

**PRESCRIPTION DRUGS: MODERNIZING MEDICARE  
FOR THE 21ST CENTURY**

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**HEARING**  
BEFORE THE  
SUBCOMMITTEE ON  
HEALTH AND ENVIRONMENT  
OF THE  
COMMITTEE ON COMMERCE  
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

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## **PRESCRIPTION DRUGS: MODERNIZING MEDICARE FOR THE 21ST CENTURY**

**WEDNESDAY, JUNE 14, 2000**

HOUSE OF REPRESENTATIVES,  
COMMITTEE ON COMMERCE,  
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT,  
*Washington, DC.*

The subcommittee met at 10:10 a.m. in room 2322, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Upton, Greenwood, Deal, Burr, Bilbray, Whitfield, Ganske, Norwood, Coburn, Cubin, Shadegg, Bryant, Brown, Waxman, Pallone, Deutsch, Stupak, Green, Strickland, Barrett, Capps, Hall, Towns, and Eshoo.

Staff present: Carrie Gavora, majority professional staff; Tom Giles, majority counsel; Kristi Gillis, legislative clerk; Bridgett Taylor, minority professional staff; Karen Folk, minority professional staff; and Amy Droskoski, minority professional staff.

Mr. BILIRAKIS. The topic of today's hearing is Prescription Drugs. Modernizing Medicine for The 21st Century.

I believe that this title is especially appropriate because we must examine broader reforms to preserve Medicare for the future as we consider adding a prescription drug benefit to this already financially troubled program.

In three prior hearings we discussed both prescription drug plans which had been introduced at that time and more general concepts. Today we will hear more about the specific details of different coverage options.

As most of you know, our committee colleagues, Congressmen Biley, Burr and Hall yesterday announced a bipartisan plan called "Medicare RX and Modernization 2000," a plan to help senior citizens by expanding access to prescription drugs in a context of Medicare modernization.

As our panelists and members of this subcommittee are aware, in any effort to add a prescription drug benefit to Medicare the devil truly is in the details. The path to a sensible, salient plan is riddled with potential land mines and we must tread carefully and cautiously.

Among the issues we will discuss today, this hearing will shed light on the possibilities for disease management services, the role of pharmacies, and the fate of Medicare+Choice.

As July 1 approaches we are beginning to hear about more Medicare+Choice plans withdrawing from the program. An important part of the Medicare RX and Modernization Plan 2000 would

put the administration of the Medicare+Choice Program under the purview of the Medicare Benefits Administration, the same new agency that would administer the new prescription drug benefit.

I look forward to hearing the view of the insurance industry represented by our witnesses, Karen Ignagni and Chip Kahn, about how this proposal could help stabilize the Medicare+Choice Program.

As I have continued to examine the issue of prescription drug coverage under Medicare, the role of pharmacies and pharmacists is an issue we all have carefully considered:

What is the appropriate role and function for pharmacists and organized pharmacies, and how can they help in the administration of prescription drug benefit?

I hope that Craig Fuller from the National Association of Chain Drug Stores can shed some light on these questions.

Today's hearing will again underscore the need for prescription drug coverage for Medicare beneficiaries. I am hopeful that it will also help us better understand all aspects of the new prescription drug benefit, including administration, pricing, choice, and costs. I would also like to welcome all of our panelists. Our first witness is Nancy-Ann Min DeParle, Administrator of the Health Care Financing Administration. It has been some time since she last appeared before a subcommittee, and I know that my colleagues join me in extending our congratulations on the birth of her child. I look forward to hearing from all of our witnesses, and I would like to thank them for their time and effort in joining us today.

In the interests of time, after the opening statement of the Ranking Member Mr. Brown, I would encourage my fellow subcommittee members to limit their opening statements to 3 minutes. I know that we all want to hear what our witnesses have to say and still have ample time for questions. Thank you.

The Chair now yields to Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. I would first ask unanimous consent to enter into the record Mr. Dingell's statement and statements of any other Members.

Mr. BILIRAKIS. Without objection, the statement of Mr. Dingell and all members of this subcommittee will be made a part of the record.

Mr. BROWN. Thank you, Mr. Chairman.

I would like to thank Nancy-Ann and other distinguished witnesses for joining us today.

Mr. Chairman, I am glad we have been given the opportunity to discuss the need for Medicare prescription drug coverage today. I am concerned, however, that the Republican proposal that prompted this hearing is being taken seriously when, frankly, it should not be.

How can you try to convince seniors that you are helping them when the only thing you have promised to them is a low-income subsidy. You are not helping seniors above 150 percent of poverty by subsidizing insurers; you are helping the insurers.

Your plan guarantees nothing other than some assistance for the lowest-income seniors. In my district, prescription drugs are not just a low-income problem. Seniors who thought they were finan-

cially secure are watching their savings go straight into the pockets of drug makers.

You are trying to tell seniors that there will be a choice of reliable, affordable private prescription drug insurance plans available to them. Based on what? Certainly not history.

Even the insurance industry is balking at this idea. It should tell us all something that insurers do not sell prescription drug coverage on a stand-alone basis today even to young and healthy individuals. That is because it simply does not make sense.

Medicare is reliable. It is a large enough insurance program to accommodate the risks associated with prescription drug coverage. Individual, stand-alone prescription drug policies are not.

You are actually trying to convince seniors who stand firmly behind the Medicare program that expanding the current benefit package is less efficient and more onerous than manufacturing a new bureaucracy and conjuring up a new insurance market.

Seniors are too smart for that.

I do not want to ask seniors in my district and across the country to rely on a market that does not want the business, to provide a benefit not suited to stand-alone coverage to a population that, let's face it, has never been well served by the private insurance market.

I do not want seniors in my district and across the country to be coerced into managed care plans in order to avoid dealing with three different insurance plans. Medicare, Medigap, and individual prescription drug coverage.

I do not want seniors in my district or across the country to receive a letter from their employers telling them the retiree prescription drug coverage has been terminated on the premise that "the government is offering private insurance now."

I do not want to forsake volume discounts and economies of scale by segmenting the largest purchasing pool in this country and then waste Trust Fund dollars on insurance company margins and on insurance company marketing expenses.

And I do not think the individual health insurance market is a reasonable model for Medicare prescription drug benefits.

In fact, as anyone who has had to purchase or sell coverage in that market will tell you, the individual health insurance market is not even a good model for individual health insurance. It is the poster child for selection problems, for rate spirals, and for insurance scams.

The very fact that the drug industry backed Citizens For A Better Medicare supports the private-plan approach is a giant strike against it. The drug industry and their puppet organization clearly feel that undercutting seniors' collective purchasing power, relegating seniors to private, stand-alone, you're-on-your-own prescription drug plans is the key to preserving discriminatory, outrageously high prices.

My office has been deluged by FAXes and postcards, as we all have, from Citizens For A Better Medicare warning us, "not to force seniors into a Federal Government run one-size-fits-all prescription drug plan." But Medicare itself can be characterized as a Federal Government run one-size-fits-all insurance program. It is

also the most popular and successful public program in our Nation's history.

Medicare came into being because half of all seniors were uninsured—not by their choice. Medicare, a nationwide plan with a risk pool over 30 million strong, is a stable, reliable way of insuring coverage for our seniors.

Medicare works because it guarantees the same basic benefits to all beneficiaries regardless of where they live, regardless of their income, regardless of their health status. Simply put. It is equitable.

The Republican proposal leaving seniors to search for private coverage means varying premiums and varying levels of restrictiveness on access to prescription drugs.

One other thing, Mr. Chairman. The subsidy to insurers means completely unpredictable liability for the Federal Government. The single most important objective we can fulfill this year is to secure a meaningful prescription drug benefit for Medicare beneficiaries.

Let us not make a mockery of that objective by focusing on an option that is neither responsible nor realistic.

I thank the chairman.

Mr. BILIRAKIS. I thank the gentleman.

Mr. DEAL for an opening statement.

Mr. DEAL. Mr. Chairman, I will yield my time in an effort to expedite the testimony of the witnesses.

Mr. BILIRAKIS. I appreciate that.

Mr. Waxman for an opening statement.

Mr. WAXMAN. Thank you very much, Mr. Chairman.

I welcome this hearing. I think a drug benefit for seniors under Medicare is long overdue, but I am disturbed by the evident intention of this subcommittee to use this hearing to justify moving through our committee and taking to the House floor a Republican bill that has not yet been made available to the public, that our witnesses have not even seen, that has been explained only in vague and contradictory terms, and that apparently fails to meet critical conditions for effective, available, and affordable prescription drug coverage.

In my view we can only meet our obligations to Medicare beneficiaries if we make coverage of prescription drugs a benefit that all Medicare recipients are entitled to, a benefit that covers all medically necessary drugs, a benefit that is available in every part of this country, a benefit that is accessible and affordable to seniors in fee-for-service Medicare as well as Medicare+Choice plans, and a benefit that assures Medicare beneficiaries will no longer face the discrimination in drug prices which has resulted in their paying the highest prices out of their own pockets. But that is not the approach of the Republican bill.

It tells seniors that they can purchase a private insurance drug policy patterned on Medigap policies which already fail to deliver an affordable drug benefit. That is a cruel hoax.

Except for the poor, the Republican bill does not help seniors pay their premiums. It subsidizes private insurance companies and tries to claim that that will help seniors. What that really does is mislead and confuse people about the help that is available.



The Republican bill shifts the responsibility to insurers to try to provide a benefit when they know there is going to be an adverse selection that almost certainly will make their product unaffordable and unavailable. That is not a responsible choice.

The drug companies might like it. It will pay what the drug companies want to continue to be paid. But seniors will not like this plan.

I know that the Republicans have a public relations consultant, and we have a document that came out of their consultant's distribution to the Republican Members. They suggested to the Republicans that they tell the American people that:

I care. It's easier to say I care.

And then the consultant told Republican Members. It is more important to communicate that you have a plan as it is to communicate what is in the plan.

Well that approach results in a bill that tells seniors they can purchase this policy, but it is not going to really be available to them. The Republican bill does not help seniors pay their premiums. It subsidizes private insurance companies, and then tries to claim that seniors will have a benefit.

The drug companies might like this bill. It is rhetoric but it is not reality. I think the cynicism is breath taking.

Seniors do not need us playing politics with their health care. Seniors need real coverage for prescription drugs. They cannot afford the high price of drugs, and they cannot afford to pay twice what the big buyers pay. They do not need another Medigap. They need a Medicare drug benefit.

Let's join together in a bipartisan way and in a responsible way to do exactly that.

I yield back the balance of my time.

Mr. BILIRAKIS. Dr. Norwood for an opening statement. Three minutes, please, for members other than the chairman and the ranking member.

Mr. NORWOOD. Thank you, Mr. Chairman.

I want to begin by thanking you very much for holding this hearing. As we move forward on this issue, it is important to express our gratitude to you for the series of hearings which you have held which I believe makes us far better equipped to address a drug benefit for seniors.

Now from my perspective I believe there are many critical issues that we must address in any bill we consider, but I will mention just two.

If there is one thing we can be absolutely certain of it is that a 3-week stay in the hospital typically is far more expensive than taking medications that have been prescribed for you.

When seniors are forced to ration drugs, or stop taking drugs because of the expense, they incur the likelihood that they will end up in the hospital, which in the long run draws down on the Medicare Trust Fund.

Any drug benefit proposal we consider must be targeted to help those seniors who can least afford expensive medications. Ultimately we know those seniors are most at risk to face the consequences of not taking their medication.

As I have discussed these issues with seniors in my district, I have heard again and again and again that seniors are most concerned about the seemingly endless cost of prescription drugs.

The one thing we can do to help all seniors most I believe is to provide a drug benefit that gives them some peace of mind; that makes clear that there is only so much a senior will have to pay out of pocket.

Providing seniors with stop-loss coverage for their prescription drugs will frankly ease that concern.

Mr. Chairman, I am very pleased to read that my colleagues have addressed these two key issues in Medicare Treatment 2000. I am actually looking forward to reading the bill.

It would certainly make a real difference in the concerns expressed by my constituents, and I appreciate the attendance today, Mr. Chairman, of our witnesses and look forward to their testimony.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Pallone for a 3 minute opening statement.

Mr. PALLONE. Thank you, Mr. Chairman.

Mr. Chairman, I cannot help but express my frustration this morning over the fact that the Republicans apparently have put together some sort of proposal on prescription drugs which we have not really had a copy of, which is not in legislative form but the points have been put out there and, frankly, from what I can see this Republican proposal is just an imaginary drug benefit that does nothing for seniors and is just political cover and empty promises.

As Mr. Waxman has pointed out, the House Republican Conference put out a presentation by Glen Bolger on June 8 that basically talks about this from a communications point of view.

I have to say that that is all this is. There is nothing here. It is just an effort to try to pretend that they are doing something which will never pass, will never go any place, but will be used to try to show that somehow they are trying to address this issue for the next campaign in November.

From what I can see, the Republican proposal is not a defined benefit. It is a premium support bill. It gives people whatever the insurance companies can provide. You know, we do not know what the insurance companies will give them, and they leave it up to the insurance companies to decide what kind of benefit it is going to be.

It is very cumbersome. It is ineffective. It is almost nutty, I would say. What this should be—and the Democrats have proposed—is this should be a benefit plan.

I do not understand the whole concept of saying that somehow we are going to have drug-insurance-only policies because we know that insurance is risk-oriented. This is something that everybody is going to take advantage of.

Everybody is going to need prescription drugs at some point. So it should not be used in the insurance model; it should be a benefit program under Medicare. It should not vary from State to State or from region to region; it should be defined.

Also, from what I can see about the Republican proposal it does nothing to put any pressure on price. Price discrimination is the main thing that most of the seniors talk about today.

Now rather than proposing a prescription drug benefit that is part of the Medicare Program itself, the Republicans want to force the insurance industry to offer prescription drug-only policies outside of Medicare's umbrella that the insurance itself says will not get the job done.

Indeed, just yesterday Chip Kahn, the head of the Health Insurance Association of America, told the Ways and Means Committee that the likelihood is that the people most likely to purchase this coverage will be the people anticipating the highest drug claims and would make drug-only coverage virtually impossible for insurers to offer to seniors at an affordable premium.

The insurance industry's opposition to a Republican plan that proposes to pump billions of Federal dollars into its own coffers is very telling.

This is in my view a clear reason why the Majority once again seems poised to offer a proposal on a pressing health issue that it knows has no chance of going anywhere. And, Mr. Chairman, I have to say it is just like the Patient's Bill of Rights.

We know the Conference got bogged down. The Republicans have no intention of passing a Patient's Bill of Rights, or addressing HMO reform, just like they have no intention today or any time between now and the end of the year of addressing Medicare prescription drugs.

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

Mr. PALLONE. I thank the chairman.

Mr. BILIRAKIS. Thank you.

Mr. Whitfield for an opening statement.

Mr. WHITFIELD. Mr. Chairman, thank you very much.

I am glad we are having this hearing. I find it interesting that our friends on the other side complained about not seeing the bill and then yet are very specific in their criticism of the bill.

Most of us on this side have not seen it either, but the importance of this hearing is simply to start addressing this issue. It is complex and we look forward to hearing the testimony of our witnesses as we work to fashion an effective prescription drug benefit plan.

Mr. BILIRAKIS. Mr. Towns for an opening statement.

Mr. TOWNS. Thank you very much, Mr. Chairman.

Let me say, I think this is a very serious matter and we should not be playing games with it. I think that we have a third of our seniors out there who are without coverage of any sort. I think that we owe them more. I think they need to have coverage, and I think that this is an opportunity to do it.

But to move forward with this kind of legislation that we have got ideas and going forward in the dark to me just does not make a lot of sense if we are serious about doing what is right on behalf of our seniors.

Our seniors in many instances of course they have paid a tremendous debt, and of course to come to this time in their life and have to worry about whether or not they will be able to pay for their medication to me does not make a lot of sense.

So I am hoping that we get very serious here and begin to look at this. Because when I look at New York City, or New York State I should say, New York as 2.3 million seniors who rely on Medicare. In about 2025 that number will rise approximately to 3.3 million. Only 24 percent of New York firms offer retirees health insurance.

The monthly premium for Medigap Insurance, including prescription drugs, average \$159, which is out of reach for many seniors in New York. Medicare enrollment in New York in the coming years is increasing while at the same time access by retiree health insurance and Medicare managed care is decreasing or inadequate.

This situation is not unique to New York. Other States also fall into this same pattern.

The economy is doing well. With our budgetary surpluses, it is time we start addressing our seniors' concerns about affordable prescription drug coverage.

I think we should do it. We should do it now.

Mr. Chairman, on that note I yield back. And I say to you that we need to make certain that information is shared among all Members because this is a very serious issue and I am hoping that this is not being used for any kind of political maneuver.

I yield back.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Ganske for an opening statement.

Mr. GANSKE. Thanks, Mr. Chairman, and thank you for having this hearing.

I certainly think some seniors in particular need help with their pharmaceuticals. There is a group that do not qualify for Medicaid if they are in the QMBY or SLMBY groups, the groups that are just above the requirement for Medicaid, then they get help with their premiums and in some cases with their deductibles but they cannot get into the Title XIX, the Medicaid Drug Programs.

And they definitely have a problem. I also think that all Americans are concerned about the high cost of the drug prices. I hear this from employers who are having to deal with 18 percent increases, annual increases in their prescription drug costs, and from individual citizens.

I hear from seniors that they are concerned, and from others, that they are concerned about the cost differential in drugs between Canada, Mexico, Europe, and the United States. And they do not think that it is fair.

So I do want to say that I do have a plan, and I do have some ideas on how we can accomplish this.

I sat through 8 hours yesterday of the Ways and Means testimony, and I took copious notes on this. Why did I have to do that? Why did I have to listen to questions to Chairman Thomas yesterday?

It is because I have not seen a bill. I am told that there is a bill in Speaker Hastert's office. I am told that legislative counsel has a bill, and I am told that the CBO has a bill.

I will not gainsay some of the Members who have worked hard on this, but this is way, way too important an issue to be making a decision on the biggest benefits expansion in Medicare history without fully vetting this process.

I want to put a plea in. This is an issue that should go through Regular Order, hearings, more than one, a subcommittee markup, a full committee markup, both in the Commerce Committee and in Ways and Means.

Why? Not for the benefit of the members of this committee but for the benefit of our colleagues so that this issue is fully vetted so that they understand fully what they are going to be voting on.

It would be a tragedy to put a bill on the floor that most Members do not understand what the implications would be. I just cannot support a bill that goes through that kind of process.

What did I learn from the chairman, Chairman Thomas, yesterday? I learned that there will be a SOP made to rural Members with some modest increase in the AAPCC to try to buy their vote.

It will never be enough to get HMOs into those rural districts like mine which are composed of elderly citizens that the HMOs do not want to cover that have medical problems.

I heard yesterday that there will be a whole new separate bureaucracy set up in the GOP plan. We need to think about that.

But what is the big problem?

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

Mr. GANSKE. Mr. Speaker, could I ask unanimous consent for 1 additional minute?

Mr. BILIRAKIS. Well now if we start that, Greg, we are never going to get to the hearing.

Mr. GANSKE. I understand that, Mr. Chairman, but how big an issue are we going to face?

Mr. BILIRAKIS. Well this is a big issue and we have spent a lot of time on it and we are going to continue to spend an awful lot of time on it. I would appreciate it if the gentleman would withdraw his request.

Mr. GANSKE. I can take up this issue in comments later and I will submit my statement.

Mr. BILIRAKIS. Ms. Eshoo for an opening statement.

Ms. ESHOO. Good morning to you, Mr. Chairman, and all the members of the committee, and certainly to the distinguished individuals who are going to testify at this important hearing today.

I have of course a fuller statement for the record, but let me just try to summarize in a brief period of time. There are time limits around this. I know that that is important. We want to hear from the witnesses. But as the gentleman just stated, this is an issue that is not just large, it is a giant issue.

We really have to be devoted to giving the kind of time to the scrutiny of the ideas and plans that are being placed before us here in the Congress. We know what the problem is. It is not an issue of whether we should do something about it, but rather how to.

I am very proud to have introduced legislation that really builds upon the President's plan and moves beyond it by incorporating competition to bring down pricing. Seniors are paying too much for their prescription drugs. But I think that we also have to reduce the efficiencies that could be there relative to the administration of a new benefit.

This legislation, the Medicare Prescription Drug Act of 2000, H.R. 4607, I am very proud to say is originally co-sponsored by many Democrats on this committee.

Suffice it to say that at least in my view—and I think in many Members' views—this is a benefit that needs to be consistent for seniors.

I do not believe that insurance companies hold a great deal of credibility today with seniors. They did not a couple of years ago with HMOs. Now it seems to me that there is a move to HMO/insurance prescription drug benefits.

The insurance industry says that they do not want to insure this, or that they can't, and today in my district and I think districts around the country insurance companies are pulling out of the market.

If there is anything that my mother wants it is some consistency in her life. You know? She has gone through the peaks and valleys of life, and there are some things that she and her peers really want to be able to rely upon.

So I think that the Congress needs to move in the direction to make a benefit that can be counted on in Medicare, a full benefit. And if someone has a benefit through their previous employer as a retiree, so be it. If they want to count on it as a Medicare benefit, it should be there. But we should not be backdooring it through some kind of insurance plan.

I too spent a great deal of time yesterday, along with my Republican colleague and many others at the Ways and Means Committee testifying on my bill—

Mr. BILIRAKIS. The gentlelady's time has expired. Please finish up.

Ms. ESHOO. I think that the direction at least that Mr. Thomas is taking is really not the most prudent one for seniors. So I look forward to hearing from our witnesses today, and I thank you, Mr. Chairman, for holding this hearing.

[The prepared statement of Hon. Anna G. Eshoo follows.]

PREPARED STATEMENT OF HON. ANNA ESHOO, A REPRESENTATIVE IN CONGRESS FROM  
THE STATE OF CALIFORNIA

When Medicare was created in 1965, seniors were more likely to undergo surgery than to use prescription drugs. Today, prescription drugs are often the preferred, and sometimes the only, method of treatment for many diseases. In fact, 77% of all seniors take a prescription drug on a regular basis.

And yet, nearly 15 million Medicare beneficiaries don't have access to these life-saving drugs because Medicare doesn't cover them. Countless others are forced to spend an enormous portion of their modest monthly incomes on prescription drugs. Right now, 18% of seniors spend over \$100 a month on prescriptions. Seniors comprise only 12 percent of the population, yet they account for one-third of all spending on prescription drugs.

The question before Congress is not whether we should provide a Medicare drug benefit, but **how** to do it.

Our Republican colleagues believe that we should turn the problem over to the private insurance market, but the private insurance market is pulling out from under seniors in the Medigap and Medicare+Choice markets. I receive letters and calls every day from seniors in my Congressional District who are frantic that their Medicare HMO has raised prices, scaled back benefits, or is pulling out of the market entirely. Why should seniors trust the private insurance industry if this is what is happening to them today? Chip Kahn of the Health Insurance Association of America (HIAA), the trade association that represents the health insurance industry, has stated publicly that health insurance companies won't offer Medicare drug-only plans because they can't make enough money. So, I don't believe that the private insurance model will work.

Some believe that the federal government should limit how much drug companies can charge for their products. I disagree. Price controls are anti-competitive and can

place patient access at risk. I have the largest concentration of biotechnology and pharmaceutical companies located in my Congressional District and I see every day the capital risk that is inherent in research and development. Start-up companies in my district won't get the capital necessary to develop that next breakthrough Alzheimer drug if the investors know that the federal government is going to cap how much they can charge for it.

I've introduced legislation that builds upon the President's plan by incorporating open competition and reduced administrative inefficiency. My bill, *The Medicare Prescription Drug Act of 2000* (H.R. 4607), stays true to the hallmark of the Medicare program by providing a generous, defined benefit package that's easy for seniors to understand; yet we took a step into the future by introducing private-sector competition. The result will be a more affordable drug benefit for both beneficiaries and the Federal government.

The bill is simple. Available to all Medicare beneficiaries, the Federal government will pay half of an individual's drug costs up to \$5,000 a year, when fully phased in. For seniors who exceed \$5,000 in drug expenditures—or \$2,500 in out-of-pocket costs—the Federal government picks up the whole tab.

PBMs will deliver the benefit and seniors will choose among multiple options much like we do today in the Federal Employees Health Benefits Plan (FEHBP). By allowing multiple PBMs to use the same tools that have made them successful in reducing costs and promoting quality for employees in the private sector, my bill will, for the first time, introduce open competition into Medicare, reduce prices, and increase consumer choice.

According to CBO, if only one PBM is allowed in each region and PBMs are not allowed to offer a selective formulary, there would be little incentive for reduced pharmaceutical costs. Simply purchasing a large quantity of drugs does not drive prices lower in the private sector. Pharmaceutical companies grant discounts when a PBM can show that it increases a company's *market share*.

By contrast, allowing for multiple PBMs, and allowing the PBMs to be more selective about the drugs they offer will result in price competition among pharmaceutical companies. We would also allow PBMs to pass cost savings on to Medicare beneficiaries in the form of lower co-payments. The result would be lower drug prices for beneficiaries and significant savings to Medicare. To ensure patient quality, when only one drug is available for a given disease or condition, the PBM would be required to carry it on the formulary.

We've also removed sole administration of the program from HCFA. HCFA will continue to oversee beneficiary eligibility and enrollment but it can't, by itself, run this program. The healthcare system has evolved rapidly, and regrettably HCFA has not kept pace. HCFA lacks the expertise to run a benefit that relies on private sector competition to control costs.

Fortunately, there is another agency that has expertise interacting with private sector health plans, and has proven that it can administer benefits effectively and efficiently with a minimum of bureaucracy. It's the Office of Personnel Management (OPM)—which runs the widely acclaimed FEHBP. OPM will define market areas, articulate quality and performance standards, and evaluate PBMs—just as it does currently for health plans. OPM will ensure that competition is harnessed to run an efficient benefit of the highest quality. Under OPM's leadership, I'm confident that an efficient and effective competitive benefit can be integrated successfully into the Medicare program.

I'm proud of this legislation and proud of the support it has received to date. Original cosponsors of the bill include a large number of Commerce Committee members and a broad cross-section of the Democratic Caucus. We agree that the best way to get this done is to provide a generous, reliable Medicare drug benefit for seniors without price controls and without harming innovation.

For our Nation's seniors, prescription drugs are not a luxury. During these times of historic prosperity and strength, there is absolutely no reason to be forcing seniors to decide between buying prescription drugs or other necessities of life. In the words of Franklin Delano, "the test of our progress is not whether we add more to the abundance of those who have much; it is whether we provide enough for those who have too little." It's time that we stop wasting our budget surplus on tax cuts for the wealthy and use it to provide our Nation's seniors with a basic healthcare need—coverage of prescription drugs.

Mr. BILIRAKIS. Mr. Bryant for an opening statement.

Mr. BRYANT. Thank you, Mr. Chairman. I too want to add my appreciation to both you for calling this hearing and the panel, the very distinguished panels we will have today.

I think when I came to Washington about 6 years ago I was an optimist. I felt like we could come up here and work in the system and both sides wanted to get a solution that would help everybody.

And over a period of time, that has somewhat eroded as I have seen partisanship not just on one side but certainly on both sides.

You know we have a problem in this country on seniors having access to affordable prescription drugs and we all want to solve it, I think.

And then I come in today and I hear something about we have got a public relations guy helping us. Gosh, that is a shock up here in Washington.

Then I hear this term "Republican bill" and Republican bill, rather than a bipartisan bill. There are some Democrats on this.

It kind of makes me believe what I read in one of the papers up here the other day that on the Senate side the Democrat Senator who is co-sponsoring one of the Republican bills is facing sanctions over there, punishment for doing that because he is not playing politics.

Because everybody up here knows, and maybe it is unspoken, today that some people want this to be the issue in the election rather than trying to get down to business and solve the problem.

I think we can do that. I think both sides, when you really look at it, really are not that far apart, particularly on dollars. I know our plan we have worked very hard on it. It is a universal plan. It is a voluntary plan. It is a choice out there to the citizens. It helps those in financial need. It helps on the high end to prevent people from having to sell their homes or use up their savings account if they have a catastrophic drug bill each year.

It is a good bill. I guess I would like to reach down and bring back up some of that optimism and hope that we can work together and not have this as a campaign issue but work together to get a bill that will truly help our senior citizens.

I would yield back my remaining time.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Stupak for an opening statement.

Mr. STUPAK. Thank you, Mr. Chairman—

Mr. BILIRAKIS. And, Bart, our sincere sympathy, publicly.

Mr. STUPAK. Thank you, Mr. Chairman.

Mr. Chairman, we have really not seen the bill, but the talking points we have seen reminds me of the old Golden Rule that seems to be followed in this bill. Do not hurt the pharmaceutical. Increase the insurance company profits, and make coverage as complex as possible.

The GOP bill says. "Trust private insurers."

Trust the pharmaceutical companies whose profits are \$20 billion, whose net operating profit is 28.7 after all the research, after all the advertising, it is 28.7 percent on pharmaceuticals when the rate of inflation is less than 3 percent. It is price gouging.

This is a study from my district in October 1998. Take any drug you want. Zocor for cholesterol. If you are the Federal Government you pay \$42.95. If you are a major wholesaler, you pay \$85.47. The average price is \$106.84. If you are a chain market, it is \$101.29. Independent pharmaceutical companies or stores pay \$99.38. The average retail price is \$100.33. The price differential is 134 per-



cent. That is in my district in northern Michigan. That is price gouging. That is price discrimination.

Those who can least afford it, who do not have the insurance coverage, pay 134 percent more.

The GOP plan has more bureaucracy. There are no real protections. The GOP plan really says to the American people. Look, each senior, you go out and negotiate whoever you want with the private insurance companies, with the big HMO plans. We are not going to help you. You negotiate. We will then give you some money. Not to the American people but to the insurance companies and to the HMO. Your pharmaceutical company will reap the benefits. Government will give you nothing.

This is the same GOP plan. Remember, they are the ones who want to privatize Social Security? Now they want to privatize your prescription drug coverage. That is the same group that wants to let Social Security wither on the vine.

If you take a look at it, we privatize Medicare—excuse me, Medicaid in Michigan. Two years ago, the State of Michigan ran it. The administrative cost was \$28 million. Two years later, after it was privatized, the administrative cost is \$141 million. In 2 years, \$141 million.

It is unbelievable what you can do when you can privatize systems like we did in Michigan. Medicaid. Medicaid? Unbelievable. Look at those administrative costs, \$28 million to \$148 million. That is exactly what is going to happen to our prescription drug plans.

Look it. The Democrats for 2 years had the Allen bill out there, the Stark bill. We had the President's plan. Give us some hearings on it. Universal coverage. That's what we need. Stop and think. We need universal coverage so that all seniors are covered.

Stop the price gouging. If you do not, the profits will remain at 28.7 percent. No problem with profits. But if it is going to continue to price gouge, we will all be in trouble.

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

Mr. STUPAK. Most Americans after this is over will not be able to afford any type of drug coverage.

Mr. BILIRAKIS. Mrs. Cubin for an opening statement.

Mrs. CUBIN. Thank you, Mr. Chairman.

I would like to begin by associating myself with the remarks of several of my colleagues, Mr. Bryant and Mr. Towns, stating that this issue is far too important to politicize.

What we need to look out for are the best interests of our senior citizens. I do not think anyone here at all underestimates the value and the importance of drafting a prescription drug proposal program for our seniors.

We all want the life-saving drugs to be available, and no one should go without food to get them. Our intentions are good, and our expectations are very high. That makes crafting a drug plan all that much harder.

Seniors are looking to us to help make a difference in the quality of their life. They are not looking to us to politically attack one another and to try to find grounds to do that.

Today we are going to be considering some very pointed aspects of the issue:

How do we administer a prescription plan?  
 Should it be voluntary?  
 Should it be market based?  
 Or should it be government run?  
 What kind of benefits are to be offered?  
 How much will the government subsidize?  
 How does it affect Medicaid?

I agree that all of these questions have to be adequately addressed for any plan to be successful, but I also think there is one critical component that is not getting the attention that it deserves. That is, how does any plan affect rural America?

As most of you know, I represent the State of Wyoming which is the most rural State in the country. While you may be able to identify Jackson Hole and Yellow Stone National Park with Wyoming, I do not think that it is easy for some people to be aware and grasp the concept of the State's true size and the amount of vast open spaces.

With approximately 480,000 people covering almost 100,000 square miles, we sometimes have to drive hundreds of miles just to access medical care. Oftentimes that means going to another State.

We have to rely almost exclusively on fee-for-service in Wyoming. And because of that, seniors in Wyoming have less access to drug coverage than seniors would in California, for example, where there are many Medicare HMOs.

Programs within the present Medicare system, such as Medicare+Choice, have not been beneficial to rural areas as originally envisioned due to a lack of customer base in these areas.

So as a result, options for rural populations of our country are often very limited, or many times nonexistent.

Having said that, I worry that a similar problem may occur in any prescription drug plan benefit that does not adequately address the needs of rural Americans.

I urge all of my colleagues on the committee to keep that in mind because there are a lot of people who live in rural America that could be very adversely affected by any program that does not take these elements into consideration.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. Mr. Green for an opening statement.

Mr. GREEN. Mr. Chairman, I thought Mr. Strickland was here earlier.

Mr. BILIRAKIS. Well I don't know. I am taking you by order of seniority.

Mr. STRICKLAND. I am very generous. Go right ahead.

Mr. GREEN. Okay. Thank you, Mr. Chairman.

Mr. BILIRAKIS. That is unusual.

Mr. GREEN. I will be glad to take my time from my colleague from Ohio.

Mr. Chairman, I want to thank you for calling this hearing today. I appreciate the number of hearings we have had on the prescription drug initiative and hopefully we will have legislation to look at to actually mark up.

Sadly, it appears, that what I see in the press is the effort is not as bipartisan as I would like it to be. We see a press release that gives some ideas but not actually legislation.

Hopefully, by our committee working together, as is the tradition of the Commerce Committee, we can come up with a plan that a majority of Americans will support.

A plan that actually puts money into the pockets of seniors for prescriptions and not necessarily insurance carriers. Working together we can put together a plan. Unfortunately, what I have seen up to this point we have not been able to, and I hope our subcommittee can do that.

And again, all we are working from today is a press release, so that is what I will base my remarks on. Medicare was created in 1965 because private-sector insurance could not provide coverage for senior citizens.

Everyone was a claimant. Everybody had a claim. So profit and loss would not work. We are having the same example today with prescriptions. Every senior citizen has prescriptions. In fact, sometimes half a dozen of them. That is why the private sector cannot work.

Except in this press release we are using it shows that that is what it will do. The proposal is a new drug-benefit-only policy that the experts say will be ineffective and inexpensive.

The drug-only benefit will have adverse selection for seniors. Even worse, it allows the insurance companies to select what drugs they will cover and how much they will charge. There is no guaranteed standard benefit.

Allowing insurance companies to set the benefit and price is like letting the wolf guard the chicken house. And any savings would not go to those seniors.

Some in the insurance industry will be able to set the prices. I wonder why, instead of using taxpayer dollars wisely, the proposal we have is to create a new bureaucracy: the Medicare Benefits Administration, or MBA, which duplicates what HCFA and our committees already do.

So we are going to take money straight out of the Medicare Trust Fund to pay for this new bureaucracy.

Medicare has the most efficient administration. It is less than 1 percent, and I think that can be comparable to any other insurance plan.

America's seniors need prescription drugs. They are sick and tired of the Medigap policies. The Medigap policies we have now, the costs are going up so substantially and this would add just another Medigap policy to seniors who are already having to pay upwards from \$200 to \$300 a month in some cases.

So, Mr. Chairman, hopefully we will see a bill. And hopefully the press release I have seen and the guidelines is not what our committee is going to be looking at.

Thank you.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Bilbray for an opening statement.

Mr. BILBRAY. Thank you, Mr. Chairman.

Mr. Chairman, I would really like to echo the words of my colleague from New York, Mr. Towns, and also my dear friend from Wyoming.

The partisanship sounds great in Washington, and the bickering between Republicans and Democrats may play well to the afternoon news, but I think the American people are sophisticated enough to see that not only is this issue important enough to be able to ignore partisan lines, but they are sophisticated enough to know when people are trying to manipulate issues for political reasons on both sides.

I think they will hold us both accountable if we approach this issue from a partisan point of view. I would just ask that my colleagues understand that as we snipe across the aisle we do not make the other person look bad, we make ourselves look bad.

I would just ask us to consider the fact that there is a lot of common ground that we have here, not just political differences. We have parents that need to leave healthy. We have children that need not to be taxed to death to support their grandparents health care.

We have the challenge of how we are going to administer the next level of service to our seniors in this country.

Now there has been some sniping about the creation or the alternative way of administering this new benefit. The fact is that Democrats and Republicans agree in many instances that HCFA is not the agency to administer this program.

I want to commend my colleagues on the other side of the aisle who have been brave enough to say we not only can do better than HCFA, we have to do better than HCFA.

Now we may disagree with the President, and I think Democrats and Republicans can convert the President over to our way of thinking that there needs to be a better way than the traditional HCFA way.

I want to thank my colleagues on the Democratic side for being brave enough to say that.

I just ask us to really, let's listen to the facts. Let's not find reasons to snipe. Let's look at these issues where we have common ground. We can build on this common ground and build a foundation that not only makes us look good in the eyes of the voters but also is going to provide the service that is going to make us look good in the pages of history in the future.

I would ask you to consider the fact that we are going to be making decisions that are not only going to affect us, they are going to affect our parents and they are going to affect our children and our grandchildren.

I think that come November we are going to be judged by how well we work together, not how quickly we found excuses to fight.

I yield back, Mr. Chairman.

Mr. BILIRAKIS. The Chair thanks the gentleman.

Mr. Strickland.

Mr. STRICKLAND. Thank you, Mr. Chairman.

My colleague from Tennessee said a few moments ago that some would like for this to be an election issue. I do not know if that is true, but I do know that it is true that it is going to be an election issue.

It is going to be an election issue because this issue is important to the American people. They are paying attention.

When I hear my friend, Dr. Ganske, talk, I realize that it is not a totally Democrat/Republican controversy, but it involves political philosophy, and it involves each Member deciding who it is that we were sent here to represent.

I think we will be held accountable district by district, Member by Member.

This bill, as we have read about it, has nothing that I can see on the cost side. In my district, just as in Representative Stupak's district, my senior citizens are paying twice as much for these life-saving medications as are large HMOs or large insurance companies or the Federal Government.

As far as I can tell, this bill does nothing about that problem. The American people are rightly outraged—outraged—that American tax dollars are used to develop medications that are being sold in Canada, and Mexico, and everywhere else around the world for one-third to one-half of what the American senior citizen has to pay for that very same medication.

They are outraged.

They are not going to tolerate it anymore, and we have got to do something about that.

For one, I am just tired of going to my district and seeing senior citizens stand in these public meetings with trembling voices, quivering hands, and talking about their problems.

We are Representatives. Our response to this issue will decide who it is that we represent. Yesterday in the House of Representatives there was a vote. It was fairly simple. It said that if tax dollars are used by pharmaceutical companies to develop drugs, those drugs should be then sold to the American consumer at a reasonable rate. And it failed to pass.

I think that says something about why we sometimes talk about this issue in partisan terms. It is not totally Democrat/Republican. But as I said before, Mr. Chairman, it does reflect our political philosophies and our value systems.

I yield back my time.

Mr. BILIRAKIS. Ms. Capps for an opening statement.

Ms. CAPPS. Good morning, Mr. Chairman, and thank you for holding this hearing on one of the most pressing health care issues facing our country today, which is prescription drug coverage.

The creation of Medicare in 1965 found seniors more likely to undergo surgery for major health problems than to use prescription drugs. Today it is the opposite. Prescription drugs are often the only method of treatment for many illnesses and diseases.

In fact, 77 percent of all seniors take a prescription drug on a regular basis and yet nearly 15 million Medicare beneficiaries have no insurance coverage at all for prescription drugs.

Most of us today would agree that Medicare's most glaring problem is the lack of drug coverage. Clearly, no one would design a health insurance program for seniors today that does not include a drug benefit.

I do not think anyone here would voluntarily choose a plan for their family that did not cover this. And Medigap policies, which

were designed to fill this need, are too often expensive and inadequate.

We hear again and again about seniors on modest fixed incomes choosing between food on the table and life-saving medication. At this time of prosperity and strength, we really can and should do better than that for older Americans.

This problem is getting worse. According to Families USA the price of prescription drugs most often used by seniors has risen at double the rate of inflation for 6 years in a row.

Congress can no longer sit idly by. As we consider different plans to tackle this problem, I believe that any worthy proposal will provide certain key elements.

A strong plan would be universal, voluntary, affordable, accessible to all, and based on competition. It must also address the issue of catastrophic coverage.

Many worthy legislative proposals have been raised. For example, the Allen bill, the Stark-Dingell bill, the Pallone bill. Most recently, I have co-sponsored H.R. 4607, Medicare Prescription Drug Act of 2000 introduced by our colleague, Anna Eshoo.

Like the President's proposal, the Eshoo bill creates a new voluntary Part D prescription drug benefit in Medicare that is optional and available to all beneficiaries regardless of income.

It includes a defined stop-loss benefit to prevent any individual beneficiary from being bankrupted by a single catastrophic event that causes unusually high drug costs, and it uses proven market-based approaches to promote competition and drive down prices.

The Office of Personnel Management would administer the plan in coordination with HCFA.

Mr. Chairman, Democrats have offered many different approaches to this problem, but I am disappointed that we do not yet have a finalized bill from the Majority. It would be my hope that we could work together in a bipartisan fashion as we craft the best possible legislation for older Americans.

As I think about the countless seniors in the district I represent on the central coast of California that have shared their personal stories with me about crushingly high drug prices, I know in my heart the prescription drug coverage is not a political issue.

It is simply the right thing to do as we seek to honor our seniors and care for them as they move into their golden years.

And so I thank you, Mr. Chairman, for holding this hearing. I hope we can move legislation as soon as possible on this most pressing issue for our country.

Mr. BILIRAKIS. I thank the gentlelady.

Mr. SHADEGG for an opening statement.

Mr. SHADEGG. Thank you, Mr. Chairman.

I will be brief. With your consent, I will insert my entire opening statement in the record.

Mr. BILIRAKIS. Without objection.

Mr. SHADEGG. I simply want to thank you, Mr. Chairman, for holding the hearing on this very, very important subject. I agree with many of the comments that my colleagues have made. Clearly no one in our society, and certainly not a Member of Congress representing a State like Arizona with many senior citizens, can not

be concerned about the cost of prescription drugs for our seniors today.

So I think it is important, and indeed essential, that this Congress look at the issue and address it and do so in a thoughtful and bipartisan fashion.

I think it is clear, however, that as we proceed that we make sure that we do not do more harm than good. And I think that is one of the injunctions that we have to be aware of. Our efforts have to make sure that we do not unduly burden the current Medicare system; that we do not create for it a financial obligations that it cannot fulfill and burden its ability to do the other tasks that it has to pay for the other parts of health care.

This is indeed I think one of the toughest challenges we face in this Congress. I think it is also important in focusing specifically on the drug issue that in what we do we do not cause the cost of drugs to go up.

I compliment you, Mr. Chairman, and the other Members of this Congress on both this committee and others that are looking at the reasons behind the dramatic increase in drug prices and examining whether or not the drug industry is in fact abusing the American marketplace in some fashion, and if there are not other things that we need to be doing to ensure that drug prices are not going up in this country in an unfair fashion. So I think we have to keep those issues before us. I think we have to act thoughtfully. I think it is appropriate that we hold this hearing, and I am anxiously awaiting seeing the full proposal that will be before us I guess early next week, if not sooner.

And again, Mr. Chairman, I compliment you for holding this hearing. I look forward to working with you, and I do urge all my colleagues that we look at whatever costs we incur and whatever obligation we place on future generations in what we do through this legislation.

Thank you, Mr. Chairman.

[The prepared statement of Hon. John Shadegg follows.]

PREPARED STATEMENT OF HON. JOHN SHADEGG, A REPRESENTATIVE IN CONGRESS  
FROM THE STATE OF ARIZONA

Thank you Mr. Chairman for holding this important hearing. I share my colleagues' concerns about segments of our elderly population that are truly in need when it comes to the prescription drug issue. At the same time, I also realize the tremendous political pressure that has developed behind providing a Medicare prescription drug benefit. Before we discuss the positives and negatives of such proposals, I wanted to highlight concerns about the current solvency of the Medicare system.

When I first came to Congress in 1995, the Medicare Part A Trust Fund was expected to be insolvent by 2002. As a result of Republican leadership and tough choices we made in the Balanced Budget Act of 1997, the outlook for Medicare has improved significantly. In fact, the March 2000 report by the Social Security and Medicare Board of Trustees shows that we have pushed out the projected insolvency date for the Hospital Insurance Trust Fund to 2025. I do want to caution all of my colleagues, however, not to get lulled into a false sense of security. No matter what we do, we still cannot redirect the demographic freight train bearing down on Medicare. It bears repeating that when the baby boom generation begins to reach retirement age in 2010, there are expected to be 3.6 workers per Medicare beneficiary. This ratio shifts to 2.3 in 2030 as the last of the baby boomers reach age 65, and continues to decline thereafter. Based on the intermediate assumptions of the Medicare Board of Trustees, income in the Hospital Insurance Trust Fund is projected to exceed expenditures for the next 17 years, **but is projected to fall short by steadily increasing amounts in 2017 and later.** Furthermore, Medicare spend-

ing will continue to grow by an average of nearly 7 percent over the next 10 years, doubling current Medicare spending of \$200 billion to more than \$400 billion in 2010.

These are the sobering realities of Medicare's current fiscal health. And they do not take into account any new prescription drug benefit. Does this preclude us from considering a Medicare drug benefit? No, and in fact, I am glad to see that the House Bipartisan Prescription Drug plan takes a step in the right direction by involving the private sector. But, as we examine the prescription drug issue in Medicare, let us not lose sight of the overall Medicare picture. If we don't do it right, it could have disastrous consequences on our nation's and children's future.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Barrett.

Mr. BARRETT. Thank you very much, Mr. Chairman. And thank you for holding this hearing. I appreciate the work that you have done on this issue.

I sense from the comments of some of my colleagues on the other side of the aisle that there is a frustration or a feeling that this has become a partisan issue.

