as necessary, the services available within the Department.

The Formulary Committee's primary responsibility would be to compile, publish, and revise periodically a Medicare Formulary which would contain a listing of the drug entities (and dosage forms and strengths) within the therapeutic categories covered by the program which, based upon its professional judgment, the committee finds necessary for proper patient care, taking into account other drug entities included in the Formulary. To aid fully its consideration as to whether a drug entity should be included in the Formulary, the Formulary Committee would be authorized to obtain any records pertaining to a drug which were available to any other department or agency of the Federal Government and to request of suppliers of drugs and other knowledgeable persons or organizations pertinent information concern-

ing the drug. The committee would be authorized to establish procedures which it might require to determine the appropriateness of including or excluding a given drug from the Formulary.

The Formulary Committee would exercise utmost care in maintaining the confidentiality of any material of a confidential nature made available to it.

For purposes of inclusion in or exclusion from the Formulary of any drug entity (in a given dosage form and strength), the principal factors to be taken into account by the committee would be: (1) Clinical equivalence, in the case of the same dosage forms in the same strength of the same drug entity; and (2) relative therapeutic value in the case of similar or dissimilar drug entities in the same therapeutic category. The price of a drug entity would not be a consideration in the judgment of the Formulary Committee.

In considering which drug entities and strengths, and dosage forms, to include in the Medicare Formulary, the Formulary Committee is expected, on the basis of its professional and scientific analysis of available information, to exclude such drugs as it determines are not necessary for proper patient care taking into account those drugs (or strengths and dosage forms) which are included in the Formulary.

For example, in their consideration of drug entities in the therapeutic category known as anti-anginals, a therapeutic category included in the covered categories, the Formulary Committee would be expected to take into account professional appraisals such as the following which appears in "Drug Evaluations—1971," an authoritative publication of the American Medical Association:

> "The effectiveness of the short-acting agents, such as nitroglycerin and amyl nitrite, has been established through many years of use. * * * The oral administration of the so-called 'long-acting nitrates e.g., pentaerythritol tetranitrate, . . . erythrityl tetranitrate, . . . isosorbide-dinitrate, as well as some preparations of nitroglycerin are alleged to reduce the number of episodes and the severity of the pain of angina pectoris. The effectiveness of these agents is even more difficult to determine than that of the short-acting nitrates, and thus the beneficial value of their long-term use is controversial. * * * Thus, it cannot be concluded that the long acting nitrates are of definite therapeutic value for prolonged use.
>
> "Many products are available that contain a mixture of antianginal agents or an antianginal agent with a sedative or other drug(s); however, none of these fixed-dose combinations is rational. There is no evidence that a combination of antianginal agents has any advantage over the individual agents and, if more than one type of drug is needed, they should be prescribed separately."

The above quotation is illustrative of the type of source and information to which the Formulary Committee is anticipated to give serious consideration and weight in determining those drug entities (and dosage forms and strengths) which are reasonably appropriate as eligible drugs for purposes of medicare reimbursement.

Prior to removing any drug entity (or a particular dosage form or strength) from the Formulary, the committee would afford reasonable opportunity for a hearing on the matter to persons engaged in manufacturing or supplying the drug involved. Similarly, any person manufacturing or supplying a drug entity not included in the Formulary, but which he believed to possess the requisite qualities for inclusion, could petition the committee for consideration of the inclusion of his drug and, if the petition was denied, might, at the discretion of the committee, upon reasonable showing to the Formulary Committee of ground for a hearing, be afforded a hearing on the matter.

In addition to the list of drug entities included in the Formulary, the Formulary would also include a listing of the prices (generally the average-wholesale prices) at which the various products of the drug entities are usually sold by suppliers to establishments dispensing drugs.

The Formulary Committee would be solely responsible for professional judgment as to which drug entities (and dosage forms or strengths) are included in the Formulary. The Secretary would not be involved in the making of those professional determinations.

Reimbursement

Reimbursement would be based, generally, on the average wholesale price at which the prescribed product of the drug entity included in the Formulary is sold to pharmacies plus a professional fee or other dispensing charges, except that reimbursement could not exceed an amount which, when added to the copayment required of the beneficiary, exceeded the actual customary charge at which the dispenser sells the prescription to the general public.

Both components of the reimbursement would be subject to overall limitations just as medicare's reimbursement to physicians, hospitals and other suppliers is subject to overall limitations. The professional fee or other dispensing charge would not be recognized for medicare reimbursement purposes to the extent that it was in excess of the 75th percentile of fees or charges for other pharmacies in the same census region. In establishing the 75th percentile limit in an area where some pharmacies use one system of ca.. ulation and others use a different system, it is the intent that the 75th percentile of charges be calculated independently for the two systems only where a substantial number of pharmacists in an area used each of the methods of charging for dispensing costs. Otherwise, use of the percentile would have the result that a scattering of pharmacists using a given form could set their own limit which might not be reasonable in relation to the usual practices in a community. In order to avoid this undesirable effect, where only a few pharmacists in an area used a given form of dispensing charge, the limit on this charge would normally be set at a level essentially equivalent to the 75th percentile for the form of dispensing charge most frequently used by pharmacists in an area. In determining the 75th percentile, pharmacies with a lesser volume of prescription business would be compared with each other and all larger volume pharmacies would be similarly compared with each other.

Increases in the prevailing professional fees or other dispensing charges would be recognized in a manner similar to recognition of

increases in prevailing physicians' fees. That is to say, increases in prevailing fees or dispensing charges could be recognized (not more than annually) up to limits established for program purposes by factors based upon changes in costs of doing business and average earnings levels in an area during a given period of time. A given pharmacy could change from a professional fee to another dispensing charge basis or vice versa, but for program reimbursement purposes the net effect of such change should be neutral.

Program payment for the drug entity (in given dosage forms and strengths) would be limited to reasonable allowances determined by the Secretary on the basis of the average wholesale prices at which the various products of the drug entity (in a given dosage form and strength) are commonly sold to pharmacies in a region plus the professional fee or dispensing charge. The beneficiary would be obligated to pay $1 of the reasonable allowance. If there was only one supplier of a drug entity, the price at which it was generally sold (plus the fee or dispensing charge) would represent the reasonable allowance. If, however, several products of the drug (in the same strength and dosage form) were generally available, reasonable allowances would be established which would encompass the lower priced products which were generally available and sold to pharmacies in a region. The number of lower priced products selected would stop at the point where reasonable availability of the drug entity is assured. In the latter case, other products of the drug entity (in the covered dosage form and strength) could also be reimbursable—even though not specifically included in the range of lower-priced products—where the average wholesale price of any such product was at or below the point used by the Secretary in establishing a reasonable allowance. This procedure avoids the problem of having to list every eligible drug product falling within the range of acceptable supplier prices in order for it to be reimbursable.

Products of a drug entity included in the Formulary which are priced above the highest reasonable allowance would be reimbursable but only to the extent of the highest reasonable allowance. The beneficiary would be obligated to pay the excess cost.

There would be three circumstances under which the program payment for a prescription could exceed reasonable allowances. First, if the supplier of a given drug product (of a drug entity in a strength and dosage form included in the Formulary) can demonstrate to the Formulary Committee that his product possesses distinct therapeutic advantages over other products (of the same dosage form and strength) of that drug entity, then the reasonable allowance for that drug product would be based upon the price at which it was generally sold to pharmacies. Second, where the Formulary Committee believed there was legitimate question concerning the clinical equivalency of the various products of different suppliers of a covered drug entity (or of given dosage forms and strengths) the Formulary Committee would be expected to list all of the products of the covered drug entity (in the dosage forms and strengths in question) so as to provide the prescriber with complete discretion until such time as the matter was resolved. Thus, the reasonable allowance would be based upon the reasonable customary price to the pharmacy for the product prescribed by

the physician in such cases. Third, if the physician felt in a specific instance that a particular manufacturer's product of a drug entity included in the Formulary, but which was priced above the highest product price component of the reasonable allowance, provides superior therapy to his patient and if he prescribes that product in his own handwriting by its established name and the name of its supplier, the reasonable allowance for the product would be based upon the price at which it was generally sold to pharmacies. Thus, a physician's reasonable discretion to prescribe a particular product of a drug entity included in the Formulary would be accommodated. In such cases, however, the reasonable allowance would not be greater than the actual usual or customary charge at which the pharmacy sells that particular drug product to the general public. The committee expects that these unusual prescribing situations will occur in only a small percent of cases, and this procedure would not negate the overall medicare requirement that services be reasonable and necessary. The Professional Standards Review Organizations (or, in the absence of a PSRO, other appropriate professional review), would be available to routinely review prescribing practices.

In circumstances other than those described above, where the cost of the drug product prescribed by the physician exceeds the highest product price component of the reasonable allowance, the beneficiary would be liable for charges to the extent of this excess including any related dispensing fee or charge.

Ordinarily, however, the beneficiary's obligation would be $1 per prescription, with the program paying the balance to the pharmacy.

Reimbursement to providers participating under medicare for other than the drugs program (such as hospitals) would be made on the regular reasonable costs basis.

In the case of insulin, reimbursement would be made to a pharmacy for its reasonable, usual and customary charge to the general public, plus a reasonable billing allowance less the $1 copayment.

Reimbursement would generally be made only to participating pharmacies. The exception would be that payment may be made for covered drugs dispensed by a physician where the Secretary determines that the drug was required in an emergency or that no pharmacy was reasonably available in the area.

Participating Pharmacies

As mentioned above, reimbursement under this program would be limited to participating pharmacies. No program reimbursement would be made either to the beneficiary or to a pharmacy where the prescription was dispensed by a non-participating pharmacy. The use of participating pharmacies would substantially decrease the administrative costs of the program, as participating pharmacies would generally submit batches of prescriptions and the program would not need to reimburse individual beneficiaries on a prohibitively costly prescription-by-prescription basis.

Such pharmacies would have to be licensed (where required) in the State in which they operate and would have to meet conditions of participation established by the Secretary of Health, Education, and Welfare. Participating pharmacies would file with the Secretary

instatement of their professional fee or dispensing charges (including minimum charges) as of June 1, 1972, so that the Secretary could determine the initial prevailing fee or charges in the census region for purposes of calculating reasonable allowances.

Participating pharmacies would agree to accept medicare reimbursement as payment in full and would further agree not to charge the beneficiary more than $1 copayment (except to the extent that a product prescribed by a physician was one whose cost exceeded the reasonable allowance).

The participating pharmacy would be paid directly by medicare on a prompt and timely basis with respect to eligible prescriptions submitted. The prescriptions from each pharmacy would be audited from time to time, on a sample basis to assure compliance with program requirements.

ADMINISTRATION

The committee amendment has been structured in such a way as to simplify and facilitate provision of and payment for benefits.

However, the committee has chosen not to specify a particular method or mold of administration. Because this is a new benefit, it is difficult to forecast which methods or organizational structures might most suitably implement the committee's intent that the drugs benefit be administered in the most efficient, expeditious and economical fashion. Fulfillment of the committee's intent would not necessarily entail uniform organization and procedures in each region. The Secretary could find that different means of administration in different regions or areas were appropriate in achieving the administrative objectives of the committee.

Inspector General for Health Administration

(Sec. 216 of the bill)

Based upon its years of inquiry and extensive examination of the medicare and medicaid programs, the committee found that these programs have suffered from the lack of a dynamic and ongoing mechanism with specific responsibility for continuing review of medicare and medicaid in terms of the effectiveness of program operations and compliance with congressional intent.

While the Comptroller General and the Department of Health, Education, and Welfare's Audit Agency have done some valuable and helpful work along the above lines, there is a pronounced need for vigorous day-to-day and month-to-month monitoring of these programs, conducted by a unit relatively free of constant pressures from various nonpublic interests at a level which can promptly call the attention of the Secretary and the Congress to important problems and which is charged with authority to remedy such problems in timely, effective, and fully responsible fashion.

To achieve the above objectives, the committee has approved an amendment which would establish an Office of Inspector General for Health Administration in the Department of Health, Education, and Welfare. The amendment is similar to the amendment approved by

II

100TH CONGRESS
1ST SESSION

S. 1240

To amend title XVIII of the Social Security Act to provide coverage for certain preventive care items and services under part B and to provide a discount in premiums under such part for certain individuals certified as maintaining a healthy lifestyle.

IN THE SENATE OF THE UNITED STATES

MAY 20 (legislative day, MAY 13), 1987

Mr. GRAHAM introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend title XVIII of the Social Security Act to provide coverage for certain preventive care items and services under part B and to provide a discount in premiums under such part for certain individuals certified as maintaining a healthy lifestyle.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. ELECTIVE COVERAGE OF CERTAIN DRUGS AND BIOLOGICALS UNDER MEDICARE PART B PROGRAM.

(a) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(1) by striking "and" at the end of subparagraph (J),

(2) by adding "and" at the end of subparagraph (K), and

(3) by adding at the end thereof the following new subparagraph:

"(L) in the case of an individual who (in such manner and for such period as the Secretary shall provide) elects to receive coverage under this subparagraph and pay the additional premium required under section 1839(g), such prescription drugs and biologicals as the Secretary designates (from among such drugs and biologicals included under subsection (t)) for treatment of hypertension, diabetes mellitus, arthritis, cardiovascular disease, hypercholesterolemia, osteoporosis, chronic obstructive pulmonary disease, mental illness, and such other chronic disease states as the Secretary may provide;".

(b) ADDITIONAL PREMIUM FOR INDIVIDUALS ELECTING TO RECEIVE COVERAGE.—Section 1839 of such Act (42 U.S.C. 1395r) is amended by adding at the end thereof the following new subsection:

"(g) Notwithstanding any other provision of this section, the amount of the monthly premium otherwise determined under this section with respect to an individual for months

occurring in a calendar year shall be increased by $4 with respect to any individual who elects to receive coverage for the items described in section 1861(s)(2)(L).".

(c) DEDUCTIBLE AMOUNT.—Section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended—

(1) by striking "and" at the end of subdivision (3), and

(2) by inserting before the period at the end of subdivision (4) the following: ", and (5) such deductible shall be $100 in the case of expenses incurred for the items described in section 1861(s)(2)(L)".

(d) COPAYMENT AMOUNT.—

(1) Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking "and" before subdivision (H); and

(B) by adding at the end thereof the following: "and (I) with respect to expenses incurred for the items described in section 1861(s)(2)(L), the amounts paid shall be 95 percent of the reasonable charges for such items,".

(2) Section 1866(a)(2)(A) of such Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting after the second sentence the following new sentence: "In the case of items described in section 1861(s)(2)(L), clause

(ii) of such sentence shall be applied by substituting 5 percent for 20 percent.".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to items furnished on or after the first day of the first calendar month to begin more than 60 days after the date of the enactment of this Act.

SEC. 2. ELECTIVE COVERAGE OF ROUTINE PHYSICAL CHECK-UP UNDER MEDICARE PART B PROGRAM.

(a) IN GENERAL.—

(1) Section 1862(a)(7) of the Social Security Act (42 U.S.C. 1395y(a)(7)) is amended by inserting "except as provided in subsection (j)," immediately after "(7)".

(2) Section 1862 of such Act (42 U.S.C. 1395y) is amended by adding at the end thereof the following new subsection:

"(j) In the case of an individual who (in such manner and for such period as the Secretary shall provide) elects to receive coverage for the services described in this subsection and pay the additional premium required under section 1839(h), the exclusion from coverage under subsection (a)(7) shall not apply to expenses incurred for services furnished by a family practitioner, general practitioner, internal medicine specialist, general preventive medicine specialist, obstetrical/gynecological specialist, or any other primary care physician

during a routine physical checkup (without regard to the location at which such services are furnished, but no more than once each year for any patient) to diagnose or prevent illness or injury. Such services shall include hypertension screening, glaucoma screening by tonometry, cholesterol screening, screening for any of the infectious diseases specified in section 1861(s)(10), a routine exfoliative cytology (Papanicolaou) test for the detection of cervical cancer, test for blood in the stool, rectal examination, breast examination, a mammogram for the detection of breast cancer, and appropriate referral for diagnosis or treatment of mental illness.".

(b) ADDITIONAL PREMIUM FOR INDIVIDUALS ELECTING TO RECEIVE COVERAGE.—Section 1839 of such Act (as amended by section 1) is further amended by adding at the end thereof the following new subsection:

"(h) Notwithstanding any other provision of this section, the amount of the monthly premium otherwise determined under this section with respect to an individual for months occurring in a calendar year shall be increased by $3 with respect to any individual who elects to receive coverage for the services furnished in connection with the routine physical checkup described in section 1862(j).".

(c) WAIVER OF COPAYMENTS.—

(1) Section 1833(a)(1) of such Act (as amended by section 1 of this Act) is further amended—

(A) in subdivision (D) by inserting "for tests furnished in connection with a routine physical checkup (as described in section 1862(j))" after "1870(f)(1),";

(B) by striking out "and" before subdivision (I); and

(C) by adding at the end thereof the following: "and (J) with respect to expenses incurred for the services furnished in connection with the routine physical checkup described in section 1862(j), the amounts paid shall be 100 percent of the reasonable charges for such services,".

(2) The last sentence of section 1866(a)(2)(A) of such Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting after "with the first opinion)," the following: "with respect to services furnished in connection with the routine physical checkup described in section 1862(j),".

(d) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to services furnished on or after the first day of the first calendar month to begin more than 60 days after the date of the enactment of this Act.

SEC. 3. COVERAGE OF CERTAIN IMMUNIZATIONS UNDER MEDICARE PART B PROGRAM.

(a) IN GENERAL.—Section 1861(s)(10) of such Act (42 U.S.C. 1395x(s)(10)) is amended—

(1) by striking "and" at the end of subparagraph (A), and

(2) by adding at the end thereof the following new subparagraph:

"(C) such immunizations as the Secretary designates for prevention or treatment of tuberculosis, influenza, meningococcal meningitis, tetanus, and such other infectious diseases as the Secretary determines present a public health problem, furnished to individuals who, as determined in accordance with regulations promulgated by the Secretary, are at high risk of contracting any of such diseases; and".

(b) WAIVER OF COPAYMENT.—

(1) Section 1833(a)(1) of such Act (as amended by sections 1 and 2 of this Act) is further amended in subdivision (B) by striking "1861(s)(10)(A)" and inserting in lieu thereof "1861(s)(10)".

(2) The last sentence of section 1866(a)(2)(A) of such Act (as amended by section 2 of this Act) is further amended by striking "1861(s)(10)(A)" and inserting in lieu thereof "1861(s)(10)".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to items and services furnished on or after the first day of the first calendar month to begin more than 60 days after the date of the enactment of this Act.

SEC. 4. MEDICARE PART B HEALTHY LIFESTYLE PREMIUM DISCOUNT.

(a) IN GENERAL.—Section 1839 of the Social Security Act (as amended by sections 1 and 2 of this Act) is further amended by adding at the end thereof the following new subsection:

"(i)(1) Notwithstanding any other provision of this section, the amount of the monthly premium otherwise determined under this section with respect to an individual for months occurring in a calendar year shall be reduced by $1 if the individual is certified by a physician for that year (in accordance with procedures established by the Secretary in regulations) as an individual who maintains a healthy lifestyle.

"(2) An individual may be certified as maintaining a healthy lifestyle under paragraph (1) if—

"(A) the individual does not use any tobacco or tobacco product,

"(B) the individual does not consume medically detrimental amounts of alcohol, and

"(C) the weight of the individual is within a weight range that is appropriate for an individual of the same age and health status.".

(b) CONFORMING CHANGES.—Section 1839 of such Act (42 U.S.C. 1395r) is amended—

(1) in subsection (a)(2) by striking "provided in subsections (b) and (e)" and inserting in lieu thereof "otherwise provided in this section".

(2) in subsection (a)(3) by striking "subsection (e)" and inserting in lieu thereof "this section".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to premiums after December 31, 1987.

O

Senator MITCHELL. Thank you very much, Senator Graham, for a very thoughtful and persuasive statement.

Do any of the Senators have any questions of Senator Graham? Senator Durenberger?

Senator DURENBERGER. Bob, as I understand—I want to be sure I understand you—it sounds as though you are suggesting to us that we add an optional benefit to Medicare which would be a specific set of prescribed drugs for a specific set of illnesses, primarily those that would fall in the category of chronic illness, and there would be a specific premium attached to the provision of that service. Have I thoroughly stated your recommendation?

Senator GRAHAM. Yes. Those are the essential elements, that it would be prevention-oriented, that it would be targeted towards those chronic conditions which have the greatest likelihood of escalating into crisis health conditions, that there would be a relationship between those identified conditions and the drugs which are most likely to be medicative of those conditions, and that the costs would be voluntary shared costs between the client and Medicare.

In order to make this a no cost to the Federal Government program initially, we are suggesting a $100-deductible, a 5-percent copay on individual prescriptions, and a $4 voluntary monthly additional premium.

Your committee has unexcelled resources to evaluate whether those proposals will accomplish the objective of making this a no-cost-to-the-Federal-Government program.

I believe the fundamental issue is not, as the Chairman said, to debate the question of whether it is desirable to add prescription medication to Medicare, it is the question of how to begin the process. Where do we place our priority emphasis in terms of the quality of life for older Americans, in the economics of all Americans? I believe this is a reasonable place to start. We should have commenced in 1972; and now, some 15 years later, it is no longer acceptable that we delay in moving forward.

Senator MITCHELL. Senator Chafee?

Senator CHAFEE. Senator, I didn't quite understand the voluntary $4-payment. How would that work?

Senator GRAHAM. It would be at the election of the client, the Medicare-eligible participant, to pay an additional $4 per month under Part B of Medicare in order to receive these prescription drug benefits.

Senator CHAFEE. Oh, I see. It would be a Federal insurance program?

Senator GRAHAM. It would be a voluntary additional benefit under Medicare which, if elected, would have those costs to the client that I indicated—$4 a month voluntary additional payment under Part B, a $100 annual deductible, and 5 percent copay on individual prescriptions.

Senator CHAFEE. All right, thank you very much.

Thank you, Mr. Chairman.

Senator MITCHELL. Thank you again, Senator Graham, we appreciate it. We look forward to working with you in this area.

Senator GRAHAM. Thank you, Mr. Chairman.

Senator MITCHELL. We are pleased to be joined by the distinguished Chairman of the Committee, Senator Bentsen, at whose di-

rection these hearings are being held, and who is the author of the principal catastrophic cost legislation that will be on the Senate floor in the near future.

Mr. Chairman, do you have any statement you would care to make?

The Chairman. Mr. Chairman, I have no prepared statement to make, but I want to congratulate you on expeditiously holding these hearings. They are a matter of great concern to the Medicare beneficiaries who are duly upset and disturbed over the problem of out-of-pocket expenses on such drugs.

It is an awfully complex issue, as has been set forth by Senator Graham, who was making his statement. And what you are trying to do is resolve this, help it, take care of it, set out the priorities, while at the same time not increasing that premium up to the point where we have people dropping out of the program completely. And that is not an easy one to resolve, Senator. But I appreciate very much your proceeding with these hearings.

Senator MITCHELL. Thank you, Mr. Chairman.

Our next witness is the distinguished Chairman of the Labor and Human Resources Committee, who has been a leader in this area with concern for the elderly. We look forward to hearing the testimony of Senator Kennedy.

Good morning, Mr. Chairman.

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

Senator KENNEDY. Mr. Chairman, I appreciate the opportunity to be able to appear before the committee; I know you have a full morning.

Mr. Chairman, I want to commend you and Senator Bentsen and the other members of the Committee for your leadership on legislation to assure that senior citizens will have the health insurance they need and deserve.

By embracing Secretary Bowen's path-breaking proposal and adding to it, the Senate and the House have already signaled that this is more than minor tinkering with the existing program, in that we have an historic opportunity to deal with the major inadequacies of Medicare that continue to plague millions of elderly Americans.

This hearings will explore the priority improvements that should be included in the bare bones catastrophic bill that the Reagan Administration has proposed—the Committee has already acted to improve the bill in significant respects, but we need to do more. This is our best chance since Medicare was enacted to make the program what it ought to be. Far too many senior citizens will continue to pay an unacceptable price if we leave the job undone.

These charts show why enactment of the Bowen plan or even the Finance Committee bill do not meet the pressing needs of senior citizens. They illustrate the kinds of improvements that are necessary.

CHART NO. 1—HIGH RISK OF CATASTROPHIC EXPENDITURE

[All charts will be found at end of Senator Kennedy's prepared statement.]

This chart shows that a high proportion of senior citizens experience catastrophic health expenses every year, even when long term care expenditures are excluded from the calculation. Almost a quarter of all the elderly—6.8 million people—spend more than fifteen per cent of their income on health care. More than two million spend more than twenty-five percent of their income.

CHART NO. 6—ELDERLY AT FINANCIAL RISK

The previous charts have dealt with acute care costs. This chart shows the financial devastation that can result when a senior citizen enters a nursing home. Sixty-three percent of those who are single will spend down to a Medicaid level of pauperization after 13 weeks in a nursing home; 83 percent will reach that level after a year.

For the elderly who are married, more than a third will spend down to the pauper level in 13 weeks; more than half will reach that level after a year. And spending down to that level means that the non-institutionalized spouse loses all possibility for a decent retirement.

I respectfully suggest a number of improvements in the bill before this Committee.

First, it should include coverage for outpatient prescription drugs, which are critical to basic medical care and are a major element of the high medical costs not addressed by the pending measure. Coverage under Medicare is important because it is typically not available in private policies. An elderly person suffering from chronic ailments common among the elderly such as arthritis, hypertension, angina, and ulcers, could easly spend in excess of $1,000 a year for essential medication. As you know, the House Energy and Commerce Committee has included an affordable outpatient drug benefit in its catastrophic proposal, as has the Ways and Means Committee. I urge the Finance Committee to do the same.

Most senior citizens who need outpatient drugs require only small amounts, so the cost of worthwhile outpatient drug coverage can be kept in check if a moderate deductible is used. But it must not be so high as to deter needed use or to create excessive burdens for the elderly when considered in conjunction with other health costs. The Energy and Commerce Committee has established a $500 deductible, which I urge this Committee to adopt. I would like to see it lower—but certainly it should be no higher.

In addition, a drug benefit should also encourage the use of "smart cards" or other data processing technology to reduce or eliminate the need for senior citizens to submit complex claims for reimbursement. The processing of such claims drives up administrative costs and is unduly burdensome for the elderly.

Finally, any drug benefit should be based on mandatory assignment. Medicare reimbursement for drugs should be payment in full, and not leave any beneficiary exposed to additional charges by providers.

CHART NO. 2—MOST ELDERLY EXPERIENCING CATASTROPHIC EXPENSE (15 PERCENT OF INCOME SPENT ON HEALTH CARE) SPEND LESS THAN $1,700 OUT-OF-POCKET

This chart shows that the vast majority of the elderly with catastrophic expenses spend less than $1,700 out of pocket. They are low income elderly for whom an expenditure of $1,000 or $1,500 is catastrophic in terms of their already low living standard. Overall, about 77 percent—5.2 million—of the elderly who have catastrophic expenses spend less than $1,700.

CHART NO. 3—LOW INCOME ELDERLY ARE MOST VULNERABLE

This chart reinforces the point that it is the low income elderly who are most vulnerable. More than a third of the elderly with incomes less than $10,000 suffer catastrophic costs in a year, compared to less than six percent of those with higher incomes.

CHART NO. 4—ALMOST ONE HALF OF CATASTROPHIC EXPENSE IS FOR SERVICES NOT COVERED BY MEDICARE

This chart demonstrates that if we are to provide genuine catastrophic protection to senior citizens, we must expand the services covered by Medicare, not just put a limit on out-of-pocket costs for covered services. Almost half—46 percent—of the costs of seniors with catastrophic expenses is for services not covered by Medicare. And that does not even include long term care. As the chart shows, the largest single category of expense for non-Medicare services is outpatient drugs.

CHART NO. 5—FINANCE BILL HAS LITTLE IMPACT ON CATASTROPHIC BURDEN

These two factors:

Almost half of catastrophic expenses are for non-covered services; and

the elderly with catastrophic expenses are predominantly low income with low total costs

mean that the current Finance Committee bill cannot help much with the catastrophic expense problem. This chart shows that the current bill reduces the proportion of the elderly that spend more than 15 percent of their income on health care by only three-tenths of a percentage point, and it reduces the proportion that spend more than 20 percent only four-tenths of a percentage point.

I also urge the Committee to include coverage for outpatient mental health care. Unique psychological strains are associated with aging—loss of spouse and friends, changes in life style, vulnerability to organic brain diseases associated with old age—that require special treatment by mental health professionals.

Today, Medicare's outpatient mental health benefits are so inadequate as to be essentially nonexistent. As a result, the mental health problems of senior citizens are too often treated inappropriately and ineffectively by untrained practitioners—if they are treated at all. A decent benefit will assure that elderly Americans get appropriate mental health care at a cost they can afford.

Our legislation should also include special provisions for the low income elderly, who are the most vulnerable to high health care costs, and who are pauperized long before they reach the caps at the levels in the pending bills. The result is that low income elderly will go without essential care. They already use fewer services than other senior citizens, and they tend to be in poorer health, and that is unacceptable.

The most effective way to deal with this issue is to expand Medicaid eligibility. The time is overdue for Congress to require all States to cover all elderly citizens below the poverty line. Others who come close to the poverty line are vulnerable too, and I urge the Committee to permit States to provide Medicaid for elderly persons up to 150 percent of the poverty level.

Finally, Congress should also begin to address the problem of long term care. The Committee bill makes significant improvements in the current home health care benefit and expands Medicare's nursing home coverage for acute care situations.

The cruellest aspect of the long-term care problem is the pauperization of a spouse when a husband or wife must enter a nursing home. The enormous cost of long-term care makes it very difficult to deal with such care in a comprehensive way in light of the current budget deficit. But at the very least, we should change the Medicaid trigger to prevent pauperization of an elderly spouse in order to qualify for Medicaid assistance for long term care.

The cost of these basic Medicare improvements I am recommending—outpatient drugs and mental health care—is under $2 billion a year. The Medicaid improvements are around $700 million. The Medicare cost could covered by a five to six dollar monthly increase in the Part B premium, on top of the eight dollar additional premium for the increase that will occur under current law and for the improvements already included in the Committee's catastrophic bill.

That is too big an additional bite for the low-income elderly. However, the Committee bill already combines a flat-rate premium and a progressive charge related to ability to pay. If the additional Medicare benefits are financed in this fashion, the cost will not be unduly burdensome for either upper income or low income elderly.

In any event, the budget resolution, if it materializes at all, is likely to contain room for these improvements and for the needed Medicaid changes. And, as you know, this Committee has the flexibility to provide additional revenues to cover these costs if necessary.

When I first came to the Senate in 1962, Congress was in the final stages of the long and successful battle to insure the elderly against the intolerable burden of serious illness. Medicare made a vast difference in the health and security of the elderly, but it needs reinforcing now. The senior citizens of America look to us to keep the promise of Medicare. This is the year, this is the Congress, and this is the Committee to make that promise a reality.

[The prepared statement of Senator Kennedy follows:]

from the office of

Senator Edward M. Kennedy

of Massachusetts

TESTIMONY OF SENATOR EDWARD M. KENNEDY ON MEDICARE
HEARING ON CATASTROPHIC ILLNESS INSURANCE
SUBCOMMITTEE ON HEALTH
SENATE FINANCE COMMITTEE

For immediate release:
June 18, 1987

Mr. Chairman, I want to commend you and Senator Bentsen and the other members of the Committee for your leadership on legislation to assure that senior citizens will have the health insurance they need and deserve.

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These hearings will explore the priority improvements that should be included in the bare bones catastrophic bill that the Reagan Administration has proposed -- the Committee has already acted to improve the bill in significant respects, but we need to do more. This is our best chance since Medicare was enacted to make the program what it ought to be. Far too many senior citizens will continue to pay an unacceptable price if we leave the job undone.

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These two factors:

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I respectfully suggest a number of improvements in the bill before this Committee.

DRUGS

First, it should include coverage for outpatient prescription drugs, which are critical to basic medical care and are a major element of the high medical costs not addressed by the pending measure. Coverage under Medicare is important because it is typically not available in private policies. An elderly person suffering from chronic ailments common among the elderly such as arthritis, hypertension, angina, and ulcers, could easily spend in excess of $1,000 a year for essential medication. As you know, the House Energy and Commerce Committee has included an affordable outpatient drug benefit in its catastrophic proposal, as has the Ways and Means Committee. I urge the Finance Committee to do the same.

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In addition, a drug benefit should also encourage the use of "smart cards" or other data processing technology to reduce or eliminate the need for senior citizens to submit complex claims for reimbursement. The processing of such claims drives up administrative costs and is unduly burdensome for the elderly.

Finally, any drug benefit should be based on mandatory assignment. Medicare reimbursement for drugs should be payment in full, and not leave any beneficiary exposed to additional charges by providers.

MENTAL HEALTH

I also urge the Committee to include coverage for outpatient mental health care. Unique psychological strains are associated with aging -- loss of spouses and friends, changes in life style, vulnerability to organic brain diseases associated with old age -- that require special treatment by mental health professionals.

Today, Medicare's outpatient mental health benefits are so inadequate as to be essentially nonexistent. As a result, the mental health problems of senior citizens are too often treated inappropriately and ineffectively by untrained practitioners -- if they are treated at all. A decent benefit will assure that elderly Americans get appropriate mental health care at a cost they can afford.

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LONG TERM CARE

Finally, Congress should also begin to address the problem of long term care. The Committee bill makes significant improvements in the current home health care benefit and expands Medicare's nursing home coverage for acute care situations.

The cruellest aspect of the long-term care problem is the pauperization of a spouse when a husband or wife must enter a nursing home. The enormous cost of long-term care makes it very difficult to deal with such care in a comprehensive way in light of the current budget deficit. But at the very least, we should change the Medicaid trigger to prevent pauperization of the elderly in order to qualify for Medicaid assistance for long term care.

FINANCING

The cost of these basic Medicare improvements I am recommending -- outpatient drugs, mental health care, and long term care -- is $700 million a year. That cost could covered by a five to six dollar monthly increase in the Part B premium, on top of the eight dollar additional premium for the increase that will occur under current law and for the improvements already included in the Committee's catastrophic bill.

That is too big an additional bite for the low-income elderly. However, the Committee bill already combines a flat-rate premium and a progressive charge related to ability to pay. If the additional Medicare benefits are financed in this fashion, the cost will not be unduly burdensome for either upper income or low income elderly.

In any event, the budget resolution, if it materializes at all, is likely to contain room for these improvements. And, as you know, this Committee has the flexibiity to provide additional revenues to cover these costs if necessary.

CONCLUSION

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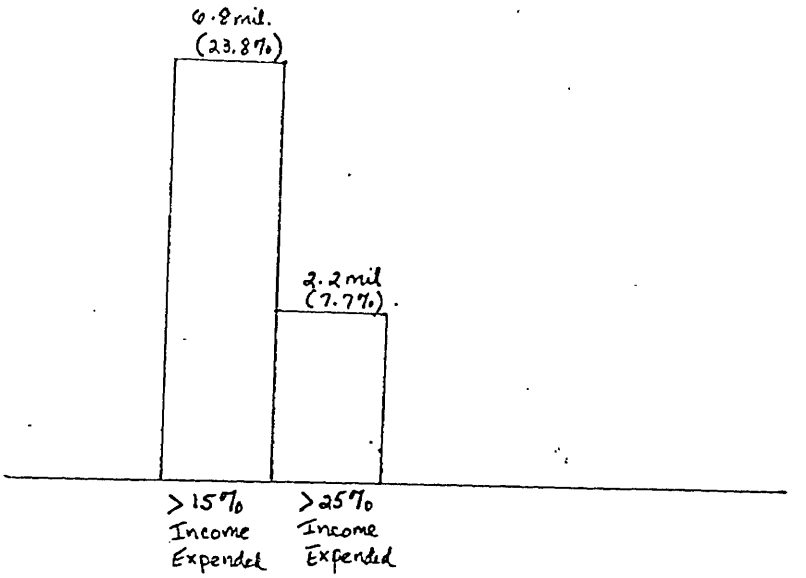
Chart I

1

Elderly are at high risk of catastrophic spending for acute care services.



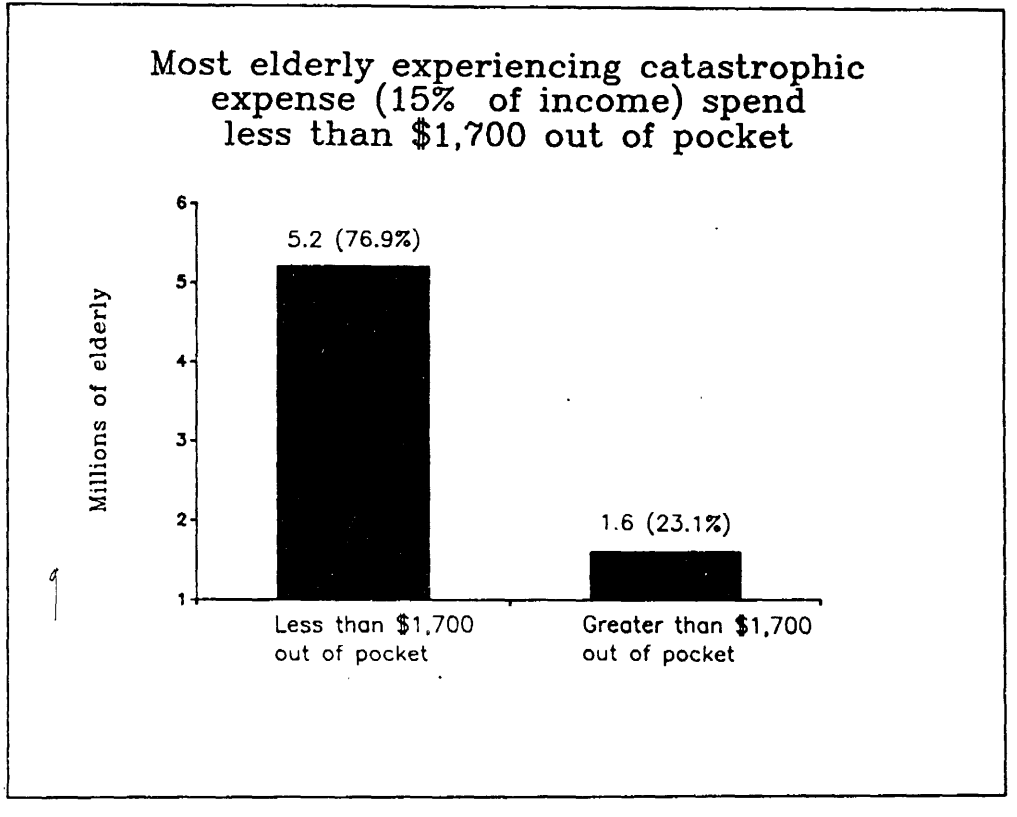

Most elderly experiencing catastrophic expense (15% of income) spend less than $1,700 out of pocket
Millions of elderly
6
5
4
3
2
1
5.2 (76.9%)
1.6 (23.1%)
Less than $1,700 out of pocket
Greater than $1,700 out of pocket

CHART III

The low income elderly are most vulnerable.

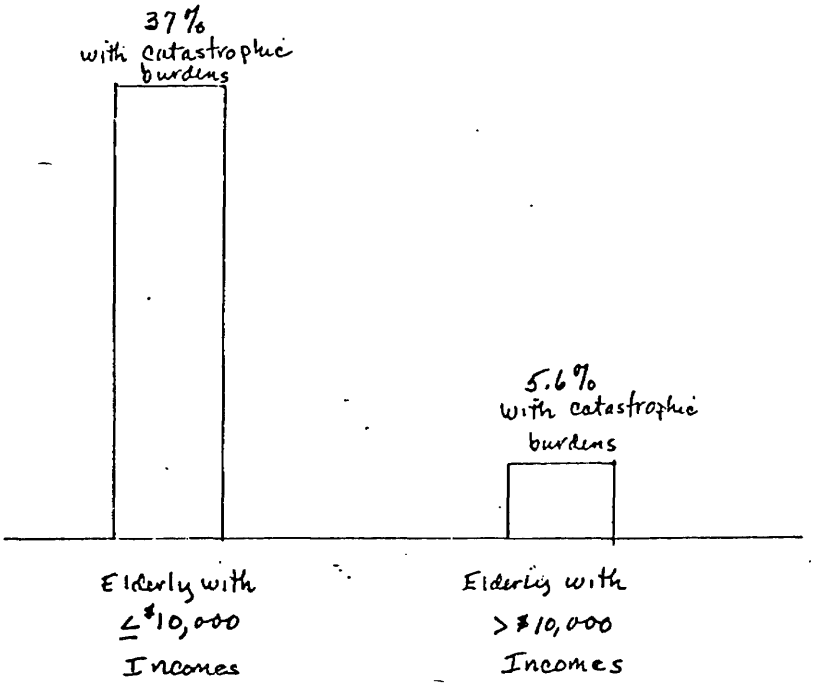
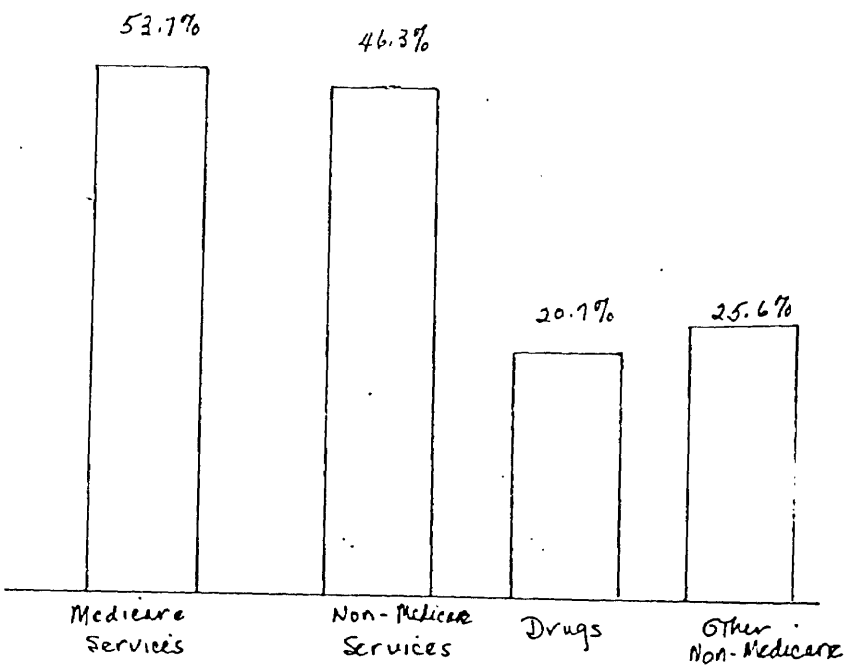
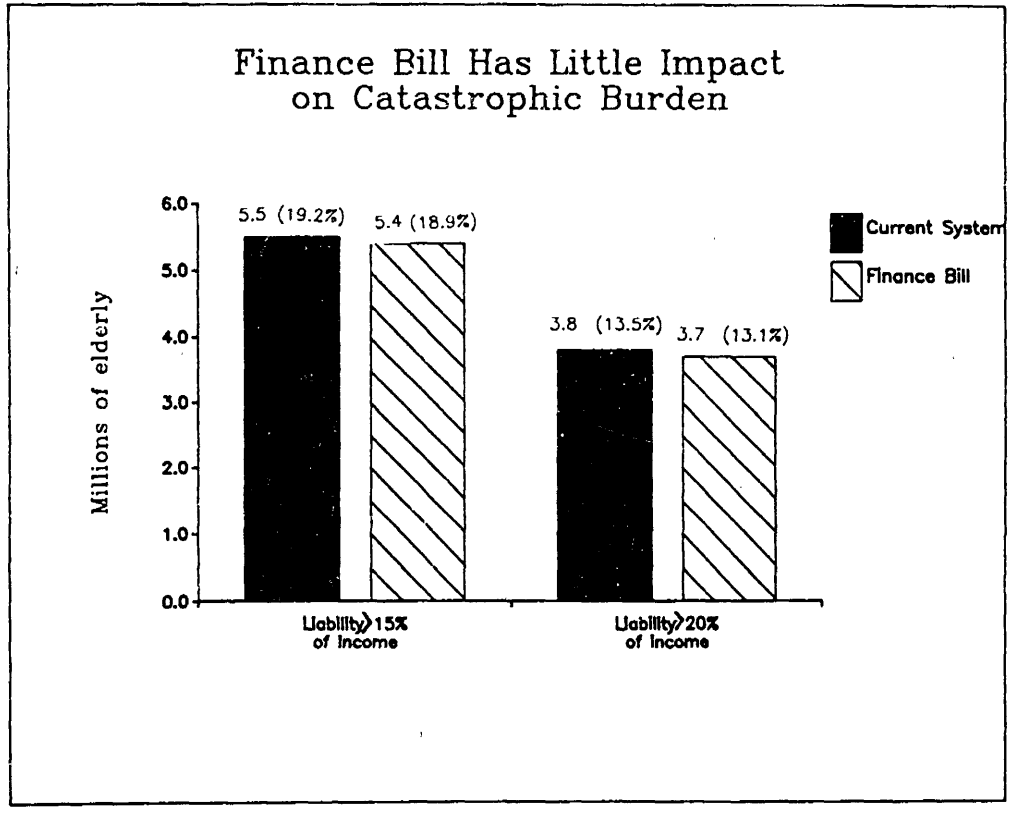
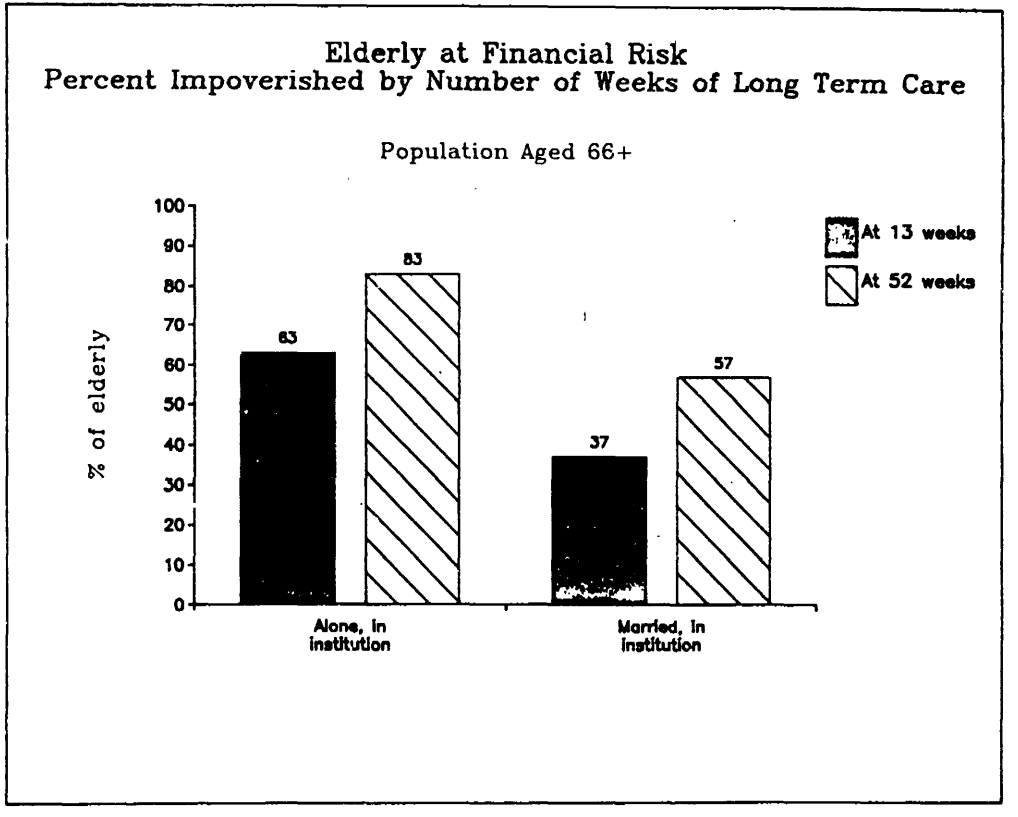


CHART IV

Almost half of catastrophic expense is for non-medicare services.




Finance Bill Has Little Impact
on Catastrophic Burden
Millions of elderly
6.0
5.0
4.0
3.0
2.0
1.0
0.0
5.5 (19.2%)
5.4 (18.9%)
3.8 (13.5%)
3.7 (13.1%)
Liability>15%
of Income
Liability>20%
of Income
Current System
Finance Bill


Elderly at Financial Risk
Percent Impoverished by Number of Weeks of Long Term Care
Population Aged 66+
% of elderly
100
90
80
70
60
50
40
30
20
10
0
63
83
37
57
At 13 weeks
At 52 weeks
Alone, in institution
Married, in institution

Senator MITCHELL. Thank you very much, Senator Kennedy, for a very thoughtful statement.

Are there any questions of Senator Kennedy by any member of the panel?

Senator Durenberger.

Senator DURENBERGER. Ted, you are one of the few people who, despite your youth, was around here through the creation of the Medicare program and for the 20-plus years since.

I have authored, and a number of people here have, some of the improvements in the mental health coverage, and since you and your family have been so committed to that area for so long, I wonder if you wouldn't just give us some idea how it is possible that over 22 years we haven't changed that benefit? I mean, why? You have a benefit that is sort of hospital-oriented, and, even at that, it is so limited in its access and has these ridiculous caps on it that when you look at it in 1987 you can't believe that we have let that happen for 22 years. Why have we?

Senator KENNEDY. It was—and is a $250 benefit program. It is virtually nothing.

I think, Mr. Chairman, the reason this benefit has not been expanded and was set so low originally is the issue of cost. As you well know, we are expending in total health care costs about $460 billion a year; we have the highest costs of any country in the world in percent of GNP, and there are enormous inefficiencies. And rather than addressing those inefficiencies and moving those savings to areas of need, the Congress has been reluctant to come to grips with this issue. I think this is part of our dilemma today.

I think, second, there is a greater appreciation, as you know, Senator, there is a greater appreciation today of the special needs in mental health.

Yesterday I attended a press conference on depressive illness, which is so rampant in our society. I think we are only recently coming to, one, recognizing the widespread aspects of mental health and their relationship to a lot of other public health problems such as drug abuse and alcoholism, and we have been very reluctant to try and come to grips with these and give them the attention and resources which they need. That's really the best I could say about it.

Senator MITCHELL. Thank you, Senator.

The CHAIRMAN. Yes. Thank you very much, Mr. Chairman.

Senator Kennedy, I am most appreciative of your appearance and your concern. You have certainly been a leader in this issue for a long time.

