PCMA
PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION

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Before the

UNITED STATES SENATE
COMMITTEE ON FINANCE

Medicare Drug Card: Delivering Savings for Participating Seniors

June 8, 2004

I. **Introduction**

Good morning Chairman Grassley, Ranking Member Senator Baucus, and Members of the Committee. I am Mark Merritt, President and CEO of the Pharmaceutical Care Management Association (PCMA). I am pleased to be here today to discuss the role pharmacy benefit managers are playing to make the Medicare drug discount card program a success for senior and disabled beneficiaries.

PCMA is the national association representing America's pharmacy benefit managers (PBMs). PCMA represents both independent, stand-alone PBMs and health plans' PBM subsidiaries. Together, PCMA member companies administer prescription drug plans that provide access to safe, effective, and affordable prescription drugs for more than 200 million Americans in private and public health care programs. PCMA appreciates the opportunity to testify before the Senate Finance Committee regarding the recently enacted Medicare prescription drug discount card program. I applaud you, Chairman Grassley, Ranking Member, Senator Baucus and all the other committee Members who worked so hard to bring the promise of more affordable medicines to millions of America's seniors and disabled beneficiaries.

The bipartisan Medicare Modernization Act (MMA) provides a historic opportunity for the private sector to work in partnership with government to make prescription drugs more affordable to our nation's elderly and disabled, particularly those most in need. PCMA and its member companies have long supported efforts to provide Medicare beneficiaries with the benefit of drug discounts made available through competitive price negotiation and quality drug management services. We believe PBMs will play a pivotal role in the overall success of the drug discount card program and many of our member companies have made a considerable investment to that end.

Today, I would like to focus my testimony on four key areas:

- How vertical and horizontal competition among drug card sponsors, retail pharmacies, and drug manufacturers is driving down drug prices and providing savings and value to beneficiaries, particularly those with low incomes;

- How PBM-sponsored drug cards are providing beneficiaries with more than just discounts on drugs, but also valuable care management services that can lead to additional cost savings and enhance the quality of care for seniors and the disabled;

- Highlight steps PBMs have taken to prepare for the launch of the discount card; and

- The challenges and opportunities we see in educating seniors and the disabled about the drug card program's benefits.

II. Competition Works to Benefit Consumers

The Medicare drug discount card program is providing seniors and the disabled with a maximum choice of medications and flexibility in how and where they get their medications filled. Beneficiaries have access to virtually all classes of outpatient drugs available by prescription at discounted rates. Moreover, they have been provided an important new option: the mail-service pharmacy option, which adds further cost-savings, quality and safety protections, and convenience. This freedom of choice and flexibility for seniors and the disabled is what drives card sponsors to compete for their business and is critical to the government's effort to make prescription drugs more affordable.

Preliminary estimates by the Centers for Medicare & Medicaid Services (CMS) indicate that as many as 2.87 million eligible beneficiaries have enrolled in the program, with the majority being automatically enrolled by managed care plans. It is still too soon to tell how many seniors will ultimately enroll in the drug card program or how deep the savings will be for beneficiaries. That said, PCMA member companies believe that enrollment is continuing at a brisk pace and that there are several positive signs that point to the program's long-term success.

The Discounts are Real. There is ample evidence to suggest that the discounts provided to beneficiaries participating in the program are meaningful and making a difference. The savings are real, particularly for the estimated over 4 million Medicare beneficiaries who qualify for the $600 transitional assistance. Low-income seniors who can now avail themselves of PBMs' cost-management tools can make their $1200 subsidy go even further because PBMs can help them stretch those dollars.

- Based on a survey of PCMA member companies conducted prior to the launch of the card program, PCMA estimates that seniors with the Medicare drug card will see discounts averaging 17 percent for brand-name drugs and 35 percent for generics, compared to consumers paying retail pharmacy prices with no prescription drug coverage. These data are in keeping with CMS' own data which shows that drug cards are offering savings of up to 18 percent on brand name drugs and 30 to 60 percent on generics.