I would simply ask them, and those who are listening, to re-examine this and understand the frustration felt by the Members on this side of the aisle because over 2 years now, sometimes as long as 4 years, we have been talking about this issue, introducing bills, trying to get hearings, trying to get this Congress and this Republican Party to focus on this issue.

We have been met time and time again with nothing but roadblocks. I am extremely pleased that finally this logjam has broken and we are able to move forward.

I do think, and I think probably most of us recognize, part of the reason for that is every single person at this panel knows that this issue is literally off the charts when it comes to seniors in this country.

This is a real-world issue. And I would bet anybody on this panel who has held a town hall meeting in the last 6 months has heard about how serious a problem this is for real people in our districts.

It is democracy working at its best when we respond to it. So I am delighted to have the conversion—the pre-July 4 recess conversion—that we are seeing here that is allowing us to at least consider the merits of a bill.

I think, having said that, we can move to the next level. And the next level is. Where do we go?

Here I think we can have a legitimate debate over what the best course of action is. I do not buy into the notion that somehow we are going to create a new insurance industry for prescription drugs.

I think that if there were a market for prescription drugs that could be handled by the insurance companies that would have occurred long ago. I compare it, coming from Wisconsin, to saying well let's create a market for snow insurance. Anybody who doesn't want to get snowed upon can buy snow insurance.

Well nobody wants to get snowed on, but everybody is going to get snowed on. In the same vein, nobody wants to buy prescription drugs but everybody needs prescription drugs, especially when you are elderly. So no one in Wisconsin is going to sell snow insurance, and my guess is no insurance company voluntarily is going to come and say, oh, sure, we will start selling prescription drugs knowing every single person who buys this policy is going to make a claim. It is just not realistic.



So we have to focus on the benefit. And I think that the plan that the Democrats have developed is one that rightfully recognizes that this is a benefit program and of course we are going to pay for it. Of course, we have to pay for it. But to somehow suggest that the laws of economics which for decades have prevented the creation of this industry will somehow be translated shortly before an election because we pass a piece of legislation I think defies economic logic.

It is just not going to happen. And I think we are trying to sell people a pig in a poke if we are telling them that that is what we are going to do.

So again I look forward to the debate on the merits. I think the American people deserve this benefit. I think the American people need this benefit. And I think it is our obligation to provide it to them.

And I would yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Deutsch for an opening statement.

Mr. DEUTSCH. Thank you, Mr. Chairman.

You know I think Congressman Barrett made some points that I think are really worthy of a follow-up.

I believe most of us have probably had town meetings within the last 6 months, and for any of my colleagues who have not they should. Because this is an issue, if you are having a town meeting and you are opening up the floor, people are going to talk about.

If you are in your office and you are looking at your mail, it is the thing you are going to hear about.

We did a town meeting, an electronic town meeting, where we sent follow-up letters where we had 9000 people in my district send specific proposals, specific incidences of problems that they have had in terms of Medicare coverage for prescription drugs.

That is off the charts in terms of any response that we have had on any other issue. We had another electronic town meeting recently with the same type of overwhelming, real response we have had physical town meetings with people, and the stories that you hear are what our job is about.

The personal suffering, the personal tragedies, the things that are disheartening because each of us on this committee know that we can do something about it. And we can do something about it within a policy context with only doing good.

The tradeoffs that exist are really not there. It is a question of the political will to make this happen. Several colleagues, and my colleague Ms. Capps, pointed this out, and I think this is also something that we need to really focus on, if we were sitting here in 1965 and creating Medicare there is no chance we would not have included prescription drug coverage like we as Democrats and the President are proposing.

The whole concept of Medicare as a national insurance program for seniors is illogical in a sense without prescription drug coverage. And that is what we are proposing.

I think it is important to understand that there is a fundamental distinction between at least the drafts and the press accounts of what the Republicans are proposing.

The Republicans are, at least by press accounts, are in fact proposing a fundamental change in the concept of Medicare. One of the reasons why Medicare has existed so well, and I think that sometimes we need to pinch ourselves to remind ourselves that at one point in time Medicare did not exist, and it does not exist by an Act of God; it exists because of an act of people in the U.S. Congress in passing legislation, but the—

Mr. BILIRAKIS. The gentleman's time has expired. Please finish up.

Mr. DEUTSCH. Thank you, Mr. Chairman.

I will just close by saying that the Republicans—in at least the proposals we've been able to read about—are changing the fundamental concept of universality within Medicare. It is an attempt to really change Medicare in an incredibly and I think long-term negative way, and—

Mr. BILIRAKIS. The gentleman's time has expired—

Mr. DEUTSCH. [continuing] I urge debate to continue to openly we will vote on the floor on a proposal that—

Mr. BILIRAKIS. Dr. Coburn for an opening statement.

Mr. COBURN. I thank you, Mr. Chairman.

Mr. Chairman, I find myself in the peculiar position of being opposed to any Medicare drug benefit simply because we are fixing the wrong problem.

We have this tremendous rise in drug prices and we need to ask ourselves why that price rise is there. And I honestly believe that it is there because there is a lack of competition in the drug industry, and I plan on demonstrating that on prices that have been surveyed throughout this country on competing drugs that have been introduced in the last years.

And if there is no competition, there certainly is collusion among the drug industry as they introduce new products.

So I find it ironic that no matter whose program we put forward, the Republicans or the Democrats, we are putting forward a program that is going to spend too much for existing drugs because there is way too much collusion within the industry.

I hope in the next 6 weeks to prove that to the American people.

I think the other thing is that Medicare is actuarially unsound. There has never been a time where this government has correctly estimated the costs of any new benefit to Medicare.

As a matter of fact, the closest they have come that my staff can find is they have missed it 700 percent. So if you take the conservative estimates of both the Democrats and the Republicans you are talking about \$280 billion over 5 years added to Medicare.

That is something that will sink it within about 6 years. We must not forget that once we add a benefit we are not going to be taking it away, as what we saw in the last 1989-1990.

The other thing that is important is the distribution by MedPak of the total prescription drug expenditures in this country. Six percent of the Medicare patients spend over \$3000, 14, \$1500 to \$2999.

Fourteen percent do not spend any money on drugs. So whatever plan we devise, what we have to do is to make sure that the price that is paid for the drug is based on a competitive model that most properly allocates the scarce resource in this country.

It is my contention that that does not exist in this time, and no matter what we do in terms of Medicare benefit we are not doing a good job for the public until we have assured ourselves that there is in fact competition in the drug industry.

With that I would yield back.

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

Mr. BURR. Thank you, Mr. Chairman.

It is difficult to listen to just the opening statements of members of this subcommittee, and probably Members from the House of Representatives at large, and not get a feel for how difficult this task is.

This is the most difficult thing I have ever worked on since I came to this institution. Mr. Deutsch hit on a very good thing, but there is—we ought to look at people that have looked at the entire situation and look at the advice they gave us.

Gosh, as it relates to Medicare, I think it is the Medicare Commission who spent over a year looking at every aspect and said, not only should there be drugs, there should be comprehensive modernization of the Medicare system. Our seniors deserve the best.

Well, politically we all know that the reality is we cannot do it. In the absence of that, we try an approach that addresses the most severe need of 38 million seniors and disabled who qualify for Medicare, to make sure that a benefit, a benefit designed within the limits of the financial tools that we have got available, exists.

Now we have a fundamental difference between those on the left side of the dais and those on the right side. It is an argument over whether government controls this new benefit or whether in fact we use the competition of the private sector to monitor and to hopefully make it successful and cost effective.

That is a huge difference. It is a huge difference, and it may in the end defeat this effort. But I am confident that if we can put words aside like “nutty,” “cruel hoaxes,” if we can take consultants out of it at a time that we are out-purchasing \$25 million worth of TV ads for the fall to hit on this issue, that we can take politics out of the debate on the Medicare drug benefit; that we can work with Democrats, insurance companies, PBMs that Mr. Pallone’s impression of insurance companies will be the same as the day he introduced his bill which was insurance based and not today where insurance companies are bad. But we have got to get past this.

Mr. Chairman, I am hopeful that we will get on the words “accessible,” “affordable,” “voluntary,” but that also every Member will get in their vocabulary “security.” That without a stop-loss we have done nothing for seniors.

Without the ability to say to a senior here is a dollar amount that you will not be responsible for one penny after that point, that we have fallen short of the predictability they need to plan in a time of their life where their incomes are limited we can help to make their futures predictable.

I am hopeful that this hearing today, which is not about our bill, Ms. Eshoo’s bill, Mr. Pallone’s bill, Mr. Allen’s bill, or the President’s bill; it is here to educate us as to what should be part of a bill for seniors and disabled in America.

I hope that we can move forward not only today but before the end of this session of Congress. I yield back.

Mr. BILIRAKIS. I thank the gentleman.  
[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM  
THE STATE OF MICHIGAN

Mr. Chairman, thank you for holding today's hearing to examine alternatives for crafting a prescription drug benefit for Medicare beneficiaries. I am deeply concerned about the burden borne by many individuals who do not have insurance coverage for prescriptions. No senior citizen should be forced to forego needed medication, take less than the prescribed dose, or go without other necessities in order to afford life-saving medications.

I read and sign all of my mail, and I have seen a dramatic increase over the past several years in the number of Medicare beneficiaries writing to me about the struggle they are having with rising prescription drug costs. These are not form letters I am referring to. They are hand written letters—often with their bills enclosed. We are fortunate in Michigan to have a state prescription drug program, but this covers only low-income individuals with high monthly drug costs. Further, we have no Medicare managed care plans in our district because Medicare's payment rates are too low to attract plans. Thus, my constituents are denied access to coverage through this route. Yet they have paid the same Medicare payroll taxes into the system over the years and pay the same monthly premiums as beneficiaries who do have this choice. This is a matter of fairness, as well, for my constituents.

Because of my keen interest in addressing this issue, I am very glad to be serving with you the House Leadership's prescription drug task force led by our Chairman. Our nation leads the world in the development of new drugs and medical devices that enable us to effectively treat diseases and conditions. But if people cannot afford to buy these drugs, their benefits are lost to many in our population.

I share the task force's goal of and commitment to ensuring that every Medicare beneficiary has access to affordable coverage and has protection from unusually high out-of-pocket costs. I am committed to crafting a plan that is senior friendly—one which avoids the often complex, complicated bureaucracy of the current Medicare program.

Our goal in crafting this plan must also be one of ensuring that our nation continues to lead the world in the development of life-saving new drugs. Over the past decade, we have seen so many breakthroughs in drug therapy, from a new, much more highly effective treatment and perhaps preventive for breast cancer, to antivirals for AIDS and other diseases, to treatments for cystic fibrosis. As we continue to map the gene and understand more fully the link between genes and disease, think of the possibilities. We are perhaps within reach of preventing or curing diabetes, Parkinson's, Alzheimer's, and other debilitating and terrible afflictions. As our population ages, we need to encourage further breakthroughs in the prevention, treatment, and management of chronic, debilitating conditions such as arthritis and osteoporosis, for that is the only real hope of controlling health care costs. Crippling the incentives and resources needed for new drug discovery and development would dash these hopes, leave these promises unfulfilled, and condemn many to suffering and premature death.

The task before us is daunting. It will take all of us, Republicans and Democrats, Ways and Means and Commerce, House and Senate and Administration, working together to pull this off and plug a huge hole in the Medicare program with a common-sense, workable, comprehensive drug benefit. We need to put aside partisanship and short-term political considerations and do what is right for our constituents and for the future of health care in America.

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PREPARED STATEMENT OF HON. TOM BLILEY, CHAIRMAN, COMMITTEE ON COMMERCE

I'm pleased that the Subcommittee is holding this hearing today. This is the fourth hearing this Committee has held on the topic of senior citizens access to prescription drugs.

I've been studying this issue closely for a long time now and it is a tough one. It is clear that too many seniors have trouble affording their medications. It is equally clear that many seniors have drug coverage today that they like and don't want threatened by anything we do in Congress.

Americans have the best health care in the world. My first goal in helping seniors afford medicine is to preserve what is good about our health system today. We are on the edge of remarkable breakthroughs in new drug therapies to treat and even

cure diseases that just ten years ago were considered death sentences. We don't want to do anything to jeopardize this work.

Yet, America's role as the world leader in drug research has its costs. Our challenge is to find ways to make sure seniors have access to needed medication without resorting to price controls or big-government drug purchasing schemes.

Many folks under 65 years old are fortunate to have health insurance to cover the costs of their prescription drugs. But Medicare does not pay for most drugs for seniors. In my view, Medicare does not reflect how modern medicine is practiced and delivered.

This is why I truly want to explore a way to give seniors access to coverage options available to Americans *under* the age of 65. Every Member of Congress has coverage options. Let's give seniors the same.

My colleagues and I have been working on legislation that provides all seniors access to affordable, private drug coverage. We will be introducing legislation soon. We have a good bill which can and will draw bipartisan support. I hope to work with our Democratic colleagues and the Administration on this proposal.

We share many common goals—that all seniors get access to a voluntary benefit and that low-income seniors get extra assistance in purchasing their drugs. We want to get a level of security for those seniors with the highest costs, so no one has to choose between food or medicine. What's more, no senior should be locked into a one-size-fits-all benefit.

Again, I want to thank the Chair for holding this hearing and look forward to the witnesses testimony.

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

Mr. Chairman, I welcome this hearing on the critical issue of providing prescription drug coverage for Medicare beneficiaries. The time to enact legislation to provide this critical service is long overdue.

I am disturbed, however, by the evident intention of this Subcommittee to use this hearing to justify moving out of Committee and to the House floor next week a Republican bill that has not been made available to the public, that our witnesses haven't seen, that has been explained only in vague and contradictory terms, and that apparently fails to meet critical conditions for effective, available and affordable prescription drug coverage.

In my view, we can only meet our obligations to Medicare beneficiaries if we make coverage of prescription drugs

- a benefit that all beneficiaries are entitled to,
- a benefit that covers all medically necessary drugs,
- a benefit that is available in all parts of the country,
- a benefit that is accessible and affordable for seniors in fee-for-service Medicare as well as Medicare+Choice plans, and
- a benefit that assures Medicare beneficiaries will no longer face the discrimination in drug prices which result in them paying the highest prices out of their own pockets.

But that's not the approach of the Republican bill. It tells seniors that they can purchase a private insurance drug policy, patterned on MediGap policies which already fail to deliver an affordable drug benefit. That is a cruel hoax.

Except for the poor, the Republican bill doesn't help seniors pay their premiums. It subsidizes private insurance companies and tries to claim that helps seniors. What that really does is mislead and confuse people about the help that's available.

And the Republican bill shifts the responsibility to insurers to try to provide a benefit when they know adverse selection is almost certainly going to make their product unaffordable and unavailable. That is not a responsible approach.

The drug companies might like it, but seniors will not.

I know the public relations consultants have told our Republican colleagues that "it is more important to communicate that you have a plan as it is to communicate what is in the plan." That sounds suspiciously like saying it's the rhetoric that's important, not the reality of putting a decent drug benefit in Medicare. The cynicism is breathtaking!

Seniors don't need us playing politics with their health care. Seniors need real coverage of prescription drugs. They can't afford the high prices of drugs. They can't afford to pay twice what the big buyers pay. They don't need another MediGap, they need a Medicare drug benefit.

Let's join together in a responsible way and do it right.

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

I am delighted that the Commerce Committee is having another hearing on a Medicare prescription drug benefit. My delight that we are continuing to explore this issue in Committee is surpassed only by my delight that the House Republican Leadership is finally unveiling a proposal to provide prescription drug coverage for Medicare beneficiaries.

We have not had the opportunity to review the details of the Republican plan, but we understand there are some key differences between it and the proposals put forward by the President and House and Senate Democrats. If, and as, we attempt to bridge those differences, we should try to respect certain principles.

First, we should preserve choice of drugs and choice of pharmacies for seniors.

Second, we should offer a defined, meaningful benefit for all.

Third, we should minimize the ability of health plans to attract only the healthy and the wealthy and ensure an affordable benefit for all.

Fourth, we should provide incentives to achieve price discounts and spend taxpayer dollars wisely. The skyrocketing cost of prescription drugs is a serious matter that is not properly addressed by giveaways to HMOs or drug companies.

Fifth, the program should benefit the people who need it most and not the insurance industry who doesn't.

Unfortunately, the majority's plan at this point seems to offer an illusory drug benefit that people can't afford. I am hopeful that we can address these shortcomings through the committee process, and I look forward to further exploration of this issue and a coming Committee mark up.

Mr. BILIRAKIS. Well, waiting patiently is our first panelist, the Honorable Nancy-Ann Min DeParle, Administrator of the Health Care Financing Administration.

Madam Administrator, welcome. As per usual, we will set the clock to 10 minutes for you, and you of course may take whatever time you feel you might need. Obviously, your written statement is a part of the record.

If we can have order before the Administrator starts.

**STATEMENT OF HON. NANCY-ANN MIN DePARLE, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION**

Ms. DEPARLE. Thank you very much, Chairman Bilirakis and Congressman Brown, and other distinguished subcommittee members.

I appreciate the opportunity to be here today to discuss prescription drug coverage for 39 million Medicare beneficiaries who need it.

I am glad to be with you and, Mr. Chairman, I appreciate your kind words.

Your subcommittee has been very interested in the topic of Medicare prescription drugs. I sit here and look at many Members who have themselves introduced bills to try to deal with this subject.

The administration welcomes this opportunity to further our bipartisan dialog. As you indicated, I have submitted written testimony for the record that goes into much more detail about the President's proposal and why we hope this committee will view it favorably.

But I want to say this morning that we are encouraged by the growing commitment embodied in the new proposal announced yesterday by Congressman Burr, Congressman Thomas, Congressman Peterson, and others to address this issue.

We want to continue working with you to enact legislation that meets the key principles that President Clinton has laid out for a Medicare drug benefit.

The drug benefit should be voluntary and it should be accessible to all beneficiaries.

It must be affordable for beneficiaries and to the Medicare program.

It should be competitive and it should have efficient and effective administration.

It should ensure access to needed medications and encourage high-quality care.

And it should be consistent with broader reform.

We have said many times that we are flexible on the details of how a Medicare drug benefit is provided as long as the design ensures that we meet these key principles.

The plan that was announced yesterday appears to mark some important progress toward those principles, but as you pointed out in beginning the hearing, Mr. Chairman, the devil is truly in the details.

We need to see the details and then engage in a serious discussion and dialog about our differences as well as the places where there are similarities.

Unfortunately, from what little we know about it so far the plan does not appear to meet the President's test of a meaningful prescription drug benefit that is affordable and accessible for all beneficiaries. And I want to talk about why.

Key among our concerns is the plan's heavy reliance on participation by private insurers who have made clear that stand-alone drug policies are not feasible.

Our concern is that even if some insurers do offer coverage, they would likely come in and out of the market. They would be likely to move to more profitable areas. And they would be likely to significantly modify benefit design from year to year based on the prior year's experience.

We have seen this before and it is not a good thing for beneficiaries. We are concerned that it would result, this kind of structure would result in the same instability and the same pullouts and uncertainty that we see in managed care today.

The new proposal's suggestion of a fallback mechanism whereby the government—and here I am speculating but presumably the traditional Medicare program would step in—seems to acknowledge the difficulties inherent in trying to guarantee access through a drug-only program.

The fallback mechanism also raises, I think from a health policy perspective, serious risk-selection issues. These are very, very difficult issues and we need to have a serious discussion once we have seen the details.

We continue to believe that the new prescription drug benefit must be integrated into the Medicare Program, and that Medicare should provide drug coverage the same way that virtually all private insurers do, by contracting directly with pharmacy benefit managers in each region of the country.

That is what our proposal does. And Mrs. Eshoo also has a proposal that is slightly different but also relies on pharmacy benefit managers.

This will ensure that all beneficiaries have access and that Medicare gets the best prices through the pharmacy benefit managers who will negotiate the best prices on behalf of beneficiaries.

Another critical concern that we have with what we have seen so far about the new plan that was announced yesterday is that it does not appear to provide direct premium subsidies to individuals with incomes above \$12,600 a year.

Instead, it relies on indirect subsidies to the private insurance plans to lower premiums. And I heard one person today refer to this as a sort of a form of premium support, and I thought that was interesting because I think it is sort of analogous to that.

It is unclear whether that amount of subsidy would ensure that affordable coverage is available to all and would be equally affordable in all regions of the country, but I can tell you that we looked at this very closely, this idea of what level of subsidy is necessary, and I believe it would need to be substantially more than 25 or 30 percent to avoid risk selection problems.

We have additional questions that are outlined in my written testimony and we look forward to discussing them with you.

I also want to say that I think Congressman Burr is right. This is a terribly difficult issue, and it is important that we see the details. I do not want to be speculating about what is in their plan because it I believe has changed from the first version I saw and I want to provide you with the best answers I can about what we are talking about here.

But I do think the most critical question of all—and I heard many of you raise this question but it bears repeating—is how does this plan, the one that was announced yesterday, the President's plan, whatever the plan is, how does it really meet the needs of Medicare beneficiaries, the 39 million Americans who are depending on us to try to do something here?

Is the plan really a defined benefit that is guaranteed?

Can Medicare beneficiaries depend on it being affordable and accessible?

Will the new plan really result in more efficient and effective administration of Medicare?

These are important questions. They are difficult questions. While all of these critical concerns remain, I do think the good news is that we appear to have broad consensus that a Medicare drug benefit is needed.

It is now time to get into the all-important deeper and very, very, very tough details of how to make sure the benefit can succeed; that it can succeed for the Medicare beneficiaries and that it can succeed for the Medicare Program.

We look forward to getting the details of this new plan because it is obvious that a great deal of work remains, and it is time to sit down and get it done.

I look forward to continuing to work with you as we enter the next phase on this critical issue.

Thank you, Mr. Chairman.

[The prepared statement of Hon. Nancy-Ann Min DeParle follows:]



PREPARED STATEMENT OF NANCY-ANN DEPARLE, ADMINISTRATOR, HEALTH CARE  
FINANCING ADMINISTRATION

Chairman Bilirakis, Congressman Brown, distinguished Committee members, thank you for inviting me to discuss Medicare prescription drug coverage. This Subcommittee's previous hearings on this issue have been highly constructive, and we are grateful for the opportunity this hearing provides to make further progress. We are encouraged by the growing commitment embodied in the new Medicare Rx 2000 proposal presented by Congressmen Thomas, Burr, Hall, and Peterson yesterday to address this issue. We want to continue working with you to enact legislation that meets the principles President Clinton laid out earlier this year.

*Background*

As we know, pharmaceuticals are as essential to modern medicine today as hospital care was when Medicare was created. Lack of prescription drug coverage among senior citizens today is similar to the lack of hospital coverage among senior citizens when Medicare was created. Three out of five beneficiaries lack dependable coverage. Only half of beneficiaries have year-round coverage, and one third have no drug coverage at all.

Those without coverage must pay for essential medicines fully out of their own pockets, and are forced to pay full retail prices because they do not get the generous discounts offered to insurers and other large purchasers. The result is that many go without the medicines they need to keep them healthy, out of the hospital, and living longer lives.

Drug coverage is not just a problem for the poor. More than half of beneficiaries who lack coverage have incomes above 150 percent of the federal poverty level. Millions more have insurance that is expensive, insufficient, or highly unreliable. Even those with most types of coverage find it costs more and covers less. Copayments, deductibles, and premiums are up.

And coverage is often disappearing altogether as former employers drop retiree coverage, Medigap is becoming less available and more expensive, and managed care plans have severely limited their benefits. Clearly all beneficiaries need access to an affordable prescription drug coverage option.

*Key Principles*

The President has identified key principles that a Medicare drug benefit must meet, and we are willing to support proposals that meet these principles. It should be:

- **Voluntary and accessible to all beneficiaries.** Medicare beneficiaries in both managed care and the traditional program should be assured of an affordable drug option. Since access is a problem for beneficiaries of all incomes, ages, and geographic areas, we must not limit a Medicare benefit to a targeted group. At the same time, those fortunate enough to have good retiree drug benefits should have the option to keep them.
- **Affordable to beneficiaries and the program.** We must ensure that premiums are affordable enough so that all beneficiaries participate. Otherwise, primarily those with high drug costs would enroll and the benefit would become unstable and unaffordable. And beneficiaries must have meaningful protection against excessive out-of-pocket costs.
- **Competitive and have efficient administration.** Medicare should adopt the best management approaches used by the private sector. Beneficiaries should have the benefit of market-oriented negotiations.
- **Ensuring access to needed medications and encouraging high-quality care.** Beneficiaries should have a defined benefit that assures access to all medically necessary prescription drugs. They must have the assurance of minimum quality standards, including protections against medication errors.
- **Consistent with broader reform.** The drug benefit should be consistent with a larger plan to strengthen and modernize Medicare.

*The President's Plan*

The President has proposed a comprehensive Medicare reform plan that meets these principles. It includes a voluntary, affordable, accessible, competitive, efficient, quality drug benefit that will be available to all beneficiaries. The President's plan dedicates over half of the on-budget surplus to Medicare and extends the life of the Medicare Trust Fund to at least 2030. It also improves access to preventive benefits, enhances competition and use of private sector purchasing tools, helps the uninsured near retirement age buy into Medicare, and strengthens program management and accountability.

The President's drug benefit proposal makes coverage available to all beneficiaries. The hallmark of the Medicare program since its inception has been its social insurance role. Everyone, regardless of income or health status, gets the same basic package of benefits. This is a significant factor in the unwavering support for the program from the American public and must be preserved. All workers pay taxes to support the Medicare program and therefore all beneficiaries should have access to a new drug benefit.

A universal benefit also helps ensure that enrollment is not dominated by those with high drug costs (adverse selection), which would make the benefit unaffordable and unsustainable. And, as I described earlier, lack of drug coverage is not a low-income problem—beneficiaries of all incomes face barriers.

The benefit is completely voluntary. If beneficiaries have what they think is better coverage, they can keep it. And the President's plan includes assistance for employers offering retiree coverage that is at least as good as the Medicare benefit to encourage them to offer and maintain that coverage. This will help to minimize disruptions in parts of the market that are working effectively, and it is a good deal for beneficiaries, employers, and the Medicare program. We expect that most beneficiaries will choose this new drug option because of its attractiveness, affordability, and stability.

For beneficiaries who choose to participate, Medicare will pay half of the monthly premium, with beneficiaries paying an estimated \$26 per month for the base benefit in 2003. The independent HCFA Actuary has concluded that premium assistance below 50 percent would result in adverse selection and thus an unaffordable and unsustainable benefit.

Premiums will be collected like Medicare Part B premiums, as a deduction from Social Security checks for most beneficiaries who choose to participate. Low-income beneficiaries would receive special assistance. States may elect to place those who now receive drug coverage through Medicaid into the Medicare drug program instead, with Medicaid paying premiums and cost sharing as for other Medicare benefits.

We would expand Medicaid eligibility so that all beneficiaries with incomes up to 135 percent of poverty would receive full assistance for their drug premiums and cost sharing. Beneficiaries with incomes between 135 and 150 percent of poverty would pay reduced premiums on a sliding scale, based on their income. The Federal government will fully fund States' Medicaid costs for the beneficiaries between 100 and 150 percent of poverty.

Under the President's plan, Medicare will pay half the cost of each prescription, with no deductible. The benefit will cover up to \$2,000 of prescription drugs when coverage begins in 2003, and increase to \$5,000 by 2009, with 50 percent beneficiary coinsurance. After that, the dollar amount of the benefit cap will increase each year to keep up with inflation. For beneficiaries with higher drug costs, they will continue to receive the discounted prices negotiated by the private benefit managers after they exceed the coverage cap. To help beneficiaries with the highest drug costs, we are setting aside a reserve of \$35 billion over the next 10 years, with funding beginning in 2006.

Benefit managers, such as pharmacy benefit manager firms and other eligible companies, will administer the prescription drug benefit for beneficiaries in the traditional Medicare program.

These entities will bid competitively for regional contracts to provide the service, and we will review and periodically re-compete those contracts to ensure that there is healthy competition. The drug benefit managers—not the government—will negotiate discounted rates with drug manufacturers, similar to standard practice in the private sector.

We want to give beneficiaries a fair price that the market can provide without taking any steps toward a statutory fee schedule or price controls. The drug benefit managers will have to meet access and quality standards, such as implementing aggressive drug utilization review and patient counseling programs. And their contracts with the government will include incentives to keep costs and utilization low while assuring a fairly negotiated contractual relationship with participating pharmacists.

Similar to the best private health plans in the nation, virtually all therapeutic classes of drugs will be covered. Each drug benefit manager will be allowed to establish a formulary, or list of covered drugs. They will have to cover off-formulary drugs when a physician certifies that the specific drug is medically necessary. Coverage for the handful of drugs that are now covered by Medicare Part B will continue under current rules, but they also may be covered under the new drug benefit once the Part B coverage is exhausted.

The President's plan also strengthens and stabilizes the Medicare+Choice program. Today, most Medicare+Choice plans offer prescription drug coverage using the excess from payments intended to cover basic Medicare benefits. Under the President's proposal, Medicare+Choice plans in all markets will be paid explicitly for providing a drug benefit—in addition to the payment they receive for current Medicare benefits. Plans will no longer have to depend on what the rate is in a given area to determine whether they can offer a benefit or how generous it can be. This will eliminate the extreme regional variation in Medicare+Choice drug coverage, in which only 23 percent of rural beneficiaries with access to Medicare+Choice have access to prescription drug coverage, compared to 86 percent of urban beneficiaries.

And beneficiaries will not lose their drug coverage if a plan withdraws from their area, or if they choose to leave a plan, because they will also be able to get drug coverage in the traditional Medicare program. We estimate that plans will receive \$54 billion over 10 years to pay for the costs of drug coverage.

Beneficiaries will have access to an optional drug benefit through either traditional Medicare or Medicare managed care plans. Those with retiree coverage can keep it and employers would be given new financial incentives to encourage the retention of these plans.

#### *Meeting Key Principles*

We are flexible on the details of how a Medicare drug benefit is provided, but the design must ensure that we meet the President's key principles of a benefit that is voluntary, affordable, competitive and efficient. We believe the Medicare Rx 2000 plan marks important progress. However, we believe it does not meet the President's test of a meaningful benefit that is affordable and accessible for all beneficiaries. Key among our concerns are the apparent lack of an individual premium subsidy for all beneficiaries, an inadequate level of support, and reliance on insurers who are unlikely to participate.

**Will prescription drug coverage be available?** The Medicare Rx 2000 plan appears to rely extensively on participation by private insurers who have made clear that stand-alone drug policies are not feasible. Subsidizing private insurers instead of establishing a reliable Medicare benefit means that outpatient prescription drugs would not be part of the Medicare benefits package like doctor or hospital care. Beneficiary premiums would pay for expensive, private Medigap plans whose administrative costs are on average more than 10 times higher than Medicare's, according to National Association of Insurance Commissioners statistics, rather than an affordable Medicare option. Furthermore, Medigap plans have little experience negotiating with drug manufacturers and relying on numerous plans does not pool the purchasing power of seniors; both elements are needed to keep the benefit affordable.

Building on the private Medigap insurance market would be especially difficult in sparsely populated rural areas, where risk pools are smaller and seniors are more likely to have higher costs, as a report released by the President today shows. There also is no certainty or stability in the drug coverage options in the Medicare Rx 2000 proposal. Even if some insurers do offer coverage, they would likely come in and out of the market, move to profitable areas, and significantly modify benefit design from year to year based on prior year's experience. This would result in the same pull-outs and uncertainty we see in managed care today.

The Medicare Rx 2000 proposal's reliance on a "fall back" mechanism, in which the government would ensure availability everywhere seems to acknowledge the weakness of the drug-only insurance plans. We continue to believe that Medicare should provide drug coverage the same way that virtually all private insurers do—by contracting directly with pharmacy benefit managers in each region of the country. This will ensure that all beneficiaries have access and that the pharmacy benefit managers can negotiate the best prices.

**Is drug coverage affordable to all beneficiaries?** The Medicare Rx 2000 plan does not provide direct premium subsidies to individuals with incomes above \$12,600 a year. Instead, it relies on indirect subsidies of 25 to 30 percent to lower premiums. It is unclear that this amount will ensure that affordable coverage is available to all or would be equally affordable in all regions of the country.

There are several additional areas where we have questions about the new Medicare Rx 2000 plan. These include:

- *Is it a defined benefit?* The Medicare Rx 2000 plan allows insurers to offer an unspecified "standard" benefit, or an actuarial equivalent benefit. Only the stop-loss amount is specified, and insurers would set deductibles and copays. This could lead to beneficiary confusion and benefit packages designed for "cherry-picking" of low-cost, healthy enrollees, with insurers offering no deductible, low copays, and a low benefit cap that leaves a large gap before the stop-loss kicks

- in. This would be a step backwards from the Medigap reforms of the early 1990s that standardized benefits so plans compete on price and quality rather than consumer confusion.
- *Does the plan assure access to needed medications?* The Medicare Rx 2000 plan requires insurers to cover only all “major” therapeutic classes of drugs. Depending on how that is defined, and the degree to which each insurance company is permitted to define it, some seniors could be left without the medications they need. It also requires a beneficiary to go through a formal appeals process to get coverage of off-formulary drugs the physician deems to be medically necessary, which could limit access. Furthermore, the Medicare Rx 2000’s multi-insurer approach breaks up the pooled purchasing power of seniors, forcing insurers to reduce costs through restrictive formularies and limited pharmacy choice.
  - *Will the plan increase access to coverage for rural beneficiaries?* The Medicare Rx 2000 plan relies on additional assistance for Medicare+Choice plans as a means of bringing those plans into rural areas where, because of sparse health care service delivery structures, managed care has often had difficulty thriving. It is not clear this will work.
  - *Will the proposed approach to remove international drug pricing disparities work?* We agree that Americans, particularly those who now lack prescription drug coverage, should not disproportionately subsidize drug development. However, it is not clear that having the U.S. Trade Representative negotiate to address drug price controls in other nations will result in fairer prices here at home. This proposal could simply result in higher prices abroad without having an impact on the high prices American consumers now pay.
  - *Will the plan result in more efficient Medicare administration?* The Medicare Rx 2000 plan would create a Medicare Benefits Administration (MBA) to administer the drug benefit and Medicare+Choice program. It appears to be adding a new layer of bureaucracy since many MBA activities would duplicate those that HCFA would also need to continue, such as beneficiary education, resulting in duplication and ignoring HCFA’s expertise.

#### *Conclusion*

We may be turning a corner in our efforts to secure the Medicare drug benefit that we all agree is needed. We are nearing a workable consensus on the broader outlines of how the benefit should be structured. Critical concerns about providing an affordable, accessible, meaningful benefit and relying on private insurers remain. But we are beginning to get into the all-important, deeper details of how to make sure the benefit can succeed. While a great deal of work remains, momentum is now with us. The challenges before us can be met if we continue the constructive approach that we have, together, taken to date. And I look forward to continuing to work with you as we enter the next phase on this critical issue.

Mr. BILIRAKIS. Thank you, Madam Administrator.

You are of course correct. The legislation in terms of its specificity is still not out there. But one thing that seems to be relatively specific is the establishment of the new entity to manage the program.

And of course you state in your testimony that establishing a new entity to manage a direct benefit program would simply be, using your words, “adding a new layer of bureaucracy.” And I am not sure that anybody would disagree with that. Yes, it does add that.

But clearly the Bipartisan Medicare RX 2000 Plan is not the only proposal, as you know, which suggests that the management of the drug benefit be administered by a separate entity outside of HCFA.

Ms. Eshoo’s plan proposes that OPM manage the benefit, as I understand it.

Mr. Pallone’s plan establishes a board outside of HCFA, as does the Breaux-Frist bipartisan proposal in the Senate.

So I would ask you this question: Do you believe that all these bills seek to establish redundant beneficiaries? But more impor-

tantly, why don't you just respond to the fact that so many plans feel it should be managed outside of HCFA?

Ms. DEPARLE. Well I think the one thing I believe I have heard this morning is that we all agree that a new prescription drug benefit, if it is added to Medicare, should be administered in an effective and efficient way.

I think over the past 2 years that I have been at HCFA I have probably talked to every single member on this committee about concerns you have about Medicare's administration. Some of them are very specific about providers in your districts.

Certainly we can do better, and I would like to have the opportunity at some point to show you all the things we have done to improve the way we are administering Medicare.

One of the Members—I think it was Mr. Green—pointed out that we are very efficient in our administration, and that is true. Our administrative costs hover around 1.5 percent. I do not think there is any insurance company in the country that would attempt to run a program as complicated and as important as the one we are running with as many beneficiaries and more than \$200 billion of taxpayer dollars with that kind of administrative expenses.

In my view sometimes we are a little too efficient. I want to thank the committee because I have made this point with many of you and you have helped us in the past with our budget to make sure that we got the resources we need to do a better job.

But I think we have to go back to the question that Dr. Coburn posed, which is we have to think carefully about what is the problem we are trying to fix here?

I think what you want is an efficient and effective administration. I think it is possible to do that the way the President's plan proposes using private pharmacy benefit managers like private insurers do, and having us contract with them.

What I would say to you is, we are eager to get into that discussion with you. If you give us the authority and the resources to do that job, I can promise you that we will do a good job of it.

Mr. BILIRAKIS. Well I expect there will probably be others who will explore the area you mentioned about the private drug benefit managers and how its usage is intended under the President's plan, but I would go to an area that I think practically everybody's opening statements referred to. That is, the need to help those with real high drug costs with a stop-loss benefit, the catastrophic, if you will, a word that we do not like to use up here for obvious reasons.

The President's plan did not provide for that. Afterwards of course, sometime afterward, he decided to set aside funds for patients with high out-of-pocket costs to begin in 2006. Not to begin now, or even close to now, but in 2006.

So I guess I would ask you—and I think we all wonder because we have not seen anything in that regard—how would you propose those funds be spent? Has HCFA or the President come up with a plan that would use those funds in order to help those people with very, very high out-of-pocket cost?

Ms. DEPARLE. Well, Mr. Chairman, we did not propose the stop-loss benefit, the catastrophic coverage, in our original proposal 2 years ago.

The President did propose it in this year's budget, but he said we had set aside \$35 billion to start in 2006 and we wanted to sit down and work with the Congress to talk about the details of that.

We have been looking at various benefit designs. There are a number of proposals up here already looking at various benefit designs, and we are ready to sit down with the Congress whenever you all are ready to talk about how best to design such a program.

Mr. BILIRAKIS. All right, my time is about to expire so I am just going to go ahead and yield to Mr. Brown at this point.

Mr. BROWN. Thank you, Mr. Chairman.

In light of your comments about the devil being in the details, and Administrator DeParle echoing the same thing and going through a very dispassionate, well thought through analysis of some of the strengths and weaknesses of this legislation and other proposals, and Dr. Ganske's point of how serious a matter this is and how we do not have the legislation yet and need to learn more, I was shown a letter to Chairman Bliley from Speaker Hastert saying it is his intention to have legislation addressing prescription drugs on the House floor the week of June 19, I would just hope that we would be able to—I would hope we could go through the process on this subcommittee and this full committee with markup both places prior to that date, if possible, so we really do have a better understanding of this issue.

We have not seen the bill yet. I mean Members on this side certainly have opinions and have seen outlines and have heard rumors and everything else. We know about the bill, or we think we know about the bill, but I think it is important that we have that opportunity, this subcommittee, on an issue that is so enormously complex as this and is so important for so many people in this country.

I would like to talk about the PBMs that the chairman mentioned, Administrator DeParle. The President's plan proposes using these private entities as pharmaceutical benefit managers to provide the benefit to seniors.

How do you ensure that these private-sector entities are actually providing the care that they promise?

Ms. DEPARLE. Well we would have quality standards. It would not just be competitive bidding based on price, Congressman. And we would do a competitive bidding in various areas of the country.

We have met with pharmacy benefit managers who currently provide this kind of service to other private insurers, and I believe they would be able to do a good job of doing it with Medicare.

We would have to be very specific with them about what we wanted. We might want them to do some disease management. We might want them to do utilization review and provide us with data about that kind of thing. We would just have to be very specific in contracting with them and telling them what we expect.

Then we would have to make sure they got it done.

Mr. BROWN. The Republican plan relies on the private sector to administer the Medicare drug benefit. In this proposal, private insurance companies would be in charge of running the program.

How does that plan assure that these private-sector plans are providing the care that they promised to seniors?

Ms. DEPARLE. Well I suppose the new Medicare Benefits Administration that is referred to in the document that I saw yesterday would be in charge of contracting with private insurers.

It sounds to me almost like a Medigap model, although yesterday I did attend a hearing in Ways and Means and I heard some of the sponsors of the bill say that it is not supposed to be that, but it sounds like a Medigap model.

In that model our oversight is quite limited. It is not clear how much ability the Medicare Benefits Administration would have to oversee the provision of prescription drugs by these plans.

I would add another thing, too, which is that there is a real tension in here between what I heard yesterday from the sponsors who talk about wanting to provide seniors with as many different choices as possible.

That is a philosophical view, and it is something I have talked to Congressman Burr and others about, that they would like to see lots of different kinds of plans out there I think.

There is a tension between that and the thing that Mrs. Eshoo talked about earlier, and that I hear when I talk to seniors, which is their desire to have a reliable, guaranteed benefit and to know what their costs are going to be from year to year.

That is something that is going to be a very difficult issue for this committee and for your colleagues to grapple with. How much do you go in the direction of choice? And what does that do in terms of risk selection?

It enables plans then to “cherry pick” the healthier seniors. What sort of oversight would you need to have over that kind of thing? And what are the results of that?

And one of the results would be much higher premiums for everyone, if the seniors are “cherry picked” into certain private plans. And then what happens in the areas where these plans do not go in.

There are a lot of questions here, and it is unclear to me how we would ensure that the private insurers, if they exist and if they come into the market, are providing what they are supposed to be providing.

There is not a defined benefit, as I understand it, in this plan.

Mr. BROWN. You mentioned Medigap. One of the major criticisms of Medigap is that it is simply not affordable to a large number of people.

In a private plan model such as the Republicans have suggested, talk about the affordability for seniors there. Would they be affordable for most seniors?

Ms. DEPARLE. Well again we have to see the details. As I understood it yesterday from Mr. Thomas, there would be an indirect premium subsidy to the plans. So that would indirectly subsidize individuals who chose those plans, if they were available.

There are a lot of “ifs” here. My concern is the level of the subsidy as he described it at around 25 or 30 percent, from my discussions with the independent actuaries who work for the Medicare Program and the Medicare Trustees, as well as with private insurance company executives, what they have suggested is that that level of subsidy will not be enough to attract most seniors to join.

So then you would end up with the same problem Medigap has, which is the problem I guess that Congressman Barrett described where they are trying to provide health insurance for the sickest people, or drug insurance coverage for the sickest people who are going to use the most drugs.

It starts a spiral that our actuaries call a death spiral in terms of the premium getting higher and higher and fewer people being able to afford it. This is a complicated issue that we really would have to spend time analyzing.

Mr. BROWN. I thank the chairman.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Burr to inquire.

Mr. BURR. Nancy-Ann, welcome.

Ms. DEPARLE. Thank you.

Mr. BURR. It is a long, difficult process but the one thing that we can feel confident in is that at some point we will get to the end of it. The question today is will we get it right?

Let me ask you. From the plans that you have read, or read about, is there anybody that is not aspiring to the belief that every plan has to be voluntary?

Ms. DEPARLE. No.

Mr. BURR. So we can take one of those four things that we talked about and say everybody agrees that "voluntary" is an absolute necessity?

Ms. DEPARLE. Yes, but—if I could—

Mr. BURR. Sure.

Ms. DEPARLE. The first principle is it should be a voluntary benefit accessible to all beneficiaries.

Mr. BURR. So—

Ms. DEPARLE. The voluntary part—Yes, sir.

Mr. BURR. [continuing] But it has to be accessible?

Ms. DEPARLE. Accessible, I'm not so sure about. Yes.

Mr. BURR. You mentioned yesterday in the Ways and Means hearing that it had to be voluntary but we had to guarantee. Could you distinguish between the two? What do you mean?

Ms. DEPARLE. When I talk about guarantee, I mean that, just like a Medicare beneficiary today knows they have physician coverage. They have coverage if they need to go to their doctor.

And just like they know they have coverage if they need to go to the hospital, they need to know they really have drug coverage.

I do not think it can be something that is contingent on whether a private insurance plan comes into their area.

Mr. BURR. So as long as there is a provision in a bill that one would see in the absence of everything that could exist, nothing exist, here is the answer, as long as that exists, then the guarantee exists for all eligible?

Ms. DEPARLE. Well I would have to see the language, but I believe, as I understood yesterday from the description, there has been a change, and that, yes, the plan that I heard described is attempting to say that there will be something provided for everyone; that a drug benefit will be available if there is not a private insurance plan. That is what I heard.

Mr. BURR. Given the approach that you are familiar with to a large degree, to have more than one option, or more than one



choice for seniors in a given market, whether it is a benefit manager or whether it is an insurance product or whether it is a new entity that we have not even discovered yet, is it beneficial to the eligible beneficiaries out there?

Ms. DEPARLE. Well, you know, I would like to give you a “yes” or “no” answer but I really cannot. It can be beneficial. The problem is, it also—every time you segment the market more you introduce more likelihood of risk selection.

Mr. BURR. Why doesn't OPM only allow a small number of health plans for Federal employees, then? Why is the list in North Carolina some 30 people that I have to pick from? Does that help people negotiate?

Ms. DEPARLE. I assume because the law—well, I think you would have to ask them. I think—so your contention is it helps them to negotiate better prices somehow?

Mr. BURR. Yes.

Ms. DEPARLE. The problem is, it may help you some on the negotiating side but it also hurts you some in that you segment the market. You introduce risk selection. So plans can—

Mr. BURR. We spread the risk out.

Ms. DEPARLE. Not as much as you do if you have only a couple of plans. If you had just—under the President's plan, for example, you can go to an HMO and we would reimburse them directly for providing prescription drugs which we don't today, because it would be a Medicare-guaranteed benefit, and then you could also be in the fee-for-service plan.

When you go beyond that, you start introducing in more and more risk selection by segmenting the market. And you get—plans will be smart enough to design benefit packages that could end up excluding some people and picking out the healthiest people.