Looking at those charts, frankly, they are very disturbing to me, and I assume we will have those available to us for the record, so we can look at some of the background information as to how those numbers were developed.

Senator KENNEDY. Yes.

The CHAIRMAN. Because if I become satisfied that those numbers are basically correct, obviously it would be a matter of great concern to me.

But here is part of our problem: There isn't much of a data base. We don't have the experience in this. We have got to address this

problem, but our judgment is going to be on some great contradictions in information that we are getting insofar as costs.

I looked at the numbers from the HHS and CBO, and we talk about a $500 deductible and 20 percent co-insurance. The CBO numbers say the cost will be $1.4 billion, $3.90 a month. And I look at HHS's numbers, and they say it is $7 billion and $20 a month. It makes it pretty difficult to legislate.

Well, I couldn't agree with you more about the concern and the problem and having to try to address it.

Senator KENNEDY. Well, just two comments, Mr. Chairman. I think this committee obviously has to make the tough decisions as to how the funding of this total will be split between flat rate premiums and graduated premiums, and the rest, and I respect that. In terms of decisions on the cost of alternatives we have relied on the CBO historically for information and I think that this has served us well.

The other point I would underline, Mr. Chairman: If these costs are that much higher, we are getting that much more of a burden on the elderly. And the figures that we use here would even be taller pillars.

The CHAIRMAN. Yes.

Senator KENNEDY. And it is even more of a burden on our seniors. Perhaps we as a society aren't prepared to bite that particular bullet, but that is the reality. Either those figures are going to be higher and more of a burden on the elderly people, or it is a more affordable situation. Either way, I would hope that we would get the accurate figures.

But I think we should be equally alarmed if those figures are the correct ones of what the burden is in terms of outpatient drugs on the elderly people and how much of their money is being used for that. And the question then becomes: do you want those higher figures found by an insurance mechanism that spreads those costs across all the elderly and perhaps the general population as well, or do you want them to fall only on those seniors that have the misfortune to get sick.

Senator MITCHELL. Thank you very much, Senator Bentsen, and thank you, Senator Kennedy.

Senator Chafee?

Senator CHAFEE. Mr. Chairman, if I might?

Senator, what do you think about expanding the Medicaid program for the low-income working poor, and those who weren't covered by employers' insurance.

What I am worrying about is not just solely the elderly; but I am thinking about those in other categories who just aren't covered. What would you think of a big expansion of the Medicaid?

Senator KENNEDY. I have a different approach for the working poor. I think the employer ought to be providing health services for working poor people. There are many employers who are providing coverage, and they are at a competitive disadvantage compared to the companies that aren't providing it. It seems to me that, as we have a minimum wage, we ought to have a comparable minimum health program. We accept the minimum wage. There are ways in which we can work out special treatment for the smallest employers in terms of developing a consortium for the smaller businesses

to buy basic health insurance at less expensive rates. The premium rates are about 30 to 40 percent higher for small business, compared to the largest employers. But I think that could be worked out, and we are attempting to work with the insurance groups and others.

But I think if you are working, that burden ought to be borne by the employer rather than be put on the taxpayer, quite frankly.

In other words, you have 34 million Americans that don't have any coverage whatsoever.

Senator CHAFEE. That is the group I am worried about.

Senator KENNEDY. Right. Twenty-four million of those—and almost half of them are children—24 million of those are in working families. So, you can address great numbers just by mandating the coverage.

But it seems to me you still are going to have some others, and we need to address their needs. If the specific question is: Should you pick those up? I would say, "Yes."

But with regard to the 24 million who are working poor, I would do it through mandated coverage. There is a controversy about it, and I respect that, particularly in terms of mandating specific services; but that I think is the best way.

Senator CHAFEE. In your testimony you talked about the amount of money that is in the budget for Medicaid, and for the expanded coverage I think it is $400 million.

Senator KENNEDY. Yes.

Senator CHAFEE. And you advocated that all of that go for the elderly. We are all concerned about the elderly, but what about some of the other groups having a portion of that? What is your thought on that?

Senator KENNEDY. The Finance Committee has flexibility in how it allocates the spending, and whether it raises some additional revenue to meet the most important needs. You have a good program here in Finance for child benefits, prenatal and well-baby care. Senator Bradley has—I am a cosponsor and I know of a number of others—a plan to try to target care to high-risk mothers and infants. I am for the expansion of prenatal care for all expectant mothers, for example, that live below the poverty line. That is a very modest expenditure. But that does not mean that we should not meet the essential needs of the elderly.

And we have sort of targeted programs. Frankly, I am for a lot more, but what we are trying to do is address the highest priority needs. And I think there are targeted kinds of things you can do, particularly for the expectant mother who is living in poverty, given where we are in terms of infant mortality. There are a number of things that you can do, and they are dollar wise.

But I know what you are saying, and that is, if you have X-amount of money, how should we allocate it in terms of the whole range of needs?

I would do it this way for the elderly, I would do a mandated program for the working poor, I would do a targeted program and work through community health services for expectant mothers, and I would do a nutrition program for expectant mothers.

Senator CHAFEE. Well, I just do hope that we can do something on getting rid of the link between Medicaid and AFDC, that we can

provide Medicaid coverage for those working poor and those who are above, who now have to qualify for AFDC to get the Medicaid. I just hope we can press on.

Senator KENNEDY. Let me just finish. The principal inhibitor for people getting off welfare is the fact that they don't get any kind of medical coverage. And that is true in your part of the country as it is true in mine. This committee has some experience with the WIN program. We see it in our program. Lack of day care and medical coverage are the main inhibitors. If we assure medical coverage for everyone who works, we will begin to make some really important progress on welfare.

Senator CHAFEE. Well, we will look forward to working with you on that. Thank you.

Senator KENNEDY. Thank you.

Senator MITCHELL. Are there any other questions of Senator Kennedy? Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Senator, I join with others in commending you for your leadership here, and it is an area we have to address.

Senator Graham, who apparently is not here, when he testified suggested perhaps limiting coverage to a shorter list of drugs, drugs that are preventive in nature—that is, they help control diabetes or they retard arthritis—to prevent greater costs that might result from hospitalization, with a lower deductible, rather than more drugs, greater in nature, with a higher deductible. I am just curious as to what your reaction to that is.

Senator KENNEDY. I admire what the Senator is attempting to do. I have trouble, however, making a choice between acute care and chronic care. Basically you are talking about out-of-pocket costs for the poorest people, and whether it is acute or chronic, the need is just as great and the care is just as great. It seems to me that if it is out of pocket and we are talking about the elderly people, and they are the neediest people, whether it is acute or chronic, I don't really——

Senator BAUCUS. I think, though, somewhat Senator Bentsen's point, the data is just not all that convincing or clear.

Senator KENNEDY. Oh, I understand. I think all of us are trying to at least hopefully put on as much as the train will bear on these things, and trying to find ways of doing it. It is costly, but there are some important equity and humanitarian issues involved.

As I say, you know, you might be able to get a special justification if you can provide additional kinds of resources for certain types of disease, and you are going to prevent those people from going in the hospital, and that kind of thing. That gets you involved in very fine tuning.

I know that the materials have already been provided to this committee in terms of the amount of utilization for those particular diseases—and these figures are even more up in the air than the total cost figures. I think I would probably stick with reaching some kind of basic deductible limit—$500, or whatever.

One additional administrative issue I would like to mention is that of a "smart" card. That smart card is working down in the Southwest; it is saving a lot of resources. If you legislate a drug benefit with this kind of provision you save a lot of administrative costs. It

has been out in the field, and it is working. If you reach something on the drugs, I would hope that you would give some consideration to that.

Senator BAUCUS. Thank you.

Senator MITCHELL. Thank you very much, Senator Kennedy. We appreciate it and look forward to working with you.

During the Senator's testimony, Senators Pryor and Baucus came in. I want to recognize them.

Do you have an opening statement you would care to make, Senator Pryor?

Senator PRYOR. Mr. Chairman, I thank you, and I join the others in applauding Senator Kennedy for his statement this morning. I know we are in a tough situation, trying to work out a hard problem. I thank him for his presentation.

But, Mr. Chairman, I do have an opening statement. I would like to just submit it for the record.

Senator MITCHELL. All right.

Senator Baucus, do you have an opening statement?

Senator BAUCUS. No statement.

Senator MITCHELL. Then, let me call the next witness, Dr. Ronald Docksai, Assistant Secretary for Legislation, Department of Health and Human Services, accompanied by Louis Hays, Associate Administrator for Operations, Health Care Financing Administration.

STATEMENT OF RONALD F. DOCKSAI, PH.D., ASSISTANT SECRETARY FOR LEGISLATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC, ACCOMPANIED BY LOUIS HAYS, ASSOCIATE ADMINISTRATOR FOR OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION, AND GUY KING, CHIEF ACTUARY OF HCFA

Dr. DOCKSAI. Thank you very much, Mr. Chairman.

Senator MITCHELL. Good morning. We look forward to hearing from you.

Dr. DOCKSAI. With your permission, sir, I would like to enter my formal statement into the record and briefly summarize it.

Senator MITCHELL. All right.

[Dr. Docksai's prepared statement follows:]

STATEMENT BY

RONALD F. DOCKSAI, PH.D

ASSISTANT SECRETARY FOR LEGISLATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON FINANCE

UNITED STATES SENATE

JUNE 18, 1987

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the Administration's views on Medicare coverage of prescription drugs, and to specifically answer the question of whether a prescription drug benefit should be included in catastrophic protection legislation. I am accompanied by Mr. Louis Hays, Associate Administrator for Operations, Health Care Financing Administration.

The Administration strongly believes that this legislation should provide acute care, catastrophic protection for the elderly. Expansions to Medicare unrelated to acute care, catastrophic protection should not be included in a catastrophic bill. The Administration conveyed to the House that inclusion of an outpatient prescription drug benefit alone could lead to a veto recommendation by the President's senior advisors. The merits of such a benefit expansion may be debatable, but it should not be included in a catastrophic bill sent to the President.

Specifically, I would ask you to consider the following questions relating to a prescription drug benefit: Is it needed? Is it catastrophic? Would it be <u>self-financing?</u> What would it cost the Medicare Program? Is it administrable? Is it appropriate as a Federal Medicare benefit, or is it more appropriately placed in the private sector?

What is the Need for a Prescription Drug Benefit?

Almost all elderly citizens use prescriptions drugs. However, drug expenses do not usually represent catastrophic costs. In fact, we estimate that 50 percent of the elderly will spend less than $175 on drugs in 1989, and 20 percent will spend nothing. For those who spend the most, these costs are often picked up by insurance.

- o prescription drugs for low-income beneficiaries are paid for by Medicaid in all but two States; and
- o thirty percent of non-Medicaid beneficiaries have Medigap policies with at least some prescription drug coverage.

Futhermore, proposals to restructure Medicare would alleviate most of the residual out-of-pocket liability. Beneficiaries who incur significant costs for drugs are usually those who also utilize a great deal of other Medicare services. Therefore, adding a stop-loss feature to current Medicare benefits should serve to reduce the burden of drug expenses.

Would it be Self-Financing?

According to our actuaries, preliminary estimates of the various drug proposals under consideration have been severely understated. Our estimates are that the major prescription drug proposals offered in the House of Representatives would cost from $6.18 to $8.4 billion -- that's with a "b" -- in 1989. Ongoing administrative costs could range from $470 to $577 million,

approximately 7 percent of the benefits paid out under this program expansion. Thus, a drug benefit is very costly to administer, compared with other Medicare services, for which administrative costs average 1.3 percent of service costs.

We have analyzed the various proposals in the House and we estimate that, for prescription drugs alone, the premium would range from $18 to $24 per month in 1989. And this is in addition to the basic part B and catastrophic premiums.

The initial cost to the beneficiary, we feel, would be overwhelming. I cannot resist pointing out that some critics denounced the part B premium proposed by the Administration as being unaffordable. It is one-fourth the cost of the premium we are discussing today.

It is doubtful that costs of this magnitude could be designed into a self-financing benefit package. Even if five-year estimates could show it to be budget-neutral, there would be, no doubt, a tendency at some future time to look toward general revenues to subsidize the benefit, rather than increase the beneficiary's premium to keep pace with inflation. Consequently, the Medicare program would be at risk for continuing a high cost benefit package.

I would like to turn now to the question of our ability to administer a program as complex as drug coverage.

Administration

We believe the administrative problems would be immense. Much further analysis is required before we could even recommend an appropriate strategy.

I will list a number of significant issues upon which Mr. Hays is prepared to elaborate, should you have questions.

- o Payment and Coverage

Foremost among the problems of designing and implementing a Medicare drug benefit is determining which drugs are to be paid for and how much one should pay for their coverage.

A difficult choice would need to be made between covering all drugs that require a prescription and establishing a Federally prescribed formulary. A formulary could be either a list of drugs that Medicare will cover -- a positive formulary -- or a list of drugs that Medicare will not cover -- a negative formulary. While a formulary may seem desirable in terms of limiting the benefit to cost-effective drug products, the administrative process and political controversy entailed in distinguishing among these products could outweigh any benefit savings.

Without a formulary, other significant problems would arise. First, would be the issue of program costs. Any prescribed drug approved by the Food and Drug Administration such as antibiotics and cough medicine would be covered under Medicare, including drugs used only episodically for short-term illnesses. Second, another adverse consequence would likely occur without a formulary because of inevitable substitution effects. Such medications as vitamins and skin ointments now sold as over-the-counter remedies would surely decline and be replaced by prescribed forms of these medications.

We all want Medicare to get the best possible deal for its dollars while paying a fair amount. To accomplish this, however, more work would be necessary. HCFA would have to do extensive surveying, data gathering, and auditing to assure our beneficiaries, who would be paying for this coverage, that they are getting the best possible deal.

You should be aware that, ultimately, the result could be to move Medicare in the direction of administered-pricing.

o Claims Processing

A new drug benefit would necessitate the establishment of a complex and costly administrative system. Depending on its design, Medicare may have to process as many as 300 million claims per year and monitor about 67,000 pharmacies. As I indicated earlier, the ongoing costs for administering a drug benefit would be significant.

Since an average drug claim will be only $10 to $20 in 1989, the ratio of administrative cost to benefit cost would be very high. We estimate that the average per-claim cost to Medicare, primarily for claims processing, would be $1.72. This does not include the additional costs of audits, medical reviews, and other administrative tasks. Total start-up costs would be about $110 million.

o Participating Pharmacists

To reduce the number of claims that HCFA would process, one suggested approach we have heard advanced would be to institute the concept of "participating pharmacies." This would not only create confusion on the part of beneficiaries, but significant resources would be required to audit the benefit to ensure that claims were submitted only for valid prescriptions. Under this approach, pharmacists would have to keep comprehensive records that would stand up to post-adjudicative audits.

Since pharmacists would be required to keep track of individual beneficiary drug expenses, their costs would be substantial. Only 13 to 19 percent of beneficiaries might meet the deductible, so eventual billing and payment to the pharmacy for its effort would be limited. Pharmacists may be willing, initially, to accept a set administrative allowance of, say, $4.50, which has been suggested. However, given their increased record-keeping burden, they might soon expect to receive a higher amount, especially if payment for product costs are tightened.

Coordination of records to keep track of beneficiary expenses is also an important issue. It would be especially complicated for beneficiaries who use more than one participating pharmacy. Not all pharmacies have the capacity for electronic mail claims. In fact, only 40 percent do, and they tend to be the larger pharmacies. Clearly, pharmacies in rural areas do not generally have this capability.

The alternative to the participating pharmacy concept is for beneficiaries to submit claims directly to Medicare. Medicare would then have to process hundreds of millions of additional claims, most of which would not be eligible for payment. In addition, based on our experience, we would expect that many of

the claims would be submitted with incomplete information. Beneficiary dissatisfaction with this process would be noticeable, since only a few of the claims submitted would be eligible for payment.

Another approach would be to require Medicare beneficiaries to hold their drug bills until they reach the deductible, and then submit them to Medicare. While this would reduce the number of separate transactions, all of the other time consuming problems of screening for eligible drugs, applying cost limits, and obtaining missing information would remain. Further, maintaining the record system would be a burden on some persons of advanced age or infirmity.

CONCLUSION

Mr. Chairman, as you are aware, the Department of Health and Human Services recently spent over a year analyzing approximately 50 different proposals for a catastrophic health insurance program. In the end, the President decided on a plan which would provide peace of mind, and which would be affordable to both taxpayers and beneficiaries. Whether new benefits such as prescription drugs are advantageous or not is a separate question from that of simply and directly adding catastrophic coverage to

the Medicare program. We do not believe that a catastrophic protection bill is the appropriate vehicle on which to place additional and worrisome costs that will eventually threaten the entire Medicare program. Secretary Bowen has signaled to the House leadership that inclusion in the legislation of a drug benefit, which -- if it could be crafted -- would run into billions of dollars in expenditures per year, could cause recommendation of a Presidential veto. I hope the Committee will keep this in mind as you weigh this issue.

Prescription Drug Data Summary

HCFA Program Cost Estimates

	Calendar Year			
	1988	1989	1990	1991
1. Annual Mean Expenditure per beneficiary	$342	$370	$400	$432
Aged	336	364	392	424
Disabled	411	443	480	518
2. Cost Per Rx				
Aged	$18.97	20.19	21.32	22.67
Disabled	18.92	20.15	21.32	22.60
3. No. of Rx Per Beneficiary				
Aged	17.7	18.0	18.4	18.7
Disabled	21.7	22.0	22.5	22.9
4. Beneficiaries With Expenditures Exceeding				
$400 (No Coin.)	23.6%			
$500 (20% Coin.)	19.2%			
5. Estimated Total Annual Incurred Program (Beneficiary) Cost (billions)				
$400 (No Coin.)	-	$8.9	$10.2	$11.7
* $500 (20% Coin.)	-	6.4	7.4	8.3
6. Incurred Premium Required Excluding Administrative Costs (monthly premium)				
$400 (No Coin.)	-	$22	$25	$28
* $500 (20% Coin.)	-	16	18	20

(*increasing after 1988)

HCFA Administrative Cost Estimates

1. Start Up Cost FY 88 — $110 million
2. Processing Cost Per Claim
   - Hard Copy (65%) — $1.84
   - Electronic (35%) — $1.49
3. Bill Volume — 240 million
4. Total Cost (millions)

FY 88	FY 89	FY 90	FY 91	FY 92
$110	$470	$486	$500	$512

5. Additional Premium
   To Cover Adm. Costs < $2.00 monthly

HCFA/CBO Comparative Costs

An item by item comparison of HCFA and CBO estimates is not possible because some CBO estimates are provided on a fiscal year basis while HCFA used a calendar year basis and in other circumstances we do not have comparative data for all years beyond 1989. However, items that can be compared are reflected below.

1. Annual Mean Expenditure per beneficiary. 1988
   - CBO $250
   - HCFA 342
2. Average Price Per Prescription 1988
   - CBO $16.25
   - HCFA 18.97

3. Administrative Costs:

Start-up costs	1988	
CBO	100 million	
HCFA	110 million	
Processing Cost Per Claim	1989	
CBO	$1.40 Manual	$1.10 Electronic
HCFA	1.84 Manual	1.49 Electronic

Dr. DOCKSAI. As always, Mr. Chairman, it is a great privilege to be here with you and with the other distinguished members of the committee, in the case this morning to discuss the question of whether a prescription drug benefit should be added to the pending health/catastrophic protection legislation.

I am accompanied by the Associate Administraton for Operations of the Health Care Financing Administration, Mr. Louis Hays, as well as the Chief Actuary of HCFA, Mr. Guy King, both of whom would be pleased to join me in answering any questions you may have in the wake of my testimony.

Mr. Chairman, it is no secret where we stand on the legislative issues of catastrophic health insurance in itself. Borrowing a phrase from the great Dean Acheson, our Secretary, Dr. Otis Bowen, was present at the creation of this proposal. Likewise, I don't believe any reasonable person can doubt the benefit to be accrued to older Americans by a proposal to lighten the burden of having to pay for prescription drug items, especially for those in need.

Your own legislative leadership, Mr. Chairman, as well as that of the other members of this committee—particularly Senator Heinz, Senator Durenberger, Senator Baucus, Senator Chafee, Senator Bentsen—suggests that——

Senator MITCHELL. You'd better get Senator Pryor up here, too. [Laughter.]

Senator PRYOR. By unanimous consent, we'll all think, surely. There might be an objection. [Laughter.]

Dr. DOCKSAI. That goes without saying, Mr. Chairman.

Senator MITCHELL. Did you hear what he said? It is so obvious that you are aware it goes without saying.

Dr. DOCKSAI. And obviously, Mr. Chairman, the interest in a prescription drug benefit is bipartisan. Equally bipartisan is an increasing concern about the costs, and that is: What would adding a prescription drug benefit to a catastrophic bill do to the Medicare program? What would it mean for the beneficiary? Exactly how much would it cost? Would it be self-financing; or, as we fear, must the money come from elsewhere? And where is that? And if we do it under Medicare, is it administerable? Might it be more appropriately placed in the private sector?

Now, these are obviously important questions, and may in fact be pending proposals' operative questions; but the answers to them remain controversial.

Because of these questions and the widely differing estimates, I was informed just before this hearing, Mr. Chairman, that the President will be asking our Department to conduct an additional full-cost and administrative-impact study of the pending drug add-on proposals. President Reagan's and Secretary Bowen's highest level of interest in this issue will help to get these questions satisfactorily answered, and hopefully answered sooner rather than later.

Until then, Mr. Chairman, the Administration must oppose adding on this costly benefit to the Medicare program, based upon our best actuarial estimates. This is, after all, an add-on, the self-financing of which cannot now be guaranteed.

This is not to question the appeal of adding a prescription drug benefit to the proposed catastrophic program. And perhaps in the wake of our imminent study ordered by the President, a solution could be found to the cost and administrative problems cited earlier. However, such a solution is nowhere in sight.

This is largely why we do not believe that a catastrophic protection bill is the appropriate vehicle on which to place additional and worrisome costs—costs that could eventually threaten the entire Medicare program. In fact, Secretary Bowen recently signaled to the House leadership that inclusion in the legislation of a drug benefit—which, even if it could be crafted, would run into billions in additional expenditures each year—could cause recommendations of a Presidential veto.

Mr. Chairman, I have sent to each member of the committee and to all key legislative staff a copy of this letter by Secretary Bowen, the so-called "Bowen veto letter," as euphemized right now. We have sent that to each member of the committee and to key legislative staff, and I ask that it be put in the record.

Senator MITCHELL. Without objection.

[The letter from Secretary Bowen follows:]

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON D.C. 20201

The Honorable John D. Dingell
Chairman
Committee on Energy and Commerce
House of Representatives
Washington, D.C. 20515

JUN 15 1987

Dear Mr. Chairman:

When the President announced in his State of the Union message this year that he would transmit to the Congress legislation providing for acute care, catastrophic coverage under the Medicare program, a dialogue began which emphasizes the substantial consensus across the Nation for providing the elderly with this protection. Indeed, the debate thus far has centered largely -- not on whether to provide this protection -- but on how to accomplish this goal.

Unfortunately, we are most concerned that unanimity on the need for the legislation could be jeopardized by the content of the bills currently being debated by the Ways and Means and Energy and Commerce Committees. These bills contort the concept the President endorsed: to provide an acute care, catastrophic benefit under Medicare. Instead, it appears that the legislation has become a vehicle for modifications and add-ons to the basic Medicare program.

Enactment of legislation of the variety currently under consideration in the Congress will result in a cruel hoax on the intended beneficiaries. These program add-ons, combined with the lower out-of-pocket threshold, result in program cost increases that quickly outpace the bill's financing, greatly jeopardizing the stability of the program's design. The elderly will once again be faced with uncertainty as to the dependability of their coverage. This Administration will not tolerate that result.

Preliminary estimates by the Medicare actuary and Treasury indicate that even without the estimated $7-9 billion annual cost of a drug benefit, by 1993 the House bill's program costs will exceed revenues, with a shortfall of close to $10 billion likely by the year 2000. I know that every member of the Committee shares the Administration's concern that this coverage must be self-financing and budget-neutral. Given current projections as to the future solvency of the Medicare trust funds, such a shortfall would threaten Medicare itself -- a truly catastrophic event this Administration cannot allow.

This Administration has continually expressed its opposition to the financing mechanism contained within H.R. 2470, the Medicare Catastrophic Protection Act of 1987. We prefer the Administration's premium approach that avoids the serious problems created when the financing for an insurance program is tied to the tax code.

The bill which emerged from the Ways and Means Committee contained a number of disturbing add-ons to the concept of a catastrophic health care proposal.

When H.R. 2470 was approved by the Energy and Commerce Health Subcommittee, the list of expansions grew even longer, as the Subcommittee added: a costly, new drug benefit; a new, in-home care benefit for homemaker services; a further expansion of the Ways and Means expansion for mental health coverage; and others. The merits of these proposals to the Medicare program can be debated, but this is not the appropriate vehicle on which to place additional and worrisome costs that will eventually threaten the entire Medicare program.

We strongly oppose the addition of a new drug benefit to the Medicare program. Our actuaries have estimated that the Ways and Means approach to the drug benefit could cost $7 billion the first year alone, and the Energy and Commerce approach $9 billion. Even if either of these provisions were to be enacted, this benefit could not be administered through Medicare until January 1989, or perhaps 1990, at the earliest. We believe that the administrative problems would be immense. Much further analysis is required before the Administration could even recommend an appropriate strategy.

Inclusion in the legislation of several provisions alone could cause recommendation of a veto, namely the mandated Medicaid buy-in, which impinges on an area best left to the States, and the well-intentioned but ill-advised drug benefit, which -- if it could be crafted -- would run into billions of dollars in expenditures per year.

While we continue to stand enthusiastically behind our desire to enact a catastrophic health care program to ensure this Nation's elderly against devastating acute illnesses, that is not what the legislation currently before the Congress has become.

Should this legislation reach the President's desk in its current form, other senior advisers and I would be forced to recommend a veto. This is not a step we would take lightly, for we are committed to providing the elderly and disabled with this catastrophic protection.

I strongly urge that you reconsider the direction in which this legislation is headed and steer it back toward our original goal of providing catastrophic health care insurance for the elderly and disabled. We are advised by the Office of Management and Budget that enactment of H.R. 2470 would not be in accord with the program of the President.

Sincerely,

Otis R. Bowen M.D.

Secretary

Dr. DOCKSAI. Also, sir, I request that HCFA's actuarial drug benefit assessment to date—all the studies, the black box, all the methodology outlined—that that be entered into the record as well.

Senator MITCHELL. That will be done, without objection.

[The HCFA assessment follows:]

Special Report

Outpatient prescription drug spending by the Medicare population

by Daniel R. Waldo

Legislation proposed in the 100th Congress and debated during the summer of 1987 would cover prescription drug spending by Medicare enrollees after the enrollee had met a deductible. However, at the time that the legislation was proposed, there were no comprehensive estimates of the extent of current expenditures for prescription drugs by that population, nor of the expected cost of the proposed coverage.

In this article, the author estimates "current-law" drug spending by Medicare enrollees. A distribution around the average expenditure is developed, demonstrating the proportion of users that exceed any given annual expenditure and the proportion of total expenditures comprised by spending in excess of that "deductible."

Introduction

Aged and disabled Medicare enrollees will spend an estimated $310 per person for outpatient prescription drugs in 1987. Mean spending is expected to rise to $342 in 1988 and to $432 in 1991 under current-law assumptions (that is, without considering the effects of proposed coverage of prescription drug spending by the Medicare program or of any other proposed caps on out-of-pocket health expenditures).

Spending for prescription drugs has increased more than can be explained merely by price inflation. For example, aged users of prescription drugs spent an average of $96 in 1977, according to the Current Medicare Survey for that year (Grindstaff, Hirsch, and Silverman, 1981). Had the average changed by no more than the growth in the prescription drug component of the consumer price index (CPI), that figure would reach $240 in 1987. In fact, however, there is considerable evidence of trends for the aged population in the number of prescriptions per capita and in the "real" (CPI-adjusted) cost per prescription, both of which raise the rate of growth in spending for drugs.

The distribution of spending for prescription drugs seems to be changing as well. Not only has the mean level of expenditure increased (due to price and use changes); the variance ("spread") has increased commensurately, although the overall shape of the distribution has remained the same. Consequently, correct modeling of prescription drug spending must take into account trends in price, use, and distribution of that spending.

The purpose of this report is to present current-law estimates of prescription drug spending by Medicare enrollees. The derivation of use per capita and of cost per prescription is shown, as is the development of a distribution of that spending. The mean and distribution of expenditure are used to estimate a premium needed to cover the cost of that expenditure.

The problem of estimating drug spending is compounded by the absence of recent surveys on the subject. Subsequent to the last of the Current Medicare Surveys in 1977, the National Medical Care Utilization and Expenditure Survey (NMCUES) in 1980 and the Consumer Expenditure Surveys of 1982 through 1984 measured health expenditures. Other surveys addressed some facets of health spending or some facets of health care delivery. Consequently, the estimates presented in this article are the product of a piecing together of information found in a variety of other surveys, rather than the results of a direct survey of drug spending. However, the results of the process are, by their nature, consistent with most other estimates of drug expenditure.

Estimating prescriptions per capita

In this article, "prescriptions" refers to outpatient use of prescription drugs. Medicare hospital insurance pays for almost all prescription drugs when they are furnished to beneficiaries confined to a hospital or skilled nursing facility, but these prescription drugs are not counted in this article. However, prescription drugs given by physicians to supplementary medical insurance beneficiaries who are outpatients or who are patients in nursing homes are counted. Prescriptions include those filled or refilled by registered pharmacists in retail drug stores or hospital clinics and those dispensed in person or by telephone by physicians, with or without charge (Grindstaff, Hirsch, and Silverman, 1981).

The number of prescriptions per capita for Medicare enrollees was estimated for each of six groups: aged institutionalized, four age cohorts of the noninstitutionalized aged population (ages 65-69, 70-74, 75-79, and 80 or over), and the (nonaged) disabled.

Prescription rates for the aged population are based on results from the Current Medicare Survey (CMS), which provided annual estimates of spending in calendar years 1967 through 1977. The CMS covered a random sample of institutionalized and noninstitutionalized enrollees and elicited information on covered and noncovered medical goods and services consumed (excluding inpatient care).

The first step in estimating prescription rates was to establish a relationship between use by institutionalized and noninstitutionalized aged

Reprint requests: Daniel R. Waldo, L1, 1705 Equitable Building, 6325 Security Boulevard, Baltimore, Maryland 21207

Author's note:

In the report on "Outpatient prescription drug spending by the Medicare population" (Health Care Financing Review, Fall 1987, pages 83-89), I described some of the contents of Table 2 incorrectly. On page 88 of the report, what is labelled (both in the table and in the text) as the proportion of expenditures *that exceeds* the annual deductible actually is the proportion of total expenditures *incurred by people whose spending exceeds* the annual deductible.

Using terms defined in the report, the proportion of spending that exceeds the deductible is written:

$$\frac{\int_k^\infty (x-k)\, f(x)\, dx}{\int_0^\infty x\, f(x)\, dx} = \frac{\int_k^\infty x\, f(x)\, dx - k \int_k^\infty f(x)\, dx}{\int_0^\infty x\, f(x)\, dx} = E - kU/M$$

For example, to find the proportion of total expenditures over a $600 deductible in 1990, we would use Table 2 to get:

$$.6912 - (600 \times .3059 / 513) = .3334 = 33\%$$

I apologize for any confusion the ambiguity of the report may have created.

Daniel R. Waldo

enrollees. Published data for 1973 show that the institutionalized used twice as many prescriptions per capita on average as did the noninstitutionalized (Deacon, 1977). In the absence of any published information to the contrary (the institutionalized population has not been surveyed since termination of the CMS in 1977), that relationship was assumed to be constant over time.

The second step in estimating prescription rates was to establish relative use among the noninstitutionalized population. Because published CMS data included only two age breaks, data from a report on the 1980 NMCUES were used (LaVange and Silverman, 1987). It was assumed that relative use of drugs among the age cohorts of the noninstitutionalized population was invariate over time. The 1980 use rates were adapted to the 1973 noninstitutionalized total through use of population estimates and the assumption of relative invariance of use over time among cohorts.

The third step in the estimation of use per capita for the aged was to establish figures for the 1967-77 period. Because the CMS had already generated estimates of aggregate prescriptions per capita, this step merely disaggregated that overall average into the various subgroups (institutionalized, and noninstitutionalized aged 65-69, 70-74, 75-79, and 80 years or over). Once again, this was done by using population estimates and assuming the constance of relative use rates over time.

The fourth step in estimating prescription rates was to extend the 1977 figures through 1980, using data from the 1977 CMS, the 1977 National Medical Care Expenditure Survey (NMCES), and the 1980 NMCUES. NMCES and NMCUES both understated actual experience during their respective years,and it was necessary to inflate the estimates of prescription rates produced from them to conform to the results of the more representative CMS figures. To do so, relationships among the three surveys were compared with independent estimates of outpatient prescription drug sales for the total population (Trapnell and Genuardi, 1987). As a result of the comparison, NMCES figures were increased by 28 percent and NMCUES figures by 22 percent.

The fifth step in the process of estimating use per capita was to derive figures for 1980-85. Although there have been no surveys of the population concerning drug use since 1980, the National Ambulatory Care Survey (NAMCS) did survey office-based physicians in 1980 and again in 1985 to determine characteristics of drug use (Koch, 1982, 1987). The NAMCS figures are for drug "mentions," which cover drugs prescribed or provided during a physician office visit (about 80 percent of which involve prescription drug use as defined in this article). Drugs provided or prescribed during other contacts (telephone, hospital visit, nursing home visit, etc.) are excluded. Growth in drug mentions, adjusted for population growth, was used to extend prescription rates after 1980; the 1.7 percent annual rate was slightly lower than a figure for the 1981-86 period established by similar estimates from the National Diagnostic and Therapeutic Index.

Finally, prescription rates were carried forward from 1985. In the absence of more recent data, the trend established between 1973 and 1985 was used to project prescription rates under current-law assumptions. The resulting time series, covering 1967 through 1991, shows rapid growth in use per capita between 1967 and 1973, and more moderate growth since that time (Figure 1).

Rates for the disabled population were based on a tabulation of the 1977 NMCES file. In that tabulation, prescription rates were calculated for aged Medicare enrollees and for nonaged Medicare enrollees; the latter group was presumed to be disabled. Disabled people were found to use about 30 percent more prescriptions than noninstitutionalized aged use, a factor that was assumed to hold constant over time.

Estimating cost per prescription

Estimating cost per prescription for Medicare enrollees was done using methods parallel to those used to estimate prescriptions per capita.

During the first years of the analysis, CMS data were available to estimate cost per prescription for the aged (Grindstaff, Hirsch, and Silverman, 1981). Estimates for five subgroups of the aged (institutionalized, and noninstitutionalized aged 65-69, 70-74, 75-79, and 80 years or over) were controlled to the CMS aggregate figure for years 1967 through 1977 using population, estimated prescription rates developed with the methodology described above, and relative cost per prescription for the subgroups. (Relative cost per prescription was held constant at factors determined by the 1973 CMS study [Deacon, 1977] and NMCUES data for the noninstitutional population [LaVange and Silverman, 1987].

Subsequent to 1977, two methods were used to estimate cost per prescription. From 1977 through 1986, data from the National Prescription Audit conducted by IMS America were used to stand for the growth rate for cost per prescription for each of the aged subgroups. Then cost per prescription was deflated by the prescription drug component of the consumer price index (CPI-Rx) (Figure 2). Forecasted values of the CPI-Rx through 1991 were combined with an extension of the observed trend in the deflated cost per prescription to arrive at a nominal (current-dollar) cost for the aged population.

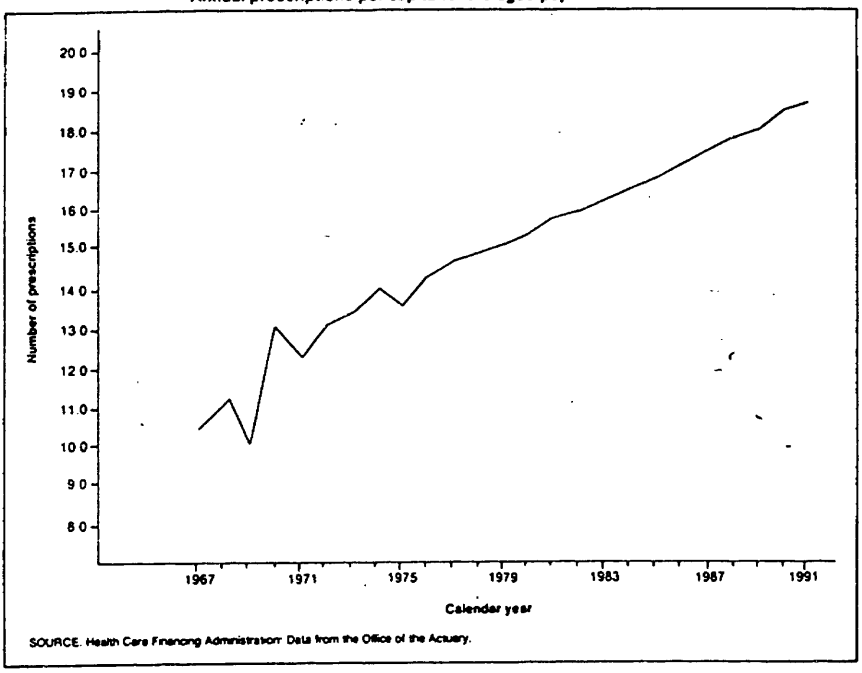
The disabled population was assumed to have the same cost per prescription as did the aged population. This assumption was based on the tabulation of NMCES data described earlier.

Estimating cost per enrollee

Once prescriptions per capita and cost per prescription were estimated, it was a simple matter to weight each group's expenditure by an enrollment count to arrive at an aggregate figure for expenditure

Figure 1

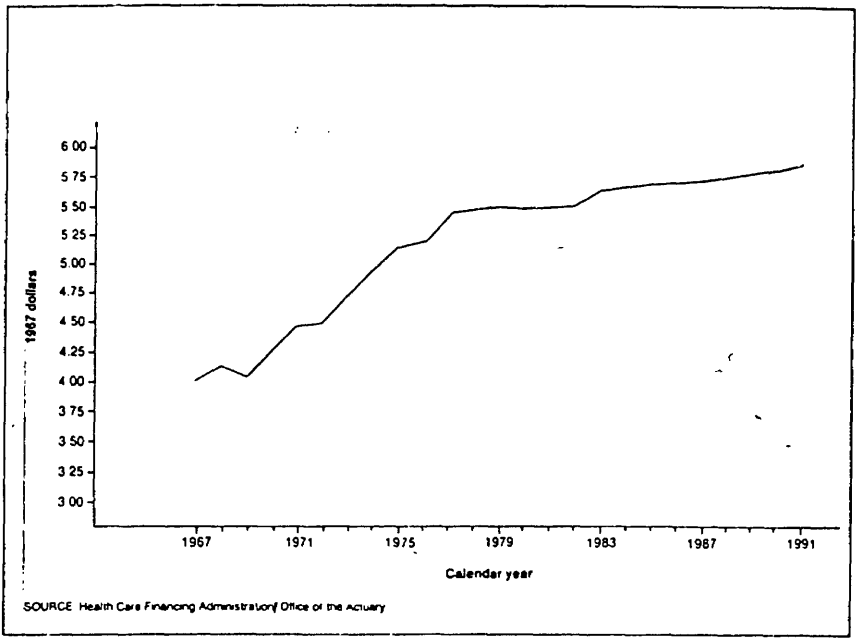
Annual prescriptions per capita for the aged population: 1967 - 91



SOURCE: Health Care Financing Administration: Data from the Office of the Actuary.

Figure 2

Constant-dollar cost per prescription for the aged population: 1967-91



SOURCE: Health Care Financing Administration, Office of the Actuary

per Medicare enrollee (Table 1). Enrollment subsequent to 1985 was estimated: The number of disabled enrollees was held constant, while the proportion of the aged population enrolled in Medicare Parts A or B was assumed to increase from 97.5 percent in 1985 to 98.0 percent in 1991.

Comparability with national health expenditures estimates

National health expenditure (NHE) estimates of drug spending are published by the Health Care Financing Administration (HCFA) for years 1965 through 1986, with projections through the year 2000 (Lazenby, Levit, and Waldo, 1986; Health Care Financing Administration, 1987). The published figures combine prescription drugs with nonprescription drugs and medical sundries and represent spending for the entire population.

The NHE estimates of spending for drugs and sundries are based mainly on personal consumption expenditures (PCE) for medical nondurables, published by the Commerce Department's Bureau of Economic Analysis (BEA) as part of the gross national product (GNP). PCE levels are adjusted to remove estimated payments through Medicaid and other transfer-type programs, and HCFA's estimate of government spending is added to arrive at the NHE level.

There are two reasons why the growth in the NHE figures for consumption of drugs and sundries is not a good proxy for that of Medicare enrollees' spending for prescription drugs.

First, the growth of NHE for drugs and sundries understates that of prescription drug spending. This, in turn, stems from the composition of the NHE figure and from the technique by which the PCE estimate (on which it is based) is calculated. NHE includes nonprescription drugs and drug sundries, consumption of which has grown more slowly than has consumption of prescription drugs. According to the Census Bureau's quinquennial census of retail trade, prescription drug sales through drug stores and grocery stores grew at an annual rate of 12.8 percent between 1977 and 1982 (the most recent period available), one-half a percent per year faster than growth of total retail sales of the broader "drugs, health aids, and beauty aids" (U.S. Bureau of the Census, 1980, 1985). In addition, the techniques used

Table 1

Medicare enrollee prescriptions per capita and prescription costs, by age, institutional status, and disability status: Selected calendar years, 1967-91

Reason for eligibility	1967	1973	1977	1985	1986	1987	1988	1989	1990	1991
					Annual prescriptions per capita					
All enrollees	10.4	13.6	14.7	17.1	17.4	17.8	18.1	18.3	18.7	19.1
Aged	10.4	13.4	14.4	16.8	17.1	17.4	17.7	18.0	18.4	18.7
Institutionalized	19.8	25.5	27.3	31.3	31.8	32.4	32.9	33.5	34.1	34.7
Noninstitutionalized	9.9	12.8	13.7	16.0	16.3	16.5	16.8	17.1	17.5	17.8
65-69 years	8.2	10.6	11.4	13.1	13.4	13.6	13.9	14.1	14.4	14.7
70-74 years	9.9	12.8	13.7	15.8	16.1	16.3	16.6	16.9	17.2	17.5
75-79 years	12.3	15.9	17.0	19.7	20.0	20.3	20.7	21.0	21.4	21.8
80 years or over	10.9	14.0	15.0	17.4	17.7	18.1	18.4	18.7	19.0	19.3
Disabled	—	16.5	17.7	20.5	20.9	21.3	21.7	22.0	22.5	22.9
					Cost per prescription					
All enrollees	$4.00	$4.74	$6.60	$14.41	$15.78	$17.43	$18.96	$20.19	$21.32	$22.66
Aged	4.00	4.74	6.60	14.41	15.78	17.43	18.97	20.19	21.32	22.67
Institutionalized	4.02	4.74	6.62	14.72	16.10	17.80	19.33	20.59	21.79	23.10
Noninstitutionalized	4.01	4.73	6.59	14.41	15.76	17.43	18.92	20.15	21.32	22.60
65-69 years	4.23	4.99	6.97	15.24	16.66	18.42	19.99	21.28	22.52	23.87
70-74 years	4.10	4.84	6.76	14.80	16.19	17.90	19.43	20.69	21.90	23.22
75-79 years	3.81	4.50	6.28	13.80	15.10	16.70	18.14	19.33	20.47	21.71
80 years or over	3.75	4.42	6.17	13.54	14.82	16.40	17.81	18.98	20.10	21.32
Disabled	—	4.73	6.59	14.41	15.76	17.43	18.92	20.15	21.32	22.60
					Annual cost per enrollee					
All enrollees	$42	$65	$97	$247	$275	$310	$342	$370	$400	$432
Aged	42	64	95	242	270	304	336	364	392	424
Disabled	51	78	117	295	329	371	411	443	480	518

SOURCE: Health Care Financing Administration, Office of the Actuary

to extrapolate PCE from the quinquennial census base tend to underestimate the growth of prescription drug spending. PCE for drugs and sundries (which, like NHE, includes more than just prescription drugs) grew at an average annual rate of 9.3 percent between 1977 and 1982, clearly less than the 12.8 percent growth or retail prescription drugs. Consequently, the NHE figures for drugs and drug sundries understate the growth in spending for prescription drugs alone.

A second reason why the NHE series cannot serve as a proxy for growth in spending for drugs by the aged is that the aged population appears to have a different trend in consumption of drugs than does the rest of the population. Data from the 1980 and 1985 NAMCS show a decline in drug mentions per capita for the total population and for the population under age 65, while those for the aged population increased over the same period.

Estimating the distribution of spending

From the standpoint of program expenditures, it is just as important to know the distribution of spending as it is to know the mean expenditure. The proportion of enrollees who spend more than a given amount per year and the amount spent by those enrollees are essential pieces of information in the calculation of program costs.

A useful candidate for the theoretical distribution is the gamma. In this distribution, the probability of a value λ occurring is:

$$f(x) = \frac{a^b}{\Gamma(b)} x^{b-1} e^{-ax}$$

where the arithmetic mean and variance of the distribution are:

$$E(x) = \frac{b}{a} \text{ and}$$

$$V(x) = \frac{E(x)}{a} = \frac{b}{a^2}$$

A nonlinear least-squares fit of interval frequencies for each of the years 1967 through 1977 (Grindstaff, Hirsch, and Silverman, 1981) yields estimates of the two parameters of the gamma distribution. The values of b appear to be constant over time, and the average value of b from the 1967-77 regressions has been carried forward through time. Values for a, the scale factor, have been determined by the value of b and the arithmetic mean; in this way, the distribution for any given year will be centered on the average expenditure per enrollee.

The gamma distribution is not defined when $x = 0$, so that the distribution applies only to users of prescription drugs. Therefore, mean expenditure per enrollee must be translated into mean expenditure per user. Evidence from CMS, NMCES, and NMCUES suggest that the user rate has stabilized at about 78 percent since 1977. This assumption was used when projecting the distribution forward in time.

Estimating cost per enrollee

Knowledge of the mean and distribution of spending for prescription drugs allows one to calculate the current-law cost per enrollee of that spending over and above any given annual amount. To do so requires three pieces of information. First, one needs to know the proportion of users who exceed the annual spending limit. This is found by integrating the gamma function from the annual limit through infinity:

$$U = \int_k^\infty f(x)dx$$

where $f(x)$ is the gamma density function. The second piece of information needed is the proportion of expenditures over the given annual amount:

$$E = \frac{\int_k^\infty xf(x)dx}{\int_0^\infty xf(x)dx}.$$

Third, one needs to know the proportion of enrollees who are users of prescription drugs. As explained earlier, it is assumed in this article that 78 percent of enrollees are users. These three pieces are then combined to determine the monthly cost per enrollee were expenditures over the deductible spread over all enrollees (users or not). If M is the average expenditure per user and P is the proportion of enrollees who are users, then the monthly cost per enrollee of expenditures in excess of k dollars per year is:

$$\frac{P * (E*M - U*k)}{12}.$$

The data in Table 2 show these monthly costs for a number of alternative deductibles. By their nature, the current-law estimates shown in Table 2 do not measure the full cost of proposed Medicare coverage of prescription drugs: They exclude administrative costs and changes in consumption that would occur due to enactment of the proposed coverage. The latter item, in particular, is of unknown magnitude at this point. Based on a review of the literature, Ginsburg and Curtis (1978) suggested that a sensible range for the increase in demand caused by going from no insurance to full insurance coverage would be 50 to 150 percent. The relative size of "own-price" — elasticity of demand for prescription drugs as opposed to "cross-price" elasticities (with physician services, for example) is still debated, as is the extent to which prescription drugs complement or substitute for other medical goods and services. The price of a good or service historically has risen when third-party coverage is introduced, which could raise program costs. On the other hand, program features such as generic substitution could reduce the program cost per prescription. The net effect of all these factors, although important to the ultimate decision regarding proposed coverage of drug spending, is outside the scope of this article.

Table 2

Distribution of Medicare users and their expenditures for prescription drugs and monthly expenditures per enrollee in excess of a specified deductible, by amount of deductible: Calendar years 1988-91

	Proportion of users who meet or exceed the annual deductible				Proportion of total expenditures that exceeds the annual deductible				Monthly expenditure per enrollee in excess of the annual deductible			
Deductible	1988	1989	1990	1991	1988	1989	1990	1991	1988	1989	1990	1991
$50	0.8667	0.8751	0.8829	0.8902	0.9930	0.9939	0.9947	0.9954	$25.50	$27.80	$30.30	$32.90
100	0.7660	0.7800	0.7931	0.8054	0.9760	0.9791	0.9818	0.9841	22.80	25.10	27.60	30.20
150	0.6809	0.6990	0.7162	0.7323	0.9519	0.9579	0.9631	0.9677	20.50	22.70	25.10	27.70
200	0.6071	0.6284	0.6486	0.6677	0.9226	0.9319	0.9401	0.9473	18.40	20.60	22.90	25.40
250	0.5426	0.5660	0.5884	0.6099	0.8896	0.9024	0.9138	0.9239	16.50	18.60	20.90	23.40
300	0.4856	0.5105	0.5347	0.5578	0.8540	0.8704	0.8851	0.8981	14.90	16.90	19.10	21.50
350	0.4351	0.4611	0.4863	0.5107	0.8167	0.8366	0.8545	0.8705	13.40	15.30	17.40	19.70
400	0.3903	0.4168	0.4427	0.4680	0.7784	0.8016	0.8227	0.8417	12.00	13.90	15.90	18.10
450	0.3503	0.3770	0.4033	0.4291	0.7397	0.7661	0.7901	0.8119	10.80	12.60	14.50	16.70
500	0.3146	0.3412	0.3677	0.3937	0.7012	0.7303	0.7571	0.7816	9.80	11.40	13.30	15.30
600	0.2542	0.2800	0.3059	0.3319	0.6257	0.6596	0.6912	0.7204	7.90	9.40	11.10	13.00
700	0.2057	0.2301	0.2550	0.2802	0.5542	0.5915	0.6268	0.6599	6.40	7.80	9.30	11.00
800	0.1667	0.1893	0.2128	0.2368	0.4877	0.5273	0.5653	0.6014	5.20	6.40	7.80	9.30
900	0.1353	0.1560	0.1777	0.2004	0.4269	0.4676	0.5074	0.5456	4.30	5.30	6.50	7.90
1,000	0.1098	0.1286	0.1486	0.1696	0.3719	0.4130	0.4535	0.4930	3.50	4.40	5.50	6.70
1,500	0.0391	0.0494	0.0612	0.0745	0.1774	0.2112	0.2470	0.2843	1.20	1.70	2.30	3.00
2,000	0.0141	0.0192	0.0254	0.0330	0.0799	0.1022	0.1276	0.1559	0.40	0.70	0.90	1.30
3,000	0.0019	0.0029	0.0045	0.0066	0.0147	0.0218	0.0311	0.0429	0.10	0.10	0.20	0.30
4,000	0.0002	0.0005	0.0008	0.0013	0.0025	0.0043	0.0071	0.0110	0.00	0.00	0.00	0.10
5,000	0.0000	0.0001	0.0001	0.0003	0.0004	0.0008	0.0015	0.0027	0.00	0.00	0.00	0.00

NOTES: This table is based on a gamma distribution in which the shape parameter is set at .87 and the scale parameter is adjusted to accommodate the mean expenditure per user. The estimates presented in this table are based on average expenditures per enrollee of 342, 370, 400, and 432 in 1988-91 respectively. Expenditures per user are estimated to be 438, 474, 513, and 554 in 1988-91, respectively. Enrollees include both users of prescription drugs and persons who are eligible for Medicare benefits but who do not use prescription drugs. An estimated 78 percent of enrollees are prescription drug users.