- Furthermore, according to CMS preliminary estimates, card sponsors are passing over 90 percent of the discounts they receive on to seniors participating in the program. This shows that competition is working to deliver savings for seniors, and it proves that the rebate and discount disclosure requirements included in the MMA are working to benefit beneficiaries as Congress intended.[1]

- Savings are even greater for low-income beneficiaries who need the help the most. Take, for example, a hypothetical 66 year-old man living in Brooklyn, NY, with high cholesterol, high blood pressure, diabetes, and impotence. His drug needs can be met with a combination of two brand-name drugs and two generics. Without the Medicare discount card, he could get these drugs through AARP's drug program (available to all AARP members at an average discount of 16 percent off retail) for $195 per-month at retail and $182 per-month through mail order. With the Medicare card, the $600 dollar subsidy, and additional discounts offered directly by drug manufacturers for low-income

[1] "Medicare Rx Card Sponsors Are Passing On 'More than 90%' of Discounts," The Pink Sheet, May 24, 2004.

seniors, he can get the same drugs for $71 per month retail and $60 per month mail order. This is an overall savings of 63 percent and 67 percent respectively.[2]

Competition Among Card Sponsors Yields Further Discounts. Since the first publication of drug prices offered by the different card programs in early May, there has been considerable competition among card sponsors to provide the most affordable drugs. PCMA's own internal analysis of price changes from May 11 through June 1 shows the following:

- Overall, for a large basket of commonly prescribed drugs[3] with no generics yet available, prices declined for retail -- and particularly mail service -- in the three weeks they were monitored.

- The following chart compares the top five drug discount cards offering the best mail service (90-day supply) prices for this basket of brand-name drugs.

Card Sponsor[4]	5/11/04	6/01/04	*Difference ($)	Difference (%)
Card #1	$1697.27	$1559.41	$137.86	-8 %
Card #2	$1829.21	$1661.15	$168.06	-9%
Card #3	$2082.04	$1673.14	$408.90	-20%
Card #4	$2094.03	$1829.21	$264.82	-13%
Card #5	$2215.35	$1829.21	$386.14	-17%

- As this chart shows, the average reduction to already discounted prices for the top 5 cards over the three week period was 13 percent.

- It is also worth noting that not only did prices decline within each of the top 5 slots during the three week period, but that the price differential between the Card #1 and Card #5 was also halved during this time. On 5/11/04, the difference in price between Card #1

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[2] Joe Antos, "The Truth About the Medicare Drug Discount Card," American Enterprise Institute, May 27, 2004. Statistics are based on a 7-month cost estimate (May - December 2004) of price information available on May 3 at www.medicare.gov and assumption of use of the $600 subsidy available to low income seniors on June 1.

[3] The following drugs and their strengths were included in this basket of drugs: Cozaar (100mg) for angina; Viagra (50mg) for impotence; Lipitor (40mg) for high cholesterol; Fosamax (40mg) for osteoporosis; Celebrex (200mg) for arthritis; Nexium (20mg) for gastric reflux disease; Lexapro (10mg) for anxiety; and Norvasc (5mg) for high blood pressure.

[4] Note that the top five drug cards on 5/11/04 may not necessarily be the same top five cards on 6/01/04.

and Card #5 was $518. On 6/01/04, the difference was $269. This shows that card sponsors jockeying for a spot in the top five made even more significant reductions in prices in order to compete.

Direct Government Purchasing Schemes Offer a False Hope of More Access, Affordability. Some have proposed reopening the Medicare law to permit the federal government to negotiate directly with drug manufacturers and purchase prescription drugs on seniors' behalf, similar to the Veterans' Administration (VA). However, there is considerable evidence to suggest that direct negotiation of drug prices by the federal government may actually *limit* seniors' access to prescriptions and will not necessarily yield the savings predicted by proponents. First, to replicate the VA model would mean adoption of a national formulary, something Members of this Committee fought hard to avoid during negotiations on the Medicare drug benefit. The VA formulary restricts access to prescription drugs to 31 classes. In contrast, most commercial plans offer a much broader selection of therapeutic classes. Moreover, an August 2000 US General Accounting Office (GAO) report concluded that if the federal government was to provide other purchasers access to the VA's government-mandated discounts, those discounts will disappear as drug manufacturers raise the wholesale price of their drugs to make up for the loss in revenue.[5] Finally, in January 2003, the GAO has reported that PBMs have been able to get better discounts than some state Medicaid programs. In a review of five state Medicaid programs, the GAO found that Medicaid was only getting an 11 percent discount off of cash-paying retail prices versus PBMs' 18 percent discount.[6]

PBMs are Better Able to Deliver Value to Seniors. Because PBMs are neither retail pharmacies nor drug manufacturers, they are generally able to achieve discounts at both ends of the pharmaceutical chain—from the manufacturer and from the retail pharmacy. PBMs are uniquely capable in securing these discounts, managing pharmacy care, and delivering savings to consumers. PBMs are able to achieve these important goals because PBMs represent significant volume in their customer base; are able to leverage inherent efficiencies in their electronic claims

[5] US General Accounting Office, "Prescription Drugs: Expanding Access to Federal Prices Could Cause Other Price Changes," GAO/HEHS-00-118. August 2000.