Now if your desire is to provide as much choice as possible, you may see that as an advantage. My concern is it raises the premium costs for beneficiaries.

It can result in the people being left in a plan that is more expensive, and then as I said you start this sort of death spiral with the premiums.

Mr. BURR. If I understand you correctly, the more people who might join a plan the cheaper the premium gets because of volume?

Ms. DEPARLE. In general, yes, sir. In general, that is what insurance is. You spread the risk over as many people as possible because then you lower the chances that you are going to get just sick people who are going to need to really heavily use the benefit.

Mr. BURR. Aren't we both—

Ms. DEPARLE. So you have to weigh that against your desire to have choice. And as I said, you and I have discussed this, and I know why you like that.

The other thing, though, I would raise is what Mrs. Eshoo raised about her mother and what she wanted. And when I talk to seniors—maybe we talk to different ones—some of them may like choice, but the main thing I hear is I need to know what my costs are going to be.

Mr. BURR. It needs to be predictable, doesn't it?

Ms. DEPARLE. Yes, sir, it does.

Mr. BURR. That is an important aspect. Let me just—

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

Mr. BURR. I thank the chairman.

Mr. BILIRAKIS. Mr. Waxman.

Mr. WAXMAN. Thank you, Mr. Chairman.

What is so frustrating to me about this hearing is that we do not have a bill before us. We have some concepts on the piece of paper, really just a couple of pages, and we are asking very specific questions which you cannot answer because you cannot see the proposal.

We are being told this proposal may be on the House floor next week, so you wonder what a committee is supposed to do and why we have witnesses here if we cannot get testimony about a specific proposal.

But we have a Communications Document that the Republicans have put out. I want to ask you about what you understand that proposal in that document to mean.

Is it correct to say that there is no defined benefit in the Republican plan? In other words, you do not know what you are actually going to get if you are in Medicare if you are able to buy an insurance policy for prescription drugs.

Do we know, in any way, from their communications how much people are going to have to pay out of their pockets for these pharmaceuticals? Or even for their premiums?

Ms. DEPARLE. Well I do not know it from the paper I saw yesterday. I did hear discussion at the Ways and Means Committee of I think the sponsors are still in active negotiations and deliberations with the Congressional Budget Office trying to get the premium numbers down.

But I did not see a defined benefit in what I looked at yesterday.

Now I will say, the President's bill has been up here since March. We spent a lot of time drafting it. So I would be happy to discuss that. And of course when the other bill does come out, if we can provide any technical assistance we will.

Mr. WAXMAN. Well could it mean that if you are on Medicare and you need certain kinds of drugs you might not have an insurance policy to provide those drugs that you need?

Ms. DEPARLE. It could mean that, if there is not a defined benefit.

Mr. WAXMAN. And if all they are saying is you have a chance to buy some insurance, could it mean that there is no insurance really available for you to buy, or affordable for you to buy?

Could it mean that you are only going to have a chance to have some drugs covered if you sign up at a managed care plan and that is it? Maybe you have a choice of two managed care plans?

Ms. DEPARLE. If there is no defined benefit, there could be lots of variation about what is provided. It would be very important for people to know, I believe, what is in the plan, how much they are going to be expected to pay, and that cuts against some of the arguments about having lots of choices.

Mr. WAXMAN. Well choices are great if everybody wants you to choose them. But when you are a real sick elderly person who is not anxious to represent a huge cost to an insurance company, they are not anxious to have you sign up with them. They would like you to choose someone else.

When we adopted the Medicare Program, we said that no matter how sick you are, no matter how wealthy or poor you might be, you are going to be guaranteed coverage for your doctor bills when it is medically necessary, your hospital bills when it is medically necessary, and a lot of other services.

Shouldn't we say that you are going to be guaranteed coverage for prescription drugs? Isn't that what this is all about? Isn't that what the American people really want?

Ms. DEPARLE. Well I believe that is what we should do. I believe that that is consistent with Medicare's principles.

And I do believe it is different from the way the Federal Employees Health Benefit Program has been structured under the law. There, there are choices. And it is more a defined contribution program.

Medicare has been a defined benefit. There is a discussion in the materials I saw yesterday about an actuarial equivalence in dollar terms, but it is not, as I understand it, a defined benefit as Medicare has traditionally had.

Mr. WAXMAN. The most peculiar thing to me about this proposal is we do not give anybody anything. We just tell them, we are going to give you a chance to buy private insurance. But since private insurance companies do not now have affordable plans for drug coverage, we are going to give the money to the insurance companies—not to the beneficiaries—in hopes that they will lower their prices and make a plan available, and maybe some people can afford it.

Is there any beef there? Where is the beef in all this? If a senior is watching this hearing, can they feel that if this plan is adopted they will know their drugs are going to be covered and they are going to be able to buy any policy wherever they may live in this country?

Ms. DEPARLE. Well I do not know that yet. I think that, as I said, we have questions based on what we have seen about the affordability and accessibility of the plan that we are discussing today.

We are eager to see the details. We heard from the sponsors that they intend to provide a fallback mechanism so that there will be something available. But we need to see the details on that.

Mr. WAXMAN. Well I think you are right. We have to see the details. But this may be the only hearing this committee, which has jurisdiction over these issues, will ever have on this proposal. So when the details come out, we may just see them when the bill is already on the House floor and we are told you vote "yes" or "no," and if you vote "no" there will be nothing. But if we vote "yes," we may not have anything that is really worth it when all is said and done.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. the gentleman's time has expired.

Mr. Whitfield.

Mr. WHITFIELD. Thank you, Mr. Chairman.

Mr. Burr was focusing on the importance of choice and using the Federal insurance plan for Federal employees as an example. Of course philosophically one of the reasons that any of us advocate a choice is we feel like the competition can keep prices in line.

And as Dr. Coburn mentioned earlier, we know that in the long term there are some real financial difficulties facing the Medicare Program, its solvency.

Do you agree that choice is a way to promote competition, and in doing that can maybe keep the costs down of a prescription drug benefit?

Ms. DEPARLE. Well choice can be a way to promote competition. But what we have seen in the past is that the competition has really not been on price in the same way that you would expect.

You referred to the Federal Employees Health Benefits Program. In our discussions with the Office of Personnel Management—and they actually testified with me in front of the Senate Finance Committee—they made the point that you have to take into consideration that the two programs and the populations they serve are really very different in that Medicare serves an elderly population with much more intense and predictable health care needs than the Federal employees program does.

And again, when OPM negotiates with plans, under the statute it is pretty much open to any plan that meets a certain requirement. There is no defined benefit package, really. It is more of a defined contribution system.

So I am not sure. I just don't think the incentives are the same. Now in our plan, we want seniors to get the best prices possible. We want Medicare to get the best prices possible for drugs and we want to do it in a way the private insurance companies do it, that some of these same insurance companies that participate in FEHBP use pharmacy benefit managers to negotiate with the drug companies to keep the prices lower.

So we want to get the benefits of competition. I am just not convinced that competing among the plans with the senior population is the right way to go.

Mr. BURR. Mr. Chairman, I think the microphone system has gone out.

Mr. WHITFIELD. How legitimate is the—

Mr. BILIRAKIS. I think it has gone out.

Mr. BILBRAY. The gentleman from Kentucky will rise to the occasion.

Mr. WHITFIELD. How legitimate is the concern that for senior citizens the more choices you have in trying to understand the different plans the more it is difficult and confusing for them? Do you think that is a legitimate issue?

Ms. DEPARLE. I am glad you asked about that issue because I would like to, at some point if the committee is interested, provide you with some more details about that.

As a result of the National Medicare Education Program that we have been doing to provide seniors with information about Medicare and about their Medicare choices, we have done a lot of focus groups around the country about what do they understand.

What we are told is, even the information about basic Medicare and the Medicare+Choice Plans that are available in some areas of the country, despite all of our efforts at getting that to be really understandable, it is still something that is difficult to convey to seniors.

I am not saying it is impossible, but it is very difficult to do. And what we find is, they tell us things like—we want to provide them with quality information, and they tell us, gee, this is like homework. It is very difficult to get through all of this.

So I do hope the committee will be sensitive to that in looking at how to structure this.

Mr. WHITFIELD. Would you review for me, there were a few Republicans—and I was one of them—at the White House when the President revealed his plan back in March. Would you just go over quickly the cost structure and what he was proposing for costs for senior citizens?

Ms. DEPARLE. Yes. Is my mike out, too? I will do the best I can.

The President's proposal would provide a prescription drug benefit that in the first year would be worth around \$2000 to beneficiaries. The government would share in 50 percent of the cost up to \$2000. The beneficiary would pay a premium of about \$26 a month, our actuaries estimate. Then they pay 50-50 up to the \$2000.

We would phase in our benefits so we would get up to \$5000 in about 2010, I believe. And at that point, the premium would be around \$50 and the co-insurance would still be 50 percent.

During that time, after that time, the cap, the \$5000, would grow at the rate of inflation. So there would be some increase in it, and the President announced in March that he had set aside \$35 billion to be used for stop-loss coverage for beneficiaries with usually high costs, and he has not laid out the details of that piece of the plan yet.

We want to sit down and work with the Congress to come up with what would be a good proposal there for stop-loss coverage. But that is the basic parameters of the plan.

Mr. WHITFIELD. So over—

Mr. BILIRAKIS. We are well past the 5-minute time limit.

Mr. Pallone.

Mr. PALLONE. The microphones are not working.

Mr. BILIRAKIS. We will have to speak up a little bit.

Mr. PALLONE. Thank you, Mr. Chairman.

I want to go back to what Mr. Waxman was mentioning about the difference, if you will, between the President's proposal and what we believe is the Republican Thomas proposal, I guess, is in terms of the lack of a defined benefit.

The way I understand the President's proposal, we have access to medically necessary drugs in the language, and that seems to me basically a decision by a physician, or a pharmacist, or whoever, about what is medically necessary. So that is a defined benefit.

On the other hand, under the Republican proposal we are getting language—again I am looking at what apparently Thomas described—the benefits have to equal an actuarial value of \$740 or an actuarial equivalent to a certain dollar amount.

I guess my concern is, I think the way the Thomas proposal is essentially a voucher that limits a certain dollar amount because of the language about actuarially equivalent.

On the other hand, the President says “medically necessary drugs.”

Would you just comment on this distinction there? I know you have sort of gotten into this, but I think there is a big difference there. One seems to be targeted to a dollar amount, and one is to a specific description about what is medically necessary.

Ms. DEPARLE. As I understood the plan yesterday, it offered an unspecified benefit. It does talk about an actuarial equivalent benefit. I think the \$740 number you heard is what I heard as well, but as I understand it only the stop-loss amount is really specified.

So insurers could then set deductibles and co-pays. That is the issue we have been discussing about whether we really think seniors want and need all of those different choices, or whether that structure would guarantee adverse selection and then difficulties with unaffordable premiums and access.

I do want to add, though, that it mentioned something about covering major therapeutic classes of drugs. We are not sure how that is defined. It is different. The language is different than saying all medically necessary medications, but we do not know whether that is intended to signify a term of art, or whether some will be covered and others not, or whether someone put an adjective in that they really didn't mean.

So I can't tell you at this point what exactly would be covered in terms of the drugs.

Mr. PALLONE. It varies from day to day and year to year. Theoretically there might be some selection that gives you some idea of what you get, but on the other hand what is to stop you from varying depending on what the costs are, because this leads to some kind of fixed dollar.

Ms. DEPARLE. That would be a mistake. I would hope that the language would specify a definition for this and would say it is not up to each insurance plan to decide what is a therapeutic class of drugs. I imagine, frankly, that that will be necessary to get it scored.

Mr. GREENWOOD. Would the gentleman yield for 5 seconds?

Mr. PALLONE. I will give you 5 seconds.

Mr. GREENWOOD. It is true that in both cases there is a formulary? Is that not correct? There is a formulary in the President's plan? There is a formulary in the Republican plan and caps in each plan?

Mr. PALLONE. My understanding is you don't have the formulary.

Mr. GREENWOOD. Caps in each plan.

Mr. PALLONE. I'm glad you raised that, because it is my understanding you do not have the formulary.

Ms. DEPARLE. Well I do not think I am clear, Mr. Greenwood—

Mr. GREENWOOD. PMBs would establish formularies in both instances.

Ms. DEPARLE. They are permitted to, although in the President's plan if a physician says a drug is needed a beneficiary is allowed to get that drug.

In the plan that I heard about yesterday, it does make mention of a formal appeals process that a beneficiary can go through to get off formulary drugs. So therefore I assume a formulary must be in there, but I have not seen the details about that.

Mr. PALLONE. I just want to take back my time.

Mr. BILIRAKIS. You can use a mike now, I think.

Mr. PALLONE. The way the President defines this in terms of medically necessary I think is very important. There is a big difference there in terms of what the President's proposal says in saying it is medically necessary drugs.

Ms. DEPARLE. The President says this has to be a defined benefit that ensures access to all medically necessary prescription drugs. And that means that if there is a drug that a beneficiary needs according to their physician, but it is not on a formulary that a PBM has, that the beneficiary can get that drug. The physician's medical judgment is what would rule.

Mr. PALLONE. Thank you.

Is my time up?

Mr. BILIRAKIS. Your time is up. Thank you.

Mr. PALLONE. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Let's see.

Dr. Ganske.

Mr. GANSKE. Thank you, Mr. Chairman.

I hope that our electrical problems this morning are not indicative of how the grid will work after electric deregulation.

Well, Ms. DeParle, I want to first start out with a comment that is a follow-up of a question that Chairman Archer asked you yesterday. You have already alluded to it in some of your answers.

I will be bipartisanly critical of both plans as I have seen them so far. I would point out that when we are talking about bipartisanship on these bills it will take more than 2 or 3 members of the other side of the aisle, as much as I love Ralph Hall, to make a bipartisan bill and be able to move a big issue like this.

But this is what I see as the big problem with both the President's proposal and what I am seeing coming out of the Republican plan. It relates back to 1988 when Congress passed a catastrophic bill that had prescription drugs in it.

That applied to all senior citizens. It involved a premium increase. I want to read what Chairman Rostenkowski said recently about that experience. He said:

We adopted a principle universally accepted in the private insurance industry. That is, that people pay premiums today for benefits they receive tomorrow. Apparently the voters did not agree with those market principles.

So what has been the lesson in Washington on that experience? The lesson has been. Well, by George, we better make this voluntary. This has to be a voluntary benefit. But this is the problem. And we were able to get some of this information from the hearing yesterday.

Chairman Thomas, when he testified, pointed out that the Republican bill will cost somewhere between \$450 to \$500 a year in premiums plus a 50 percent co-pay, and we know that the President's plan I think originally costed out at something like \$25 per month, but that you are willing to talk about stop-loss so it will be higher than that.

Congressman Burr in a previous hearing very aptly pointed out that under the President's plan for this to be a cost-effective maneuver by a Medicare beneficiary they are going to have to have out-of-pocket expenses somewhere around \$1200.

It will probably be somewhat similar to that with the GOP plan. And this is the problem. If you look at the data for MedPak, they show that of current Medicare beneficiaries—this is 1999 data—14 percent of Medicare beneficiaries today spend nothing on prescription drugs; 36 percent spend from \$1 to \$500.

So you have got 50 percent of Medicare beneficiaries today with less than \$500 out-of-pocket expenses. Now if you are a senior citizen and you are looking at having to have expenses of greater than \$1000 for either the GOP plan or the Democratic plan, to make signing up for this voluntary program cost effective for you, why on earth would you do that? Why on earth would 50 percent of people do that?

The answer is. They won't.

They won't.

So that gets into the adverse risk selection of those who will. These are going to be the seniors, you know, that 6 percent, or 14 percent, who have expenses of more than \$1500.

What do we know happens from the current program under that scenario? Well, we know what happens because there already are Medicare supplemental programs that provide that drug benefit. And the only people who sign up for them are those who have a lot of expenses.

And what happens? The premiums are very high for those programs. So unless we take a huge amount of extra dollars from the General Fund to cushion that shock for those who will sign up for it, I think we are looking at significantly higher expenses.

This is what I think the solution should be. And I think that is the fundamental problem with both. I happen to agree with Mr. Kahn on this. Here is what he said. He represents insurance:

I am happy to say this because not always do I agree with the insurance industry. I've got Karen Ignani here, too. He said, private-drug-only coverage would have to clear insurmountable financial, regulatory, and administrative hurdles simply to get to the market.

Assuming that it did, the pressures of ever-increasing drug costs, the predictability of drug expenses, and the likelihood that the people most likely to purchase this coverage will be the people anticipating the highest drug claims would make drug-only coverage virtually impossible for insurers to offer to seniors at an affordable premium.

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

Mr. GANSKE. So I would just finish by saying, you know we have a big adverse risk problem in both of the plans that have been presented and I look forward to additional time. Thank you.

Mr. BILIRAKIS. Well let's see here. Mr. Stupak.

Mr. STUPAK. Thank you, Mr. Chairman.

You were asked some questions by Mr. Burr and Mr. Whitfield on choice and risk. In the Federal Employees Health Benefit Package, that basically reflects people like ourselves where prescription drug risk you are talking about would be people who are 65 and older, is it not?

Ms. DEPARLE. I think that in talking to the people at OPM who run and manage the FEHBP program, they do believe that the two populations are very different.



Mr. STUPAK. And the risks are very different?

Ms. DEPARLE. The risks are very different for an insurer facing those populations. And I think the insurance companies would tell you the same thing.

Mr. STUPAK. Okay. I understand that yesterday the President released a report prepared at the request of Senator Max Baucus that showed rural elderly are 60 percent more likely to fail to get needed prescription drugs because of the cost.

Could you please discuss some of the conclusions of that report, since I have a large rural district myself?

Ms. DEPARLE. Yes, and I have been to your district—

Mr. STUPAK. Yes, you have.

Ms. DEPARLE. [continuing] and I do know that.

It is the cost, as well as the fact that, if you look at the Medicare population, the people who are fortunate enough to have prescription drug coverage have it primarily because they worked for large employers which are less likely to be in rural areas. So as retirees they got that coverage from their former employer. They are less likely to have that.

As well, they are less likely to have access to a Medicare HMO. In the past—

Mr. STUPAK. We do not have any up there.

Ms. DEPARLE. You do not have any up in the Upper Peninsula. And in the past, in some areas of the country where those are available, then beneficiaries go to a Medicare HMO to get prescription drug coverage.

Mr. STUPAK. Well then—

Ms. DEPARLE. So those two things combined with some of the factors that you raised in your opening statement about the price discrimination and the fact that it is harder to negotiate on behalf of large numbers of beneficiaries in a rural area means they have less access.

Mr. STUPAK. Well how would the President's plan then address prescription drug coverage in rural areas like mine?

Ms. DEPARLE. Well under our plan we would have pharmacy benefit managers in different areas of the country that would cover a region and would negotiate on behalf of those beneficiaries who lived in that region to get the best drug prices possible for them under this defined benefit.

Then when the beneficiary had gotten up to the cap, they would still get the benefit of those negotiated lower prices if they needed to go further than that.

Mr. STUPAK. From what we know of the Republican plan, and I understand you were at the hearing yesterday, what does the Republican plan do to help elderly in rural areas like mine?

Ms. DEPARLE. Well what I know about that is what I heard discussed by the Members of Congress who were talking about their plan.

Mr. Peterson, who is from Minnesota—

Mr. STUPAK. That is a rural area.

Ms. DEPARLE. [continuing] said he believed it would help rural areas in I guess two ways. One is that he believes there will be a fallback mechanism whereby the government would step in where plans are not available and provide prescription drug benefit.

As I said, we have a lot of questions about whether that would really be affordable and accessible and what the premiums would be, but that is what he said would be there for rural beneficiaries.

And also I believe the plan includes some additional payments for Medicare HMOs in rural areas. He thinks that will entice them to come into some rural areas and provide Medicare HMO coverage, which they have not in the past.

Mr. STUPAK. Okay. So if we do not have an HMO like up in my district there are no HMOs in my area, then the government would be the fallback here and negotiate those prices? Is that your understanding?

Ms. DEPARLE. That is my understanding of what he said.

Mr. STUPAK. Well what would stop, then, the government being the fallback whether they are in a rural area or an urban area as insurance companies cherry pick only the healthy seniors to put in their plan?

Ms. DEPARLE. That is my concern, is that the more you segment the market like that, the more it results in adverse selection and then higher premiums for the people who do not have other choices, and subsidies for people who do have other choices. I am just not sure that is the right direction to go in.

Mr. STUPAK. There has been some talk about Medigap policies and the administrative costs. In fact, I brought up the Medicare situation in Michigan where the State ran it for \$28 million. Now they have turned it over to these private companies, including private HMOs, and now the administrative cost is \$141 million in Michigan per year.

The Medigap, is that the administrative costs to run the plan and market it to individuals, is that high, the Medigap policy, is that low? For example, with Medicare you said you run it at about 1.5 to 2 percent?

Ms. DEPARLE. Yes.

Mr. STUPAK. That's your overhead. Medigap plans, do you know what their administrative costs are?

Ms. DEPARLE. Well on average their administrative costs are around ten times higher than Medicare's according to the National Association of Insurance Commissioners.

Mr. STUPAK. So that would be about 20 percent as their administrative cost?

Ms. DEPARLE. Well, no, I guess it would be 10 or 11 percent, if ours is 1.5 percent.

Mr. STUPAK. Right. Okay.

Mr. BILIRAKIS. Mr. Norwood—Oh, I beg your pardon. Were you finished?

Mr. STUPAK. Just one more.

Mr. BILIRAKIS. Very quickly.

Mr. STUPAK. If the administrative costs are higher than the 20 to 15 percent, then the money that the seniors would be paying would not go necessarily for a drug benefit but more money would go for the administrative costs? Right?

Ms. DEPARLE. Well both the seniors and the Federal Government would pay because this is a 50-50 proposition in the President's plan. But I assume some of this would be paid by the Federal Government in their plan as well. It is not clear.

But, yes, we would be paying for higher administrative costs.

Mr. BILIRAKIS. Dr. Norwood to inquire.

Mr. STUPAK. Thank you.

Mr. NORWOOD. Thank you, Mr. Chairman.

Nancy-Ann, how many people are on Medicare?

Ms. DEPARLE. 39 million-plus, sir.

Mr. NORWOOD. Could we examine your first sentence in your statement? You said that 39 million people need drug benefits? Are you saying that everybody on Medicare needs a government-run drug benefit plan?

Ms. DEPARLE. No, sir, I am not saying that because in our plan—

Mr. NORWOOD. So it's not 39 million that need drug benefits?

Ms. DEPARLE. If I can finish? In our plan, we have proposed to include some subsidies to encourage employers who are currently providing coverage to continue providing it, and we hope they will.

Mr. NORWOOD. So just let's get to this answer—

Ms. DEPARLE. But when I say they need it—

Mr. NORWOOD. [continuing] Do 39 million people need drug benefits or don't they?

Ms. DEPARLE. I believe they need a guaranteed Medicare prescription drug benefit. They don't have that—

Mr. NORWOOD. All 39—

Ms. DEPARLE. [continuing] now.

Mr. NORWOOD. All 39 million?

Ms. DEPARLE. Yes, sir, because they do not have security right now that they have a drug benefit. Some of them—

Mr. NORWOOD. Even the 50 percent that Dr. Ganske referred to that are very happy with their supplemental drug plans paying zero or very little, they need it, too?

Ms. DEPARLE. What I find when I talk to seniors—maybe the ones in your district are different—but when I talk to them, they are concerned about the rising costs of drugs and the fact that they do not have coverage.

Some of them have retiree coverage but they are not sure it is still going to be there. So what I am talking about here is—

Mr. NORWOOD. Well they are not sure Medicare is going to be there, either, the way we act. But the point is, you can't make the statement that 39 million Americans need or even want a government-run prescription drug plan. That is not a true statement.

Ms. DEPARLE. I don't want to argue with you, Mr. Norwood, but what I am trying to say is—

Mr. NORWOOD. You can't argue with me. I know them in my district who don't want it. So don't tell me everybody out there on Medicare wants the government to take over their medications. They don't. I just want you to be honest before this committee. You said—

Ms. DEPARLE. I am being honest, sir.

Mr. NORWOOD. [continuing] that all 39 million—

Mr. BROWN. Mr. Chairman, I—

Mr. NORWOOD. You may not interrupt, sir.

You said all 39 million Americans can't wait for government-run prescription drug—

Ms. DEPARLE. Now that is not fair. That is not what I said.

Mr. NORWOOD. That is what you said, 39 million people need a drug benefit.

Mr. BILIRAKIS. The witness will respond as best as she can, and then let's just move on.

Ms. DEPARLE. We obviously have a philosophical difference here. I believe—

Mr. NORWOOD. Well, no. I am just trying to find out if you actually believe that every American wants to have a government-run medication plan. That's all. You obviously believe they do. I know they don't.

Now let me go to the next question because my time will run out.

Mr. BILIRAKIS. Right.

Mr. NORWOOD. It seems to me that presently when you are 65 years old you have to go into the government-run health care known as Medicare. You do not have any choice about that.

If you are a patient over 65 years old and you wish to seek treatment from a physician for example who maybe does not take Medicare, or wish to seek—Regular Order—if you wish to seek, for example, a treatment that Medicare does not cover, we today as a Congress and as a government say you go to that physician and that physician treats you, we're going to give that physician a great deal of pain, whether it's putting them in jail, or fining them, or whatever. Now that's presently what we do in Medicare.

If the President's plan were to be put into Medicare, would that then mean the same thing for seniors in terms of their prescription medication? Would that mean they would have no other choices but then to use the two options in the President's plan?

Ms. DEPARLE. Well, no, sir. And I do not agree with your characterization of what happens now. If beneficiaries need or want treatments that are not covered by Medicare, that would not be the case.

Mr. NORWOOD. It is not the case that they can leave then and go to the physician of their choice, and if the physician of their choice treats them that the Federal Government comes down on that physician to take their license or put them in jail or fine them?

Ms. DEPARLE. That is not the case.

Mr. NORWOOD. That's not true?

Ms. DEPARLE. No, sir.

Mr. COBURN. Will the gentleman yield?

Mr. NORWOOD. I will yield.

Mr. COBURN. Can I referee here a little bit? The physician if he gets a disclaimer notifying the Medicare patient that this is not a covered benefit, the government cannot touch him. The problem is if your nurse fails to get a disclaimer.

Mr. NORWOOD. Or if it is a benefit that happens to be covered where you wish to go to a physician who does not take Medicare. That is what happens, whether you say it is or isn't, and that is what we do.

I am asking you if we put the President's plan into Medicare, does that mean then the senior citizens, half of them who presently have supplemental plans that they seem to enjoy and like, would no longer be able to use those but have to simply use those two offered by the President's plan?

Ms. DEPARLE. No, sir, it does not mean that.

Mr. NORWOOD. I will yield back, or yield to Mr. Burr.

Mr. BILIRAKIS. Well you only have 7 seconds left to yield to Mr. Burr.

Mr. BURR. Clearly us Southerners cannot even ask one in that time.

Mr. BILIRAKIS. Amen to that.

Ms. DEPARLE. Nor can I answer in that amount of time.

Mr. BILIRAKIS. Let's see. Mr. Strickland to inquire.

Mr. STRICKLAND. Thank you, Mr. Chairman.

Mr. Chairman, I would like to correct the record on something I said in my opening statement. Although the amendment I referenced, Mr. Sanders amendment, did pass the House, it was opposed by well over 100 Members.

I would like to give you a chance to explain, if you can, to my colleague what it is that you mean by that sentence that apparently is in question. If you would, I think you are an honest person and I do not think you are trying to mislead us, and so I would like to give you a chance to explain the difference of opinion that apparently exists between Dr. Norwood and yourself on that particular statement.

As I read it, it says it includes a voluntary, affordable, accessible, competitive, efficient quality drug benefit that will be available to all beneficiaries.

I do not interpret that as you saying that every Medicare-eligible person would choose, and the fact that it is voluntary is in there, it seems to me to be rather clear that it is not something you are wanting to impose on all Medicare beneficiaries.

Ms. DEPARLE. That is right. And in fact the President's plan, as I was trying to explain, includes some subsidies so that people who are fortunate enough to have coverage through their employer now as retirees would continue that coverage; that the employers would find it to be in their interest financially to continue providing coverage. I think the philosophical difference I have with Dr. Norwood—and I actually agree with him on a lot of things—but I think on this what I am saying is that I believe that beneficiaries need the same kind of assurance that they are going to have their physician visits covered, and that they are going to have their hospital visits covered, about prescription drugs.

Right now, today, they do not have that. Some of them are fortunate enough to have prescription drug coverage. That is great. We want that to continue. But unfortunately there are many seniors who have unreliable coverage, who are losing coverage, who may have it 1 month and not another, whose Medicare HMO has left.

So what we are talking about here partly is a philosophical issue about whether they need that security in insurance or whether they don't.

Mr. STRICKLAND. Thank you for that clarification.

I have a document that is supposed to be an analysis of the Republican plan. On the covered drug section it says:

"The proposal will cover all outpatient prescription drugs, excluding those already covered by Medicare Part B."

And then it says:

“Individual plans may establish formularies, however, that may limit beneficiary access to certain drugs.”

And then it goes ahead to say that if your physician feels like you need a drug that has not a part of the formulary, there can be an appeal process.

Now one of the reasons many of us want a Patient’s Bill of Rights is that we think decisions are made that are different than what a physician would choose.

Do you see a problem with setting up a system where the physicians may have to once again advocate for something that they think is in the best interests of the patient when we are finding it very difficult to develop an appeals process even under a Patient’s Bill of Rights?

Is this a problem in your judgment in terms of drugs that would be available?

Ms. DEPARLE. I think it is a problem any time we are not clear about what is covered and what is not covered. And I think that in working together to design this benefit, we should try to do everything we can to make sure that a physician’s medical judgment about that is allowed to govern.

Mr. STRICKLAND. And last, I am troubled that under the President’s plan the stopgap measure kicks in in 2006. That is a long way away. And could you briefly compare what it is you know about the Republican plan’s stopgap measures versus the Democratic plan? Because quite frankly, I think the President’s plan is very troublesome to me.

Ms. DEPARLE. Well, as I said, the President’s plan, really the only detail that he specified was that we had reserved \$35 billion, set aside that, to work with the Congress to design a stopgap plan. And his does start in 2006. And frankly, that is a question of the availability of the dollars that we think will be necessary to design such a benefit.

The House Democrats announced the outline of a plan a few weeks ago that has a stop-loss that begins at \$3,000 of out-of-pocket spending for a beneficiary.

And I believe it would start right away, or 2002, anyway, earlier than the President’s plan had talked about. And the Medicare RX2000 Plan, just looking here, again I believe that it starts at the same time the House Democrats’ plan does.

Maybe I should ask Congressman Burr. And I think it starts at \$6,000. Is that right?

Mr. BURR. Yes.

Ms. DEPARLE. So there are 2 or 3 ideas on the table. It is not clear. I think they said their premiums were going to be \$35 to \$40, and I guess that includes the catastrophic or stop-loss protection. That is what we know so far.

Mr. BILIRAKIS. The gentleman’s time has expired.

Mr. STRICKLAND. Thank you.

Mr. BILIRAKIS. Ms. Cubin—Mr. Bryant is back. Mr. Bryant.

Mr. BRYANT. Thank you, Mr. Chairman. Welcome.

I apologize for having to step out to attend a conflicting meeting here, and I missed—I did hear your statement and missed most of your examination. As I hear bells ringing, we may be leaving and

have to go vote, but I wanted to pick up on my friend from Ohio's question, because they are important.

I think one of the key things that makes our proposal attractive, because many of the bills that are offered today that are out there do rely on private sector insurance companies, and management of those outside HCFA. So this is not an idea unique to the particular bill that the Republicans are talking about.

But one of the things that makes that bill particularly attractive is the stop-loss provision. And like I assume so many of us that buy regular health insurance that are healthy, we buy that insurance to protect us against that catastrophic and—apparently we do not like that word around here, I do not know—but those bad things that can happen to you.

We would envision the same concept at the level of prescription drugs and senior citizens in this bill. Not every senior citizen uses prescription drugs, and obviously some use more than others. But it is that concept that is very important.

And that is why I want to go back to Mr. Strickland's questions about the President's plan taking til 2006 and even then, in reviewing the language—and I hope I am not quibbling over semantics here, but as I read that particular language he does reserve that \$35 billion from our surplus for either debt reduction or in the event that the President, he and Congress agree, whoever the President may be, on a policy that provides for protections against catastrophic drugs costs for Medicare beneficiaries or policies that otherwise strengthen the Medicare program.

So I think there is some probably flexibility in his proposal that that \$35 billion is not specifically dedicated to the stop-loss type program.

And again I think that is one of the things in ours is. It is dedicated for that. I mean, it is a guarantee, as much as we can guarantee anything.

So I would hope that as the administration looks at that very important piece of this modernization that there is more of a lock in and more of a guarantee to that rather than leaving that up to the administration and the Congress at that time.

Do you follow that?

Ms. DEPARLE. Yes. I do. And as I said to Chairman Bilirakis, we clearly need to sit down with all of you and discuss what the contours of a catastrophic or stop-loss protection should be.

I think the good news is that everyone here agrees that that needs to be a component of this, with the possible exception—I did listen carefully to what Dr. Ganske said about some of the difficulties in designing this. But I think we ought to sit down and talk about it.

Mr. BRYANT. Well, you know, we have I think a very good benefit on this committee of having some doctors who really have first-hand experience and add so much to the committee in discussions like this. And I think many of us I think, if I understand on the other side now agree that it is a very important issue that we have to begin to sort of set partisan politics aside and continue to work toward solving this problem together.

But I think any bill that comes up with the underlying principles that it is going to be universal, it is voluntary for people to be in

or stay in the very good program they might be in already as far as drug costs, and they are going to have choices within that, and you have got this stop-loss provision. So I think as long as we all maintain those concepts that, again, I am becoming perhaps more of an optimist that we can work this out and solve a very important problem.

Do you have any comment on that?

Ms. DEPARLE. Well, I am optimistic too. Thank you.

Mr. BRYANT. Thank you. Yield back.

Mr. BILIRAKIS. Ms. Eshoo to inquire. Anna?

Ms. ESHOO. Yes. Thank you, Mr. Chairman. I am sorry I had to step out of this all important hearing, but there was an important bill on the floor on digital signatures. So while that may not seem so related to everything that is going on here, we have gone past pen and quill and ink and even wax imprints. Now in a new century we are going to be able to transact things in cyberspace. So that is being done on the floor.

Thank you, Madam Administrator, for your opening statement. Let me just try to get some socks on this octopus. As I said in my opening statement, it is no longer a question of whether we should or should not do this. The reason why this hearing is so important is because we are trying to flesh out how to do this.

It seems to me that at the heart of this debate of how to is the benefit package. I know that you touched on that in your opening statement. I have not had the benefit of some of the questions and your responses, but could you for the record just for a moment—because I want to come back in on the coverage part of this—say why in your view it is so important for beneficiaries to have a defined Medicare drug benefit?

Ms. DEPARLE. Well, for several reasons.

First and foremost really is the one that you mentioned in your opening statement, which is that the seniors I talk to want to know what they have, how much they have to expect in terms of their cost. They want it to be predictable, and they want to know what is covered. And that is one of the I think very positive things about Medicare today, is they know that they are covered to go to the doctor, they know that they are covered to go to the hospital, and they need to have that same level of assurance about their prescription drug coverage.

I also think that if we do not have a defined benefit that we introduce a really scary element of additional risk selection into this. And several of the members on this committee have talked about that, and I can tell that everyone is trying to grapple with it. And that is, if you allow plans to design lots of different benefit packages, that promotes choice, which is a value that some members want to promote, but you have to be very careful not to introduce cherry picking of the healthiest seniors in risk selection and then also Mr. Whitfield raised the question of confusion for beneficiaries and the fact that it would be very difficult for them to navigate among the plans.

Ms. ESHOO. Right.

Ms. DEPARLE. All those things are things that we are really going to have to look at carefully.



Ms. ESHOO. Because they are all warning signals in terms of how we should design this.

Let me just cover two other points, and they both have placement and direct attention in the legislation that introduced.

In one area, and there are different ideas out there on this and that is what we are talking about today, ideas. The idea of stop-loss—catastrophic insurance—and how it is designed and how it kicks in.

Now there are different ideas about it. In the bill that I introduced, the out-of-pocket expenses of the beneficiary are \$2,500; the government, Medicare, picking up the other half. So once you reach the ceiling of \$5,000, then the stop-loss kicks in.

There are other plans out there that do not work that way. There is a gap between what is covered, what the beneficiary pays out-of-pocket, and how long they have to wait until stop-loss kicks in. And I put this out more as a red flag, because members are going to have to consider this, because their constituents will face it.

The reason why I think it is important to have stop-loss is very obvious. I do not know how many of us would be able to afford some of these drugs even with our salaries and the insurance coverage that we have once it goes past the out-of-pocket. So I say this to this subcommittee that is going to have something to do with that.

The other thing is the administration of this. With great curiosity yesterday, I listened to Mr. Thomas talk about the bureaucracy that he is designing, which, I am assuming, is going to be in my Republican colleagues' bill. I am issuing a warning on that. I really do not think we need to do that.

Now, in the bill that I have introduced along with 10 Democrats on the Commerce Committee, I do not have, as you know, Madam Administrator, your agency administering the program. Rather, I put it into OPM.

Now I am the first to admit that many of the problems that HCFA has are congressionally inspired, but there are problems. I think that you are already—

Mr. BILIRAKIS. The gentlelady's time has expired.

Ms. ESHOO. Can I take just 30 seconds so that she can answer this?

Mr. BILIRAKIS. Well, not 30 seconds, but a very brief answer.

Ms. ESHOO. Okay.

Mr. BILIRAKIS. But you have to briefly ask the question, too.

Ms. ESHOO. I think that you are understaffed and overburdened. Do you have a problem with OPM administering this, or do you feel strongly that HCFA must administer it, or—maybe you could just answer that.

Ms. DEPARLE. Well, I feel strongly that—

Ms. ESHOO. I think it is a tough question, but I want to ask it.

Ms. DEPARLE. I feel very strongly that this benefit needs to be integrated into the Medicare program. And I believe that HCFA can administer it the most efficiently, effectively, and I would like a chance to convince you of that.

Ms. ESHOO. Thank you. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Ms. Cubin to inquire.

Ms. CUBIN. Mr. Chairman, I yield to Dr. Ganske.

Mr. GANSKE. I thank the gentlelady. I will get to a question.

I think we need to look at will either the Republican plan or the President's plan work, how much will it really cost. I have already expressed some reservations about the first. I do not think we really know the second.

I think we need to think about making sure that we continue drug research. Drug research companies—or the drug companies have had basically a flat line in R&D. They have increased their marketing a lot. But we have got a lot of antibiotic-resistant bacteria out there that could cause some very, very significant problems to everyone who flies in an airplane and is worried about antibiotic-resistant tuberculosis, for instance.

We need some real dollars going into that, so I do not want to hurt that.

I think it is fair for me to criticize plans without offering a solution. So my question at the end of this is going to be, you know, will the administration think about this if this is the only way that we can get something done this year? And this is what I think a partial solution to this could be.

I sat on the bipartisan Medicare Commission for a while. In the context of comprehensive care, we were looking at expanding basically the prescription drug benefit, because there is some prescription drug benefit for dual eligibles; i.e., Medicare beneficiaries who are so poor they qualify for Medicaid.

There are two groups in Medicare that have enough assets that they are not quite in Medicaid, but they get some assistance on their premiums and some assistance on their copayments and deductibles. They are called qualified Medicare beneficiaries, QMBYs and SLMBYs. And it is that group, the poor widow who is existing on her Social Security, who has to make that choice between her rent, her food, and her prescription drugs, who is not quite so poor that she is in Medicaid, that I think we need to significantly look at helping, and sooner rather than later.

So when we looked at this in the bipartisan Medicare Commission, we thought we can expand the Medicaid prescription drug benefit to those people and the cost would be about \$61 billion over 10 years. And furthermore, to prevent a notch, you could create a spend-down group, so that if those people, Medicare beneficiaries who have some additional expenses, higher expenses, they could deduct that from their income and then they could get into that qualifying group. That helps the neediest.

But we also have 40 million people in this country who have no insurance at all, and I think we need to look at how do we cover them. And we also have to think about the fact that in a few years we know that the Medicare program is not going to have sufficient funds for any of the benefits that it is offering.

So my solution would be this. Do the QMBY SLMBY with a spend-down, address the issue of cost in some way for all Americans, whether you are looking at something like propose a modification or something proposed by Tom Allen or Gil Gutnick, or simply saying to the FDA and Customs, you can warn people who order their drugs from Geneva, Switzerland, but you cannot intercept an individual's drugs. So it is buyer beware.

I mean, there are many ways that we could look at trying to get some competition into that market for everyone, not just looking at a senior citizen.

My question to you, Ms. DeParle, is this. If it looks like this is just going to be a simply straight line Democratic vote on a Democratic bill, the President's bill that will go down, or a straight line partisan vote on a Republican bill that the President will veto, is the administration interested at looking at any compromise type of legislation?

Ms. DEPARLE. Well, Dr. Ganske, you know that your suggestions are always thoughtful, and you know that I will listen to them. And I believe—I am from Tennessee like Congressman Bryant. I am an optimist. So I think we can work together to get something done.

I would say, I hear you on the low income benefit, and I am concerned about those people, too, but when I look at our numbers, as you have done, I see that, you know, 60, 70 percent of our beneficiaries have less than \$16,000 a year, something in that range. So while I hear you about the very, very low income, my concern is, if we have an opportunity here to do something that assures security on prescription drugs for all beneficiaries, I would like to do that. I do not want to give up on that.

Mr. GANSKE. But we should not forget—

Mr. BILIRAKIS. The gentlelady's time has expired.

Mr. GANSKE. Thirty additional seconds?

Mr. BILIRAKIS. Well, the gentlelady has the time, and it has long expired.

Mr. GANSKE. I will ask next round, Mr. Chairman. Thanks.

Mr. BILIRAKIS. Ms. Capps.

Ms. CAPPS. Thank you. And if you would like, Dr. Ganske, you can have 30 seconds of my time.

Mr. GANSKE. I thank the gentlelady. I think it is fair to point out, you know, that there are a significant number of Medicare beneficiaries who do have a drug benefit. They have it from their employers, and that helps keep their out-of-pocket expenses down. We have a significant number of Medicare beneficiaries who have a pretty low out-of-pocket expense. As I said, from MedPAC, 50 percent have less than a \$500 out-of-pocket expense.

So if we are looking at trying to balance providing some health care assistance to those who do not even have anything, much less a prescription drug benefit, would not it be advisable to take some of—a little bit more global approach to where we are heading than to try to piecemeal this and have some unintended consequences for the later fiscal solvency of the program? Or for that matter, not being able to have sufficient funds to handle those who do not have any insurance at all?

Ms. DEPARLE. Well, if understand your question, if by a global approach you are referring to covering the uninsured, I would love to sit down and talk to you about that. And I am listening to what you have to say.

Mr. GANSKE. Thank you.

Ms. CAPPS. Thank you. And I am going to be brief. I want to ask you about two different things, and Administrator DeParle, I thank

you for enlightening us and for being willing to go through this conversation. It is very helpful to me.

I am sitting here as we have been discussing this thinking about me being, all of us on this subcommittee, being part of arguably one of the best benefit packages of any employee, the Federal Government. And there has been a lot of comparison between the Federal Government benefit plan and Medicare. And maybe you could articulate—and I know it is repetitive a little bit—so that we are clear.

We are a very different kind of pool across this country of employees, working people, hopefully fairly healthy, compared with the population that Medicare serves. And this issue of the importance that some would say to giving seniors choices of their plan, I would like you to contrast that with what I hear frequently, seniors saying my doctor—I need to take this particular heart medicine to keep me alive, and my HMO will not cover it.

Ms. DEPARLE. Well, you have raised some issues that we have been grappling with this morning. On the differences between Medicare and the FEHBP program, I think you are exactly right. And in speaking with the people who run FEHBP at OPM, they say the populations are very different, that the insurance companies who come in to participate in the FEHBP program say the populations are different, and that the risk that you are assuming is quite different among the two populations.

Medicare beneficiaries tend to be poorer, sicker. They are not active employees. There are a lot of factors that lead to higher expenditures.

Ms. CAPPS. Now could I raise one caution also about, as we are entertaining these various plans. I represent a rural district, one about 100 miles north of Los Angeles, where there is a great reimbursement rate from HCFA. Ours is about half of that. Our cost of living is not half of that in Los Angeles.

This disparity that impacts service, whether through hospitals or providers, is so pervasive. There are no HMOs in a large part of my congressional district. Seniors have no choice there.

And any kind of plan that is going to come in in discussion my district is going to meet a jaundiced ear both about HMOs and people's disenchantment with that form of service for medicine and also with the pairing of that with delivery of a vital part of seniors' health care, which is prescription drugs.

That is an enormous hurdle I believe that we have to get through in this discussion.

Ms. DEPARLE. I agree that it is a hurdle. And as you know, the amount that we pay the managed care plans is based on historical costs under Medicare for fee-for-service, and we have some—well, one of our doctors left, but Dr. Ganske is still here, who can talk about why is it that it is so different in different areas of the country.

But that is what those payment rates are based on. And let me say too that we are not reimbursing managed care plans right now to provide prescription drugs—

Ms. CAPPS. I know.

Ms. DEPARLE. [continuing] which they tell us they need to offer to seniors in order to get them to join. So one of the things we need

to do is to reimburse HMOs to provide prescription drugs, and that is one of the things we want to do.

Ms. CAPPS. I turn back the rest of my time. Thank you.

Mr. COBURN [presiding]. Thank you. I am sitting in for Chairman Bilirakis, and I believe I am the next in order, so I will recognize myself for 5 minutes.

I believe that is accurate. I wanted to ask you the most important question today, is how is your baby?

Ms. DEPARLE. He is great.

Mr. COBURN. Great.

Ms. DEPARLE. Thank you for asking.

Mr. COBURN. Great. You know, I made some statements in my—some sentences and statements in my opening statement about the best way to allocate a scarce resource is vigorous competition. And I do not know if you are familiar with some of the FTC actions of late against several drug companies and four others that are pending on collusion that have cost American citizens a ton of money, several hundred million dollars in the last year.