SOURCE: Health Care Financing Administration, Office of the Actuary.

Dr. DOCKSAI. Finally, Mr. Chairman, I share with the committee several brief key insights taken from the full testimony.

To the question of whether a drug add-on would be self-financing: According to our actuaries, preliminary estimates of the various drug proposals under consideration have been severely understated. Our estimates are that the major prescription drug proposals offered in the House could cost from $6.2 to $8.4 billion, and that is with a "B"—billion dollars—in 1989. Ongoing administrative costs could range from $470 to $577 million, approximately seven percent of the benefits paid out under this program expansion.

So, a drug benefit is very costly to administer compared with other Medicare services for which administrative costs range 1.3 percent of service costs.

We have analyzed the various proposals in the House nine ways to Sunday, and we have estimated that for prescription drugs alone the premium would range from $18 to $24 per month in 1989, and this is in addition to the basic Part B and catastrophic premiums.

The initial cost to the beneficiary, we feel, would be overwhelming, and I can't resist pointing out, Mr. Chairman, that some critics denounced the Part B premium proposed in the original Bowen Plan, saying it was "unaffordable." And yet, that was only one-fourth of the cost of the premium we are discussing today. So, in other words, Mr. Chairman, what we are really talking about here is not so much adding a modest benefit to a catastrophic bill, so much as really adding a catastrophic bill to a massive drug benefit proposal. In other words, the training wheels have become the bike, and we have to look carefully at those costs. That is essentially where the Administration is coming from.

It is doubtful that costs of this magnitude can be designed to fit into a self-financing benefit package. Even if five-year estimates could show it to be budget-neutral, there would be, no doubt, a tendency at some future time to look toward general revenues to subsidize the benefit rather than increase the beneficiaries' premiums to keep pace with inflation. Consequently, the Medicare program would be at risk for continuing high-level cost/benefit packages.

Turning briefly to the question of our ability to administer a program as complex as this: We believe the administrative problems would be immense. Much further analysis is required. And once again, we expect that analysis to be included in the imminent study.

There are several key issues upon which Mr. Hays will be able to elaborate. I will skip over those, because we have added those to the record, and go on to say, in conclusion, Mr. Chairman, that as you are aware, our Department recently spent over a year analyzing approximately 50 different proposals for a catastrophic health insurance program.

I was honored to be on that task force, as others were. We worked very hard, many weekends, going over these proposals, and over the course of a year we covered much less territory than has to be covered in the imminent study we are now being asked to do.

In the end, the President decided on a plan which would provide peace of mind and which would be affordable to both taxpayers and beneficiaries.

Whether new benefits such as prescription drugs are advantageous or not, is in itself a separate question, separate from that of simply and directly adding catastrophic coverage to the Medicare program. We at HHS do not believe that a catastrophic protection bill is the right place on which to tack additional and worrisome costs that will eventually threaten the entire Medicare program.

And so, finally I say, Mr. Chairman, that Secretary Bowen signaled to the House leadership that inclusion in this legislation of a drug benefit, which even if it could be carefully crafted, would run into billions of dollars in expenditures the first year, could cause recommendation of a Presidential veto. And on behalf of my Department and the Administration, I implore the committee to please keep this in mind as you carefully weigh this issue.

Senator MITCHELL. Thank you very much, Dr. Docksai.

Before going to questions, I want to recognize Senator Rockefeller, who has joined us.

Senator, do you care to make an opening statement?

Senator ROCKEFELLER. Mr. Chairman, I have no formal statement. This is a highly perplexing problem for me. As I indicated to this committee at one of our earlier hearings, in public forums that I have held in West Virginia on health care, the cost of prescription drugs was the subject that was raised as much or more than home health care. So, it is also something that I want to be able to do something about; but also it is something about which I worry in terms of the cost of the benefit, because I think that once Congress binds ourselves to providing the benefit—as I hope we will at some point—it is not an area from which we can retreat. It will be something that we will have to push forward on.

So, my conscience works very hard on me. I have a sacred obligation to my seniors at home and across this country, and I want to see movement. Yet, I want to know that we can afford it and pay for it. I guess that is the struggle that all of us in one way or another are going through.

So, I will listen today, and I will learn, and as always I respect your efforts to bring this to the forefront.

Senator MITCHELL. Thank you very much, Senator.

We will now proceed to questioning, in accordance with the committee rules, in order of appearance by the Senators. Questions will be limited to five minutes. I would ask the Senators to try to limit their questions to five minutes, because we have a total, in the two hearings this morning, of 16 witnesses, and we are only on the third one.

So I will defer first to Senator Heinz.

Senator?

Senator HEINZ. Mr. Chairman, thank you very much.

Mr. Docksai, you mentioned that you were afraid that the prescription drug coverage proposals would end up being the dog that wagged the tail of catastrophic coverage. That may not be bad in and of itself, if the dog is fully paid for. Do you agree?

Dr. DOCKSAI. Yes, sir, I agree with that.

Senator HEINZ. Then your main concern is making sure that we pay for whatever benefits are made available under a prescription drug proposal?

Dr. DOCKSAI. That would be the major concern, sir, the solvency question. And once again, although we have not yet seen the letter or paper asking us to do this, I am told that the study we will be asked to do will involve both the cost and the administrative impact.

In fact, I must also say that both Mr. King and Mr. Hays will play a key role in that study, and ask them if they have anything to add.

Senator HEINZ. Now, there are some substantial differences between your cost estimates and CBO's.

Mr. Chairman, would it be possible to have CBO come up and maybe we can have some discussion between HCFA and CBO?

Senator MITCHELL. Certainly. Is there a representative from CBO here?

Do you want to get them a little closer together? [Laughter.]

Dr. DOCKSAI. I might sit between them, Mr. Chairman.

Senator HEINZ. Let me just ask, Mr. Docksai, did you base your estimate of annual cost per beneficiary—which for 1988 is estimated to be $242—did you base that on cost data from the State Pharmaceutical Assistance Programs for the Poor? Is that where that comes from?

Dr. DOCKSAI. I will ask Mr. King to comment on that.

Mr. KING. No, sir, we didn't base our projections at all on the low income data. I believe you are referring to the PACE program.

Senator HEINZ. Well what did you base it on?

Mr. KING. Our cost estimates were based on a variety of data.

Senator HEINZ. Any experience data? Based on any experience data?

Mr. KING. I might say that although we didn't base our cost estimates on experience data, we do have a variety of experience data that supports our projections and this suggests to me that our projections are basically correct, or perhaps even a bit low.

Senator HEINZ. But you did not base your projections on any experience data? All right. That is what I was afraid of, because that makes it very hard to compare what you and CBO have done.

Mr. KING. Excuse me, Senator, are you referring to experience through a drug reimbursement program, or are you referring to experience? The experience data that we offer is the current Medicare survey data, which was a direct survey of Medicare program beneficiaries to ascertain their costs of drug coverage.

Senator HEINZ. Survey data is one kind of data; but, actually, State programs or HMO experiences with their beneficiaries is another.

Let me ask CBO. Dr. Muse, have you and Dr. King had an opportunity to sit down together and figure out why you come out with a roughly $200-figure compared to their $342 per beneficiary figure? Have I got the right figures, first of all?

Senator MITCHELL. Before you respond, Dr. Muse, for purposes of the record, could you identify yourself and your associate by name and title?

STATEMENT OF DONALD MUSE AND JACK RODGERS OF THE CONGRESSIONAL BUDGET OFFICE

Dr. MUSE. I am Dr. Donald Muse. I am the principal analyst for Medicare and Medicaid in the Congressional Budget Office.

Mr. RODGERS. My name is Jack Rodgers. I am a principal analyst at the Congressional Budget Office in the Human Resources Division. I also work with health programs.

Senator CHAFEE. Would you please repeat that? I didn't hear what you said.

Mr. RODGERS. My name is Jack Rodgers, and I work with the Congressional Budget Office also, but I work in a different division than Dr. Muse; I work with the Human Resources Division.

Senator CHAFEE. Thank you.

Senator MITCHELL. I think we should give Senator Heinz another minute to take up for the interruptions by Senator Chafee and myself.

Senator HEINZ. Dr. Muse, would you proceed?

Dr. MUSE. Yes, sir. The chronology of events—I just happen to have a package that the Senators might be interested in, to hand out.

The chronology of events is, we were asked earlier, in May, to begin to estimate the prescription drug benefit. We prepared estimates which we formally submitted for a draft Ways and Means bill on the fourth of June.

We received the written cost estimate of the Administration on June 9. We met I believe it was June 12 for approximately four hours with both staffs from HCFA and CBO, and we prepared men and responded on June 15 with our analysis of the differences between the two estimates.

If you have the packages, Tab A is just an overview of costs. Tab B is our initial cost estimate of the Ways and Means bill. Tab C is the Administration's estimate of the same bill. And Tab D is a two-page analysis of the differences.

Senator HEINZ. To get back to my very first question, just in terms of the amount of money a beneficiary spends annually, the difference between the $200 figure and the $342 figure——

Mr. KING. I believe, Senator that $200 is incorrect; CBO has revised that figure now, after talking to us, to $250.

Senator HEINZ. Two hundred and fifty?

Mr. KING. The original number was $160; then we spoke with CBO informally and they increased it to $200. Now we have met with them again, and they have increased it to $250.

Senator HEINZ. They have raised it; have you raised yours?

Mr. KING. No, sir.

Senator HEINZ. That is a $100 difference, almost. Can you identify, Dr. Muse, what the main reason for that $100 difference is?

Dr. MUSE. There are five reasons that you can get different numbers when you do a cost estimate.

Senator HEINZ. I don't mean theoretically; I mean in fact.

Dr. MUSE. We are relying essentially on different data sources. We are using the 1984 consumer expenditures.

Senator HEINZ. Mr. Chairman, to save the committee's time, would it be in order for me to ask—unless another committee

member wishes to do so—to ask Dr. Muse to submit to the committee an explanation of the differences between them? Why there are differences in the estimations by HCFA and CBO?

Senator MITCHELL. I believe he has done that. The last tab on the document he has submitted is an analysis of the differences.

Senator HEINZ. It is an analysis of the differences?

Senator MITCHELL. At Senator Heinz's request, that will be made part of the record.

Senator HEINZ. All right. One quick last question—and I am sorry, Mr. Chairman.

Do either of your estimates incorporate an offset or savings resulting from Medicare paying less for outpatient chemotherapy or outpatient intravenous antibiotic therapy?

Mr. KING. Ours do not.

Dr. MUSE. Ours do not.

Senator HEINZ. Well, maybe we can get both estimates done.

Thank you, Mr. Chairman.

Senator MITCHELL. Thank you, Senator Heinz.

Senator Durenberger?

Senator DURENBERGER. Don, let me ask you. On the very first page under Tab A you have the estimated costs of the outpatient prescription drug benefit for Medicare beneficiaries at varying deductible levels and then play out the dollars involved. Do you know the income distribution of the people that are covered on this tabulation, or can you speculate on it?

Dr. MUSE. It would take us some time to do that. It is possible. I would tend to say, at the higher level, given other data: Poor people are generally sicker and would therefore take more drugs. And as you go up the scale, I would assume that you would basically encounter increased proportions of poor people.

Senator DURENBERGER. Then let me ask you, Ron, to what degree has the Department looked at or is looking at the matter of individual income against drug utilization or the acquisition of drug protection through insurance and so forth. Do you have the data?

Dr. DOCKSAI. Senator, there was a household survey of medical care utilization conducted by the Public Health Service—in 1977, I think it was, a similar study is now underway.

Medicare billings for all types of Medicare-funded services were aggregated based on a one percent sample. The study underway now would have to complement what we are being asked to do by the President.

In the area of costs, this in fact would be an updating of the household survey, with more empirical data. I would ask Mr. King to comment on that.

Mr. KING. I think that would probably be useful to both CBO and us in continuing to improve our estimates on drug coverage.

Dr. DOCKSAI. So, the current estimates are based on that earlier study for projections of this year. Is that correct?

Mr. KING. CBO's estimates are actually based on the consumer expenditure survey. We contemplated using the consumer expenditure survey, which was conducted by the Bureau of Labor Statistics for purposes of our estimate, also; but we were told by the BLS analysts that we contacted that it wouldn't be appropriate to

use that data because the data in the consumer expenditure survey was not designed to measure the aggregate per-capita expenditures of the elderly.

Trying to get data on the elderly from that data, which is basically designed to get weights for various indexes, they told us that since the only elderly you can get in that survey are those who are heads of consumer-expenditure units, that you miss all the frail elderly who are living with their children, who are likely to have very high drug expenditures.

If a person has drug coverage through insurance and they don't know what the insurance paid for their drug coverage, then that goes in as zero. Also, since it is consumer units headed by a person age 65 or older, if you have, for example, a man who has $800 a year in drug expenses and he is living with his daughter who is divorced and has moved in with her six children, then his drug expenditures go down as $100, because the $800 is spread over every member of the consumer unit.

So if you try to use that data in order to make drug projections, you have to make so many adjustments to it that your estimate becomes largely speculation.

Senator DURENBERGER. What can you tell us, to follow along this line of where the need is and who can contribute how much? What can you tell us about Medicaid coverage for prescription drugs, and then what can you tell us about these States that seem to be moving into coming in on top of Medicaid at the low-income not Medicaid-eligible elderly?

Dr. DOCKSAI. As you know outpatient drugs are not covered under Medicare Part B, except for immunosuppressives, which are covered up to one year following transplantation. The Part B premium is now $17.90 a month.

On Medicaid, Guy may have more information.

Mr. KING. I can add a little more to that, Senator. I received this data—I didn't tabulate it myself, so I don't know how accurate it is. The average drug expenditure per enrollee in the Medicare program in Calendar Year 1985 was $368.

New Jersey has a pharmaceutical assistance program for the aged, and their average expenditure in 1986 was $380. The Pennsylvania PACE program had an average expenditure in the period of July 1 of 1985 to June 30 of 1986 of $400.

We didn't really use any of these data in making our estimates, because they are low-income programs and the Medicaid program and don't necessarily have any relevance to drug coverage under Medicare.

Senator MITCHELL. Thank you very much, Senator Durenberger.

Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman.

Mr. Docksai, I assume that in calculating your figures you used the savings that would incur under Medicaid?

Dr. DOCKSAI. Well, actually there would be a small savings due to Medicaid, but there wouldn't be a reduction in the Medicare monthly premium.

Senator CHAFEE. I have listened to you carefully and have looked over your presentation about the administrative costs and the fear of excessive utilization, but it doesn't seem to me that is enough of

an answer here. What do we do? We have people who are suffering greatly because of the high cost of the drugs, and we are talking about the elderly now. So what do we do? What is the answer? Is it to say that the administrative problems are just insurmountable? There must be a way of controlling the costs or controlling the utilization. I don't think we have to throw in the towel on this thing. What is your answer to that, Mr. Docksai?

Dr. DOCKSAI. With the number of elderly people over 65 growing at a geometric rate every 10 years, regardless of whose figures one is using, and with only an arithmetic increase in the means available to pay for increasing services, there would be an increasing concern over the costs, and with respect to administration, I would ask Mr. Hays.

Mr. HAYS. The same would be true with respect to administrative costs. As the number of claims increases with the size of the program each year, the administrative costs would also increase over the years, from a base of something in the neighborhood of $500 million a year.

Senator CHAFEE. Well, I just don't find that an adequate answer. You are saying the administrative problems are insurmountable, that the utilization is going to be excessive, and therefore we can't do anything about it. Certainly, other countries in the world wrestled with this problem successfully, and I would like to hear some constructive guidance from your folks. We are going to tackle this problem hopefully now, if not, in the future. And it is not enough to come in here and just say we can't handle it.

Dr. DOCKSAI. Once again, Senator, with increasing services and with increasing utilization, it is a question of where one sets the balance. We are not expecting all answers to be forthcoming in the wake of the imminent study, but one question we do need answered is where does one set that balance.

I talked with a friend the other day who had just had his fortieth year as a pharmacist. We are talking generally about the drug benefit proposals, and he said that he knows in his own mind that patients who have come to him have used a prescription substitute for aspirin, this is in a markedly different situation from the patient who is asking for an item which is of extreme urgency, for an acute illness, and at a different pay scale. This kind of balance is something that would have to come in the wake of the study; we don't now have the information.

Congress is asking the Department to give a definitive answer on whether or not we can pay for this. We are saying that, while our figures hold for our catastrophic plan, our acute hospital plan, we are not sure about the other questions. I would have to add that long-term chronic care now being studied by the Treasury Department, was also part of Secretary Bowen's study.

Senator CHAFEE. Well, I only have limited time here. What is your answer to this problem we have before us here—it is too expensive?

Dr. DOCKSAI. It is too expensive, and there are many administrative questions recently being asked for which we don't yet have the answers, and a study is going to need to be conducted, too, to answer those questions.

Senator CHAFEE. Thank you, Mr. Chairman.

Senator MITCHELL. Mr. Docksai, I would like to pursue Senator Chafee's line of questioning. You say the answer is that it is too expensive, but you now have an aggregate number of elderly paying a total sum of money for prescription drugs.

Dr. DOCKSAI. Yes, sir.

Senator MITCHELL. Some of them pay a lot, much more than they can afford; the majority do not. Now, if you take the same aggregate number of persons and the same total costs but merely redistribute it through an insurance program as part of Medicare, on the principles of fire insurance or any other insurance principle, the total costs will be borne, if the premium is sufficient to pay for it, by the same group of people, merely restributed.

Dr. DOCKSAI. Yes, sir.

Senator MITCHELL. Your response makes sense only if one assumes that that cannot be done, that the insurance mechanism will so stimulate utilization and therefore drive up costs to a point where it will be unaffordable or politically unacceptable in terms of a premium. That is your argument.

Dr. DOCKSAI. Yes, sir.

Senator MITCHELL. But when you say "too expensive," if that's what you mean, you don't mean that there is no aggregate cost now being borne, no total cost being borne by an aggregate number of people, is that correct?

Dr. DOCKSAI. Yes, sir. But we are, being candid, when we say we are not exactly sure what the utilization figures would be. It could be that Senator Kennedy's figures are correct; I have talked to his staff earlier, but we are just not sure. And this comes at a time when Congress is considering various ways to try to limit the size of the drug benefit. Perhaps, you are considering adding proposals now being discussed in the House: Various ways of raising the deductible, various ways of raising the co-insurance, the question of a formulary—all these questions now being debated in the House which you are considering here are questions we are naturally asking in our own Department. But we don't have the answers for most of them.

Senator MITCHELL. No, I understand that, but I just want to get straight that, if we could devise a plan that would merely redistribute the total costs among the same aggregate numbers of persons, you don't object to that, do you?

Dr. DOCKSAI. No, sir, the Administration doesn't.

Senator MITCHELL. Your only concern is that this is going to trigger a sequence of events that will result in a total cost which cannot be, either financially or politically, borne by that group, and therefore it will result in some demand for general revenue or other form of financing outside the group that is now the subject of our attention. Is that a fair statement, from your position?

Dr. DOCKSAI. Yes. Self-financing and these administrative problems can be and will be solved—will be solved. And at the same time it complements what is being done in the private sector. To the extent the private sector takes the lead in insurance, we believe they do a better job at it. All these factors considered, the answer is yes.

Senator MITCHELL. But you have just come in with a catastrophic insurance proposal for acute care.

Dr. DOCKSAI. Yes, sir.

Senator MITCHELL. I mean, if you are going to stand on philosophy, you have already abandoned that; and unless you propose repeal of the Medicare program in its entirety, which I don't think you do——

Dr. DOCKSAI. No.

Senator MITCHELL [continuing]. Then you have already abandoned that. I mean, why are those arguments relevant in drug costs but irrevelant in acute care costs for catastrophic acute care costs, and other provider costs under Part A and Part B of the problem.

Dr. DOCKSAI. Well, Senator, to answer that question, philosophically we believe we are consistent—we know we are consistent. There is a linkage. We believe that the administration's catastrophic hospital plan now pending in Congress—which does not include the chronic long-term care elements now being studied by Treasury—complements what would be done by the private sector. This would open up a whole new market for Medigap and other companies to look at insurance coverage below a $2000-cap and insurance items not covered in our acute hospital plan. We are saying that we should give the private sector this opportunity to cover these additional areas. To the extent they can't, and to the extent that we find a way of administering a program and paying for it without increasing taxes, without taking general revenues, that will be something that we would be the first to jump aboard.

Senator MITCHELL. Well, I have to say to you that that answer comes dangerously close to suggesting that the primary criterion to be applied here is what is good for the private sector providers of a particular service, as opposed to what is good for the persons who are in need of the services involved. And I think you have to be very careful with that.

Obviously, ours is a combination public/private system, and we don't want to move into one area without any concern. But our principal concern, and I think it exists across the broad spectrum of this committee, is, while we are mindful and respectful of the interests of the providers and the industries involved, our principal concern is with the millions of Americans who require this health care and who we want to see have it accessible and affordable and of a high quality. That has got to be our prime consideration. I would ask you if you don't agree with that, because my time is up.

Dr. DOCKSAI. Senator, for the record, I agree with that. And let me say I am also cognizant of our public health service role, as HHS, to get more bang for the buck.

Senator MITCHELL. Yes. Thank you, Dr. Docksai. My time is up.

Senator Pryor?

Senator PRYOR. Thank you, Mr. Chairman.

Doctor, in pursuing the question, I think by Senators Durenberger and Heinz a moment ago, I would like to make this request; I would hope that the Department would supply us with sort of an information sheet on what the 50 States are doing with their respective Medicaid programs, I think for two reasons. I think, one, we might see some concepts out there that we could study and look at, and maybe it would give us a lead-in to some ideas that we might pursue. I think that would be helpful, to see the scan of the

50 States, and maybe the limitations they have, the concepts that are in place now with prescription drug programs, if any, in those States. I think that would be constructive.

Dr. DOCKSAI. We will provide that.

[The information follows:]

DRUG REIMBURSEMENT BY STATE MEDICAID PROGRAMS

Through October 1987, drug reimbursement conformed to the maximum allowable cost (MAC) and estimated acquisition cost (EAC) principles of reimbursement. MAC was the principle used to reimburse for a specific list of approximately 30 to 60 drugs. For these drugs, the Department established the lowest unit price at which these drugs are widely and consistently available and required participating DHHS programs to reimburse at that price. EAC was the Medicaid reimbursement principle used to determine the ingredient portion of the payment for all non-MAC drugs. The average wholesale price (AWP) was used widely in developing the EAC. EAC varied considerably from State to State.

States also vary in retail pharmacy dispensing fees, recipient copayments, limitations on use, over-the-counter exclusions and formulary status of legend drugs. The attached table from Pharmaceutical Benefits under State Medical Assistance Programs, September 1987 (Reston, Virginia: The National Pharmaceutical Council, Inc.) shows these interstate variations. For example, retail pharmacy dispensing fees (per prescription) range from a low of $2.00 in Montana to a high of $5.12 in Nevada. Of the 48 States sponsoring a drug program, 26 charge no copayments; the remainder charge copayments to recipients ranging from $.50 to $3.00, most having copayments of $.50 to $1.00 per prescription. Twenty-six states exclude some drug categories and another twenty states maintain a restricted drug list.

On July 31, 1987, the Health Care Financing Administration (HCFA) published in the Federal Register new regulations on Departmental procedures for setting limits on payments for drugs supplied under Medicaid programs; and revised Medicaid rules concerning the methodology for determining upper limits for drug reimbursement. The rule enables the Federal and State governments to take advantage of savings that are currently available in the marketplace for multiple-source drugs. At the same time it maintains State flexibility in the administration of the Medicaid program. The regulations became effective October 29, 1987, by which time States were to have submitted a State plan amendment specifying their drug reimbursement methodology.

Through promulgation of these regulations, HCFA hopes to achieve several objectives essential for providing acceptable care to Medicaid recipients and for increasing the efficiency with which pharmaceutical products and services are delivered to recipients. These objectives are to:

- Establish simple, administrable methods of applying two separate and distinct upper limits on State Medicaid expenditures: one for certain therapeutically equivalent multiple-source drugs, and one for all other drugs.

- Promote wider and more efficient distribution of pharmaceutical products and services, and avoid potential disruptions in the supply of drug products which appear to be a major drawback of the present method of reimbursing retail pharmacists under the MAC program.

- Encourage more judicious purchasing of pharmaceuticals on behalf of Medicaid recipients, thus conserving scarce Federal and State resources, while preserving or enhancing current levels of service.

HCFA will prescribe aggregate upper limits on certain therapeutically equivalent multiple-source drugs determined to be readily available, and on sole-source and other multiple-source drugs. The limits for readily available drugs is to be based on 150 percent of the lowest known price for each drug on the HCFA multiple-source drug list. The limits for sole-source and other multiple-source drugs will be based on the amounts paid by other payors. HCFA is setting separate aggregate limits on "listed drugs" and on "other drugs." The States are free to make payments for individual drugs on any reasonable basis as long as total payments for each group of drugs do not exceed the aggregate limit on that group. By providing this measure of flexibility, State agencies will be able to develop their own payment methodology and solutions to local problems.

Through these regulations we also hope to provide State agencies the incentive to encourage prudent purchasing practices on the part of retail pharmacists and foster price competition among wholesale suppliers and manufacturers of multiple-source drugs.

When the State plan amendments have been submitted and compiled, HCFA will be able to provide more detailed information on State reimbursement methodologies and initiatives for cost-effective purchasing of pharmaceuticals on behalf of Medicaid recipients.

MEDICAID DRUG REIMBURSEMENT CHART

Legend:

AWP - Average Wholesale Price
EAC - Estimated Acquisition Cost of the drug, (the price generally and currently paid by providers for a particular drug in the package size most frequently purchased by providers), as determined by the program agency, plus a reasonable dispensing fee

(1) Collection by pharmacy is optional
(2) Plus incentive fee for dispensing lower cost product
(3) State funded recipients only
(4) Most multi source drugs
(5) Texas: Amount paid Pharmacy = (EAC+$3.26) divided by 0.945
(6) Wholesale Cost Plus a percentage
(7) Plus $2.00 additional when 30 days supply is dispensed
(8) AWP minus a percentage on most drugs
(9) AWP or direct cost or cost to wholesale + 18%, whichever is less
(10) Per product per month

A No drug list - all legend drugs reimbursed
B No drug list - but certain categories of drugs excluded from reimbursement
C Restricted drug list

* Approximate number

Over the Counter Drugs (OTCs)
A = All
B = Most
C = Few
D = None

NATIONAL PHARMACEUTICAL COUNCIL, INC.

MEDICAID DRUG REIMBURSEMENT — 12-Aug-87

---- Fiscal Year 1987 ---- | ----Fiscal Year 1986----

STATE	1987 Dispensing Fees	1987 Copayment	Ingredient Reimbursement Basis	1987 Formulary	1987 Formulary Status	1987 State MAC	State MAC'd drugs 1987	Ingredient Cost Per Claim*	Average Prescription Price*	Number of Prescription Processed*	Vendor Drug Payments	OTC Status
Alabama	$3.25	.50-3.00	WAC+8.45%	Yes	C	Yes	9	$8.18	$11.43	3,898,502	$40,788,404	C
Alaska	--- No Vendor Drug Program ---											
Arizona	--- AHCCCS Capitation Plan ---											
Arkansas	$4.01		AWP	Yes	C	Yes	20	$11.73	$15.74	2,957,033	$47,867,538	B
California	$4.05	(1) $1.00	AWP/EAC	Yes	C	Yes	55	$9.65	$13.41	24,717,967	$330,749,804	B
Colorado	$3.78	$0.50	AWP-EAC (8)	Yes	C	Yes	124	$9.97	$13.32	1,400,323	$18,728,435	C
Connecticut	(2)$3.55		AWP/EAC	No	B	No					$33,109,369	C
Delaware	(2)$3.65		AAC	No	B	No		$9.62	$13.02	295,775	$4,028,731	C
District of Col	$4.25	0.50	AWP/EAC	No	B	NO			$13.21	774,976	$10,225,605	C
Florida	$4.23		WAC+6%	No	B	No		$10.14	$13.47	7,330,004	$101,190,786	C
Georgia	$4.14		AWP	Yes	C	Yes	29		$14.24	7,051,999	$94,016,319	C
Hawaii	$3.22		AWP-EAC	Yes	C	No			$10.29	599,533	$8,049,701	B
Idaho	2.50-3.50		AWP/EAC	No	B	No		$7.10	$10.40	227,924	$2,133,309	C
Illinois	$3.47		AAC	Yes	C	Yes	(4)	$6.05	$10.32	14,580,506	$120,313,344	C
Indiana	$3.00		AWP-3%	No	B	No		$13.98	$16.98	4,059,536	$65,817,260	B
Iowa	(2)$5.01	$1.00	AWP-10.6%	No	B	Yes	150		$12.73	2,286,372	$28,136,733	C
Kansas	2.46-6.67	$1.00	AWP-EAC	No	B	Yes	155	$9.38	$13.17	1,571,071	$20,697,227	B
Kentucky	$3.25		AWP/EAC (8)	Yes	C	Yes	186	$6.00	$9.25	3,678,658	$34,011,612	C
Louisiana	$3.30		EAC	No	B	Yes	623	$9.99	$13.66	5,759,655	$79,476,505	C
Maine	$3.35	$0.50	AWP-EAC (8)	No	B	No	(4)				$10,434,067	C
Maryland	$3.79	(3) $0.50	AWP/EAC	No	B	Yes	173	$11.45	$14.90	3,265,811	$40,700,119	C
Massachusetts	$3.67		AWP/EAC	No	B	Yes	(4)				$75,643,085	C
Michigan	$3.38	$0.50	AAC (8)	Yes	C	Yes	95	$8.80	$11.74	9,800,000	$115,144,130	C
Minnesota	$4.00		AWP-10%	Yes	C	Yes					$40,118,568	C
Mississippi	$3.33	$1.00	EAC	Yes	C	Yes	(4)	$10.52	$13.85	3,111,336	$41,570,613	C
Missouri	$2.75	.50-2.00	AWP/EAC	Yes	C	Yes	63		$10.34	4,203,707	$40,106,301	C
Montana	2.00-3.75	$1.00	AWP/EAC	No	A	No		$9.85	$13.35	536,100	$6,614,769	C
Nebraska	4.66-5.12 (7)		EAC (6)(8)	No	B	Yes	(4)	$9.55	$12.50	1,210,446	$13,743,999	B
Nevada	$3.95	$1.00	AWP-5%	No	B	No			$17.09	235,001	$4,214,404	C
New Hampshire	$2.85	$0.75	AWP	No	B	No		$9.22	$12.07	530,522	$6,501,920	C
New Jersey	3.53-5.87		EAC	No	B	No		$9.43	$13.15	5,504,498	$88,949,648	B
New Mexico	$3.65		AWP/EAC	No	B	Yes	(4)	$10.10	$13.75	918,957	$13,149,742	C
New York	$2.00		EAC	Yes	C	No		$11.65	$14.35	23,525,220	$268,326,388	C
North Carolina	$3.67 (10)	$0.50	AWP/EAC	No	A	No		$11.08	$14.63	3,781,082	$55,989,172	C
North Dakota	$3.75		EAC	No	B	No		$9.71	$13.46	494,469	$6,489,889	C
Ohio	$3.12		AWP-7%	Yes	C	Yes	(4)	$8.28	$11.40	12,001,189	$127,634,348	C
Oklahoma	$3.55		AWP/EAC	Yes	C	Yes	81				$12,907,417	B
Oregon	3.38-3.68		AWP/EAC	No	B	Yes	132				$19,011,478	A
Pennsylvania	$2.75	$0.50	AWP/EAC	No	B	Yes	65	$10.02	$12.77	13,015,229	$135,409,978	B
Rhode Island	$3.25		AWP/EAC	Yes	C	Yes	237		$13.06	1,027,754	$13,442,899	C
South Carolina	$3.40	$0.50	AWP-7.5%	No	B	Yes	22	$11.49	$14.89	1,865,067	$29,978,778	C
South Dakota	$4.25	$1.00	AWP-10.5%	Yes	C	Yes	98	$10.10	$13.35	326,968	$4,534,495	C
Tennessee	$3.68		AAC	Yes	C	Yes	165	$9.92	$13.40	5,821,260	$68,865,101	C
Texas	($)		(6) (8)	No	B	Yes	362	$11.10	$15.15	7,153,761	$110,129,049	C
Utah	$3.75		AWP-12%	No	B	Yes	135		$10.84	733,089	$8,383,612	C
Vermont	$2.75	$1.00	AWP-EAC	No	B	Yes	167		$12.63	533,317	$6,861,944	C
Virginia	$3.40	.50-1.00	EAC	No	B	Yes	209	$9.76	$12.14	6,121,753	$50,135,219	C
Washington	3.00-3.70		99% AWP	Yes	C	Yes	224		$14.15	3,270,408	$35,869,776	C
West Virginia	$2.75	.50-1.00	AWP	Yes	C	No		$9.01	$11.76	1,432,777	$15,917,789	C
Wisconsin	$3.68	$0.50	AWP/EAC	No	B	Yes	163	$8.48	$12.69	2,948,385	$55,595,139	C
Wyoming	--- No Vendor Drug Program ---											
								average $9.42	$12.76			

Senator PRYOR. As you know, our catastrophic bill has a $1700 cap. Has the Department researched or started looking at the idea that a $1700 cap, that a portion of this would include costs of prescription drugs by the individual or by the beneficiary? Have you done any study there as for the cost of that?

Dr. DOCKSAI. No, sir, we really haven't looked into that type of a program.

Senator PRYOR. I think that would, once again, be helpful to the committee, and I hope that we would have that available in the near future.

Dr. DOCKSAI. We will do so.

[The information follows:]

Adding drugs to the items covered under the $1700 cap would add $2.1 billion to the cost of catastrophic coverage in calandar year 1988. This additional cost would rise, year by year, to $5 billion in calandar year 1993.

Senator PRYOR. Mr. Chairman, I have other questions, but I know we have a lot of witnesses. I will defer any other questions at this point.

Senator MITCHELL. Thank you, Senator Pryor.

Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Doctor, if seniors are willing to pay for increased coverage and coverage of prescription drugs through higher premiums, say in Part B, why not allow it? I mean, it seems to me that seniors are willing to pay for it in higher premiums—and they are—why not go ahead and provide the coverage?

Dr. DOCKSAI. Based on that alone, Senator, the answer is obvious, and we would agree. My formal statement included about seven or eight pages of the administrative problems, of which Mr. Hays is very familiar in running a program.

Senator BAUCUS. Don't we as public servants have an obligation to try to find answers to those administrative problems?

Dr. DOCKSAI. Yes, sir, and that is why we have been ordered to do a study by the President, ordered in the last day or so, to administer an impact study separate from just the cost questions—looking at the cost questions of the drug benefit but also these administrative questions we are raising. We are being told to do that sooner rather than later, and we will of course do that.

Senator BAUCUS. How soon is "sooner"?

Dr. DOCKSAI. I haven't even gotten the letter yet ordering us to do it, and we have begun. So we will see what the timeframe is.

Senator BAUCUS. If the Administration were pressed, what is the earliest possible date by which those problems could reasonably be worked out—not every i dotted or t crossed, but reasonably; if the Administration really wanted to get the job done, how quickly could it do it?

Dr. DOCKSAI. It is difficult to give you a thoughtful answer, Senator, because we don't have the order yet.

Senator BAUCUS. Just guess. It could be done, certainly, to be effective the first of next year, couldn't it?

Mr. HAYS. If you are asking if we could—

Senator BAUCUS. If the Congress told the Administration to work out the administrative problems, could the Administration do it by the first of next year?

Mr. HAYS. To design a program, or to actually implement a program?

Senator BAUCUS. Design and implement.

Mr. HAYS. Frankly, I think it would be virtually impossible, if you are talking about January 1, 1988.

Senator BAUCUS. What about July 1, 1988?

Mr. HAYS. Again, the earliest date that I am familiar with on the House side is January 1 of 1989.

Senator BAUCUS. Okay, how about that date?

Mr. HAYS. I have very serious reservations about our ability to implement a drug benefit by that time without seriously jeopardizing the entire Medicare program.

Senator BAUCUS. Well, frankly, if the Administration can't implement something by January 1, 1989, then we've got problems. There is just too much bureaucratic stuff, frankly, in the minds of most people, if a program cannot be implemented by January 1, 1989.

A second subject: Why are prescription drug costs going up at such a high rate? Apparently before say the 1970's, the cost of prescription drugs was slightly lower than the CPI, and in the last several years it has been about four times the CPI. Why is that? Why that difference? What has happened?

Mr. KING. We haven't actually done a study of this area, but I think there are some standard reasons, Senator: A movement towards high technology drugs, more extensive drugs that are more effective and so forth; the research costs involved in bringing drugs through the entire process and onto the market is very expensive, and of course those costs have to be reflected in the cost of the drug when it actually comes on the market. So, there are reasons why the CPI for drugs is increasing so rapidly.

Senator BAUCUS. Do you think they are legitimate reasons? Do you have any way of knowing?

Mr. KING. I have no way of knowing.

Senator BAUCUS. The margin pharmaceuticals is charging about the same amount as it was then?

Mr. KING. I have no way of knowing what the actual profit margin is on drugs, but I do realize that the research and the process that a company has to go through in order to bring a drug to the market is a very long, arduous and expensive process.

Senator BAUCUS. Did the Administration, in calculating its cost estimate, take into consideration the savings that would result because drugs would deter or minimize hospitalization?

Mr. KING. It is not clear that drugs would really deter or minimize hospitalization. The Medicare program has a very strong utilization review program, as you know, and hospital admissions that are unnecessary aren't allowed.

Senator BAUCUS. Well, we are not talking about that. You are answering a different question; I didn't ask that question. I asked the degree to which the Administration looked into whether there would be a savings with greater utilization of drugs.

Mr. KING. No, we didn't, actually.

Senator BAUCUS. You did or did not?
Mr. KING. We did not.
Senator BAUCUS. All right. Thank you.
Senator MITCHELL. Thank you, Senator Baucus.
Senator Rockefeller.
Senator ROCKEFELLER. Thank you, Mr. Chairman.

Senator Baucus's point, I thought, was a good one. I think the inflation on prescription drugs last year was close to nine percent, as opposed to general inflation in this country which was less than two percent. I don't know whether high tech explains all of that or not, and I think these are some answers that we need to have. Only 41 percent of seniors have insurance for drugs of any kind, and that is a fairly extraordinary figure.

In any event, those aren't my questions. My question is, Dr. Docksai, you have estimated—I wasn't here when you gave your testimony—but I believe you have estimated that a prescription drug benefit is going to cost $7–$9 billion in the first full year.

Dr. DOCKSAI. Yes, sir.

Senator ROCKEFELLER. I am curious about that price tag. You say the House of Representatives approach might cost $6–$8 billion, but the Ways and Means Committee has told my staff that it would cost about $350 million in 1989, $670 million in 1990, and $840 million in 1991, because they approved offsetting revenue in the form of a high deductible and coinsurance.

I want to know, Doctor Docksai, whether you agree with the Ways and Means Committee, and I want to find out if CBO agrees with that.

Mr. KING. I know the Ways and Means Committee has recently raised the deductible in their drug proposal from $500 to $800. We don't have cost estimates on that yet, but it certainly wouldn't get the costs of the prescription drug program down, out of the billion dollar range; it would still be in the billions.

Dr. MUSE. The numbers that you gave are approximately correct, sir, but the final Ways and Means bill had a number of other safeguards incorporated into it in the cost area, to control costs; but those numbers are approximately correct.

Senator ROCKEFELLER. The reason I mention this is not because I am particularly comfortable with an $800 deductible but because I think that it reflects a little bit on your credibility. Here, after all, from the House is one approach, perhaps highly undesirable to some but an approach which does not cost $7–9 billion.

So I think if we are going to go at this fairly with each other, it has to be recognized when people are putting up proposals which are not going to cause an enormous amount in outlay. Ways and Means is indicating that they are considering approaches entailing outlays that are manageable. Now, they may not be manageable by the senior citizens of either my State or anyone else's; but it is at least an approach.

You wanted to say something, Doctor.

Dr. DOCKSAI. Well, Senator, complementing what you say, the fact that we have honorable men disagreeing who have a very good background in this area shows again the warring inconsistencies in figures. There is no real consensus in the actuarial community, and really the crux of what we are saying here, aside from the study

we are being asked to do, we need to get that consensus. And until that time does come, we are urging the committee to put off adding this to a pending catastrophic bill.

It is an important matter, it is something which should be done; but should not be added on to this bill until these questions are answered—illustrated by the differences, the wide gap between CBO and HCFA on this, and I would add many others who have looked at this and actuarially have come up with different conclusions.

What we have seen is there is no one consensus.

Senator ROCKEFELLER. All right. I think that points, Mr. Chairman, to the need for us to work at the table together on this as we struggle with it. I mean, there are all kinds of questions.

In my State, Mr. Chairman, most of our seniors are poor. I remember when I was Governor I started something called The Golden Mountaineer Card Program. It was a voluntary discount program, and the Legislature said at that time, No, it was a terrible idea because you had to base eligibility on income and do a means test. I said, "Fine, so let us find out what the figures are." And it turned out that 96 percent of the seniors in West Virginia were poor, and four percent were not. So, that ended that, and we had a statewide discount card program.

Now, this is a little bit different. When you are talking about prescription drugs, you have a lot of people who can pay for it and a lot of people who can't. In my State, most people can't. So the question is, how do you get it to them? Can you get it to them? When we marked up a trade bill here and when we had hearings on the trade bill, the Administration was sitting in those two chairs right there throughout the entire process. The point was that they were trying to "help find a solution"—not to say that they agreed with everything that was done; in fact, they didn't. But we were working together, because the problem is serious. Well, trade is serious, but so is prescription drugs. I mean, it is a monumental problem—I don't have to give anybody a speech on that.

Will you all sit with us as we try to work this thing through? Not just a study on the catastrophic crisis, but help us figure out how to act on that study. Are you interested in finding a solution? I mean, we can clobber ourselves with claims of $7–$9 billion pricetags, and therefore you can walk away from the table saying it can't be done. Well, Ways and Means says it can; maybe it is not the right way to do it—the deductibles and the copayments are too high in my opinion. But will you sit with us at the table, if that is what the Chairman wants, during this process?

Dr. DOCKSAI. To assure you, Senator, prior to your getting here, that we will do so, it is bipartisan. We have sat with you before; we are doing it now; we will keep doing it until we get this done, sir.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Senator MITCHELL. Thank you, Senator Rockefeller.

Dr. Docksai, thank you very much, again, and Dr. Muse as well and the other gentlemen. We appreciate your contribution and look forward to continuing to work with you.

The next panel includes Jack Guildroy, the American Association of Retired Persons; Thomas Snedden, Director, Pensylvania Pharmaceutical Assistance Contract for the Elderly; and Alan

Spielman, Executive Director of Government Programs, Blue Cross and Blue Shield.

Good morning, gentlemen, and welcome. For your benefit and the benefit of other witnesses who are present and will be testifying, let me restate the committee's rules as they apply to persons who are not members of the Congress or spokesmen for the Administration.

Your full written statement will be included in the record. We ask that you summarize your statement in 5 minutes or less—hit the high points and leave time for questions. The lights immediately in front of me keep track of the time. While the green light is on, you are doing fine; the orange light means you had better start thinking about summarizing; and the red light here, as everywhere, means stop.

We look forward to your testimony in this important area, and we will begin in the order listed in the agenda: Mr. Guildroy?

STATEMENT OF JACK GUILDROY, MEMBER OF THE NATIONAL LEGISLATIVE COUNCIL, AMERICAN ASSOCIATION OF RETIRED PERSONS, PORT WASHINGTON, NY, ACCOMPANIED BY PATRICIA SMITH, LEGISLATIVE DEPARTMENT OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. GUILDROY. Thank you, Chairman Mitchell.

With me is Tricia Smith of our Legislative Department. On behalf of the 25 million members of the American Association of Retired Persons, I thank you and other members of the committee for giving us the chance to state our views on prescription drugs and Medicare.

In our country, persons aged 65 and older represent only 12 percent of the population, but we consume 30 percent of the prescription drugs. And while three-fourths of all adults age 19 to 64 have insurance coverage for outpatient prescriptions, only 41 percent of Americans over the age of 65 have such protection.

Prices for drugs began to skyrocket in 1981 and have far outpaced the overall Consumer Price Index. Last year, for instance, prescription drugs rose 8.6 percent, while general inflation increased by only 1.9 percent.

These high prices affect both the willingness of private insurers to cover drugs and the behavior of older Americans. An AARP national survey taken in 1986 showed that older consumers cite the cost of drugs as the second most important reason for not getting a prescription filled as ordered by the physician. As recently as 1982, this reason was fourth. Since drugs are among the most cost effective of medical care components, this change may have the poor result of increasing more costly physician visits or even hospitalization.

Prescription drugs create burdens in most elderly families. Over three-fourths of the elderly use prescription drugs, and among those with limitations due to chronic health conditions the proportion rises to 90 percent.

Many of us with high drug expenses are not the same persons who would have high expenses from a hospital stay; rather, older Americans with chronic conditions seem to be the heaviest users of

prescription drugs. This is a group we must be sure to protect. A relatively healthy older person suffering from four common but chronic conditions—arthritis, high blood pressure, angina, and an ulcer—would pay over $1000 a year in drug costs alone.

The heaviest users of drugs are likely to be women living alone. Chronic conditions are problems of the very old, a group dominated by widows. And these women are the most financially vulnerable of all the elderly.

Some who would try to introduce drug benefits gradually would limit the benefit to specific types of drugs. But meaningful distinctions between so-called "life-saving" and other essential drugs are hard to make.

Currently, eight States have implemented programs to cover outpatient drugs for elderly residents, and New York will begin coverage soon. We believe that congressional efforts to implement a drug benefit program for the elderly under Medicare would be enhanced by studying these successful State programs.

AARP recommends a Medicare prescription drug benefit with meaningful coverage to beneficiaries faced with catastrophic prescription drug costs. The benefit would include a deductible no higher than $500, with a minimal or no co-insurance payment; continuation of Medicare's existing prescription drug benefits; Medicaid coverage of individuals up to 100 percent of the Federal poverty level. And we recommend that the beneficiary deductible and co-insurance payments be counted towards the comprehensive catastrophic cap.

To implement and finance the program, we suggest cost containment and systems to encourage generic substitution of equivalent drugs; a fair pricing mechanisms which takes into account average wholesale prices, administrative costs, and other reasonable factors; administration of the benefit through participating pharmacies where conditions of participation should not restrict any current providers or pharmacy services who wish to participate. The benefit could be phased in over a period of several years and be financed through a premium and by bringing State and local employees into Medicare.

The high deductible in this benefit and inclusion of the deductible and co-insurance in the total catastrophic cap are compatible with the principle of catastrophic coverage. The minimal co-insurance would offer a beneficiary significant relief when the cap is reached.

Implementation of the benefit we propose would yield information about utilization levels, cost containment, and administration. If actual experience in administering the benefit falls within reasonable projections, then we believe it would be appropriate to lower the deductible in years to come. Ideally, the deductible should be no higher than $200.

Thank you, Mr. Chairman.

Senator MITCHELL. Thank you, Mr. Guildroy.

Mr. Snedden?

[Mr. Guildroy's prepared testimony follows:]

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

on

MEDICARE PRESCRIPTION DRUG COVERAGE

before the

SENATE FINANCE COMMITTEE

Washington, D.C.
June 18, 1987

Presented by:

Jack Guildroy
Member, AARP National Legislative Council

I am pleased to be here today to represent the American Association of Retired Persons. AARP is a membership organization of 25 million Americans age 50 and older. We are encouraged by your interest in prescription drugs and look forward to working with you to expand protection for older Americans in this vital area.

Before discussing some possible approaches to expanding Medicare to cover prescription drugs, my testimony will discuss some facts that help establish the nature of the problem. Specifically, we will discuss:

1. Drug costs and overall use;
2. Specific areas of need; and
3. Some recent state efforts to help with drug expenses.

Prescription Drugs and Older Americans

AARP has always maintained a keen interest in pharmaceutical issues; older Americans consume a disproportionately high amount of prescription drugs and are less well protected in this area than younger members of the population. In the U.S., persons aged 65 and older represent only 12 percent of the population, but they consume 30 percent of the prescription drugs. And, while three-fourths of all adults age 19 to 64 have insurance coveage for outpatient prescriptions, only 41 percent of Americans over the age of 65 have such protection. The high costs of drugs and the failure of the private sector to offer solutions underscore

the need for legislation to protect older Americans.

The reluctance of private supplemental policies to cover drugs surely arises in part from the tremendous growth in the price of pharmaceuticals. Prices for prescription drugs began to skyrocket in 1981 and have far outpaced the overall Consumer Price Index. Between the years 1981 and 1985, prices for prescription drugs rose 56 percent, compared to 23 percent for general inflation. Last year, prescription drugs rose 8.6 percent, while general inflation increased by only 1.9 percent.