[6] US General Accounting Office, "Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees and Pharmacies," GAO-03-196, January 2003, p. 10.

processing technology; are able to provide a mail-service pharmacy option; and because of their commitment to the use of generic drugs where appropriate and available.

That PBMs deliver value to their current customers in both private industry and government is well documented. In its 2003 report, the GAO found that PBMs contributed to an 18 percent reduction in the average price for brand-name drugs for, among others, Members of Congress and their staffs in the Federal Employees Health Benefit Program (FEHBP). This, in turn, caused a total annual reduction in drug spending of between 3 and 9 percent for FEHBP plans.[7]

One area that PBMs can provide unmatched value for seniors is through the mail-service pharmacy option. Mail-service pharmacies typically fill prescriptions for maintenance medications; i.e., prescriptions that are used on a continuing basis for individuals managing complex or chronic illnesses. For seniors with limited mobility or disabled beneficiaries living in rural or urban under-served areas, the mail-service pharmacy option can be a vital lifeline to maintaining their health and well-being. Plan designs often allow consumers to obtain a 90-day supply of medication instead of the usual 30- or 60-day scripts that are filled by retail pharmacies. Consumers save money as well by paying only one co-payment for the 90-day supply of medication filled by a mail-service pharmacy, rather than the three separate co-payments required for 30-day supplies filled at a retail pharmacy. A 2002 industry survey of 14,000 mail-service pharmacy consumers found that more than 95 percent were satisfied with the condition of the drugs they received; the accuracy of the drugs that were delivered; with the professionalism of customer service; and the cost savings provided by mail-service pharmacies.

These savings would not be possible without the right market conditions. One such condition is keeping the terms of a contract confidential. Competition for market share drives drug manufacturers to negotiate discounts and rebates with PBMs. It is competition for retail customers that drives retail pharmacies to negotiate discounts with PBMs. If efforts to force disclosure of proprietary contract pricing information are successful, drug manufacturers will have little incentive to negotiate deeper discounts because they will know the competition got a better deal. Last year during the Medicare prescription drug debate, Congress considered – and

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[7] *Ibid*, p. 4.

ultimately rejected – a proposal that would have undermined the competitive marketplace under the guise of "transparency" and "disclosure." The Congressional Budget Office estimated that the proposal would have cost the Medicare program $40 billion over ten years because PBMs' ability to drive discounts for beneficiaries would be undermined.[8] Moreover, as already noted, such public disclosure is not necessary. CMS is already utilizing the transparency requirements in the new law and has found that PBMs and other card sponsors are passing more than 90 percent of the discounts they secure on prescription drugs on to beneficiaries in the drug card program.

III. PBM Drug Discount Card Benefits Provide Quality Protections

Seniors need ***more*** than just discounted drugs. We believe that the funded drug benefit that will be made available in 2006 will go a long way towards meeting those needs. In the interim, however, our focus should not solely be on the cost of drugs. We must also look at how those drugs are being utilized and if they are being used safely and appropriately.

Here again, PBMs have and will continue to prove their value. When a senior enrolls in a Medicare-approved PBM drug discount card, he or she is not only receiving discounts, he or she is getting the benefit of certain care management services PBMs provide to help ensure good health outcomes. We expect that when the fully funded drug benefit begins in 2006, seniors and the disabled will have access to the full range of tools and techniques that PBMs rely upon to improve drug safety and quality. Preserving PBMs' proven tools and techniques should be a top priority as policymakers work to implement the new Medicare drug benefit.

One of the most important functions PBMs perform is drug utilization review. Consider: one in four seniors sees four or more physicians; however nearly one in 10 seniors was prescribed medications by six or more different doctors in 2002. One in three seniors used four or more different pharmacies and one in seven seniors used five or more pharmacies to fill prescriptions in 2002.[9] As these data suggest, it can be difficult for any one physician or pharmacist to know all the drugs a senior is taking at one time. PBMs, however, are able to keep a patient's

[8] Congressional Budget Office, "Cost Estimate of HR 1, Medicare Prescription Drug and Modernization Act, and S 1, Prescription Drug and Medicare Improvement Act of 2003," July 22, 2003

[9] Medco Health Solutions, 2003 Drug Trend Report

prescription drug history in one central file, with appropriate privacy protections. When a senior enrolls in a PBM-sponsored drug discount card, that senior receives the added protection of having their drug utilization continuously monitored for dangerous interactions and/or for under- or over-medicating. A real-time alert will be sent from the PBM to the pharmacy if a potentially dangerous drug interaction is about to take place.