And I just wondered if you had a comment about that, because no matter what we do—and I am sure we are going to do something despite my no vote—whatever we do is going to cost more if we are not sure that there is competition there. And I just wondered what your thought was about that.

Ms. DEPARLE. Well, I think you are right. There does need to be competition. The way we go about it, there are different ways of doing it. The way we go about it is have pharmacy benefit managers to negotiate to get the best prices. But it is a very difficult problem, and I am somewhat familiar with, just from what I read in the newspapers with what is going on over at the FTC, and it is a difficult problem to get your arms around.

Mr. COBURN. Does it surprise you that retail pharmaceutical prices, not including new drugs, rose 8 percent last year when the cost increases were about 2 percent?

Ms. DEPARLE. No. And I have talked to a lot of employers and managed care plan executives who tell me their costs, their spending is going up, you know, 17 and 18 percent.

Mr. COBURN. Does the administration have a position as to allowing the decision made in 1997 for direct television advertising for prescription drugs?

Ms. DEPARLE. I do not know, Mr. Chairman. I am aware of the decision, but I do not know about any position that we have on that.

Mr. COBURN. Just for the record, it is \$1.9 billion this last year, and that goes straight to the bottom. And I think Dr. Ganske made note of the fact that the expenditures on R&D, I think he was in error. The expenditures on R&D in the pharmaceutical industry are rising. They are not flat line. But the expenditures for advertising and promotion direct to the consumer have gone up significantly.

Have you calculated from inside HCFA the increased utilization rate of Medicare based on television advertising the pharmaceuticals?

Ms. DEPARLE. You know, we have not. But our actuaries have been looking at the kind of data that you and Dr. Ganske have

been discussing in assessing what the cost of this would be, and I know CBO has been looking at it as well.

I do not think we have looked at whether it has increased any Medicare utilization. I guess you would be suggesting—

Mr. COBURN. I am suggesting that because of promotional advertising, demand pull through advertising by the drug companies, what we are seeing is increased utilization. I am seeing it in my practice. More people are coming in because the drug company told them they had to, because they could not get well without this wonderful drug.

I would like unanimous consent to introduce into the record the FTC cite listing the consent decrees with two large pharmaceutical companies and make that a part of the record. No objection.

There was some discussion made about the efficiency of HCFA in terms of its cost. I think it is important for the record for people to know that one of the reasons HCFA is efficient is the vast majority of the work has been transferred to the provider in terms of the paperwork and the clearance and everything else.

So it is important, although the same amount of work is being done, a large amount of that work now is done in the provider's hospitals and the physician's offices across the country.

And it is true. I believe you are very efficient for what you are asked to do. I do not like the system very well, but I think you do a great job.

If we were to start all over—and this is the last question—and you could tell us, how can we go take care of those people who really are making a choice between necessities of life and their medicine in this now politicized kind of who is going to win the next election environment, would you have any advice for us to solve this problem to really meet the needs of people without ruining the drug industry, without, you know, ruining pharmacy benefit providers?

Because I see the same thing happening on pharmacy benefit providers that happened to the clinical labs. I mean, that is what is going to happen.

We are going to have 3 or 4 major clinical labs in the country—I mean, pharmacy benefit providers—and that is it.

And so I just wondered, is there an advice that you could give us that if we were to start over on this that would take it out of the political to where we really went to solve the problems?

Ms. DEPARLE. You always ask the easy questions. You know, Medicare is going to be 35 years old next month. So I have actually, just was watching recently the video of the signing of Medicare and the speeches that were given. And there is no question that there have been difficulties and challenges that Medicare has faced and continues to face, but I think it was a great thing to do.

I think if you were looking at it today, you would put prescription drug coverage into Medicare. And I think we should figure out a way to do it, and I do believe it should be something that is universal and voluntary. It is going to be very tough. And I already heard you say that you think the problem is so tough and the challenges that Medicare faces are so great already that you would not go there.

But I hope that we can have some conversations and I can convince you that for our generation and the generations to follow that it is the right thing to do, because I believe it is.

Mr. COBURN. I thank you. I just would make one comment before I recognize Mr. Greenwood is—is Mr. Deutsch next? Is that we are adding a cost to a program that is technically bankrupt from an actuarial standpoint. And it is important that the American people know that. They may want us to do that, but there is no actuarial that would go out there and say you should add another cost to this program based on what the numbers looked like today.

Mr. Deutsch, I would yield you 5 minutes.

Mr. DEUTSCH. Thank you, Mr. Chairman. I want to give you a chance at least to respond, because I think to leave a statement like that open-ended would be a mistake; the system is not bankrupt. That it is an actuarial system that in the 8 years I have been in Congress we have made changes which have increased the actuarial stability of the Medicare system.

And a lot of the actuarial problems are high class problems. High class problems in that part of—the average life expectancy of Americans has gone up dramatically. I mean, one of the incredible statistics in that 1965 when Medicare was created, the average life expectancy of Americans was in fact 65, and now we are talking about it being over 75 years old. So as a person who administers the Medicare program, if you can—I want to give you the opportunity to respond a little bit to the chairman's comments about the system being bankrupt.

Ms. DEPARLE. Well, and you also highlighted the reasons why I say Medicare was a great thing and why—you know, I can remember what it was like when my grandmother did not have Medicare coverage, and then when it came into effect. And I know what a difference it has made in the lives of not just senior citizens but, frankly, our generation. That we have not had to worry as much about providing for them, and that we have been able therefore to concentrate on our educations and other things. So I do think it has been a great thing.

I think what the chairman is talking about is the fact that while we have made some very tough decisions together up here, which have been, you know, extremely difficult for all of you and things that providers in your districts have been very unhappy about, that have extended the life of the trust fund through 2025. I think that was the right thing to do. I also think it was a very, very difficult thing to do. And frankly, I think it is one of the reasons why HCFA is not the most popular agency in town these days.

He is right, though, that we face a huge demographic challenge as all of us in the next 20 years come into Medicare.

Mr. DEUTSCH. Can I just, again, just to interject and highlight something you just said. There are two separate issues. Medicare is an insurance plan where there is an obligation for it to be actuarially sound. So what you have just stated is something people need to hear. Until the year 2025 under the present projections, we are actuarially okay out to 2025, which is 25 years from now. Not to say that we should not do something about that on an actuarial basis today.

But I think it really is somewhat disingenuous to say the system is bankrupt today. It is not bankrupt today. There is the baby boom issue, the demographic issue that we are going to have to deal with. But a reason not to do a complete Medicare prescription drug plan under the premise that the system is bankrupt is just not—it is not credible. The system is fundamentally sound to 2025.

I wish we did it this year, hopefully we will do it this year, I doubt we are going to do it this year. We can do it next year in terms of dealing with the baby boom issue, which we can do. But that is not a reason not to do prescription drugs under a universal Medicare program today, which is really the essence of the final question, which is something also that you have talked about.

I think—and I mentioned in my opening statement as well—the fundamental difference between what the Republicans are proposing and what we are proposing is really that issue. I think what we are saying, what the President is saying is that we ought to extend Medicare to include prescription drugs, and what they are saying is, hey, you cannot do that. You ought to do it maybe just for people at 135 percent of poverty, or at poverty or a limitation.

And I think if you can elaborate a little bit more about that fundamental difference and what type of impact that would have on Medicare in general or for that matter the stability that Medicare consisted, I strongly believe that one of the successes of Medicare is that it has been a universal system. That if it was funded at 135 percent of poverty when it was created, it probably would not exist today, because the political will to push the system, to make the hard choices that you talked about to change the actuarial dates that we have done in the last 8 years, I do not think you would have had the political will to do that if it was a system that only provided for coverage 135 percent of poverty.

Ms. DEPARLE. I agree with you, Congressman. I think that one of the great strengths of Medicare is that it has been a program that is available for everyone, everyone pays into it, everyone participates in it, and I think that has been one of its strengths. And as I said, I believe there is a way to provide a prescription drug benefit for all beneficiaries, and I think that is the right way to do it.

Mr. DEUTSCH. And I guess just because I think it really is the essence of the difference. I mean, if we are talking about the Republican proposal, even if it is 135 percent of poverty, we are really talking about prescription drugs from a welfare context. And I think, you know, just as a Congress which collectively and with the President we have eliminated welfare as we know it, which was a positive thing, I mean, that is really what they are proposing, effectively.

And I just see, you know, we have just gone through this process of eliminating welfare as we know it to come back and sort of create welfare for Medicare beneficiaries.

Mr. COBURN. The gentleman's time has expired. The gentleman from Pennsylvania is recognized for 5 minutes.

Mr. GREENWOOD. Good morning—afternoon. You indicated earlier that you are optimistic that we can get this job done, and I am optimistic, too, and I think there are reasons for us to be optimistic. And the President clearly wants to do this. I think he wants



this to be part of his legacy that he leaves office having accomplished a Medicare prescription drug benefit.

Clearly, Republicans in the House and the Senate want to get this done. The Democrats in the House and the Senate want to get this done. I think we all want to do it this year, and whether it is the third of the Medicare beneficiaries that have no coverage, I mean, they certainly want us to do it; and whether it is the half that maybe have inadequate, either no or inadequate coverage, they certainly want us to do it. So there is a huge national consensus I think to get this thing done.

The only thing that would make me pessimistic is the extent to which partisanship creeps in. Because obviously, you have a Republican Congress and a Democratic President, and if we do not—if everyone gets partisan about it, the job will not get done. The President's not going to sign a bill he does not like, and we are not going to send him a bill that we do not like. So it has to be bipartisan.

It seems to me that there are two ways that partisanship creeps into this debate. The first one is the—and we have heard it here in the course of this hearing already today. The first is the what took you so long argument, what is taking you so long? You do not have a bill yet. Get on the mark and get this done.

The reality is—and I do not want to sound partisan in this—but the fact of the matter is that the Democrats controlled the Congress for 40 years since the birth of Medicare and did not come up with a prescription drug benefit. The President's been in office 7½ years, and it took him that long to get one on the table, and it is taking us a little while, too, because it is hard.

But the fact is that the reason it was not done sooner is because we were in deficit spending for most of that time. And now because of a lot of things that have gone on in this town the several years, we have a balanced budget, we have a surplus, we have taken Social Security off the budget, and now we have the ability fiscally to do this, and I think that we can do it.

Another way partisanship creeps in is we accentuate the differences between the bills. We spend all our time saying, well, the President's bill does this and yours does not, or ours does this and the President's does not, and that is what the people hate about what happens in this town, because we accentuate our differences instead of looking at how we can find commonalities.

But there are more commonalities, it seems to me, than there are differences if you look at the two plans. The fact is that both plans are based on the reality that we have finite resources. We would all love to just say, everyone go get free drugs and Uncle Sam will pay for it, whatever it is, for however much money you have. But we do not have the resources to do that.

We have limited resources, and that is why both of us are looking at premiums, both of us are looking at copays, both are looking at deductibles, both are looking at some kind of limitation or cap on the benefit, and that is because reality dictates that.

Both the President and the Republican, or I should say the bipartisan bill actually that we will be introducing later this week, both want to make sure we do not disincentivize or create disincentives

to the private sector continuing to produce the benefit. You are for that and we are for that. That is good.

Neither of us wants adverse selection. We have to have a process that makes sure we do not have that problem. Both of us see the value of the private sector being involved, whether it is PBMs or whether it is insurers or both, the private sector has to be involved, it seems to me, because the pace of change in the prescription drug world is so fast that it would be impossible for a bureaucracy to keep adding this drug to the benefit and that drug to the benefit. You have to have the private sector out there being able to move at a much quicker pace so that seniors can benefit from these changes.

Both of us see the need for a stop-loss. You have indicated today repeatedly that that is something that is not in the President's plan, but you see the value of it, it is in our plan, and we need to get there. Both of us agree that it needs to be voluntary.

So my question is, if you were to sit down with Republican leaders who have been most familiar with this issue tomorrow, and you said let's get this compromise done. Let's get a hybrid bill here between what the President has put on the table and what Republicans and some Democrats who have joined with us have put on the table, what would be the areas, maybe 2, 3, 4 areas where you think we would have to work the hardest? Where are the differences that we need to compromise in order to get to a plan that we can all happily feel good about?

Ms. DEPARLE. Well, I would start with whether or not there is a defined benefit package. And we have had a lot of discussion about that today, and I think that is very important.

Mr. GREENWOOD. And I would say I think that is very malleable to that kind of work. I think we are pretty much on the same page there, that we want medically necessary drugs to be available.

Ms. DEPARLE. And then I would also want to look at whether the plan as I have heard it described that Congressman Burr and others are working on relies too heavily on private insurance plans.

I believe this needs to be a guaranteed benefit, an entitlement. There are lots of views about that up here, too, but that is what I believe. So I would be looking to see, is this thing really affordable, is it really accessible? And the question I have there—and frankly, I think it is partly—it may be malleable, but it is partly governed by what is in the budget resolution. I am not sure that the subsidy in the way it is provided, the indirect subsidy, is enough to provide a benefit package that is attractive enough to attract most beneficiaries and therefore guarantee access and affordability.

So I would want to spend a lot of time working with you on those issues.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Mr. Barrett.

Mr. BARRETT. Thank you very much, Mr. Chairman. I want to talk about the merits of the plan that is being proposed, but first I have to just address for a moment the comments of the previous speaker who I think tried or implied that somehow the Democrats, because we controlled Congress for 40 years did not address this problem.

As you said in your statement, this was not an issue when Medicare was created. It was not an issue in 1965. And the reason it has become an issue in the last 5 years is because the price of prescription drugs has gone totally through the ceiling, and that is why people are mad about it, and that is why it has been an issue for the last 3 or 4 years and why we have had Democrats in Congress who have tried desperately to try to move this issue as a national issue.

I thought perhaps one of the most telling indicators was just the vote we had yesterday, the vote that was the tripartisan amendment with Bernie Sanders and Republicans and Democrats, that called for some cooperation with pharmaceutical companies if they have benefited greatly from NIH grants. And when we had a vote on that 4 years ago, it garnered 180 votes. When we had the vote on it yesterday, there were over 300 votes in favor of the same amendment. You do not need a weatherman to tell which way the wind is blowing.

And it is clear that the American people are sending a message through their elected representatives that this is a problem now, and it is a much more serious problem now than it was even 4 years ago.

Mr. GANSKE. Would the gentleman yield?

Mr. BARRETT. I would be happy to yield briefly.

Mr. GANSKE. I agree with the gentleman that because of the price of—the cost of drugs has gone up a lot and the volume, the usage has gone up a lot, that it is really on the radar screen. But I think it is also fair to say that, you know, if you look at the record, 1965, pharmaceutical benefit was discussed, and it has been discussed many times over the last 30 years. The predominant problem has always been, as Chairman Rostenkowski has said, where is the money coming from for that?

Mr. BARRETT. And I agree, and I would reclaim my time. I want to get to that point now in terms of the plan that is being proposed. And specifically, as I understand the plan, and we have not seen the plan, is that this would rely primarily on private insurance companies.

My question for you is, is there a market out there right now? Is there a number of private insurance companies that are offering prescription drug-only plans? Are companies interested in doing that? Where is this supply going to come from?

Ms. DEPARLE. Well, the closest I guess experience that we have is with Medigap. There are some Medigap plans that are primarily there because they offer prescription drug benefits, and the experience there has not been great; partly because I think the benefit design is not rich enough to attract a lot of seniors to join it. And therefore—the premiums are very high and you do not get much for what you pay.

So I do think, as I have said several times today, that there are some real difficulties inherent in trying to do a plan that relies so heavily on private insurance plans. Now, should there be Medicare HMOs offering a prescription drug benefit? Yes. And we intend under our plan to reimburse them for doing it. But a drug-only plan, I think the industry has suggested, is not an attractive risk for them to assume.

Mr. BARRETT. In your plan, one of the problems that some of us have is the Medicare reimbursement rate. And there are wide geographic disparities in this. How do you address that?

Ms. DEPARLE. Do you mean the Medicare+Choice plan?

Mr. BARRETT. My good friend from Florida, Mr. Deutsch, who just left, represents what those of us in other parts of the country call the poster child of Medicare reimbursement rates, where their Medicare reimbursement rates are much higher in Florida than they are in Minnesota or Wisconsin.

Mr. BILIRAKIS. Not in all of Florida, by the way, Tom, only South Florida.

Ms. DEPARLE. That is true. It is not in Mr. Bilirakis's area. There is only, you know, I guess I was talking about Medicare turning 35 next month, and it is appropriate therefore to look at the history.

The history of this is that from the beginning, Medicare reimbursement rates were supposed to be tied to what physicians were charging or hospitals were charging in a particular area. That is a heavy part of it. And therefore, the volume and intensity of what is provided by doctors and hospitals is reflected in the cost, and Medicare HMO payments under the statute are tied to those payments. So that is why you have such dramatic differences around the country in what the capitation payments are.

Mr. BARRETT. And I do think that at some point if the parties are interested in working something out that there will be some sort of compromise. But I think that what we are seeing is in some parts of the country, you can have a generous prescription drug benefit, and in others you can't.

Ms. DEPARLE. Right. And that is what I do not think is fair. I think this is a national program, and all beneficiaries should have access to an affordable drug benefit.

Mr. BARRETT. Thank you. And I would yield back my time.

Mr. BILIRAKIS. Thank you, Tom. Well, Madam Administrator, thanks so very much for your patience and for being here, and you have been very helpful. I do not know what the future holds, but obviously—I honestly feel that we all want a prescription drug plan, and hopefully, if we all work together and put partisanship aside, we will get it done. But we always say that and then it never really happens, does it? We will do our best. Thank you very much.

Ms. DEPARLE. Well, I am optimistic, and I want to thank the committee for your serious commitment to helping beneficiaries.

Mr. BILIRAKIS. Thank you. The second panel, if they will come forward, please, consists of Ms. Karen Ignagni, President and Chief Executive Officer of American Association of Health Plans; Mr. Craig Fuller, President and Chief Executive Officer of the National Association of Chain Drug Stores; Mr. Charles N. Kahn, President of the Health Insurance Association of America; Ms. Judy Feder, Dean of Public Policy Studies, Georgetown University; Mr. Patrick B. Donoho, Vice President of Government Affairs and Public Policy for the Pharmaceutical Care Management Association; Mr. Ron Pollack, Executive Director of Families USA; and Ms. Nancy Davenport-Ennis, Founding Executive Director, Patient Advocate Foundation of Newport News, Virginia.

Ladies and gentlemen, your written statement as per usual is a part of the record, and we will set the clock at 5 minutes and ask that your oral testimony complement your written statement.

We will start off with Ms. Ignagni.

**STATEMENTS OF KAREN IGNAGNI, PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERICAN ASSOCIATION OF HEALTH PLANS; CRAIG L. FULLER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NATIONAL ASSOCIATION OF CHAIN DRUG STORES; CHARLES N. KAHN III, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA; JUDITH FEDER, DEAN OF PUBLIC POLICY STUDIES, GEORGETOWN UNIVERSITY; PATRICK B. DONOHO, VICE PRESIDENT OF GOVERNMENT AFFAIRS AND PUBLIC POLICY, PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION; RONALD F. POLLACK, EXECUTIVE DIRECTOR, FAMILIES USA; AND NANCY DAVENPORT-ENNIS, FOUNDING EXECUTIVE DIRECTOR, PATIENT ADVOCATE FOUNDATION**

Ms. IGNAGNI. Thank you, Mr. Chairman, members of the committee. I would like to make four points in speaking with you this afternoon.

First, our members support creating a drug benefit for Medicare beneficiaries. It is a long overdue matter that this Congress can and should confront, in our view.

Making prescription drug coverage available is an essential part of the effort to bring the 1965 program in sync with the benefits programs of today. In fact, a linchpin of effective disease management strategies is actually the presence of prescription drugs, and many physicians report around the country that they have barriers to prescribing the right and most appropriate procedures for beneficiaries because of the absence of prescription drugs in this population.

No. 2, in our view, an essential part of ensuring that seniors have access to affordable prescriptions will be to build on what works. To that end, we have been encouraged both this morning, in the Ways and Means committee discussions yesterday, and indeed in the public dialog, that choice is a key principle within so many proposals.

And second, there is a growing recognition about the need to preserve what exists as a building block for taking the next step.

No. 3. Medicare+Choice is already providing drug coverage to millions of beneficiaries who otherwise would not have access. However, in a little over 3 weeks, our plans face a deadline to let HCFA know whether they are going to be able to continue to participate in the Medicare+Choice program. We have seen pullouts, we have seen plans being forced out because of the unintended consequences of the Balanced Budget Act, which this committee has spent a great deal of time on, as well as the sheer number of regulations and instability and unpredictability within the regulatory environment.

Now to her credit, the Administrator DeParle has recognized many of these problems as well and has already embarked on a strategy designed to deal with some of the unpredictability, but more needs to be done.

You have it in your power to stabilize this program, and we urge you to act now to preserve the program that has in fact served so many low- and moderate-income beneficiaries who have nowhere else to turn for protection from high out-of-pocket costs in the traditional Medicare benefit, catastrophic benefits, and prescription drugs.

Also I would like to comment, Mr. Chairman. There's been some discussion this morning about rural areas and whether managed care is interested in being in rural areas, and I would suggest to the committee that plan decisions are very much influenced by the willingness of single hospital-based systems in rural areas that in fact contract with our plans.

Finally, No. 4, in testimony we have offered principles for your consideration in designing prescription drug coverage. These principles are embedded in many of the proposals being discussed today, beginning with the concept of universality, which is that all beneficiaries should be eligible to participate in this benefit. We believe that that is common to both proposals as we have heard them discussed.

Subsidies for low-income beneficiaries. That seems to be common to both proposals.

Sustained funding is a challenge for all proposals in this area, as it would be for any new benefit, and options and flexibility. You are having a great deal of discussion about that. We commend you for that.

And finally, a floor package of benefits, which we understand the concept of a floor is common to both.

In conclusion, Mr. Chairman, we stand ready to work with you to contribute to the committee's efforts, and we support the objective which we know all of you share of providing this important benefit and this important population with affordable prescription drug coverage. Thank you.

[The prepared statement of Karen Ignagni follows:]

PREPARED STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CEO, AMERICAN ASSOCIATION OF HEALTH PLANS

I. INTRODUCTION

I am Karen Ignagni, President and Chief Executive Officer of the American Association of Health Plans (AAHP). On behalf of the more than 1,000 HMO, PPO and other network-based health plans that are members of our association, I am pleased to testify this morning on the vitally important issue of extending prescription drug coverage to this nation's 38 million Medicare beneficiaries.

It bears mentioning that our membership includes the majority of Medicare+Choice organizations, which collectively serve more than 75 percent of those beneficiaries who have chosen Medicare managed care over the traditional fee-for-service option. As such, we are delighted that Congress is focusing so much attention on this urgent national priority that affects so many American seniors and their families.

II. PRESCRIPTION DRUG COVERAGE CRITICAL TO MEDICARE PROGRAM

We believe that creating an affordable prescription drug benefit under Medicare is the single most important piece of unfinished business this Congress can and should confront. Not because the issue is important to those who will play a role in actually delivering a prescription drug benefit, but because it affects so profoundly the lives of Americans who have given so much to our nation and to the generations behind them.

We owe it to these millions of Americans—the men and women that have so eloquently been called the “Greatest Generation”—to ensure that no Medicare senior

in this nation faces the cruel reality of having to decide between paying for drugs or the monthly food bill.

Our great economic expansion—which has created so much prosperity for so many—must now be big enough to accommodate a simple proposition: that Medicare seniors deserve access to affordable prescription drugs. And that no one will be left behind.

When established in 1965, Medicare reflected the state of the art in health care delivery and benefits design. At that time, few people with private health insurance had coverage for prescription drugs. Today, most commercially-insured individuals receive care through managed care plans, and prescription drug coverage is the norm, not the exception. Prescription drugs have transformed the treatment of innumerable illnesses and conditions and have improved the quality of life for millions of Americans. Access to prescription drugs is particularly crucial for Medicare beneficiaries. Although the elderly comprise 12 percent of the population, they account for 34 percent of total prescription drug costs (Mueller, 1997). It is estimated that individuals over the age of 65 use four times as many prescription items as those under 65. Prescription items are common treatment regimens for chronic conditions, which are highly prevalent among the elderly. Health plans and disease management companies have pioneered programs to help individuals with chronic conditions, such as congestive heart failure and cancer, among others, to maintain their health, and prescription drugs are a central component of these programs.

### III. MEDICARE+CHOICE PROGRAM IS CRITICAL TO ENSURE A STRONG FOUNDATION FOR PRESCRIPTION DRUG COVERAGE

We believe that Congress can deliver a prescription drug benefit to America's seniors through a bipartisan effort, and that members can create a system that is faithful to Medicare seniors and indeed all Americans.

The job won't be simple. And the choices won't be easy. But the first step is to listen closely to what seniors really want from their Medicare system, and to build upon what's already working in the marketplace.

First and foremost, seniors are telling us that they want control over their health care to rest with them, not with Washington. That means preservation of choice—so that Medicare seniors can choose a prescription drug benefit that's right for their unique needs and wants, and that no one gets locked into a one-size-fits-all system.

Second, we can't find common ground by, in essence, throwing out a coverage option that has proven to be effective. Managed health care has played a significant role in providing an affordable prescription drug benefit to most of the 6 million seniors who have chosen the Medicare+Choice option. The simple fact is that managed health care has already played a key role in expanding a prescription drug benefit under Medicare to millions of Americans who otherwise would not have had access to it.

Building on that success—instead of allowing Medicare+Choice to remain in a state of crisis—is the first significant step we can make to answering the Medicare prescription drug challenge that has been laid before us.

AAHP's member plans have had a longstanding commitment to Medicare and to the mission of providing beneficiaries high-quality, comprehensive services and lower out-of-pocket costs. Many of our member plans have served beneficiaries since the inception of the Medicare HMO program as a demonstration project. Recent studies highlight Medicare beneficiaries' high levels of satisfaction with their Medicare health plans. HCFA data show that, among beneficiaries who identified themselves as having strong preferences, HMOs have a larger proportion of very satisfied enrollees than fee-for-service Medicare. Beneficiaries' satisfaction with the program was further demonstrated last month, when more than one hundred beneficiaries who have chosen a Medicare+Choice plan over the fee-for-service delivery system came to Washington to talk about the importance of having a choice of coverage, having additional benefits, and having protection from higher out-of-pocket costs.

Health plans participating in the Medicare+Choice program have long recognized the importance of prescription drugs in meeting their members' health care needs. In fact, almost 70 percent of plans and most of the more than 6 million beneficiaries enrolled in a Medicare+Choice plan have a prescription drug benefit. A recent AAHP analysis of HCFA data showed that many of these beneficiaries are "unsubsidized"—meaning they do not receive any third party assistance from, for example, a former employer or through Medicaid, in purchasing supplemental coverage for prescription drugs. **Specifically, AAHP found that a majority of unsubsidized beneficiaries with coverage for prescription drugs were enrolled in health plans** (see attachment: "Financially Vulnerable Medicare Beneficiaries Rely on HMOs for Prescription Drug Coverage"). Without this option, these financially vul-

nerable beneficiaries undoubtedly would be forced to forego medication therapies that would help maintain their health and improve their quality of life. This is why we believe it is critically important to assure that Medicare+Choice beneficiaries maintain the important benefits they currently receive through their Medicare+Choice plans.

The promise made to beneficiaries in the 1997 Balanced Budget Act (BBA) of a stable Medicare program that offered a wide array of choices all over the country to allow beneficiaries to meet their health needs in the most effective way possible has yet to be fulfilled. Unintended consequences of the BBA have resulted in beneficiaries who chose to join a health plan losing benefits, facing sharp premium increases, and, in many instances, losing the option of even remaining in the plan of their choice. Since enactment of the BBA, nearly 700,000 beneficiaries have had their Medicare+Choice coverage disrupted. Already, a number of plans have announced that they will be forced to exit the program effective January, 2001 because of inadequate funding and excessive regulatory burdens.

Last year, this Congress, in passing the Balanced Budget Refinement Act of 1999 (BBRA), took the first steps to correct the BBA's unintended consequences. The phase-in of HCFA's risk adjuster was slowed in order to minimize its impact on Medicare+Choice enrollees. Among other changes, Congress expressed its intent that the risk adjuster be budget-neutral rather than used to reduce total payments on behalf of seniors and individuals with disabilities who choose a Medicare+Choice plan; and user fees for the beneficiary information campaign were fairly apportioned. We appreciate the work of members of this Committee in recognizing the importance of Medicare+Choice and in advancing proposals to further stabilize the program. We strongly urge you to take bold measures this year to preserve beneficiary choices and avoid any further disruptions in coverage. These efforts are crucial to ensuring a strong foundation for the effort to expand prescription drug coverage.

#### IV. AAHP PRINCIPLES AND ISSUES FOR CONSIDERATION IN EXPANDING ACCESS TO AFFORDABLE PRESCRIPTION DRUG COVERAGE

Again, AAHP member plans favor expanding access to prescription drug coverage. This topic was central among those discussed by our Board of Directors last winter. AAHP's Board believes that beneficiaries deserve a wide variety of coverage choices. Recognizing that all beneficiaries do not have the same needs and that many have already exercised their choice of coverage, our Board committed to conveying the importance of respecting choices currently available and minimizing any disruption of these choices. Our Board approved the following principles on prescription drug coverage:

- **Enhance Coverage of and Financial Support for Prescription Drugs:** Any proposal to expand prescription drug coverage should reflect Medicare's underlying philosophy of universality. All beneficiaries should have equivalent financial support for affordable prescription drug coverage. Additional financial support should be made available for those with special needs.
- **Sustainable and Actuarially Sound Funding that is Equivalent Across All Funding Options:** Expanding prescription drug coverage will increase total Medicare spending. The additional costs should be supported by a responsible and sustainable financing mechanism, not on a discretionary basis. Any sustainable initiative should be designed with the incentives needed for a stable private sector delivery system. Federal contributions should be equivalent across all coverage options. New funds dedicated to prescription drug coverage should include options that have previously provided prescription drug coverage.
- **Allow Beneficiaries a Range of Options So They Can Select Coverage That Best Meets Their Needs:** Any proposal should recognize various existing coverage options and other potential innovative solutions and should retain beneficiaries' ability to select the option that best meets their coverage needs.
- **Meet Beneficiaries' Needs through Flexibility in Benefit Design and Effective Delivery Strategies:** Flexibility in benefit design and strategies that promote the effective use of prescription drugs are critical features of effective drug coverage. Should an initiative link financing to a minimum benefit, entities that offer coverage should be allowed to structure benefits that meet or exceed this minimum according to an actuarial equivalence or similar standard. Likewise, strategies—such as formularies, generic substitution, and programs to prevent problems associated with use of multiple prescriptions—are essential to high-quality coverage for beneficiaries. Permitting flexibility in structuring coverage will promote broader choices and better care for beneficiaries.



- **Minimize Disruption of Benefits Among Beneficiaries Who Currently Have Coverage By Ensuring Equity and Value in the Government's Contribution:** Recent reductions in government funding have forced many Medicare+Choice plans to reduce the scope of their prescription drug benefits or to increase beneficiary cost-sharing. Stabilizing the Medicare+Choice program is crucial to prevent the further erosion of benefits and coverage choices. Although the Balanced Budget Refinement Act of 1999 (BBRA) was a good first step toward this end, much work remains to ensure that the promises made to beneficiaries with the passage of the BBA will be fulfilled.
- **Preserve Access to Integrated Health Care Benefits:** Health plans that offer prescription drug coverage have sought to fully integrate this benefit into other coverage that Medicare enrollees receive. For example, medication therapy is a central component of health plans' disease management programs, which coordinate the delivery of health care services to beneficiaries with chronic conditions. Any proposal should preserve health plans' abilities to incorporate prescription drugs into an integrated benefits package.

In addition, proposals to expand prescription drug coverage for Medicare beneficiaries must address the difficult issue of adverse selection. To be viable, a program must strongly encourage beneficiaries to begin purchasing coverage when they are using few prescription drugs, rather than when they need or anticipate the need to use many prescription drugs. Failure to address this issue could jeopardize the Committee's efforts by undermining every organization's long-term ability to offer affordable prescription drug coverage.

To expand on the issue of flexibility in benefit design and management, we urge the Committee to consider the implications of state requirements governing prescription drug coverage. Simply stated, the application of state mandates or restrictions limits plans' abilities to design affordable prescription drug benefit packages that best meet beneficiaries' needs. Although the BBA preempts state benefits mandates, HCFA has interpreted the BBA preemption to exclude state cost sharing standards related to those mandates. The consequence is that a Medicare+Choice plan that offers benefits beyond the fee-for-service benefits package, such as prescription drug coverage, may be bound by the cost sharing requirement in state law. Another concern involves state requirements related to benefits management and administration. We support clarifying the preemption language so that state requirements do not prohibit health plans from managing benefits effectively and achieving the goal of maintaining the affordability of coverage over the long-term. A federal benefit will not remain affordable if state law requirements still restrict flexibility.

#### V. CONCLUSION

The American Association of Health Plans (AAHP) and its member plans stand ready to contribute as the Committee continues its deliberations on the best way to expand access to affordable prescription drug coverage. We have tried today to contribute to the Committee's dialogue and pledge any further assistance on the issues of expanding prescription drug coverage, broader Medicare reform, and the need to preserve the Medicare+Choice program as an important building block toward these objectives.

As you move forward with specific legislative proposals, we urge you to allow beneficiaries a range of options so they can select coverage that best meets their unique needs and circumstances. At the same time, please assure that beneficiaries maintain control over their health care choices and do not lose any of the coverage options they currently enjoy. Any legislation Congress enacts this year should place a high priority on protecting the benefits and choices of Medicare beneficiaries who currently receive prescription drug coverage through Medicare+Choice plans.

AAHP is pleased that Congress is addressing this critical issue of prescription drug coverage for Medicare. As described today, our health plans have significantly contributed to the ability of beneficiaries to access prescription drugs. We thank you for the opportunity to testify.

Mr. BILIRAKIS. Thank you, Karen. Mr. Fuller. And nice to see you, sir.

#### STATEMENT OF CRAIG L. FULLER

Mr. FULLER. Thank you, Mr. Chairman, and members of the committee. It is a pleasure to be here. I have submitted a state-

ment which you have for the record, and maybe during the questioning we can address some of the issues there.

I thought that I might reflect a little bit on some of the comments that were made by the members in their opening statements as well as some of the questions, because there was much that we agreed with and many very fine questions raised.

I represent 150 chain pharmacy companies, 32,000 pharmacies. And for many of the seniors that are without drug coverage today, I sense something of a train wreck coming. I fear that with thoughtful deliberation which you are having today and in other places that the Congress—most of us spent 8 hours yesterday at Ways and Means. We are prepared to—and happily we would spend 8 hours with you today to advance this. Some of us would.

Because it is—and it is a serious issue. But at the end of the day, if nothing passes this Congress, there are hundreds of thousands of Americans who will go into those 32,000 pharmacies today, they are going to continue for years to face the same problem.

We worried about this some months ago. And as a result, we at the National Association of Chain Drug Stores considered an approach slightly different than what has been talked about during much of the day, but it relates to some of the issues that have been raised.

Because if you take the 39 million people on Medicare and you take out the 70 percent that have some prescription drug coverage now and you look then, as we have done, at the individuals that are 200 percent of the poverty line and below, you could provide coverage for them through the States with a grant of \$30 billion at the Federal level, supplemented by the States, or you can put \$41 billion out there to the States and cover it all. You might have a copayment at the State level. You would not have a cap. You would not have a premium.

You could put it into effect fairly quickly, because somewhere—Chip and I are close. We say 15 and he says 19. We are approaching 20 States that already offer benefits to seniors. And you could do it this year. And you could provide them with the coverage very quickly, so that with all the fine deliberation that is going on, you would give yourselves next year with the Congress and a new administration a chance to really tackle major Medicare reform, which we are all for, and I think we all believe should have prescription drug benefit.

Mr. BILIRAKIS. So you would do that outside of the scope of Medicare?

Mr. FULLER. Pardon me?

Mr. BILIRAKIS. Your suggestion would be outside of the scope of Medicare?

Mr. FULLER. It would be provided by the States outside of HCFA and—yes. Yes, sir. And in fact, it would be similar to a State-based approach, sir, that you have offered as H.R. 2925 and—

Mr. BILIRAKIS. That is just coincidental.

Mr. FULLER. It is coincidental. But we find much to recommend it.

My statement says, and we have really applied three tests to our plan and to others. We say, look, first of all, there needs to be a

sense of urgency about this. I have addressed that. It needs to be enacted this year.

Second, it needs to recognize and it ought to enhance patient care and patient outcomes. After all, at the end of the day what we want to make sure of is that seniors are getting the kind of care they need.

You raised, Mr. Chairman, in your opening remarks the comments about the role of pharmacy. I have great respect for insurance companies. I have great respect for pharmacy benefit managers. But frankly, it is pharmacists that manage health care for patients, working with their doctors. And if we turn the program over or hope to turn some of these programs over to institutions that do not recognize the role of the pharmacist—I am not suggesting insurance companies do not recognize it—but if we do not recognize the role of pharmacists, clearly, the kind of problem that Mr. Stupak mentioned where a patient buys a prescription for \$100, whether he agrees or disagrees with the price, for a drug that has to be used properly or it is not worth anything, we are going to see a further erosion of the quality of patient care.

So part of our plan and part of our SeniorRx Gold plan, would specify the kind of pharmacy services that should be covered.

And finally, and I will close with this third test—third question is, a fair return for community pharmacy. You know, 10 years ago, 75 percent of people purchased their prescriptions at retail. Utilization is increased, the quality of pharmaceutical medication has dramatically increased. They are of tremendous benefits to people. Certainly the cost has increased. But so has the whole process by which—the process has evolved by which we pay for this medication. So that today most of the chains that I represent, 90 percent of the prescriptions are paid for by a third party plan, usually involving a PBM, which has driven down the price.

A CBO study, which I can provide you with, shows most of the costs are driven out by attacking costs at the pharmacy level. But at pharmacy, the margin is about 2 percent or less. So you are not going to find much more savings there. And you are in fact making it more and more difficult for community pharmacy to provide the kinds of services they should be able to provide. Perhaps I can discuss that more in some of the questions.

Thank you for the this opportunity.

[The prepared statement of Craig L. Fuller follows:]

PREPARED STATEMENT OF CRAIG L. FULLER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NATIONAL ASSOCIATION OF CHAIN DRUG STORES

Mr. Chairman and Members of the Committee. I am Craig Fuller, President and Chief Executive Officer of the National Association of Chain Drug Stores (NACDS). I appreciate the opportunity to appear before you today to discuss various legislative proposals to cover prescription drugs under Medicare, and their impact on Medicare beneficiaries and community retail pharmacies.

NACDS represents more than 150 chain pharmacy companies that operate over 32,000 community retail pharmacies in the United States. The NACDS membership base fills about 62 percent of the approximately 3 billion prescriptions that are dispensed each year in the United States. We employ approximately 94,000 pharmacists in our stores.

First and for the record, let me say that NACDS and its members applaud the significant time and effort that you have contributed to the debate about the best way to expand prescription drug coverage to Medicare beneficiaries. We understand and appreciate the need to improve prescription drug coverage for seniors. Every

day, we see the impact on people who too often must choose between the food they need to sustain them, and the medication they need to treat an illness.

As many of you know, NACDS has been working for several months on a state-based plan that would fund a prescription benefit plan for needy seniors that we call SenioRx Gold. SenioRx Gold is supported by a coalition of groups, including the American Pharmaceutical Association, the American Society of Consultant Pharmacists, the Food Marketing Institute, and the National Consumers League.

Mr. Chairman, you offered a similar state-based approach to providing prescription drug coverage to low-income seniors in H.R. 2925, “The Medicare Beneficiary Prescription Drug Assistance and Stop Loss Protection Act”, which has bipartisan support. We applaud your efforts in this regard, and believe that, at the end of the day, this approach makes the most sense this year.

While the specifics of “The Medicare Prescription Drug and Modernization Act” are new to us, because of our work on SenioRx Gold, we have a pretty clear idea of the critical elements that must be considered if real prescription drug assistance is going to reach those who need it most. Indeed, we have attempted to apply three important tests that we believe should be applied to any proposal designed to enhance prescription drug coverage for seniors.

#### *Sense of Urgency*

First, we need a national sense of urgency about reaching needy seniors across America *this year* with a program that allows them to receive the prescription medication they and their doctor agree they need. Frankly, the leadership in Congress has repeatedly stressed the importance of meeting this challenge, and with these hearings today, your committee is expressing an urgency, which we fully commend. However, as you are aware, the insurance industry has expressed concerns about the viability of private-market “drugs only” insurance proposals, calling them “unworkable” and raising serious questions about whether they would amount to nothing more than “unfulfilled” promises to needy seniors.

We also know from experience that the Balanced Budget Act of 1997 created various other types of health insurance and provider options for Medicare beneficiaries, which have not come to fruition. We are concerned that “drugs only” policies would meet the same fate.

#### *Enhance Patient Safety/Improve Patient Outcomes*

Second, any successful plan must enhance patient safety and improve patient outcomes. We must not settle for an approach that fails to safely care for seniors, who generally have more intense prescription medication management needs than non-senior populations. We know that Members of Congress are truly concerned about structuring a benefit that provides medication management programs for seniors.

The House leadership proposal would create “drugs only” insurance policies that Medicare beneficiaries could purchase in the private marketplace. These policies will likely be administered by pharmaceutical benefit managers—or PBMs. As you know, community retail pharmacy has a significant amount of experience in dealing with PBMs.<sup>1</sup>

For the record, let me state that, with all due respect, insurance companies and PBMs do not manage care—pharmacists do. The role of the pharmacist in reducing the risk of conflicting medications and in assisting patients with proper dosage and usage requirements is a well established, critical element of healthcare delivery.

But seniors need more intense care—medication management, disease management, refill reminders, and consistent monitoring. Will “drugs only” insurance plans be structured so that we are providing both prescription drugs *and* important medication therapy management programs to seniors?

We believe that any new Medicare prescription drug plan should assure that these important programs are part of the standard benefit package—just like the prescription drug product—especially for those seniors most at risk for potential medication-related adverse events.

We also believe that it is important that legislation assure that pharmacists have adequate time and proper incentives to deliver these important quality improvement services for Medicare beneficiaries.

<sup>1</sup> According to IMS Health, almost 75 percent of prescriptions filled in a community pharmacy were paid for with cash outside of a plan in 1990. Now, almost 85 percent of all prescriptions are paid for by plans—most with a prescription benefit manager involved.

*Fair Return for Community Pharmacy*

Which leads me to my third point: any successful plan should assure that the highly-efficient community pharmacy infrastructure—which operates on 2 percent net profit margins—remains viable to serve the health care needs of all Americans.

I'm not suggesting that the entire issue of pharmacy reimbursement for public health care programs be tackled by this committee (at least in this session), but I do want to point out that PBMs tend to focus most of their cost containment on pharmacy providers. This has resulted in a steady reduction of margin at the pharmacy level.

While I want to point out that language currently in the proposal allows PBMs to aggressively negotiate discounts from pharmaceutical manufacturers, you should be aware that a 1998 CBO study said:

“Much of the savings that PBMs achieve appear to come from the lower prices paid to pharmacies rather than from the rebates offered by drug manufacturers.”<sup>2</sup>

Moreover, the plan before us today would allow for “price controls” on retail pharmacies. That's right—the plan before us today would allow PBMs to mandate a certain price that pharmacies could charge Medicare beneficiaries for prescriptions after they have reached their coverage cap. We are unsure why Congress would impose price controls on a highly competitive industry that operates on a 2 percent net profit margin. We urge Congress to reject price controls on retail pharmacies.

*Conclusion*

Mr. Chairman, I'd like to conclude by saying we recognize that these are serious and difficult issues and we appreciate your leadership and that of members of your committee for bringing this important legislative proposal forward for review and discussion. You, members of your committee and your staffs have encouraged us to be frank and candid during this entire process. We would be pleased to work with you in addressing some of the concerns I have outlined in my testimony. We think, as I suggested earlier, that there are several reasons we can provide an important perspective.

Finally, I will end by saying that we also remain committed to the notion that if the Medicare Prescription Drug and Modernization Act cannot be advanced in the shortness of time, we hope given the sense of urgency you and others have shown for the millions of needy seniors and their families, that you would consider turning to the state-based program we call SenioRx Gold. It is not perfect and it is not the long-term solution. However, it does, in our view, meet the three critical tests I outlined to you today and would provide meaningful benefits, effectively and safely to those seniors with the greatest need.

This program is designed as an interim, or stopgap approach. By providing federal assistance to states that voluntarily elect to develop prescription assistance programs, SenioRx Gold builds upon the 15 states that already have been successfully operating these programs. It gives the states the flexibility to meet the needs of 64 percent of those Medicare beneficiaries without prescription drug coverage. In fact, SenioRx Gold would provide a more comprehensive benefit than other proposals. With no premiums, no annual deductible and lower copays, needy seniors would not be deterred from participating.

Whichever course you pursue, we thank you for the opportunity to share our views and remain committed to working with you to address this and other issues. Thank you very much.

Mr. BILIRAKIS. Thank you, Mr. Fuller. Mr. Kahn.

**STATEMENT OF CHARLES N. KAHN III**

Ms. KAHN. Thank you, Mr. Chairman. As you know, Mr. Chairman, over a decade ago, I worked long and hard on the last attempt by the Congress to develop a drug benefit for seniors in Medicare Catastrophic. Later I staffed the members who led the effort to repeal that law also. So I have a deep and personal under-

<sup>2</sup>Congressional Budget Office, *How Increased Competition from Generic Drugs Has Affected Prices and Returns in the Pharmaceutical Industry*, July 1998, p. 8. The study found that 50 to 70 percent of the drop in the plans' spending on prescription drugs resulted from lower retail prescription prices. Only 2 to 21 percent of the savings resulted from manufacturer rebates that the PBMs shared with the health insurance plans.

standing of how truly difficult it is to develop a Federal policy to assist seniors in purchasing drugs.

If nothing else, as has been pointed out today, I think it is critically important that seniors have full confidence from the get go in whatever policy you develop and that they understand there will be cost sharing and that cost sharing is bound to be acceptable to them before you enact anything.