These high prices also affect the behavior of older Americans. An AARP national survey taken in 1986 showed that older consumers cite the cost of drugs as the second most important reason for not getting a prescription filled as ordered by their doctors. As recently as 1982, this reason was fourth. Clearly, cost has become an increasingly important factor in patients' non-compliance with recommended treatment. Since drugs are among the most cost-effective of medical care components, this increasing noncompliance with prescribed drug regimens may have the untoward result of increasing more costly physician visits or even hospitializations.

Perhaps as much as any type of medical care epxense, prescription drugs create burdens in most elderly families. Over three-fourths of the elderly use prescription drugs, and among those with limitations due to chronic health conditions, the proportion rises to 90 percent. Interestingly, many of those with high drug expenses are not the same persons who would have high expenses from a hospital stay. Rather, older Americans with

chronic conditions seem to be the heaviest users of prescription drugs

Acute and Chronic Conditions and Drug Use

Some who would try to introduce drug benefits gradually would limit the benefit to specific types of drugs. problems arise here, however. When, for example, do we assume one type of drug is more essential than another? Meaningful distinctions between "life-saving" and other essential drugs are difficult indeed to make. A careful look at drug use suggests that we must be careful to protect the chronic user. Although available data do not offer a clear cut look at the relationship between medical conditions and drug use, we can discern a number of areas where the elderly are likely to be particularly vulnerable to high drug costs. For example, according to AARP's mail order pharmacy, the ten most commonly dispensed drugs are all for the treatment of hypertension and/or heart conditions. More than a third of all elderly persons suffer from hypertensive disease; in fact this is the second most common chronic condition following arthritis. Moreover, costs of such treatment are not cheap. One common hypertensive drug at the AARP pharmacy (where prices are likely to represent an underestimate of costs to most consumers) is $24.45 for 100 tablets--about a one month supply.

Since many older Americans suffer from multiple chronic conditions, the costs of prescription drugs can multiply quickly. For example, a relatively healthy older person suffering from four common but chronic conditions--arthritis, high blood pressure, angina and an ulcer--would pay over $1000 per year in drug costs alone. (See

attached Table 1).

As already mentioned, older Americans are very likely to suffer from arthritis or hypertension. In addition, more than a fourth of all the elderly suffer from heart conditions (see Table 2). Diabetes also ranks high among the elderly--affecting over 8 percent of those over age 65. All of these chronic conditions are likely to require considerable outlays for prescription drugs.

The heaviest users of these drugs are likely to be women living alone. Chronic conditions are problems of the very old, a group dominated by widows. And these women are the most financially vulnerable of all the elderly. For example, one fifth of such women live below the poverty line.

Thus, while we hear a lot about immunosuppressant drugs and other extremely expensive pharmaceuticals, it is likely to be the more common ailments that lead to high drug expenses, and the burden will be greatest on those least able to pay. The most common prescriptions are for cardiovascular problems, pain relief, and central nervous system problems (see Table 3). These are not the glamorous drugs--merely the ones needed by the elderly to help sustain a reasonable life style. Moreover, three of the four chronic conditions in our example above are life-threatening if essential medications are not taken.

We should not discount the burden of drug costs on those who are acutely ill. Although a few will be affected by the immunosuppressant drug benefit in current law, the drugs are very expensive. The Congressional Budget Office estimates that the

costs of providing immunosuppressant drugs to 9000 Medicare beneficiaries with kidney transplants will approach $35 million in 1987 (or about $4000 per transplant beneficiary). Restricting any new drug benefit to the expansion of immuno-suppressants would constitute only a very minor improvement in Medicare coverage.

Some Medicare beneficiaries could avoid hospitalization or be discharged earlier if certain drug therapies were covered on an outpatient basis. For example, recent studies suggest that Medicare hospital expenditures could be reduced significantly through coverage of at-home antibiotic infusion for several categories of Medicare patients (i.e. those suffering from diseases such as osteomyelitis, endocarditis, and cellulitis which typically require a several-week course of intravenous antibiotics). This limited expansion of the Medicare benefit could be made now, even in the absence of additional funding.

State Efforts

Currently eight states have implemented programs to cover outpatient drugs for elderly residents who meet eligibility requirements. New York, the ninth state, will begin coverage for its plan starting this October.

All programs have differing co-pays and eligibility requirements, but basically all serve to cover marginally poor older persons whose incomes are too high to qualify for Medicaid. AARP believes that Congressional efforts to implement a drug benefit program for the elderly under Medicare would be enhanced

by studying these successful state programs. We conclude that these programs demonstrate the feasibility of providing drug coverage under Medicare.

For example, the Pennsylvania system, PACE (Pharmaceutical Assistance Contract for the Elderly), was started in 1984 and now has 458,000 enrollees. PACE covers all drugs that are available by prescription only. In their first two and one-half years of operation, PACE provided $234 million in benefits and spent only $15.5 million (about 6 percent) on administrative costs. Two categories of drugs, cardiac and gastrointestinal, account for 60 percent of the PACE budget.

AARP Recommendations

AARP recommends a Medicare prescription drug benefit that would provide meaningful coverage to beneficiaries who are faced with catastrophic prescription drug costs. This benefit would include:

- a deductible no higher than $500 per year with a minimal or no coinsurance payment;
- continuation of Medicare's existing prescription drug benefit; and
- Medicaid coverage of individuals up to 100 percent of the federal poverty level.
- Further, we recommend that the beneficiary deductible and coinsurance payments be counted toward the total catastrophic cap..

Little data exist on the potential utilization of a full Medicare prescription drug benefit, its cost, or its administration. AARP recognizes the seriousness of these considerations and, therefore, is proposing a benefit that is fiscally responsible, administratively manageable, a source of useful data, and, most importantly, a benefit of real value. Accordingly, our recommendations for implementation and financing are as follows:

Cost Containment

Cost containment mechanisms and systems to encourage generic susbstitution of equivalent drugs are essential to any program that seeks to implement or expand a prescription drug benefit.

Pricing and Reimbursement

A fair pricing mechanism should be developed which allows for reasonable profits for manufacturers and reasonable dispensing or administrative fees for providers of pharmacy services.

We should look to the rather unsuccessful experience in the MAC (Maximum Allowable Cost) program for Medicaid prescription drug reimbursement to avoid a similar experience. Under MAC, pharmacists were constrained by reimbursement limits imposed on single-source drugs.
These limits did not take into account the frequent and sharp rises in prices for drugs at the manufacturers' level and

therefore, the burden of this difference fell solely on the pharmacists. We believe that the impact of cost containment strategies should be shared by the manufacturer.

It is generally accepted that in the single-source drug market there is neither rhyme nor reason in pricing policies. Virtually every country except the U.S. employs some mechanism to control prescription drug prices. AARP recommends implementing a reimbursement system for single-source drugs similar to systems that operate in many countries whereby manufacturers submit data on manufacturing costs, research and development expenditures and other factors that relate to the costs associated with a new drug product. Reimbursement rates for individual products are then calculated to include other factors such as reasonable advertising and promotional expenditures.

We recognize that traditionally, the U.S. market has been vital to drug manufacturers in recouping the costs of bringing new drugs on the market. Consequently, we do not wish to peg or target reimbursement at the same absolute level as some other countries, many of which are especially austere.

For multiple-source drugs, market factors should prevail and reimbursement could be set as a reasonable percentage of the lowest-priced equivalent product that is generally available to all pharmacy outlets. Alternatively, reimbursement levels could be pegged at the median average wholesale price (AWP) for all equivalent products, with the pioneer product's, price serving as the highest price consideration.

Administration

Administration of the benefit would employ the concept of participating pharmacies. Beneficiaries would enroll with a participating pharmacy or pharmacies each year. Pharmacies would batch claims by individual beneficiaries and submit them together when the deductible has been met. Beneficiaries themselves could batch claims and bill Medicare directly if desired. Conditions of participation by pharmacies should not restrict any current providers of pharmacy services who wish to participate.

Timeline

The benefit should be phased in over a period of several years to allow for proper implementation mechanisms to be put into place.

Financing

The benefit would be financed through a premium and by bring all state and local employees into Medicare.

The high deductible in this benefit and inclusion of the deductible and coinsurance in the overall catastrophic cap are compatible with the principle of catastrophic coverage. The minimal coinsurance would offer a beneficiary significant relief when the deductible is reached. In addition:

- o The approach we propose is more equitable than drug specific approaches in that it covers both medication needed by patients with chronic conditions and the very

high cost of medication needed for treatment of acute care conditions.

- Because the benefit covers the full range of prescription drugs, it can be used to develop data on utilization (diagnosis/types of drugs prescribed/price) by those who meet the deductible.
- The benefit would be easy for beneficiaries and physicians to understand, since coverage is not based on specific types of diseases of drugs prescribed. Implementation of of the benefit we propose would yield information about utilization levels, cost and cost-containment, and administration. If actual experience in administering the benefit falls within reasonable projections, then we believe it would be appropriate to lower the deductible in years to come. Ideally, the deductible should be no higher than $200.

Conclusion

We hope that 1987 will be the year of meaningful catastrophic coverage for older Americans. We recognize that after this year we will still have far to go in protecting the nation against some of the most burdensome health care costs. But in the area of prescription drugs we can take steps this year to provide a benefit that is fiscally sound and administratively manageable. AARP applauds the leadership of this committee in addressing this issue.

We look forward to working with you to achieve passage of Medicare prescription drug benefit and urge you to call on us for any information we can provide.

TABLE 1

Rx DRUG COSTS EXAMPLE

Even if one is not catastrophically ill, one can incur rather catastrophic prescription bills. The example below is of a relatively healthy older person who suffers from four common, but chronic conditions: arthritis, high blood pressure, angina and an ulcer. All drugs listed are commonly prescribed but also newer drugs so that generic copies are not yet available.

		Price per 100 at AARP Pharm...
Diagnosis:	Arthritis	
Treatment:	Feldene (piroxicam) 20 mg. q.d.*	$102.45
Diagnosis:	Hypertension (high blood pressure)	
Treatment:	Dyazide (triamterene & HCT) 1 cap. q.d.	$ 19.65
	Tenormin (atenolol) 50 mg. q.d.	$ 39.15
Diagnosis:	Angina (heart pain)	
Treatment:	Procardia (nifedipine) 10 mg. t.i.d.	$ 24.45
Diagnosis:	Ulcer	
Treatment:	Tagamet (cimetidine) 300 mg. (q.i.d for 6-8 weeks, then 300 mg. q.d.)	$ 39.35

Occasional use of over-the-counter preparations:
Metamucil
Milk of Magnesia

Daily prescription drug costs: $ 3.93 (for 2 months, then $2.73/day)
Monthly prescription drug costs: $117.90 (for 2 months, then $81.90/month)
Yearly prescription drug costs: $1,054.80

Note: Dosages listed are conservative. Prices are also on the conservative side since the AARP Pharmacy is both not-for-profit and buys in large quantities. Prices are accurate as of October 1986.

*q.d. - once a day
t.i.d. - three times a day
q.i.d. - four times a day

TABLE 2

PREVALENCE OF TOP CHRONIC CONDITIONS

AMONG OLDER AMERICANS

Condition	Total persons 65 years and older	Rate per 1000 persons for those 65 years & older
Arthritis	11,547,889	464.7
Hypertensive disease	9,406,958	378.6
Hearing impairments	7,051,238	283.8
Heart Conditions	6,883,416	277.0
Chronic sinusitis	4,562,037	183.6
Visual impairments	3,395,397	136.6
Orthopedic impairments	3,185,565	128.2
Arteriosclerosis	2,410,125	97.0
Diabetes	2,073,037	83.4
Varicose veins	2,067,311	83.2
Hemorrhoids	1,637,487	65.9
Frequent constipation	1,471,915	59.2
Disease of urinary system	1,395,187	56.1
Hay fever	1,290,449	51.9
Corns and callosities	1,289,933	51.9
Hernia of abdominal cavity	1,220,156	49.1

Source: "DataWatch", Health Affairs, Spring 1985.

TABLE 3

PERCENT DISTRIBUTION OF PRESCRIPTIONS BY THERAPEUTIC FUNCTION FOR AGED NON-INSTITUTIONALIZED MEDICARE BENEFICIARIES (1980)

1.	Cardiovascular/Renal	39.4%
2.	Pain Relief	11.3
3.	Affecting Nervous System	8.3
4.	Hormonal Agents/Hormones	7.3
5.	Respiratory/Allergy	7.0
6.	Gastrointestinal	5.6
7.	Homeostatic/Nutrient	5.0
8.	Antimicrobial	4.9
9.	Ophthalmological	3.1
10.	Others	8.1

Source: LaVange, Lisa (Research Triangle Institute) and Herbert Silverman (HCFA), "Prescription Drug Utilization and Expenditure Patterns of Aged Medicare Beneficiaries", Draft Report NMCUES Series (in press), September, 1984.

STATEMENT OF THOMAS SNEDDEN, DIRECTOR, PENNSYLVANIA PHARMACEUTICAL ASSISTANCE CONTRACT FOR THE ELDERLY, PACE, HARRISBURG, PA

Mr. SNEDDEN. Thank you, Mr. Chairman, and other members of the committee.

On behalf of Governor Casey, Secretary of Aging Linda Rhodes, we are honored by the opportunity to assist you in these deliberations.

As I was sitting here this morning listening to the debate going on about the issues and problems associated with this bill you are considering, I decided to revise my highlights so that they might be more instructive to you this morning in the deliberations, and if you will bear with me I will read through these little notes that I have made. I will have these typed up and return them to you tomorrow or Monday for the record. I do have a written statement to be read into the record, and I have some other program reports that might be of use to you also.

As you said at the opening, Mr. Chairman, the need for this concept is very much in evidence. Pennsylvania learned that lesson over four years ago. In November of 1983, the Pennsylvania General Assembly passed what has become to be known as 'The PACE Program,' which stands for Pharmaceutical Assistance Contract for the Elderly. The approach that the General Assembly took at that time was a comprehensive approach, which is much in contrast to the catastrophic approach that you are considering here today.

We have had essentially three eligibility criteria in the PACE program. First and foremost, you obviously have to be a Pennsylvania resident for at least 90 days prior to application.

Second, you must be 65 years of age or older.

Third, you must meet certain income limitations. They are: In the year prior to your application, your income could not have exceeded $12,000, if you are single. If you are married, the limit is $15,000.

We estimate that in our State population there are approximately 750,000 people who fall within that criteria. As of today, 470,000 people are enrolled in the PACE program and who meet that criteria.

The average person in the PACE program is a 75-year-old white widowed female living alone in private residence. Eighty-two percent of those 470,000 cardholders have income between $3000 and $12,000 annually. Sixty-four percent of the 470,000 have incomes below $9000.

The average cardholder in the program is using 26 prescriptions per year, a benefit value of $370. In other words, the program is paying on those 26 scripts $370 a year. This means that the average person in the program is spending $473 a year on drugs. The difference between the $473 and the $370 comes about because the PACE program requires that the cardholder pay a $4 copayment on each prescription. That is it; there are no coinsurances, no premiums, no spend-ups, no spend-downs, just a flat $4 copayment each time they get a prescription filled.

The mix of drugs that we use in the program might be instructive to you: Twenty-nine percent of the drugs that we pay for fall

in the therapeutic class known as "the diuretics." Twenty-eight percent fall within the cardiovascular class, and the analgesics make up the 13 percent, and gastrointestinal, 12 percent.

We are now coming to the conclusion of the first three years of the PACE program. And in fact, the administration, Governor Casey, plans to introduce on Monday a bill to re-authorize the program—this coming Monday—for an unlimited period of time.

In the first 3 years of the program, however, we will have spent $330 million for 26 million prescriptions. The accrual value of the program in the first three years will be approximately $350 million, because approximately 20 million claims will be in the pipeline as of the end of this month. Those claims, of course, will be paid in August and September.

I would like to point out, too, that pharmacists play a key role in the operation of the PACE program.

Aside from dispensing drugs and providing consultative services to cardholders, the pharmacists are responsible for all the claims paperwork that go into the operation of the program, so that none of that burden falls upon the older people who are participating in the program.

Senator MITCHELL. Thank you, Mr. Snedden. I am sure members of the committee will have questions for you on your program.

Mr. Spielman?

[Mr. Snedden's prepared testimony and information follow:]

Testimony on the
Pennsylvania
Pharmaceutical Assistance Contract for the Elderly (PACE)

Presented by
Thomas M. Snedden
Director, PACE Program
Pennsylvania Department of Aging

Before the
Committee on Finance
Subcommittee on Health
United States Senate

Washington, D.C.
June 18, 1987

GOOD MORNING. I AM INDEED HONORED TO REPRESENT THE COMMONWEALTH OF PENNSYLVANIA BEFORE THIS COMMITTEE. I HAVE BEEN ASKED TO PROVIDE A GENERAL DESCRIPTION OF THE PACE PROGRAM, PENNSYLVANIA'S PHARMACEUTICAL ASSISTANCE CONTRACT FOR THE ELDERLY, WITH PARTICULAR ATTENTION TO THE ADMINISTRATIVE COMPLEXITIES, COSTS EXPERIENCE, DRUG UTILIZATION CONTROLS AND QUALITY ASSURANCE CONTROLS. THE PURPOSE OF PACE, A STATEWIDE PROGRAM FUNDED BY THE PENNSYLVANIA LOTTERY, IS TO PROVIDE ASSISTANCE TO ELIGIBLE PERSONS AGE 65 AND OVER IN PAYING FOR THEIR PRESCRIPTION MEDICATIONS. PACE IS THE LARGEST PHARMACEUTICAL PROGRAM FOR THE ELDERLY IN THE NATION AND IS RECOGNIZED AS A PROGRAM WHICH HAS HELPED HUNDREDS OF THOUSANDS OF OLDER PEOPLE TO BE MORE INDEPENDENT AND TO LEAD MORE HEALTHY AND PRODUCTIVE LIVES THAN MIGHT HAVE OTHERWISE BEEN POSSIBLE.

ACCORDING TO THE AGING HEALTH POLICY CENTER, A RESEARCH ORGANIZATION WITHIN THE SCHOOL OF NURSING IN THE UNIVERSITY OF CALIFORNIA, PERSONS OVER THE AGE OF 65 CONSUME NEARLY TWICE AS MANY PRESCRIPTION DRUGS PER PERSON THAN DO THE REST OF THE POPULATION. IN ADDITION, THEIR PRESCRIPTIONS ARE, ON THE AVERAGE, MORE EXPENSIVE THAN THOSE USED BY THE YOUNGER POPULATION. RECENTLY, IN FACT, THE CONGRESSIONAL BUDGET OFFICE ESTIMATED THAT, IN 1987, THE ELDERLY REPRESENTED ABOUT TWELVE PERCENT OF THE OVERALL NATIONAL POPULATION, BUT ACCOUNTED FOR ABOUT THIRTY PERCENT OF ALL PRESCRIPTION DRUG SPENDING.

IN ORDER TO ASSIST PENNSYLVANIA'S OLDER CITIZENRY IN PAYING FOR THEIR PRESCRIPTION MEDICATIONS, THE PENNSYLVANIA LEGISLATURE CREATED THE PACE PROGRAM WHICH BEGAN NEARLY THREE YEARS AGO, ON JULY 1, 1984. THE PROGRAM HAS BEEN INTENTIONALLY STRUCTURED SO THAT IT IS EXTREMELY EASY TO USE. ANY PENNSYLVANIA RESIDENT WHO IS AT LEAST 65 YEARS OLD AND MEETS THE INCOME ELIGIBILITY REQUIREMENTS (CURRENTLY LESS THAN $12,000 ANNUAL INCOME FOR

SINGLE APPLICANTS AND LESS THAN $15,000 COMBINED INCOME FOR MARRIED PERSONS) MAY APPLY SO LONG AS THEY DO NOT ALREADY RECEIVE PRESCRIPTION DRUG BENEFITS (OR BLUE CARDS) FROM THE PENNSYLVANIA MEDICAL ASSISTANCE PROGRAM. IN ORDER TO BECOME ELIGIBLE, THE FIRST STEP IS TO COMPLETE AND SUBMIT A ONE PAGE APPLICATION WHICH IS READILY AVAILABLE FROM ALL PARTICIPATING PHARMACIES, SENIOR CENTERS OR LEGISLATIVE OFFICES. ONCE APPROVED, AN APPLICANT WILL RECEIVE A PLASTIC PACE CARD WITH THEIR NAME AND PACE IDENTIFICATION NUMBER ENGRAVED ON THE FRONT. (A PACE CARD IS ABOUT THE SAME SIZE AS MOST CREDIT CARDS AND FITS EASILY INTO A WALLET.) EACH TIME THE CARDHOLDER HAS A PRESCRIPTION TO BE FILLED, HE OR SHE PRESENTS THE CARD TO THE PHARMACIST, PAYS A FOUR DOLLAR COPAYMENT, AND RECEIVES THE PRESCRIPTION. THERE ARE NO INVOICES FOR THE CARDHOLDER TO SAVE OR REPORTS TO BE COMPLETED BY THE CARDHOLDER. THE PHARMACY THEN SUBMITS A BILL TO THE PROGRAM FOR THE REMAINDER OF THE PRESCRIPTION COSTS AND REIMBURSEMENT IS MADE TO THAT PROVIDER WITHIN AN AVERAGE OF THIRTEEN DAYS OF RECEIPT OF THE INVOICE. (IT SHOULD BE MENTIONED THAT THE PACE PROGRAM REIMBURSES PHARMACIES FOR ALL FEDERAL LEGEND DRUGS, INSULIN, INSULIN NEEDLES, AND INSULIN SYRINGES DISPENSED TO CARDHOLDERS.)

SINCE THE PROGRAM'S BEGINNING, 3 YEARS AGO, NEARLY 26 MILLION PRESCRIPTIONS HAVE BEEN FUNDED BY PACE. THESE PRESCRIPTIONS WOULD COLLECTIVELY HAVE COST OUR LOW INCOME SENIOR CITIZENS SOME 350 MILLION DOLLARS. INSTEAD, THE COST OF THESE PRESCRIPTIONS WAS PAID FOR BY THE PENNSYLVANIA LOTTERY. NO TAX DOLLARS WERE USED TO PAY FOR ANY OF THESE PRESCRIPTIONS.

THE POLITICAL HISTORY OF THE PACE PROGRAM IS RATHER INTERESTING. ALTHOUGH EARLY VERSIONS OF LESS COMPREHENSIVE PHARMACEUTICAL ASSISTANCE

PROGRAMS HAD BEEN DISCUSSED PRIOR TO 1983, THEY HAD NOT CAPTURED WIDESPREAD ATTENTION, AND CONCERNS OVER HOW TO CONTROL COSTS HAD CAUSED THE PROGRAMS TO DIE QUIETLY IN LEGISLATIVE COMMITTEES IN PRECEDING YEARS. SEVERAL FACTORS CAN BE IDENTIFIED THAT CONSOLIDATED PUBLIC OPINION AND EXPANDED LEGISLATIVE INTEREST IN THE PHARMACEUTICAL ASSISTANCE PROGRAM.

FIRST, DEMOGRAPHIC, INCOME AND MEDICATION USE PRESSURES WERE BECOMING MAJOR CONCERNS TO THE MAJORITY OF OLDER PERSONS. PRESCRIPTION EXPENSES BEGAN TO INCREASE FASTER THAN THE CONSUMER PRICE INDEX IN GENERAL. THE 1980 CENSUS DOCUMENTED CONTINUED DRAMATIC GROWTH IN THE NUMBER AND TYPE OF SENIOR CITIZENS WHO WERE EXPECTED TO BE MORE LIKELY TO BE HEAVY USERS OF PRESCRIPTION MEDICINE, AND HAVE LOWER INCOME. THUS, A REALISTIC AND STATISTICALLY SUPPORTED FOUNDATION ADDRESSING THE INCREASING COMPLAINTS ABOUT PRESCRIPTION EXPENSES WAS PROVIDED.

SECOND, AT THAT TIME, THE PENNSYLVANIA LOTTERY HAD BUILT UP A LARGE SUM OF UNCOMMITTED REVENUES, AND WAS BEING OBSERVED CLOSELY BY ELDER CONSTITUENCIES. IT WAS ALSO BEING SCRUTINIZED BY LEGISLATIVE AND EXECUTIVE BRANCH POLICY MAKERS WHO HOPED TO FINANCE OTHER PROGRAMS NOT SPECIFICALLY AIMED AT THE ELDERLY, BUT PERCEIVED AS NEEDED IN THE COMMONWEALTH (SUCH PROGRAMS INCLUDED AID TO EDUCATION, JOB TRAINING PROGRAMS, AND MORTGAGE ASSISTANCE). WHILE THESE ATTEMPTED "RAIDS" OF LOTTERY FUNDS ALONE MAY HAVE GALVANIZED SENIOR LOBBYING, THERE WAS ALSO AN INCREASING SENSE OF AGREEMENT ON LEGISLATIVE PRIORITIES AMONG GROUPS OF OLDER PERSONS THAT WAS UNPRECEDENTED IN THE STATE. WITH THE PASSAGE OF THE RURAL TRANSPORTATION PROGRAM, ELDERS' LEGISLATIVE PRIORITIES ACROSS THE STATE BEGAN TO FOCUS ON PHARMACEUTICAL ASSISTANCE. THE EXISTENCE OF NEIGHBORING NEW JERSEY'S PHARMACEUTICAL ASSISTANCE PROGRAM ALSO HELPED STRENGTHEN ARGUMENTS AND PROVIDED A CLOSE GEOGRAPHICAL MODEL.

THE EXECUTIVE BRANCH HAD ALSO BEEN AWARE OF INTEREST FOR SUCH A PROGRAM, AND HAD CONDUCTED AN INTERNAL REVIEW OF OTHER PHARMACEUTICAL ASSISTANCE PROGRAMS OPERATED BY THE COMMONWEALTH. PRELIMINARY INTERDEPARTMENTAL PLANNING TO DESIGN A PROGRAM FOR PROVIDING PHARMACEUTICAL ASSISTANCE TO THE ELDERLY OCCURRED IN APRIL OF 1983, AND INCREASED IN URGENCY AS THE PROGRAM BEGAN TO APPEAR MORE A REALITY. ADDITIONALLY, THE DEPARTMENT OF AGING WAS CONDUCTING AN EXTENDED SERIES OF COMMUNITY MEETINGS THROUGHOUT THE COMMONWEALTH IN THE SUMMER OF 1983. THE MEETINGS EXPOSED A HIGH DEGREE OF INTEREST AND CONCERN OVER PHARMACEUTICAL ISSUES, AND PROVIDED VERY STRONG GRASS ROOTS SUPPORT FOR A PHARMACEUTICAL ASSISTANCE PROGRAM. INDEPENDENT GROUPS BEGAN TO LOBBY VIGOROUSLY WITH THEIR LOCAL LEGISLATORS, AND THE DEPARTMENT OF AGING, AS PART OF ITS LEGISLATED ADVOCACY ROLE, COMMUNICATED INTERNALLY WITH MEMBERS OF THE EXECUTIVE BRANCH IN TECHNICAL ASSISTANCE AND PLANNING ACTIVITIES.

CONCURRENTLY, THE AGING AND YOUTH COMMITTEE OF THE PENNSYLVANIA SENATE, WHICH HAD BEEN THE SETTING FOR EARLIER DEBATE ABOUT SUCH A PROGRAM, TOOK UP THE ISSUE WITH A BILL INTRODUCED BY SENATOR F. JOSEPH LOEPER, IN MID-SUMMER, 1983. ALTERNATE BILLS WERE ALSO INTRODUCED. GOVERNMENT RELATIONS STAFF OF THE PENNSYLVANIA PHARMACY ASSOCIATION AND OF A NUMBER OF PHARMACEUTICAL MANUFACTURING FIRMS WERE ACTIVE IN CRITIQUING THE PROPOSED PROGRAM, AS WERE THE VARIOUS SENIOR GROUPS. EARLY DEBATE FOCUSED ON ELIGIBILITY, FISCAL MECHANISMS FOR ACTUALLY COVERING COSTS, SCOPE AND TYPE OF REIMBURSEMENT TO PHARMACISTS AND THE ADMINISTRATIVE STRUCTURE OF A PROGRAM. WHILE THE EXECUTIVE BRANCH COOPERATED WITH LEGISLATIVE COMMITTEES IN COMPILING ELIGIBILITY AND COSTS ESTIMATES, AND IN REACTING TO DRAFT LEGISLATION, CONCERNS OVER HIGH COSTS RESULTED IN A LOW PUBLIC PROFILE ON THE ISSUE. EARLY PLANS CALLED FOR A DECENTRALIZED OPERATION, WITH EACH AREA AGENCY ON

AGING USING A COMPUTER TERMINAL TIED TO A CENTRAL PROCESSING FACILITY, BUT A CENTRALIZED CONTRACT APPROACH WAS FINALLY ADOPTED. ON NOVEMBER 4, 1983, ACT 63, FORMALLY ESTABLISHING THE PACE PROGRAM, WAS SIGNED INTO LAW. THE PROGRAM WAS FULLY OPERATIONAL LESS THAN 8 MONTHS LATER, ON JULY 1, 1984.

SINCE THAT TIME, ONLY TWO MAJOR PROGRAMMATIC CHANGES HAVE BEEN IMPLEMENTED. FIRST, THE ORIGINAL INCOME LIMITS OF LESS THAN $9,000 FOR SINGLES AND LESS THAN $12,000 FOR MARRIED PERSONS WERE RAISED TO THE CURRENT LEVEL OF $12,000 AND $15,000, RESPECTIVELY. SECOND, THE USE OF MAIL-ORDER PHARMACY SERVICES, ORIGINALLY PROHIBITED IN PACE, WERE PERMITTED BEGINNING JULY 1, 1985. WHILE THE PROVISION ALLOWING FOR MAIL-ORDER SERVICES WAS STRONGLY OPPOSED BY THE PENNSYLVANIA PHARMACEUTICAL ASSOCIATION, (AN ORGANIZATION WHICH REPRESENTS MOST INDEPENDENT PHARMACISTS), THE LEGISLATURE WAS UNABLE TO FIND COMPELLING PROOF THAT MAIL-ORDER SERVICES WERE NECESSARILY INFERIOR TO IN-PERSON PHARMACY SERVICES, ESPECIALLY FOR THE ACQUISITION OF MAINTENANCE MEDICATIONS. THEY ARE ALSO FREQUENTLY LESS EXPENSIVE. ALTHOUGH THE NUMBER OF MAIL-ORDER CLAIMS TO DATE HAS BEEN NEGLIGIBLE, APPROXIMATELY .08% OF ALL CLAIMS, THEIR AVAILABILITY HAS EASED CONCERNS REGARDING THE ACQUISITION OF PRESCRIPTION DRUGS BOTH FOR CARDHOLDERS AND THEIR FAMILIES. PRESENTLY ELEVEN PHARMACIES PARTICIPATE IN THE PROVISION OF MAIL-ORDER PRESCRIPTION SERVICES TO CARDHOLDERS.

OVER THE COURSE OF THE FIRST THREE YEARS, THE PACE PROGRAM HAS PROVIDED PRESCRIPTION BENEFITS TO NEARLY HALF A MILLION PENNSYLVANIA SENIOR CITIZENS. AS OF TODAY, 471,756 CARDHOLDERS ARE ENROLLED IN THE PROGRAM. THIS COMPARES WITH AN ENROLLMENT LEVEL OF 387,000 AT THE END OF THE FIRST PROGRAM YEAR AND 446,000 AT THE END OF THE SECOND PROGRAM YEAR.

WE HAVE COLLECTED A SUBSTANTIAL AMOUNT OF DEMOGRAPHIC DATA DESCRIBING OUR CARDHOLDERS, AND I WOULD BE GLAD TO SHARE SOME OF THE SPECIFIC DATA WITH YOU LATER ON IF YOU SO DESIRE. A BRIEF SKETCH OF THEIR CHARACTERISTICS REVEALS THAT THE AVERAGE CARDHOLDER IS A WIDOWED FEMALE BETWEEN 75 AND 79 YEARS OF AGE WHO LIVES INDEPENDENTLY AND EARNS BETWEEN 6 AND 9 THOUSAND DOLLARS ANNUALLY.

NEARLY EVERY ELIGIBLE PHARMACY IN THE COMMONWEALTH IS A PACE PROVIDER. WE CURRENTLY HAVE SLIGHTLY MORE THAN 2,900 PROVIDERS ENROLLED IN PACE, OF WHICH THERE ARE 1,850 INDEPENDENT PHARMACIES, 950 CHAINS, 110 PHARMACIES LOCATED IN EITHER NURSING HOMES OR INSTITUTIONS AND 43 DISPENSING PHYSICIANS. MAIL-ORDER SERVICES ARE AVAILABLE THROUGH 10 DIFFERENT MAIL-ORDER PROVIDERS.

AS I STATED PREVIOUSLY, PACE PROVIDERS HAVE DISPENSED NEARLY 18 MILLION PRESCRIPTIONS TO DATE. OF THE TOP TEN DRUGS RANKED BY AMOUNT PAID, PHARMACEUTICAL PRODUCTS INTENDED FOR THE USE OF CARDIOVASCULAR PROBLEMS SUCH AS ANGINA AND HYPERTENSION COLLECTIVELY ACCOUNT FOR THE SINGLE LARGEST DOLLAR EXPENDITURE. DRUGS USED IN THE TREATMENT OF GASTROINTESTINAL DISORDERS AND THOSE USED FOR ARTHRITIS AND PAIN CONSTITUTE THE SECOND AND THIRD LARGEST EXPENDITURES, RESPECTIVELY. ANTI-DIABETICS ACCOUNT FOR THE FOURTH LARGEST EXPENDITURE. THE MIX OF THESE HIGH VOLUME, HIGH PRICED DRUGS HAS REMAINED PRETTY MUCH THE SAME OVER THE FIRST TWO YEARS OF THE PROGRAM. THESE DRUGS, ON THE AVERAGE, COST THE PROGRAM TWICE AS MUCH AS THE AVERAGE DRUG CHARGE TO PACE.

AS OF THIS DATE, THE PACE PROGRAM HAS PAID $324 MILLION FOR PRESCRIPTIONS AND PROGRAM OPERATION. DURING THE FIRST PROGRAM YEAR, EXPENDITURES TOTALED 62 MILLION DOLLARS. SECOND YEAR EXPENDITURES WERE

DOUBLE THAT AMOUNT AND IT IS ANTICIPATED THAT THIRD YEAR COSTS COULD BE THREE TIMES THE AMOUNT SPENT DURING THE FIRST YEAR. COST ESCALATIONS, THEREFORE, ARE A MAJOR CONCERN TO THE PACE PROGRAM. (IT IS IMPORTANT TO NOTE THAT TOTAL ADMINISTRATIVE COSTS ARE RUNNING AT LESS THAN 5% OF ALL PROGRAM EXPENDITURES.) THE PRIMARY REASONS FOR THE SUBSTANTIAL INCREASES IN COSTS ARE THAT THE NUMBER OF CARDHOLDERS, THE NUMBER OF PRESCRIPTIONS FILLED FOR EACH CARDHOLDER, AND THE AVERAGE COST OF EACH PRESCRIPTION HAVE ALL INCREASED STEADILY SINCE THE PROGRAM'S INCEPTION. BY THE END OF THE FIRST PROGRAM YEAR, FOR EXAMPLE, THE AVERAGE STATE SHARE PER PRESCRIPTION WAS $10.85. AT THAT TIME, THERE WERE 387,000 CARDHOLDERS SUBMITTING BETWEEN 18 AND 22 PRESCRIPTIONS PER YEAR. ONE YEAR LATER, ON JUNE 30, 1986, THE AVERAGE STATE SHARE PER PRESCRIPTION WAS $12.65. THE NUMBER OF CARDHOLDERS HAD GROWN TO NEARLY 446 THOUSAND AND EACH PACE CARD WAS USED BETWEEN 22 AND 24 TIMES PER YEAR. NOW, THE AVERAGE PRESCRIPTION IS COSTING THE PROGRAM $14.19 AND ON AVERAGE THE PACE CARD IS BEING USED BETWEEN 25 AND 26 TIMES EACH YEAR.

WHILE THESE INCREASES ARE STAGGERING AND SOMEWHAT ALARMING TO PACE, IT IS ALSO IMPORTANT TO OCCASIONALLY STEP BACK AND LOOK AT THE BROADER PERSPECTIVE. WHEN WE LOOK AT THE OVERALL COST OF HEALTH CARE IN THE UNITED STATES, PHARMACEUTICAL PROGRAMS SUCH AS PACE SERVE TO CONTRIBUTE TO THE DECREASE IN HEALTH CARE COSTS EVEN THOUGH THE COSTS OF PHARMACEUTICAL PRODUCTS AND THE MONTHLY EXPENSES INCURRED BY PACE AND SIMILAR PROGRAMS MAY BE INCREASING.

IT HAS BEEN ESTIMATED THAT A TOTAL DOLLAR BENEFIT TO THE NATION OF $134 BILLION HAS RESULTED FROM PHARMACEUTICAL AND OTHER MEDICAL INTERVENTIONS DEVELOPED BETWEEN THE YEARS 1900 AND 1977. THIS IS DUE PRIMARILY TO PREVENTIVE THERAPIES, A LESSENING IN THE SEVERITY AND CORRESPONDING COMPLEXITY OF MANY HEALTH PROBLEMS, AND ALSO TO A REDUCTION IN THE DURATION

OF HOSPITAL STAYS. THE MEAN LENGTH OF STAYS HAS DECREASED 13% FROM 8.5 DAYS TO 7.4 DAYS DURING THE PAST 10-YEAR PERIOD; MUCH OF THIS HAS BEEN ATTRIBUTED TO EXPANDED USE OF DRUG TREATMENT THERAPIES.

IN ORDER TO PRESERVE THE PACE PROGRAM FOR THOSE WHOM IT WAS ORIGINALLY INTENDED TO SERVE, PACE IS STRIVING TO CONTAIN COSTS. SUCH EFFORTS ALSO ADDRESS OUR PRIMARY RESPONSIBILITY OF PROTECTING THE HEALTH OF OUR CARDHOLDERS.

THE PACE ENABLING LEGISLATION APPROPRIATED $315 MILLION TO PROVIDE PRESCRIPTION DRUG BENEFITS FOR A THREE-YEAR PERIOD. WITH EXPENDITURES CONTINUING TO ESCALATE, IT WILL BE IMPOSSIBLE TO REMAIN WITHIN THIS APPROPRIATION. TO OFFSET OUR INCREASING EXPENDITURES, PACE HAS IMPLEMENTED SEVERAL COST-CONTAINMENT STRATEGIES.

PACE CURRENTLY HAS THREE UTILIZATION REGIONAL COMMITTEES WHICH MEET BI-MONTHLY TO REVIEW THE CLAIM PROFILES OF SELECTED CARDHOLDERS TO ASSESS WHETHER THE PERSON IS BEING MEDICATED PROPERLY OR WHETHER THERE IS A POSSIBILITY OF A DRUG INTERACTION WHICH MIGHT IMPAIR THE HEALTH OF THE CARDHOLDER. THE COMMITTEES ARE ALSO TRYING TO DETERMINE WHETHER ANY FRAUD OR ABUSE OR PROGRAM NON-COMPLIANCE IS OCCURRING. TO DATE, THESE COMMITTEES HAVE REVIEWED OVER 9,000 PATIENT PROFILES WHICH HAS RESULTED IN POSITIVE CORRECTIVE ACTION IN ALMOST TWENTY-FIVE PERCENT OF THE CASES. THE ACTIVITIES WILL REDUCE COSTS BY MINIMIZING UNWARRANTED EXPENDITURES, AND WILL PROTECT THE HEALTH AND SAFETY OF THE CARDHOLDERS BY ASSURING THAT DRUGS PAID FOR BY PACE ARE APPROPRIATELY DISPENSED AND UTILIZED.

ANOTHER STRATEGY WE ARE USING INVOLVES VARIOUS FORMS OF DRUG EDUCATION. IN JUNE 1985 THE DEPARTMENT OF AGING LAUNCHED ITS STATEWIDE COMPREHENSIVE PROGRAM WHICH WAS TARGETED FOR THREE AUDIENCES--CONSUMERS, PHYSICIANS, AND HEALTH AND SOCIAL SERVICE PRACTITIONERS. THE PROGRAM CONTAINED FOUR COMPONENTS: A MEDIA BLITZ CONSISTING OF A SERIES OF PRESS RELEASES AND PUBLIC SERVICE ANNOUNCEMENTS, DEVELOPMENT OF AN INFORMATIONAL BROCHURE AND A MEDICATION PASSPORT, DISSEMINATION OF RESOURCE MATERIAL TO THE AGING NETWORK, AND DEVELOPMENT OF TRAINING MODULES FOR THE THREE TARGETED AUDIENCES. THE DEPARTMENT IS NOW ASSESSING THE EFFECTIVENESS OF THE PROGRAM SO THAT WE CAN ENCOURAGE ONGOING UTILIZATION OF ALL MATERIALS WHICH PROMOTE THE PROPER USE OF MEDICATIONS BY OLDER PENNSYLVANIANS.

GREATER USE OF GENERICALLY EQUIVALENT DRUGS IS ALSO BEING ENCOURAGED BY THE DEPARTMENT. DATA INDICATES THAT EVERY FIVE PERCENT INCREASE IN UTILIZATION OF GENERIC DRUGS COULD SAVE THE PROGRAM BETWEEN 3 AND 5 MILLION DOLLARS ANNUALLY. ALTHOUGH I WILL NOT GO INTO DETAIL REGARDING OUR GENERIC PLANS, SUFFICE IT TO SAY THAT WE ARE APPROACHING THIS EFFORT WITH A GREAT DEAL OF AGGRESSIVENESS AND PLAN ON THE IMPLEMENTATION OF VARIOUS APPROACHES WITHIN THE UPCOMING YEAR.

ANOTHER COST-CONTAINMENT STRATEGY, WHICH HAS ALREADY SAVED PACE 7.5 MILLION DOLLARS, IS OUR EFFORT TO RECOUP MONIES FROM INSURANCE CARRIERS WHO HAVE POLICIES COVERING PACE CARDHOLDERS. OVER HALF OF OUR CARDHOLDERS HAVE SOME FORM OF PRESCRIPTION DRUG COVERAGE. SINCE PACE IS THE "PAYOR OF LAST RESORT," WE HAVE BEEN SEEKING RECOUPMENT OF MONIES WHICH WE HAVE PAID ON BEHALF OF OTHER INSURERS, AND EXPECT TO RECOUP AN ADDITIONAL FIVE TO SIX MILLION DOLLARS DURING THIS PROGRAM YEAR.

AN ADDITIONAL STRATEGY FOR CONTAINING COSTS IS TO ENSURE THAT THE PROGRAM ONLY PROVIDES SERVICES TO ELIGIBLE CARDHOLDERS. THIS IS ACCOMPLISHED BY VERIFYING THE REPORTED INCOMES OF PARTICIPANTS WHEN WE HAVE REASON TO BELIEVE THEY HAVE UNDER-REPORTED THEIR INCOME. TO DATE, WE HAVE CHECKED 6,500 INDIVIDUAL CARDHOLDERS AND DETERMINED 186 TO HAVE BEEN INELIGIBLE FOR PACE BENEFITS. THESE INELIGIBLE CARDHOLDERS HAVE BEEN REMOVED FROM THE PROGRAM AND WE ARE SEEKING RESTITUTION OF THE FUNDS WHICH WERE PAID ON THEIR BEHALF.

A FINAL COMPONENT OF OUR ONGOING COST-CONTAINMENT EFFORTS INVOLVES THE REVIEW OF CLAIMS SUBMITTED BY THE PACE PROVIDERS TO ENSURE THAT PRESCRIPTIONS FUNDED BY THE PROGRAM ARE BILLED AND DISPENSED APPROPRIATELY. AT LEAST 10% OF THE PACE PROVIDERS ARE AUDITED ANNUALLY FOR THE PURPOSE OF CONDUCTING CONTRACTUAL COMPLIANCE REVIEWS. THE PURPOSE OF THESE REVIEWS IS TO ENSURE THAT CLAIMS AND CORRESPONDING INVOICES ARE SUBMITTED IN ACCORDANCE WITH PACE REGULATIONS. THIS PROCEDURE ALSO PROVIDES PROGRAM REPRESENTATIVES WITH AN OPPORTUNITY TO ANSWER ANY QUESTIONS POSED BY THE PROVIDERS PERTAINING TO ACCEPTED BILLING PROCEDURES. IN ADDITION TO THESE COMPLIANCE REVIEWS, A SERIES OF IN-DEPTH AUDITS ARE JOINTLY CONDUCTED BY THE DEPARTMENT OF AGING AND THE COMPTROLLER'S OFFICE WITHIN THE DEPARTMENT OF HEALTH. THE PURPOSE OF THESE AUDITS IS TO CONDUCT A MORE INTENSIFIED INVESTIGATION OF SPECIFIC FISCAL MATTERS PERTAINING TO INVOICES SUBMITTED BY PROVIDERS FOR PAYMENT OF CLAIMS FUNDED BY PACE. THESE EFFORTS WILL LEAD TO INCREASED EFFICIENCY IN PROCESSING CLAIMS AND TO THE RECEIPT OF REMUNERATION FOR INVOICES WHICH MAY HAVE BEEN INAPPROPRIATELY SUBMITTED TO AND PAID BY THE PROGRAM.

TO DATE, ELEVEN PROVIDERS HAVE BEEN TERMINATED FROM PARTICIPATION IN THE PROGRAM. DUE TO A COOPERATIVE AGREEMENT BETWEEN THE DEPARTMENT OF PUBLIC WELFARE AND THE DEPARTMENT OF AGING, PHARMACIES TERMINATED BY THE DEPARTMENT

OF PUBLIC WELFARE ARE ALSO TERMINATED FROM PARTICIPATION IN PACE. SEVEN OF THE PACE PROVIDER TERMINATIONS RESULTED FROM ACTIONS TAKEN BY THE DEPARTMENT OF PUBLIC WELFARE. THE TERMINATION OF THE OTHER PROVIDERS RESULTED FROM INFRACTIONS SOLELY RELATED TO THE DISPENSING OF PACE-FUNDED PRESCRIPTIONS. A BALANCE BETWEEN THE FINES AND ACTUAL SUSPENSIONS IS SOUGHT WHEN PROVIDERS SUBMITTING INAPPROPRIATE BILLS ARE DISCOVERED. WHILE IT IS DESIRABLE TO MAINTAIN A SUFFICIENTLY LARGE POOL OF PROVIDERS TO MEET THE NEEDS OF THE CARDHOLDERS, IT WOULD BE BOTH FISCALLY AND MORALLY IRRESPONSIBLE TO PERMIT POTENTIALLY DANGEROUS DISPENSING PATTERNS TO CONTINUE. GUIDELINES FOR MAKING RELATED DECISIONS ARE PROVIDED IN THE PACE REGULATIONS.

THE PACE PROGRAM IS SERVING NEARLY HALF A MILLION CARDHOLDERS AND IS PROJECTED TO PROCESS 26 MILLION CLAIMS AND TO SPEND 345 MILLION DOLLARS FOR PRESCRIPTIONS COVERING THE THREE-YEAR PERIOD ENDING JUNE 30, 1987. TO DO THIS, PACE UTILIZES THE SERVICES OF A SUBCONTRACTOR WHICH IS RESPONSIBLE FOR CONDUCTING DAY-TO-DAY PROCESSING RESPONSIBILITIES. THE OVERSIGHT RESPONSIBILITIES FOR PROGRAM IMPLEMENTATION, OF COURSE, REST WITH THE PACE PROGRAM, A BUREAU WITHIN THE PENNSYLVANIA DEPARTMENT OF AGING.

I TRUST THIS TESTIMONY WILL BE HELPFUL TO YOU IN YOUR DELIBERATIONS ON ADDING COVERAGE FOR PRESCRIPTION DRUGS UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT. I WILL BE HAPPY TO PROVIDE ANY ADDITIONAL INFORMATION I CAN TO ASSIST YOU IN THIS EFFORT. AGAIN, I THANK YOU FOR THIS HONOR AND PLEASURE.

PACE

Pharmaceutical Assistance Contract for the Elderly

QUARTERLY REPORT TO THE PENNSYLVANIA GENERAL ASSEMBLY

October 1, 1986 - December 31, 1986

PRESENTED BY

PENNSYLVANIA
DEPARTMENT
OF AGING

INTRODUCTION

The purpose of this report is to provide a broad overview of the PACE Program's growth over its two and one-half years' existence, while focusing primarily on information pertaining to the three-month period from October 1986 - December 1986.

Section II of the report provides information describing enrollment trends, utilization patterns and drug utilization review activities pertaining to the PACE cardholders. Nearly 15,000 cardholders were added to the program during the quarter, bringing the cumulative number of cardholders to 435,758 on December 31, 1986. On the average, each PACE card was used six times or twice per month during the period. Drug profiles for over 1,000 cardholders were reviewed during the quarter and therapeutic interventions were determined necessary in 208 cases.

Section III describes the distribution of PACE providers and contrasts dispensing patterns between each of the five major provider types.

A delineation of the top ten PACE-funded drugs ranked by amount paid combined with the top ten drugs ranked by claims volume is provided in Section IV. A brief analysis of generic utilization and shifts in usage patterns within key therapeutic groups is also included in this section.

Section V describes the major findings of a research project entitled, "Medicine, Health and Aging," which was recently completed after having been conducted jointly by the Department of Aging and the Gerontology Center at the Pennsylvania State University. The study compares PACE participants with individuals (over the age of 65) who do not participate in the program. It also addresses issues pertaining to barriers to participation in PACE, advantages of different data collection techniques and includes a comparison of PACE with other state-level pharmaceutical programs.

Section VI delineates both quarterly and cumulative payouts for PACE-funded claims and Section VII describes the various cost-containment strategies which have been implemented to keep program expenditures as low as possible.

Finally, Section VIII provides a description of all program expenditures to date and projects that total accrued PACE expenditures through June 1987 will range from 330 to 350 million dollars.

Any questions or comments pertaining to information included in this report should be addressed to:

The PACE Program
Pennsylvania Department of Aging
231 State Street
Harrisburg, PA 17101

II. CARDHOLDERS

By the end of December 1986, nearly 436,000 cardholders were enrolled in the PACE Program. This represents an increase of almost 15,000 cardholders since the previous report period and reveals an overall growth rate of 6% over the same period in 1985.

A. Enrollment Trends

As shown in Figure 1 below, only 17% of the current cardholders are "new" participants, having submitted their first PACE application during the 12-month period from January 1, 1986 - December 15, 1986. The vast majority (83%) are cardholders who enrolled prior to January 1, 1986, and have renewed their program benefits.