IV. PBMs Will Play Pivotal Role in Drug Card's Success for Beneficiaries

As already noted, PBMs have a proven track record in bringing high quality, affordable medicines to beneficiaries in public programs and to the under-65 population with prescription drug coverage provided by employers, Taft-Hartley trustee plans, state and federal-employee benefit plans, and health plans. Now the Medicare drug discount card program has challenged PBMs to step up to the plate and prove their value to millions of Medicare beneficiaries, particularly those with low incomes, who today pay full retail prices for their prescription drugs. PBMs are meeting this challenge.

Since the Medicare Modernization Act was signed into law last December, PCMA member companies have worked countless hours and spent millions of dollars to develop and market their drug cards. This effort includes 1) submitting proposals for drug cards to CMS for approval; 2) once approved, working with CMS on marketing, disclosure, compliance and drug price submission requirements; 3) engaging in new contract negotiations with network pharmacies and drug manufacturers for thousands of drugs covered by the program; and 4) rolling out the new cards through marketing and enrollment campaigns which have required sponsors to increase call center staff by up to 15 percent.

The information reporting requirements alone are staggering. These requirements include not only providing a complete inventory of covered drugs, but also a weekly updated list of the retail and mail-service pricing for each dosage of each drug. In addition, each card sponsor must provide a list of the retail pharmacies where seniors can go to get their drugs. Furthermore, each card sponsor is required to inform CMS the extent to which negotiated price concessions with manufacturers are being passed on to beneficiaries through pharmacies. If adequate discounts are not being passed on, or card sponsors attempt to "bait and switch" beneficiaries by luring

them with artificially low drug prices only to raise those prices once they have enrolled, CMS has broad auditing authority – backed by tough sanctions and civil monetary penalties – to protect beneficiaries.

Some critics' assertion that drug card sponsors will game the system are unfounded. The flexibility included in the MMA with regard to drug pricing and drug lists stands primarily to benefit Medicare beneficiaries.

- In the commercial marketplace, prescription drugs are rarely, if ever, removed from a formulary during a contract period unless the FDA determines a drug to be unsafe. With respect to the drug discount card program, we do not anticipate a drug being withdrawn from a list unless the FDA determines it to be unsafe.

- To the extent that there are changes to the drug list in the discount card program, they are likely to occur because a drug card sponsor is adding a new brand name or generic drug to the drug list. Adding a drug to the drug list would presumably further drive down drug prices because of increased competition within a therapeutic class.

- If a drug manufacturer *does* raise the price of a drug, the card sponsor must submit pricing changes to CMS, with supporting rationale. In reviewing price increases, CMS has the authority to impose penalties or expel a card sponsor from the program if they deem the price increase to be excessive or unwarranted. Given the potential penalties, it is unlikely that card sponsors will raise drug prices without compelling data.

V. Consumer Education Is Greatest Challenge and Opportunity Going Forward

Without a doubt, the greatest challenge to making the drug card a success for beneficiaries is informing them about how to enroll and to choose the drug card that best meets their needs and provides the maximum benefit. The www.medicare.gov website is a crucial tool -- the near and long-term benefits of making available retail pricing on thousands of drugs cannot be overstated.

Of course, seniors need to be able to rely on the accuracy of the information. There have been a few kinks in the system since the website was launched over a month ago, but CMS is working collaboratively with Medicare drug card sponsors to make the information better and more usable for seniors and the disabled. CMS should be commended for its effort in this endeavor.

In many ways, the Medicare price comparison web site lets the genie out of the bottle. Not only are retail drug prices available on one site, but information about the availability of generics and home delivery of medicines may provide seniors with new options they previously did not know existed. This information is helping to provide greater savings and enhanced convenience for seniors and provides all consumers – not just seniors – with a valuable tool for understanding and gauging competing drug prices. As a result, we expect consumers to demand more information so that they may make more informed choices. The Medicare price comparison website may well become the engine that drives quality and sparks greater transparency throughout the entire health system.

VI. Conclusion

PCMA and its member companies stand committed to do what we can to ensure the Medicare Modernization Act makes good on its promise to deliver more affordable prescription drugs to our nation's elderly and disabled, particularly those most in need. While the Medicare drug discount card program was conceived as an interim first step in this effort, we believe the program holds the potential to change the way beneficiaries access and use prescription drugs and may well have ramifications beyond the life of the program and into other parts of the system.

In time, we expect to learn more about the lessons these experiences will provide as we prepare for 2006. PCMA and its member companies will continue to work hard to conduct outreach and enroll beneficiaries in the drug card program because we believe in the tangible value it represents to Medicare beneficiaries.

Mr. Chairman and Members of the Committee, thank you for the opportunity to testify today and I look forward to answering any questions you might have.