This and other lessons of that Medicare Catastrophic debate are important to draw upon as the committee examines this complex issue.

I also assisted in the development of Medicare+Choice, and share the subcommittee's concerns about the future of that program. I believe that the future of market-oriented approaches to preserving Medicare depends on keeping Medicare+Choice viable.

Mr. Chairman, I believe there is a consensus today that seniors need help with prescription drugs. Advances in drug therapies have vastly improved medical care, as well as the very health of millions of Americans. However, at the same time, these advances come at a tremendous cost.

A study done for HIAA and the Blue Cross/Blue Shield Association by the University of Maryland projects that the Nation's spending for prescription drugs will increase by 15 to 18 percent annually over the next 5 years. I repeat, over the next 5 years. This reflects more than doubling of annual drug costs to \$212 billion by 2004. These growing drug costs are clearly putting a squeeze on our Nation's seniors.

Mr. Chairman, we all agree on the goal of helping seniors with drugs. But as you and the subcommittee consider solutions, I urge you to weigh carefully the consequences of the policy alternatives. The lessons of unintended consequences were learned well in 1988 and 1989.

I will be happy to comment specifically on the new bipartisan drug coverage plan when the legislative details are available. I can say, however, from my understanding of the proposal, it appears to provide a realistic approach to assuring seniors that coverage for drugs will be available to them since it has a fallback.

However, HIAA continues to maintain its strong conviction that the much discussed private-drug-only insurance option is unworkable and will not fulfill the expectations of seniors.

In my written testimony I provided a detailed critique which elaborates on our member companies' concerns.

Additionally, as you consider options, because of the expensive nature of drug coverage, we are equally concerned that simply mandating that Medicare HMOs or Medigap plans cover outpatient prescription drugs will not serve beneficiaries well.

Next, the bipartisan proposal recognizes that Medicare+Choice plans are severely underpaid, and action is necessary now to save this important option that so many seniors depend on.

Most Medicare HMO plans now offer prescription drugs coverage. However, sustaining this benefit will be difficult since payment inequities and regulatory burdens are major hurdles. Medicare+Choice cannot continue to offer even the basic Medicare benefits if the status quo remains.

Therefore, for a seniors' drug program to be successful, Medicare must make a firm commitment to provide payments to Medicare HMOs that keep pace with escalating medical costs, including those for pharmaceuticals.

Finally, the proposal for a new Medicare Board to replace HCFA has great potential. Our experience indicates that HCFA has had great difficulties implementing the Medicare+Choice program, and a fresh start is needed.

Last week HIAA released a white paper by Bruce Fried, the former director of HCFA's HMO office. The paper well documents the problems that have caused many HMOs to throw up their hands and either exit all or part of the Medicare program. I urge you to review the Fried report and consider his recommendations.

In conclusion, I would like to reiterate the point that if the Congress and the administration do not address the pressing problems facing Medicare HMOs, it will be difficult if not impossible to succeed at developing true, market-oriented approaches to reforming Medicare.

Thank you very much, Mr. Chairman. I will be happy to answer any questions the subcommittee may have.

[The prepared statement of Charles N. Kahn III follows:]

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

INTRODUCTION

Chairman Bilirakis, distinguished members of the Committee, I am Charles N. Kahn III, President of the Health Insurance Association of America (HIAA). Before joining HIAA, I devoted a significant portion of my professional life to working on Medicare policy as a staff member for both the United States Senate and the House of Representatives. I was involved in the last attempt to provide seniors with access to prescription drug coverage through the Medicare program through enactment of the Medicare Catastrophic Act over one decade ago. I also worked on the subsequent repeal of that legislation. As Staff Director to the Subcommittee on Health of the Committee on Ways and Means, I also played a major role in the development of the Balanced Budget Act of 1997 and the creation of the Medicare+Choice program.

HIAA is the nation's most prominent trade association representing the private health care system. Its 294 members provide health, long-term care, dental, disability, and supplemental coverage to more than 123 million Americans. HIAA also is the nation's premier provider of self-study courses on health insurance and managed care. We represent companies offering a broad range of insurance products to our nation's seniors, including Medicare+Choice, long-term care insurance, Medicare Select, and Medicare Supplemental plans.

I am very pleased to be here today to speak with you about how best to increase access to affordable prescription drugs for our nation's seniors.

SENIORS SHOULD HAVE EXPANDED ACCESS TO NEEDED PHARMACEUTICALS

Clearly, pharmaceuticals have become a critical component of modern medicine. Prescription drugs play a crucial role in improving the lives and health of many patients, and new research breakthroughs in the coming years are likely to bring even greater improvements. With older Americans becoming an ever-increasing percentage of the overall United States population, the need for more medicines for this sector of the population is becoming equally urgent. There is continuing emphasis on new pharmaceuticals to treat diseases typically associated with aging. Over 600 new medicines to treat or prevent heart disease, stroke, cancer, and other debilitating diseases are currently under development. Medicines that already are available have played a central role in helping to cut death rates for chronic and acute conditions, allowing patients to lead longer, healthier lives. For example, over the past three decades, the death rate from atherosclerosis has declined 74 percent and deaths from ischemic heart disease have declined 62 percent, both due to the advent of beta blockers and ACE inhibitors. During this same period, death rates resulting

from emphysema dropped 57 percent due to new treatments involving anti-inflammatories and bronchodilators.

#### PRESCRIPTION DRUG EXPENDITURES ARE RISING AT A RAPID RATE

These advances have not come without their price. Rapid cost increases are putting prescription drugs out of reach for many of our nation's seniors. Because of both increased utilization and cost, prescription drug spending has outpaced all other major categories of health spending over the past few years. For example, while hospital and physician services expenditures increased between 3 and 5 percent annually from 1995 through 1999, prescription drug expenditures have increased at triple that rate, averaging between 10 and 14 percent. According to projections by the Health Care Financing Administration (HCFA), prescription drug spending will grow at about 11 percent a year until 2008, more than double the rate of spending on hospital and physician services.

A study for HIAA and the Blue Cross and Blue Shield Association by the University of Maryland's School of Pharmacy found that drug spending will increase at an even faster pace than the government is predicting. University of Maryland researchers project that the nation's expenditures for prescription drugs will increase at a rate of 15-18 percent a year over the next five years, more than doubling annual drug spending from \$105 billion in 1999 to \$212 billion by 2004. According to the lead author of the study, C. Daniel Mullins, Ph.D., 60 percent of those expenditures will be caused by increases in the price and use of drugs already on the market today, while 40 percent will be attributable to the cost of drugs still under development—so-called "pipeline" pharmaceuticals. I have attached a copy of the executive summary and slides from that study, and ask that it be made part of the record of this hearing.

#### MANY SENIORS HAVE SOME DRUG COVERAGE, BUT BENEFITS OFTEN ARE LIMITED

About two-thirds of seniors have some type of insurance coverage for pharmaceuticals—either through employer-sponsored retiree health plans, private Medicare+Choice plans, Medicaid, or individual Medicare Supplemental (Medigap) policies. But this coverage often provides limited benefits for prescription drugs, and it is likely to decline over time as cost pressures mount for employers, insurers, and individual consumers. For example, recent surveys indicate that employers are contemplating several changes to their retiree health care plans over the next several years, including increasing premiums and cost-sharing (81 percent of respondents to a 1999 Hewitt Associates survey sponsored by the Kaiser Family Foundation) and cutting back on prescription drug coverage (40 percent).

Also, unrealistically low government payments to Medicare+Choice plans are having the effect of reducing drug coverage for many seniors enrolled in these plans. Increases in per capita payments on behalf of beneficiaries enrolled in Medicare+Choice plans from 1997 to 2003 are projected to be less than half of the expected increases during the same period for those individuals in the Medicare fee-for-service program. In fact, the President's Fiscal Year 2000 budget projected five-year medical cost increases of 27 percent for the original Medicare fee-for-service program and 50 percent increases for the Federal Employee Health Benefit Program, while Medicare+Choice payment increases during the same period will be held to less than 10 percent in many counties. The toll these lower payments are taking on drug benefits is already apparent—only three years into the new Medicare+Choice payment scheme. Some beneficiaries now face higher out-of-pocket costs, lower maximum benefits, and higher co-payments on brand name drugs.

Adding to the problems is the fact that most seniors live on fixed incomes and their purchasing power will continue to erode over time as drug expenditures increase more rapidly than their real income. In terms of current dollars, seniors' income has increased very little over the past ten years. From 1989 to 1998, the median income of households with a family head 65 years of age or older increased from \$20,719 to \$21, 589. This represents an increase in real income of less than 5 percent over the entire decade.

#### HIAA HAS DEVELOPED A SOLUTION TO HELP ALL SENIORS

It is important to recognize that we all share a common goal—to improve drug coverage for seniors. The fact that Members of Congress have chosen different routes to achieving this goal is a testament to the magnitude and complexity of the task.

As this Committee begins to weigh options for expanding pharmaceutical coverage to seniors, we want to bring to your attention several important policy considerations that draw upon our member companies' considerable experience providing



health insurance coverage in the private market and through government programs such as Medicare.

In particular, we believe that the potential effects of any new proposal must be carefully examined to ensure that unintended consequences do not erode the private coverage options that beneficiaries rely on today to meet their health care needs. I want to emphasize that, although it has proven difficult to provide affordable prescription drug coverage through the private options available to seniors today (and I will discuss the reasons for that later in my testimony), the private coverage seniors rely on to supplement Medicare is extremely important to them. Medicare covers just one-half of beneficiaries' health care costs and provides no coverage for truly catastrophic illness. Supplemental insurance and Medicare+Choice coverage protect seniors from financial ruin and is highly valued by them for that reason.

Before I outline some of the concerns we have about aspects of several drug coverage plans that have been proposed, let me first make clear that HIAA believes strongly that the status quo is unacceptable. Reforms clearly are needed to expand access to prescription drugs for the nation's seniors. My belief is that the most rational and responsible way to accomplish this is in the context of overall Medicare reform and restructuring. HIAA believes that broad reforms are necessary and that a sustainable long-term solution to providing affordable drug coverage for seniors is best accomplished in the context of securing Medicare for the baby boom generation—and beyond.

However, we also recognize that significant steps can be taken in the short term to provide relief to seniors. Last year, HIAA's Board of Directors approved a three-pronged proposal developed by our member companies that would help seniors better afford prescription drugs. The HIAA program would: (1) help lower-income seniors through a federal block grant to expand state drug assistance programs; (2) provide a tax credit to help offset out-of-pocket drug costs for all other seniors; and (3) ensure fair payments to private Medicare+Choice plans that are struggling to provide prescription drug coverage for seniors despite unrealistically low government payments that will not keep pace with medical inflation and the projected increases in drug costs.

Nineteen states already have drug coverage programs for low-income seniors; several more are considering such programs in the current legislative session. We believe a federal block grant, with no requirement for state matching funds, would give needy seniors additional support in these states and encourage other states to adopt such programs. Each state would receive a per-capita payment sufficient to cover the equivalent of drug coverage with a \$1,500 annual maximum for eligible beneficiaries. States would have considerable flexibility under our approach, and could use the funds to expand existing drug assistance programs or create new ones. We estimate that about 10 million lower-income seniors would be eligible for this subsidy.

The HIAA program also would provide a tax credit to offset out-of-pocket prescription drug expenses for those seniors who file tax returns. A single Medicare beneficiary with income above about 200 percent of poverty (about \$16,300) would have been eligible for a tax credit worth up to \$1,000 a year, after incurring \$500 in out-of-pocket expenses. A couple with an income above approximately 250 percent of poverty (about \$28,000) could access a tax credit worth up to \$1,500 per year after they jointly paid \$500 in out-of-pocket drug expenses. The value of this credit would grow over time to keep pace with inflation. We estimate that nearly 22 million beneficiaries would be eligible for this federal tax credit.

Finally, the HIAA proposal includes a number of measures to assure that seniors choosing to enroll in Medicare+Choice plans are not disadvantaged by unrealistically low government reimbursements. As members of this Committee know, the vast majority of Medicare+Choice plans provide some coverage for prescription drugs and this has proven to be a very popular benefit for seniors. However, inequitable government payments are undermining the Medicare+Choice program and harming seniors who depend on these plans for their health coverage. In effect, the growing disparity between payments to Medicare+Choice plans and per-capita payments for seniors enrolled in traditional Medicare fee-for-service disadvantages the former, forcing them to shoulder an increasing out-of-pocket burden for prescription drugs.

The Balanced Budget Act of 1997 (BBA) reduced payments to Medicare+Choice plans by \$22 billion over five years and HCFA plans to reduce payments by another \$9.9 billion through "risk adjustment." The Balanced Budget Refinement Act of 1999 restored less than \$1 billion of the cuts made through the BBA. Clearly, additional steps are needed: (1) HCFA should be required to implement risk adjustment in a budget neutral manner and the current phase-in should be halted at its current 10 percent level; (2) HCFA should not expand encounter data collection beyond the

hospital inpatient setting and should replace the planned universal encounter data-based risk adjustment scheme with a less burdensome approach; and (3) Medicare+Choice payments should be linked more closely to local medical inflation trends.

The HIAA proposal represents an immediate and workable step that will provide meaningful relief for seniors, while avoiding the disruption and confusion for beneficiaries that surely would result were Congress to make changes in seniors' private benefit options before addressing needed changes in the underlying Medicare program. Equally important, it would not foreclose the integration of drug coverage into broader Medicare reform.

#### CONCERNS ABOUT PRIVATE DRUG-ONLY INSURANCE AND PRIVATE SECTOR MANDATES

As you work to develop a solution to this very difficult issue, we hope that you will draw upon the HIAA proposal. We recognize, however, that Congress is weighing various Medicare drug coverage initiatives that do not involve block grants or tax credits.

Some of the proposals we have examined that rely on "stand-alone" drug-only insurance policies simply would not work in practice. Designing a theoretical drug coverage model through legislative language does not guarantee that private insurers will develop that product in the market.

Other proposals seek to assure seniors drug coverage by mandating that private health plans—either Medigap or Medicare+Choice, or both—provide enhanced coverage for pharmaceuticals. While this option has the perception of being virtually cost-free from a federal budgetary standpoint, it would be far from inexpensive for seniors who, according to our estimates, would experience premium increases for Medigap products of between 50 and 100 percent. It also would result in many seniors dropping the supplemental coverage they depend upon, possibly creating new public policy challenges. Seniors in rural areas, in particular, rely heavily on Medigap coverage to help them meet their health care needs. If coverage that consumers cannot afford is mandated, the result will be unsustainable premium increases, limited choice, and reduced coverage.

#### WHY A "DRUG-ONLY" BENEFIT IS UNLIKELY TO MEET THE GOAL OF UNIVERSALITY

Some have proposed that seniors' drug coverage needs could be met through new private insurance coverage options. Theoretically, these "drug-only" policies would be offered either as stand-alone policies, or sold in conjunction with existing Medigap coverage. However, the evidence suggests that it would be extremely difficult to ensure the universal availability of drug coverage to seniors through this type of proposal.

Creating a new form of insurance is not easy. As with any new product, start-up efforts are costly and time-consuming. Adding to the difficulty is that such insurance policies would have to meet existing (and possibly new) dual state and federal requirements before they could be sold. Thus, before making its entry into the marketplace, a "drug-only" policy would have to clear a multitude of economic and regulatory hurdles. Our members have told us these hurdles are likely insurmountable.

#### *Economic Barriers and Adverse Selection Problems*

Insurance carriers attempting to bring this type of product to market would face many barriers, including the costs of development, marketing, and administration. Premiums for the policy would have to reflect these costs. Adding to these administrative expenses is the inherent difficulty of developing a sustainable premium structure for a benefit that is so widely used and for which costs are rising so dramatically.

Volatility in pharmaceutical cost trends also will make a stand-alone "drug-only" policy difficult to price. While there has been relative stability in the rate of increase of hospital and physician costs during the past two decades, pharmaceutical costs have been more difficult to predict. In March 1999, for example, HCFA estimated that prescription drug expenditures would reach \$171 billion by 2007. Just six months later, in September, HCFA was forced to revise these projections and now predicts that prescription drug spending will reach \$223 billion by 2007, a 30 percent increase over the previous estimate. Since the Administration first offered its Medicare drug benefit proposal just last year, it has had to revise cost estimates for the program upward by more than 30 percent due largely to greater-than-expected increases in the costs of prescription drugs.

For many reasons, "drug-only" policies would be very expensive to administer. Adding to the economic liabilities of these policies are the expense margin limitations insurance carriers must meet under Omnibus Budget Reconciliation Act of

1990 (OBRA), which are likely to be too small to support separate administration of drug benefits.

The most difficult factor driving up premiums, however, will be “adverse selection.” Adverse selection occurs because those who expect to receive the most in benefits from the policy will purchase it immediately, while those who expect to have few claims will hold off purchasing coverage until they believe it is needed. When people with low drug expenses choose not to enroll in coverage while those with high costs do enroll, insurance carriers are forced to charge higher premiums to all policyholders. Higher premiums over time will price many seniors out of the supplemental market. As beneficiaries drop their coverage, premiums invariably will rise yet again—creating what insurers call a rate “death spiral.” Moreover, the more opportunities there are for enrollment, the greater the risk of adverse selection.

Adverse selection would be a very real problem for this type of product. Projections indicate that one-third of seniors (even if all had coverage for outpatient prescription drugs) will have drug costs under \$250 in the year 2000, with the average cost estimated at \$68. These seniors are unlikely to purchase any type of private drug coverage, given that the additional premium for such a policy would be at least 10 times higher than their average annual drug costs. Of the two-thirds who might buy the coverage, many would be doing little more than dollar trading. Some may actually end up much worse off: a person with \$500 of drug expenses could have premium, deductible, and coinsurance costs equal to over 200 percent of the actual costs of drugs. Consequently, many seniors are not likely to purchase the product, resulting in further premium increases for those that do.

Limiting the sale of these policies to the first six months of Medicare eligibility would help in theory only, given legislators’ demonstrated proclivity to expand on “guaranteed issue.” The Clinton Administration’s Medicare drug coverage proposal seeks to avoid adverse selection by limiting enrollment in a government-provided drug coverage plan to the first six months when beneficiaries initially become eligible for Medicare. While this type of rule theoretically helps, the concept seldom works in practice because legislators and regulators expand guaranteed issue opportunities over time in response to political pressure. For example, the “first time” guaranteed issue rule originally in place for Medigap policies has been greatly expanded over time—both through new federal rules in the Balanced Budget Act of 1997 (BBA) and through state law expansions.

#### *Regulatory Hurdles*

Even if such insurance policies were economically feasible, they would face significant regulatory barriers. The National Association of Insurance Commissioners (NAIC) would likely have to develop standards for the new policies; state regulators would have to approve the products before they could be sold, as well as scrutinize their initial rates and any proposed rate increases. Even relatively straightforward product changes based on proven design formulas can take several years to progress from the design stage through the regulatory approval process and, finally, to market.

Because insurers would be required to renew coverage for all policyholders (as they are required to do with Medigap products), policies could not be cancelled if new alternatives were authorized by subsequent legislation or regulations. This would exacerbate adverse selection problems for these plans, since people with the greatest drug needs would retain them while others may seek out less costly alternatives. It also would dampen interest in offering the product in the first place, as insurers would be locked into offering these policies once they were issued.

Guaranteed renewability also would exacerbate pricing problems for these “drug-only” products. While many in Congress have said that they oppose government price controls for pharmaceuticals, private insurers offering “drug-only” coverage are sure to face premium price restrictions on their products at the state level (all states have adopted either rate bands, modified community rating, or full community rating for Medigap as well as medical insurance coverage options available to non-seniors). Even when proposed premium increases are consistent with state law parameters, state regulators are likely to be resistant to the magnitude of increase it would likely take to sustain a “drug-only” insurance policy as drug prices grow over time.

If the NAIC did standardize these policies, as some have proposed, it could impose unworkable limitations on insurers. If insurance carriers were prevented from adjusting co-payments and deductibles as drug costs continue to skyrocket, effective cost management would not be possible without significant premium increases over time. On the other hand, allowing needed flexibility would destroy the standardization of Medigap that Congress and the NAIC have worked so hard to achieve during the past decade.

*High-Deductible Options Introduce Additional Practical Limitations*

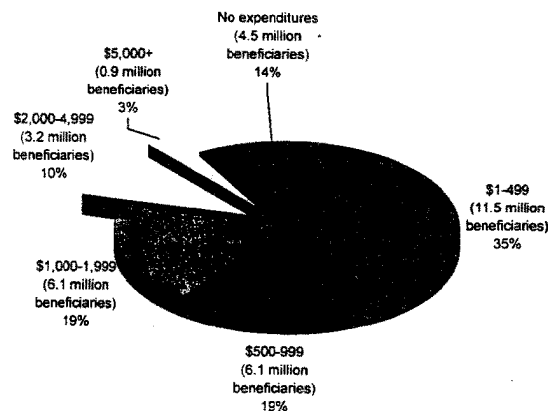
Various suggestions have been made to render these policies economically viable. One suggestion that flies in the face of historical reality is to design the policies with very high deductibles—a feature that has never been popular with seniors. Comprehensive high-deductible Medicare+Choice medical savings account plans authorized under the Balanced Budget Act of 1997 (BBA) are not available because no company believes it can develop sufficient market size to make offering such a product worth the effort. It is also notable that the high-deductible Medigap policies with drug coverage authorized under the BBA 97 have not gained market acceptance, largely out of the knowledge that this product would not be attractive to a large enough block of seniors to make it viable. Primary carriers have not entered this market and, as far as we are able to determine, only a handful of these policies, if any, have been sold. The most common reasons for this cited by insurers are: (1) lack of consumer demand; (2) consumer confusion; and (3) unworkable systems change requirements and regulatory barriers (e.g., states will not approve policy forms for 2000 or 2001 because of the federal government's delay in publishing allowable deductible levels). The \$1,500 deductible in those BBA Medigap policies is considerably lower than some of the deductible levels proposed by advocates of the new drug-only policies.

*Government-Funded "Stop-Loss" Coverage Is Unlikely to Make Such Policies Affordable*

Some have discussed providing government-funded "stop-loss" coverage as a way to help those beneficiaries with catastrophic annual drug costs and reduce the cost of private drug-only insurance. While this proposal would no doubt help seniors with extremely large annual drug expenses, it would do little to make drug-only insurance affordable. Nearly nine out of 10 Medicare beneficiaries have annual drug costs under \$2,000 (see Figure 1). Moreover, stop-loss coverage provided to beneficiaries with drug expenses in excess of \$2,500 a year would cover just 16 percent of annual drug costs (see Figure 2). Stop-loss protection would cover just 4 percent of annual drug costs if offered to beneficiaries with pharmaceutical expenses above \$5,000 per year (see Figure 3).

**Figure 1**

Nearly Nine Out of Ten Medicare Beneficiaries Have Annual Drug Costs Under \$2,000<sup>1</sup>

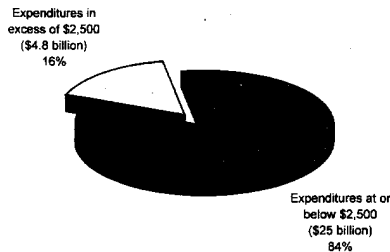


Source: National Academy of Social Insurance, 1999; estimates of 1999 expenditures by Actuarial Research Corporation based on data from the 1995 Current Beneficiary Survey. HIAA estimates for distribution above \$2,000.

<sup>1</sup> Expenditures include out-of-pocket spending and third-party payments. Figures are for all non-institutionalized Medicare beneficiaries except those who enrolled in a Medicare+Choice plan at any point during the calendar year.

**Figure 2**

Stop-Loss for Expenses Above \$2,500 Will Cover Just 16 Percent of Total Annual Drug Spending by Medicare Beneficiaries<sup>2</sup>

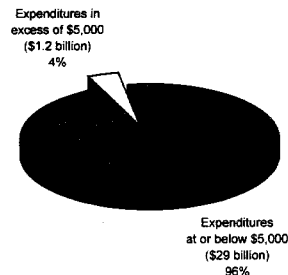


Source: National Academy of Social Insurance, 1999; estimates of 1999 expenditures by Actuarial Research Corporation based on data from the 1995 Current Beneficiary Survey. HIAA estimates of amounts within each category.

<sup>2</sup>Expenditures include out-of-pocket spending and third-party payments. Figures are for all non-institutionalized Medicare beneficiaries except those who enrolled in a Medicare+Choice plan at any point during the calendar year.

**Figure 3**

Stop-Loss for Expenses Above \$5,000 Will Cover Just 4 Percent of Total Annual Drug Spending by Medicare Beneficiaries<sup>3</sup>



Source: National Academy of Social Insurance, 1999; estimates of 1999 expenditures by Actuarial Research Corporation based on data from the 1995 Current Beneficiary Survey. HIAA estimates of amounts within each category.

<sup>3</sup>Expenditures include out-of-pocket spending and third-party payments. Figures are for all non-institutionalized Medicare beneficiaries except those who enrolled in a Medicare+Choice plan at any point during the calendar year.

In short, a “drug-only” policy is unlikely to meet the promise of guaranteeing all seniors access to expanded prescription drug coverage.

#### *A Drug Mandate Is Also a Bad Idea*

Another bad idea is mandating drug coverage for Medicare+Choice plans or Medicare supplemental insurance. (More than 20 million Medicare beneficiaries have Medicare supplemental coverage, with about nine million policies purchased individually and 11 million through the group market.)

HIAA is strongly opposed to proposals that would require Medicare supplemental insurance or Medicare+Choice plans to cover the costs of outpatient prescription drugs without the addition of prescription drug coverage as a Medicare covered benefit. The growing cost of pharmaceuticals would force plans with mandated drug coverage to raise premiums, increase enrollee cost-sharing, or reduce other benefits, all of which would be counterproductive as seniors dropped their supplemental or

Medicare+Choice coverage. Mandated drug coverage could also lead to overly-restrictive government limitations on private plans, such as prohibitions on the use of formularies or mandating certain levels of coinsurance.

Today's Medigap marketplace is convenient and flexible, offering many choices to seniors. Of the 10 standard Medigap policies (A through J) sold, three (H, I, and J) provide varying levels of coverage for outpatient prescription drugs. Largely because of the increased costs of the policies with drug coverage, only a relatively small number of seniors have chosen to enroll in them. Of the 9.5 million Medicare beneficiaries with individually purchased Medigap policies, HIAA estimates that only 1.3 million have drug coverage through the standardized H, I, or J plans.

Several studies show that adding a drug benefit to Medigap plans that currently do not include such coverage would increase premiums dramatically. Seniors who today have chosen to purchase Medigap policies that do not provide a drug benefit would end up paying \$600 more a year (assuming a \$250 deductible for the policy), according to HIAA estimates.

If Congress were to require more comprehensive drug coverage, those premiums could double. According to a May 1999 study by HIAA and the Blue Cross Blue Shield Association, requiring all Medigap plans to include coverage for outpatient prescription drugs would raise Medigap premiums by roughly \$1,200 per year, an increase of over 100 percent.

Premium increases of 50 to 100 percent would result in many seniors dropping their Medigap coverage, leaving them without protection against the high out-of-pocket costs of the hospital and physician services not covered by Medicare. Moreover, increases of this magnitude would discourage employers (who are also purchasers of supplemental coverage) from offering such a benefit at all.

It is doubtful, then, that requiring all Medigap policies to include a drug benefit would be popular with seniors—who would experience diminished choice of policies, higher prices, and in some cases, loss of coverage.

#### *Initial Comments on House Republican Drug Plan Concept*

Mr. Chairman, while the press has reported over the past several days about aspects of the developing House Republican Medicare drug coverage proposal, HIAA has not had an opportunity to review the details of this proposal. We applaud those members of Congress that have worked hard to address this problem; however, we must reserve final judgment until we have had the opportunity to review the final legislative language.

First, it appears that the proposal will not rely solely on private health plans to meet its goal of offering universal drug coverage to seniors. The “fallback” mechanism that has been reported in the press is a contribution to the debate that we expect to examine more fully in the days ahead.

Second, there appears to be a recognition that Medicare+Choice plans are severely underpaid and that more needs to be done in the short run to save the important private health plan options that many seniors now enjoy.

The vast majority of Medicare+Choice plans now offer coverage for prescription drugs and view this as an important benefit for seniors that they would like to continue offering. However, to the extent Medicare+Choice plans are required to cover prescription drugs, we need to ensure payments are adequate. Under the BBA payment rules, payments to Medicare+Choice plans serving the vast majority of beneficiaries have increased only 2 percent per year, while medical inflation is increasing at 8 percent or more. Medicare+Choice plans cannot continue to offer even the basic Medicare benefits if this underpayment is not addressed. And as you know, prescription drug costs are increasing at a much greater rate than overall medical spending. Therefore, for this program to be successful, the government must make a firm commitment to provide payments to private plans that will keep pace with escalating medical costs, including those for pharmaceuticals.

Finally, we view the new Medicare board as a potentially positive development. It is clear from our experience that HCFA's implementation and management of the Medicare+Choice program has been difficult. The new Medicare board may allow for a fresh start.

Last week, HIAA released a white paper by Bruce M. Fried, the former director of HCFA's office of health plans and providers, which oversaw the Medicare+Choice program. The paper finds that a combination of inadequate payments and the crushing cost of excessive government regulation are causing HMOs to withdraw from the Medicare program “at an alarming rate.”

This is an important point, Mr. Chairman and members of the Committee. In the short term, whether or not Congress is able to pass a Medicare prescription drug benefit this year, immediate steps need to be taken to resuscitate the

Medicare+Choice program. Mr. Fried's paper suggests a course of action that includes:

- Congress must increase payments to Medicare HMOs to keep up with medical inflation.
- HCFA should take immediate steps to reduce the administrative burden and expense of prescriptive government regulation, and Congress should exercise its oversight authority to ensure that this occurs.
- Congress should require HCFA to implement risk adjustment in a budget neutral manner and direct HCFA to explore more cost effective—and less administratively burdensome—methods of assessing health risk status. Until a less burdensome system is developed, HCFA should (1) halt plans to collect multiple site encounter data, and (2) freeze the phase-in approach so that no more than 10 percent of an Medicare+Choice Organization's capitated payment amount would be based on the current risk adjustment method.
- Congress should engage in increased scrutiny of the level and type of administrative burden imposed on Medicare+Choice Organizations and the impact and cost of such burden.
- The Secretary of the Department of Health and Human Services (HHS) should consolidate HCFA's responsibility for overseeing the Medicare+Choice program in one division.

We commend this paper to you, and we urge this Committee to take immediate action to rescue this troubled program. If Congress and the Administration ignore the pressing problems and developments in the Medicare+Choice program, the program will die a slow and painful death, and it will be difficult—if not impossible—to generate industry support for, and involvement in, future market-oriented approaches to delivering Medicare services.

*Comments on the Democratic Drug Coverage Proposal*

The Democrats' plan to extend drug coverage to Medicare beneficiaries relies primarily on an expansion of the traditional Medicare fee-for-service program. While it avoids some of the problems that would be associated with the creation of private "drug-only" insurance policies, it would create a costly new benefit entitlement without substantive programmatic reforms that are so desperately needed to ensure that the program remains on solid footing for the baby boom generation and beyond.

Moreover, it is far from clear whether payments to Medicare+Choice plans competing with the traditional fee-for-service program to provide prescription drug coverage would be adequate under the Democratic proposal to ensure the long-term survival of the Medicare+Choice program. If these payments indeed prove inadequate, seniors could lose the private health plan options that provide them with high quality coverage today.

*Conclusion*

The plight of seniors who are struggling to make ends meet and are finding it difficult to pay for medicine is very real. But the immediacy of the problem should not lead to short-term fixes that would do much more harm than good. We believe Congress should step back and examine a broad range of proposals—such as financial support for low-income seniors, tax credits, and fair payments to Medicare+Choice plans, most of which offer drug benefits. We believe there are workable solutions that can meet the needs of our seniors without undermining the coverage they currently rely upon. HIAA stands ready to work with the members of this Committee, and all in Congress and the Administration, to ensure that all seniors to have access to affordable prescription drugs.

MR. BILIRAKIS. Thank you, Chip. Dr. Feder, we have had the pleasure of having you here before, and it is good to see you again. Please proceed.

**STATEMENT OF JUDITH FEDER**

Ms. FEDER. Thank you, Mr. Chairman. Mr. Chairman, Congressman Brown, members of the committee, it is a pleasure to be with you this afternoon to discuss the design of a Medicare prescription drug benefit.

In brief, it is my view first that a meaningful benefit is sorely needed. Prescription drugs have become a fundamental part of medical treatment. It is a travesty that prescription drug coverage

has become a standard part of insurance coverage for the working-age population and is still not provided to the population over age 65, who most needs the protection.

Second, it is my view that the way to provide the benefit is to build on the success of the Medicare program, not to pretend that a means-tested voucher or reliance on a private insurance market can be any substitute for the financial access and financial protection that is achieved by a universal public program.

Let me elaborate first very briefly on the need. Despite the widely recognized importance of drug protection, the sources of that protection are deteriorating, not improving. In recent years we have seen a dramatic decline in the number of employers who are providing prescription drug coverage for their employees. Medicare+Choice plans have restricted the benefits they are providing, and Medigap plans have to charge so much for their limited coverage that it is hard anymore even to call that insurance.

In short, the sources of protection are indeed drying up.

Happily, we see less debate today than even a year ago that the limited availability of affordable coverage is a significant problem. But as shown this morning, we still see significant debate about how to address that problem.

Some argue that public support is needed only by the low income population. That argument ignores lots of evidence and lots of experience. First it ignores that the problem of affordability does not stop at incomes of 133 or 150 percent of poverty. An individual with \$15,000, \$16,000 or \$17,000 is no better able to afford insurance coverage than an individual at \$12,000 or \$13,000. And for people with these incomes, even relatively modest expenses on drugs can be catastrophic.

Second, it ignores that means-tested programs, in the words of Congressman Waxman, tend to be mean programs. They tend to pose barriers to participation rather than promoting ready access. They are likely to offer lower quality care. Think for a minute whether Members of Congress would like to be in the lowest cost plan. And as compared with programs that bring together all people of all incomes as Medicare does, they are likely to be vulnerable to inadequate political and financial support.

Some also argue that the appropriate vehicle for coverage is a private insurance market, again ignoring lots of evidence and experience. The Medigap and the Medicare+Choice markets show us that competition does not provide beneficiaries service and efficiency they can count on.

On the contrary, competition creates tremendous uncertainty as to what plan or what benefits will be available to beneficiaries at any given time. And competition tends to divide the healthy from the sick and the modest income from the better off as plans compete to get good risks and avoid those in need of service.

It is disconcerting at best that even when insurers themselves acknowledge that they are not the ones to count on for stable, affordable coverage, that some nevertheless continue to insist that they can do the job.

Today's arguments about means testing and private insurance and even about the destruction of industry of the private sector are remarkably similar to the arguments that were made prior to en-



actment of Medicare in 1965. We rejected those arguments as a Nation in 1965. It is time to reject them again.

Contrary to what some would have us believe, Medicare is an enormously successful program. It is time to incorporate prescription drug coverage that ought to be there within it according to Medicare's principles.

In brief, the drug benefit must be designed to provide, not just claim, that it is a universal entitlement for all Medicare beneficiaries. That—

Mr. BILIRAKIS. Please summarize, if you will, Doctor.

Ms. FEDER. Absolutely. It must be affordable for all beneficiaries, which means subsidies must grow across the income spectrum so that we have universal participation to match universal entitlement, and the benefit must be defined, specific, and uniform for everyone, because we cannot have an entitlement unless beneficiaries know what they are entitled to.

In sum, the evidence and experience makes clear that the right thing to do is to incorporate a prescription drug coverage into Medicare, not to invent or create an alternative that is doomed to failure.

Thank you, Mr. Chairman.

[The prepared statement of Judith Feder follows:]

PREPARED STATEMENT OF JUDITH FEDER, PROFESSOR AND DEAN OF POLICY STUDIES,  
GEORGETOWN UNIVERSITY

Chairman Bilirakis, Congressman Brown, distinguished Subcommittee members, thank you for inviting me to discuss my views on the design for a long overdue Medicare drug benefit. While there seems to be increasing agreement in Congress about the need to provide a Medicare drug benefit, there is less consensus about the benefit design required to ensure access to needed medications by beneficiaries. I would like to take this opportunity to explain why a Medicare drug benefit is necessary and outline the principles that I believe are essential to keep in mind as the legislative process unfolds.

Increasingly, advances in medical treatment take the form of new prescription drugs which improve health outcomes, replace surgical treatments and provide therapies for conditions that were once untreatable. Medicare beneficiaries use prescription drugs at a rate that far exceeds the non-Medicare population but they are much less apt to have drug coverage than the general insured population. More than one observer has noted the similarities between the current state of drug coverage for the Medicare population and the inadequate health insurance available to the elderly before the passage of the program. Thirty-five years ago, many of the elderly were denied the benefits of medical advances, represented then primarily through technological breakthroughs in hospital care, because of lack of insurance. While about one half of the population over the age of 65 had some form of hospital insurance, the rest either could not afford insurance or did not have access to it. Despite arguments against a government program supplanting the private market, a bipartisan majority in Congress recognized that private insurance could not ensure that all beneficiaries would have access to the advances of modern medicine.

As was the case with hospital insurance in 1965, Medicare beneficiaries currently receive drug coverage through a patchwork of public and private programs. In the 1990s, many beneficiaries sought drug coverage through access to employer-sponsored retiree benefits, enrollment in Medicare managed care offered by private plans, and purchase of individual supplemental Medigap policies. Experience has shown that much of this coverage has been either unreliable, unavailable or unaffordable, and sometimes all three.

- While retiree health benefits typically provide a generous drug benefit, access to this coverage depends upon whether the individual's former employer chooses to provide retiree coverage. Those who worked in small firms or live in rural areas are less likely to receive these benefits. Further, all recent surveys indicate that this coverage is eroding. For example, the 1999 Kaiser Family Foundation and Health Research and Educational Trust (HRET) survey recorded a

decline in large firms offering retiree benefits from 40 percent in 1993 to 28 percent in 1999.

- Medicare+Choice plans, which had been a source of increasing coverage in the mid-1990s, have cut back on their drug benefits in the past few years. For example, 70 percent of these plans now cap drug benefits at \$1000 or less. Here in the District, one plan limits coverage for brand name drugs to \$400 per year; another in suburban Maryland sets a \$300 cap on coverage for all drugs. Depending upon the particular condition of the beneficiary, that limit might cover the cost of only two prescriptions for the entire year. Further, decisions by private plans to pull out of the Medicare program in the last few years have left beneficiaries uncertain of whether their benefits will be there when they need them.
- Lastly, some beneficiaries obtain drug coverage through the purchase of supplemental Medigap policies. Yet, Medigap policies with drug coverage are expensive, unavailable, and inadequate. In many cases, policies with drug benefits are subject to medical underwriting and not available for all. In other cases, premiums are far higher than the total value of the drug benefit. The high cost of these policies has sharply limited their appeal. A recent analysis of 1998 NAIC data shows that fewer than 2 million beneficiaries have drug coverage through standardized Medigap plans.

There are many similarities between the current debate over a prescription drug benefit and the earlier debate over the enactment of the Medicare program itself. In 1965, some policymakers believed that gaps in insurance coverage could be filled by providing medical coverage to the low-income elderly. This argument is often heard today. Yet even with modest subsidies for individuals with incomes above 150 percent of poverty (as low as \$13,000), a beneficiary would be forced to pay substantial premiums for a private plan or do without coverage. Since it is unlikely that many low to middle income beneficiaries could afford unsubsidized premiums, they would be forced to do without coverage despite the existence of a nominal Medicare drug benefit. In addition, the type of coverage available in a means-tested program is likely to be both more vulnerable and of lower quality.

We rejected a means-tested model in 1965 and we should reject it now.

In 1965, Congress rejected the notion that the private insurance market could be counted upon to ensure health insurance coverage for the elderly. However, we continued to rely upon supplemental private coverage to fill in the gaps in benefits not covered by Medicare. Yet failures in the individual Medigap market make it clear that this is not a realistic expectation as far as drug coverage is concerned. *Consumer Reports* shows premiums for a 65 year old woman to purchase Plan I, which covers 50 percent of drug costs up to a cap of \$1250 after a \$250 deductible, that range from \$2049 to \$4358 in Florida. In most states, premiums rise with age. Thus, for a 75-year old woman in Florida the premium rises as high as \$4850. The cost of the premium ensures adverse selection as only those with a strong likelihood of high drug expenses will purchase these policies. An adverse selection cycle leads to a spiraling of premium costs. As a result, many firms do not offer Medigap policies with drug coverage at all. For example, MedPAC reports that in New York 14 carriers offer Plan A but only one offers Plan J, the policy with the most generous drug benefit. Even with a modest subsidy, these policies are unlikely to be made affordable. Given the problems of adverse selection and high premium costs, it is not surprising that HIAA reports little enthusiasm for a stand alone drug policy among its member companies. They were quoted again this week saying they were unaware of any members that would offer coverage in response to the anticipated Republican proposal.

**We recognized that private insurance could not fill the coverage gap in 1965 and we should reject that model now.**

**I would argue that three principles must be maintained as a drug proposal goes through the legislative process.**

- **The drug benefit must be designed as a universal entitlement for all Medicare beneficiaries.** Since the program's inception, *all* Medicare-covered benefits have been available to *all* eligible beneficiaries, subject only to medical requirements. This guarantee goes to the heart of the social insurance model that has made Medicare one of the most successful and popular programs in the history of this country. As a result of the Congressional decision to create a universal entitlement, seniors went from being among the least likely Americans to have health insurance to the most insured segment of the population with 97 percent of seniors covered by Medicare. Not coincidentally, the average life expectancy for a 65 year old woman has increased by almost 20 percent since 1960.

- **The drug benefit must be affordable for all beneficiaries.** No one would deny that low income beneficiaries are in great need of help affording the cost of medications. However, both the cost and critical importance of new breakthrough medications has created a problem for all beneficiaries without access to prescription drug coverage. More than half of all beneficiaries without coverage have incomes about 150 percent of poverty and one-fourth have incomes above 400 percent. It is entirely unreasonable to assume that a widow with an income of \$15,000 per year could afford to purchase private drug coverage even if that coverage was offered to her. This problem would only increase over time as premiums surged because of the same cycle of adverse selection that currently affects the Medigap market.
- **Beneficiaries in all areas of the country, rural and urban, healthy and ill, must have secure access to a standard benefit.** As long as it is left to the private market to design actuarially equivalent benefits, beneficiaries will be forced to navigate their way through a confusing morass of differing benefit limits, deductibles, copays, formularies, and pharmacy networks. The potential for benefits designed to facilitate cherry-picking of healthy beneficiaries will be great. Access to coverage will continue to depend upon where an individual lives and what her medical condition is. In addition, insurers might offer low option coverage that would erect barriers to beneficiaries receiving the innovative medical treatments that they required. Paper drug coverage might turn out to be less than adequate when an individual most needed it.

Drugs are expensive no matter who buys them. Seniors cannot bear this cost alone. The increased use of prescription drugs by all of us but particularly seniors, and the rising cost of new therapies makes cost containment concerns inevitable. We must use the best tools available to us to control costs and recognize that we will learn more as we go along. In sum, Mr. Chairman, Medicare has been a successful program for 35 years. It is time that we built upon this system that we know works to fill the critical gap in coverage that still exists so that we, as a society, have ensured that the benefits of pharmaceutical advances are available to all who need them.

Mr. BILIRAKIS. Thank you. Mr. Donoho.

#### STATEMENT OF PATRICK B. DONOHO

Mr. DONOHO. Mr. Chairman and Mr. Brown, members of the committee, my name is Patrick Donoho. I am Vice President of Government Affairs and Public Policy for the Pharmaceutical Care Management Association.

PCMA represents managed care pharmacies and organizations who a substantial part of their business is managing pharmacy benefits. We are the PBM industry.

I am pleased to provide you some of our outlooks on views on providing the prescription drug coverage under Medicare.

Our members currently provide care for over 10 million Medicare beneficiaries through employee retirement plans and Medicare+Choice plans.

Collectively they cover benefits for over 150 million Americans. We are pleased that many of the pending proposals recognize that it would be more efficient to use existing drug benefit managers in an expanded Medicare drug benefit program than to attempt to re-create these capabilities in HCFA.

Let me give you our six basic principles that we think would make a successful program.

First, the benefit should be delivered in a manner that enhances the health of seniors and the disabled. It is essential that the program not simply help pay for drug costs but also protect the health of seniors. Some drugs are inappropriate for use among the elderly; others are used at different dosing levels than are appropriate for younger populations.

Seniors without prescription drug coverage do not currently benefit from the safety of drug interaction screening mandated by OBRA 1990 for Medicaid recipients and presently in virtually all third-party programs.

Second, legislation should provide the benefit through the private sector. Competition among private sector PBMs delivers significant cost savings and has spurred innovation in the use of advanced technology for administering those benefits.

A new drug benefit should embrace and promote competition among these entities and ensure the vitality of innovation through competition.

We had a slight discussion yesterday in Ways and Means and repeated it here today about rural coverage. Many of the plans in the private sector today mandate that you have rural coverage, and I think there are 52,000 pharmacies in the United States, and we have to ensure that we have coverage for the people in the plans that we administer.

Third, the legislations should retain flexibility and cost controls within the private sector. Prescription drug coverage for Medicare enrollees must permit pharmacy benefits managers to continue such programs as pharmacy network management, formulary development and management, mail service pharmacies, disease management, prescription compliance and adherence programs, utilization review, and provider profiling for adherence to best medical practices.

Fourth, legislation should encourage the continuation of current prescription benefit plans. A prescription drug benefit plan for seniors should contain some incentives for employers to continue to provide prescription drug coverage to their current retirees.

Fifth, a plan should be designed to protect beneficiaries against catastrophic liability.

And sixth, the goal of an agency overseeing the administration of a prescription benefit should be to foster innovation and competition. The legislation should not freeze in time the management techniques used today by PBMs.

In examining the various proposals that have been announced or introduced, we see much commonality. In particular, most proposals appropriately focus on PBMs, encouraging or mandating use of the latest tools to improve health outcomes and to eliminate medical and medication errors.