Figure 1 also reveals that the overall rate of enrollment has gradually declined over each of the previous three quarters. As reported previously, the ten percent drop in enrollment which occurred between June 30, 1986 and the end of the July - September 1986 quarter was anticipated because of deaths, increasing incomes, people moving out of Pennsylvania, and late re-enrollments.

Figure 1

NUMBER OF CARDHOLDERS BY QUARTER
(July 1984 - December 1986)

	Period Covered	Number Cardholders Enrolled in Quarter	% of Total who are "First Time" Participants	Percent Increase/ Decrease	Cumulative Total
First Program Year	July-Sept. 1984	273,001	100%	NA	273,001
	Oct.-Dec. 1984	23,561	100%	9%	296,562
	Jan.-March 1985	20,941	100%	7%	317,503
	Apr.-June 1985*	69,436*	100%	22%*	386,939*
	NOTE: 36,512 cards expired on June 30, 1985 which were not renewed as of July 1, 1985				
	*Income eligibility limits were increased on April 1, 1985				
Second Program Year	July-Sept. 1985	38,750	32%	1%	389,177
	Oct.-Dec. 1985	20,522	35%	5%	409,699
	Jan.-March 1986	18,770	38%	5%	428,469
	Apr.-June 1986	17,367	42%	4%	445,836
	NOTE: 48,655 cards expired on June 30, 1986 which were not renewed as of July 1, 1986				
Third Program Year	July-Sept. 1986	23,595	15%	-6%	420,776
	Oct.-Dec. 1986	14,982	17%	4%	435,758

The number of cardholders by county of residence is shown in Figure 2. As with previous quarters, Philadelphia County contains the greatest number of cardholders (65,344) and Cameron County the fewest (289).

CARDHOLDERS BY COUNTY OF RESIDENCE
As of December 31, 1986

01)	Adams	2,391	24)	Elk	1,763	47)	Montour	674
02)	Alleghenv	51,185	25)	Erie	9,749	48)	Northampton	7,770
03)	Armstrong	3,038	26)	Fayette	5,753	49)	Northumberland	7,218
04)	Beaver	7,072	27)	Forest	325	50)	Perrv	1,191
05)	Bedford	2,231	28)	Franklin	3,527	51)	Philadelphia	65,344
06)	Berks	11,798	29)	Fulton	546	52)	Pike	794
07)	Blair	6,516	30)	Greene	1,250	53)	Potter	889
08)	Bradford	2,470	31)	Huntingdon	1,951	54)	Schuylkill	12,110
09)	Bucks	9,935	32)	Indiana	2,480	55)	Snyder	1,286
10)	Butler	4,623	33)	Jefferson	2,367	56)	Somerset	3,199
11)	Cambria	6,912	34)	Juniata	835	57)	Sullivan	413
12)	Cameron	289	35)	Lackawanna	16,052	58)	Susquehanna	1,732
13)	Carbon	3,497	36)	Lancaster	9,977	59)	Tioga	1,682
14)	Centre	2,682	37)	Lawrence	4,603	60)	Union	1,066
15)	Chester	5,753	38)	Lebanon	3,388	61)	Venango	2,321
16)	Clarion	1,737	39)	Lehigh	8,961	62)	Warren	1,761
17)	Clearfield	4,073	40)	Luzerne	25,233	63)	Washington	7,644
18)	Clinton	1,801	41)	Lycoming	4,983	64)	Wayne	1,923
19)	Columbia	3,309	42)	McKean	2,309	65)	Westmoreland	14,230
20)	Crawford	3,518	43)	Mercer	4,464	66)	Wyoming	1,066
21)	Cumberland	4,106	44)	Mifflin	2,616	67)	York	9,836
22)	Dauphin	6,982	45)	Monroe	2,585			
23)	Delaware	15,413	46)	Montgomery	14,556		TOTAL	435,758

B. Patterns of Utilization

During the three-month period from October - December 1986, only 79% of the program participants actually used their PACE cards. Of those, the average usage during the quarter was nearly eight PACE-funded prescriptions per person. If this pattern were to continue, the average PACE card held by active participants would be used approximately 32 times during the 1986/87 program year. When the non-users are included in the total population of participants to be considered, however, the average utilization rate for all participants during the quarter becomes slightly over six PACE-funded prescriptions per cardholder during the three-month period.

As evidenced during the 1985/86 program year, however, approximately 86% of all participants can be expected to use their PACE cards at least once during a full 12-month period. This pattern, combined with an increased use of home health care treatment programs, could result in an overall annual average utilization of around twenty-six PACE-funded prescriptions per cardholder during the 12-month period from July 1, 1986 - June 30, 1987.

Figure 3 provides summary claims data corresponding to cardholders categorized within various income levels who used their cards at least once during the quarter. As shown, six percent of the participants who used their PACE cards reported annual incomes of less than $3,000. Although expenditures for claims paid on behalf of this group was a corresponding six percent, the actual number of claims was disproportionately higher (7%). Conversely, although cardholders categorized in the highest income category represent twelve percent of all cardholders and expenditures paid on their behalf is a corresponding twelve percent, their prescriptions represent only eleven percent of all claims paid. This indicates that the PACE Program generally pays less, on a per-claim basis, for claims dispensed to individuals reporting lower incomes. This is a trend which was noted in previous reports.

Figure 3

Claims Data by Cardholder Income Level
October 1 through December 31, 1986

INCOME LEVEL	CARDHOLDERS*	AMOUNT PAID	TOTAL CLAIMS
$ 0 - $ 2,999	21,706 (6%)	$ 2,245,062.08 (6%)	171,445 (7%)
$ 3,000 - $ 5,999	84,033 (25%)	$ 8,612,609.00 (25%)	659,507 (24%)
$ 6,000 - $ 8,999	114,138 (33%)	$11,734,046.19 (33%)	895,228 (34%)
$ 9,000 - $11,999	82,819 (24%)	$ 8,591,879.88 (24%)	640,780 (24%)
$12,000 - $14,999	40,680 (12%)	$ 4,174,086.12 (12%)	303,422 (11%)
TOTALS	343,376 (100%)	$35,357,683.27 (100%)	2,670,382 (100%)

*Refers only to cardholders who used their PACE cards at least once during the quarter.

Another pattern is becoming more apparent this quarter. This pattern suggests that the preponderance of less expensive prescriptions may vary in accordance with the number of prescriptions used by cardholders when this factor is combined with the cardholders' level of income. In previous quarters, the average state expenditure for claims dispensed to lower income cardholders was almost always less than it was for cardholders in the upper income categories, regardless of the number of prescriptions funded. In this quarter, however, the lowest average share per claim was not consistently dispensed to cardholders in the lowest income level. Although the lowest-priced claims were generally dispensed to cardholders in either of the two lowest income categories, Figure 4 shows that the average expenditure for claims dispensed to individuals using more than thirty PACE-funded prescriptions was substantially higher for cardholders reporting the least income. This extreme variance was not apparent in previous quarters. Overall, however, the tendency for cardholders in the lower income categories to receive lower-priced PACE prescriptions was again supported during this report period.

Figure 4

Average Per Claim Expenditure
By Income Level and Claims Volume

Income Level	Average Expenditure 1 - 10 Claims	11 - 20 Claims	21 - 30 Claims	Over 30 Claims	Avg./Claim Expenditure
$ 0 - $ 2,999	$12.78	$13.20	$13.63	$14.11	$13.09
$ 3,000 - $ 5,999	$12.79	$13.19	$13.61	$13.50	$13.06
$ 6,000 - $ 8,999	$12.89	$13.21	$13.57	$13.48	$13.11
$ 9,000 - $11,999	$13.17	$13.54	$13.93	$13.57	$13.41
$12,000 - $14,999	$13.44	$14.00	$14.38	$13.81	$13.78

Utilization during the quarter was relatively consistent among cardholders in each of the five income classifications. Although cardholders in the highest income group used fewer prescriptions per person than those in the lowest income group, approximately 75% of the cardholders in each category used ten or fewer prescriptions during the three-month period. Around 20% of the cardholders in each income category used between 11-20 prescriptions; fewer than 4% used between 21-30; and less than 1% of the cardholders in any of the income groups used more than 30 PACE-funded prescriptions.

C. Usage Grouped by Utilization Review Region

The geographic location of the cardholders seems to have little bearing on program utilization patterns or on the average amount paid for PACE-funded claims.

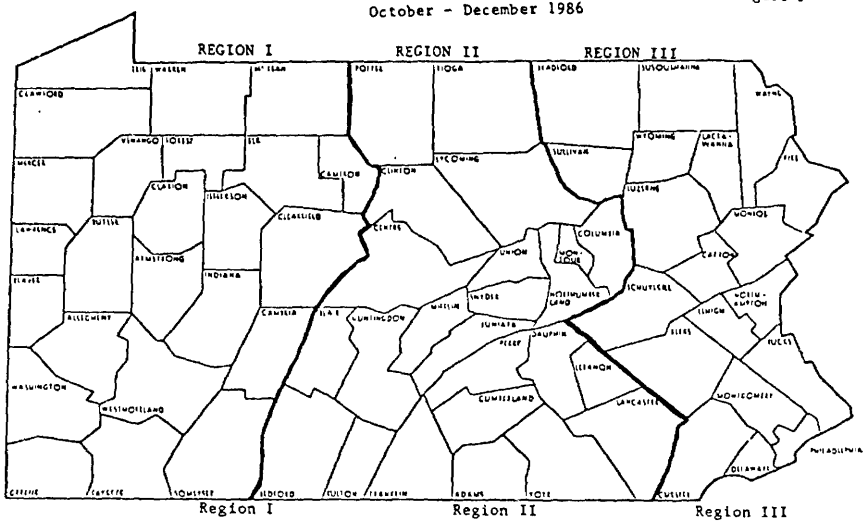
Figure 5 delineates the counties contained within each of the three utilization review regions and describes the slight variances in utilization which exist between the regions. As shown, both the average amount paid for claims and the number of claims paid for cardholders in Region I is slightly lower than it is for cardholders in the other two regions. The average amount paid for claims is higher in the Eastern Region, and cardholders in the Central Region appear to use the greatest average number of claims per person.

D. Drug Utilization Review Activities

Drug utilization profiles for over 1,000 PACE cardholders were reviewed this quarter. As shown on Figure 6, it was determined that therapeutic intervention was warranted for 208 cardholders, or 19% of the profiles reviewed.

Cardholder Data Grouped By
Utilization Review Region
October - December 1986

Figure 5



	Region I	Region II	Region III
Number & Percent of Cardholders in Region	146,665 (34%)	81,683 (19%)	207,410 (47%)
Percent of all PACE Claims	33%	19%	48%
Percent of all Expenditures for Claims	33%	19%	48%
Average State Share per Claim	$13.04	$13.11	$13.43
Number Claims per Person for Those Using PACE Cards in Region	7.73	7.88	7.77
Number Claims per Person for All Cardholders in Region	6.07	6.22	6.13

Figure 6

Number of Drug Profiles Reviewed and Acted Upon
Each Quarter by the Three Utilization Review Committees

	Region I	Region II	Region III	Total
Profiles reviewed per quarter:				
January - March 1985	600	800	700	2100
April - June 1985	364	403	485	1252
July - September 1985	883	580	689	2152
October - December 1985	245	230	205	680
January - March 1986	490	636	514	1640
April - June 1986	230	287	287	804
July - September 1986	744	702	751	2197
October - December 1986	324	414	352	1090
Profiles acted upon each quarter:				
January - March 1985	65	62	48	175
April - June 1985	33	41	36	110
July - September 1985	88	113	85	286
October - December 1985	27	72	54	153
January - March 1986	64	153	98	315
April - June 1986	24	64	52	140
July - September 1986	74	92	85	251
October - December 1986	54	76	78	208

*Utilization Review Committee meetings are held bi-monthly.

During the October-December 1986 quarter, 351 letters had been sent to the 220 physicians and 131 providers who either prescribed or dispensed prescriptions for the cardholders whose profiles had been reviewed during the quarter. Inasmuch as there is generally a lapse of about two months between the date when a letter of inquiry is sent and the date when a corresponding response is received, it is not surprising that no responses to the letters sent during the October - December 1986 quarter had been received by January 27, 1987. Based on previous program experience, however, it is expected that at least 44% of the physicians and providers will ultimately respond to letters sent to them by the PACE utilization review committees. In order to increase the rate of response to utilization review committee activities, new procedures involving the distribution of follow-up letters have been initiated. These follow-up letters will be sent if no responses are received from the initial correspondence or if no changes in utilization patterns are observed over a reasonable time period. Two of the utilization review committees have already initiated expanded follow-up procedures by re-reviewing the July profiles to determine if the requested corrective action has been taken. It was found that although less than 40% of the professionals contacted in July wrote direct responses to the initial letters sent by the utilization review committees, corrective actions had been taken in 69% of the cases. This indicates that lack of direct response to correspondence does not preclude implementation of committee recommendations or corresponding changes in prescribing or dispensing patterns. Through the use of profile re-reviews, it is expected that the rate of corrective actions taken in response to utilization review activities will continue to increase. Figure 7 shows the number of letters sent by each utilization review committee and corresponding responses received since January 1985.

Figure 7

UTILIZATION REVIEW LETTERS SENT AND CORRESPONDING RESPONSES RECEIVED

QUARTER	REGION	PHARMACY LETTERS SENT	PHARMACY RESPONSES RECEIVED	PERCENT RESPONSES RECEIVED	PHYSICIAN LETTERS SENT	PHYSICIAN RESPONSES RECEIVED	PERCENT RESPONSES RECEIVED
JANUARY -	I	42	28	67.0%	47	25	53.0%
MARCH 1985	II	40	33	82.0%	8	1	12.0%
	III	49	37	76.0%	74	37	50.0%
TOTAL		131	98	75.0%	129	63	49.0%
APRIL -	I	63	59	82.5%	44	26	59.0%
JUNE 1985	II	48	29	60.4%	12	5	41.6%
	III	48	38	79.1%	17	8	47.0%
TOTAL		159	126	79.2%	73	39	53.4%
JULY -	I	79	49	62.0%	47	14	30.0%
SEPTEMBER 1985	II	110	80	73.0%	44	20	45.0%
	III	82	53	65.0%	86	58	67.0%
TOTAL		271	182	67.0%	177	92	52.0%
OCTOBER -	I	17	12	70.0%	24	5	21.0%
DECEMBER 1985	II	57	34	67.0%	72	37	51.0%
	III	30	23	77.0%	82	56	68.0%
TOTAL		104	69	66.0%	178	98	55.0%
TOTAL 1985		665	475	71.0%	557	292	52.0%
JANUARY -	I	57	41	72.0%	92	29	32.0%
MARCH 1986	II	146	90	62.0%	174	74	43.0%
	III	83	49	59.0%	114	58	51.0%
TOTAL		286	180	63.0%	380	161	42.0%
APRIL -	I	28	19	68.0%	36	9	25.0%
JUNE 1986	II	66	29	44.0%	72	21	29.0%
	III	45	12	27.0%	60	25	42.0%
TOTAL		139	60	43.0%	168	55	33.0%
JULY -	I	56	23	41.0%	112	42	38.0%
SEPTEMBER 1986	II	51	25	49.0%	90	40	44.0%
	III	28	11	39.0%	90	31	34.0%
TOTAL		135	59	44.0%	292	113	39.0%
SUBTOTAL FOR JANUARY - SEPTEMBER 1986		560	299	53.0%	840	329	39.0%
OCTOBER -	I	40	No responses		46	No responses	
DECEMBER 1986	II	36	received as of		79	received as of	
	III	55	1/27/87		95	1/27/87	
TOTAL		131			220		

III. PROVIDERS

The number of active providers increased from 2,866 on September 30, 1986 (the end of the previous report period) to 2,877 on December 31, 1986. Of those, eight independent pharmacies and two chain pharmacies continue to provide separate mail-order services in accordance with the PACE regulations.

A slight shifting in the distribution of providers by type occurred during the three-month period from October-December 1986 in that the number of independent pharmacies dropped from 1,797 to 1,789 (decrease of 8) and the number of chain pharmacies grew from 908 to 925 (increase of 17). The trend for independent pharmacies to be acquired by or merged to become chain pharmacies is one which has been observed and noted in previous PACE reports. (Chain pharmacies are generally defined as six or more pharmacies owned by the same individual or group of individuals.)

As shown in Figure 8, the highest average state share paid for prescriptions funded by PACE is for claims dispensed by physicians and the lowest average amount is for prescriptions dispensed by nursing home pharmacies. This trend is consistent with previous quarters and is generally related to the degree to which generic drugs are dispensed by the PACE providers.

Figure 8

Claims Data by Provider Type

	Independent Pharmacies	Chain Pharmacies	Nursing Home Pharmacies	Institution Pharmacies	Dispensing Physicians
Percent of all Providers	62.18%	32.15%	1.98%	2.12%	1.57%
Percent of all claims dispensed	61.45%	36.31%	1.27%	.94%	.03%
Percent of funds expended for claims	61.38%	36.37%	1.24%	.98%	.03%
Average state share paid for claims	$13.22	$13.26	$12.99	$13.82	$15.11

In several previous reports, it was noted that the Area Agency on Aging transported cardholders in Forest County to surrounding counties in order to obtain their PACE-funded prescriptions. This was done to compensate for an absence of any PACE providers in that county. Program administrators are pleased to report that one PACE provider (independent and located in a medical center) now exists in Forest County.

IV. TOP TEN DRUGS

Figure 9 provides a combined list of the top ten drugs ranked by amount paid and the top ten drugs ranked by claims volume for all claims paid during the October - December 1986 quarter. Together, claims for these drugs comprise fifteen different brand drugs and represent nearly 25% of PACE outlays and 18% of all prescriptions reimbursed during the quarter. The composition of drugs included on this combined list of top ten drugs has not changed since the previous report period.

A. Generic Utilization

Generic equivalents for two of the drugs included on Figure 9 were added to the Pennsylvania State Formulary on July 12, 1986. Each of these brand drugs has dropped substantially in their ranking both by amount paid and by claims volume during the past three months. Diabinese, ranked as number nine in the list of top drugs by amount paid for the period from January - June 1986, and number six in the list of drugs ranked by claims volume during the same period, dropped to the nineteenth position in the ranking for drugs by amount paid and to the eighth position in the ranking of claims volume during the October - December quarter. Likewise, Aldomet, formerly ranked as number ten in the ranking by amount paid and as number four by claims volume, dropped to the twenty-first and sixth positions, respectively.

This decrease in the relative amount paid for Aldomet and Diabinese is unquestionably a direct result of the addition of their generic equivalents to the Pennsylvania State Formulary. Only three additional drugs shown on Figure 9 (Darvocet, Lasix and Slow-K) are currently available in generic form. However, none of these generic equivalents are included on the State Formulary.

Utilization of generic drugs by PACE participants is clearly increasing. During the April - June 1986 quarter, only 9.7% of all PACE-funded claims and 3.3% of all monies paid for claims were for generic products. By the end of the October - December 1986 quarter, however, generic utilization in PACE had grown to 11.2% of all claims and represented 3.8% of all monies paid for claims during the quarter. Savings realized from an increased use of generic drugs grew from over two million dollars during the April - June period to nearly three million dollars during the recent quarter. It is anticipated that increased use of generic drugs could result in savings of between ten and fifteen million dollars annually.

B. Utilization Within Therapeutic Groups

The relative importance of drugs grouped within certain therapeutic categories has also shifted over the past six months. Drugs used in the treatment of Angina, for instance, represented 19% of all claims and 28% of all monies paid for claims shown in the combined list of top ten drugs (ranked by volume and amount paid) for prescriptions dispensed during the six-month period from January - June 1986. During the quarter, from October - December 1986, however, use and expenditures for these same drugs increased to 23% of all claims (for drugs included in the top ten combined list) and 34% of all monies paid for corresponding claims. Figure 10 provides a complete delineation of the changes which occurred over the past six months for the combined list of top ten drugs as categorized within six major therapeutic classes.

Combined List of Top Ten Drugs Ranked by Amount Paid and Claims Volume
October - December 1986

Figure 9

Drug Name	Amount Paid	Ranking by Amount Paid Jan.-June '86	Ranking by Amount Paid This Period	Number Claims Paid	Ranking by Claims Volume Jan.-June'86	Ranking by Claims Volume This Period	Usage	Generic Available?	Listed on PA Formulary
Zantac 150mg.	$1,543,918.77	1	1	33,839	9	4	Gastrointest-inal	No	NA
Procardia 10mg.	850,607.04	3	2	32,975	5	5	Angina	No	NA
Tagamet 300mg.	713,231.59	4	3	25,472	8	10	Gastrointest-inal	No	NA
Feldene 20mg.	705,959.42	2	4	20,197	11	14	Arthritis	No	NA
Cardizem 60mg.	614,730.70	8	5	16,834	27	20	Angina	No	NA
Transderm-Nitro 5	613,178.87	5	6	20,944	14	13	Angina	No	NA
Clinoril 200mg.	515,223.48	6	7	15,111	28	11	Arthritis	No	NA
Dyazide	497,907.54	7	8	82,503	1	1	Hypertension	No	NA
Darvocet-N 100	453,521.00	11	9	29,250	7	7	Pain	Yes	No
Transderm-Nitro 10	434,241.65	12	10	12,981	41	31	Angina	No	NA
Lasix 40mg.	185,338.42	31	47	62,185	2	2	Hypertension	Yes	No
Slow-K 600mg.	225,814.87	24	41	40,969	3	3	Potassium	Yes*	No
Aldomet 250mg.	356,868.82	10	21	31,667	4	6	Hypertension	Yes	Yes
Diabinese D-Pak 250mg.	377,933.28	9	19	26,043	6	8	Diabetes	Yes	Yes
Tenormin 50mg.	329,089.99	20	11	25,606	10	9	Hypertension	No	NA

*The generic equivalent for Slow-K has not yet been widely distributed.

Figure 10

Shifts in Usage and Expenditure Patterns for Claims Paid Within the Top Ten List from January - June 1986 and October - December 1986 as Categorized Within Six Major Therapeutic Classes

Therapeutic Class*	% of All Expenditures For the Top Ten Claims J-J '86	O-D '86**	% of Claims Paid Within the Top Ten List J-J '86	O-D '86	Average State Share Paid Per Claim J-J '86	O-D '86	% Increase in Average Share Per Claim
Cardiac (Procardia, Tenormin, Cardizem, Transderm Nitro 5 & 10)	28%	34%	19%	23%	$23.03	$25.99	12.8%
Gastrointestinal (Zantac & Tagamet)	26%	27%	12%	12%	$33.91	$38.06	12.2%
Replacement Solutions/ Potassium Supplement (Slow-K)	3%	3%	9%	9%	$ 5.36	$ 5.51	2.8%
Nonsteroidal Analygesics (Feldene, Darvocet-N, & Clinoril)	23%	20%	14%	14%	$25.10	$25.94	3.3%
Diuretics and Hypotensive Agents (Dyazide, Lasix & Aldomet)	14%	12%	39%	37%	$ 5.78	$ 5.90	2.1%
Anti-Diabetic Agents (Diabinese)	6%	4%	7%	5%	$13.51	$14.51	7.4%

*Classes as defined by American Hospital Formulary Service

**J-J '86 = January - June 1986
O-D '86 = October - December 1986

V. PENNSYLVANIA STATE UNIVERSITY RESEARCH PROJECT

Understanding the pharmaceutical needs and utilization patterns of a population which is growing older, living longer and relying heavily on prescription medications, is becoming an increasingly important goal of leaders in both the public and private sectors. Inasmuch as the PACE Program provides pharmaceutical benefits to nearly half a million senior citizens each year, program administrators are constantly striving to learn more about the needs and utilization patterns of current and potential program participants. For this reason, major research endeavors which could lead to a better understanding of the PACE cardholders and their pharmaceutical needs have been strongly supported by the Department of Aging.

The first phase of one of these research projects, conducted jointly by the Gerontology Center at the Pennsylvania State University (PSU) and the PACE Program, has recently been completed. This project report, entitled, "Medicine, Health and Aging," was made possible through a grant from The Medical Trust, one of The Pew Charitible Trusts of Philadelphia.

The goals and corresponding highlights of findings based on a sample of 1,002 PACE cardholders and 801 non-participants were as follows:

GOAL 1. To identify similarities and differences between the PACE participants and other individuals over the age of 65 who do not participate in the program.

Highlights of Findings:

a) As a group, the PACE participants are older than their counterparts over the age of 65 who do not participate in the program.
b) The ratio of females to males and widowed to non-widowed is higher for the PACE participants than for the non-participants.
c) PACE participants have generally completed fewer years of formal education than the non-participants.
d) PACE cardholders report a substantially higher rate of poor health (both mental and physical) than do the non-participants.
e) PACE participants take a substantially greater number of prescription medications than their non-participating counterparts.

GOAL 2. To identify barriers and predict enrollment in or use of the PACE Program.

Highlights of Findings:

a) The two best predictors of enrollment in the PACE Program are limitations in activity resulting from chronic conditions and limited income. Thus, the PACE Program is meeting a targeted group of elderly in need of assistance.

b) Many individuals over the age of 65 who are not enrolled in PACE report that they do not need the program or have other insurance to cover the cost of prescription medications. Of the 801 individuals included in the survey sample who are not PACE participants, 326 (41%) reported they were ineligible because they either exceeded the income limits or had other prescription drug coverage. One-third of the 475 eligible but non-participating individuals surveyed indicated that they lacked sufficient information about the program. Thus, lack of knowledge appeared to be the greatest barrier to enrollment at the time of the study despite significant public relations efforts by the Department of Aging.
c) Approximately 20% of impaired elderly who may be eligible for and in need of the program have not enrolled. They are most likely to be older urban females in poor health and more likely to be minority group members.
d) Elderly with very low income and poor health comprise approximately 30% of the PACE Program and 20% of the Eligible but Non-Participating Group. The latter group's participation in PACE or in Pennsylvania's Medical Assistance Program raises a fiscally significant policy issue and deserves further study.
e) Links to physicians and direct-care providers may be one way of improving access to information about the program for eligible but non-enrolled individuals.

GOAL 3. To compare different data collection techniques which may be used in assessing medicine use and functioning among the elderly.

Highlights of Findings:

In conducting this study, four sources of information were used: telephone interviews; mail follow-up questionnaires; the archival PACE database of prescriptions purchased through the PACE Program; and an in-home medicine inventory conducted during home visitations. It was found that the validity of medicine use information varies by source of information, level of specificity needed, and by the characteristics of the older adult who provides the self-report.

GOAL 4. To collect data describing other state-level pharmaceutical assistance programs for the elderly.

Highlights of Findings:

a) As of December 1985, six other states and one territory reported active implementation of similar pharmaceutical assistance programs and several others reported plans to implement such programs in the future.
b) A great amount of variance in the pharmaceutical programs exists among the states. Key variables include: eligibility requirements, type of drugs covered, reimbursements to providers, and extent of payment required from participants.
c) When compared to other state-level pharmaceutical assistance programs, the PACE Program is the largest in terms of numbers of elderly enrolled and program outlays.

GOAL 5. To establish an empirical foundation for conducting longitudinal research on the effects of medicine therapies on the elderly.

Highlights of Findings:

The current panel of 1,803 elderly, those involved in the study, provide a valuable resource for a longitudinal study of the effects associated with enrollment in state-level pharmaceutical assistance programs. Information for subsequent studies of the sample should be useful both to researchers interested in medicines, health and aging, as well as practitioners and policy makers who are responsible for providing for the well-being of older adults.

The second phase of this valuable research project is now underway. Activities will include the expansion and refinement of data previously collected, and a special focus on review of specific utilization patterns and prevalence of drug interactions among the PACE cardholders.

VI. CLAIMS AND CORRESPONDING PAYMENTS

As shown on Figure 11 below, the PACE Program funded over 20 million prescriptions and paid nearly 240 million dollars for corresponding claims during its first 2 1/2 years of program operation.

Figure 11

CLAIMS AND CORRESPONDING PAYMENTS
(July, 1984 - December, 1986)

Quarter	Number Claims	Payout Amount	Average State Share* Per Claim
July-September 1984	704,920	$ 6,957,973	$ 9.87
October-December 1984	1,396,499	$ 13,756,712	$ 9.85
January-March 1985	1,629,241	$ 16,543,122	$10.15
April-June 1985	1,846,199	$ 20,035,980	$10.85
TOTAL FOR FIRST YEAR	5,576,859	$ 57,293,787	$10.27
July-September 1985	2,052,743	$ 23,346,932	$11.37
October-December 1985	2,319,725	$ 27,269,402	$11.76
January-March 1986	2,373,329	$ 28,567,898	$12.04
April-June 1986	2,593,207	$ 32,800,295	$12.65
TOTAL FOR SECOND YEAR	9,339,004	$111,984,527	$11.99
July-September 1986	2,502,013	$ 32,493,850	$12.99
October-December 1986	2,735,128	$ 36,292,264	$13.27
THIRD YEAR-TO-DATE	5,237,141	$ 68,786,114	$13.13
CUMULATIVE TOTALS	20,153,004	$238,064,428	$11.81

*The State Share is the amount paid by PACE for each claim. It is calculated as follows:

+	Average wholesale price of drug (AWP) plus dispensing fee or usual and customary charge, whichever is less
-	the $4.00 copayment
=	State Share per claim

The average amount paid by PACE for each prescription has risen steadily and significantly every quarter since the program's inception. According to the December 10, 1986 issue of "Prescription Pricing Report," a newsletter published by Eberstadt Fleming, Inc. (World Trade Center, New York City), the following five factors continue to exert pressure on firms

to raise drug prices in excess of inflation:

1) Minimal unit growth in U.S. prescriptions except for those in selected therapeutic categories.

2) Intensified competition.

3) Regulated prices in foreign markets.

4) Market penetration by generics.

5) High cost of research and development.

The newsletter further states, "Projected increases for drug prices in the fourth quarter have reached 11%, a rate which is somewhat higher than that which was experienced during the first three quarters of 1986. This brings estimated increases for the full 12-month period to 10.5%."

As shown on Figure 12, however, the average state share paid for PACE-funded prescriptions increased by 13%, during the year, an amount which is greater than the national average. This discrepancy may be attributed to a greater utilization by PACE cardholders of drugs grouped within the key therapeutic classes which generally experience higher rates of price increases. Price variances among drugs categorized within certain therapeutic classes were referenced previously in the list of five major factors contributing cost increases described in the "Prescription Pricing Report."

Figure 12

COMPARISON OF COST-RELATED DATA
(October-December 1985 and October-December 1986)

	Oct.-Dec. 1985	Oct.-Dec. 1986	Percent Increase
Number Cardholders at End of Quarter	409,699	435,758	6%
Number Prescriptions During the Quarter	2,319,725	2,735,128	18%
Average Number of Prescriptions Per Person During the Quarter	5.66	6.28	11%
Average State Share Per Prescription During the Quarter	$11.76	$13.27	13%
Average Expenditure Per Cardholder During the Quarter	$66.56	$83.29	25%
Total Expenditures for Prescriptions During the Quarter	$27,269,402	$36,292,264	33%

VII. COST CONTAINMENT

The implementation of five major cost-containment strategies was continued during the October - December 1986 quarter. Collectively, these efforts saved the program over five million dollars.

Over $1,900,000 in reimbursements from other third-party payment programs was received this quarter. This brings the total amount of reimbursements from third-party sources to slightly over 7 million dollars. It is anticipated that at least one million dollars in third-party reimbursements will be received during the next three-month period.

Payments totaling $11,566 were received this quarter as restitution from cardholders who received program benefits to which they were not entitled. To date, over $25,000 in such restitution payments has been received from the 182 individuals who were found to be over income when verification of their reported incomes was requested. Efforts to ensure that program benefits are made available only to those individuals who meet the eligibility requirements will be continued during the next quarter.

Over 9,000 claims as submitted by 80 providers were reviewed this quarter. Major discrepancies in dispensing and billing practices found by program auditors were related to poor record keeping, limited use of generic products and errors in dispensing appropriate quantities. At least $2,200 will be recovered as a result of the provider audit reviews conducted this quarter.

In response to the July 12, 1986, expansion of the Pennsylvania State Formulary, cardholder utilization of generic drugs increased from 9.7% during the previous report period to 11.2% this quarter. As a result, nearly three million dollars in expenditures was saved. It is expected that the use of generic products by PACE cardholders will continue to increase in future months, resulting in a savings of between 12 and 15 million dollars annually.

As described in Section II, drug utilization profiles for over 1,000 cardholders were reviewed this quarter. These reviews generated action letters to 351 physicians and providers who provided services to the 208 PACE cardholders who were identified for special review. Although actual funds are rarely recovered through such activities, modifications in utilization patterns which occur as a result of letters sent by the Utilization Review Committees and resulting improvements in the health of the PACE cardholders lead indirectly to substantial program savings.

These cost-containment strategies will be continued during the next three-month period and are expected to yield increasingly higher savings for the program.

VIII. PROJECTIONS

By December 31, 1986, the end of 2 1/2 program years, cash outlays for PACE had grown to nearly 250 million dollars. Figure 13 below delineates the distribution of expenditures to date within four major cost categories. These figures do not include accrued expenditures, estimated at approximately $13 million, consisting largely of unsubmitted prescription claims.

Figure 13

CUMULATIVE PACE EXPENDITURES
(July, 1984 - December, 1986)

CLAIMS		TCC CONTRACT		PDA ADMINISTRATION		MISCELLANEOUS	
Checkwrites	$238,064,428	Start-Up	$ 2,753,674	Personnel	$535,576	Comptroller	$193,561
Claims Adjustments	3,527,578						
Less Refunds (Third Party & Other Reimbursements)	- 7,445,571	Operation	11,625,270	Operation*	519,552	Third Party Liability Administration	28,850
		Special Reports	25,927	Fixed Assets	61,034	Department of Public Welfare (Fraud and Abuse)	1,304
						Department of Health (Data Processing Services)	1,436
SUBTOTAL	$234,146,435 (93.70% of Total)	SUBTOTAL	$14,404,871 (5.76% of Total)	SUBTOTAL	1,116,162 (.45% of Total)	SUBTOTAL	$225,153 (.09% of Total)
				*Includes advertising contract for $283,145 implemented as part of start-up activities			

ALL EXPENDITURES: $257,338,192
LESS REFUNDS: - 7,445,571
TOTAL: $249,892,621

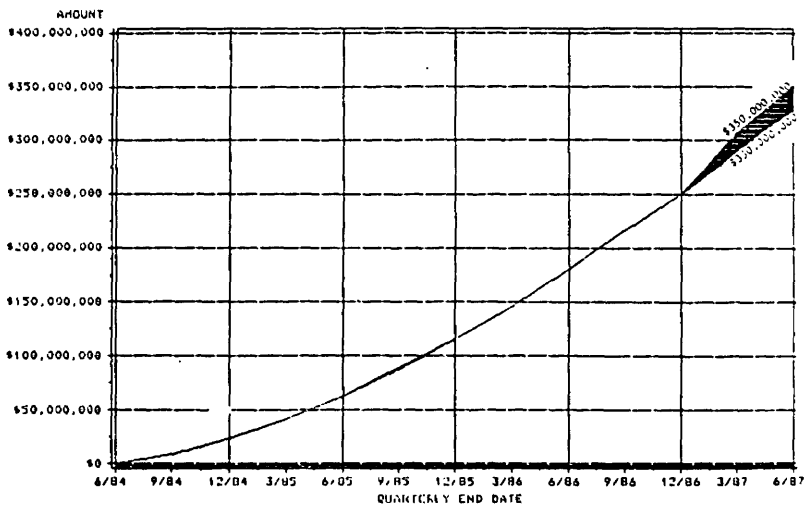
Of the total amount expended to date, 35 million dollars or 14% was dispersed within this report period. During the three-month period from October - December, expenditures for claims grew to nearly 96% of all funds paid. Contractor remuneration during the quarter dropped to 3.76% of all funds expended and Departmental and miscellaneous expenses absorbed .23% and .11%, respectively. This indicates that the ratio of funds spent for pharmaceuticals is increasing when contrasted with the amount expended for program operation.

As discussed previously in this report, disbursements to cover the cost of PACE-funded claims have risen steadily each quarter. It is interesting to note, for example, that funds spent for claims during the first two quarters of the 1986/87 program year, surpassed those which were expended during the entire first 12 months of the program (refer to Figure 11). These escalations in costs are attributable mainly to expanded utilization patterns and to a rapid rise in the price of PACE-funded prescriptions.

Cumulative projected expenditures through June 1987 are shown on Figure 14. PACE staff will continue to carefully monitor program expenditures and develop revised projections as appropriate.

Figure 14

Three Year Cost Estimates – Actual and Projected



STATEMENT OF ALAN SPIELMAN, EXECUTIVE DIRECTOR, GOVERNMENT PROGRAMS LEGISLATION, BLUE CROSS AND BLUE SHIELD ASSOCIATION, WASHINGTON, DC

Mr. SPIELMAN. Thank you, Mr. Chairman. We do appreciate this opportunity to testify on this subject.

Our comments are based both on our experience in administering Medicare, as carriers and intermediaries, and on our experience in the private market. My written statement provides details on the drug coverage for the elderly provided by Blue Cross and Blue Shield programs.

While private insurance does provide prescription drug coverage for a significant proportion of the elderly, the fact remains that most beneficiaries are not covered. As you consider proposals to expand Medicare in this area, we would urge you to consider carefully the benefit costs of the new program, the administrative issues involved, and the financing mechanisms for the new benefits.

Including prescription drug coverage in insurance programs is expensive. The cost of drug benefits for the elderly is particularly expensive. Increases in the price and volume of prescriptions will work to make the benefit costs of the Medicare drug program substantial. Moreover, the historical record of Medicare illustrates how difficult it is for anyone to predict accurately the cost of new benefits.

We would, therefore, urge you to assess carefully the estimates of benefit costs and to include measures designed to manage both the price and the volume of prescriptions.

Regarding program administration, we urge that efforts be made to make the program as simple as possible and to provide the greatest incentives for billing by providers rather than by beneficiaries. Provider billing, which often can be done electronically, can result in significant savings in the administrative costs of the program.

Finally, we believe strongly that the financing mechanism for major benefit expansions should not place undue burdens on those with low incomes.

We now would like to provide you with comments on some specific design features of the proposals under consideration.

A $500 to $800 deductible is consistent with the concept of providing a catastrophic drug program. This approach does increase administrative costs relative to benefit payout, but on balance we do think it is a reasonable approach.

Requiring beneficiaries to pay for part of the cost of each prescription is an approach commonly used in our private health benefit programs to help contain benefit costs. In this area, we recommend use of a fixed-dollar copayment per prescription, such as $3 to $5 per prescription, rather than a percentage coinsurance like 20 percent, for the reasons set forth in my statement. If the subcommittee concludes that beneficiaries should bear some of the financial consequences of obtaining a more expensive brand name drug, a variable copayment scheme could be adopted.

We do have some concerns about the reimbursement formula included in the proposals. The use of the Average Wholesale Price

could result in excessive benefit payments. The subcommittee may wish to explore using Estimated Acquisition Cost data in this calculation.

We would note, however, that a key issue in this area is balancing cost-containment with concerns about access, and that the higher payment levels under an AWP approach would likely encourage higher levels of pharmacy participation.

We are also concerned about the level of the dispensing fee included in the limits. In our view, a $4.50 fee is too high; we believe a $4 fee would likely compensate pharmacies fairly for their administrative tasks.

Our statement also includes other suggestions regarding cost containment.

Finally, I would like to note that we do believe the administrative costs of a $500 to $800 deductible program would be substantial. Depending upon the volume of claims that would be received, and estimates range from as low as 100 million claims to 240 million claims, costs for the administration of the program could range from $200 million to about $500 million to administer the program.

We would urge you to encourage that the necessary funds to prepare for startup of the new program be included in the Fiscal Year 1988 appropriation, and that funding for the ongoing administration of the bill be included in subsequent appropriations.

In conclusion, Mr. Chairman, we do appreciate this opportunity to testify on this important subject. This is an area where we would urge thoughtful attention to program design and to the administrative aspects of the program. We are convinced that HCFA and the Medicare contractors could make this program work effectively if adequate administrative funding and lead time is provided, and we stand ready to assist you in any way we can.

Thank you.

Senator MITCHELL. Thank you very much, Mr. Spielman.

[Mr. Spielman's written prepared statement follows:]

TESTIMONY

OF THE

BLUE CROSS AND BLUE SHIELD ASSOCIATION

ON

COVERAGE OF OUTPATIENT PRESCRIPTION DRUGS UNDER MEDICARE

before the

HEALTH SUBCOMMITTEE
of the
COMMITTEE ON FINANCE
UNITED STATES SENATE

by

Alan P. Spielman
Executive Director
Government Programs Legislation

Thursday, June 18, 1987

Mr. Chairman and members of the subcommittee, I am Alan P. Spielman, Executive Director, Government Programs Legislation, of the Blue Cross and Blue Shield Association. We appreciate this opportunity to testify on the issues related to expanding Medicare to cover outpatient prescription drugs. The Blue Cross and Blue Shield Association and its member Plans have been major participants in the administration of Medicare since its beginning. Blue Cross and Blue Shield Plans also have developed and implemented outpatient prescription drug benefit programs in the private market.

The lack of Medicare coverage for outpatient prescription drugs does leave beneficiaries liable for significant expenses. Many, but certainly not most, beneficiaries are protected against major out-of-pocket costs for prescription drugs by private coverage which supplements Medicare benefits — Medigap — and through enrollment in health maintenance organizations (HMO's) or comprehensive medical plans (CMP's). In 1985, we estimate that 43% of Blue Cross and Blue Shield Plan non-group Medigap programs included coverage for prescription drugs. We expect that the percentage of retiree group plans covering prescription drugs is even higher. In addition, of the 45 Blue Cross and Blue Shield Plan health maintenance organization programs that participate in Medicare, 18 offer prescription drug coverage.

The Blue Cross and Blue Shield Plans across the country vary widely with respect to the prescription drug programs they offer. Plans prescription drug programs generally cover all drugs that, under federal law, require a written prescription by a physician and that have been approved by the Food and Drug Administration. There are generally two types of benefit designs — either a freestanding drug program or coverage under major medical policies.

Under most freestanding programs, the patient pays a fixed copayment amount ($.75 to $5.00) per prescription. In most instances, the subscriber pays the copayment amount when picking up the prescription and the pharmacy bills for and receives payment from the insurer for the remaining cost.

Under major medical, prescription drugs are subject to any front-end deductible and coinsurance provisions of the contract, the same as any other covered services. The subscriber pays the cost of the prescription and is reimbursed by the insurer after filing a claim.

Some Plans now offer generic drug programs. Generally, these programs require the subscriber to pay more, either in the form of a copayment or coinsurance amount, if a brand name drug is chosen instead of the generic equivalent. Also, a few programs will only pay at the generic drug price unless the more expensive product is specifically authorized by the physician.

Other cost containment features used by our Plans include drug utilization review programs whereby providers and subscribers prescription drug patterns are monitored, limits on both the quantity of each prescription and the length of time after a prescription is written that a refill can be obtained, and "preferred provider" selective contracting arrangements.

While private insurance does provide prescription drug coverage for a significant proportion of the elderly, the fact remains that most beneficiaries are not covered. According to AARP, almost 60% of Americans over age 65 lack insurance coverage for outpatient prescriptions.

As the subcommittee considers legislative proposals to expand Medicare to help pay for outpatient prescription drugs, we would urge you to consider the following issues:

- o Benefit Costs
- o Program Administration
- o Financing Mechanisms

Benefit Costs

Including prescription drug coverage in insurance programs is expensive. The cost of drug benefits for the elderly is particularly expensive. For example, one large Blue Cross and Blue Shield Plan reports that the average number of prescriptions filled for retirees in its private health plans was almost three times as high as the average number of prescriptions filled for all enrollees. The average prescription cost for retirees in that area was about 22% higher per retiree prescription than the average prescription cost for all enrollees. This Plan also reports rapidly rising costs of its drug program. Between 1980 and 1986 spending on prescription drugs almost tripled and in 1986 alone, spending increased by 21% above 1985 levels.

Data on the utilization and cost of drug benefit programs administered by Blue Cross and Blue Shield Plans in two large states further confirm the high cost of drug benefits for the elderly. These data show benefit payments for about 20 prescriptions per year for elderly subscribers filing claims at an average cost of about $18 to $19 per prescription in 1986. Data from one of these states indicate that of the total number of retirees enrolled in the program, 27% spent more than $500 for drugs in 1986. Moreover, the average annual spending of those people with expenditures over $500 was $1,052.

Increases in the costs of drug coverage are driven by the high rate of inflation in drug prices, new technology, increasing numbers of prescriptions per subscriber, and in some

cases, adverse selection. When consumers have a choice of varying benefit options, they often will purchase a program that covers drugs if they anticipate greater than average expenditures for drugs. This phenomenon raises the cost of the benefit programs.

While including outpatient prescription drugs as a covered benefit under Medicare for all beneficiaries should not result in any adverse selection, the other factors — increases in the price and volume of prescriptions — will work to make the benefit costs substantial. Moreover, the historical record of Medicare illustrates how difficult it is for anyone to predict accurately the cost of new benefits. We would, therefore, urge you to assess carefully the estimates of future year benefit costs for this program and to include measures designed to manage effectively the amounts that Medicare will pay for each prescription and the utilization of drugs by beneficiaries.

Program Administration

In designing an outpatient prescription drug program under Medicare, the complexity and cost of program administration should be assessed carefully. As a guiding principle, all efforts should be made to make the program as simple as possible and to provide the greatest incentives for billing by providers rather than by beneficiaries. Provider billing, which often can be done electronically, can result in significant savings in the administrative costs of the program. In relation to benefit payments, the administrative costs of handling paper claims on prescription drugs can be very high because the billed charge per claim is generally small. Even with a substantial amount of electronic billing by providers, we would expect the administrative costs of implementing and administering a new drug program under Medicare to be high because of the large volume of claims that could be expected. In 1988, without any changes in law, we anticipate a total of 455 million Medicare claims will be processed by the contractor community. Depending upon the design of the drug program, the volume of claims could be increased by 50% if a drug benefit were

added. Adequate administrative funding and lead times will be critical to assure the success of any program that is enacted.

Financing Mechanisms

As we indicated in our testimony before the subcommittee on the Medicare catastrophic bill, we believe strongly that the financing mechanism for major benefit expansions should not place undue burdens on those with low incomes. Since the benefit and administrative costs of a new drug program will likely be high, we would urge that it be financed through an income-related approach or through other financing sources that do not require contributions from beneficiaries with low incomes.

Legislative Proposals

We would also like to provide the subcommittee with comments on the design features of some of the prescription drug programs under consideration in the Congress.

Proposals under consideration include the following features:

- o $400 to $500 annual deductible after which Medicare would cover all outpatient prescription drugs;
- o a 20% coinsurance requirement per prescription;
- o payment limits based on the average wholesale price of the drug plus a $4.50 dispensing fee;
- o authorization for development of a drug formulary; and
- o establishment of a participating pharmacy program.

The establishment of a $400 to $500 deductible is consistent with the concept of providing a catastrophic drug program. While this approach does limit benefit costs, it should be recognized that it will increase administrative costs relative to benefit payments because an

eligibility tracking system must be developed and judgments must be made on each claim even though no Medicare payment is made.

If most pharmacies decided to participate in Medicare and perform the required administrative functions of accumulating beneficiary charges and billing carriers only after the deductible had been reached, the administrative costs of the deductible feature would be constrained somewhat. Based on our experience in administering Medicare, however, we would anticipate a great deal of confusion and a long start-up period before the program is at the point where the pharmacies themselves, rather than the Medicare carriers and HCFA, will be able to handle most of the administrative work for beneficiaries prior to the point at which they meet the deductible. On balance, while the deductible feature is administratively cumbersome, we believe it is necessary to avoid excessive program costs.

Requiring beneficiaries to pay for part of the cost of each prescription is an approach commonly used in our private health benefit programs to help contain benefit costs. Beneficiary cost-sharing would likely have some effect in deterring unnecessary prescription filling. It would, of course, reduce program outlays by the cost-sharing amount. The use of a 20% coinsurance, rather than a fixed dollar copayment, would provide beneficiaries with an incentive to seek out lower-priced drugs. It also would have the advantage of being consistent with the beneficiary cost-sharing applicable to most other Part B services.

The disadvantages of a 20% coinsurance provision are three-fold. First, those beneficiaries requiring the most expensive medications will be faced with the largest financial liability. Lower income beneficiaries could be particularly disadvantaged under this approach. Second, coinsurance based on a percentage of the prescription charge would create an incentive for the ordering and filling of prescriptions in lower quantities. This would be

particularly relevant for lower income beneficiaries who would likely prefer to spread the out-of-pocket costs of a prescription over several purchases when a small prescription is refilled rather than paying a large initial copayment. Third, a percentage copayment would be more difficult for beneficiaries to understand and would increase Medicare administrative costs, particularly in handling inquiries.

For these reasons, we recommend use of a fixed dollar copayment per prescription, such as $3.00 to $5.00 per prescription. While this approach would not provide explicit incentives for beneficiaries to choose lower priced products, it would be much simpler to understand and administer. Other features of the program, such as the reimbursement formula, could encourage the use of lower-priced products where appropriate. If the subcommittee concludes that beneficiaries should bear some of the financial consequences of obtaining a more expensive brand name drug when a lower cost substitute is available, a variable copayment could be considered. Under this approach beneficiaries would be responsible for a lower copayment when a generic prescription is filled, for example, $1.00 per prescription.

We do have some concerns about the reimbursement formula contained in the proposals under consideration. The proposed use of average wholesale price (AWP) in the calculation of a payment limit for drugs could result in excessive benefit payments. Based on our experience, we believe that the average wholesale price does not accurately reflect the acquisition cost of most pharmacies. It is, however, a simple, widely-understood measure the use of which can avoid the more costly task of pharmacy financial audits. The subcommittee may wish to explore using estimated acquisition cost data in the payment limit calculation. Estimated acquisition cost amounts could be based on the cost of the most commonly purchased package size.

In determining the most appropriate basis for the reimbursement formula, a key issue is balancing cost containment with concerns about access. The higher payment levels under an AWP approach would likely encourage higher levels of pharmacy participation.

We are also concerned about the level of dispensing fee that is included in the payment limit. In our judgment, the $4.50 fee is too high. While a reasonable fee is needed to compensate pharmacies both for their normal administrative overhead and for the increased costs they would incur in helping Medicare beneficiaries with their claims, a $4.00 fee would likely accomplish this objective.