Where proposals differ is on whether we as PBMs will have the flexibility to use our tools in the management of the benefit. Any legislation that does not empower us as PBMs to negotiate discounts in the pricing concessions from drug manufacturers and pharmacies, as we do today in private plans, will not be able to deliver on the anticipated cost savings.

We share the concerns expressed by the Congressional Budget Office and the General Accounting Office that political pressures on policymakers and PBMs might limit the tools available to a PBM, making it more a transaction processor than a benefit manager.

We also share the concerns of some of the authors of the proposals that HCFA is unlikely to favor competition over regulation. Therefore, we are pleased to see that some legislation envisions new structures for administering a Medicare drug benefit.

I am willing to answer questions hereafter and am willing to help you craft a bill. Thank you.

[The prepared statement of Patrick B. Donoho follows:]

PREPARED STATEMENT OF PATRICK B. DONOHO, PHARMACEUTICAL CARE  
MANAGEMENT ASSOCIATION

Mr. Chairman, Mr. Dingell, members of the Committee, my name is Patrick Donoho and I am Vice President of Government Affairs and Public Policy for the Pharmaceutical Care Management Association (PCMA). I am pleased to appear before you today to testify on behalf of the PCMA.

PCMA represents managed care pharmacy and pharmacy benefit management companies (PBM). Members are organizations that, as a substantial portion of their business, manage pharmacy benefits. PCMA's member firms are an extremely diverse group, including both publicly traded companies and divisions or subsidiaries owned by other healthcare organizations. While many of our members serve broad national populations, some focus on the needs of specific communities such as patients with HIV/AIDS, organ transplants, or cancer.

We are pleased to provide our association's views on providing coverage for prescription medicines for those individuals enrolled in the Medicare program. Our members have a deep interest in the subject of this hearing. Already today, our member companies provide quality, affordable pharmaceutical benefits to more than ten million current Medicare beneficiaries who receive these benefits through their or their spouse's former employers or through Medicare+Choice plans. Collectively, PCMA's members administer prescription drug programs for more than 150 million Americans. All of the major legislative proposals for expanding prescription drug coverage propose using PBMs to deliver these benefits. We are pleased that all of these proposals recognize that it would be more efficient to use existing drug benefit managers in an expanded Medicare drug benefit program than to attempt to recreate those capabilities within HCFA.

As an industry, we have been successful in not only managing the cost of these benefits but also in managing the quality. We know how important good pharmaceutical care is to the elderly and disabled. Therefore, PCMA supports legislative efforts to ensure that all seniors have access to prescription drug coverage. Any program to provide prescription drugs to seniors should rely on the demonstrated drug management experience of the private sector to operate an efficient and cost effective program.

*PCMA's Principles*

As the Committee examines various proposals for expanding access to medicines for Medicare beneficiaries, we urge you to consider six principles that we have agreed to as an association of member companies to whom much responsibility will be placed by any legislation.

First, the benefit should be delivered in a manner that enhances the health of seniors and the disabled. It is therefore essential that the program not simply help pay for the cost of drugs, but also include pharmacy benefit management services to ensure that seniors obtain, and remain compliant with, clinically appropriate and cost effective drug therapy.

Many drugs are inappropriate for use with the elderly, others should be used at different dosing levels than are appropriate for younger populations. Seniors without prescription drug coverage do not currently benefit from the safety of drug interaction screening mandated by OBRA '90 for Medicaid recipients and present in virtually all third party programs.

Second, legislation should provide the benefit through the private sector. Competition among private sector PBMs deliver significant cost savings and spurred innovation and the use of advanced technologies for administering drug benefits. PBMs develop and administer disease and wellness management programs specifically designed for elderly populations. A new benefit should embrace and promote competition between these entities and ensure the vitality of innovation through competition.

Third, legislation should retain flexibility and cost controls within the private sector. Innovation and creativity in pharmaceutical care has resulted in a number of programs and services that have improved care and managed costs. Prescription drug coverage for Medicare enrollees must permit pharmacy benefits managers to continue this development and use such programs as pharmacy network management, formulary development and management, mail service pharmacy, disease management, prescription adherence programs, utilization review, provider profiling

for adherence to best medical practices, and other such programs to manage the benefit.

Fourth, legislation should encourage the continuation of current prescription benefit plans. In order to encourage employers to continue to provide prescription drug coverage to their retirees, a new prescription drug benefit for seniors should contain financial incentives to compensate employers for, and recognize the financial impact of, their efforts.

Fifth, a plan should be designed to protect beneficiaries against catastrophic liability. Recognizing that many seniors have limited incomes and that major or chronic illnesses can impose significant drug costs in a single year, any new Medicare prescription drug benefit should endeavor to include an out-of-pocket expenditure cap.

Sixth, the goal of any agency overseeing the administration of a prescription drug benefit should be to foster innovation and competition for improving pharmaceutical care and the provision of a cost-effective program. PBMs must be able to create financial incentives to encourage Medicare beneficiaries to help control the cost of the benefit. Moreover, the legislation should not freeze in time the management techniques used today by PBMs. To do so would cause the drug benefit to lose the opportunity for innovation and improvement, which has been the hallmark of the pharmacy benefits management industry.

#### *Review of Current Proposals*

In examining the several proposals that have been announced or introduced as legislation, we see much commonality in meeting the goals we seek. In particular, most proposals appropriately focus on PBMs, encouraging or mandating use of the latest tools to improve health outcomes and eliminate medical and medication errors. Most proposals also seek to ensure that those Medicare beneficiaries who today have good private sector coverage can keep that coverage by rewarding, through financial incentives, employers that have served well the interests of their retirees by covering prescription drugs within their health benefits. And, importantly, most proposals would address the issue of providing protection against catastrophic costs.

Where proposals differ is on whether we as PBMs will have the flexibility we need to control costs. Any legislation that does not empower us as PBMs to negotiate discounts and other pricing concessions from drug manufacturers and pharmacies—as we do today in private plans—will not be able to deliver the anticipated cost savings. Our members are strongly united on this point. Restrictions on the use of common, private-sector cost containment tools, as we see in some legislation, will deny our members the ability to do what we do best in terms of providing a cost effective benefit in the interests of patients and the taxpayers who will pay for this program.

We share the concerns expressed by both the Congressional Budget Office and the General Accounting Office that political pressures on policy makers and PBMs might limit the tools available to a PBM, making it more a transaction processor than a robust benefit manager. Such tools as managed pharmacy networks and negotiated reimbursements, formulary development and management, and beneficiary cost sharing of areas which may be restricted by a program that is less private sector are examples oriented, and therefore less competitive.

Proposals also differ on the administration of the program. We share the concerns of some of the authors of proposals that HCFA is unlikely to favor competition over regulation. Therefore, we are pleased to see that some legislation envisions new structures for administering a benefit.

In conclusion Mr. Chairman, as an industry we are ready, willing and able to provide our expertise and experience in providing prescription drug benefits to all Medicare beneficiaries. Our support of the various proposals will be based on the authority and flexibility granted PBMs to implement all of their programs to effectively manage costs, foster innovation, and enhance the quality of pharmaceutical care for seniors. We will assess the probability of regulatory limitations, de jure or de facto, on the ability of PBMs to perform this role. We again appreciate your seeking PCMA's views and look forward to your questions.

Mr. BILIRAKIS. Thank you for that, Mr. Donoho. Mr. Pollack.

#### **STATEMENT OF RONALD F. POLLACK**

Mr. POLLACK. Mr. Chairman, thank you very much for inviting us to lunch. I appreciate it.

In my testimony, I focused on the need for a prescription drug benefit and for moderating prices. Here I would like to focus on the legislation that we have been talking about this morning, mainly

because there appears to be a rush to mark up this legislation, and notwithstanding the fact that this is still a work in progress, I think we know enough to say there's reason for abundant caution.

Clearly, the proposal looks much better from a distance than it does closer up. Let me suggest to you five areas that I would like to see us look more carefully at.

First is the question about the reliance on the private insurance industry to provide this policy. We have had ample discussion about this this morning. We know that the industry, notwithstanding the fact that it has been offered very significant subsidies, has balked at offering this coverage through its own private plans.

But we do not need merely the protestations of the industry to tell us that we have to look at this with abundant caution. We have experience with the Medigap program which for many years has been offering a prescription drug benefit. And I would suggest if I may, if you look on Appendix 2 that is appended to my testimony, one of the things we looked at were the differences in prices that people experienced for very comparable policies, one that provides prescription drug coverage, and another that does not.

Now what we find first of all is that only 8 percent of America's seniors in the Medicare program have opted into a Medigap plan that provides prescription drug coverage. This is a mature product, and yet only 8 percent of America's seniors have opted into it.

If you look at the comparison between Plan F and Plan J under Medigap, with J being the one that provides a prescription drug benefit, you will see on average the price differential is over \$1,700. It gives you good reason why it is unlikely that the industry is going to be able to develop a plan that is going to be usable.

And if I can accentuate one thing, it is the second point. That is, that I do not think that seniors are going to get good value for their premium dollar under this proposal. There are three reasons for that. One reason Mr. Ganske has already explained, and that relates to adverse selection. I would be happy to discuss what I think is a real comparison between the potential adverse selection problems in the administration's proposal and this one. I think there is a major difference. But obviously there is a significant adverse selection problem.

But there are two other concerns. And that is that Medigap plans use about 35 percent of the premium dollar on items that have nothing to do with claims benefits, whether it includes agent's fees, advertising and marketing, profits and administration, it is considerably more expensive than it is under the Medicare program, and that means less value is provided.

But perhaps the most important reason really goes to the question as to why the pharmaceutical industry, sight unseen, is giving us full-page advertisements telling us why they support legislation that has not even been crafted into language. And I think the reason is very obvious. The pharmaceutical industry knows that if we establish private insurance policies, we are not going to have the same kind of marketing power that exists in the Medicare program. We will have very vulcanized bargaining power when you have various insurance companies negotiating for seniors as opposed to the Medicare program that can really bring clout to the table. And

frankly, that is the bottom line difference between this bill and the administration's bill.

Under this bill, there would not be that bargaining power to rein in the prices, and as a result, senior citizens would not get the value that they would receive under Medicare.

Third, it is really absurd to now pull at the thread of the genius of the Medicare program, which is a program that brings people together irrespective of their age, irrespective of their health condition, and irrespective of their income. And now we want to in effect provide a means-tested benefit.

Now I do not want to take second seat to anyone in saying I support a special care for the poor. But as Judy Feder indicated, we are talking about a very miserly standard here. When we are talking about 150 percent of the Federal poverty level, we are talking about \$12,525 a year in income for a widow.

And if I may just refer you to Appendix 8 in the testimony, let's take a look at what the costs are for that widow and what a bite out of her income it will take when she has just minor health conditions.

If she has a problem with diabetes, hypertension and cholesterol, she is going to take Glucophage, Procardia XL, and Lipitor 10, and that is going to cost her as much as \$2,295 a year. That comprises over 18 percent of her income. One out of every \$6 of her total income just for those three pills, and we are saying we are not going to provide benefits for people at that income level.

Mr. BILIRAKIS. Mr. Pollack, your time has long expired. If you could summarize within just a few seconds, I would appreciate it. You know, you will probably have an opportunity to make these points, which are very good ones, during the inquiry section.

Mr. POLLACK. Well I guess the last point I would make, very shortly, is the question about this fallback. What is this fallback? Is this fallback in effect going to be a public program for those portions of the population that the industry does not wish to serve?

If it does, we are going to have wonderful segmentation. We are in effect inviting the insurance industry to provide coverage for those people who are the easiest to cover. The least sick, the youngest, and those portions of the geography of our country that they think they can make a profit in. And of course then perhaps the Medicare program would wind up holding the bag for all the rest. I fear that years from now we are going to come back and look at such a scheme—

Mr. BILIRAKIS. Mr. Pollack—

Mr. POLLACK. [continuing] and we are going to say the Medicare program does not function well.

[The prepared statement of Ronald F. Pollack follows:]

PREPARED STATEMENT OF RONALD F. POLLACK, EXECUTIVE DIRECTOR, FAMILIES USA

Mister Chairman and Members of the Committee: Thank you for inviting me to testify today. Families USA is a national non-profit organization dedicated to protecting and improving the health care of consumers. We have been engaged in analyzing the implications of changes in the Medicare program on Medicare beneficiaries for some time. Our most recent research efforts have focused on examining the prices of prescription drugs and what impact those rising prices have on prescription drug coverage for Medicare consumers. This testimony will describe what we have learned about drug prices. The bottom line is that seniors need help to buy the drugs they need. A sound public policy will ensure that seniors gain the benefit



of two basic policy changes, Medicare coverage of prescription drugs and reasonable steps to ensure that drug costs are moderated.

Medicare beneficiaries are the only insured population group without prescription drug coverage. At any point, approximately 35 percent of all Medicare beneficiaries are without drug coverage. Over the course of the year, nearly half of all Medicare beneficiaries are without drug coverage for all or part of the year. (See Appendix 1.) Based on recent trends, it is likely that this situation will get worse. Among the primary sources of prescription drug coverage for those beneficiaries who have it—Medigap, Medicare+Choice, and employer-sponsored coverage—drug coverage is increasingly unaffordable and unreliable.

*Medigap:* Individually purchased Medigap policies cover a relatively small number of Medicare beneficiaries, roughly 3.3 million beneficiaries (or about eight percent of all Medicare beneficiaries). Given the additional cost of a prescription drug policy, it is understandable why a senior living on a fixed income does not see this as an affordable option. Looking at the average cost of Medigap policies with and without prescription drug coverage, the cost differential clearly illustrates why few people purchase plans with drug coverage. Simply put, the costs of the plans with drugs are considerably more expensive—substantially as a result of adverse selection.

If you compare premiums for two moderate policies (of the ten standardized plans)—plans letters E and H, where the only significant difference in coverage is that the latter covers drugs and the former does not—you will see an annual premium difference of approximately \$600. Even so the drug plan is sparse. The drug benefit under plan H has a \$250 deductible, a 50 percent copayment, and a cap of \$1250—coverage that still leads to significant out-of-pocket costs for beneficiaries. The premium differential is considerably larger for plans with more considerable health coverage. The difference between Plan F (without drug coverage) and Plan J (with drug coverage) is more than \$1,700 per year. Clearly, for many, the premiums for Medigap drug plans are unaffordable (see Appendix 2).

*Medicare+Choice:* Approximately 13 percent (5.2 million) Medicare beneficiaries had some prescription drug coverage through a Medicare+Choice plan. However, Medicare+Choice plans are an increasingly unreliable source of prescription drug coverage for seniors because plans covering prescription drugs are not offered consistently across the country and the benefits they offer are being reduced. In 2000, beneficiaries in four states (AR, IO, NE, and WV) have no access to plans offering drug coverage. In an additional four states (DE, LA, NM, and NC), beneficiary access to plans with drug coverage decreased significantly.

Obviously, as health plans drop out of Medicare+Choice, the availability of prescription drug coverage is jeopardized. For those beneficiaries who do have access to plans with drug coverage, the value of the drug benefit is decreasing. Between 1999 and 2000, the proportion of plans with benefit caps of \$500 increased by 50 percent. During the same period, the number of beneficiaries living in areas with copayments on brand name drugs averaging at least \$25 more than tripled. Recent announcements from two major Medicare+Choice plans suggest beneficiaries will have fewer options in 2001. Cigna Corporation recently reported it will no longer serve Medicare markets in 11 states beginning January 2001. Aetna Inc., will also terminate its participation as a Medicare+Choice provider in a number of markets in January 2001.

*Employer-Sponsored Retiree Coverage:* Employer-sponsored retiree coverage is declining, leaving more Medicare beneficiaries on their own to purchase coverage or to pay for drugs out-of-pocket. Among large firms of 1,000 or more, the percentage of large firms offering retiree coverage dropped from 80 percent in 1991 to 67 percent in 1998. The trend is the same across firms of all sizes. According to a recent Mercer Foster-Higgins survey, the percentage of firms offering retiree coverage dropped from 40 percent in 1994 to 28 percent in 1999. Thus, employer-sponsored retiree coverage—which has been the most significant pathway to drug coverage for seniors—is diminishing rapidly (see Appendix 3).

#### *Rising Prices and the Impact on Seniors*

Seniors without drug coverage are most affected by rising prescription drug prices. In November 1999 Families USA released a report looking at prices of the 50 top-selling drugs for seniors. The report found that prices of these 50 top-selling drugs rose much faster than inflation. In April we released an updated version of that report, “Still Rising: Drug Price Increases for Seniors 1999-2000.” Among the 50 top-selling drugs for seniors, there was some good news and some bad news. The good news for the 1999-2000 period was that the prices of 12 of the 50 drugs rose slower than inflation—with nine of those not increasing in price at all. The bad news was that 33 of the 50 drugs rose in price at least one and one-half times inflation. Half of the drugs rose at least twice as fast as inflation. Sixteen drugs rose

at least three times inflation and one-fifth (11) rose at least four times the rate of inflation (see Appendix 4).

Some drugs are rising at much faster rates. For example, the price for furosemide, a generic drug, rose 50 percent in this one year. Klor-con 10, a brand name drug, rose 43.8 percent (see Appendix 5).

The report also compared prices over the six-year period of 1994-2000. Thirty-nine of the 50 drugs were on the market for the full six years. Of those 39 drugs, prices for 37 rose faster than inflation (see Appendix 6). Prices for three-fourths (30) rose at least 1.5 times inflation. Over half (22) rose at least twice as fast as inflation and over a quarter (11) rose at least three times the rate of inflation. Six drugs rose at least five times the rate of inflation. Examples of some of the faster growing drugs include lorazepam (which rose 409 percent, or 27 times inflation) and furosimide (which rose 210 percent, or 14 times inflation). (See Appendix 7.)

While these price increases may seem dramatic, the impact on seniors is clear when we look at two examples:

For a widow or widower with a gastrointestinal problem, the drug most likely to be prescribed is Prilosec. Based on 1998 data from the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE) program (the largest outpatient prescription drug program for older Americans), Prilosec is the second highest of all the top-selling drugs prescribed for seniors. The annual cost for a senior with no drug coverage taking Prilosec (20 milligram, controlled release capsules) is \$1,455. For a widow or widower subsisting at 150 percent of poverty (\$12,525 of income per year), the annual cost of Prilosec alone will consume more than one in nine dollars (11.6 percent) of that senior's total budget. Even at twice the poverty level (\$16,700 per year), Prilosec will consume almost one out of eleven dollars (8.7 percent) of that widow's total income (see Appendix 8).

The second example is a senior with no drug coverage who has diabetes, hypertension, and high cholesterol—three conditions that often occur in conjunction with one another. A widow with these three conditions is likely to be treated with Gluophage, Procardia XL, and Lipitor. Annual costs for Gluophage (500 milligram tablets) will be \$708. Annual costs for Procardia XL will either be \$521 or \$901, depending on whether 30-milligram tablets or 60-milligram tablets are prescribed. The annual cost for Lipitor (10 milligram tablets) will be \$686 (see Appendix 9).

Thus, total annual spending for seniors with diabetes, hypertension, and high cholesterol—for these three drugs alone—will range from \$1,915 to \$2,295. For a widow subsisting at 150 percent of poverty, this expenditure will constitute as much as 18.3 percent of her annual income. Even at twice the poverty level, these costs will consume up to 13.7 percent of her annual income. These costs, therefore, are likely to cause significant economic hardships.

Clearly, affordability of prescription drugs is a problem. Coverage for prescription drugs, for those people who have it, makes a difference as to whether or not seniors get the drugs they need. In 1996, seniors with drug coverage obtained, on average, 21 prescriptions, while those without drug coverage received only 16 prescriptions (see Appendix 10).

#### *Paying More For Prescription Drugs in the U.S. Than In Other Countries*

It is clear that drug prices are much higher in the United States than they are in other countries. Several months ago *USA Today* compared prices in the U.S., Canada, Great Britain, and Australia for the ten best-selling drugs. The comparison found that Prilosec was two to two-and-one-half times as expensive in the U.S.; Prozac was two to two-and-three-quarters as expensive; Lipitor was 50 to 92 percent more expensive; and Prevacid was two-and-one-third to four times more expensive. Only one drug was cheaper in the U.S. than in the other countries, Epogen. In the case of all other ten drugs, the U.S. price was highest, by far (see Appendix 11).

Two General Accounting Office studies from 1992 and 1994 show similar results. Comparing prices for 121 drugs sold in the U.S. and Canada, prices for 98 were higher in the U.S., and almost half were more than 50 percent higher. Comparing 77 drugs sold in the U.S. and in the United Kingdom, 86 percent of the drugs were higher in the U.S. and more than 60 percent were more than twice as high in the U.S.

#### *The R&D Defense is a Canard*

The pharmaceutical manufacturers argue that they need these higher prices so they can undertake research and development. They say that, if we reduce these prices, research and development will be curtailed. The drug industry's assertion in this respect is wildly exaggerated. Among the top pharmaceutical companies, more money goes for marketing, advertisement, and administration than for research and development. More money is received in profits than is spent on research and devel-

opment. In 1999, among the five companies with the highest revenues, four spent at least double on marketing, advertising and administration than was spent on research and development. For example, Merck spent considerably more than twice as much on marketing, advertising, and administration than it did on research and development. Comparable comparisons apply to other large pharmaceutical companies. Indeed, for the ten companies with the highest revenues (for which data are available), only one reports spending more on research and development than on marketing, advertising, and administration. Merck's profits for that year were approximately three times its research and development budget (see Appendix 12).

For the manufacturers of the top 50 drugs sold to seniors, profit margins are more than triple profit rates of other Fortune 500 companies. These drug manufacturers are receiving an 18 percent profit rate of total revenues compared to approximately five percent for other Fortune 500 companies (see Appendix 13). Given their profit margins and advertising budgets, it is a wild and irresponsible exaggeration for pharmaceutical companies to suggest that, if prices were moderated, the first and only place they would cut is their research and development budget.

The pharmaceutical manufacturers are quick to overstate the role they play in research and development and to understate the role the government plays in this area. According to a study conducted by MIT and cited in the New York Times, of the 14 most medically significant drugs developed over the past 25 years, 11 have roots in research funded by the government. In general, much of the basic research essential to the development of new drugs is conducted at NIH or funded by the government. Taxol and Xalatan are examples of drugs developed from basic research conducted by the government. These two drugs alone now earn their manufacturers, Bristol-Myers Squibb and Pharmacia, hundreds of millions of dollars annually (see Appendix 14).

It is amusing to see how the pharmaceutical industry has a love-love-love-love-hate relationship with the US government. On the one hand, the industry loves the advantages gained through NIH research, patent protections, and laws governing re-importation. In addition, the industry loves the multiple tax advantages it receives, including the research and development tax credit and tax breaks for manufacturing in Puerto Rico. On the other hand, they continue to object to any effort by the government to moderate prices for the population most in need of drugs, the seniors and persons with disabilities in Medicare.

The rising prices of prescription drugs in the U.S. and the difference between what consumers pay in the U.S. compared to other countries raises real questions about equity and fairness of the drug industry's pricing practices. However, the best protection for consumers against high prices is to have guaranteed coverage that uses market clout to moderate drug prices and helps consumers pay for these drugs.

#### *Recommendations for Affordable Drugs for Seniors*

A sound public policy will ensure that seniors gain the benefit of two basic policy changes, Medicare coverage of prescription drugs and reasonable steps to ensure that drug costs are moderated. The principles for those changes include:

- *Coverage must be a defined benefit (both basic and catastrophic) included in Medicare, not the promise of access to a private insurance policy:* Prescription drug coverage should be added to the Medicare benefits package in such a way that beneficiaries have the same guaranteed coverage for drugs that they have today for hospital, physician and other Medicare covered services. Public policy predicated on the availability of private-sector drug-only insurance will be a mirage for most seniors. Insurance companies are unlikely to provide such coverage, and the premiums would quickly be unaffordable due to adverse risk selection.
- *Prescription drug costs must be contained:* A Medicare drug benefit will not be affordable if it does not include efforts to contain prescription drug costs. There are a number of mechanisms that Medicare can use to contain costs but Medicare should use its size to leverage the lowest price possible.
- *The Medicare benefit must be affordable to all seniors, with special subsidies for low-income beneficiaries:* The Medicare benefit must offer coverage that is affordable, including reasonable premiums and coinsurance requirements, and it should include catastrophic protections. Poor and near-poor Medicare beneficiaries should receive special assistance in paying for their premiums and out-of-pocket expenses. Low-income beneficiaries should have the premiums fully subsidized and should also receive help with any coinsurance requirements.
- *Administration of low-income protections should be improved:* The low-income assistance component of Medicare should eventually be integrated into the Medicare program, including full federal funding and federal administration of this benefit. It makes little sense to foist responsibilities of low-income protections on the states through Medicaid.

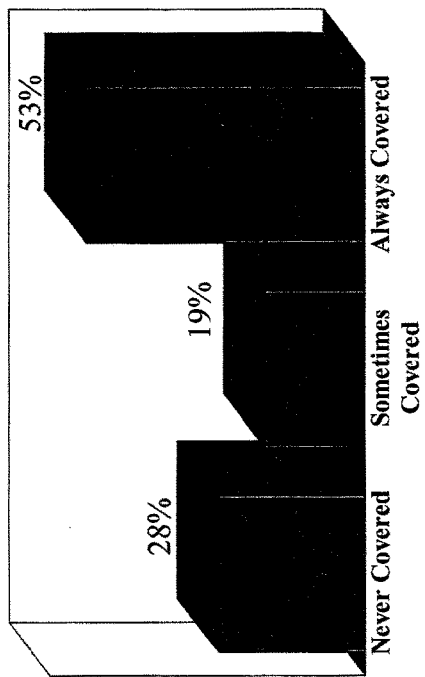
*Concerns about "Medicare Rx 2000"*

In response to the prescription drug plan unveiled by Congressman Bill Thomas, we have a number of concerns regarding the contents of this proposal. We believe this plan will not provide a real benefit for seniors and it does not meet the basic principles outlined above. More specifically, we raise the following concerns:

- Medicare Rx 2000, like previous versions of this plan, relies on private insurance offering prescription drug coverage, something the insurers have already emphatically stated they will not do. In fact, the president of the Health Insurance Association of America called this idea "an empty promise to America's seniors."
- The plan apparently has a provision that requires the government to step in when plans are not available. This means that the government will try to negotiate with the plans to make offering coverage more attractive to them. It does not mean that the government will offer a plan. When the sponsor, Cong. Thomas, testified that "this is a guaranteed entitlement," it remained unclear how seniors would get this coverage and now much he proposes that the government should pay insurance companies to induce their participation. There appears to be no mechanism to ensure that Medicare beneficiaries gain the benefit of the subsidies to insurance companies.
- Under this plan, consumers with incomes over \$12,525 a year must pay 100 percent of the cost of the private plan, even if the insurance companies can be persuaded to offer it. Under this income level there is some help for the premium of the lowest-cost plan. There is no help for co-payments or the deductible. The lowest-cost plan could be a lower-quality plan. This scheme potentially creates a two-tiered system with lowest-income people segregated into lower-quality plans.
- Consumers don't know what they will to get in drug coverage. The proposal leaves the actual benefit undefined. The plan has an actuarial value of \$740. The deductible, co-payments and benefits will vary across the country. In some areas this amount will buy more than in others. Administrative costs (usually around 35% in Medigap plans as compared to 3% in Medicare) will most likely come out of the actuarial amount.
- For oversight, the proposal—ironically—creates a new federal bureaucracy with its own budget authority. It makes recommendations directly to Congress and the President. The term of office is not concurrent with the administration. The "new agency" does not report to the secretary. This appears to be a "new agency" that has office space within the Department of HHS, but acts independently on all matters within its charge.

In conclusion, we hope to work with members of this committee and the rest of the Congress to make a prescription drug benefit in Medicare a reality.

**Appendix 1**  
**Nearly Half of Medicare Beneficiaries Lack**  
**Full Year Prescription Drug Coverage**



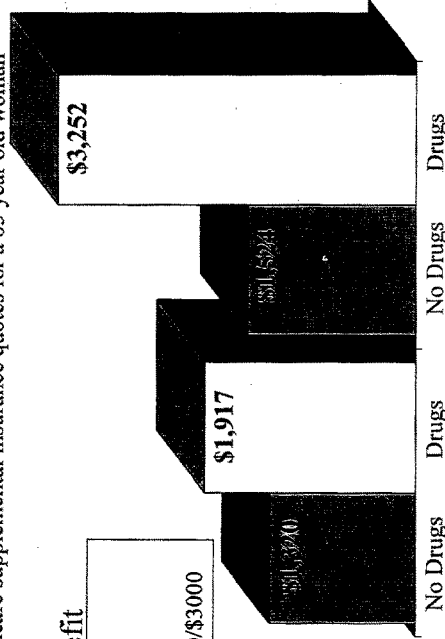
Source: Stuart, B., Shea, D., and Briesscher, B., *Prescription Drug Costs for Beneficiaries: Coverage and Health Status Matter*, The Commonwealth Fund, January 2000.

## Appendix 2 Prescription Drug Benefit Makes Medigap Coverage Much More Expensive

Average annual Medicare supplemental insurance quotes for a 65 year old woman

### Medigap Drug Benefit

Deductible:	\$250
Coinsurance:	50%
Cap (H/I):	\$1250/\$3000



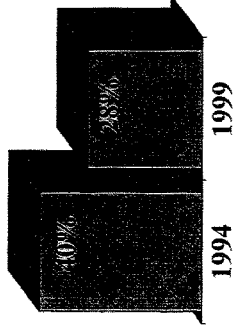
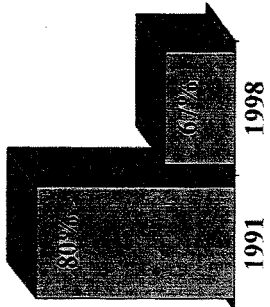
Note: \*Average of quotes from five counties: Butler Co, KS; Multnomah Co, OR; Sacramento Co, CA; DuDe Co., FL; New York Co., NY  
Source: Quotesmith.com as cited in Marilyn Moon, *Assessing the President's Proposal to Modernize and Strengthen Medicare*, January 2000.

### Appendix 3

## Retiree Health Coverage is Declining

Firms Offering Retiree Health Coverage <sup>2</sup>

Large Firms (1,000 +) <sup>1</sup>



Source: (1) McArdle and Associates, *Retiree Health Coverage: Trends and Employer Perspectives*, Hewitt Associates, Oct. 1999.

Source: (2) Mercer Foster-Higgins, 1999



Appendix 4

**50 Top Selling Drugs for Seniors**  
1 year (1999-2000)

→ 12 rose less than inflation

But...

↑ 33 rose at least 1.5 x inflation

↑ 25 rose at least 2 x inflation

↑ 16 rose at least 3 x inflation

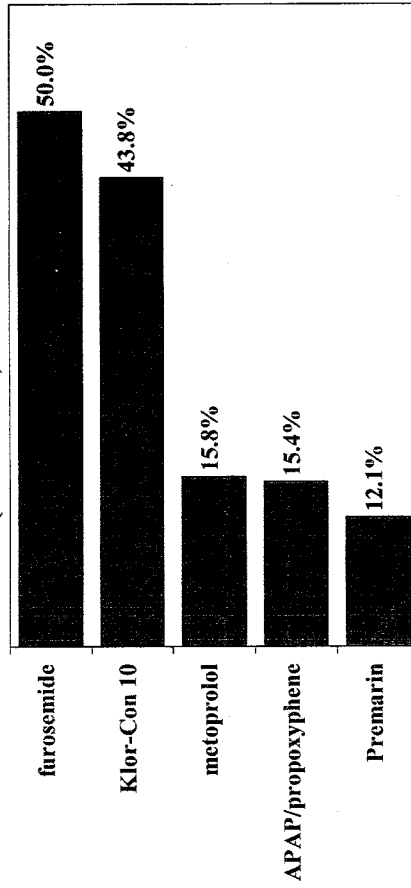
↑ 11 rose at least 4 x inflation



Families USA, April 2000



### Appendix 5 Price Increases in Prescription Drugs Most Commonly Used by Seniors (1999-2000)



## Appendix 6

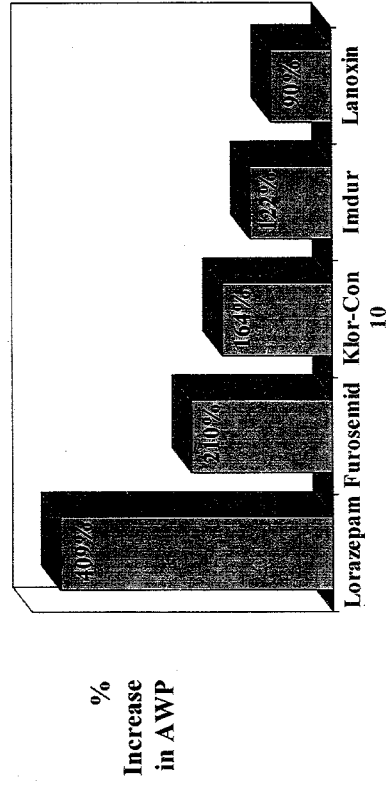
### 50 Top-Selling Drugs for Seniors 6 years (1994-2000)

- 39 of the 50 were marketed all 6 years
- ↑ 37 of 39 rose faster than inflation
- ↑ 30 of 39 rose at least 1.5 x inflation
- ↑ 22 of 39 rose at least 2 x inflation
- ↑ 11 of 39 rose at least 3 x inflation
- ↑ 6 of 39 rose at least 5 x inflation

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## Appendix 7

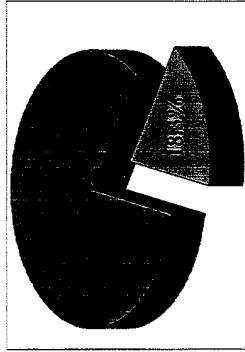
### Price Increases in Prescription Drugs Most Commonly Used by Seniors (1994 to 2000)



## Appendix 8

### Widow Living on \$12,525 a Year (150% of Poverty)

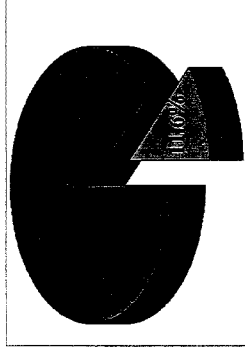
Diabetes, hypertension, & high cholesterol



Drug costs consume up to 18.3% of income

	Annual Cost:
Glucophage 500 mg (Diabetes)	\$ 708
Procardia XL 30/60 mg (hypertension)	\$ 521/901
Lipitor 10 mg (cholesterol)	\$ 686
<b>TOTAL</b>	<b>\$1,915/2,295</b>

Acid reflux disease



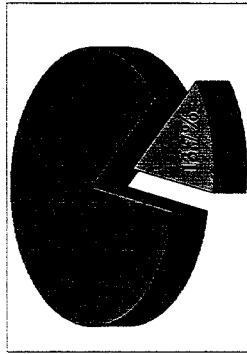
Drug costs consume 11.6% of income

Prilosec 20 mg	Annual Cost: \$1,455
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## Appendix 9

### Widow Living on \$16,700 a Year (200% of Poverty)

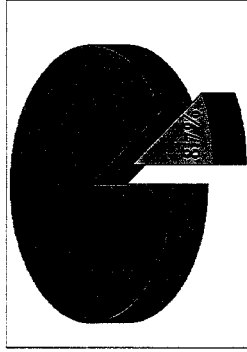
Diabetes, hypertension, & high cholesterol



Drug costs consume up to 13.7% of income

Annual Cost:  
 Glucophage 500 mg (Diabetes) \$ 708  
 Procardia XL 30/60 mg (hypertension) \$ 521,901  
 Lipitor 10 mg (cholesterol) \$ 686  
**TOTAL \$1,915,295**

Acid reflux disease

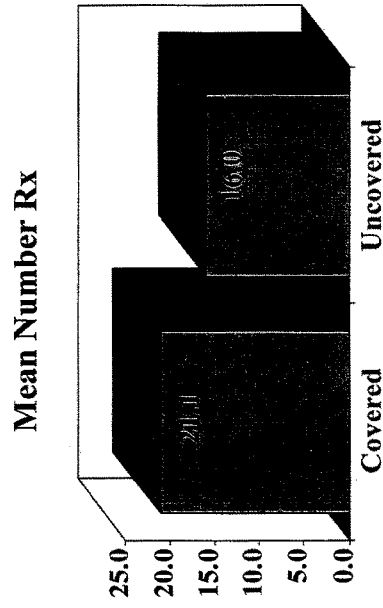


Drug costs consume 8.7% of income

Prilosec 20 mg Annual Cost: \$1,455

## Appendix 10

### Medicare Beneficiaries with Rx Coverage Are More Likely to Get Prescriptions.



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## Appendix 11

### 10 Best-Selling Prescription Drugs in the USA Cost Less in Other Countries

(Retail price of the most commonly prescribed dose of each drug, converted to U.S. dollars)

Rank	Drug	Condition	U.S.	Canada	Germany	Australia
1	Prilosec	Heartburn/Ulcer	\$3.31	\$1.47	\$1.67	\$1.29
2	Prozac	Depression	\$2.27	\$1.07	\$1.08	\$0.82
3	Lipitor	High cholesterol	\$2.54	\$1.34	\$1.67	\$1.32
4	Prevacid	Ulcer	\$3.13	\$1.34	\$0.82	\$0.83
5	Epogen	Anemia	\$23.40	\$21.44	\$27.48	\$29.24
6	Zocor	High cholesterol	\$3.16	\$1.47	\$1.73	\$1.75
7	Zoloft	Depression	\$1.98	\$1.07	\$0.95	\$0.84
8	Zyprexa	Mood disorder	\$5.27	\$3.39	\$2.86	\$2.63
9	Claritin	Allergies	\$1.96	\$1.11	\$0.41	\$0.48
10	Paxil	Depression	\$2.22	\$1.13	\$1.70	\$0.82

**FamiliesUSA**  
The Voice for Health Care Consumers

Source: USA TODAY, November 10, 1999.

**Appendix 12**  
**Pharmaceutical Companies Spend More on  
 Marketing Than Research and Development**

COMPANY	REVENUES (in millions)	PROFITS (as a % of revenue)	MARKETING COSTS (as a % of revenue)	R&D (as a % of revenue)
Merck	\$32,714	18.0	15.9	6.3
Pfizer	\$16,204	19.6	39.2	17.1
Eli Lilly	\$10,003	27.2	27.6	17.8
Schering- Plough	\$9,176	23.0	37.4	13.0
Pharmacia & Upjohn	\$7,253	11.1	38.6	19.8

Sources: *Fortune Magazine*, April 17, 2000; Eli Lilly 1999 Annual Report, pg. 18, Consolidated Statements of Income; Schering-Plough 1999 Annual Report, pg. 21, Statements of Consolidated Income; Pfizer 1999 Annual Report, Financial Review, Page 2, <http://www.pfizer.com/pfizer/investing/annual>; Merck 1999 Annual Report, pg. 42, Consolidated Statement of Income; Pharmacia & Upjohn Fourth Quarter Sales and Earnings 1999, pg. 7, Consolidated Statement of Earnings.



Mr. BILIRAKIS. Mr. Pollack, I am sorry to cut you off, but I have really got to move on.

Ms. Davenport-Ennis, please proceed.

#### STATEMENT OF NANCY DAVENPORT-ENNIS

Ms. DAVENPORT-ENNIS. Thank you, Chairman Bilirakis and members of the committee for your invitation to be here this afternoon.

I am Nancy Davenport-Ennis. I am the Executive Director of two national organizations, one of which is the National Patient Advocate Foundation. Our organization supports public policy that ensures patients timely access to cutting-edge therapies.

Our affiliate, the Patient Advocate Foundation, provides oncology nurse case managers, coding and billing specialists, and attorneys to both consult and intervene on behalf of patients who have faced denial of access to care in the health care delivery system in this country.

Based on the work of our organizations, we are pleased to share our ideas for the design and implementation of such a program.

Our ultimate goal is a rational and balanced prescription drug program that will meet the needs of all seniors, including individuals with serious and life-threatening diseases.

Because of our experience with cancer patients and perhaps because I am a twice survivor of cancer, I am the mother-in-law of a cancer survivor, I am the aunt of a now-deceased 34-year-old niece who died after a 5-year battle with ovarian cancer, and perhaps because I have the opportunity to interface with case managers that served over 29,000 Americans last year who were facing denial of care, many of my recommendations will be specific to the issue of cancer protection.

I would also like to cite for the record that because I have not had access to the bill that has been introduced, I am here to talk about Medicare modernization and not to address specific tenets of specific legislation.

I would like to go back to the evolution of cancer care and cite that Medicare does pay for prescription drugs, as you know, that are provided incident to a physician's services.

Because most current anti-cancer drugs are administered intravenously by physicians, they are already covered by Medicare.

Cancer patients have come to expect, and in fact to prefer dramatically, care in the community setting. And I thank the Congress for their role in seeing that we have been able to maintain continuity of care in this particular area.

With regard to the future of cancer care, Medicare currently pays only for those oral chemotherapy agents that are a replacement for intravenous chemotherapy agents. Oral chemotherapy drugs that are not a replacement for existing IV drugs will be a critical part of cancer care in the future. And cancer patients have expressed a strong desire to use these medications.

Medicare reimbursement will play a key role in the acceptance and proper use of these drugs. It will not be sufficient for physicians to give a patient a prescription for these drugs and have no further responsibility for that patient's use of the drugs.

The payment system must recognize that these drugs will need to be monitored more carefully than many other self-administered drugs because of issues of side effects and compliance; therefore, physician reimbursement for supervision of this therapy must be adequate.

In order to prevent financial disincentives against the use of these drugs, including the imposition of unreasonably large copayments or coverage caps, oral chemotherapy drugs should be incorporated in the existing Medicare drug coverage system.

Our constituents—cancer patients and others with serious and life-threatening illnesses—will benefit from a new prescription drug benefit only if it is administered fairly and consistently.

In administering any benefit, it is essential that a balance be achieved between the availability of the benefit and the preservation of funding for the benefit.

At times it appears as though the balance struck by HCFA is weighted more toward preservation of financing than availability of benefits.

I base that again on the fact that we have served so many Americans that have confronted problems with denial within the Medicare program.

Last year alone, patients from 44 States contacted us for help with regard to denial of Medicare benefits.

A series of agency actions, both recently and historically, confirm our concerns about HCFA's administrative approach.

These actions include development of an outpatient prospective payment system that would have severely limited if not eliminated cancer care in the hospital outpatient department.

The problems in this proposal were remedied legislatively after an outcry from patients and others.

We are concerned about the policy for injectable drugs. And certainly the Congress has been successful in once again making certain that patients will continue to have access to physician point-of-service injectable drugs.

The issue of average wholesale pricing has also been a concern. HCFA has repeatedly sought to reduce reimbursement for Medicare outpatient drugs, threatening a situation where oncologists would suffer a loss of drugs administered to Medicare patients.

Cancer patient groups have made clear their objections to these changes unless the modifications are accompanied by appropriate and adequate adjustments in chemotherapy administration fees.

With regard to clinical trials coverage, the cancer patient community celebrated a victory last Wednesday when the President announced a policy of Medicare coverage for routine patient care costs for those enrolled in clinical trials.

We are now quite concerned to learn that HCFA has prepared a program memoranda implementing the President's directive that would in fact negate the President's announcement on this fact.

Mr. BILIRAKIS. Please summarize, Ms. Davenport-Ennis.

Ms. DAVENPORT-ENNIS. I will be happy to. I am here this afternoon to say to each of you, we are most willing to share with you data that we have as a result of our patient cases that may be beneficial to you as you design a new Medicare program that is going to work in the area of prescription drug benefits.

We will be happy to share the specifics of what we feel would be important in that, and we are most happy to answer questions from members of the panel this afternoon.

Mr. BILIRAKIS. Thank you, ma'am.

[The prepared statement of Nancy Davenport-Ennis follows:]

PREPARED STATEMENT OF NANCY DAVENPORT-ENNIS, NATIONAL PATIENT ADVOCATE FOUNDATION

Good morning and thank you for inviting me to testify today on the issue of modernizing Medicare drug coverage. I am Nancy Davenport-Ennis, Executive Director of the National Patient Advocate Foundation, or NPAF. Our organization supports public policy that ensures patients timely access to cutting-edge therapies. Our affiliate, the Patient Advocate Foundation, provides caseworker services to individuals who have been denied coverage for their health care.

Through our work at NPAF and the Patient Advocate Foundation, we have become quite familiar with the difficulties that Medicare beneficiaries experience in reliably securing reimbursement for potentially life-saving therapies under the current limited drug benefit. That experience has provided valuable insights into the appropriate structure and administration of an expanded Medicare prescription drug benefit, and we are pleased to share our ideas for the design and implementation of a prescription drug program.

Many—although not all—of our direct services are provided to cancer patients, and our advocacy program focuses on cancer policy issues. Therefore, some of my remarks will refer specifically to cancer patients. However, our recommendations have relevance for all Medicare beneficiaries. Our ultimate goal is a rational and balanced prescription drug program that will meet the needs of all seniors, including individuals with serious and life-threatening diseases.

*Evolution of Cancer Care*

As you know, Medicare pays for prescription drugs that are provided incident to a physician's services. Because most current anticancer drugs are administered intravenously by physicians, they are already covered by Medicare. This is a system that works well for cancer patients, and we would be concerned if any new Medicare drug benefit changed this situation.

The gradual shift of chemotherapy from the inpatient setting to the physician's office has been aided by the introduction of certain supportive care products and by the availability of Medicare reimbursement. Cancer patients have come to expect, and in fact to prefer dramatically, that their chemotherapy be administered in the physician's office and that they recuperate from the effects of the therapy in their own homes with the support of family and friends.

This shifting of practice from hospital to physician's office has been cost-effective for Medicare, and it has been a humane development for patients, who benefit not only from care in the outpatient setting, but also from limited copayment requirements and the absence of a benefit cap for their cancer chemotherapy. Continuity of care for cancer patients is very important, and changes to the current successful system of cancer care should be approached with caution.

*The Future of Cancer Care*

Medicare currently pays only for those oral chemotherapy agents that are a replacement for intravenous chemotherapy agents. Oral chemotherapy drugs that are not a replacement for existing IV drugs will be a critical part of cancer care in the future, and cancer patients have expressed a strong desire to use these medications. Medicare reimbursement will play a key role in the acceptance and proper use of these drugs.

It will not be sufficient for physicians to give a patient a prescription for these drugs and have no further responsibility for that patient's use of the drugs. The payment system must recognize that these drugs will need to be monitored more carefully than many other self-administered drugs because of issues of side effects and compliance; therefore, physician reimbursement for supervision of this therapy must be adequate. In order to prevent financial disincentives against the use of these drugs, including the imposition of unreasonably large copayments or coverage caps, oral chemotherapy drugs should be incorporated in the existing Medicare drug coverage system.

*Role of HCFA in Administering an Expanded Drug Benefit*

Notwithstanding our desire to have a comprehensive program of cancer benefits administered under Part B, we have some concerns about the expansion of HCFA

authority to administer a new program including all drugs. Our constituents—cancer patients and others with serious and life-threatening illnesses—will benefit from a new prescription drug benefit only if it is administered fairly and consistently. In administering any benefit, it is essential that a balance be achieved between the availability of the benefit and the preservation of funding for the benefit.

At times, it appears as though the balance struck by HCFA is weighted more toward preservation of financing than availability of benefits. We are mindful of the need for HCFA to be a responsible guardian of Medicare funds, but we do not think that it should be the highest priority of the agency. Where the balance has not been appropriately struck, we have seen narrow coverage determinations, resistance to introduction of new technology, and unwarranted reimbursement denials.

A series of agency actions, both recently and historically, confirm our concerns about HCFA's administrative approach.

- **Ambulatory Payment Classification System**—HCFA's proposal for an outpatient prospective payment system would have dramatically underpaid for certain chemotherapy agents, failed to pay for supportive therapies, and created disincentives for the introduction of new therapies. Congress had to intercede with revisions of the outpatient prospective payment proposal because the original plan would have severely limited, if not eliminated, cancer care in the hospital outpatient department. Just as patients prefer care in the physician's Office over inpatient care, they also prefer care in the hospital outpatient department to care as an inpatient.
- **Policy for Injectable Drugs**—Since the inception of the Medicare program in 1965, reimbursement has been available for injectable drugs based on the usual method of their administration. In the last two years, however, HCFA has attempted to modify that policy and eliminate reimbursement for many injectable drugs. The agency has challenged the expectation of Medicare beneficiaries that injectable drugs administered in the physician's office will be reimbursed. In 1999, Congress was forced to intervene and direct HCFA to restore its historical reimbursement policy based on the usual method of administration of injectable drugs. The appropriations rider that mandated that coverage is in force only until September 30, 2000, and HCFA has already indicated an intention to revise its coverage policy.
- **AWP**—HCFA has repeatedly sought to reduce reimbursement for Medicare outpatient drugs, threatening a situation where oncologists would suffer a loss on drugs administered to Medicare patients. This situation would not be sustainable, and in the past Congress has directed HCFA to refrain from implementing these reductions. Cancer patient groups have made clear their objections to these changes, unless the modifications are accompanied by appropriate and adequate adjustments in chemotherapy administration fees. I have attached the NPAF statement and copies of Cancer Leadership Council letters on this topic.
- **Clinical Trials Coverage**—Although the cancer patient community recently celebrated a victory when the President announced a policy of Medicare coverage for routine patient care costs for those enrolled in clinical trials, this accomplishment came only after years of delay. Cancer advocates suggested years ago that HCFA had the authority to cover clinical trials and proposed specifically how that might be accomplished. After years of resisting this change, HCFA made the modification only because of a Presidential directive. We are still awaiting the details of the coverage announcement.
- **Coverage of Off-Label Drugs and New Medical Devices**—Beyond these recent issues, HCFA historically has expressed reluctance to cover certain new or developing technologies even after they have been fully incorporated into good medical practice. The cancer community still chafes under the recollection of Medicare policy during the 1980's and early 1990's, when the program routinely denied coverage for medically accepted uses of anticancer drugs that were different from the specific use approved by the Food and Drug Administration. When supported by sound clinical data, these so-called off-label uses of drugs are standard therapy for many cancers. HCFA firmly resisted efforts to reform its backward reimbursement policy in this regard, until Congress finally felt compelled in the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) to take the unusual step of mandating that HCFA follow the recommendations of certain private review bodies with respect to the off-label use of drugs for the treatment of cancer. In addition, Medicare acceptance of new medical devices is notoriously slow, leaving many approved devices unreimbursed by Medicare years after their introduction in the private sector.

Our organization recommends that Congress, when considering its options for administration of a Medicare prescription drug benefit, include among those choices market-based mechanisms for procurement of drugs for seniors.

*Fundamental Principles of Prescription Drug Coverage*

As advocates for individuals with cancer, we believe the issues we have discussed above deserve serious consideration during debate on a prescription drug plan. I would also like to discuss briefly some additional issues of broad impact that should be weighed by Congress.

We propose a number of fundamental principles of prescription drug coverage that are important to individuals with cancer and other serious and life-threatening illnesses:

- Formularies**—We cannot foresee any venue where a restrictive formulary would be appropriate. Decisions regarding medical care should be made by the patient in consultation with his or her physician and should not be limited by a formulary. Differences in prescription drugs that are perceived by benefit managers to be minor may be a matter of life and death for cancer patients. It is not adequate to have an appeals process for access to drugs not on the formulary, because delays during appeal may be life-threatening for some individuals.
- Pharmaceutical benefit managers**—For individuals with serious and life-threatening illnesses, care by a comprehensive health care team is important and the involvement of a pharmaceutical benefit management company does not facilitate such care.
- Appeals of coverage denials**—The new prescription drug plan should include procedures for the timely review of denials of coverage, including complaints by beneficiaries, providers, and pharmacists.
- Information and education campaign**—Implementation of a new benefit will create confusion among Medicare beneficiaries. Therefore, a substantial educational effort is a necessary component of the new program. While patient and provider organizations can play a pivotal role in beneficiary and provider education, the agency responsible for program implementation must also have a broad-based dissemination initiative and provide funds for private sector educational efforts.

We believe enactment of a prescription drug benefit is necessary to ensure Medicare beneficiaries access to life-saving therapies. However, the success of any new plan will depend significantly on a fair and balanced approach to program implementation. In light of our experience to date with HCFA implementation of the current benefit, we urge Congress to evaluate a range of administrative options, including market-based solutions, before you reach your decision.

I would be glad to answer your questions.

Mr. BILIRAKIS. You have been so patient sitting here all of these hours and sharing lunch with us so I really hesitate and hate to cutoff anyone. But you have got to have structure in order to be able to function. So I hope you will forgive me in that regard.

Ms. Eshoo—I am glad to see that she is still here—coined a phrase earlier which probably said it better than any of us could when she talked about this problem being like putting socks on an octopus.

It says it all I think. It is just so very, very difficult to do this right. Not just to do it, but trying to do it correctly.

I have as much optimism as anyone and I like to think we will get the job done and get it done this year.

We have to be practical. Will we be able to get it done this year? Politics certainly plays a very large part in all this. Partisanship will play a big role, as will the details of any proposal.

So I guess I would raise the question, and Mr. Fuller touched on it. There are people out there who are hurting. And I know that a couple of you made comments about means testing. For the life of me I cannot understand why, when there are a limited amount of resources available, we cannot rightly focus those resources for those who are more in need than others.

Mr. Fuller referred to State-based programs that are in place already—there are approximately 20 around the country. In fact, I understand that one of the top priorities at the National Governors'

Conference was to install a prescription drug program in their States. Florida just recently completed it in their legislature, and they are putting a program into place.

If we have these programs in place, what is wrong with complementing and supplementing those existing programs with Federal dollars until we get it right and make a prescription drug benefit a part of Medicare? I trust, if it is done correctly, that these programs could help even more people, maybe double the number of people, for example, than they take care of presently.

And of course, if you add to that some help for those people who maybe do not qualify as being very poor, if you add to that the stop-loss concept for those who would not qualify for the subsidy but at the same time have prescription drug costs that would be out of the roof and really run them into a hole.

So I raise that question. Very quickly. I do not have that much time. If each of you could take maybe just a few seconds to respond to that, I would appreciate it. Negative or positive, whatever.

Mr. KAHN. Well, Mr. Chairman, HIAA believes that the issue you are raising is an important one, which is we ought to do now what can be done. And clearly, States are showing they can very rapidly implement these programs. I mean, it has grown from around 13 to about 19 in just a few short weeks actually.

Mr. BILIRAKIS. Right.

Mr. KAHN. And I think anyone at the table has got to admit that the current pricing of drugs is Byzantine and the complexity of adopting any kind of benefit, whether it is private sector or public sector, that is universal is such that it will take years.

And so we believe firmly that the best to do now would be to help those most in need immediately. Because otherwise, it is going to be years.

Mr. FULLER. I would just maybe supplement what I said by saying that in the months that we have been working on this, we have seen the American Pharmaceutical Association come on board supporting it. They represent the Nation's pharmacists.

The American Society of Consultant Pharmacists, Food Marketing Institute, and the National Consumers League all signed on to the program. So we think there is growing attraction to the State-based approach.

I would also add that we would recommend that the program be sunsetted, so that this does not continue forever; to sunset it in 5 years or whenever there is major Medicare reform so we keep the pressure on.

Mr. BILIRAKIS. Right.

Mr. FULLER. But it is the kind of pressure in which there can be constructive dialog.

Mr. BILIRAKIS. That would be a concern. You have got to keep the pressure on, that is for sure.

Ms. IGNAGNI. Mr. Chairman, I think that without a doubt if the choice is doing something or doing nothing, something is always better than nothing.

Having said that, we have a time of tremendous prosperity in this country, probably like no other we have seen in a very long time.

There are two issues that remain to be addressed in health care, and probably many, many others, but two large ones loom over us. One is the matter of prescription drugs to update this 1965 benefit program; and the second is the matter of the uninsured, which looms large and will undoubtedly get larger as the economy slows.

So we would say on the part of our members that we would like to sit with you, to sit with members of the minority, and work together to try at this juncture to address this unique opportunity to fulfill that promise that was made in 1965 to beneficiaries.

Mr. BILIRAKIS. Dr. Feder.

Ms. FEDER. I actually agree with Karen Ignagni that the promise of Medicare of mainstream protection is no longer being fulfilled without the prescription drug protection.

Mr. BILIRAKIS. Agreed. Agreed.

Ms. FEDER. Good. And the barrier really is political. Sure it is hard to do the specific design, and it takes effort, and there is contention around it. But we are capable of agreeing as policy analysts on a design.

The greatest underlying problem that I see in reaching agreement is that rather than having a political consensus on the value of the Medicare program, the Medicare program, even its basic benefit, in addition to its administration, has been under siege for the last 5 years.

And it seems to me that to go in a direction of very modest means-tested benefits which we know from the outset will be inadequate, is to walk away from what we need to do and have the resources to do, which is to strengthen and recognize and support the program that we know works.

Mr. BILIRAKIS. But in the meantime, of course, an awful lot of needy people out there would not have—

Ms. FEDER. But that is because we are not willing to act. We can do it.

Mr. BILIRAKIS. Mr. Donoho.

Mr. DONOHO. Mr. Chairman, I guess, you know, our association starts with the premise that Medicare needs to be reformed. We spent a year or more in the last couple of years studying this issue. What we are here today about is taking a piece of that study an enacting it for Medicare.

From what I understand, and I guess the concern I would express, because our association has not taken a position on a State-based plan, is that once you give it to the States as a block grant or however you do that, how do you bring it back under a Medicare style program?

I mean, it is just a question. And once you get a program operating similar to Title 19 Medicaid, how do we achieve reform and how do we come back to it in terms of Medicare itself?

Mr. BILIRAKIS. Which is a question that would have to be answered.

Mr. Pollack.

Mr. POLLACK. Mr. Chairman, let me tell you that we actually have worked with numerous States actually to establish some of these programs.

Having said that, let me make clear what the impulse was on the part of the States and why I do not think it is the right direction to go in here.

The States have done this because they have thrown their hands up, and they have said we are waiting for the Federal Government. We cannot do anything else. We are at a position today where we can do something much more significant.

I have three fears.

One fear is that if we move in this direction, we are not going to keep the same sense of urgency about the real reform that we need.

Second, these low-income programs have very poor participation rates. If you look at things like the Qualified Medicare Beneficiary program, the SLMBY program as well, they have very low participation rates because they are treated very differently than when you have a universal program.

And last, these programs do not have the opportunity of containing costs and containing prices. And so if we do not contain those costs and prices, that benefit quickly will be less meaningful.

Mr. BILIRAKIS. Well, all right. Ms. Davenport-Ennis, very briefly, if you can, since you are last.

Ms. DAVENPORT-ENNIS. Thank you. I would like to concur with the remarks that Karen Ignagni made in terms of the need to absolutely look at addressing prescription drug benefits while we have an economy that will allow us to do that.

I think also from our experience, we must do something to deal with the uninsured population.

I would also have to say that based on our experience in State legislation before moving to the Federal level in that activity, each time that we worked in a State to effect reform, what we found was that the process was usually a slow process. It was hit-or-miss process.

We ended up with citizens in one group of States having one set of services and in other States having no services at all.

With regard to the Block Grant Program, we would share the same concern that has previously been voiced, that if we get it started at the State level, how are we ever going to get it back?

And, as you say, Chairman Bilirakis, there are so many people that are hurting, right now the one vehicle that we have available to them in all States is to try to get them into an indigent drug program either through their State or through a pharmaceutical manufacturer.

And I can share with you, in great detail,—

Mr. BILIRAKIS. Please don't, please don't today.

Mr. DAVENPORT-ENNIS. No, I won't go into great detail, but I will share with you that it is very difficult to effect remedy for the at-risk populations that find themselves needing this help the very most.

Mr. BILIRAKIS. Thanks. I asked for it and I got it.

Mr. BROWN? I appreciate the committee's indulgence.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. Pollack, you held up a larger, but a black and white version of this. This was in Congress, I think in Congress Daily today. "Pri-



vate Drug Insurance Lowers Prices 30 Percent To 39 Percent: Shouldn't Seniors Have It?

Your point was that it segments the market not using Medicare buying power, if you will. There is another underlying perhaps inadvertent message, I think, that says something else.

That is, that in the background you hear the drug companies, over and over, talking about \$500 million, it costs them \$500 million to research a new drug, they have never really provided evidence of that \$500 million but that is the number that even the media sometimes accept without really any documentation. It has almost become part of the rap in this town that it costs \$500 million, no questions asked, even though almost 50 percent of prescription drug research and development is paid for by taxpayers. And that is rarely mentioned in all this.

The drug companies go on and say, "Any action by Congress to reduce prices in any way would make the drug companies unable to do this wonderful"—and it is wonderful—research that they do.

But this ad says, "If all seniors had access to private market discounts, the medicine they need on average would cost 30 to 39 percent less, private prescription drug insurance is the cure. A hundred-and-fifty-million Americans don't pay full price for the medicines. Why should any senior?"

Are they suggesting in your mind that if senior citizens could get a 30, 39 percent discount that they still would be able to do all this research?

Mr. POLLACK. I made that very point in testimony yesterday in the Senate with Alan Homer, the President of the Pharmaceutical Research and Manufacturers Association. In effect, they seem to be saying, come at us with 30 to 39 percent discounts. It is not going to be harmful to us.

You know, the point you are making I think is amplified in Appendix 12 to my testimony. If you look at the various companies, you will see that they are spending considerably more on marketing, advertising, and administration than they are spending on research and development.

They take considerably larger amounts in profits than they spend on research and development. If I just might give you two illustrations:

Merck spends 2½ times as much on marketing-related costs than it does on research and development. It receives profits that are three times as high as what they spend on research and development.

Eli Lilly spends 1½ times as much on marketing and takes 1½ times as much of research and development for profits.

Clearly, if we moderated prices, it would not hamper the ability to undertake research and development. And the industry seems to be admitting this with their advertisement.

Mr. BROWN. Dr. Feder, if I could switch gears. The Republicans claim that relying on the private sector would permit flexible benefits and avoid a one-size-fits-all approach that Medicare's traditionally successfully used.

Give us the downsides of that in a prescription drug program.

Ms. FEDER. Sure. I think that the one-size-fits-all language is intended to be pejorative, and if we step back, No. 1, we need to step

back and look at what the one size that does fit all is being advocated, that being that we are saying that everybody is to be entitled, every senior ought to be entitled to a defined prescription drug benefit.

That kind of protection everybody does indeed need. So the label itself is misleading. When they talk about flexibility, I think that they are implying that there ought to be a variation in benefits, a wide choice of plans, and we have heard a lot of problems in that argument discussed this morning.

One is that the flexibility that is talked about in terms of relying on a private market is a flexibility to serve some areas and some people and not others.

It is a flexibility and uncertainty that has plans coming and going from markets and changing their benefits because that is the way the market works.

So we have heard a lot of discussion about the uncertainty that it creates for beneficiaries.

In terms of the flexibility on benefits, it means, as we have heard many others say this morning, and many members of the panel say of the committee say that it creates concerns about what people can expect, as well as a competition in the marketplace that is designed to avoid risky patients, rather than to really provide care efficiently.

So I would say, in all those respects and add to them the administrative costs and the marketing costs and the lack of knowledge that consumers will have going into a plan on what they are really getting with formularies, for example.

That what is being called flexibility is really confusion and fragmentation.

Mr. BILIRAKIS. The gentleman from Pennsylvania, Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman.

In quick response to Mr. Brown's commentary, I would agree it would be a good idea for us to get documentation of what exactly it costs to produce a drug, because I know I use that \$500 million per drug figure. And by virtue of this statement, I would hope the pharmaceutical industry would provide us with that substantiation.

I would also like some substantiation of the gentleman from Ohio's statement that 50 percent of the profits of pharmaceutical companies come from, are taxpayer funded because that gets bandied around a bit too, and needs some substantiation. So I hope you can provide the committee with that.

Mr. Pollack, in your testimony, you say that prescription drug coverage should be added to the Medicare benefits package in such a way that beneficiaries have the same guaranteed coverage for drugs that they have today for hospital physicians and other Medicare care coverage services.

I want to understand what your proposal is. Would you assume that the beneficiaries pay a premium for that?

Mr. POLLACK. Yes, I do.

Mr. GREENWOOD. And would you assume that there is a co-pay?

Mr. POLLACK. Probably, yes. With the probable, hopeful exception to those of lower income who would have that subsidized.

Mr. GREENWOOD. You assume that there is a deductible?

Mr. POLLACK. Not necessarily. It might, might not.

Mr. GREENWOOD. Would you assume that there is a stop loss. In other words, would you assume that there is a cap, I should say. Do beneficiaries have access to whatever the costs are, if it is \$10,000, \$20,000, \$30,000,—

Mr. POLLACK. There should be a catastrophic benefit, yes.

Mr. GREENWOOD. And what would that cost?

Mr. POLLACK. Well, it depends on how it was designed. I am not an actuary so I do not think I can give you that cost, and of course it will depend very much on a variety of factors, and so I do not know how I could give you an estimate of that without knowing the details.

Mr. GREENWOOD. Well, in your testimony, you say we have been engaged in analyzing the implications of changes of the Medicare program and Medicare beneficiaries for some time. And you talk about the research you do. And you have come to the committee and made a very clear recommendation.

And I am a little surprised if you have not any idea what your recommendation would cost because that is—

Mr. POLLACK. I did not say that we are coming in with a proposal. We said the approach should be to incorporate this into the Medicare program. There are many ways to do it, and those different ways are going to cost very different amounts of money.

Mr. GANSKE. Would the gentleman yield?

Mr. GREENWOOD. Briefly, Mr. Ganske. People would yield to you before and lose their time.

Mr. GANSKE. One additional question to your series of questions. And that is, it sounds to me like Mr. Pollack is saying that there should be a standard part of Medicare.

And that to me means that if it is like physician services or other services, that it is not voluntary.

Mr. POLLACK. Well, Part B is voluntary and—

Mr. GREENWOOD. Is to further describe the gentleman's proposal. Would yours in fact be voluntary or would it be a requirement that everyone that participates in Medicare pay this premium whether they already have coverage from their employer or not?

Mr. POLLACK. I think the likelihood is that it would be voluntary. I do not think it is feasibly probably politically to enact a plan that was not voluntary.

Mr. GREENWOOD. In all due respect, Mr. Pollack, you spend a lot more time criticizing the proposals that are on the table than you have proposing something yourself. And continued in all due respect, that is the easy part of this process.

The easy part of this process is knocking other people's ideas; the hard part of the process is coming up with something that we can afford and that makes sense, and I have not seen that in your testimony.

Do you believe that the pharmaceutical industry ought to be nationalized, or do you think it ought to remain in the private sector?

Mr. POLLACK. No, I think the pharmaceutical industry should be in the private sector.

Mr. GREENWOOD. Okay, if you were running—

Mr. POLLACK. Even, even in the private sector—

Mr. GREENWOOD. Okay, thank you for answering the question. Let me just get to where I want to go here.

If you were running a private sector pharmaceutical company, would you forego marketing, advertising and administration and profits, or any of those?

Mr. POLLACK. Of course not, and I am not saying they should.

I am saying, however, that when the industry keeps on asserting research and development is going to go down the tubes if we do something to moderate prices, I suggest to you that that is very misleading—

Mr. GREENWOOD. Well let me—

Mr. POLLACK. [continuing] because there are much larger pots of money, including marketing, advertising, administration and profits that dwarf the amount of money that is spent on research and development.

And to say that when we moderate prices, the only thing that is going to happen is that we are going to limit research and development is absurd.

Mr. GREENWOOD. Well, the reality is that if you were running a company, whether you were making pharmaceuticals or whether you are making widgets, you cannot survive if you do not have marketing, and you cannot compete if your marketing isn't robust. You cannot survive if you do not have administration unless management's going to work for free. You cannot survive if you do not have profits because nobody is going to invest in your company.

So research is the one thing that then becomes dispensable because that is the one thing that is not necessary to survive. You can survive into the future without research, but you cannot survive without those other costs.

Mr. POLLACK. Au contraire, I do not believe that for a moment.

First, I am not suggesting at all that we should do away with marketing and do away with advertising, and I am not saying there should be x-amount spent on it or y-amount on profits. That is not the point I am making.

But what I am saying is that when the industry tells us the only thing that is going to give is research and development, that is plain nonsense, and it is in the industry's interest to undertake research and development.

It does not do this merely for altruism. The reason it undertakes research and development is it brings new products to market for which they can make a profit.

Mr. GREENWOOD. Of course.

Mr. POLLACK. It is in the interest of any company to do research and development, but to say if we moderate prices, that the only thing that is going to be harmed is research and development, is a wild exaggeration.

Mr. GREENWOOD. I would love to respond but my time has expired.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Pallone?

Mr. PALLONE. Thank you, Mr. Chairman.

I wanted to ask Mr. Pollack a question but I, to me, I think you have been quite clear in basically suggesting that, you know, something like the President's proposal that is part of the Medicare pro-

gram that is universal, that you know is affordable, that has some kind of effort to deal with the price discrimination issue is certainly, you know, one way to go. And that you have been concerned about, you know, this Thomas, I call it the Thomas proposal, the Republican proposal is not accomplishing those goals.

And what I wanted to ask Mr. Pollack is that, you know, I try to get down to specifics and give an example if we could maybe contrast the Thomas proposal with the President's with an example.

And I am going to give you an example of a widow living at 150 percent of poverty who has diabetes, hypertension, high cholesterol, no supplemental drug coverage. Drug costs for medication to treat these illnesses consume over 18 percent of her income.

What kind of prescription drug benefit does she need?

And, you know, keep in mind the two options, the Thomas versus the President's.

Mr. POLLACK. Well clearly the proposal we have been talking about this morning does not provide a subsidy for that individual. The way the plan is structured, as I understand it, is that it provides a subsidy up to 133 percent of poverty, and then it phases down, and it phases completely out at 150 percent.

So this widow is provided with no subsidy whatsoever. And so she is going to have to bear the brunt of those costs.

Under the administration's proposal, there would be a subsidy in effect for everybody and so this individual would get assistance. There would be a significant contrast.

Mr. PALLONE. I mean, I think that is the bottom line is how this is going to apply to individuals, but thank you.

I wanted to ask Mr. Kahn, and I may have misunderstood what you said, but let me see if I can clarify it.

You said that the private drug insurance option is essentially unworkable, and you said how you were pleased with Thomas having the possible fall back on a government program, and then you talked about how Medicare+Choice needs more dollars, particularly for drug coverage.

Are you basically saying to us that, I mean, I do not know what this fall back is because that is been very unclear to me.

But I mean you do not really want to see the private insurance with the fall back? Wouldn't it make more sense to have some kind of a, you know, Medicare program along the lines of what the President suggests to begin with rather than have this private insurance with the fall back?

Mr. KAHN. The President's plan presumes that Medicare+Choice will continue on into the future. Medicare+Choice offers a comprehensive benefit. We are only talking about a piece of that benefit when we are talking about pharmaceuticals.

So presumably whether it's the fall back or whether it's the President's plan, there will be money in there to subsidize the coverage in the Medicare+Choice plan for pharmaceuticals.

Mr. PALLONE. And there is in fact. But I guess what I am trying to pinpoint is, you know, I think you were saying clearly that the private drug insurance option is unworkable.

I mean, it does not seem to me to make sense to say, okay, we will try that and if it does not happen, you know, we will fall back on the government.

I mean, it would seem to me to make more sense if you really believe that the private insurance is unworkable, is simply do something like the President rather than hope that somehow, you know, we are going to fall back on something that is undefined at this point.

Mr. KAHN. Well my member companies have not chosen to endorse any of the universal plans. That is one of the reasons, when the chairman asked the question, I answered positively about our member companies' feeling about helping the low income elderly through the block grant.

But I guess my answer to you is that either the fall back or the President's plan, if it is universal, it answers your problem of making sure there is something for all Medicare beneficiaries, depending on how it is structured.

Mr. PALLONE. Well, let me just say this one more thing, because I think my time is up.

In the Thomas plan, what we are told is that, you know, there is a subsidy of like 30 to 35 percent. Do you feel that if there was a larger subsidy that, you know, private drug insurance options would be workable?

Is it just a question of the level of subsidy, or you just think the idea is unworkable?

Mr. KAHN. I think the idea is unworkable. I mean, let's say in Part B right now, you have a 75 percent subsidy and you have 98 percent compliance with a voluntary program. But it is a universal program and also the premiums are collected, and also the premiums are collected with your social security check.

So there is a sort of big hammer there to make sure those premiums are collected.

I guess we have our doubts, both on the administrative side, the risk selection side, and just the cost containment side of providing any kind of drug-only benefit in any form, drug-only. I need to stress that because Medicare+Choice and comprehensive benefits are fundamentally different than a drug-only benefit.

Mr. PALLONE. Thank you.

Mr. BILIRAKIS. Mr. Burr to inquire.

Mr. BURR. Thank you, Mr. Chairman.

Craig, let me say to you I hope you will be happy when this bill is finalized to read that we do understand the importance of pharmacists, but more importantly, we have written in language that will address the medication management/disease management function that many druggists around the country currently perform. And it is a very important part of the overall health care system today.

It is going to be up to plans to determine some reimbursement, but hopefully there is a framework that has thought through everybody who plays a role in this.

Mr. Pollack, let me go to you, because you were very specific on the 150 percent of poverty and that there not be a means test. And I do not think anybody's portrayed it as one.

The President's plan cuts off at 150 percent of poverty. Does that make you objectionable to the President's plan?

Mr. POLLACK. No. What the President does——

Mr. BURR. The President's cuts off——

Mr. POLLACK. No, no. No, no. What the President does is very different than this proposal. So let's be——

Mr. BURR. Mr. Pollack, you have not read our plan.

Mr. POLLACK. I have read what you have issued. You do not have a bill.

Mr. BURR. Well, then to make a statement that you just made,——

Mr. POLLACK. Sir, I can only go by what you have released so far.

Mr. BURR. The President subsidizes everybody's premium, correct?

Mr. POLLACK. Correct.

Mr. BURR. He has 150 percent cutoff of poverty on where additional subsidies go.

Mr. POLLACK. That is correct.

Mr. BURR. And if Ms. DeParle is correct that we use, instead of a subsidy to the premium, we use our subsidy to buy down the high risk, and by her statement, our subsidy might be a little bit larger, but we go to the same 150 percent of poverty. We are just using the subsidy not for the premium but to buy down the high risk.

Now where is the difference?

Mr. POLLACK. I think there is a significant difference.

First of all, the subsidy that is provided in effect goes directly to the beneficiary, and so it in effect pays for 50 percent of the cost of that benefit.

Mr. BURR. Long term is more important?

Mr. POLLACK. Pardon me?

Mr. BURR. Ms. DeParle said that predictability was one of the primary objectives, and I think Ms. Davenport, you know, she speaks for the groups that are out there, the human face behind this issue.

Do these people want to know there is a point they could reach in an illness in a given year and not have any financial exposure?

Ms. DAVENPORT-ENNIS. Yes. I am delighted to answer that question. Absolutely the patients that contact us will say often, is there a vehicle for insurance for me that is going to tell me how much I need to pay, how much will be my co-pay, where will my stop loss be, what happens to me if I have cancer or need a heart transplant and have a catastrophic event that I need coverage for, and what is it going to cost me when I am 65, 70, and 75?

I brought with me today two stories of two Americans. One is a woman in Nicholasville, Kentucky, 68 years old. Her total income per month is \$830. She is a widow. She has throat cancer. She needs to take eight maintenance medications for this cancer to keep her in remission. The total cost of that medicine per month is \$600 a month.

She does not have \$600. When she called us to help, she had been 8 months with buying two medicines a month, and each month, she would switch to another two medicines.

And the reality was——

Mr. BURR. And the reality is that Part B probably has gone up because of some medical need in the meantime.

Ms. DAVENPORT-ENNIS. Absolutely. And then what we did was we assisted her in an application process to get her into what is

referred to as SLMB program through Medicaid, which she is now paying a \$45 a month premium for but she can get the medicine and she can have the care.

Mr. BURR. Hopefully, she will have some options that might be less than \$45.

Ms. DAVENPORT-ENNIS. Absolutely.

Mr. BURR. Let me go on to one last thing for you, and that is the issue of self-injectable drugs. I am sure that you have watched HCFA, who had drugs that they reimbursed on, and because technology now allowed those drugs to be self-injectable, HCFA has determined they are no longer reimbursable.

What comfort level would you have with that experience at HCFA, at putting them in charge of determining the coverage determinations of a new prescription drug benefit for 38 million Americans?

Ms. DAVENPORT-ENNIS. I think for our organization, and perhaps we are joined I know by other professional organizations in the country, the physicians and the nurses, we feel that the medical decision has to be made by the physician, by the treating physician. And if the treating physician determines that a medication can be self-administered, is appropriate for that patient, we still want to see a vehicle for reimbursement for that American consumer to have.

Our experience with HCFA, as we have seen program memoranda that have changed from State-to-State and medical director-to-medical director, is one of inconsistency. And inconsistency is a simple word for us to say today but it is not a simple process to reverse when it impacts an entire State at a time when you have to go through process to change it.

So to answer your question summarily, we would be very troubled if we added another area of responsibility to an agency that at this point we feel has very good intentions is overburdened, is understaffed, and we feel the issue of administering a prescription drug benefit program is a complicated program that needs a fresh approach, high energy, and complete attention to the details that will be part of that process.

Mr. BURR. I thank you.

Mr. Chairman, let me also point out, for the purposes of the members because I know Ms. Eshoo and others, we have worked aggressively for a number of years to try to change a policy at HCFA relating to immunosuppressant drugs, drugs that are needed to be taken by every person who gets an organ transplant for their entire life.

Medicare's policy still is that we pay for 3 years. Now we will pay for an additional organ transplant when they reject it because they cannot afford the continuation of the drugs. It is ludicrous for us to believe that we can have example after example after example and not consider a new entity to do nothing but—

Ms. ESHOO. Would the gentleman just yield for a moment?

Mr. BURR. I have no time.

Mr. BILIRAKIS. The gentleman's time has expired and it is now the gentlelady's turn.

Ms. ESHOO. It is now my time. Thank you, Mr. Chairman.



The reason I was asking you to yield was to point out that Congress put what you just described in place as law on the books. And that is why we are trying, as Members of Congress, to change that. But that is not HCFA, okay?

I mean, what is fair is fair.

Mr. BURR. Regarding the injectable drugs, though, you would agree that it was HCFA?

Ms. ESHOO. Exactly. Exactly.

Thank you to every single one of the panelists. I think whether members agree or disagree with different parts of what you have said, I think you are just absolutely terrific.

I think if all of the members of this subcommittee, both sides of aisle, and all of you could stay in this room for the next 48 or 60 hours, we would really come up with something because we have got the expertise here in front of us. So thank you very much.

I want to go to something that I think has been touched on but perhaps members do not have the clearest of understanding about, and that is the whole issue of risk.

Now there are different ideas, i.e., proposals. The Thomas proposal, although it is not in writing, again I spent a lot of time at Ways and Means yesterday listening, and what I believe is the case with the Thomas proposal which will be in legislation is that the risk is assigned to insurers.

Now to Mr. Kahn, you were saying, and I think you have caused some people considerable heartburn, but nonetheless, you have said, look, we will not and cannot design a vehicle freestanding for drug-only insurance.

But the Thomas plan assumes that the risk will be assumed at least partially by insurers.

Can anyone tell me who these insurers are, and how you assign this risk?

And I think that it is an important question. You are touching on some of it, and others have in different ways. Medicare, human beings, are called beneficiaries.

So are they going to assume the risk, are we, as a Nation, through a system going to assume the risk, or is there a vehicle that is going to assume the risk?

Who and what is this vehicle?

So in designing a plan, members, especially of this subcommittee because we have a huge responsibility here, or maybe we do not, maybe it will be ripped out of the subcommittee and just be dragged to the floor, which has happened before too, but I mean I want to be respectful of this.

Who can answer this question for us, not just for me, but for us?

Does anyone want to take a stab at it? Maybe Mr. Kahn should start.

Mr. KAHN. Well if there is a fallback, or if there is a government, a broad program, then the risk is spread and the taxpayers are paying part of it and the beneficiaries, through whatever premiums you charge, are paying the other part, and then they are paying whatever the copayment is, the cost sharing. So that is where the risk is being spread.

Ms. ESHOO. I will just jump in. I mean, it is some advertising for my legislation. We encourage PBMs to bring the price down.

Now, I believe in the Thomas approach, they are required to do that.

Mr. KAHN. You really need to separate the role of the PBMs, they are the mediators.

Ms. ESHOO. Right.

Mr. KAHN. And they can contain the base cost and possibly the growth over time.

Ms. ESHOO. Yes.

Mr. KAHN. I do not want to speak for them but I do not think they are waiting here to accept 100 or even 50 percent of the risk.

Ms. ESHOO. No, they are not. It is not the way they work. That is not why they work well, either.

Mr. KAHN. But the dilemma here is that you have many people who use no drugs and many people who use drugs in a very predictable way because they have a chronic illness or because of their situation.

Ms. ESHOO. Right.

Mr. KAHN. And so those who have a predictable use will want to buy the coverage and those who do not will be less likely to.

Ms. ESHOO. Um-hmm.

Mr. KAHN. So the selection is obvious. So then you have got a product, one product, so you cannot manage across a whole comprehensive benefit package.

Ms. ESHOO. But does everybody understand this answer, though? I do not know if the Members do. But again, what I am trying to do, as you are, each one of you, I guess, is to highlight the areas that we have to be really very concerned about.

Well, there is a vinyl wrap around this thing, and we have got to know what the words mean. I would much rather be up front and say, as a Nation, we are going to assign the risk collectively to ourselves.

And most frankly, Members, if you are not willing to assign dollars to this, then you are not for a prescription drug benefit because you cannot do this on the skinny. You cannot be skinflints and say we are for it. It will not work.

So I do not know if anyone else wants to—Karen, do you want to take a stab at this risk business?

Ms. IGNAGNI. Thank you, Ms. Eshoo. I appreciate the opportunity.

I am not talking about a specific proposal now. We too are looking forward to seeing all the proposals and analyzing them. But just in terms of the issue of risk and how you go forth, one option that has been discussed by a number of members very well on the panel has been the issue of government program risk pooling.

Another way that is often adopted in the private sector and sometimes it works well and sometimes it does not, quite frankly, but there are opportunities I think to build on it, which is the option of risk pooling.

So to the extent you are taking catastrophic costs and aggregating them and trying to distribute those costs across a broad population and subsidizing from that, that is one strategy to think about.

Ms. ESHOO. I know what pooling, and risk-pooling, and that is, but if we are going to design a benefit, I think the question that needs to be answered legislatively is: who takes on the risk?

Ms. IGNAGNI. Well, and I think that is one of the issues that the committee is going to need to zero in on as you look at details of proposals.

However, what we have seen is that there are ways to distribute risk other than one particular approach, and I think that that will be part of the art of crafting the right proposal.

Ms. ESHOO. Or, you know, in cruder language, who is left holding the bag. And so, you know, we will have a revolution in this country if in fact there is something that is designed and marketed to be one thing, and then turns out to be something else. It's all going to come back on us.

Mr. BILIRAKIS. It would not be the first time, though, would it?

Ms. ESHOO. Mr. Chairman, I think probably my time is up—

Mr. BILIRAKIS. Yes, it is.

Ms. ESHOO. [continuing] but I would ask unanimous consent to insert these letters relative to this issue in the record.

Mr. BILIRAKIS. Without objection, that is the case.

Doctor Ganske to—

Ms. ESHOO. Thank you very much. And thank you to all the panelists. I think you are terrific.

[The letters follow:]

ALZA CORPORATION  
June 6, 2000

The Honorable ANNA ESHOO  
205 Cannon House Office Building  
Washington, DC 20015

DEAR ANNA: I was delighted to hear of your newly-introduced plan for a Medicare Drug Benefit. While some of your colleagues in the Congress have done little more than play politics by proposing all sorts of plans that simply can't pass and wrongly cast our industry as the "bad guy," your plan directly addresses both the needs of the uninsured and the necessity to protect pharmaceutical research and development.

We believe that your proposal, by relying on robust competition by pharmaceutical benefit managers, will allow Medicare to offer a generous and realistic drug benefit to American seniors without busting the budget. Your proposal to use the OPM to administer parts of the plan (rather than HCFA) takes due notice of the expertise developed by that agency in administering the PBM-based government employee health plans. Your innovative "stop loss" provision insures that seniors who require oftentimes expensive new biotech technologies will not be left without necessary treatments.

Finally, your explicit exclusion of government-imposed price controls insures that our industry will continue to have the financial resources and investment necessary to bring new and innovative treatments to market in the future.

As with your key roles in FDA reform and passage of the Biomaterials bill, you have once again shown an extraordinary commitment to help our industry save lives, cure disease and end pain. ALZA and the millions of patients we serve thank you.

Sincerely,

ERNEST MARIO,  
Chairman and CEO, ALZA Corporation

GENETECH, INC.  
June 7, 2000

The Honorable ANNA ESHOO  
U.S. House of Representatives  
205 Cannon House Office Building  
Washington, DC 20515

DEAR REPRESENTATIVE ESHOO: On behalf of Genentech, Inc., I am pleased to write in support of your bill, the "Medicare Prescription Drug Security Act of 2000," which guarantees seniors much needed coverage of outpatient prescription drugs. Genentech supports enactment of a Medicare prescription drug benefit this year, and your proposal creates a real opportunity for a bipartisan compromise to be reached on this critical issue.

Specifically, we are encouraged by your proposal's competitive approach to delivering prescription drugs to seniors. By rejecting government price controls and relying instead on competing pharmaceutical benefit managers to negotiate on behalf of seniors, your plan most effectively ensures seniors access to affordable prescription drugs while also preserving and encouraging vital investment in biomedical research. In addition, placing administration of the new drug benefit to the Office of Personnel Management (OPM) is an important step forward in providing Medicare benefits to seniors through a more competitive approach, and away from the bureaucratic approach that has burdened seniors for decades. Finally, the stop-loss benefit included in your proposal is critical to addressing the needs of seniors who require treatments for often serious and life-threatening illnesses.

Your consistent commitment to policies that encourage innovation and the development of new lifesaving technologies has directly benefited the lives of countless patients. We appreciate your leadership and encourage you to continue in your effort to enacting a Medicare prescription drug benefit for seniors this Congress.

Sincerely,

ARTHUR LEVINSON  
Chairman and Chief Executive Officer

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PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION  
June 6, 2000

The Honorable ANNA ESHOO  
United States House of Representatives  
205 Cannon House Office Building  
Washington, DC 20515

DEAR REPRESENTATIVE ESHOO: The Pharmaceutical Care Management Association (PCMA) recently adopted the enclosed Medicare Prescription Drug Policy Statement. PCMA and its members are committed to providing quality, cost effective pharmaceutical care to the Nation's elderly. Within the PCMA Policy Statement are the guiding principles which PCMA and its members believe will advance pharmaceutical care for Medicare beneficiaries, as they have for the over 150 million lives currently receiving prescription drug benefits through PCMA members.

PCMA applauds your leadership in introducing the "Medicare Prescription Drug Act of 2000." This bill represents a major step forward in the Congress' important deliberations on prescription drug benefit for Medicare beneficiaries.

Your proposed bill creates a competitive system, through which drug costs would effectively be managed without unnecessary or burdensome regulation. This bill provides seniors with access to safe, affordable, prescription drugs and improved pharmaceutical care by relying on pharmacy benefit managers (PBMs)—organizations whose proven expertise in managing pharmaceutical care allows seniors to obtain the most drug benefit for their money. It also promises a generous benefit that protects beneficiaries from large out-of-pocket expenditures.

Enacting a prescription drug benefit that relies on competitive principles is in the best interests of Medicare beneficiaries, and should be the first order of business for this Congress. We look forward to working with you and your staff as well as other members who support the role of PBMs in competitive based models.

If you have any questions, please do not hesitate to contact me at (703) 920-8480, ext. 110,

Sincerely,

PATRICK B. DONOHO  
Vice President, Government Affairs and Public Policy

Enclosure: PCMA Medicare Prescription Drug Coverage Policy Statement



*PCMA*  
Policy Statement

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Medicare  
Prescription  
Drug Coverage

## **Medicare Prescription Drug Coverage**

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*The Pharmaceutical Care Management Association (PCMA) supports legislative efforts to ensure that all seniors have access to affordable prescription drugs. Any program developed to provide prescription drugs to seniors should rely on the demonstrated drug management experience of the private sector to operate an efficient and cost effective program. A prescription drug benefit administered by the private sector should be included in any reform of the Medicare system to ensure appropriate drug therapy outcomes for the nation's elderly.*

### **Background**

Since the enactment of the Medicare program in 1965, prescription drugs have come to play an ever more important role in preventing and treating diseases and improving patients' quality of life. The absence of affordable prescription drug coverage for seniors without employer-sponsored retiree coverage has resulted in many seniors not having access to the medicines they need.

PCMA represents managed care pharmacy, pharmacy benefits management companies (PBMs), and their healthcare partners in pharmaceutical care. Active members are organizations that, as a substantial portion of their business, manage pharmacy benefits. PCMA's member firms are an extremely diverse group, including both publicly traded companies and divisions or subsidiaries owned by other healthcare organizations. While many of our members serve broad national populations, some focus on the needs of specific communities, such as patients with HIV/AIDS, organ transplants, or cancer. PCMA members provide a variety of services in managing funded prescription drug benefits including:

- On-line, point-of-sale (POS) adjudication of prescription drug claims;
- A variety of drug interaction screening protocols;
- Monitoring patient adherence with their prescribed prescription drug regimen;
- Establishing pharmacy networks with negotiated prices and managing their performance;
- Delivering pharmacy services through licensed community and/or mail service pharmacies;
- Negotiating discounts with pharmaceutical companies to lower the cost of prescription drugs for health plans and their members;
- Designing and conducting disease management programs;
- Managing high risk patients through case management programs;
- Conducting epidemiological and other outcomes studies;
- Developing and administering physician and patient education programs;
- Developing and managing formularies; and
- Developing physician connectivity with pharmaceutical care to improve efficiency and reduce medication errors.

These programs and services assist in improving pharmaceutical care and containing drug costs. Currently, PBMs manage over 1.8 billion prescriptions annually. A Medicare drug benefit program should build on the innovation and proven experience of the private sector, rather than seek to develop an entirely new structure for this purpose within the public sector.

### **Guiding Principles of Medicare Prescription Drug Coverage**

Although there is a wide variety of approaches to providing prescription drug coverage for senior citizens under Medicare, there are some guiding principles that, if met, would result in better health outcomes for seniors while ensuring a more affordable, innovative, and better managed program.

- **Enhance the health of seniors.** The primary goal of providing prescription drug coverage to Medicare beneficiaries is to enhance the health of seniors through affordable access to prescription drugs. It is essential that the program not simply help pay for the cost of drugs, but also include pharmacy benefit management services to ensure that seniors obtain, and remain compliant with, clinically appropriate and cost

effective drug therapy. The private sector has developed sophisticated technology to protect against drug interactions as well as to identify drugs that may not be safe for use by the elderly. These technological innovations are especially important since many seniors consult with multiple physicians who may be unaware of the drug regimes being prescribed by other physicians. These services must be an integral part of any new benefit.

- **Provide the benefit through the private sector.** Effective prescription benefits have been delivered through private-sector pharmacy benefits managers including insurers, health maintenance organizations, Blue Cross Blue Shield plans, and PBMs. Competition among these organizations is intense. This competition has spurred innovation and the use of advanced technologies for administering drug benefits, resulting in the development of health and disease prevention programs specific to the elderly. A new benefit should embrace and promote competition between these entities.
- **Retain flexibility and cost controls within private sector.** Innovation and creativity in pharmaceutical care has resulted in a number of programs and services that have improved care and managed costs. Prescription drug coverage for Medicare enrollees must permit pharmacy benefits managers to continue this development and use such programs as pharmacy network management, formulary management, mail service pharmacy, disease management, prescription adherence programs, utilization review, provider profiling, and other such programs to manage the benefit. While all of these programs should be held to high standards to protect the public health, the government should not burden these programs with requirements that would undercut their effectiveness.
- **Encourage the continuation of current prescription benefit plans.** In order to encourage employers to continue to provide prescription drug coverage to their retirees, a new prescription benefit should contain financial incentives to compensate employers for, and recognize the financial impact of, their efforts.
- **Protect against catastrophic liability.** Recognizing that many seniors have limited incomes and that significant illnesses can impose significant drug costs in a single year, any new Medicare prescription drug benefit should endeavor to include an out-of-pocket expenditure cap.
- **Administration of the prescription drug benefit.** The goal of any agency overseeing the administration of a prescription drug benefit should be to foster innovation and competition for improving pharmaceutical care and the provision of a cost/effective program. It should not prescribe the details of the prescription drug benefit to avoid freezing in place programs and services that are in effect today, thereby losing the benefits of innovation and improvement which have been hallmark of the pharmacy benefits management industry.