We support providing the authority for HHS to develop a drug formulary, although we believe that a formulary should not be required. Conceptually, a drug formulary may be appropriate. However, beneficiaries and providers may not understand it, resulting in a high number of inquiries and a high level of dissatisfaction with the new program. The policy and operational issues relating to the establishment of a drug formulary for Medicare reimbursement purposes should be explored thoroughly before a decision is made to move forward.

We also recommend against provisions that would specifically authorize regional carriers for administration of the new benefit. Such provisions are unnecessary since HCFA already has the authority under current law to establish regional carriers for handling certain types of Part B claims. It also should be noted that a regional approach to the administration of this benefit may not be in the best interest of the program or its beneficiaries. The need for beneficiary and provider communication and familiarity with the local environment will, in our view, be critical to the success of this new program. We would recommend that the program be administered through the existing carrier structure.

Regarding the financing mechanisms under consideration, we would recommend that the new benefits be financed by the Medicare income-related supplemental premium for catastrophic coverage. General revenue financing sources could also be considered to help finance the new benefits. Financing even a part of an expensive new benefit through the regular Part B premium charged to all enrollees could result in an excessive burden on beneficiaries with low incomes.

We would like to raise three additional issues for your consideration. First, the proposals being discussed appear to provide no explicit control over the cost of the first $400 to $500 of drugs that will trigger the catastrophic benefit. The lack of control could encourage excessive prices for beneficiaries who are likely to reach the threshold sometime during the year. At a minimum, it could trigger catastrophic benefits based on drug prices that are higher than the Medicare payment allowance. While administratively costly, it would be advisable to subject the first $400 to $500 in drug expenses to the same payment limits applied to prescriptions billed after the deductible is met.

Second, to provide greater incentives for beneficiaries to seek out participating pharmacies we would recommend that you consider establishing a lower payment level for drugs provided by nonparticipating pharmacies, such as 75% of the amount paid to participating pharmacies. This approach is used by Blue Cross and Blue Shield of Michigan in its private market prescription drug programs. It should be noted that 98% of pharmacies in Michigan participate in these programs.

Third, we believe the administrative costs of the proposals under consideration would be substantial. The capacity will have to be developed to sign-up participating pharmacies, to process both provider claims and unassigned hard copy claims filed by beneficiaries, to

determine whether a deductible is met, to establish an inquiry capability, to conduct pharmacy audits, to handle beneficiary and provider appeals, to develop provider and beneficiary profiles to detect and prevent abusive practices, and to handle other administrative tasks. A major effort to educate physicians, pharmacies, and beneficiaries about the new program will also have to be undertaken. Because of all these tasks, we believe initially it will cost the same amount to process a prescription drug bill as it will cost to process other Part B bills — about $1.90 per claim in 1989 based on our estimates. After the program has been operational for some time and as more claims are submitted electronically, it may be possible to process drug bills at lower costs. Depending upon the volume of claims that would be received, it could cost as much as $500 million in 1989 to administer a prescription drug program with a $500 deductible. It would, of course, cost more to administer a program with a lower deductible.

We are, however, convinced that HCFA and the Medicare carriers could make this program work if adequate administrative funding and lead time is provided. We would, therefore, urge you to encourage that the necessary funds to prepare for program implementation be included in the FY 1988 Labor/HHS appropriations bill. Adequate funds for ongoing administration of the program should be included in the appropriations for FY 1989 and later years. At this point, an effective date of January 1, 1989 appears reasonable.

Conclusion

The Blue Cross and Blue Shield Association appreciates this opportunity to provide the subcommittee with comments on proposals to expand Medicare to include outpatient prescription drugs. This is an area where we would urge thoughtful attention to program design and to the administrative aspects of the program. We stand ready to assist the subcommittee in any way we can to analyze these proposals further.

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Senator MITCHELL. Mr. Guildroy, your organization proposes to fund the benefit in part by adding State and local employees to the payroll tax for the hospital trust fund—current employees.

Mr. GUILDROY. Yes.

Senator MITCHELL. Wholly apart from whether or not that is fair, do you think it is responsible to fund a major new benefit with a revenue source that must inevitably disappear in a relatively short period of time, and that would then, thereafter, shift costs to current workers?

Mr. GUILDROY. May I ask my colleague, Ms. Smith, to comment?

Senator MITCHELL. Yes. Ms. Smith?

Ms. SMITH. We recognize that that funding source is likely to disappear shortly.

Senator MITCHELL. Well, not likely; it certainly will disappear.

Ms. SMITH. It is certain to disappear at the beginning of the next century, and we fully anticipate that the costs of the program would then be borne by the beneficiariy, in toto.

Senator MITCHELL. By the what?

Ms. SMITH. By the beneficiary, in total. At that point, the premium would undertake to cover the full cost of the benefit.

Senator MITCHELL. Well, you have heard the Administration, and you have heard others, saying that the premium wouldn't be enough to pay for it now.

Now, let us assume that you are wrong and the Administration is right; what would we do then? What would you recommend we do then, raise the premium even further?

Ms. SMITH. At this point the beneficiary is paying for their prescription drugs out of pocket.

Senator MITCHELL. Right.

Ms. SMITH. And we are looking at a program which would make that payment more predictable. It will spread the burden of that cost, but it will not take away any of the burden that currently is being paid by America's seniors. It will only distribute those payments more evenly.

Senator MITCHELL. Do you recommend that it be an optional participation, or mandatory?

Ms. SMITH. We recommend that it be a portion of Part B, and as Part B is optional, this benefit would be as well. We recognize that almost everyone is covered by Part B.

Senator MITCHELL. It would be optional?

Ms. SMITH. As a portion of Part B, but only optional to the degree at Part B is optional.

Senator MITCHELL. Are you saying that you can foresee no circumstance in which the premium would increase to a point that it would be unacceptable to beneficiaries?

Ms. SMITH. The next 20 years of this program will be a difficult road. We don't have as much experience as any one of us would like. On the other hand, that was the case in 1965 when Medicare was enacted.

Senator MITCHELL. And of course we saw what happened with respect to the premium there.

Ms. SMITH. We certainly did.

Senator MITCHELL. The initial concept was that the premium would pay for 50 percent of the costs of Part B. And because that

would have resulted in an increase, that was politically unacceptable to the members of your organization; that percentage steadily declined and then had to be arrested at 25 percent.

So, what is there in that history that could lead anyone to conclude that the same thing won't occur again?

Ms. SMITH. We can't conclude with absolute certainty what the direction of this program will be. We have heard very, very different testimonies from both CBO and HCFA regarding costs, and we ourselves are very concerned about the future. We can make no guarantees, but we have said that the beneficiary is already paying, and the predictability of a monthly premium is far preferable to outrageously high catastrophic costs.

Senator MITCHELL. No one disputes that for the persons who incur the outrageously high catastrophic costs; but of course, the only way this works in the insurance principle is if a large number of people end up paying a little more and the few people, or a smaller number of people, end up paying a lot less.

Well, we are going to have some kind of a program, I don't think there is much doubt about that; but it seems to me that there is a very legitimate concern here, particularly when we get to the question of the rising costs about how this will be borne in the future. You might not be here, Ms. Smith or Mr. Guildroy, and none of us might be here, but there will be other persons filling these roles, and it seems to me it is not going to be very long before someone is going to come in saying, "Look, this premium is unbearable, and we have got to find another source for it."

Well, my time is nearly up, so I will defer. I do have a question for Mr. Snedden and Mr. Spielman on the question of cost increases over the past few years in your programs. We will get to that after my colleagues have had a chance to question.

Senator Durenberger?

Senator DURENBERGER. Thank you.

Mr. Guildroy and Ms. Smith, I think we all understand why we are here; I am not real sure whether we are all sure exactly what we want to do, and that is what I am going to try to clarify.

It seems to me we are here because of catastrophic and because of the way in which we have defined catastrophic. Our definition of catastrophic is, in financial terms, $1700, and then it is also in benefit terms of covered out-of-pockets for covered benefits. I assume that is why we are here, because if we are going to use that as a threshold for this new Medicare benefit, catastrophic, then it is in the interests of the beneficiaries to expand the definition of "covered benefit."

The first and most likely benefit appears to be for the inconsistency between Medicare's Part A coverage for drugs if you are in a hospital or other appropriate facility, and its not paying for the same or similar kinds of drugs under Part B if it is not administered in a hospital.

So we can have all kinds of examples by which we compare A and B and say, "Gee, this is just inconsistent, so why don't we start with that benefit?" I think that is why we are all here.

Now what we seem to be having trouble with all across the board here is, if that is where we want to head, where do we head in?

I am hearing that for the genuine low-income folks in almost all the States except Wyoming and Alaska, we have a program that picks up some part of the drug benefit. Then in eight, now nine States like Pennsylvania we have added up to a certain economic level to that and constructed that much the way Mr. Snedden has told us Pennsylvania has constructed theirs.

Now I see us wanting to build upon that for everybody else. And some of the questions that have been raised here are about, you know, who needs it after such-and-such a point in time? And if you really were going to add benefits to Medicare for the middle and upper income people, would you be starting with drugs or would you be starting somewhere else?

But let me ask a couple of questions like of Mr. Snedden. Suppose that House Ways and Means bill that got marked up yesterday, if that were the law today, if we were passing it today, do you think that the Governor of Pennsylvania would be having a press conference next Monday to reauthorize your PACE program?

Mr. SNEDDEN. Let me clarify something first before I answer the question, Senator. The version of the bill you are talking about, is that an $800 spend-up in that bill? That is the key.

Senator DURENBERGER. It has both $500 and $800.

VOICE. Ways and Means is $800. Energy and Commerce is $500.

Mr. SNEDDEN. All right. Well, if it is $800 as it is in Ways and Means, only eight percent of the PACE cardholders would be affected, because only eight percent spend more than that in any given year. If it is $500, as it is in Energy and Commerce, only 21 percent of the PACE cardholders would be affected. So, I would presume or recommend for the Governor that, yes, the PACE program be reauthorized under those conditions.

Senator DURENBERGER. Now, suppose we didn't do a deductible approach but we did a co-payment approach like you do in Pennsylvania—and I am curious here if I have any time to hear AARP's rationale for why don't you like copays, why do you want to load it on the deductible. But if we went the co-pay approach with this program rather than the deductible approach, then what would Pennsylvania be likely to do?

Mr. SNEDDEN. Well, we probably would still hold a press conference to say how appreciative we are that you are going to save the PACE program an awful lot of money in the future. [Laughter.] And I am sure the Governor would applaud you.

Senator DURENBERGER. But I take it you in Pennsylvania went through the process of deciding what is the fairest, in the largest sense, way—considering utilization, considering the needs of low-income elderly—the fairest way to do this, and you came to the conclusion that co-pays was the fairest way to go.

Now let me ask AARP why you've come to a different conclusion.

Mr. GUILDROY. We believe, Senator Durenberger, first of all in the $500-deductible, and then, after that, in a 20-percent coinsurance payment, up to the cap.

Senator DURENBERGER. But not a co-pay like they are talking about, $3, $4, $5?

Mr. GUILDROY. Not a copayment but a coinsurance percentage of 20 percent.

Senator DURENBERGER. All right. These two fellows said that they didn't like that idea. Why does AARP think that coinsurance and deductibles first?

Mr. GUILDROY. That is because they got there first.

Senator DURENBERGER. Well, you would learn off of them, wouldn't you? I mean, wouldn't that be instructive?

Mr. GUILDROY. We like many things from the PACE program, no doubt about it. We prefer a coinsurance, 20 percent.

Senator DURENBERGER. The question was why—why do you prefer it?

Ms. SMITH. Coinsurance would be preferable to us over a flat payment because it creates an incentive for the beneficiary to seek a lower cost drug. That incentive would not exist if there were a flat payment instead of a percentage payment. With the percentage payment the beneficiary would seek or would have the potential of seeking the lower cost drug.

Senator MITCHELL. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Mr. Guildroy, earlier I asked the Administration why they would oppose including prescription drugs when basically seniors are willing to pay for it—that is, through higher premiums and what not. They talked about administrative expenses, and so forth.

I think another major reluctance is basically the point drawn out by Senator Mitchell—namely, well, maybe seniors through higher premiums and deductibles are willing to pay today, but tomorrow, if the cost of drugs keeps rising as fast as they have, politically it is going to be difficult for Congress to resist allowing the premium to rise to pay for the drugs.

What, in your estimate, will the increased premium be under your plan in the next several years?

Mr. GUILDROY. I don't know that we have a firm prediction. As Ms. Smith pointed out, it is not going to be easy. But we feel that this is such an integral part of medical insurance that we should attempt to do this.

Senator BAUCUS. Do you have any ripe estimates?

Ms. SMITH. We have not made firm projections, based on the data that we had, in any firm fashion. The information that we have been able to obtain from CBO regarding utilization, et cetera, has been changing, as you well know, and therefore we don't have any firm figures.

Senator BAUCUS. Do you plan to come up with an estimate?

Ms. SMITH. We are working on that at this point.

Senator BAUCUS. Like when do you think you might have one?

Ms. SMITH. Probably two to three weeks out.

Senator BAUCUS. Mr. Spielman, since Blue Cross and Blue Shield tends to be an intermediary in many parts of the country, I would like to ask you about how this would work in very sparsely populated areas of the country where there may be a pharmacist, there may not be a pharmacist, the pharmacist may decide not to participate, people move around a little bit, and if you have a deductible and it is included in the overall cap, say in the catastrophic bill?

I can just perceive problems facing seniors who try to get the drugs. I mean, the pharmacist may not want to participate, with the recordkeeping requirements. What advice do you have here as

to how we could meet some of those problems that seniors might face in very sparsely populated areas?

I know that in the rural West, you can drive 100 miles at least to get to a pharmacist, and he may be the only pharmacist in a very small town. How do we meet that problem?

Mr. SPIELMAN. The Ways and Means version of the bill, at least prior to yesterday's markup, did address that in a sense. But there is a trade-off in terms of the administrative costs involved. The Ways and Means approach would pay claims for drugs that are furnished by nonparticipating pharmacies. In this case the beneficiary would file the claim. You get the shoebox phenomenon when that occurs, and of course that increases the cost of the processors; but this approach would assure that a beneficiary in any area would have access to benefits. Again, however it is a more costly approach from an administrative standpoint.

Senator BAUCUS. The second question goes to a list of approved drugs—that is, not only drugs approved by the FDA but approved for this program, drugs that are more medical in nature. As I understand, you suggested that there should be such an approval list, as we want to give drugs that are medically helpful and don't want to pay to cover cosmetics and other FDA-approved drugs that don't have much of a medical relationship.

Yet, as I understand it, the Medigap plans basically pay for all drugs. I am wondering how we work out that inconsistency.

Mr. SPIELMAN. Well, let me just clarify our position: Our position was not that a list should be established but rather that we agree with granting HHS the authority to establish such a list if, after review, it is appropriate.

The lists tend to be designed to identify the lowest cost drug for a particular need. To the extent the payment system has good safeguards built in to it to encourage generic prescriptions and lower cost, you may not need a formulary. Formularies tend to be confusing to beneficiaries, and our point is one of caution: Let us look at it; it may be appropriate, but it may not be necessary. We are not recommending immediate implementation of a formulary.

Senator BAUCUS. This is off the point slightly, but to the degree that Medigap coverage does include prescription drugs, should we try to limit those drugs to medically necessary and exclude cosmetics?

Mr. SPIELMAN. Well, I think under any circumstances you would want to do that. There is a general prohibition under Medicare against payment for items that are not reasonable and necessary for the treatment of illness. You wouldn't want to pay for birth control pills, for example.

Senator BAUCUS. I don't think that's your problem. [Laughter.]

Mr. SPIELMAN. Thank you.

Senator MITCHELL. That is what might be called "an excess of caution." [Laughter.]

Mr. Snedden, I just have a couple of brief questions for you. How do you pay for your program in Pennsylvania?

Mr. SNEDDEN. We do not use any tax dollars, Mr. Chairman. This program is supported, every penny of it, from the Pennsylvania State Lottery.

Senator MITCHELL. In each of the past three years, in percentage terms, what has been the rate of increase in the cost of the program?

Mr. SNEDDEN. Well, let me preface this answer by saying that you have to keep in mind that the first year was a start-up year. The first year of the program cost us $63 million, as contrasted with $118 million for the second year, and as contrasted with what would probably be, as I mentioned, $150 million for the third year. So, I think it is more instructive to look at the comparisons between the second and third year where it went from $118 to $150 million.

When you said you were going to ask this question before the other Senators asked some questions, you asked what are the reasons behind that. There are a couple, but there is a common misconception that the increasing cost of the program is attributable to increases in the enrollment levels. That is not true; our enrollments have more or less leveled off.

The costs are attributable primarily to two things and two things only: First and foremost, as was mentioned here earlier, are the increasing costs of drug prices. Drug prices just keep going up and up and up. The national average for drug price increases has been about 10 percent over the last 6 years.

For the PACE program, drug prices have been going up even higher, because of the mix of drugs that the cardholders use. We are looking at a 15-percent increase in the cost of drugs to the program.

The second reason our costs are going up is attributable to cardholder utilization. I mentioned that the average cardholder is using their benefit 26 times a year; that contrasts with 18 times at the end of the first year and 22 at the end of the second year. It seems to be a phenomenon associated with these kinds of programs; if you give somebody a benefit like this, they will find ways to use it.

Senator MITCHELL. Once you separate receipt of a service or benefit from its payment, increase of utilization seems to me to be inevitable.

How much does the lottery take in? How much will it take in this year?

Mr. SNEDDEN. The lottery gross has been around a billion dollars a year, the revenues from which have been about $700 million or $650 million.

Senator MITCHELL. The net revenues, $650 million?

Mr. SNEDDEN. The money we are using for programs such as PACE. PACE is one of five programs funded by the lottery.

Senator MITCHELL. I see. That is not a very good buy for the lottery purchasers, is it? We have a deal up in Maine called "The Megabucks" where they do a little bit better, so we have been advertising in Pennsylvania, I think, for that one.

Mr. SNEDDEN. We have a lot of new millionaires in Pennsylvania as a result of that.

Senator MITCHELL. Right. Thank you very much, Mr. Snedden.

Mr. SNEDDEN. You bet.

Senator MITCHELL. Senator Durenberger has one question.

Senator DURENBERGER. One question, to follow up my line of questioning on how to involve the beneficiary in payment: The re-

sponse to my question as relative to coinsurance from AARP was related to lower cost alternatives. Now I will ask each of you two, Mr. Snedden and Mr. Spielman, whether you agree with that response, and then a related question—which I don't really know the answer to, and I am going to ask it again of the next panel.

The use of generic drugs sounds very attractive, because its cost is lower than the so-called original. However, I would guess, without knowing the answer, that the original has in it all the real high cost of research and development and the generic has none of that. So, I would guess what we are doing by putting this big emphasis on generics is making a lot of money for drug companies, because there is probably a much larger markup in the generic, even though the overall cost is lower, than there is in the original drug. Would either of you be responsive to that, also?

Mr. SPIELMAN. I wouldn't know; you might direct that at the next panel.

Mr. SNEDDEN. That is an easy way out. I would say that you are essentially correct; but the truth of the matter, Senator, is that the generic drug is cheaper. The average cost of a brand-name drug to the PACE program is $14.75; the average generic only costs us $4.57. So, if the markup is higher on the generics as contrasted to the brand, we really don't care, because we are paying $10 less for each claim.

Generic utilization is a problem within the PACE program. Our generic utilization rate is only 12 percent, and we are trying to get it up much higher.

What we are looking at is, if everybody used the generic when they could use the generic—and Pennsylvania has a very restrictive State generic formula, maybe the most restrictive in the country—we would be at 36 percent. So that, one out of three times tnat somebody could use the generic, the other two times we pay the $14.75. We are trying very hard to come up with some different mandates and incentives and educational programs to get our people to use more generics.

As the gentleman here on my right indicated earlier, coinsurance is an effective way to do that; but there are other means of providing generic incentives for people in programs like this.

Senator DURENBERGER. The problem I am trying to explore, and to see if you who have been paying for this have, is how do we hold down the overall cost of these programs? Yes, one generic is cheaper than the alternative; but it could be a lot cheaper if the buy—the way we make the buy or finance the buy—were changed. Obviously what all of the drug companies are afraid of, according to the newspapers, is that if we get into the drug benefit, pretty soon we are going to have a DRG for every one of these drugs, and we are going to do to the drugs what we have just done to doctors and hospitals, and all that sort of thing.

I am just curious to know—and maybe the answer is that we don't know yet—is there a way to construct the buy as between the copays, the coinsurance, and all the rest of that sort of thing, so that in effect the market here could make you make the best buy for the least amount of money?

Mr. SNEDDEN. Well, holding down the rate of increase in the cost of the PACE program is a big problem for us, and the Governor

and the Secretary of Aging are very much involved with us in trying to do that.

One of the ways of holding down the costs might be to somehow get the price of the drugs down, and there are ways to do that through things like the restrictive formulary.

However, we feel that there are a number of other ways to get down the cost of the program without resorting to something that is as contentious and difficult to administer as a restricted formulary, and I have discussed those here in my formal statement for you.

Mr. SPIELMAN. If I may respond, Senator, we would argue for a deductible approach with different standards on the price that would be paid, for example less than AWP. We would argue for a strong utilization review component and, a lower dispensing fee than is included in many of the proposals. We would also argue to increase the simplicity of the program. To protect beneficiaries who happen to have the unfortunate situation of having to need drug therapy from a single source that is very expensive and where no substitute is allowed, we would prefer a dollar copayment rather than a 20-percent coinsurance.

And finally, we would urge greater incentives for pharmacies to participate or for individuals to go to participating pharmacies. I think a combination of those changes should help to keep the benefit cost relatively manageable, although they still will be high.

Senator MITCHELL. Thank you very much, gentlemen and Ms. Smith. We appreciate your testimony, and there will be further questions in writing. We ask that you respond at your earliest convenience.

For those of you who have come in since 11 thinking that you were going to attend a hearing on mental health benefits under Medicare, this is not it. That will follow, however. We are going to proceed directly to that hearing as soon as we complete this hearing, which we will do after we hear from the next two witnesses, the final panel, which includes Robert Allnutt, the Executive Vice President of the Pharmaceutical Manufacturers Association, and John Rector, general counsel and vice president of Governmental Affairs of the National Association of Retail Druggists.

Good morning, gentlemen, and welcome. Mr. Allnutt, we look forward to hearing from you.

STATEMENT OF ROBERT F. ALLNUTT, EXECUTIVE VICE PRESIDENT, PHARMACEUTICAL MANUFACTURERS ASSOCIATION, WASHINGTON, DC

Mr. ALLNUTT. Thank you, Mr. Chairman, and thanks for this chance to testify.

I am Bob Allnutt, with the Pharmaceutical Manufacturers Association. Let me start by just associating myself with the opening remarks that the various members of the committee made. I listened pretty carefully to them, and I don't think there is anything there I disagreed with. I will have to leave out Senator Pryor, who submitted his statement for the record.

Senator MITCHELL. You don't think there was anything you agreed with, or disagreed with?

Mr. ALLNUTT. Disagreed with. I suspect I agree also with what Senator Pryor said, but since I haven't read his remarks I can't say that.

I have a statement which you will put in the record, and I will summarize it very briefly.

The danger that we see in the hasty adoption of a program without carefully defining the problem I think is highlighted by most of the testimony you have had here today. People who are for the kinds of benefit programs you are generally talking about really have profoundly different versions of those programs that they would support.

We certainly agree that drugs should be available to the elderly, that there are those who cannot afford them, that attempts should be made to define that class of persons who have those problems and then to provide drugs for them either through a Federal program or some combination of the State programs that are in place now and Federal programs, always keeping in mind the private programs that exist. So, we are not in a different position there than many of the witnesses you have had.

The question is what sort of benefit should be defined, and how should it be paid for, which requires knowing what it is going to cost.

I had planned to dwell at some length on the table that is on page seven of my statement, but I think your earlier witnesses did that. Let me point out one thing, though, that may explain the differences that some of you were trying to explore between CBO and HCFA.

The CBO number—which is wrong in my table on page seven; I say $200, and they said today $250—as I understand it from the CBO report, they assume no induced utilization, that the putting of such a program in place would not induce any additional utilization.

You heard the witness from Pennsylvania say a moment ago that the number of prescriptions per year has gone up in his program from 18 to 26. That is a 44 percent increase in two years. That is induced utilization. Induced utilization isn't bad; we assume that doctors prescribe for people who need drugs, and that people buy the prescriptions because they need them. I am not saying it is bad, but it has a lot to do with what you assume a program will cost down the road.

We note that in reporting S. 1127 the committee included a requirement for a study of drug benefits. We would suggest that that study be broadened. I just heard this morning for the first time, as you did, of the study that President Reagan is directing. Whether that is an adequate study or not, I don't know, because we will have to see what that would cover. But we propose you broaden the study to include the elements that I have outlined on page nine and on subsequent pages of my prepared testimony. It is of top priority to determine the current levels of spending by the elderly, on who is in need, and how to meet those needs. It is important to consider the integrity, fiscally, of the Medicare Fund. We talk about that at some length on page nine of the testimony.

One element that hasn't been mentioned here that should be considered by the committee is the problem of caring for victims of AIDS. Clearly, they are presently in need of prescription drugs. A number of drugs are being developed by our companies for AIDS victims. Those drugs are costly. They would be covered under the bills the House has passed. I am not saying that is a bad result, but I think the committee should consider whether Medicare or some other Federal funding would be the best way to meet those needs.

Senator Pryor asked a question earlier of the HHS witness which will lead to your getting a table of what each State provides in Medicaid and also what States that have the additional benefit programs like the PACE program in Pennsylvania provide. I think looking to those programs will be very useful to the committee, and also looking to how they are administered.

There exist across the country in all but two States bureaucracies that are prepared to and are administering drug benefit programs now. That, to us, seems to be a better way to proceed than to create a new bureaucracy in HHS to administer such a program.

I will stop with that point, Mr. Chairman, and answer your questions after my colleague testifies.

Senator MITCHELL. Thank you, Mr. Allnutt.

Mr. Rector?

[Mr. Allnutt's written prepared statement follows:]

Statement

Pharmaceutical Manufacturers Association

ROBERT F. ALLNUTT
EXECUTIVE VICE PRESIDENT
PHARMACEUTICAL MANUFACTURERS ASSOCIATION

BEFORE THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE

U.S. SENATE

JUNE 18, 1987

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to appear before the Subcommittee to testify on various legislative proposals to cover the cost of prescription drugs for outpatients. PMA represents the more than 100 research-based pharmaceutical companies that discover, develop and produce most of the prescription medicines used in the United States.

Prescription medicines are a critically important component of the national health-care system. Our industry strongly believes that all older Americans should be able to receive the medicines they need, and we welcome the efforts of this Subcommittee and the full Committee to focus on the problems some elderly people face.

1100 Fifteenth Street, N.W. Washington, D.C. 20005 (202) 835-3400

The modern medicines our companies develop enable people to live longer, healthier and more productive lives. Drugs extend lives, cure illness and improve the quality of life for all Americans, especially the elderly. Indeed, senior citizens are among those who most use the medicines our companies discover and develop, and who benefit the most from these drugs.

Prescription drugs not only save lives--they save money. Prescription drugs are the most cost-effective form of modern therapy. They save billions of dollars a year by reducing the need for alternative, more expensive forms of therapy, such as hospitalization and surgery. The use of drugs also reduces the cost of physicians' services and the number of work days lost due to illness. One anti-ulcer drug alone, Tagamet, saved Americans an estimated $4 billion in health-care costs in its first decade on the market.

Even though prescription drugs are the most cost-effective form of therapy, they represent only a small portion of health-care expenditures. As a nation, we spend less than a nickel of each health-care dollar for outpatient drugs. Drug prices have remained well below the Consumer Price Index ever since that Index was established in 1967 (Figure 1). And the cost of drugs has actually declined in terms of purchasing power.

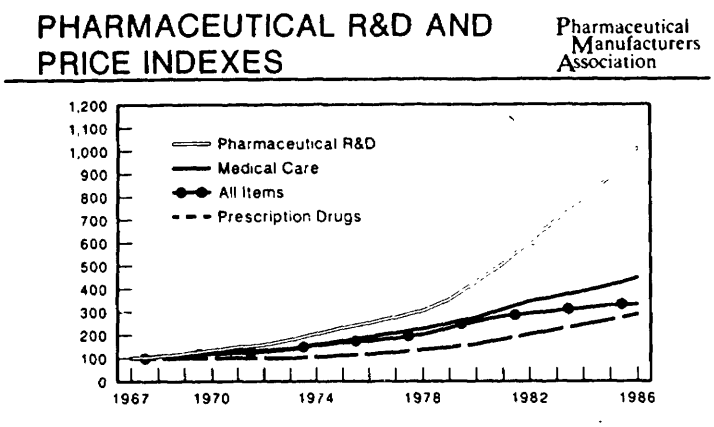

Figure 1

Every five years since 1970, the pharmaceutical industry has doubled its investment in research and development (Figure 2). This year, these companies are investing $5 billion in R&D, nearly equalling the total being spent by the National Institutes of Health for all biomedical research. The period of time during which this investment in R&D can be recovered through sales revenues, however, is being dramatically compressed due to a number of converging forces. Foremost among these forces is the unprecedented surge in competition from generic products as soon as the patent on the pioneer drug expires. Other major forces include the intense competition within the research-based

pharmaceutical industry to develop and market new patented drugs; increasing delays in the approval of new drugs, and increasing foreign competition both from developed countries that have targeted this industry and from newly industrialized countries that blatantly condone patent piracy.

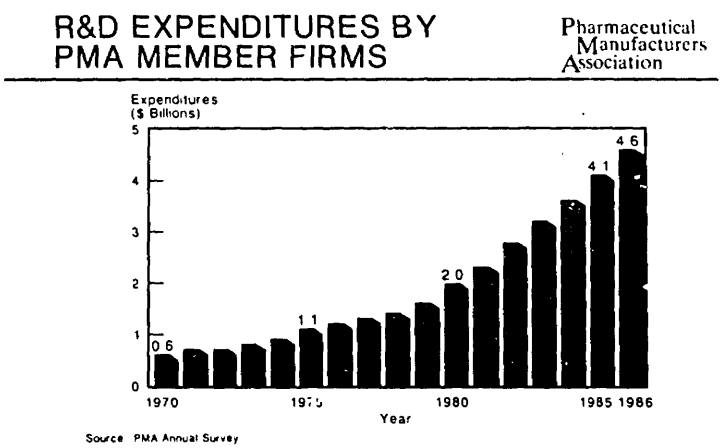

Figure 2

It is because prescription drugs are necessary to ensure that all people receive the very best health care and because they are the most cost-effective form of health care that the industry believes older Americans should have access to the full range of prescription drugs.

The danger we see in hasty adoption of a new entitlement program--without carefully defining the problem so an appropriate solution can be devised--is that the costs of the program, and of its administration, will quickly exceed the initial estimates. This will lead inevitably to proposals for cost-containment measures that would restrict freedom of choice from the full range of approved drug products, diminish quality of care and discourage the investment needed for future drug breakthroughs. Thus, those in need will be denied the very benefits intended for them, resulting in second-class care for the beneficiaries of federal programs. Indeed, several such undesirable cost-containment features already appear in pending bills.

In the House, the Ways and Means and Energy and Commerce Committees are considering bills to extend Medicare to cover outpatient drugs. Adding this benefit to Medicare would, of course, result in reimbursement of drug costs (above the deductible amount specified in the bills) for all elderly and disabled persons regardless of their ability to pay.

The vast majority of Americans, including elderly people, are financially able to obtain drug therapy. At this time, however, there are no reliable data defining the number of elderly people who cannot obtain adequate drug therapy for financial reasons. It is absolutely essential to determine the size and characteristics of such a group of older persons before it can be determined how to design an appropriate--and affordable--program.

Even the strongest proponents of expansive new drug coverage (including the American Association of Retired Persons, in testimony before the House Energy and Commerce Subcommittee on Health and the Environment on May 21) acknowledge that little data exist on the potential use of new drug benefits under Medicare, the costs of such coverage and the administration of such a program.

The Congressional Budget Office and the Health Care Financing Administration have been hurriedly preparing estimates of the cost of covering prescription drugs under Medicare over the past few weeks. These estimates differ by a considerable margin, as the following table shows:

Medicare Drug Coverage for the Elderly
Variations in Key Cost Elements

	Expenditures Per Enrollee (1986 Unless Noted)	% of Enrollees Spending More Than $400
CBO	$200 *	13.8% *
HCFA	$342 *	23.6% *
Blue Cross/ Blue Shield Group Plans		
-Michigan	$312 **	?
-Illinois	$388 **	?
-New York	$380 **	27% exceed $500 ** (Average $1,052) **
Medicaid (1985)	$368 **	?
New Jersey Pharm. Asst. Program	$380 **	?
Pennsylvania PACE Program	$400 **	30% **

* Estimated (1988)
** Based on Actual Data

On the critical question of monthly premiums, the estimates range from $5 (CBO) to $22 (HCFA), a vast difference. Clearly, a new drug benefit under Medicare should not be enacted until reliable estimates can be made of how much such a benefit would cost, and what premiums or taxes would be required to pay for it.

PMA believes that once the group in need is identified and costs can be more accurately assessed, it should be easier to

determine how an appropriate program should be designed. A well-designed program should have several important features. It should:

- Be targeted to aid the elderly who need assistance, so the added premiums or taxes required to cover costs can be minimized.

- Assure that patients receive quality care.

- Provide physicians and patients with the freedom to choose from the full range of approved drug products.

- Include a low-cost, non-burdensome administrative procedure.

- Encourage--and not stifle--the continued development of new and more effective medicines.

Before Congress provides any new entitlement program, PMA urges that you order a comprehensive study to develop and analyze the data necessary to determine the most appropriate way for the government to provide prescription-drug coverage for the elderly in an affordable manner.

We note that S. 1127 as reported by the Finance Committee contains a requirement to study drug benefits, and we would urge

that the study include these additional factors:

- Determination of current levels of spending by the elderly for prescription drugs, as well as the number of older persons unable to afford adequate drug therapy, should be the top priority.

- The long-term fiscal integrity viability of Medicare should not be jeopardized. Already, the premium for existing Medicare benefits will be increased by law in October from $17.90 to $22.80 a month. Catastrophic coverage itself will require an additional premium. And, as was pointed out in testimony before this Subcommittee last Friday, the main concern of the elderly is to obtain coverage for long-term health care, a very major additional cost.

- There are other pressing medical needs as well, including the billions of dollars in previously unplanned expenditures that we now know inevitably will be required in federal and state budgets to meet AIDS-related demands in the early 1990s. None of the estimates of providing a new program of drug coverage under Medicare take into account the substantial cost of medicines for AIDS victims that would be paid under the House bills.

- Nine states (New York, Pennsylvania, Illinois,

Maine, Rhode Island, Connecticut, New Jersey, Delaware and Maryland) already have enacted Pharmaceutical Assistance for the Aged programs for low-income elderly persons who do not qualify for Medicaid benefits. These programs cover 1.3 million people. Six additional states (Massachusetts, Ohio, Michigan, Vermont, Florida and Alabama) are considering such programs. These efforts should be carefully studied, and consideration should be given as to how a federal assistance program should relate to existing state-administered Medicaid drug programs--under which 2 1/2 million elderly Americans received drug benefits in Fiscal Year 1985--and Pharmaceutical Assistance for the Aged systems.

- The manner in which a federal program would interrelate with other forms of drug coverage should also be considered. Many elderly people are covered by private insurance, Veterans programs, private retirement plans and Health Maintenance Organizations (HMOs). The American Association of Retired Persons testified on May 21 that more than 41 percent of the elderly population has some form of drug coverage. More than 50 percent of the enrollees in the Pennsylvania assistance program have other coverage.

- Special attention should be given to administrative procedures, in view of the fact that, because of the large number of transactions, administrative costs tend to be very high for drug programs. Secretary of Health and Human

Services Otis R. Bowen, in testifying before the House Subcommittee on Health and the Environment on May 27, said the administrative costs of a new drug program under Medicare would greatly exceed $500 million. HCFA estimates this cost at $510 million by 1992. In a 1986 report, the House Appropriations Committee pointed out that less than 8 percent of Medicaid benefits are for drugs--but that these benefits account for 50 percent of the paperwork. And the United Auto Workers noted in recent testimony that it would be very costly to administer a program of drug benefits with a high deductible.

- The incentives for continued investment in pharmaceutical research and development should be preserved, and not impaired. The best hope to treat disease--including diseases of special concern to the elderly such as heart disease, cancer and Alzheimer's disease--lies in the R&D efforts of the research-based pharmaceutical industry.

In connection with these legislative proposals, some have suggested establishing restrictive drug formularies, which numerous studies have shown are counter-productive as cost-containment controls. For your record, I would like to offer a list and a discussion of those studies. They indicate that restrictive formularies produce higher program costs by increasing expenditures in other areas such as hospitalization and surgery. For this reason, restrictive formulary initiatives

were rejected in recent years in Louisiana, Oregon and Pennsylvania. In addition, South Carolina and Utah eliminated restrictive Medicaid formularies and adopted comprehensive drug coverage.

The experience of state Medicaid programs also shows that it can take considerable time--a year or two and sometimes three--for new medical therapy approved by the Food and Drug Administration to be added to formularies. For example, California took 26 months to add a breakthrough anti-ulcer medicine to its Medicaid formulary. In such cases, patients are denied access to important new medicines during the waiting period. And patients may never receive appropriate drug therapy that is never listed on a formulary.

Pending legislative proposals also refer confusingly to "therapeutic equivalents." We understand that this is not intended to refer to "therapeutic substitution"--the dispensing by a pharmacist to a patient of a different chemical than the chemical prescribed by the patient's physician. Therapeutic substitution is drug switching, and is not to be confused with generic substitution. All 50 states prohibit therapeutic substitution--which could be detrimental to the patient's health --by retail pharmacies, and this prohibition should be preserved in the interest of public health.

In conclusion, PMA strongly believes that older Americans

should receive the very best and most cost-effective medical care, including access to modern medicines. At this time, however, there are far more questions than answers about the best way to design a new drug-benefit program in support of this goal. Congress should authorize a comprehensive study, on an expedited basis, to develop the data necessary to design an appropriate and affordable program. PMA will continue its own review of the options, and would be pleased to cooperate fully with a Congressional study.

Mr. Chairman, that concludes my statement. I would be pleased to respond to any questions you or other members of the Subcommittee may have.

James W. Singer
LEGISLATIVE COUNSEL

Pharmaceutical Manufacturers Association

June 18, 1987

Mr. William J. Wilkins
Staff Director
Subcommittee on Health
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Wilkins:

For your hearing record today on Medicare Coverage of Prescription Drugs, I have enclosed the list and discussion of studies on restrictive drug formularies Mr. Robert F. Allnutt referred to on page 11 of his testimony.

As Mr. Allnutt said in his testimony, the studies indicate that restrictive formularies are counter-productive as cost-containment controls. Restrictive formularies produce higher program costs by increasing expenditures in other areas such as hospitalization and surgery.

Please let me know if we can be of any other help on this matter.

Sincerely,

James W. Singer

Enclosure

1100 Fifteenth Street NW, Washington, DC 20005 • Tel: 202-835-3483 • TWX: 7108229494-PMAWSH

Statement

Pharmaceutical Manufacturers Association

MEDICAID COST CONTAINMENT

Introduction

Medicaid is a joint federal-state program designed to provide health care to the poor. It has become one of the largest, most complex programs administered by the states, and now provides health care to approximately 22 million people. Total funding for Medicaid has increased dramatically over the last fifteen years -- from $2.2 billion in 1970 to $39.5 billion in 1985.

For individual states, Medicaid has for some time represented one of the largest state programs in terms of appropriations. Confronted by Federal budget constraints plus public opposition to increased state taxes, most states have undertaken major cost containment initiatives during the past few years. In many cases, the target of these state initiatives has been the Medicaid pharmacy program, which provides prescription drugs for Medicaid recipients.

The PMA fully understands the limited resources available to states but believes that proposals that reduce pharmaceutical benefits under Medicaid are particularly ill-advised, given the small percentage that pharmaceuticals represent of overall expenditures as well as the vital cost containment role played by appropriate drug therapy. During fiscal year 1985, for example, only six cents of every national Medicaid dollar was spent on prescription drugs. Moreover, this figure has remained fairly constant over the past several years, and actually represents a decline from about 8 cents in 1970.

Problems With Restricting Drug Availability

In an attempt to reduce drug expenditures, state Medicaid programs have frequently proposed the exclusion of certain categories of drugs from reimbursement, or the establishment of a restrictive formulary listing only those medications covered under Medicaid. PMA maintains, however, that these approaches do not constitute effective mechanisms for controlling costs and could adversely affect patient care.

If patients are unable to obtain the drug therapy prescribed by their physicians because of such restrictions, the result can be unnecessary hospitalization or repeated visits to the physician due to a worsening of their health condition. Because of the

tremendous cost differential between the price of an average prescription and the cost of one day in a hospital, it takes a relatively small percentage of such cases to more than negate any savings in the drug program expected through formulary restrictions. Therefore, the economic consequences of formulary restrictions can be increased expenditures for hospitalization and additional physician visits to deal with medical problems that might have been avoided if physicians had access to their preferred drug therapy.

The June 1980 edition of Forum published by the Health Care Financing Administration succinctly stated the problem:

> ... cutting back of optional services, such as prescription drugs, can affect the quality of care. If a patient cannot afford prescribed medication, the full treatment cannot be carried out. Ailments that can be treated easily in an early state may be much more difficult and costly to cure later ...1/

The critical role of prescription drugs in maintaining a high-quality health care system has been widely recognized by state government officials. For example, the National Black Caucus of State Legislators, a group especially sensitive to the needs of the disadvantaged, included the following statement in its 1982 resolution on Medicaid Cost Containment:

- o Preventive types of health care services should be encouraged and adequately funded. A realistic approach to cost containment is based on an understanding of the interdependence in the health care system and an appreciation for the effect some services can have on reducing expenditures for other services. Therefore, moderate expenditure increases in certain areas may yield significant decreases in outlays for expensive services such as hospitalization, as well as obviate the need for significant reductions in necessary services.

  - Prescription drugs serve as a cost-effective first-line therapy for physicians which, if severely restricted, can lead to a deterioration in patients' health condition and the need for higher-cost treatment modalities. Given the need to contain state expenditures for Medicaid, states can ill-afford to make significant cuts in the prescription drug program, which acts as an impediment to the utilization of high-cost services.2/

Numerous studies have documented the negative consequences of restrictive formularies as a Medicaid cost containment device. These analyses indicate that restrictive formularies are not effective in controlling costs, lead to higher expenditures in

non-pharmacy program areas, and may deny patients appropriate medical treatment. Findings from a number of studies conducted to date on restrictive formularies are noted below.

- A 1982 study of the California restrictive formulary and prior authorization system utilized intensive surveys with physicians and on-site audits of hospital admissions to assess the fiscal impact of the drug restrictions on non-pharmacy services. The physician survey yielded specific information on cases where individuals required unnecessary hospitalization, additional physician visits and multiple prescriptions due to the restrictive formulary/prior authorization system. The authors concluded that "total annual costs to Medi-Cal associated with utilization of additional, unnecessary services, as described by program providers, were projected to be $78.5 million."3/

- In 1976 Louisiana eliminated a substantial number of drugs from coverage under its Medicaid program. A study of the implementation of this restrictive formulary indicated that although drug expenditures decreased by $4.1 million, total program expenditures rose by $15.1 million, representing a large increase in total expenditures. After examining the relationship between changes in disease diagnoses and the uses of the removed drugs, the author suggested that the restrictive drug formulary had an adverse impact on the health status of the Medicaid population and had increased the costs for non-prescription services.4/

- A comparison of Louisiana's experience with that of the Texas Medicaid drug program (an "open formulary" system) during the same period indicated that the large increases in the utilization of non-pharmacy services found in Louisiana were not reflective of widespread trends. The Texas-Louisiana comparison provided further validation of the original study's finding that savings achieved through restrictions on drugs were outweighed by increases in the use and costs of more expensive alternative services.5/

- A comparative analysis of states with open or closed (restrictive) formularies conducted by Dr. Robert Hammel of the University of Wisconsin indicated that closed formulary states spent more on a per capita basis for total medical care expenditures than did states without restrictive formularies.6/

The overall conclusion that can be derived from the above studies is that restrictive formularies are not effective in reducing Medicaid costs and tend to produce greater utilization of (and increased expenditures for) more costly services. Though the methodologies and formularies under scrutiny in these studies differ, the critical point is that despite these differences, the analyses have resulted in the same general conclusion.

These findings are not surprising, given the existing literature on specific drugs that documents their individual cost-effectiveness. Results from a few of these studies are noted below:

- Use of a beta blocker drug to prevent second heart attacks could save an estimated $4,000 to $7,500 per patient a year.7/
- Net annual benefits of using a beta blocker were estimated to range from $746 million to $1 billion in treating glaucoma -- and to be as high as $237 million in treating angina.8/
- In a study conducted on the cost effectiveness of a drug used in the treatment of ulcers, it was demonstrated that Medicaid expenditures for all forms of health care were 25 percent lower for those patients who received this drug during an ulcer episode. Hospitalization and physician expenditures for duodenal ulcers were 64 percent lower for patients treated with this drug, and they were hospitalized 20 percent fewer days for all types of health problems.9/
- Another analysis, which looked at one state Medicaid program which deleted this drug from its restrictive formulary, yielded evidence that this action might produce for the long term a much higher incidence of expensive care.10/
- In the treatment of mental illness, one study demonstrated that drug therapy was lower in cost than other forms of treatment by 26.1 percent to 62 percent.11/

Besides the cost implications of restrictions on drug availability, there are of course profound social consequences. In California, physicians have cited the negative effects of Medi-Cal's restrictive formulary on the quality of care both in legislative hearings and in response to a random survey.12/ Moreover, a 1984 study of the impact of terminating all Medicaid services -- conducted by the UCLA Center for the Health Sciences -

- documented a number of instances where severe health problems resulted from individuals not receiving needed medications due to the elimination of their Medicaid drug benefits.13/

Limitations of Prior Approval Mechanisms

Sometimes the argument is made that the pitfalls of a restrictive or closed formulary can be remedied by a prior approval system, which allows reimbursement for non-formulary drugs if the physician first gets approval from some state official. However, there are two major problems with this approach.

First, the administrative costs of a prior approval system are significant. In California, the cost of their Medicaid prior approval system for drugs was estimated to be $904,385 in 1982 -- equalling a processing cost of $8.21 per drug request. The California Budget Office in 1982 reported that 20 staff persons were responsible for processing drug prior approval requests.14/ These high costs were noted by a California judge in a lawsuit involving the state's Medicaid prior approval process. In one 18-day period, a regional office for prior approval spent $61,620 in administrative costs to turn down 1,999 requests for exceptions to the drug formulary restrictions -- causing the judge to comment that buying the drugs would have been cheaper.15/

Second, although they are proposed as a safety valve to compensate for the admitted weaknesses of a restrictive formulary, prior approval systems can easily become a major barrier to the timely delivery of appropriate drug therapy. In seeking prior approval to use a specific medication, physicians (1) may experience difficulties in making contact with persons responsible for prior approval; (2) may be faced with inordinate delays in obtaining approval; or (3) may in fact have their preferred treatment rejected by a state official who has limited information on the medical history of the patient. As a result, physicians may be discouraged from using the system and patients may not receive needed medications.

The overall adverse impact of such a system on quality of care and on health care costs was illustrated in a lawsuit filed in California in 1983. The Medi-Cal program refused to provide reimbursement for a medication costing $4.20 for a patient suffering from a congenital heart condition. The patient went without the medication, developed medical complications, and subsequently sought assistance in a hospital emergency room -- an episode which the patient claimed ultimately cost the state $684.16/ In sum, there are significant problems with Medicaid prior authorization systems which reduce their ability to resolve the pitfalls of restrictive formularies.

More Prudent Alternatives

States should exhaust the ways in which services can be delivered effectively and more efficiently before adopting policies that in the long run may increase costs, such as excluding drugs from reimbursement. Among the various other cost containment options available to the states include: (1) programs to minimize patient and provider abuse, (2) drug utilization review, (3) cost-sharing for prescription drugs and other services to promote proper utilization, and (4) requiring more economical prescription sizes for certain medications. The first two options are briefly reviewed below.

Misuse of Medical Services. Unnecessary utilization of medical services has been a serious and costly problem within Medicaid. Utilization controls are or should be an important element of any management approach to Medicaid cost containment.

The Texas Medicaid drug program, for example, utilizes a claim screening procedure both before and after a Medicaid payment has been made. There are over 20 pre-payment screens, and numerous post-payment screens. Through the use of these screens, computer programs can generate profiles for providers and recipients who have been identified as possible program abusers. Then a team of field auditors do the required fiscal accountability checks to determine if in fact program abuse has occurred.

Although fraud and abuse efforts traditionally have been directed at provider groups, several states have launched programs designed to identify and correct abuses by beneficiaries through recipient restriction programs. These programs restrict the recipient to a single primary physician, a single pharmacy, and/or other category of provider.

The recipient restriction concept is a direct response to individual cases of chronic recipient misutilization of services, and serves both quality assurance and cost containment goals. The object is to concentrate management of the recipient's care in the hands of a single primary physician or other provider. Although the recipient can select the appropriate provider, this approach serves to improve the continuity and quality of care for the recipient as well as reduce Medicaid expenditures for unnecessary or inappropriate services.

The experience of Minnesota attests to the benefits of this type of program. The Minnesota Recipient Restriction Program improved utilization behavior without reducing the amount of services available to the restricted recipient. Average net savings per recipient ranged from about $4,400 to $5,000 over a 24-month period, a savings of $1.38 to $2.77 per dollar invested

in the program. Equally as important, participants exhibited average reductions of 35 to 47 percent in rates of service utilization during restriction and exhibited significant continued reductions of both utilization and expenditures after the restriction was lifted.17/

Drug Utilization Review. Drug utilization review (DUR) seeks to improve drug therapy and to reduce Medicaid program expenditures through detection and correction of actual or potential drug therapy problems. Specific objectives of DUR programs are to prevent underutilization or overutilization of medications, to prevent drug induced effects and adverse reactions, and to prevent undesirable effects resulting from the combined use of two or more medications. These problems can result, for example, from the patient's receiving multiple prescriptions from more than one physician or not following the recommended drug regimen. DUR programs are designed to capture information about high-risk patients through the use of computer technology, and to inform the primary physician about the problems identified so that adjustments in drug therapy can be made.

Besides improving health care, effective DUR programs can reduce Medicaid expenditures by preventing unnecessary hospitalization caused by inappropriate drug use. Obviously, savings can also be achieved in other service areas by improving health care through better use of medications.

Several states have implemented DUR programs. In Virginia, an analysis of a DUR program implemented in 1985 indicated that 286 cases of hospitalization may have been avoided due to the program -- resulting in an estimated savings of $409,000.18/ Understandably, the analysis pointed out the obvious difficulty of isolating the specific effect of DUR from other intervening variables.

In Florida, the Inspector General of the Department of Health and Rehabilitative Services concluded that its DUR program had "potential as a cost and quality control mechanism," although the project did not produce major savings during its first year of operation.19/ In short, drug utilization review shows considerable promise as a cost savings program that does not require a cutback in needed services.

Conclusion

In summary, numerous studies and state experiences indicate that prescription drugs play a cost-effective role in state Medicaid programs. They also suggest that efforts aimed at restricting the availability of drugs may well result in significantly increased costs for more expensive services, such as

physician visits and hospitalization, and thus in greater total costs for the overall Medicaid program. There are better cost containment alternatives that state and federal policy makers should explore in order to contain costs in the Medicaid program.

PMA State Government Affairs
August, 1986

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STATEMENT OF JOHN M. RECTOR, GENERAL COUNSEL AND VICE PRESIDENT OF GOVERNMENTAL AFFAIRS, NATIONAL ASSOCIATION OF RETAIL DRUGGISTS, WASHINGTON, DC

Mr. RECTOR. I am pleased to have the opportunity this morning to address drug coverage proposals for the Medicare Program. I have had the opportunity to hear most of the testimony today, so I will try, after having submitted my statement for the record, to respond in part to some observations and to highlight those submitted as a statement.

Principally, the independent druggists, the pharmacists who operate in excess of 39,000 pharmacies around the country, are satisfied with the provisions of the Energy and Commerce Committee bill, especially as it relates to the reimbursement components.

Just moments ago there was mentioned by the representative from Blue Cross/Blue Shield that they thought that perhaps the reimbursement, the Administrative allowance in the Energy and Commerce bill, was a little too generous. In fact, they suggested a $4 fee. I have no idea what the predicate is for that recommendation.

I will draw your attention to a chart that we have on page seven in our statement. It shows the very difficult experience that the pharmacists in the Medicaid program—whether it be in Texas, Maine, or Minnesota, or the other States—have had with trying to get the type of reimbursement that then Secretary Weinberger pledged to the pharmacy community when the current guidelines for Medicaid were established. So, one of our principal concerns is that, whatever you do, it be done in the statute, as is the case in the Energy and Commerce Committee bill, so as to eliminate the total discretion that the agency—in this case, HCFA, and before that SRS, and so forth—has had, the total discretion. Once they have to meet with the companies from the PMA and the EDS's of the world that administer the program in the States; our people, as the chart reveals, under the politics of dispensing a fee that is not statutory, have gotten the short end of the stick.

As your concern also relates to the others who are participating in the drug distribution system and the management of it, if outpatient during coverage were established under the Medicare program, we strongly encourage the committee to consider cost controls for those other components.

For example, those that will administer whatever program you eventually enact. To date there has been no discussion that we are aware of in either body—particular in the House with their extensive hearings in Ways and Means and in Energy and Commerce—as to cost controls for the Blue Cross and the Blue Shield, or for the EDS's. After all, EDS is a subsidiary of General Motors. They are guaranteed in managing the State Medicaid programs—in Arkansas, for example, and I know Senator Pryor is familiar with this—a guaranteed 12 percent net profit to manage the Medicaid program. Our people operate in the free marketplace with a 2.8 net profit. Under Medicaid, more than half of them are currently losing money on every prescription that they fill.

So, we think cost controls are in order for that component of the program that you are considering.

Certainly, we draw your attention to the special multitier pricing that is available in our marketplace to some entities that could become competitors of retail pharmacies under the types of programs that you are considering.

For example, hospitals generally but nonprofit hospitals in particular have the benefit of, for every $10 we pay for a drug, they pay a dollar, and sometimes in some cases we pay $100 and they pay a dollar. There are some unique aspects of the marketing of pharmaceuticals that we are concerned about, particularly if nonprofits are allowed to participate in the program.

Those are some of the primary concerns that we have. And certainly we cannot control the prices that the manufacturers make available to us. We don't have any particular notions in that regard. We know, under all the versions, that Congress is intent in setting our prices. We certainly hope that you look carefully at each of these other components that to date have not gotten a great deal of attention.

There were several points raised earlier. There is a publication available—I have a copy here which we could make available to each member of the committee—that summarizes and reviews each of the State programs, the elderly type program that Maine pioneered in 1977 and the Medicaid programs, that is published by the National Pharmaceutical Council and by our organization. I think that would prove to be a very useful tool.

There were a series of other questions that were raised. I know Senator Durenberber raised the question about the markup for the generics. We can provide that for the record. I know our general markup in a retail pharmacy is 32 percent. The source of that is the Lilly Digest, which is the principal index for such figures. It is astoundingly low for those of you who are familiar with small businesses, but that is a fact of our economic circumstances.

I think one last point is that certainly 80 percent of the generics that are in the marketplace, as I recall, are made available by the branded "nongeneric" companies.

Senator MITCHELL. Thank you very much, Mr. Rector.

[Mr. Rector's prepared statement follows:]

STATEMENT OF JOHN M. RECTOR

BEFORE THE SENATE FINANCE COMMITTEE

SUBCOMMITTEE ON HEALTH

JUNE 18, 1987

Mr. Chairman, Members of the Subcommittee*:

I am John M. Rector. I serve as General Counsel and Vice President of Government Affairs of the National Association of Retail Druggists.

The National Association of Retail Druggists represents the owners of 30,000 independent pharmacies, where more than 75,000 pharmacists dispense 70 percent of the nation's prescription drugs. Together, they serve 18 million persons daily and provide 82 percent of Medicaid pharmaceutical services. Over 60 percent of NARD's members provide home health care pharmacy services. NARD has long been acknowledged as the sole advocate for the proprietary and professional interests of this vital component of the free enterprise system.

NARD members are primarily family businesses. They have roots in America's communities. The neighborhood independent druggist typifies the reliability, stability, yet adventuresomeness that has made our country great.

As owners, managers and employees of independent pharmacies, our members are committed to legislative and regulatory initiatives designed to provide them a fair chance to compete. We appreciate the opportunity to appear before the Subcommittee to present recommendations to be considered in the fashioning of Medicare Part B outpatient drug coverage.

We believe that a major strength of the health care system is the thousands of independent community pharmacies readily accessible to virtually every segment of the population. Any revisions in the Medicare program should capitalize on the strengths of the existing retail distribution network for drugs, and related products and services.

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* George Mitchell (D-ME), Chairman
MAJORITY: (7-D) Senators Mitchell, Lloyd Bentsen (TX), Max Baucus (MT), Bill Bradley (NJ), David Pryor (AR), Donald W. Riegle, Jr. (MI), and John D. Rockefeller IV (WV)
MINORITY: (5-R) Senators David Durenberger (MN), Bob Packwood (OR), Robert Dole (KS), John H. Chafee (RI), and John Heinz (PA)

Competition in retail pharmacies is alive and well. Competition is an incentive for efficiency and the price competition in retail pharmacy is typically greater than can be found among other providers of health services and products.

We approach the subject of today's hearing with considered reluctance. Not because we oppose the concept, in fact we support it. Our statement of positions addresses it as follows:

> "NARD supports the position that any national health insurance program adopted by the Congress include outpatient medications as an integral part of its benefits. Patients participating in these programs also must be ensured that they will have the right to select the pharmacist and pharmacy of their choice to obtain their prescription drugs. Pharmacies providing prescription medications should be compensated on the basis of the marketplace price for such products and services. Independent retail pharmacists should be assured a key role in the planning and development of any such drug program."

The source of our caution is predicated on the less than favorable experience that our members have had from the outset with the non-statutory Medicaid prescription drug program, and in recent years with the home health components of the Medicare program. We are concerned that a Medicare outpatient drug benefit program not replicate unsatisfactory aspects of the current Medicaid prescription drug program. Likewise, with more than 60% of our members involved with Medicare home health, it is critical that an outpatient drug coverage benefit be designed in a manner that will avoid the scandalous failure of Medicare to pay its participating providers in a timely, business-like manner, and avoid the constant barrage of arbitrary and inconsistent regulations dictated by HCFA.

More sophisticated aspects of program design become secondary, or even irrelevant, if when operational, appropriate resources are unavailable or if, as has been the policy of the current Administration, the government refuses to pay its bills promptly. Additionally, program continuity and stability is vitally important.

Fortunately, these especially severe Medicare cash flow problems, caused by the failure of HCFA and its agents to make timely payments, were addressed in the Omnibus Budget Reconciliation Act (OBRA) of 1986 by requiring that claims submitted for Medicare Part B Services be paid within 30 calendar days in FY 1987, 26 days in 1988, 25 days in 1989, and 24 days in FY 1990 and in subsequent years. We strongly support the Subcommittee's initiatives on prompt payment, and as a member of the Prompt Payment Coalition, urge you to oppose all efforts to repeal the 1986 amendments.

This past October our House of Delegates unanimously passed a resolution calling for the establishment by law of the Medicaid prescription drug program reforms it has been advocating for more than a decade. Its full text is as follows:

WHEREAS, Congress never intended that the normal business practices of retail pharmacy such as earned discounts or marketplace pricing be placed in jeopardy, such as under MAC, EAC, PhIP and CIP, when a pharmacist serves patients in the Medicaid program; and

WHEREAS, the concept of a government discount, whether in the form of a discount off ingredient cost or a total charge, is totally unacceptable:

BE IT RESOLVED that NARD continue to oppose the concepts of a discount and instead, together with a coalition of pharmacy practitioners wholesalers, manufacturers and physicians, support the establishment by law of (1) marketplace pricing at the 90th percentile, and (2) a direct payment voucher system to reduce Medicaid administrative costs and assure prompt payment.

The two core themes of suggested reform: marketplace pricing and a direct payment system to reduce administrative costs and help assure that prompt payments are universally supported within the industry. In fact, National Association of Chain Drug Stores, Pharmaceutical Manufacturers Association, American Society of Hospital Pharmacists, American Pharmaceutical Association, National Wholesale Druggists Association, American Society for Consultant Pharmacists, and NARD all endorsed a document, "Principles for Reform of Medicaid Payment for Outpatient Drugs" in correspondence to HCFA's Administrator Roper on May 26, 1986. The principles, in our view, are equally applicable to the subject of today's hearing. Unfortunately, the Administration has not embraced them. We have provided the subcommittee with extensive information on these core ideas, including the NARD\Pracon study Marketplace Economics -- Alternatives in Medicaid Prescription Reimbursement (Oct. 1986). The full text of the "principles" follows:

PRINCIPLES FOR FEDERAL REFORM OF

PAYMENT FOR OUTPATIENT DRUGS

Following the implementation of the Medicaid program in 1965, pharmacists, more than other provider groups, enthusiastically supported and participated in this important health care program for the needy. Ten years later, in 1975, the Federal government adopted the Maximum Allowable Cost/Estimated Acquisition Cost program. This controversial approach established a complex set of formulas that imposed artificial controls on the retail marketplace and interfered with professional judgments regarding the selection of prescription drug products provided to the poor. In more recent years, the Medicaid program has been moving toward a reimbursement scheme that would further reduce reimbursement to pharmacies.

The Federal government seems content to capture limited, short-run savings at the expense of retail pharmacy providers and the research-intensive pharmaceutical manufacturing industry, while ignoring significant opportunities for reducing health care costs by allowing the competitive marketplace to function efficiently and effectively. In response, many prominent national organizations representing all components of the nation's drug distribution system--pharmaceutical manufacturers, drug wholesalers, independent pharmacies, chain drug stores, hospitals and the pharmacy profession--have been advocating a complete overhaul of the Medicaid drug reimbursement system. These organizations are calling for less government intrusion, so that the nation's pharmacies can continue to provide the highest standard of care and service to needy people.

FUNDAMENTAL PRINCIPLES

Reduce needless federal regulation. American society experienced a virtual explosion in Federal Government regulation during the past decade. Between 1970 and 1979 the number of pages published annually in the Federal Register nearly tripled and the number of pages in the Code of Federal Regulations increased by over two-thirds. The current Medicaid drug program was part of this growth.

Although well-intended when originally developed, the Medicaid drug program has failed to keep pace with rapid changes in health care delivery over the past ten years. This has resulted in pharmacy providers subsidizing the Medicaid program because they frequently lose money when they fill a Medicaid prescription. Moreover, the hardship and uncertainty imposed on business by this over-regulation has impeded business decisions and expansion plans, ultimately reducing economic growth and the creation of jobs in the private sector. This over-regulation is particularly burdensome to small and independent businessmen and women, such as pharmacists who are proprietors of community pharmacies, and causes them to defer or terminate plans for expansion.

Our position on Medicaid drug reimbursement is directed at minimizing governmental intrusion by reforming or eliminating regulations which are unnecessary and counterproductive.

Improve administrative practices. Approximately 171 million claims are processed each year by the Medicaid program. Wasteful administrative overhead consumes resources that should be targeted on the health needs of beneficiaries. Furthermore, current inefficient administrative practices impose needless hardship on retail pharmacies due to slow and erratic payment and excessive paperwork. Initiatives to improve administrative practices can reduce both public and private costs to process Medicaid claims, and insure timely payment to pharmacies.

Rely on the marketplace. We do not need excessive Federal regulation to solve the problems of Medicaid drug costs. As long as we let the forces of the marketplace work without undue interference, the ingenuity of consumers, businesses, producers and inventors will do that for us. The retail drug market is dominated by self-pay customers who, along with increasingly cost-conscious third party payers, impose competitive discipline on marketplace prices. If we allow it to, the magic of the marketplace will unleash new competition, giving the Medicaid program lower prices, and Medicaid beneficiaries more choices and better services.

To achieve meaningful reform, public policies governing the Medicaid drug program should be revised along the following lines:

- *Base drug reimbursement on sound economic principles through the elimination of artificial controls. This would be achieved by replacing the current provisions governing reimbursement with marketplace pricing, i.e., usual and customary charges for all products and services, capped, for example, at the 90th percentile for all charges within a state.*

- *Implement a new and streamlined reimbursement mechanism that would greatly lower administrative expenses in the program. Such a worthwhile objective can be easily accomplished by coupling marketplace pricing with an innovative system of drug vouchers.*

States shall build upon this basic set of principles established by the Federal Government, tailoring their individual programs to fit local circumstances.

ADDITIONAL RECOMMENDATIONS

Additionally, we recommend that the subcommittee seriously consider the following:

a) The reinstatement of the 60 day or longer public notice for changes in the Medicare reimbursement method or level of reimbursement for the prescription drug program;

b) Interest and penalties for late payments;

c) An administrative fee for the extra cost of processing or transferring Medicare forms;

d) Inclusion of both short and long term I.V. antibiotic products and services;

e) Require and reimburse for pharmacist consultation. Face to face communication between patient and pharmacist has been a vital component of pharmacy practice since its inception. Pharmacists interact daily with patients in their stores; they monitor their patients' health status, assess their compliance with drug therapy, answer questions, make recommendations, and communicate with their physicians. Patients know they can count on the pharmacists to provide expert advice on drug therapy on the spot and personally attend to their individualized health care needs. This interpersonal communication is an especially key element for Medicare eligible persons.

f) Reject suggestions to confiscate the discounts that pharmacists earn. Discounts extended to pharmacists on drug purchases from manufacturers or wholesalers as rewards for prompt payment, prudent purchasing, and other sound business practices are an earned portion of the pharmacist's business income. Such discounts are earned by pharmacists for operating their businesses efficiently. They serve as incentives to help a business to prosper and to continue to serve patients in the community.

g) If copayment is established, require that it be mandatory. More than 60% of our members' sales are for prescription drugs, 10-15% of our members sell only prescription drugs. They rarely "loss lead" prescription drugs and would be placed at a decided competitive disadvantage if the copay is not mandatory. Equally problematic are the copay forgiveness aspects of the Medicaid program for select beneficiary groups.

h) To address the problem of tax-exempt competitors, consider adopting provisions similar to OMB Circular A76 for bidding on federal contracts which, to assure a level playing field, requires the advantages of nonprofit status to be reflected. This should be reflected in reduced payment to any eligible nonprofits.

i) Require that manufacturers eliminate multitier pricing policies for prescription drugs, or in the alternative, permit independent retail druggists to acquire for Medicare purposes the drug products under the same pricing structure available to non-profit entities.

j) Review the present reimbursement for prescription drugs under Medicare Part A with an eye to determining present cost to the government in contrast to cost in the prescription drug retail marketplace.

k) Consider, as the Energy and Commerce Committee has recommended in its Oversight Subcommittee Report "Dangerous Medicine"(May 1986), denying Medicaid and Medicare funds to hospitals and other health care institutions convicted of diverting prescription drugs.

l) Consider a provision to assure that nonprofit purchasers of prescription drugs utilized in the Medicare programs comply with the 1938 Nonprofit Institutions Act. This Act permits price discrimination for purchases by true charities. We recommend that an appropriate standard would be the percent of uncompensated care provided by the nonprofit entity coupled with bad debt.

m) Include a provision that would limit physician dispensing to rare rural remote circumstances when it can be demonstrated that a pharmacy is not available. Prescription drug samples which were retained under the provisions of H.R. 1207, (which passed the House of Representatives on May 4, 1987, after having been unanimously reported by the Energy and Commerce Committee, which with S. 368, was the subject of a hearing on 6-15-87 of this Committee's Trade Subcommittee) are available for any true emergency when a 24-hour pharmacy emergency number, which is common, is not available.

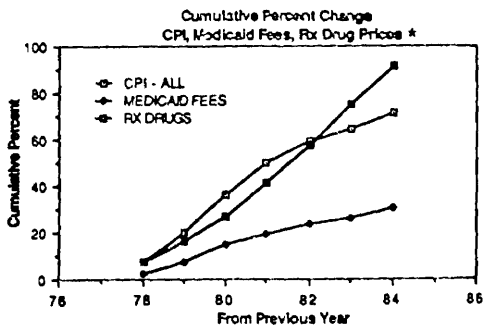
n) Consider the profit guaranteed to entities that are awarded contracts to administer state Medicaid prescription drug programs and Medicare fiscal intermediaries when attempting to establish an appropriate level for pharmacy providers.

o) Consider the prescription drug benefit program that Marion Laboratories, Inc., Kansas City, Missouri, has established for its employees. It is based on marketplace pricing and rejects the cumbersome arbitrarily fixed dispensing fee. It reflects the variety of professional services, and importantly, it has helped contain the cost of the prescription drug benefit coverage that Marion established for its employees.

INITIAL COMMENTS ON MEDICARE CATASTROPHIC PRESCRIPTION DRUG LEGISLATION OF 1987

We have attempted to assess the draft legislation as expeditiously as possible. We do expect to file more detailed comments with the subcommittee and its staff. We support the subcommittee's effort to provide appropriate Medicare outpatient prescription drug coverage and would characterize this legislation, as we have that developed by the Chairman of the Health Subcommittee of Energy and Commerce, namely, a giant step forward.

We cannot stress too much, however, our very real concerns that the shortfalls and disasters for pharmacy providers, especially under the non-statutory laissezfaire Medicaid program, not taint the excellent opportunity which the subcommittee has to address the drug needs of the elderly. The following chart effectively demonstrates one of the major problems our members have experienced under the Medicaid Prescription Drug Program.



In 1977 the average unweighted dispensing fee for all states was $2.46. This fee had increased to $3.21 in 1984, representing an increase of only 30.4 percent for the eight year period. During this same period, the Consumer Price Index for all items had increased 71.2 percent, and the cost of prescription drugs to the consumer increased 91.2 percent.

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* *"Pricing of Pharmaceuticals: An Independent Community Pharmacy Perspective" by D.C. Huffman, Jr., Ph.D., et al. Presented to the Second Annual Conference on Pharmacy Policy Issues at the Hubert Humphrey Institute, University of Minnesota, 1987.*

We have three general observations which are made in a constructive vein, each of which relate to the need for fundamental fairness in whatever program is designed. Although we prefer a marketplace pricing standard, if the subcommittee is intent upon setting our prices, you must address the prices of others participating in the program over which the pharmacist has no control.

1) We have no control over manufacturers' prices. One approach under the Waxman bill, for example, would be to require manufacturers to submit prices to the Secretary twice a year in conjunction with the "calculation period", e.g. October 1/April 1. They would guarantee such prices for that period, just as is the case presently for Medicare inpatient prescription drugs. We should not continually take a bad rap from the public, especially the needy and elderly, for the price of prescription drugs over which we have no control.

2) Hospital reimbursement for inpatient prescription drugs under Medicare similarly should be on the same terms as Medicare outpatient drugs. If cost-plus based reimbursement is rejected for outpatients, it should be rejected for inpatients and comparable cost-control mandated for both hospital settings, for example, an average wholesale hospital cost (AWHP) could be developed by the Secretary.

3) Likewise, those entities which would administer the Medicare outpatient drug program should be subjected to comparable cost controls. Such criteria should be specified in the determination of the actuarial rate.

Among our specific comments on various recent legislative proposals are the following:

1) We support the 20% co-insurance cost-sharing provision with perhaps a flat fee on single source drugs.

2) Regarding a $4.50 administrative allowance for the pharmacists, we recommend the automatic annual application of an index.

3) A national formulary could prove to be complex and costly to operate. In any case, the details of the formulary should be, to the extent possible, expressed in the statute and/or the committee's accompanying reports. Additionally, it's important in our view, that the Secretary be required to consult with individuals of recognized professional standing and distinction in the fields of medicine, pharmacology and pharmacy. In fact, if a national formulary is established, it is essential in our view that a statutory formulary committee be set up that would establish the appropriate involvement of such individuals.

4) We support provisions which would encourage electronic billing and other cost-effective direct payment mechanisms, i.e., voucher and smart cards. If such systems are mandated, we suggest flexibility for rural areas. Perhaps the definition of rural recently developed in conjunction with the authorization increasing the speed limit to 65 m.p.h. would be appropriate.

5) We recommend that Medicare payment be limited to a 34-day supply or 100 dosage units, whichever is greater. Recent studies, including that by the Pharmaceutical Data Services, documented the phenomenon known in the trade as "wastage" -- the percentage of prescription drugs filled but not used when more than this supply is authorized. The International Ladies Garment Workers Union is typical of the plans which permit its members to buy only a 30-day supply because of wastage.

It's important to emphasize that the national Pharmacy Services Administrative Organization (PSAO) movement and other developments have brought independent pharmacies to the point that the recordkeeping required in the various proposals to monitor expenditures by Medicare beneficiaries is readily achievable.

CONCLUSION

NARD seeks the support of the subcommittee for our recommendations and will assist its members and staff in the refinement of your proposals.

On behalf of the Officers, Executive Committee, and members of the National Association of Retail Druggists, we thank you for the opportunity to appear and continue to participate in the formulation of Medicare Part B outpatient prescription drug coverage.

Senator MITCHELL. I have several questions, most of which I will submit in writing, but I just want to ask a couple of them orally.

Just a small point, Mr. Rector: In your written statement you say, "The concept of a Government discount is totally unacceptable." It is my understanding that the Veterans Administration and the Department of Defense now receive discounts. Are you opposed to their continuance, or are you just talking about anything new?

Mr. RECTOR. We are not talking about a discount based on volume or the normal discounts that are available in the marketplace. What that refers to is the recent effort—which, fortunately, last summer was rejected by the administration—the recent effort in 1985 and 1986 to radically reduce the product component reimbursement for pharmacists under the Medicaid Program.

Basically, in our relationship with our wholesalers, if we pay on time or if we pay faster—if we are on line electronically, and so forth—we acquire discounts. Some at the Health Care Financing Administration who were trying to make up some shortfall undertook an effort to confiscate those discounts, to reduce our reimbursement by that percentage for the product. And that is what we oppose. Fortunately, those concepts have been rejected in the House, and even the administration has rejected that. I think Blue Cross has mentioned it occasionally.

Senator MITCHELL. Mr. Allnutt, other witnesses have testified that in the past 5 years prescription drug prices have risen much faster than the Consumer Price Index for all items. How do you account for that, and do you expect that to continue in the future?

Mr. ALLNUTT. My prepared statement, Mr. Chairman, deals very briefly with some of the factors that are involved there. Over the years since the CPI was set at 100 back in 1967, drug prices have remained well below the CPI and still are today, if you look over that long period. It is true that they have been rising more rapidly than the CPI in the last few years.

A basic component of that increase is the increased costs in research and development. There is also a table in my statement that relates to that. But basically, the investment in R&D by the industry has been doubling every 5 years since 1970. It will be around $5 billion this year, roughly the same amount that all of NIH spends in all medical research. So we are talking about a very large investment in research which does need to be recouped and paid for in drug prices.

The profit levels of the industry have not changed significantly in recent years. They are up some years and down others, but it is not simply that profits are going up rapidly by prices rising; that is not the case.

Senator MITCHELL. More importantly, for our benefit, are you able to estimate whether the trend will continue into the near future?

Mr. ALLNUTT. I really can't. Perhaps you could find others who could do that. As a trade association, we stay necessarily under law as far as we can away from individual pricing decisions of our companies. So those are individual decisions, and they are driven by a lot of factors in each company's business and product by product, so we don't make projections of prices for good reason.

Senator MITCHELL. Could each of you briefly tell me what you think the advantages and disadvantages are with the use of a formulary?

Mr. ALLNUTT. I would be happy to go first; I believe that we are both opposed to a national formulary. A clear advantage and I guess the only advantage of one is, if you have a formulary, you leave certain prescription drugs approved by the FDA off, and therefore you don't have to pay for them if someone uses them. That is the reason for having one.

The disadvantage to that, I think, should be added. And let me just give you a couple of real examples: California under Medicaid has a formulary. Tagamet, the breakthrough antiulcer drug that has in effect done away with ulcer surgery, took 26 months to get on that formulary. So for 26 months, California didn't have to reimburse the drug, but surgery continued.

If you have such a system, you have to have a way of making exceptions. And again, California has such a system. You dial a number to ask for an exception if the doctor wants to prescribe something that is not on the formulary. That is a very expensive thing to do. You have people sitting around answering phones all day, which I assume would be here in Washington somewhere, making decisions on what drugs are available all over the country. That is a very expensive thing to do.

Senator MITCHELL. Briefly, Mr. Rector, because my time is limited.

Mr. RECTOR. We haven't fully assessed either of those questions. I think if you look to the 1971-1972 bill that the committee reported, there was a formulary, and it set out the pros and cons. At the time when the rubber hit the road and we had to respond to that, I think we supported the Humphrey-Montoya bill.

In general, our people would prefer not to have a formulary. Also, on the other hand, we would prefer to see that all the participants in the distribution system experience some comparable degree of cost control, as I had mentioned a moment ago.

Senator MITCHELL. Thank you very much.

Senator Durenberger.

Senator DURENBERGER. Just a quick question, following up the Chairman's first set of questions of Mr. Allnutt.

The economists disagree with your version of what has happened in the last five years. Economists tell us that a lack of third-party payment for drugs in the seventies is probably largely responsible for the general level line of pricing, and that the increase in third-party payments in the eighties in various areas may be responsible, or at least partly responsible, as opposed to research and development costs for the increase in pricing. Are they off?

Mr. ALLNUTT. I won't dispute your economists, because I haven't read their papers and am not familiar with them.

The biggest single factor I believe that has changed in the industry over the last half dozen years or so is the really rapid escalation in investment in research and development. There are certainly other factors that enter into pricing decisions. Many factors enter into pricing decisions; but the largest single change in the industry has been the increased investment in research.

Senator DURENBERGER. Would you demonstrate that to us somehow or other? I don't know how important it is, but you said it doubles every so many years. Why? Why is it that since 1981 or something like that there has been this huge increase in research and development?

Mr. ALLNUTT. I think a significant factor has been the onset of increased generic competition which has been coming during the eighties and has been accelerated since 1984, when Congress passed the Patent Term Restoration and Generic Drug Approval Act, which expedited the approval of generic drugs. Generics now come into competition with drugs the day they go off patent. That means there is a great incentive to companies to be sure they have new drugs coming out of the pipeline. That is the nicest thing I can say about it, I guess, from the standpoint of research-based companies. But it does cause companies to be most anxious to have good research going on and new products coming out. So, there is a rapid acceleration of that rate of expenditure.

Senator MITCHELL. Thank you very much, Senator Durenberger.

Mr. Chairman?

The CHAIRMAN. Thank you very much, gentlemen. I will submit my questions to the record, in the interests of time and knowing you have a number of other witnesses to appear.[1]

Senator MITCHELL. Right.

Thank you, gentlemen, very much.

That concludes the hearing with respect to coverage for prescription drugs. We are going to take a 5-minute break, and then we will begin the hearing on Medicare coverage of mental health benefits, and we will go directly until completion of that hearing.

[By direction of the chairman the following communications were made a part of the hearing record:]

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[1] The chairman's questions were subsequently asked of the witnesses by Senators of the subcommittee.

LEGISLATIVE MEMORANDUM

CancerCare, Inc.
AND THE NATIONAL CANCER CARE FOUNDATION, INC.®

WERNER WEINSTOCK
Chairman, Public Affairs Committee

JAN C. CHILDRESS
Vice Chairman, Public Affairs Committee

DORIS B. NASH
Public Affairs Director

June 25, 1987

To: Honorable Lloyd Bentsen, Chairman
Committee on Finance
United States Senate

Re: Medicare Coverage for Prescription Drugs

Cancer Care, Inc. had the privilege of presenting to the Committee on Finance both written and oral testimony on March 19, 1987 on the general subject of Coverage for Catastrophic Illness. We are now pleased at this opportunity to expand on our original testimony, which is attached, to speak to the need for Medicare coverage of prescription drugs.

As a social agency assisting cancer patients and their families, we have day-to-day knowledge of and expertise with the many costs that are sparked by the occurrence of cancer. While we concentrated in our original testimony on the need for adequate coverage for home care, we now want to provide the Committee with more detailed information about the drug needs of elderly cancer patients and, more specifically, chemo and hormone therapies.

Medicare has traditionally covered out-patient radiation therapy provided by hospitals. However, coverage for out-patient chemo or hormone therapies which can be self-administered, is not provided by Medicare. It must be noted that these therapies have more and more been prescribed on an out-patient basis, even before the advent of DRG's and earlier discharges from hospitals.

Lower-income Medicare patients usually receive such treatments at hospital oncology clinics for which Medicare reimburses 80%. Whether the patient is treated privately or at a clinic, the co-payment is a great deal of money if the patient is poor and especially if the treatment protocol is a very expensive one.

Certain cancer medications can be taken orally and, as noted above, there is no Medicare reimbursement for this on an out-patient basis. One of these, Novadex, although considered to be reasonable in price in comparison to other hormones, can add up to as much as $600 a year. This might seem like a small amount to many of us, but it is a tremendously large amount to a poor person.

New York Office
1180 Avenue of the Americas
New York, N.Y 10036 • (212) 221-1300

Long Island Office
20 Crossways Park North, Suite 304
Woodbury, N.Y 11797 • (516) 364-8130

New Jersey Office
24 Lackawanna Plaza
Millburn, N.J. 07041 • (201) 379-7500

127 East Ridgewood Avenue
Ridgewood, N.J. 07450 • (201) 444-6630

Many cancer therapies involve a combination of drugs. One such chemotherapy protocol is MOPP, used to fight Hodgkins disease. This is a combination of drugs, some taken orally, others by injection, and they can cost upwards of $5,000! Another combination of drugs, used with leukemia patients, is equally as expensive.

And, we must not overlook the fact that an elderly cancer patient on chemotherapy usually must also purchase other pharmaceuticals for pain relief or symptom control. In addition, since it is an indisputable fact that the longer one lives, the more things can go wrong, elderly cancer patients frequently have other ailments such as heart problems, diabetes, arthritis, which require costly treatment and medications.

Cancer Care, Inc. provides comprehensive social services to cancer patients and their families. In addition to counseling and help with planning for the patient's care, some financial assistance is made available to needy families to help with the costs of home care or transportation to and from cancer therapies.

In considering whether or not a particular patient would be eligible for some financial assistance, the Cancer Care social worker compiles complete information about the patient's income and reserves, and his or her general maintenance costs, plus the many expenses created by the illness. The latter naturally includes the out-of-pocket costs for chemo or hormone therapies, which are usually considerable.

As a result of a special foundation grant, we are able to offer disbursements in 4 boroughs of New York City specifically for out-patient chemotherapy and radiation. During this past year our average grant to Medicare patients for these treatments was $1000. These are Medicare patients whose assets do not exceed $9,000 for a couple ($7,000 for a single person) and whose income cannot cover all of their current expenses. One thousand dollars is a monumental amount of money for most elderly cancer victims!

Cancer is not only a dreadful illness, it is also a very expensive one. As we stressed in our previous testimony, the home care needs of elderly cancer patients are frequently quite extensive. But the costs of cancer therapies also mount up tremendously, and some assistance with this is essential for the majority of elderly cancer patients.

Legislation purporting to offer catastrophic coverage under Medicare should contain coverage for the durgs so essential to the treatment of the many ailments, including cancer, to which the elderly are prone.

LEGISLATIVE MEMORANDUM

Cancer Care, Inc.
and the National Cancer Care Foundation Inc.

Werner Weinstock
Chairman, Public Affairs Committee

Jan C. Childress
Vice Chairman, Public Affairs Committee

Doris B. Nash
Public Affairs Director

March 19, 1987

To: Honorable Lloyd Bentsen, Chairman
Committee on Finance
United States Senate

Re: Coverage for Catastrophic Illness

We wish first to commend Senator Bentsen and the Committee on Finance for holding this hearing on the very important and urgent subject of coverage for catastrophic illness. It is crucial that there be public debate on the issue to help insure passage of an adequate plan for catastrophic coverage.

Cancer Care, Inc. is a voluntary social service agency which, for over 42 years, has offered comprehensive social services to cancer patients and their families. We have offices in New York City, Long Island and New Jersey and we are completely dependent upon contributions from the public and foundations. Our services include individual and group counseling, help with planning for the care of the patient, as well as some financial assistance to eligible families to help them meet the costs of home care plans and transportation to and from radiation or chemotherapy. We are also utilizing a special foundation grant in 3 boroughs of New York City to assist certain medically indigent patients with payments for cancer therapies. During our '85-'86 year, we served over 10,000 patients and disbursed more than $990,000, with most of the disbursements going to elderly patients. In the first 7 months of our current fiscal year we have assisted over 6300 patients and have disbursed nearly $640,000.

Since we deal on a daily basis with the dread and very often catastrophic illness of cancer, we are extremely knowledgeable about the many needs of these patients and the financial, practical, problems as well as the emotional problems, which confront them and their families. We feel that this expertise is translatable to other catastrophic illnesses which also frequently require a multitude of out-patient services.

New York Office
1180 Avenue of the Americas

Long Island Office
20 Crossways Park North Suite 304

24 Lackawanna Plaza

New Jersey Office

Many years ago our agency did a study of the illness-related costs experienced by many of its patients. We found then (1972) that the median cost was $19,054, while the median health insurance payment these families received were only $8,000. True, our definition of illness-related costs is a broad one. We include in our calculations all the special needs that are sparked by the patient's illness. Paramount among these are home health care, child care, housekeeping costs, transportation, and medication. While our definition may be broad, it is very realistic — the cost of illness cannot be measured just by hospital and physician charges.

A 1984 study of a sample of 404 of our patients reconfirmed the fact that so many of the patient's/families expenditures were related to out-patient costs. We were giving some financial assistance to over 1/3 of these patients and 26 percent of the patients had depleted 80 to 100 percent of their assets. Ninety of the patients reported that their monthly expenses had increased 40 to 79 percent as a result of the illness. The major reasons for these increases were special living costs due to the illness and out-patient medical costs.

For those with seemingly adequate health insurance coverage, an illness can still cause a catastrophe because of the "hidden" costs created by the illness. Thomas Hodgson, in an article on "Social and Economic Implications of Cancer in the United States" (Annals of the New York Academy of Science, Vol. 363, 1981), speaks to the need to study non-health sector direct costs, which he estimates may add another 5 to 25 percent to the total direct costs. The non-health sector direct costs he refers to are special diets and clothing, dwelling modifications, homemaker care.

Also, according to the NMCES study conducted by the National Center for Health Services Research and completed in September 1979, "A fifth of the nation's 80 million families incur catastrophic out-of-pocket medical expenses - costs that absorb an abnormally high percentage of their total income." (NCHSR Research Activities, May 1986, No. 85). Clearly the problem is very prevalent.

Our lengthy experience confirms that for the majority of cancer patients, inpatient care in a hospital is relatively minimal in comparison to the out-patient needs that are sparked by the illness. Therefore, we have long questioned the adequacy of any catastrophic coverage plan that is based merely on more comprehensive coverage for inpatient care. As a result, we have been critical of the President's and other proposals to ensure that Medicare patients will not be required to spend more than $2,000 a year for deductibles and co-insurance payments for hospital care.

For the great majority of the elderly, the cost of inpatient hospital care is the least of their worries, since most hospitalizations are short term and are covered by Medicare. While it is estimated that more than 200,000 elderly Americans each year experience hospital stays in excess of 60 days, this is indeed a very small segment of the many millions enrolled in Medicare -- 29,284,396 as of February 1986. Further, the average length of hospital stays for patients over age 65 was only 8.9 days in 1984. Clearly the overwhelming majority of Medicare patients experience only short hospital stays.

While we certainly sympathize with the plight of those Medicare patients whose hospital stays exceed 60 days, or those who may need several hospitalizations in one year, singling them out for increased benefits does not compensate sufficiently for the other inadequacies in Medicare coverage. We must be just as concerned with those who are forced to spend great sums of money — sometimes pauperizing themselves — to secure adequate and sufficient home care services.

We must also be concerned with how much Medicare patients must spend for drugs. And, can we dare overlook Medicare's very inadequate coverage for long-term care — how to pay for nursing home care justifiably worries Medicare patients a great deal.

A very prolonged hospital stay is far from being the only definition of catastrophic illness. The definition must be broadened to include those illnesses which require extensive home or institutional care. These patients also deserve to be helped to acquire these services with dignity and without fear of impoverization.

We feel compelled to take this opportunity also to point out that while there has been a swing towards amending Medicare to completely cover hospital care, the DRG reimbursement system, designed to decrease health care costs, has led to earlier discharges from hospitals. Medicare patients are being sent home earlier in their illnesses than ever before. Simultaneously there have been cutbacks in the availability and intensity of Medicare's home health services. This has been accomplished by reinterpretations of the Medicare statute and the creation of new definitions.

We have long criticized Medicare because of its paucity of coverage for out-patient needs, and its stringent eligibility requirements for home health care: the patient must require a skilled service, must not need more than part-time or intermittent care and, in most instances, the patient's condition must be acute and short term. These rules governing home health care always eliminated a very large number of elderly cancer patients who may need daily care from a home health aide for a more protracted period of time, or, who may not need a skilled service at home in the first place.

Now, because of the new rules and regulations governing Medicare's home health services, even fewer patients are receiving assistance at home. This is a situation that must be addressed quickly, and we are pleased that Representative Staggers and 13 other congressmen have joined in a suit against the Department of Health and Human Services, challenging "the attempted dismantling of the Medicare home health benefit..." via "actions which are violating plantiff's rights under the Medicare statute, the Administrative Procedure Act and The United States Constitution." We are hopeful that this suit will at least restore Medicare's home health services program.

Any plan for coverage of catastrophic illness is incomplete unless it includes sufficient coverage for the care-at-home needs of patients. We can and do appreciate the possibility that opening up and broadening the home health benefit will sharply increase Medicare's expenditures for home health care. We can also appreciate that eligibility criteria would have to be carefully worked out and that adequate case management would be essential. But we must remember that ignoring the problem doesn't necessarily mean that government gets off the hook entirely.

Elderly patients who need long term home health services frequently end up depleting their resources, actually pauperizing themselves. This is called "spending down" in the language of Medicaid, the federal-state health care program for the very poor. The patient's care is then paid for by the government, at least in those states such as New York that have spend-down programs. Other elderly folk, having caught on to the system, turn their resources over to their children so as to be eligible for Medicaid in advance of their actual need for care. Thus, in many instances, government ends up paying for out-patient care, including home care, just as it does for the nursing home care of millions who may have started out by paying for this care themselves. Shouldn't government be willing to help the elderly with their realistic home care needs in such a way as to avoid reducing them to poverty or duplicity?

In closing, we want to reiterate our belief that adequate coverage for home care must be an integral part of a plan for a catastrophic health insurance. Only then can a catastrophic plan be truly meaningful.

Statement

of the

HEALTH INSURANCE ASSOCIATION OF AMERICA

on

OUTPATIENT PRESCRIPTION DRUGS AND MENTAL HEALTH BENEFITS UNDER MEDICARE

Submitted for the

Committee on Finance

United States Senate

June 16, 1987
Washington, D. C.

The Health Insurance Association of America appreciates this opportunity to comment on proposals to add an out patient prescription drug benefit to the Medicare Program.

The HIAA is a trade association of 335 insurance companies who write approximately 85% of the private health insurance written by health insurance companies in the United States. Many HIAA member companies have considerable experience in providing prescription drug coverage to a broad spectrum of the population. Several HIAA companies also serve as Medicare carriers and intermediaries.

In this statement we would like to address some of the administrative aspects of covering catastrophic expenses for prescription drugs and mental health care under the Medicare program.

If there is a single message to impart to the committee, it is the importance of keeping the administration of any drug plan as simple as possible. No other sector of health benefits administration produces a greater volume of claims. Each prescription equals a claim and in comparison to other health care claims, each drug claim represents a small dollar amount. If the process is too complex...valuable benefit dollars will be consumed by the high costs of administration.

There are two basic methods in reimbursing out patient prescription drugs. The first is a major medical or comprehensive plan where there is a set annual dollar deductible. After this threshold is reached, there is

usually 80/20 reimbursement, i.e., the beneficiary pays 20% and the plan picks up the balance. In the second method a prescription drug plan is administered as a separate product line with a per prescription deductible. The beneficiary can obtain benefits from a network of participating pharmacies, including retail druggists and mail order companies. The pharmacists is usually reimbursed for the cost of the drug as defined by the plan, plus a professional fee after the per prescription deductible is satisfied. Most of the paper work goes through clearing houses for ease of administrative handling.

We strongly recommend that any prescription drug plan you may consider adopting follow the second approach.

The following comments were developed after reviewing specific proposals now under consideration in the House of Representatives. We trust they will be of value to members of the committee in your deliberations.

- o To promote cost conscious purchasing of prescription drugs by Medicare beneficiaries as well as to reduce the overall cost of this benefit, we urge you to consider applying an annual deductible before benefits begin as well as requiring some per prescription cost sharing, i.e., either a per prescription deductible or a percentage co-pay. We feel that such provisions are important to help hedge against over utilization of this benefit.

- To ease administration of a separate front-end deductible on drug benefits, we think the Part B carriers will need a special claim form. Participating pharmacies can save the program huge amounts of administrative expense if they track patient expenses and determine when the deductible has been met. Providers should bill the carriers/Medicare only after a beneficiary has reached the threshold.

- Setting limits on Medicare's costs for drugs will present some practical problems. In that regard we would like to point out that relying on the Average Wholesale Price (AWP) of drugs is troublesome. Our experience shows that in recent years AWP has become a highly inflated number and most drugs are purchased at lesser amounts, at times substantially lower.

- The HIAA recommends that any program you develop include incentives for the use of generic drugs where appropriate. The HIAA supports the use of generic drugs as an important cost containment vehicle to control health care expenditures providing the prescribed drugs are therapeutically equivalent and less expensive than their brand name counterparts. The HIAA does not support legislation that could restrict the prescriber's right to designate a brand name or generic drug.

- Any plan put into effect should be exempt from state restrictions placed on items in interstate commerce. For example, if mail order pharmacies are participating in such a plan, there should be no barrier to sending prescriptions across state lines.

- An appropriate amount of lead time is essential in order to have the necessary administrative procedures in place before a complex benefit such as this goes into effect. This benefit will create a huge volume of paper. At this time, a January, 1989 date seems reasonable.

- The increased administrative costs to Medicare's carriers associated with the huge number of new claims from this benefit must also be considered by the Congress in its annual appropriation for Medicare administration.

- It also seems important to us that only federal legend drugs plus insulin be considered for purposes of meeting the deductible. Many prescribed items are not legend drugs.

- The definition of "pharmacy" for Medicare reimbursement purposes should be limited to bonafide licensed pharmacies.

- We think the program should set limits on the supply of drugs which can be dispensed. There should be an upper limit, e.g., 90 day supply per prescription. Most drugs dispensed for this beneficiary group will be for chronic conditions and long term needs.

- o Electronic on-line adjudication of claims at the pharmacy is being developed in the private sector. We see important benefits to all parties concerned in electronic claims handling and communications between pharmacies and Medicare carriers.

- o If Medicare is authorized to use a formulary, administrative methods for overriding the formulary should be developed only after a careful cost-benefit analysis.

- o Non-assigned claims for which direct reimbursement to beneficiaries is requested should be subject to a test for "reasonableness".

We feel it is worthy to mention that prescription drug coverage for Medicare eligibles is available from the private sector under"medigap" plans. Benefits have been established by several states and cost effective drugs are sold by the pharmacies of the American Association of Retired Persons (AARP). In addition, greater use of generics, coupled with the ability to advertise drugs has somewhat alleviated upward pressure of drug costs in the retail sector.

In conclusion, if there is any point which should be stressed, it is that simplicity of administration benefits the beneficiary, the administrator and the government.

MENTAL HEALTH BENEFITS

As you consider expanding Medicare's very limited benefits for outpatient mental health care, the following general observations might be of value.

Historically, the health insurance industry has managed the payment for mental health benefits separately from payments for other medical care services.

For example, health insurance policies typically apply separate limits on benefits for the outpatient treatment of mental and nervous disorders including chemical dependency (alcohol or drug abuse).

Inpatient benefits are usually provided on the same basis as any other illness. In fact, the HIAA's recent survey of Group Major Medical Insurance found that 95% of employees in the study had coverage for inpatient treatment that was exactly the same as for other conditions. Many insurers, however, limit inpatient coverage to a specific number of days each calendar year, such as thirty or sixty.

Outpatient benefits under major medical policies are usually fifty percent of the charges incurred, subject also to a specific amount per visit, and a total maximum each calendar year. Our survey reports that more than 50% of small to midsized employers now offer annual limits on

outpatient visits of $1500 or more. In addition, it is quite common to find a lifetime non-reinstatable overall maximum benefit such as $25,000 for all mental and nervous disorders under the typical group major medical plan.

These distinctions have their roots in the widespread feeling that short term psychotherapy needs to be differentiated from long term custodial care for cost containment purposes.

It's our impression that the vast majority of employers in the United States now recognize the important role of mental health care in maintaining employee productivity. They appear to be increasingly less skeptical about offering mental health benefits. Recent surveys of employer practices in mental health coverage, however, show a reluctance to expand the scope of benefits they offer. In fact, one study we have shows that 11% of reporting employers were planning reductions in existing benefits in the next 12 months, such as further limiting the number of covered inpatient days, adding or limiting annual and/or lifetime dollar limits, and overall evaluation of mental health coverage claims.

Employers and their insurers rank mental health benefits among the most difficult benefits to control. Costs associated with psychiatric benefits continue to grow at a faster rate than other health benefits and consequently represent an ever greater proportion of overall health benefit payments.

In large part, this increase can be attributed to a substantial increase in the number of professionals providing mental health services and the substantial increase in the number of beds made available for psychiatric care.

In recent years, insurers and employers have turned to strict utilization review and case management in their attempts to manage the cost of this benefit. Psychiatric preferred provider organizations are beginning to spring up across the country. They are promising cost management vehicles in that they usually feature pre-certification of inpatient admissions and concurrent review of cases. One large insurance company estimates that between 5% and 15% of those hospitalized for psychiatric diagnosis don't need to be there. Enormous savings are possible if care is rendered on an ambulatory basis. With the cost of one day in the psychiatric wing of an acute care hospital reportedly averaging $500 to $700 per day, if inpatient utilization review and case management can reduce a patient stay by one week, the savings to an employee can exceed $4,900.

Attached is some of the survey material referred to above.

We hope these observations are of some value to you in your deliberations. Please feel free to call the HIAA if we can be of further assistance.

Company Practices In Mental Health Coverage; Plan Design Limits Reflect Increases In Cost, Use

325.3.-9
4-87

Employees are using mental health benefits more often, according to "Company Practices In Mental Health Coverage," a study by Hewitt Associates. About half of the 293 companies surveyed experienced an increase in mental health claims since 1983, while only 8% experienced a decrease. Although the number of companies that were able to track claims costs was small (28), costs increased each year from $118 in 1984 to a projected costs of $169 in 1987 per employee.

The complete study includes company practices in mental health and employee assistance programs and may be purchased from Hewitt Associates, 100 Half Day Road, Lincolnshire IL 60015. Attn: Cathy Schmidt.

Health care benefits have been subject to dramatic changes during the past five years. An increasing number of employers are concerned with one area of benefits that has been considered uncontrollable--mental health coverage.

Hewitt Associates surveyed 293 companies of various sizes and industry types to find specific prevalence patterns for mental health benefits and company-sponsored employee assistance programs. This report highlights the survey findings for the mental health benefits.

Surveyed companies were almost evenly distributed between manufacturing (49%) and nonmanufacturing (51%) industry classifications. In terms of the number of employees, 15% employed less than 1,000, 46% covered from 1,000 up to 5,000, 16% covered between 5,000 and 10,000, 19% between 10,000 and 50,000, and only 4% employed more than 50,000 employees.

Companies were almost evenly divided also in their reasons for offering mental health coverage. Moral obligation and competitive practice were the two most common responses as cited by 37% and 35%, respectively. Cost management for overall medical plan (15%), employee demand (6%), part of medical plan (4%), employee productivity (1%), and all others (2%).

Design And Usage

More than three-fourths of the companies have made no major design changes to inpatient or outpatient limits within the past two years. For the 288 companies surveyed, 80% did not change inpatient limits and 76% made no changes in the outpatient limits. However, 11% reported that they are planning changes within the next 12 months. Anticipated changes include limiting the number of inpatient days, adding or limiting annual and/or lifetime dollar limits, and overall evaluation of mental health coverage due to increasing claims costs.

In terms of utilization, 33% of the 197 companies said they have not been able to track use of the mental health benefit. Of those able to compare changes in use since 1983, just over half have seen an increase.

Design Features

Employers have ranked use of mental health benefits high on the list of health plan services that are difficult to control. The most common method used to control use places some type of special limit on plan benefits. Ninety-three percent of companies combined inpatient and outpatient limits (lifetime and/or annual) for mental health and substance abuse coverage. Of those plans, 71% had specific coverage limits for both mental health and substance abuse under the medical plan.

Specific limits for outpatient mental health benefits only was reported by 19% of the surveyed plans, and inpatient benefits were treated as any other illness under the medical plan. Seven percent reported specific limits for inpatient substance abuse only and inpatient mental health was covered as any other illness. Specific limits for inpatient mental health was reported by 3% of the companies surveyed and inpatient substance abuse is covered as any other illness.

More than half (54%) of the companies combined inpatient/outpatient limits expressed either as an annual or lifetime maximum; some companies had both. Annual dollar maximums were included in the plans of 22% of those companies with limits that ranged from

Company Practices In Mental Health Coverage; Plan Design Limits Reflect Increases In Cost, Use

$1,000 to $20,000 per year. The 91% of companies with lifetime maximums set limits from $3,750 to $500,000. The median limit was $45,000.

Design Limits

Sixty-three companies had separate inpatient limits for substance abuse coverage, 42 had separate limits for inpatient mental health coverage, but most companies (125) had the same limits for inpatient treatment for both illnesses. Those limits were expressed as shown in the table below.

Outpatient treatment limits for both mental health and substance abuse coverages vary widely, as survey responses indicate. Annual dollar limits ranged from $250-$50,000, lifetime maximums ranged from $1,000 to $100,000. None of the companies reported full coverage for outpatient treatment; 46% covered from 50% to 90% for each visit.

Of the 217 companies that placed dollar limits on visits for outpatient treatment, 28% limited between $10 and $1[illegible]0 per visit, to qualify for reimbursement, 5% limited yearly visits to between one and seven, while 21% limited reimbursable yearly visits that ranged from 16 to 52 visits.

Almost all of the 288 companies that provide coverage for substance abuse and mental health reimburse psychiatrists (98%) and physicians (93%), while 78% reimburse registered clinical psychologists. Psychiatric social workers are reimbursed by 35% of the companies, substance abuse counselors qualify for reimbursement at 24% of the companies, and only 17% of the companies reimburse marriage, family, and child counselors.

When substance abuse is covered under mental health provisions, 16% of the companies require enrollment in a rehabilitation program (e.g., Alcoholics Anonymous).

More than half of the companies (58%) use one or more cost management features for mental health benefits. Of the 277 companies using such features 38% require precertification of inpatient admissions, 34% use concurrent review of admissions, 26% use data analysis, 20% have a case management program, and 16% use retrospective review of all inpatient admissions.

Claims Costs

Only 10% (28) of the surveyed companies could provide data on their annual per employee mental health claims costs for years 1984-1987. For those companies able to report, averages per employee per year and the percent increase are as follows:

Year	Avg. Per Person	% Increase
1984	$118	–
1985	136	15%
1986 (est.)	156	15%
1987 (est.)	169	8%

Design Limits For Inpatient Treatment

	Substance Abuse Only	Mental Health Only	Substance Abuse/ Mental Health
Annual Dollar			
No. of cos.	10%	19%	14%
Range	$500-$7,500	$500-$15,000	$1,000-25,000
Lifetime Dollar			
No. of cos.	17%	14%	19%
Range	$3,750-$15,000	$15,000-$100,000	$10,000-$300,000
Annual Length-of-stay			
No. of cos.	71%	48%	36%
Range (days)	28-120	30-180	21-120
Lifetime Confinement			
No. of cos.	38%	4%	6%
Range	1-3	–	2-3
Covered Expenses			
No. of cos.	13%	40%	71%
Range	50%-80%	50%-90%	50%-90%

where employees have been able to damage 401(k) plans' attractiveness as

Firms seek psychiatric cost control

By JOANNE WOJCIK

An increasing number of employers are looking for ways to trim psychiatric costs—the fastest-growing medical treatment expense in most employee health care programs.

Until recently, utilization review and case management programs were about the only options available to cut the cost of mental health care. But now, psychiatric preferred provider organizations are beginning to spring up across the country, mostly as offshoots of these case management programs.

"Companies with liberal benefit plans realize that their dollars are not being spent wisely" for mental health care, explains Dr. William Cunnick, vp and medical director for Metropolitan Life Insurance Co. in New York.

"There's a lot of excess all over the health care field, especially in psych care" because treatment often is not provided in the most efficient setting, says Walt Wood, a group consultant in the Washington office of benefit consultant The Wyatt Co.

"Hospitals are used when outpatient care would be not only less expensive, but better for the patient," he explained.

Dr. Cunnick agrees, saying, "Between 5% and 15% of those being hospitalized for psychiatric diagnoses don't need to be there. There can be enormous savings if you provide quality care on an ambulatory basis," which is the method of treatment most psychiatric PPOs encourage.

And, by providing employees incentives to use psychiatric PPOs, employers can trim the cost of treatment for mental disorders by 10% to 30%, according to some of the PPOs.

Mental health care is the fastest-growing segment of the U.S. health care industry for several reasons, according to observers (see story, page 38).

Between 1980 and 1983, the economic cost of mental disorders rose 35.2% to $73 billion from $54 billion, according to the U.S. Alcohol, Drug Abuse and Mental Health Administration.

And, observers expect that the amount employers will pay to cover psychiatric treatment for employees will continue to increase as the stigma associated with being treated for substance abuse and "mental and nervous" disorders diminishes.

Much of the increase in psychiatric benefits costs also can be attributed to improved coding of claims payments, adds Donald Penn, consulting principal for employee benefit consultant A.S. Hansen Inc. in Deerfield, Ill.

"As we become more open about it, and as we try to identify the providers and the treatment, we get better data," Mr. Penn explained. "For example, I think AIDS (acquired immune deficiency syndrome) has been around for many, many years, but we haven't called it that."

"As we become more open about it, and as we try to identify the providers and the treatment, we get better data," he explained.

Larry Tucker, a consultant in the Santa Ana, Calif., office of Hewitt Associates, agrees. "We're seeing a lot more expenses now attributed to chemical dependency," which falls under psychiatric treatment in most health plans.

The cost of psychiatric treatment generally is calculated by multiplying the provider's reported per-diem cost per bed by the average length of stay and then adding an additional charge for ancillary services.

In this equation, both the cost of care and the length of time required to deliver the care contribute to the overall cost-effectiveness of a provider.

With the cost of one day in the psychiatric wing of an acute-care hospital averaging between $500 and $700 per day, reducing length of stay for inpatient mental health care by one week through utilization review can save an employer up to $4,900.

Continued on page 34

▶Cash balance plans

Cash balance pension plans are attracting the interest of more employers, but most are wary of actually making the switch until some questions surrounding the plans are answered. See story, page 15.

▶Hospital insurers

Mounting losses are causing mounting doubts and problems for some hospital systems that charged into the group health insurance business over the past two years. See story, page 23.

▶Multiple options

Employers now can purchase group health insurance contracts combining traditional indemnity, preferred provider and health maintenance organization options in one program. See story, page 28.

▶FSA survival

After a tough fight with two federal agencies, flexible spending accounts are still alive, and Employers report that FSAs still can be an important part of a benefit program. See story, page 40.

▶AIDS care options

Companies nationwide are using more humane and cost-effective options like case management, home health care and hospice programs to care for employees with AIDS. See story, page 53.

Co-payment lessens use of mental health care

Insurance plans offering free outpatient psychotherapy spend 133% more on that care than on similar treatment for patients required to pay a co-payment, according to a Rand Corp. study in the Oct. 10 *Journal of the American Medical Association*.

Outpatient medical care appears to be less responsive to patient cost-sharing than does psychotherapy, says the report by Willard G. Manning Jr., PhD, and colleagues at the Rand Corp., Santa Monica, Calif. The study, the Rand Health Insurance Experiment (HIE), involved families enrolled in fee-for-service insurance plans at six sites across the United States during a three-year period. About 5,800 participants were enrolled.

Although use of mental health care was significantly higher for participants with no cost-sharing, the authors report that the overall use of outpatient psychotherapy treatment was low for all those studied.

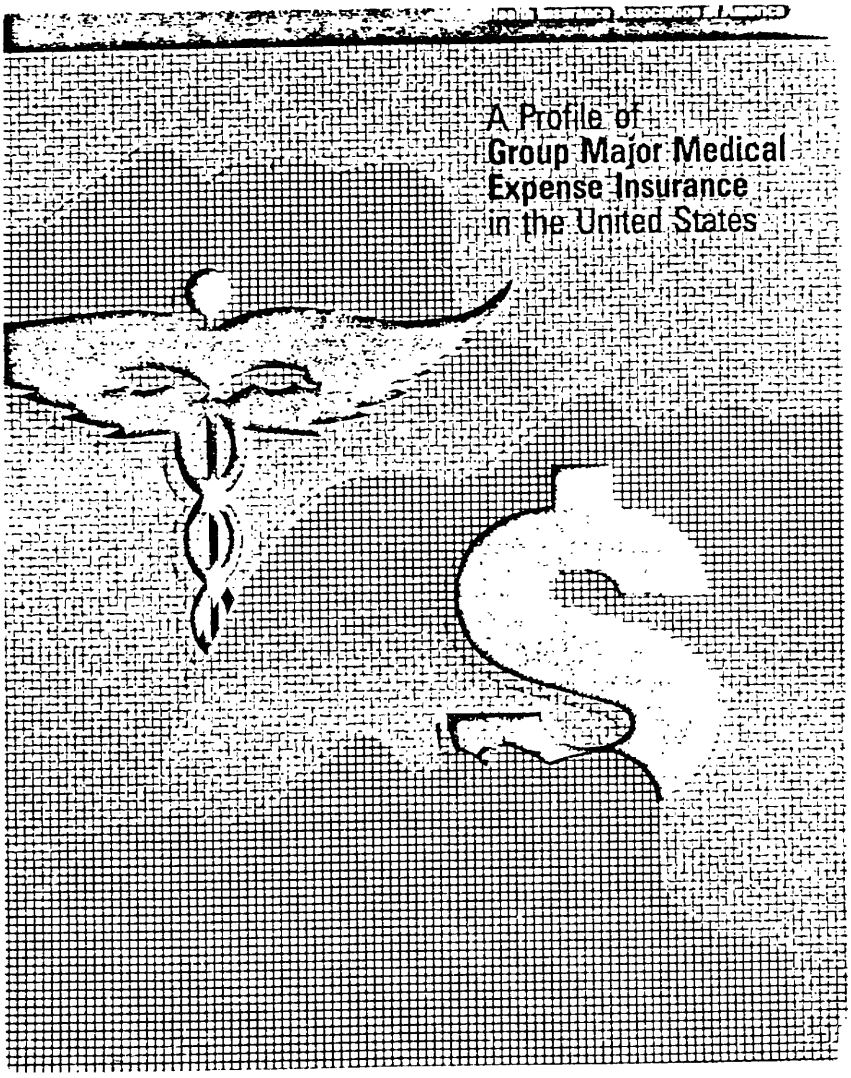
"Even with very generous health insurance, expenditures on outpatient psychotherapy amount to only 4% of total health care expenditures and 9% of outpatient health care expenditures, excluding dental services," they note. Few enrollees in any plans received intense mental health treatment.

THE RESEARCHERS say their study addresses the question of the relationship between demand for outpatient mental health care and variations in insurance coverage. They point out, however, that further research is needed "to know whether the variation in insurance coverage affects mental health status or the quality of care."

In an accompanying editorial, Jonathon F. Borus, MD, of Massachusetts General Hospital, Harvard Medical School, Boston, calls the study "carefully designed." He emphasizes that the results do not support theories that increased mental health coverage will overburden the health care system with astronomical costs but that increased coverage may offer improved clinical outcomes.

Although praising the HIE study, Dr. Borus endorses the promise of a future Rand study that will correlate care, cost, and clinical outcomes.

"The new Rand study and randomized offset studies of care, cost, and outcomes should provide needed important data on which to build a more informed national policy on health services provision and cost-effective health insurance coverage," he says.


A Profile of
Group Major Medical
Expense Insurance
in the United States

P R E F A C E

The Health Insurance Association of America undertook an analysis of the characteristics of group medical expense insurance plans in force as of the end of 1980. A questionnaire elicited data on the characteristics of group health insurance by type and level of benefit and size of case. Plans were to update the study again in the late 1980s; however, significant changes in benefit plan design that have occurred since pointed up the need for more current information. Thus, the Research and Development Committee of the HIAA, through its Survey Subcommittee, requested an interim update study.

A Profile of Group Major Medical Expense Insurance in the United States reports on results as of the end of 1984. Information was gathered only for employees who were covered under major medical (comprehensive and supplementary) benefit programs. Where comparisons between the 1984 and the 1980 study can be made, they are included in this report.

Thirty-nine member companies participated in the survey and provided data for 14.2 million employees for all or for major portions of the survey questionnaire. These companies accounted for almost 40% of the total group health insurance premiums for fully-insured plans written by health insurance companies in the United States in 1984.

MENTAL ILLNESS BENEFITS

Over 99% of the employees in the study had coverage for inpatient treatment of mental and nervous disorders. When questioned about the level of benefits, 95% were covered for the same benefits as for other conditions; however, included in the 95% were 29% who had a separate lifetime or calendar year maximum placed on mental illness. Other benefit restrictions in addition to a separate maximum applied to 5% of the employees. Variation by size of case indicated that a separate maximum on mental illness benefits was more likely in smaller size groups, as shown in the following table.

LEVEL OF MENTAL ILLNESS BENEFITS FOR INPATIENT CARE

Level of Benefit	Percent of Employees by Size of Case			
	Total	Under 50	50-499	500 or More
Same as for Other Conditions				
Same Provisions and Maximum	65.5%	39.5%	56.3%	81.4%
Same Provisions with Separate Maximum	29.1	53.4	39.4	13.6
Benefit Provision Restrictions	5.4	7.1	4.3	5.0
Total	100.0%	100.0%	100.0%	100.0%

Some 97% of the employees in the study had benefits for outpatient treatment of mental and nervous disorders. Almost all of these employees with coverage (99%) had benefits that were the same regardless of whether they are disabled or nondisabled. Where some distinction was made, there was generally fuller coverage for disabled persons with benefits being provided on the same basis as for other conditions. For the 99% with no distinction as to disability, however, 94% of these employees were covered for an annual maximum benefit amount that was less than that for other covered conditions, with the remaining 5% having maximum benefits at the same level as for any other covered conditions. In comparing the 1984 results with 1980, the table below shows that while the same percentage of employees had a limit on the maximum outpatient benefit for mental illness, a greater percentage had a higher maximum benefit in 1984.

LEVEL OF MENTAL ILLNESS BENEFITS FOR OUTPATIENTS

	Percent of Employees by Size of Case							
	Total		Under 50		50-499		500 or More	
Level of Benefit	1984	1980	1984	1980	1984	1980	1984	1980
Same as for Other Conditions	4.7%	5.3%	0.5%	0.7%	5.5%	3.8%	6.4%	6.7%
Reduced Benefits	94.5%	94.7%	98.5%	99.3%	91.3%	96.2%	93.6%	93.3%
Less than $1,500								
50% rate	37.1	49.7	66.1	62.5	39.6	59.0	22.8	44.5
80% rate	4.6	5.2	2.9	3.8	1.7	6.7	6.3	5.1
$1,500 or More								
50% rate	48.3	33.6	27.5	26.0	48.2	26.6	58.0	37.0
80% rate	4.5	6.2	2.0	7.0	1.8	3.9	6.5	6.7
Benefits Differ for Disabled and Nondisabled	0.8%	—	1.0%	—	3.2%	—	—	—
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

NAPM

National Association of Pharmaceutical Manufacturers

747 Third Avenue, New York, New York 10017 • (212) 838-3720

June 16, 1987

Bruce Kelly
Senate Finance Committee
Room SD 205
Dirksen Senate Office Building
Washington, DC 20510

Dear Bruce:

Enclosed are comments of the National Association of Pharmaceutical Manufacturers (NAPM) on the issue of outpatient prescription drug coverage under the Medicare program. NAPM is a trade association representing the interests of generic pharmaceutical manufacturers of all sizes. Our members range in size from some of the largest in the industry to many of the smaller manufacturers.

Although there are a great many issues relevant to this discussion, NAPM would like to comment on four at this time:

- o Deductible
- o Co-payment or co-insurance
- o Pharmacist reimbursement for single source drugs
- o Generic dispensing incentives.

We think that we have come up with a reimbursement alternative in this area for pharmacists that has not yet been presented; reimbursing each multisource prescription at the equivalent of the median Average Wholesale Price plus an administrative fee. This proposal offers the advantages of promoting the use of generic pharmaceutical products, saving the patient and the Medicare system significant amounts of money, and is fair to our industry.

I would be happy to review these and other pharmaceutical issues with you at your convenience.

Sincerely,

Harold M. Silverman, Pharm. D.
President

NAPM

National Association of Pharmaceutical Manufacturers

747 Third Avenue, New York, New York 10017 • (212) 838-3720

Outpatient Drug Coverage Under the Medicare Program

The National Association of Pharmaceutical Manufacturers (NAPM) supports the concept of outpatient drug coverage as a facet of catastrophic health insurance as an idea whose time has come. NAPM believes that older adults deserve this benefit, especially those who are faced with catastrophic prescription bills.

We would like to comment on several aspects of this issue that are currently being debated.

1- **Deductible.**

NAPM supports a $400-500 annual deductible feature per Medicare participant. Since the stated purpose of the current approach to outpatient drug coverage under the Medicare program is to provide catastrophic assistance, some level should be established below which the patient would have to assume the total cost for their prescription medicines.

2. **Co-Payment or Co-Insurance**

NAPM believes that this program should not require a co-payment of any kind. Since the purpose of a co-payment program is to force the consumer to retain some sense of the value of their purchase and reduce the costs of insurance, it may be prudent to establish an even higher deductible ($650-$750) to permit the establishment of a program without co-payment or coinsurance.

Should the position that consumers be forced to assume a portion of the cost of their prescription after qualifying for coverage under the program prevail, NAPM would support a 20% coinsurance over a flat co-payment fee. Coinsurance will encourage consumers to ask their pharmacist to dispense a lower priced generic product. It could also stimulate consumers, especially those using maintenance medications, to shop around and obtain the lowest cost product, enabling the Medicare system to save money and provide the greatest service for the least cost.

3. **Pharmacist reimbursement for single source drug products.**

We feel reimbursement for single source drug products should be actual aquisition cost of the drug product plus an administrative fee of $4.50 for each prescription.

4. **Generic Incentives**

It is imperative that this program have incentives for generic drug use built in to it. Without such incentives, financing the program would be impossible.

a. Physicians should be strongly encouraged, as they are in statewide Medicaid programs, to allow substitution of therapeutically equivalent products. In this regard, the Medicare system should encourage the states to adopt a "one-line" prescription form, as a growing number of states have already done, in which the physician who wants to prohibit dispensing of a less expensive generic substitute must do so in his own handwriting.

b. **Pharmacist reimbursement for multi-source drug products.** NAPM recommends that, where a prescription has been written generically or where substitution of a generic equivalent product has been authorized, pharmacist reimbursement for multisource drugs be based on the the median average wholesale price (AWP) of all generic and brand name versions of the drug on the market plus an administrative fee of $4.50.

Enclosed, you will find 10 examples of multisource drugs for which AWP data has been gathered from the 1987 Drug Topics Red Book, a standard source of prescription drug prices.

This approach would offer several distinct advantages over other proposals.

i. Reimbursing at the median figure will make a significant number of drug products available to the pharmacist for dispensing, assuring the patient of always being able to obtain medication from a local pharmacy.

ii. Since the median average wholesale price (AWP) is often less than 1/2 the AWP of the branded product, the program would achieve significant savings.

iii. The dispensing of a product whose actual cost is less than the median AWP will offer the pharmacist an opportunity for a small additional profit, adding to the incentive to dispense a generic product.

iv. In order to provide reimbursement to the pharmacist at a level that is both fair and current, AWP prices must be updated as often as possible, at least every three months.

We would be happy to meet with you at your convenience to discuss NAPM proposals for Medicare outpatient drug coverage in more detail.

CLONIDINE 0.1mg Tablets 100's

Source	Cost (AWP)
Boeringer* (CATAPRES)	$21.61
Parke-Davis	$19.61
American Therapeutics	$17.85
Lederle Standard	$16.25
Biocraft	$16.20
Bioline	$16.20
Mutual	$15.93
Danbury	$11.37
Parmed	$9.94
United Research	$8.99
Goldline	$8.44
Moore	$7.81
Regal	$6.75
Qualitest	$6.74
Richie	$6.74
Geneva Generics	$6.45
Duramed	$6.25
Purepac	$6.25
Rugby	$6.13
Par	$5.75
Dixon-Shane	$5.53
Lemmon	$5.35
Genetco	$5.03
Schein	$3.98

No.:	24
Mean:	$10.05
Maximum:	$21.61
Minimum:	$3.98
Median:	$7.25

DIAZEPAM 5mg Tablets 100's

Source	Cost (AWP)
Roche* (VALIUM)	$29.24
CMC-Cons	$27.00
Parke-Davis	$22.57
UDL	$19.85
Ascot	$16.86
Balan	$15.74
Lederle Standard	$15.16
Gen-King	$15.05
Parmed	$13.60
Zenith	$12.81
Geneva Generics	$10.80
Spencer-Mead	$9.00
Rugby	$9.00
Interstate	$8.75
Moore	$8.69
Goldline	$6.87
Genetco	$6.75
Bioline	$6 56
United research	$6.55
Par	$6.35
Purepac	$6.30
Mutual	$6.23
Duramed	$5.97
Dixon Shane	$5.50
Barr	$5.11
Schein	$4.56

No:	26
Mean:	$11.57
Maximum:	$29.24
Minimum:	$4.56
Median:	$8.87

HYDROCHLORTHIAZIDE 50 mg 100's

Source	Cost (AWP)
MSD* (HYDRODIURIL)	$13.40
Ciba* (ESIDRIX)	$11.70
Mutual	$7.02
Abbott* (ORETIC)	$6.31
Ascot	$5.35
Parmed	$4.18
Camall	$4.16
Parke-Davis	$3.67
Lederle Standard	$3.63
Vangard	$3.32
Coast	$3.20
UDL	$2.80
General Generics	$2.41
Murray	$2.25
Cooper	$2.23
Perrigo	$2.10
VHA Supply	$2.03
McKesson	$1.95
Geneva Generics	$1.94
Zenith	$1.94
Schein	$1.93
Barr	$1.67
Private Formulations	$1.60
SKF	$1.50
Rugby	$1.50
Towne	$1.49
Danbury	$1.46
Bolar	$1.45
United Research	$1 42
CMC-Cons	$1.40
Interstate	$1.38
Bioline	$1.38
Richlyn	$1 25
Superpharm	$1.25
Moore (Yellow)	$1.25
Boots	$1 25
Goldline	$1.25
Qualitest	$1.24
Moore (Peach)	$1.15
Purepac	$1.11
Genetco	$1 10
Veratex	$1 10
West-Ward	$1 10
Heather	$1.05
Vitarine	$0 85

No.:	45
Mean:	$2.64
Maximum:	$13.40
Minimum:	$0.85
Median:	$1.60

IBUPROFEN 400mg 100's

Source	Cost (AWP)
Upjohn* (MOTRIN)	$17.31
VHA Supply	$17.31
Vangard	$15.41
Major	$13.15
Lederle Standard	$13.13
Lu Chem	$12.50
UDL	$12.50
Rugby	$10.94
Spencer Mead	$10.94
Ascot	$10.92
Parmed	$10.56
Harber	$10.50
Genetco	$10.50
Towne	$10.31
Arkansas Coop	$10.30
Par	$10.00
Goldline	$9 94
Danbury	$9.85
Moore	$9.69
Interstate	$9.40
Williams	$9 38
United Research	$9.20
Gen-King	$8 78
Barr	$8.75
Bioline	$8.69
Geneva Generics	$8.50
Dixon-Shane	$8.33
Mutual	$8.31
Schein	$7 81
Lemmon	$7.62
Boots*	$6 88
Purepac	$6.25

No:	32
Mean:	$10.43
Maximum:	$17.31
Minimum:	$6.25
Median:	$9.98

INDOMETHACIN 25mg 100's

Source	Cost (AWP)
Merck® (INDOCIN)	$37.10
Ascot	$29.36
VHA Supply	$25.00
Harber	$25.00
Vangard	$24.30
General Generics	$20.83
Vita-Rx	$19 95
Parke Davis	$19.87
Lederle Standard	$19.86
Moore	$19.38
UDL	$19 30
Parmed	$19 25
Rugby	$18 06
Arkansas Coop	$16 52
Goldline	$16 19
Purepac	$16 19
Lannett	$14 80
Watson	$13 80
Zenith	$13 75
Duramed	$13 28
Interstate	$12 50
Balan	$12 29
Towne	$11 30
Regal	$11 20
Williams	$11 19
Par	$11 15
Mutual	$10 94
Spencer Mead	$10 63
United Research	$10 50
Bioline	$9 94
Geneva Generics	$9 25
Raway	$9 10
Schein	$8 44
Richie	$8 35
Genetco	$7 88
Dixon-Shane	$7 70
Qualitest	$7 59
Barr	$6 95
DM	$5 63

No.:	39
Mean:	$16.62
Maximum:	$37.10
Minimum:	$9.10
Median:	$13.75

IMIPRAMINE 10mg 100's

Source	Cost (AWP)
Geigy* (TOFRANIL)	$14.85
Cenci	$5.95
Vangard	$5.57
Coast	$4.50
Lederle Standard	$4.49
Harber	$3.70
UDL	$3.60
Biocraft	$3.50
Abbott	$3.46
SKF	$3.39
McKesson	$3.30
Balan	$2.84
Towne	$2.81
United Research	$2.80
Vita Rx	$2.78
Dixon-Shane	$2.73
Genetco	$2.63
Geneva Generics	$2.60
Gen-King	$2.52
CMC-Cons	$2.50
Goldline	$2.44
Spencer Mead	$2.38
Williams	$2.36
Best Generics	$2.30
Bolar	$2.25
Bioline	$2.25
Interstate	$2.19
Lannett	$2.10
Moore	$2.07
West-Ward	$2.05
Vita Med	$1 75

No.:	31
Mean:	$3.38
Maximum:	$14.85
Minimum:	$1.75
Median:	$2.73

LORAZEPAM 1mg 100's

Source	Cost (AWP)
Wyeth® (ATIVAN)	$33.76
Harber	$26.35
Vangard	$23.89
Geneva Generics	$23.00
Balan	$22.04
Parmed	$20.61
Rugby	$19.93
United Research	$19.80
Interstate	$18.75
Goldline	$18.69
Mutual	$18.45
Lederle Standard	$18.30
Danbury	$17.28
Moore	$17.00
American Therapeutics	$16.95
Towne	$16.42
Regal	$15.83
Quantum	$15.60
Gen-King	$15.18
Richie	$14.99
Bioline	$14.94
Purepac	$14.76
Genetco	$14.40
Barr	$14.25
Dixon Shane	$13.93
Lemmon	$13.08
Par	$12.10
Schein	$11.38
Qualitest	$11.36
Zenith	$16.48

No.:	30
Mean:	$17.65
Maximum:	$33.76
Minimum:	$11.36
Median:	$16.97

METHYLDOPA 250mg 100's

Source	Cost (AWP)
Merck® (ALDOMET)	$23.13
Vangard	$22.96
Balan	$20.99
General Generics	$20.83
Towne	$20.38
Parke Davis	$20.18
Harber	$19.50
Best Generics	$18.75
Bolar	$18.15
Parmed	$17.95
Gen-King	$17.92
Goldline (white)	$17.44
Vita-Rx	$17.37
Spencer-Meade	$16.75
Rugby	$16.75
Lederle	$16.54
Zenith	$16.50
Interstate	$16.25
Moore	$16.19
Williams	$16.19
Richie	$15.99
Danbury	$15.95
Mutual	$15.73
Goldline (beige)	$14.69
Bioline	$14.38
Dixon-Shane	$13 93
Duramed	$13.81
Rahway	$13.75
Barr	$13.71
Regal	$13 43
Roxane	$13 40
Geneva Generics	$12.65
Purepac	$12 40
Qualitest	$12 30
Schein	$10 50
Genetco	$9 75

No.:	36
Mean:	$16.31
Maximum:	$23.13
Minimum:	$9.75
Median:	$16.22

METHYLDOPA 250mg/HYDROCHLORTHIAZIDE 25mg 100's

Source	Cost (AWP)	No.:	19
Merck® (ALDORIL-25)	$33.40	Mean:	$23.54
Balan	$28.49	Maximum:	$33.40
Moore	$24.95	Minimum:	$17.26
United Research	$24.57	Median:	$23.69
Lederle Standard	$24.50		
Richie	$24.11		
Bolar	$23.75		
Best Generics	$23.75		
Parmed	$23.69		
Goldline	$23.69		
Rugby	$23.69		
Bioline	$23.44		
Lemmon	$22.61		
Dixon Shane	$22.33		
Raway	$22.00		
Schein	$21.13		
Geneva Generics	$20.80		
Qualitest	$19.10		
Purepac	$17.26		

Propranolol 40 mg 100's

Source	Cost (AWP)
Ayerst® (INDERAL)	$23.60
Parke-Davis	$17.46
Lederle Standard	$17.28
Goldline (Z)	$15.94
Bioline	$15.63
Rugby	$14.94
Spencer Mead	$14.94
UDL	$14.90
Parmed	$14.45
Watson	$14.10
Duramed	$14.05
Ascot	$13.92
Zenith	$13.68
Danbury	$12.60
Moore	$11.81
Geneva Generics	$11.80
Goldline (C)	$11.19
Gen-King	$10.92
United Research	$8.75
Raway	$8.75
Mutual	$8.49
Richie	$7.86
Par	$6.90
Lemmon	$6.64
Genetco	$6.50
Schein	$6.00
Roxane	$5.91
Barr	$4.90

No:	28
Mean:	$11.93
Maximum:	$23.60
Minimum:	$4.90
Median:	$11.80

Statement of the National Association of Chain Drug Stores, Inc.

BEFORE THE SENATE FINANCE COMMITTEE

SUBCOMMITTEE ON HEALTH

OUTPATIENT PRESCRIPTION DRUG COVERAGE UNDER MEDICARE

June 24, 1987

NACDS
National Association of Chain Drug Stores, Inc.
P.O. Box 1417-D49
Alexandria, Virginia 22313
703-549-3001

INTRODUCTION

Mr. Chairman and Subcommittee Members, the National Association of Chain Drug Stores, Inc., (NACDS) is pleased to provide testimony on the issue of an outpatient drug benefit for the elderly under Medicare.

NACDS is a non-profit trade organization, founded in 1933, which represents the management of 171 corporations that are operating close to 20,000 retail drug stores and pharmacies throughout the United States. Collectively, our members were responsible for $30 billion in retail sales in 1986 and more than 540 million prescriptions were dispensed to patients by corporate drug chains during this same period. Also, 50,000 pharmacists practice their profession for our member companies.

Our statement to the Senate Finance Subcommittee on Health represents the fourth time in recent months that we have provided testimony to Congress on what the Chain Drug Industry sincerely believes to be the most essential ingredients for drug benefit coverage under Medicare in terms of scope, reimbursement and administration. Our recommendations to this Subcommittee reflect the same sound principles that NACDS and its corporate members have previously advocated to Congress and the Administration during 1986 and this year on reforming and improving drug reimbursement policies for Federally assisted health care programs, such as Medicaid and Medicare.

RECOMMENDATIONS TO HCFA & SELECT COMMITTEE ON AGING

On October 8, 1986, we filed extensive formal comments with the Health Care Financing Administration (HCFA) on proposed rulemaking to revise Federal policies that govern prescription drug reimbursement under Medicare and Medicaid. Much of our 33-page statement touched upon the Maximum Allowable Cost (MAC) program, fashioned more than a decade ago, which has become antiquated, cumbersome, and fails miserably to take advantage of the dynamics of the competitive retail marketplace. We urged HCFA to modernize its regulatory policies and embrace a new approach that wisely recognizes emerging technology and promotes competition while harnessing opportunities for cost savings through a greater emphasis with generic drugs. NACDS and its corporate members also argued for fair, uniform reimbursement policies and streamlined administrative procedures utilizing electronic billing and debit cards. To date, HCFA has not acted on our recommendations, and the likelihood of seeing meaningful rulemaking on drug reimbursement from the agency seems remote.

On October 24, 1986, NACDS provided testimony to the House Select Committee on Aging on the issue of "High Drug Costs and Older Americans: A Prescription for the Future." In our statement to the Select Committee on Aging, we expressed our concerns over the escalating costs of prescription drugs and the hardships that these increases have on individuals who can least afford to pay for their medications. NACDS discussed the documented increases in pharmaceutical prices from manufacturers that are going upward at nearly twice the rate of other commodities in the Consumer Price Index (CPI). We further noted that

outdated Federal policies governing drug reimbursement, namely the MAC program, have been a major contributing factor to the price increases that we have seen in recent years from pharmaceutical companies. Additionally, our statement to the Select Committee showed that these same outdated Federal policies have resulted in cost-shifting among retail pharmacies to private pay patients and the elderly to compensate for inadequate rates under Medicaid.

While Medicaid and the current regulatory scheme is not entirely at fault for the cost-shifting phenomena, we noted in our testimony that Medicaid is clearly the worst offender among third party payer reimbursement programs. Two recent studies found that private pay customers, on the average, pay a subsidy of $.52 per prescription because of inadequate Medicaid reimbursement rates. Considering that, on the average, our nation's elderly receive 12 prescriptions a year, the aged who can least afford medications are having to pay an additional minimum of $6.00 in hidden subsidies as a result of Medicaid's flawed reimbursement system.

We also explained that under the current system, pharmaceutical companies basically have "carte blanche" and receive complete payment for their products while the narrow focus of the MAC regulations has been to suppress and excessively regulate prices at the retail level. With the exception of a few multi-source products, we advised the Select Committee that there is not competition or cost-containment features to encourage manufacturers to control prices under the MAC regulations. Consequently, it is not uncommon to see several price increases by brand-name companies for their product lines each year.

As evident by the Congressional hearings held in April of 1987, these manufacturer increases continue unabated. Although the CPI has risen only a scant 2.7 percent since 1985, the House Energy and Commerce Subcommittee on Health found that pharmaceutical manufacturers' prices jumped an astounding 12.2 percent.

Additionally, we told the Select Committee that these same Federal policies provide no incentive for pharmacy providers to offer less costly generic drugs to needy recipients, that the MAC program fails to cover even the basic costs of doing business with Medicaid and totally ignores the importance of encouraging program savings through competition in the retail environment.

All of these concerns have been presented in recent months to the Health Subcommittees of House Ways and Means and Energy and Commerce with respect to the establishment of outpatient drug coverage under Medicare. To a great degree, our message to these House Committees is very simple. We are recommending that Congress avoid the same mistakes of bad public policy that afflict the Medicaid program.

NACDS VIEWS ON OUTPATIENT DRUGS UNDER MEDICARE

Regarding the specific issue of providing outpatient drugs under Medicare, we strongly support adding this benefit and it is our position that all prescription drugs should be included. We further believe that the competitive marketplace is the preferred and most cost-efficient system

for delivery of drug benefits to the elderly. Furthermore, NACDS recommends that there must be adequate funding for this benefit.

In our view, Congress must proceed carefully in fashioning Medicare Part B Drug Coverage and develop components that are compatible with the retail market. Unlike other health care benefits, the vast majority of the payors of pharmaceutical services are actually the consumers of such services.

This provides a strong incentive for consumers to seek out and shop for the best value for their money and induces retail pharmacies to meet the general public's price/value needs. As an industry, NACDS estimates that more than 70 percent of all prescriptions filled by chain drug stores are dispensed to consumers who pay cash for their medications. Keep in mind that there are close to 60,000 retail pharmacies in the United States engaged in intense competition for this business. In fact, competition has greatly intensified in recent years with mass merchandisers, food chains, HMO's and mail orders joining a crowded field to fight for marketshares that have been traditionally the sole domain of independents and drug chains. The benefits of such competition are readily apparent as consumers are now being aggressively courted by price comparison ads, expanded services and computerized records and other inducements.

Recognizing the highly competitive nature of the retail drug business, NACDS strongly recommends that a reimbursement system for outpatient drugs under Medicare should adopt a marketplace approach for payment. We, therefore, support reimbursement that is based on marketplace pricing which is the retail pharmacy's actual price capped at the 90th percentile

of all charges for the same prescription. A further refinement of this sound concept is a modification of the Health Care Financing Administration's (HCFA) own Competitive Incentive Program (CIP) proposal which embraces marketplace pricing. Under this approach, generic drugs would be reimbursed at the pharmacy's full marketplace price or actual price. Reimbursement for brand-name drugs that have three or more generic equivalents would be at the pharmacy's marketplace price capped at the 75th percentile of all charges within the state. We are certain that with a Federal policy which carefully and prudently differentiates between generics and other brand-name counterparts with respect to retail reimbursement rates, there will be a greater economic incentive for pharmacies to dispense generic versions when permissible and possible.

Regarding non-multiple source drug products (i.e. sole source drugs or products which have fewer than three suppliers) these items would be reimbursed at the marketplace price capped at the 90th percentile. In our opinion, this reimbursement approach will provide for a more balanced treatment of brand-name and generic drugs than we currently have under Medicaid and significant savings can be achieved.

Beyond our strong endorsement for marketplace pricing as the basis for reimbursement, NACDS believes that consumer participation in cost containment is critically esssential. Therefore, we support the use of a high deductible for prescription drugs and a system of direct patient reimbursement. This is very similar to present major medical plans which allow for prescription drugs to be considered as part of the deductible. The strength of such a system is that the consumer maintains an incentive

to shop prudently for the best prescription price before and even after a deductible is met. As such, competition and efficiency are continually enhanced.

ELECTRONIC DEBIT CARDS

Additionally, with consumer participation as a major feature in a legislative approach to establish outpatient drug coverage under Medicare, Congress can take this important health care benefit to its next logical step by tapping into a new innovative processing system using electronic debit cards. This technology expands the realm of possibilities for prescription drug reimbursement that can be successfully tailored to the retail marketplace. Such innovative ideas as diagnostic related groups for drug products (for example, we can determine average drug costs for treating arthritis); dollar caps on reimbursement per recipient, variable co-payments which would reflect a percentage of the prescription price and other new approaches become more feasible and advantageous under an electronic process system. Thus, case managing of a patient would be ideal and would make the administration of such a benefit run smoothly and efficiently.

Further elaboration of the benefits and advantages of the electronic debit cards are succinctly presented in a recent article, dated May 23, 1987, which appeared in the National Journal. We have attached this interesting article to our testimony because of its relevancy to the issue of a drug benefit program not only for Medicare but for Medicaid as well.

CHAIN DRUG INDUSTRY'S POSITION ON STARK-WAXMAN AMENDMENTS

In terms of the amendments to H. R. 2470 pending in the House, we have endorsed both approaches and hope that the best features from Rep. Starks' and Rep. Waxman's amendments are put forth in a final bill. As such, NACDS supports the $500 annual deductible, including the indexing of the deductible to increases in drug costs.

We also favor the inclusion of cost-sharing and we believe that the 20 percent co-insurance requirement is very important. We urge that the co-insurance be determined based on a drug store's marketplace price or actual retail charge for both brand-name and generics. Our members further recommend that the Congress make the collection of the co-insurance mandatory. And it is our position that the legislation should clearly indicate a system of direct patient reimbursement.

Additionally, we have endorsed the payment approach that calls for marketplace pricing (actual charge) or Average Wholesale Price (AWP) for brand-name drugs plus a dispensing fee of $4.50, whichever is lower.

We are also supportive of the payment approach relating to generics that calls for marketplace pricing (actual charges) or 50 percent of the AWP of the corresponding brand-name drug, plus a $4.50 dispensing fee. Furthermore, NACDS is endorsing the indexing of the dispensing fee for both brand-name and generic drugs. Finally, our corporate members favor the provision that calls for uniform electronic billing and prompt payment.

As NACDS indicated in testimony to the House Ways and Means Subcommittee on Health, we will need to work closely with the Congress on the administrative aspects and to develop reasonable guidelines to clarify the case management rule that retail drug stores will play to assist patients who have met their deductible. Thus, we ask that a retail-carrier-senior citizens task force be established to iron out the mechanics for eligibility and case management to insure that the program works efficiently.

SUBCOMMITTEE SHOULD CONSIDER DEMONSTRATION PROJECTS

In conclusion, NACDS supports outpatient drug coverage under Medicare and a reimbursement system that is based on actual charges. To the extent that the final legislation may call for another payment approach, we urge the Subcommittee to develop a number of demonstration projects as part of the bill or through the appropriations process to test the advantages and benefits of marketplace pricing which could encompass, among other things, a specific dollar cap per recipient and direct patient reimbursement. Our corporate members are prepared to help design such a system with a view toward having one standard for the nation. We believe that these demonstration projects should coincide with a legislative review of the Medicare outpatient drug benefit. An outline of possible demonstration projects is attached with our testimony.

NACDS thanks the Subcommittee for this opportunity to provide testimony and hopes that our views on this important health care initiative for the elderly will be given careful consideration.

TK/kar

STATE OF THE STATES Neal R. Peirce

Has the Time Come for Credit Card Welfare?

ST PAUL—There's serious talk these days about legitimizing welfare, shifting it from a despised dole to a training-and-jobs program. But even more startling is the proposal to bring public assistance clients into the mainstream by letting them pick up their benefits at automated bank-teller windows.

"Credit card welfare" isn't a reality yet, but it may be soon if an experiment authorized by the Ramsey County (St. Paul) Human Services Department pans out.

And not just for welfare payments. "Electronic benefit transfer," as it's called, might just be a foot in the door to a single card that accesses every benefit from food stamps to medicaid to child support payments. "We're testing one thing, but we're thinking about a lot of things," acknowledged the county human services director, Thomas J. Fashingbauer.

Ramsey County's adventures into innovative financial services for the poor began with a crisis. Local banks, eager for upscale patrons, rejected the county's contract to cash welfare checks. The banks said there wasn't enough "float" to cover the expense of extra tellers or the harm to their image of having their lobbies packed with welfare mothers early each month.

Enter Truman W. Porter, an imaginative officer at Midway National Bank of St. Paul. Midway would set up a temporary special office to cash the checks each month. But the county, Porter said, would have to agree to take a serious look at electronic methods of distributing welfare benefits. The county agreed, became fascinated with the potential and decided on a pilot program. Midway, in consortium with the St. Paul-based TransFirst Corp., a wholly owned subsidiary of First Texas Savings and Loan of Dallas, and Minnesota's Norwest Bank Corp., won the contract.

The test starts on July 1. About 1,200 of the county's 14,000 welfare recipients will be issued plastic cards with photos and a magnetically encoded strip. They'll be given a secret number and an hour or two of training.

One group will get payments by using automated bank-teller machines. A second will be told to take its cards to designated stores where tellers, equipped with magnetic card readers connected to a central computer, will pay out benefits. A third group will have its choice of either method.

Will the poor feel at home using bank machines the general population often shuns? No one knows; so slow are many of us to accept new technology that even today, only 40 per cent of U.S. bank customers use automated-teller windows.

But if the experiment works, the county will save about $1 per recipient per month because it will no longer have to produce checks and mail them out.

Clients will not be stigmatized by having to go to special check-cashing locations often miles from home. They'll run less risk of being mugged as they leave with a bundle of cash; if they wish, in fact, they'll be able to receive their benefits in smaller chunks during the month.

Ramsey County isn't the first to nibble at the edges of credit card welfare. New York City, which once mailed out half a million welfare checks monthly, has shifted to plastic cards that recipients can take to about 350 specially designated check-cashing outlets. Food stamps are issued at the same locations. Reduced fraud and operating costs save the city $9 million yearly.

In Reading, Pa., there was a successful though costly experiment letting recipients draw food stamp benefits through debits registered on magnetic card readers in supermarkets or farmers' markets. Massachusetts, New Jersey and New York have implemented on-line medicaid authorization payments at hospitals and clinics with magnetic card readers.

> No one knows whether the poor will use automated bank-teller machines when only 40 per cent of U.S. bank customers use them.

But Ramsey County will be first in the nation to share the terminals used by regular banking networks. Carried to its logical conclusion, the system would allow all public assistance recipients to join the mainstream of statewide, eventually nationwide, electronic fund transfers. The only exceptions, one day, might be shut-ins who would continue to need checks.

All this makes grander visions dance in the head of banker Porter. He foresees a day when Americans will reject the idea of a thousand and one dedicated cards, for stores, oil companies, Visas and MasterCards, and demand one they can use for anything—from a charge or instant debit at a store to registering for college or drawing government benefits.

The obstacle to more efficient use, Porter said, isn't with the technology. It lies with public skepticism, with major institutions unwilling to cooperate, with credit card issuers preoccupied with their own marketing.

A leading advocate of a single tamper-proof ID system is the Rev. Theodore M. Hesburgh, departing president of the University of Notre Dame and recently chairman of the federal Select Commission on Immigration and Refugee Policy. "The average American," Hesburgh writes, "carries more driver's licenses, credit cards, check-cashing cards, medical insurance cards and employee IDs than the citizen of any other Western nation. But he or she has the least security against ID counterfeiting, forgery or fraud."

Whether or not the One Great Card awaits us all, the St. Paul experiment might well open some important doors, not only to the use of the same card for food stamps and medicaid, but perhaps even for day care vouchers as welfare systems are expanded to provide child care so that young mothers can move into jobs. All court-ordered child payments could be expedited the same way, from the debiting of one parent's account to the crediting of the other's.

The world of welfare lacks private firms clamoring to take control and sell their exclusive cards and systems. But if Minnesota's experiment pays off for banks, we might see an ultimate irony: models of convenience in financial services that are developed first for a welfare population and then are demanded by middle-class America. □

POSSIBLE DEMONSTRATION PROJECTS - MEDICARE DRUG COVERAGE

INTRODUCTION

The inclusion of demonstration projects on new reimbursement structures and processing systems within the legislation to cover pharmaceutical products under Medicare is highly desirable to help contain future cost increases of the program. These demonstration projects should be demographically representative and provide data necessary to evaluate their effectiveness for the whole program.

We have included a brief description of the possible demonstration projects with their goals. These are brief descriptions and can be expanded if so desired.

PROCESSING SYSTEMS

1. DEBIT CARDS

Description: Eligibility cards would be issued to Medicare recipients. These cards have a magnetic strip which contains pertinent access information on each individual recipient. These cards would be taken to the individual pharmacy which would access a mainframe computer system operated by the Medicare program through a magnetic card reader in the retail pharmacy. This system would verify eligibility, create a billing invoice, and return payment for the services to the pharmacy by electronic means.

Goal: This system should reduce administrative overhead on a per claim transaction for both the Medicare program and the pharmacy providers. The system should also provide for prompt payment of claims. It should reduce the number of rejects, ineligible recipients, reduce fraud, and provide for a better management of the financial liability of the program. The Medicare program should at any one time be able to know its outstanding liabilities immediately.

2. SMART CARDS

Description: This system is very similar to the debit card system indicated above. However, the vital information on the patient is stored on a microchip on the card itself rather than a mainframe. This microchip can be updated periodically and new information added. As with the debit card system, new reimbursement structures can be made possible since the processing system allows for better information and more current information to be given to the consumers and providers.

Goals: The objective of this pilot program would be to compare debit cards, paper claims processing, electronic claims processing, and smart card for cost efficiencies. In addition, the incorporation of the debit cards and smart cards with the reimbursement structure should provide a better indication of cost containment opportunities in the future.

REIMBURSEMENT STRUCTURES

1. MARKET PLACE PRICING

Description: The Medicare program would reimburse pharmacy providers their retail prices up to the 90th percentile of all the retail prices for the demonstration project for similar prescriptions. Competition within the retail pharmacy market should provide cost containment for these prescriptions. A pharmacy would be prohibited from varying the retail price for Medicare prescriptions from the retail price of similar prescriptions for the majority of cash and carry customers.

Goal: This system should reduce administrative expenses in updating and maintaining the cumbersome reimbursement structure under the Medicaid program, reduce administrative staff since the arithmetic calculation on the maximum reimbursement would be an arithmetic formula based on submissions, and provide cost containment and spur competition between retail pharmacies.

2. DIRECT PATIENT REIMBURSEMENT

Description: The patient would be directly reimbursed by the Medicare program for prescriptions purchased during the billing period. This system could be incorporated with the debit card system. It would operate similar to the present credit card operations for general merchandise. However, instead of billing the recipient, they would reimburse a recipient.

Goals: This system will maintain an incentive for the consumer to prudently shop. This should increase generic utilization, provide pressure on brand name products, and help control utilization.

3. DOLLAR RECIPIENT CARDS

Description: A debit or smart card would be issued to the recipients upon meeting the criteria for eligibility. The recipient's account would be credited with a dollar monthly allotment based on their utilization figures for meeting the deductible. This dollar figure would be credited to their account and drawn from by a pharmacy provider when the recipient presents the card at the time of dispensing a prescription. The pharmacy provider would charge the recipient's account his retail price and be reimbursed electronically. However, if the account did not have adequate funds, the recipient would be responsible for any additional amount.

Goals: This system will maintain recipient participation in financial decisions. The system should help ameliorate the price increases and promote generic substitution. In addition, it should control utilization to prescriptions since there would be limited dollars per recipient per month for coverages.

4. DRG RECIPIENT CAPITATION

Description: Utilizing a smart card or a debit card Medicare program would establish a per month dollar figure to be credited to each recipient's account. This dollar figure would be based on the average monthly cost of treating a particular disease with pharmaceutical products. The Medicare program would establish diagnostic related groups and the "normal" therapy for the treating of such conditions. An average cost would be established based on the avereage retail prices for the products needed, dosage, and standard drug regime for each DRG. The pharmacy providers would fill the prescriptions for recipient and draw from this account. Once the account is empty, the recipient would be responsible for additional charges.

The system could only work with an on-line or smart card system. However, this would also provide flexibility for new disease states to be credited to an account as they arise.

Goals: This system will provide consumer participation. It should also promote price competition between patented brand name products since there are often costly types of therapy within a particular class. It should also promote generic substitution and utilization control.

In addition, it should reduce operating and administrative expenses. The only policy administration expense would be in establishing the DRG rates. It also should promote price competition at the retail level without increasing provider costs.

PBD/jas