Private sector management and administration of a drug benefit for seniors is the primary test against which PCMA will evaluate all legislative proposals. Support of the various proposals will be based on the legislative authority and flexibility granted PBMs to implement all of their programs to effectively manage costs, foster innovation, and enhance the quality of pharmaceutical care for seniors, while assessing the probability of regulatory limitations on the ability of PBMs to perform this role.

Mr. BILIRAKIS. Dr. Ganske?

Mr. GANSKE. Thank you, Mr. Chairman.

I am having a good time at this. It is much more fun to sit in front of you than behind you at the Ways and Means hearing, to actually face you.

I also think that there is a likelihood that this will probably be the last time this committee looks at this issue. It is my understanding that in Ways and Means on Monday or sometime next week, this issue will be rammed through the committee. Republicans will march lock-step, vote for a bill, and it will come to the floor, and I think that that is unfortunate on this issue.

Because there are a lot of issues in the details that we need to know about. There have been rumors, for instance, that there would be a provision in this bill that would allow private employers to opt out of their current promises on prescription drug benefits for retirees at some "buyout." Who knows what that will be? Who knows how much the taxpayer will be taking on for that provision?

When you talk about a government fall back program, if there are no private programs, would there be a government fall back program if, for instance, a Medicare beneficiary did not like either of the two private plans?

What would that government program be?

How do you compare apples to apples in terms of benefits. We are going over a whole bunch of issues today that need to be answered.

Ms. Ignagni and Mr. Kahn, you will be happy to know that I am not going to ask you any questions about managed care today, patient protection, patient protection at all.

I am not even going to ask you how much the Republican leadership had to lean on you to mute your criticism of the, "plans" as has been reported in the press.

I do however want to address the essential problem which many of you have addressed, and that is that when you look at the current program, and you look at those Medigap policies that do offer prescription drugs as has been so aptly described by Mr. Pollack, because only the beneficiaries that need it sign up for it, who have big expenses, then you end up with very high premiums and this gets to Mr. Kahn's and Ms. Ignagni's point about adverse risk selection.

Now you can cure that by requiring all Medicare beneficiaries to be in the program. However, as Mr. Pollack aptly pointed out, that is very difficult politically.

And we are really looking, I think, at a political logjam on this.

So I want to go to then the other chart that Mr. Pollack pointed out and that was, you know, for that widow living on \$12,500 a year, and my question ties in with the chairman's question.

Now he proposes a block grant which would somehow go back to the State. I propose additional funding to go into expansion of QMBY SLMBY with a spend down.

So for instance, you could go for some specified percentage above those programs so that if a person has additional pharmacy expenses, they deduct that from their income, and then they get into the programs.



And I honestly think then that if you add a prescription drug benefit to those programs, that you will see a much increased participation because seniors will really like it, and that will take care of some of the objections that Mr. Pollack has.

I think that, you know, where we are at this year, I do not see the QMBY program as welfare. I see this as assistance to people who are above the Medicaid program, assistance with their premiums and assistance with their copayments.

Now you could say, well, maybe we should not do anything on that right now because that could take some steam out of a more comprehensive benefit later on. We see that argument frequently with bills on the Hill.

Don't put a little benefit on there because it could prevent overall reform. I think we are going to be facing overall reform regardless.

But I do see that for this widow here, that would be a significant help.

My question to you is this. Okay?

We have been talking about Medicare recipients a lot. This is a very informed group. I think we ought to be looking at the high cost of drugs for everyone.

If you address that issue and you help the QMBY SLMBYs, then you are going to be helping those Medicare beneficiaries who are above them with their prescription drug prices just as you would be helping everyone else with their prescription drug prices.

So my question is this:

What else can we do on this prescription drug cost problem that would help not just Medicare beneficiaries but everyone?

Do you have any suggestions for us on this?

There are some proposals out there in Congress, as you know about. Maybe we could start with Ms. Ignagni.

That is my question.

Ms. IGNAGNI. Thank you, Dr. Ganske.

I will be very quick because I am sure my colleagues want to interact on this question as well.

I think that you have raised a very important point. Remember, and you know well that the increase in expenditures are, roughly, according to the researchers, one-third price, two-thirds use.

What we have tried to do in our managed care programs is create formularies, create a range of strategies to in fact allocate resources as broadly as possible. And what we face in the context of patient protection discussion is a continuous chipping away and sometimes direct assault at many of the strategies that we have used.

And by the way, as we look at the President's proposal, we know he is talking about similar kinds of strategies to get costs under control. So I think both our proposals contemplate that.

We think we can build on that. But you really need to look both at the use side and whether or not there is pressure to go forward with me-too drugs when other drugs can substitute. How do we encourage generics and how do we get our hands around this issue without necessarily and unilaterally agreeing on one solution that is probably going to be limiting in what can ultimately come out of it.

So I think you are right, that this carries over to patient protection and a number of the strategies that have been proposed would do a very good job of continuing to get costs under control, but it would be harder to do.

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

Mr. GANSKE. Mr. Chairman, could we hear from the rest of the panel on that?

Mr. BILIRAKIS. If the rest take that much time, we are, no, I do not think we ought to give the rest of the panel the opportunity.

Mr. GANSKE. Are we going to have another round, Mr. Chairman?

Mr. BILIRAKIS. I am not contemplating another round. We have been here since 10 o'clock this morning.

Mr. GANSKE. Could I have a yes or question or answer on—

Mr. BILIRAKIS. By all means if it is a yes or no question.

Mr. GANSKE. A Yes or no question? Okay, here is my question: Should we repeal the advertising portion of the FDA reform bill?

Mr. KAHN. Yes.

Mr. GANSKE. Mr. Kahn says yes.

Can we go down the line?

Ms. FEDER. Can't comment.

Mr. GANSKE. No answer.

Mr. DONOHO. Don't have a position.

Mr. POLLACK. Yes.

Ms. DAVENPORT-ENNIS. I am not thoroughly versed on the issue so I cannot give you a good answer. I will be happy to get back to you with it.

Mr. GANSKE. Mr. Fuller, did I hear from you?

Ms. FULLER. We have not taken a position.

Mr. GANSKE. Karen?

Ms. IGNAGNI. Our members have not taken a position on this. I think that if you begin to do it in one sector, you are under pressure to do it in others, and the question is, is that the right strategy. But I do not want to preempt our members, they have not taken a position.

Mr. GANSKE. Thank you, Mr. Chairman.

Mr. BILIRAKIS. That was a very good question, by the way.

Mr. GANSKE. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Mr. Stupak?

Mr. STUPAK. Thank you, Mr. Chairman.

In my opening statement, I showed this chart from my district where we have different prices for the same drug with Zocore, whether you are the Federal Supply Service, major wholesaler, chain store independent, average retail, average wholesale price.

Would any of the plans before Congress right now would stop this price discrimination?

Karen?

Ms. IGNAGNI. I do not know the answer to that.

Mr. STUPAK. Mr. Fuller?

Ms. FULLER. I do not think so.

Mr. STUPAK. Mr. Kahn?

Mr. KAHN. No, they would not stop it but they would get some people better prices.

Mr. STUPAK. Okay. Dr. Feder?

Ms. FEDER. They would provide—the President’s plan, for example, would provide people for a specified premium, subsidized premium, drugs they could count on with known cost sharing. It would be very different from that situation.

Mr. STUPAK. Mr. Donoho?

Mr. DONOHO. I think my colleague, Chip Kahn, said it best; no, it will just change the market in terms of who is available to which price.

Mr. STUPAK. Mr. Pollack?

Mr. POLLACK. The administration’s plan would do a great deal to reduce those disparities.

Mr. STUPAK. Ms. Davenport-Ennis?

Ms. DAVENPORT-ENNIS. Yes. And because once again we have not had an opportunity to review all the plans, our constituents have not taken a position.

Mr. STUPAK. So the only way to get these prices down to get them somewhat reasonable so we do not have 134 percent difference is who has really the clout at the table, so to speak, when they negotiate on behalf of uninsured seniors? Right, basically?

Ms. DAVENPORT-ENNIS. Yes.

Mr. STUPAK. Yes, yes?

Ms. DAVENPORT-ENNIS. That is a very big factor.

Mr. STUPAK. Okay. Let me ask a more specific question then to Dr. Feder.

AAHP testified that many seniors who would not otherwise have access to drug coverage, either because they do not have retiree coverage or drugs, they just cannot afford them, cannot buy them, so if they cannot afford a Medigap policy that covers drugs, are able to get drug benefits through their Medicare+Choice plan, couldn’t we use that model as a way to get drug coverage to all seniors?

There has been some instability in that Medicare+Choice market, but couldn’t we provide extra funding so that more plans could get back to the market and provide drugs?

Ms. FEDER. I think we certainly can provide, through Medicare and through Medicare+Choice plans, we can provide prescription drug coverage. But the way to do that is to incorporate it into the core benefit of Medicare and then have the plans offer that benefit.

The way we are doing it now, and if I am hearing you correctly, just put some extra money in the plans, it is available in some places and not available in others.

Mr. STUPAK. With that in mind. But it sounded like the——

Ms. FEDER. Correct. In some places——

Mr. STUPAK. [continuing] like it worked.

Ms. FEDER. [continuing] but it is a function of where the plans find that given a given level of payment, they can profitably offer that benefit.

And as we have worked over the last several years to constrain Medicare costs and eliminate the deficit, we have constrained both fee-for-service and Medicare+Choice payments and we are finding that there is not as much room in this extra payment to offer this benefit.

It is not the way to do it because it does not guarantee the availability of that benefit every place. It should not rest on whether a

plan wants to be there, whether they find it profitable. That is not the way to do it.

Mr. STUPAK. Karen?

Ms. IGNAGNI. I appreciate the question, and I believe we have a track record that can be built on and with additional resources, that is a major start at moving in this direction.

But I do not want to mislead you about the need for additional resources now on the basic side before we get to additional. But it is a model that can be built on.

Mr. STUPAK. I do not totally reject the model, and if we had some more resources maybe we can get there, but how do you overcome what I see—and maybe I am using the wrong words—instability in the private market insurance? I still see a cherry picking going on.

In my district, they probably do not even offer it. I am sure if I was 70 years old and I started having a battle with cancer, I am sure I am going to be dropped because I get too expensive.

Ms. IGNAGNI. Well actually, Mr. Stupak, as you know, one of the accomplishments of our programs actually is to do a better job managing chronic illness.

The existence of prescription drugs in most of the Medicare+Choice programs has actually recruited in not only the lower income, and the HCFA data confirmed that absolutely, but the people with the highest health care costs, because of our ability to coordinate their care and offer them more and that is I think a model that can in fact be built on.

And in the rural areas is one of the major barriers—our health plans would very much like to serve the rural community—has been the unwillingness of single health care systems who do not have any competition to actually contract with our plans. So we need to talk about that as we think about going forward.

We would love to be participating in your area and other areas where we have not had the opportunity.

Mr. STUPAK. Did you want to add something further, Dr. Feder?

Ms. FEDER. Just that I think it is critical that if you do not define the benefit, you are leaving too much discretion to plans. What you need to do is define the benefit and then have a payment mechanism that plans can know what it is that they are supposed to bid on or offer and proceed that way.

Ms. IGNAGNI. And we would agree with that. We agree with the defined benefit for purposes of bidding.

Mr. KAHN. And it is also important to point out that the pharmaceutical benefits that are generally offered now by health plans under Medicare+Choice are not as generous as all these different plans anticipate. So there has got to be more funding to get those drugs at a level that these different bills anticipate.

Mr. STUPAK. So we have got to have someone with clout negotiating and we have got to have a defined plan, if that is what I am hearing you say.

Mr. KAHN. The plans can do the negotiation or work through PBMs. The question is the money.

Mr. STUPAK. Okay.

Ms. FEDER. And the defined benefit, as you said.

Mr. STUPAK. Defined benefit, yes, you have got to have a defined benefit.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Bryant?

Mr. BRYANT. Thank you, Mr. Chairman, and panel, it has been a long day so far.

Mr. BILIRAKIS. Amen.

Mr. BRYANT. Let me just take you back on a couple of questions my friend from Michigan led us into.

Mr. Donoho, you have been quiet here for awhile. Let me ask you a question directly.

In your statement, you indicate that the drug benefit should be administered through the private sector, and also that competition among private sector PBMs would deliver significant cost savings and spur innovation.

In light of this issue of the cost that we have been talking about, the high cost of drugs, would you expand on your statement?

Mr. DONOHO. Well it has been our experience in the private sector anyway that the competition has spurred the cost savings. If you talk about decisions directly, let's take on drug costs, it is the competition within a PBM in terms of formulary development, after you have done your P&T analysis, you have looked at, you have covered all your classes of product and you find out that there are two competing products in the marketplace today, then you can go back and get a reduced reimbursement.

The question I think in my opening statement was, has the Federal Government, our concern in terms of the Federal Government operating a program is the fact of do they have the will to put that kind of hard decision on the table?

Because the hard decision on the table then is to say to somebody, listen, this product—if you have competing plans—you can have choice. But if you have the hard decision of saying I am not going to cover this particular product, and then you have got no choice to seniors, then you have got a different kind of kettle of fish.

And you have got to have a prior authorization like our plans do. But the question then becomes, and that is the way you get leverage to negotiate. It is not based on volume.

Let me make sure that you understand that. It is based on market share. If you can move market share for drug manufacturers, they will negotiate on price. That has been our experience.

Mr. BRYANT. Okay, thank you.

Let me jump to another issue very quickly in terms of those of us that, in this whole concept, are also concerned with consumer protections.

The bipartisan bill that we are talking about today primarily, would indicate that in that for the first time we create an Office of Beneficiary Assistance within this MBA, this outside of HCFA agency that will administer this, it is an Office of Beneficiary Assistance. And its purpose is to provide educational materials to the beneficiaries about the entire Medicare program.

And within the Office of Beneficiary Assistance, there will be a Medicare ombudsman whose sole purpose is to assist beneficiaries when they are having trouble with claims and appeals, getting access to care, and generally need help or answers to questions.

Such a one-stop central Beneficiary Assistance-oriented office does not currently exist within the HCFA. And for those reasons, I think again, particularly the panelists on the end that are from citizens groups and family groups and so forth, that also should be of interest there.

Ms. Ignagni, on the end, a question.

I think we have talked about this a little bit, but let me clearly get your response to this in terms of the criticism of this bipartisan bill in building in flexibility that would allow health plans to provide a standard benefit or a benefit that has an actuarial equivalent.

That criticism is that that would encourage health plans to develop proposals only to attract the healthy beneficiaries, cherry picking. How do you respond to that particular issue?

Ms. IGNAGNI. Well first of all I think as I understand the proposal, and I appreciate the question, it is to have a floor benefit. There would be a clearly set out benefit.

The concept of actuarial equivalence would then allow us to do better than the floor, which is what we do now in Medicare+Choice, as you know.

We have a floor set of Medicare benefits. We meet that floor. But because we are more efficient at disease management, coordination of care, et cetera, we can, for the same dollar value, offer beneficiaries more, which is why it is such a travesty that 3 weeks before the date in which we have to notify HCFA of what plans will be forced out of this program who are serving 6.2 million people, that we are not moving to do something about that.

And we have taken heart that this committee in fact has made that a major part of its agenda over the years. So the idea that actuarial equivalence would somehow mean that there would be no baseline benefit is not something that I understand this proposal before you—and we are all looking for the details—to be.

So I think what we all are saying on this panel is that we agree with the concept of a floor. That is where you start. We in the health plan community can do better than that.

For beneficiaries, we would like to be able to be given the opportunity to do better than that for beneficiaries.

Mr. BRYANT. Just following up on that, I am curious if you have an opinion about our move from the administration of this from HCFA over to an outside agency that we establish. Do you think this would help health plans participating in the Medicare+Choice—

Ms. IGNAGNI. Two-and-a-half years ago—

Mr. BRYANT. [continuing] of this on Medicare+Choice, as you know.

Ms. IGNAGNI. Two-and-a-half years ago there was a reorganization at HCFA which I believe, based on what we have seen from the Administrator recently, is an acknowledgment of what much of what our members have said for 2½ years, that that reorganization has not worked.

The Administrator, herself, and to her credit, has begun to a] recognize it, and b] put in place some strategies to respond to that.

The concept here is whether you set up a new agency within HHS or whether you aggregate the responsibilities of HCFA differently.

We have to do things differently than the way we are doing it now. We have instability. We have no predictability with respect to the regulatory environment. We have 900 pages of regulatory compliance that we started with. But then virtually every 2 weeks there has been a policy letter with which we have to comply with.

And I am pleased that the Administrator has recognized this. She is moving in a particular direction. I think there are many options. And for us the most important thing is to aggregate these responsibilities and somehow make progress on the conflict within HCFA which is purchaser/regulator /competitor. How are we going to sort that out?

There was a model that worked well in the past. We are beginning to go back to that model. I think that is a very big and important step forward.

Mr. BRYANT. I thank the panel and yield back.

Mr. BILIRAKIS. Mr. Barrett, the current Ranking Member, to inquire.

Mr. BARRETT. Thank you, Mr. Chairman.

Mr. Kahn, notwithstanding the red tinge in your beard, I do not think of you as a flaming radical.

And it strikes me almost as counterintuitive that you are here today representing the insurance industry, and yet telling us that your industry feels that this approach that is being advanced has some problems to it.

And it strikes me as, again, just odd, although I must admit that my feelings run the same way.

Can you talk a little bit more, just about the adverse selection issue you see out there that I have got to believe you think is a fatal flaw to this proposal, or you would not be so up front about it.

Mr. KAHN. Let me say that I believe that in the case of drug-only policies and the fact that 35 percent of Medicare beneficiaries have no coverage and another number have sort of mixed coverage, you would assume that if this was a good product, it would be there. And it is not.

I mean there are not companies seeking to do it. And actually those companies that have supplemental policies, the HI&J, a lot of companies have left that and there are a few companies left in it, but they are not enthusiastic about that coverage because they end up paying actually there the highest prices just like the beneficiaries who have no coverage.

But I think part of the adverse selection issue goes down to this—that you have got some people that do not use any drugs, a very large number that use between \$500 and \$2500 worth of drugs which can be significant on somebody's budget, particularly if you are just living on Social Security or a little bit extra above Social Security, but at the same time that is not enough money to call it catastrophic.

And the fact is only 4 percent of expenditures for drugs is over 4 percent.

Actually, one of the interesting things here for the elderly is that drugs are different from all other kinds of health expenditures.

In all the areas of health, when you look at the total, most of the spending is done by few people. The trouble with drugs is it is done by many people and it is frequently predictable, and that is why we do not think you could sell an affordable policy.

At the same time, there is another factor, and I will just take—I wish I had copies of this chart to pass around—the HCFA actuaries projected drug costs in March 1999, and they thought that by 2007 they would grow to about \$170 billion.

Six months later they decided, no, they were wrong. Looking at the market, you know, seven or 8 years out, they would be at \$223 billion.

Now the point I make is that when an actuary looks at numbers like that, and that kind of volatility, you know, if he is stuck or she is stuck with the recommendation for a premium you know, on 399, and an insurance commissioner or whoever says that is the premium, then when they go back and say, well, wait a second, we miscalculated because there is a new report now that says, you know, 6 months later, that we were wrong, they are going to be stuck. And that is how the actuaries look at this.

I mean, this is just not an individual benefit that we can provide insurance for.

Mr. BARRETT. Ms. Davenport-Ennis talked about your patients or your clients and say a person with cancer or a person with a disability, I am going to ask each of you just a yes or no question.

Do you think that there is a private insurance company out there that would sell a drug-only policy to a person with cancer and that person say at 200 percent of poverty, could afford it?

Ms. Ignagni?

Ms. IGNAGNI. Our plans would do it in the context of Medicare+Choice.

Mr. BARRETT. No, that was not my question. My question was a drug-only policy.

Ms. IGNAGNI. It depends what the rules are.

Mr. BARRETT. What do you mean it depends what the rules are?

Ms. IGNAGNI. Well we have not seen the proposal. We are looking forward to seeing the proposal.

Mr. BARRETT. Okay, but I think we understand what we are talking about here. It would be a private company.

Ms. IGNAGNI. Let me give you an example.

Mr. BARRETT. I do not want an example.

Ms. IGNAGNI. Okay. Well, if you want to understand the answer, I need to give you an example.

Mr. BARRETT. I will go on to Mr. Fuller.

Mr. Fuller?

Ms. FULLER. I mean I really have to yield to the people of the insurance. I do not, I do not know.

Mr. BARRETT. Intuitively, what do you think? You are a businessman.

Mr. FULLER. Doubtful.

Mr. BARRETT. Doubtful.

Mr. FULLER. I cannot speak for all companies, but at least my own, I doubt the would offer the policy in the first place.



Mr. BARRETT. Dr. Feder?

Ms. FEDER. I would defer to Chip Kahn.

Mr. BARRETT. Okay. That is the last time we will ever see that.

Mr. KAHN. I would not know how to answer that question. I do not know.

Mr. BARRETT. Well intuitively, as a businessman, would you sell this product? Do you think you could make money selling a drug-only insurance policy to a 68-year-old woman making \$20,000 a year who has breast cancer?

Mr. KAHN. Intuitively, maybe, but probably not.

Mr. BARRETT. Mr. Pollack?

Mr. POLLACK. It may be possible. I would not take the odds with me to Las Vegas.

Ms. DAVENPORT-ENNIS. And I guess that as a 10-year survivor and one who does not have to take medications to deal with my former diagnosis, I would not be able to answer you as a specialist. I would only be able to say that if you bet the odds on me, you would have done all right in selling the policy. But I cannot answer the question for the community.

Mr. KAHN. Mr. Barrett, excuse me, but I really think you asked the wrong question. Because the question is, are there enough people who are well but concerned that they might have a risk that would buy the policy so that you could sell it to the 68-year-old who already has—

Mr. BARRETT. But why would I buy the policy if I were well?

Ms. IGNAGNI. Because you are at risk.

Mr. KAHN. Because in our society, people buy insurance every day for a lot of reasons. And my point is that if you could get enough people to buy insurance in this case, you could insure the risk. Our concern is that those people who are well now, because of the cost and the payoff year, are not likely to buy it.

Mr. GANSKE. Would the gentleman yield?

Mr. BARRETT. I know my time has run out, but let me follow up on that then. If this bill became law tomorrow, a 40-year-old man, 40-year-old woman, would they buy this policy? Of course not. Of course not.

Mr. KAHN. I would say a 65-year-old who was perfectly well would probably not buy it. And that is the problem.

Mr. GANSKE. Would the chairman entertain a question, the Acting Chairman?

Mr. BURR [presiding]. The Chair would recognize the gentleman for 1 minute.

Mr. GANSKE. Thank you. Maybe the Chair could help us on this, because this is one of the details of the plan that we do not know about. And that is will everybody, when they turn 65, be given one chance to enter this, or will you have an annual chance to get into this program?

Because most people, if they have an annual chance, and they have no prescription costs, will not but they may think well, maybe I will need some prescription drugs in September or August. I can just eat those costs until January 1 comes up, and then, since I need the drugs, then I will get into the plan.

Can the Chair answer my question? Is there an annual up for this or is this a one-time offer—

Mr. BURR. Well the Chair—

Mr. GANSKE. [continuing] or is this a detail being worked out?

Mr. BURR. The Chair is not on today's panel but I would be happy to turn that over to Mr. Kahn.

Mr. KAHN. I have not seen the bill. This is an important question. I mean—

Mr. BURR. It is an important question, and the gentleman's time has expired.

Mr. BARRETT. Thank you, Mr. Chairman.

Mr. BURR. The Chair would announce to the members that we are going to do a second round.

Has the gentleman from Ohio gone yet?

Mr. STRICKLAND. No, I have not.

Mr. BURR. Then the Chair would recognize Mr. Strickland for 5 minutes. I apologize.

Mr. STRICKLAND. Thank you.

This is a fascinating hearing. I am glad we are having it and I think if we have kept our eyes open and our ears open and listened, we have probably learned a lot.

I would just like to say, Mr. Fuller, you make a statement in your testimony that you think the highly efficient community pharmacy infrastructure needs to be protected and I feel the same way.

Are you familiar, sir, with Mr. Allen's bill? And if so, would you tell me what you think of that bill and why you either think it is a good idea or bad idea?

Ms. FULLER. First, I thank you for sharing the concern about community pharmacy, and I also appreciate the comment that Mr. Burr made earlier that some of the provisions that we have talked about are in fact being incorporated into the—excuse me, that the chairman made earlier—are in fact being incorporated into the legislation.

I am familiar with the Allen bill. I probably am not going to satisfy you. We have not taken a position on it. Our companies have not taken a position on it. We are concerned about a number of elements in it.

Any kind of price control mechanism philosophically is of concern to us, no matter who it applies to, because it at some point is going to trickle down to the pharmacy and be enforced. So we are concerned about that. We have not taken a position on it though.

Mr. STRICKLAND. Okay, thank you.

I continuously hear comments from seniors who are concerned about the cost and I think the cost is something that we ought to be concerned about as well.

And we know that, as Mr. Pollack has said in his testimony, that tax dollars are used to promote research, and that research leads to new pharmaceuticals, and those pharmaceuticals are sold to consumers, to American consumers and to foreign consumers.

And I do not think there is any really debate about the fact that foreign consumers of pharmaceutical medications pay significantly less than American consumers.

And you are here because you are experts, and I would just like your personal opinion. You do not have to even speak for the agency or association or university you are with, but I would like your personal opinion:

Do you think the government should be concerned about that and should try to find some way to keep American consumers from experiencing this kind of price discrimination, given the fact that so many of these pharmaceuticals are developed with American tax dollars in part.

Ms. IGNAGNI. I do, Mr. Strickland, and I think that there are other ways, however, in addition to price controls, that one can get at that issue.

Mr. STRICKLAND. Okay.

Ms. FULLER. I think we have to be concerned about it, and certainly we are seeing seniors every day that are going across the border to get drugs. There's proposals to allow drugs to be purchased internationally and brought here. There are concerns there.

So I think it is going to have to be examined pretty carefully. I would add that there are also very noticeable differences in the availability of certain drugs and medicines, both generic as well as branded drugs in these countries that control prices. And so there are some offsets here that you would also have to take into consideration when you look at the overall issue.

Mr. STRICKLAND. Okay. Mr. Kahn?

Mr. KAHN. I think there needs to be a complete reevaluation—I am not an expert in trade law—but of our trade law because it would be good to put some pressure on the rest of the world. Because it does not make any sense for us to pay the basic price and everybody else to pay the price at the margin.

Ms. FEDER. I guess I would look at it from the opposite perspective. I think the reason it is this way is because everybody else in the world provides everybody in their country health insurance and decides what essentially they are willing to pay. And we do not do that in this country. There are many ways for us to consider beginning to lower what we are willing to pay and I think that is what we ought to be doing.

Mr. DONOHO. I think we have to be concerned about price controls and, being an American, I think I would turn around and say maybe we should look at designing a system to take better advantage of competition within the system.

And if you look at what we have done in price controls to date, like in Title 19, Medicaid, what has the impact been on like our people's business, since you have a best price, can we negotiate down below best price without impact on the Medicaid program?

I mean, we have got competition in the market. How do you design a system to take advantage of that competition, I think is the answer we would give.

Mr. POLLACK. Mr. Strickland, I would say that we need to do something not just because there are inequities from one country to another. This is an affordability crisis for a lot of people, and that is why we need to do something.

I do not think we need price controls. I think we need to give the Medicare Program the same kind of leveraging authority that other institutions have. Hospitals, HMOs, others, they use their leveraging authority to get prices down. We should do the same thing for seniors through the Medicare program.

Ms. DAVENPORT-ENNIS. And certainly I would agree that for our constituents there is not a patient that we deal with when we get

into debt crisis resolution as a result of their diagnosis that the cost of all health care does not become problematic for them, including the costs of pharmaceutical agents.

As we look at many discussions in which we talk about what the pharmaceutical agents are sold for abroad, what they are sold for in America, there are three conclusions that we come back to routinely.

Why is that happening? What are the pressures that we can put in place in this country to look thoughtfully at why is there such a wide variation from this country to another country?

And what can we do to empower the individual consumer in America, and particularly the senior consumer, to negotiate for the most attractive prices available to them in purchasing the agents that they need.

We are not a part of the pricing structure for the pharmaceutical industry, therefore we do not have any concept of how those figures are originally introduced to the market. And I think, as a fair piece of the evaluation, that that would also have to be looked at as a Nation.

Mr. STRICKLAND. Mr. Chairman, can I make a concluding sentence?

Mr. BURR. The gentleman may.

Mr. STRICKLAND. We hear about the world economy and the fact that we are a part of it, but as long as other nations have controls and our Nation does not have some control, it is inevitable, it seems to me, that the American consumer is going to subsidize the foreign consumer.

Thank you.

Mr. BURR. The gentleman's time has expired.

The Chair would recognize the gentleman from Iowa, Dr. Ganske for 5 minutes.

Mr. GANSKE. Thank you, Mr. Chairman.

I want to try to get a handle on the Medicare HMOs. So Ms. Ignagni, you can help me on this because there have been a lot of reports about the Medicare HMOs dropping out of the market because you have not received a large enough update increase.

Are we seeing Medicare HMOs drop out of markets where their AAPCC is say above 450?

Ms. IGNAGNI. We have. And we may, as July 1 approaches. And I think that one of the things that we are working very hard on and are looking forward to working with this committee on is trying to avoid that, stabilizing this program, and continuing to allow this to be a choice for people because they can receive so many benefits. These are people on very fixed incomes with limited means.

Mr. GANSKE. And this is even despite the fact that Medicare HMOs are increasing their deductibles and copayments for their prescription drug coverage?

Ms. IGNAGNI. Yes, sir.

Mr. GANSKE. Now just so everyone is clear, a Medicare HMO is paid on a monthly basis per enrollee an amount determined by a formula called the AAPCC, adjusted per capita cost something. How much additional funds do you need for a prescription benefit, do you think, for your Medicare HMOs to continue to be able to offer prescription drug coverage?

Ms. IGNAGNI. First of all, sir, I think the first thing we need is to stabilize the program before we get to additional benefits. There is a great deal of unfinished business to fulfill that promise that was made to people in 1997 that they would have a choice.

One of the most effective strategies there is to impose a safety net so that the purchasing power of the Medicare+Choice capitation or reimbursement to the plan is actually keeping pace with what the costs of purchasing health care from the academic teaching centers, from the physicians in that community, et cetera, are.

What we have is a major problem because we have lost that relationship.

Mr. GANSKE. So you would like to see an increase across the board?

Ms. IGNAGNI. Across the board.

Mr. GANSKE. Across the board. So for instance, there are some counties where the payment for a senior citizen could be as much as \$750. What you are saying is that in order to stabilize your drug benefit programs, even for those in those areas, they need a higher increase in their adjustment?

Ms. IGNAGNI. Yes.

Mr. GANSKE. Is that right?

Ms. IGNAGNI. Yes. Well yes and no.

One, No. 1, we have to stabilize those programs across the country and there are a range of strategies to do that. We have to deal with the particular problems of the blend counties making sure that that is funded irrespective of what happens on budget neutrality, et cetera, No. 1.

The floor issue, No. 2. We have to have a better risk adjustment system than we do now. The one we have on the table does not work, is not encouraging disease management or the kinds of strategies we have employed so well.

Once you do that—and that can be done and it can be done this year—

Mr. GANSKE. But you are telling me—

Ms. IGNAGNI. Once you do that, then you need to do something additional for the prescription drug question.

Mr. GANSKE. You are telling me though that you are seeing Medicare HMOs drop out of AAPCC areas that are significantly above \$450.

And we heard in Ways and Means yesterday that they are talking about raising the AAPCC to a floor of \$475. Now that is only about \$50 higher than what it currently is in Des Moines, Iowa where there really are not any plans being offered.

How high would you have to get that AAPCC to see HMOs move into more rural areas where there have been lower AAPCCs, because we know in the rural areas we have a disproportionately number of very elderly that have a higher percentage of prescription drug costs—

Ms. IGNAGNI. Yes. That's right.

Mr. GANSKE. [continuing] than in some of the more urban areas. I mean, do you have any ideas what levels we would be looking at?

Ms. IGNAGNI. I do, actually. I think it has, in many cases, Dr. Ganske, and I know that you know this because we have had some

discussions about it, that this issue about presence of Medicare+Choice in rural areas, in many cases has little to do with payment.

It has much more to do with whether a provider system, often with no competition, is actually willing to negotiate with a health plan.

In a number of situations, because there is not a competition in the market in the provider community, individual systems are unwilling to contract.

Mr. GANSKE. I understand there are other factors that enter into it.

Ms. IGNAGNI. Yes.

Mr. GANSKE. But it would appear to me that on the face that one would have to significantly increase that floor above what I hear is currently being proposed. I think you are looking at something more in the range of \$600 or \$650.

Ms. IGNAGNI. I think if we think that the way to solve the Medicare+Choice systemic challenge now is to only increase the payment in rural areas, then I think we are kidding ourselves. And I think we will let a number of beneficiaries down.

There is more that needs to be done, and I would be happy to spend some time with you on some of the specifics because what I am excited about is people are beginning to talk very specifically about that.

Mr. GANSKE. Yesterday—

Mr. BURR. The gentleman's—

Mr. GANSKE. One additional question?

Mr. BURR. Very quickly.

Mr. GANSKE. Yesterday, Mr. McDermott asked Chairman Thomas a question about well, you know, if studies have shown that payments to Medicare HMOs have actually cost more than what they would have, and you are familiar with some of those studies, why is it that Republicans want to move all Medicare beneficiaries into HMOs?

And Mr. Thomas said this, and I would like your response to this. He said:

Well, that only tells half the story. In other words, he agreed with the initial premise, and then he said, we would like to see competitive HMOs.

Is it your position that you would like to see the majority of Medicare beneficiaries in Medicare HMOs?

Ms. IGNAGNI. I think that we offer opportunities for Medicare beneficiaries. Right now, in the here-and-now, and I could not responsibly answer any other way, we have to build capacity to accommodate all beneficiaries. So I do not want to mislead you about that, so I would not make that promise.

But what I can actually tell you is the systems that we have have done a better job in managing the chronic care challenges of people who are over 65, and the literature is beginning now to support that.

So we have coordinated care. We have early intervention. But what we have done is created a promise that has not been funded. So we need to do the second step, which is to fund the promise so that more and more seniors can take advantage.

And there is no lack of interest. There is a great deal of interest. But now, because plans have been forced out, seniors in fact are faced with situations where, in many markets, there is not a plan or likely to be no plan in the future. And that is not what we promised in 1997, and that is not what people indicated they wanted.

We have the highest degree of satisfaction in the Medicare population in our health plans because of the comprehensiveness and the breadth of the intervention here. And we want to be able to partner with the best physicians and best facilities around the country to continue to do this job.

Mr. GANSKE. You are an effective spokeswoman. I would point out that sometimes patients, when they get sick, decide to leave Medicare HMOs and then go into fee-for-service, and there may be some adverse risk selection.

But I appreciate the Chair's indulgence.

Mr. BURR. I thank the gentleman for his question.

The Chair would recognize Mr. Deutsch.

Mr. DEUTSCH. Thank you, Mr. Chairman.

Ms. Ignagni, if I could follow up a little bit on some of the questions that Dr. Ganske was talking about, from your perspective why is it important to stabilize the Medicare+Choice program if we are going to eventually have a prescription drug coverage for all Medicare beneficiaries, even who are not in Medicare HMOs?

Ms. IGNAGNI. Because I think we can build on this model and we can do better.

So to the extent that you establish a floor benefit package, that however you construct the proposal, whether you look at the bipartisan proposal and where everyone's looking for the details, and we are looking for them as well and we will be looking to analyze them, or the President's proposal or the Democrat's proposal that we have seen thus far, I think there is a broad scale recognition that once you establish a floor, because of the nature of coordinated care systems, we can do more for seniors, and we are looking forward to doing that.

But we cannot build on that track record unless we stabilize the existing program.

Mr. DEUTSCH. You know, it is interesting. In my district, I have both an urban setting, a traditional health care urban setting, and as you are aware also, Monroe County, the Keys is actually technically a rural health system because Monroe Key West, the closest regional hospital, is over 100 miles away.

The only HMO service in Monroe County has left. And so you have a phenomenon for 80,000 people in my district, 20,000 plus Medicare beneficiaries, who if they have high prescription drugs, have no choice, have no option.

Where in the urban part of my district, even though some people have left the market, there is still a competitive HMO market.

And in fact, one of the phenomenon is people using fake addresses to actually get prescription drug coverage because they cannot get HMO coverage. And the only way they can get the prescription drug coverage is by using a neighbor, a friend, a relative's address in a county that has an HMO that services—which is illegal, and I do not know the enforcement side of it or how much enforcement is going on, but it sort of talks about the problem.

In terms of just seeing how many people join HMOs because of that need, do you have any feel or any empirical data in terms of that marking tool, that coverage for prescription drugs, what does it mean?

Ms. IGNAGNI. Yes. We know that a number of beneficiaries have joined our plans because of the existence of prescription drugs. So the tenor of your question is absolutely right.

However, we also know, and I think the next point is not often recognized or not recognized enough, that people on fixed incomes value the cost containment protection, No. 1, the cost sharing protection, I am sorry.

The second is that they value, an element of what we provide is this notion of catastrophic coverage which, as we have heard this morning, was embarked upon in the traditional Medicare program, and then ultimately that was repealed.

We continue to offer not only cost-sharing protection, but catastrophic coverage and that is a very, very strong value for individuals on a limited income.

Mr. DEUTSCH. Let me, I guess—because we had our 5 minutes on an introduction—really sort of follow up and it is really not a question, but it may be a rhetorical question—but I think one of the interesting things about prescription drug coverage, and it is really sort of fascinating talking to constituents, not just Medicare constituents but people whose parents are on Medicare, but also I think what is also really interesting is talking to physicians who are not participating in HMOs. How supportive they are of prescription drug coverage.

Because I think physicians who I have talked to literally see people leaving their practice because of HMO coverage because they have someone who is a middle class senior who is spending \$500 a month on prescriptions, and that person, even though they do not want to leave their cardiologist there, whoever, effectively do not have a choice and have to join an HMO to get the prescription drug coverage.

And they know that if there was prescription drug coverage under Medicare, that is a person who they see, who they talk to, who they know is a patient who would not leave.

And it is kind of a strange phenomena. You know, if anything, we keep trying to shift this pendulum where it is an even choice, where consumers really have a choice and it is level. And in some cases, maybe the incentive to join an HMO has gotten too high. The reimbursement might have been too high. The extra benefits, health care benefits, everything else, might be too much, and then we have leveled it, and maybe now it is the other way. So this can kind of level back.

And one of the interesting things I guess that maybe you can share as well, and if anyone else on the panel, let me just open this up as well to anyone else who wants to respond, but one of the issues that we have talked about in prescription drugs is the actual potential cost savings of providing prescription drug coverage.

Because avoiding adverse health consequences because people do not take it, from the HMO perspective, where you are basically indemnifying the person, do you have empirical evidence to sort of talk about your savings—



Ms. IGNAGNI. Yes.

Mr. DEUTSCH. [continuing] about people getting the drugs regardless of their costs which is effectively the way the HMOs can do that.

Ms. IGNAGNI. Yes. Because the existence of prescription drugs allows us to do the early intervention to prevent the catastrophic illness down the road. There is no question about that.

Mr. DEUTSCH. Does anyone else want to respond to that?

Mr. DONOHO. To give you a real life example, one of the issues with the elderly is hypertension. If you look at hypertension in a managed benefit, hypertension compliance is about—on noncompliance is about 49 percent.

If you look at that, about a third of them—this is a study done by one of our members—if you look, a third of those require hospitalization. The average hospitalization is at \$15,000 a year.

So if you can increase compliance, if you can maintain people on hypertension, look at the money that you are saving. It is just one simple study.

Mr. KAHN. I guess I think that we are looking at Medicare from the standpoint of drugs because of the discussion today. And I think that you tend to get a little bit perverted.

I think from the standpoint of the beneficiary, you are describing how they join HMOs because in a sense they get a deal and that is why they give up fee-for-service.

I think we have to—and I cannot say it is this year or next year—but there is a point in the future where in a sense Medicare+Choice is not the problem, fee-for-service Medicare is the problem. Because whether it is home health, skilled nursing facilities, out-patient hospital department, I spent 13 years working on payment policy and I can tell you, it is about over.

The way HCFA applies the rules that Congress passed is such that it is going to be very hard for the infrastructure through this old fee-for-service system to be sustained.

And I do not know what the crisis is in—you know, obviously in the skilled nursing facility area you can make the argument that there are a lot of people that came in and abused Medicare for years, a lot of providers, and, you know, you can see what the stock market is doing to them today. You know, half of them are in bankruptcy.

But the point is that from an infrastructure standpoint to serve the beneficiary, I think that the fee-for-service system is extremely sick, and that if we let the managed care infrastructure fade, which it is about to do, I think we are going to have some real organizational problems in terms of getting services to beneficiaries.

And this is a serious problem. There are a lot of physicians now that do not like to take fee-for-service Medicare because of the way Medicare pays.

Ms. FEDER. Mr. Deutsch, I cannot let that one stand. I deferred onto to Chip. I cannot do it again.

It seems to me that there is an on-going issue in managing the Medicare program which I think is intrinsic to managing a health insurance program which is trying to balance what we want to pay and the access to quality care that we desire.

And it is true that in the last few years, we have adopted some new prospective payment systems that need work, and I think will continue to need work, but to say that the fee-for-service system is sick when it continues to guarantee millions of Medicare beneficiaries access to care and has simultaneously been able to slow its cost growth so that we have extended the life of the trust fund to 2025, does not make any sense to me.

I think, on the contrary, it really is that there were claims made for managed care and what it could deliver and I do not think we have seen delivery on those claims of performance.

My view is that we should not have a situation, as I said before to Mr. Stupak, when you talk about having a level playing field, we need that core benefit, and we need to have people not moving in and out of fee-for-service and managed care because they can get extra benefits one place and not another.

We need to have a core benefit, make it a reasonable price or a reasonable system of paying for that core benefit in fee-for-service and outside, and then enable beneficiaries to choose.

Mr. BURR. I thank the gentleman from Florida. He got 9 minutes.

I really did have a goal when I got in the seat to try to get these witnesses out by 3:30. You have had an extremely long day. I will not ask you questions, but I will summarize the questions that I would have asked with my own answers, if that is okay.

We have got a huge challenge. I think that is evident by the varying degrees of answers, but more importantly the questions that still remain unanswered and that means that we have to go into new ground and to plow that ground.

Illness is not predictable.

Illness is not predictable if you are young.

Illness is not predictable if you are old.

It puts a unique challenge on us to provide not only the coverage for those who are at risk, whether it is because of the financial point in the sand that was set, or because of a current health problem, but we are also challenged to produce a product that really resembles more a life insurance product, a product that assures individuals who have the means to pay today for drug costs, that they are protected against the drug costs of tomorrow. But more importantly against the terminal illness that might strike and that the resources might not be there for an unpredictable outflow of money.

So the challenge for us is to make that predictable, to bring some parameters to the process and to respond to not only those who choose between food and drugs, but to try to design a program that fits the needs of the long-term security and predictability that has been expressed by many of you.

One of the other most difficult things is to integrate a new program into a system that has had a difficult time at making any new coverage decisions.

I think every member of this subcommittee at some point in any given month has dealt with a manufacturer of a medical device of a pharmaceutical, a member of a patients' groups who seeks to try to accelerate the coverage decisions at HCFA.

Because technology changes with such a fast pace today, HCFA, for whatever reason, is unable to make those coverage determinations in a fashion that we would all want for the quality of care of the patient.

And I think that that is one thing that has contributed to many of us looking outside of HCFA, to create a new entity whose sole focus it is to administer the Medicare prescription drug benefit regardless of how it is configured.

I would say that in the proposal that hopefully will be out next week, we would also create a new responsibility within the benefit administration, Medicare Benefit Administration, which would be a Medicare ombudsman.

One place for everybody to go, whether it is for an appeals process, a coverage determination, somewhere that you can go that covers not only what HCFA's got responsibility for but hopefully the new drug entity and the administration of that.

Somebody mentioned earlier stock prices or Wall Street. Believe it or not, that is a consideration in this plan too. We understand that our hopes at bringing down drug costs and meeting the challenges of a doubling of the population under Medicare in many cases can only be met through new technological breakthroughs and non-invasive medical devices and pharmaceuticals that actually do cure things that today we treat and maintain in a very expensive way.

We are confident that we have to continue a commitment, not only a public commitment to the NIH for research, but we have to make sure that the incentive exists in the system for private sector companies to continue their research and development to find those breakthroughs.

Without that, the future will be predictable. And I think, Chip, you alluded to a deterioration in one part of the system. That we are talking about is a deterioration of the entire system.

I remember 3½ years ago when I landed in the Czech Republic and had an opportunity fresh into a new democracy to sit down with their minister of health. They had a hybrid Soviet system that they had continued over from their independence.

I also had an opportunity to go back last year on the day that the minister of health was headed to the government to drop off their new health care plan. It very much resembled a hybrid of our managed care system, but the question was why.

And they went through a very detailed statement about the lack of money. They cut reimbursements to try to save money. And when they cut reimbursements, doctors began to leave. And when doctors begin to leave, hospitals begin to close and all of a sudden they had a quality of care issue that they realized they created because they tried to treat it in the wrong way.

We understand that we need our entire system to be strengthened. If I had my choice, it would be comprehensive reform. It would be something that mirrors more what the Medicare Commission, which I think put partisanship aside and addressed some very long-term needs of our health care system for seniors. Unfortunately, I do not believe that that is possible to reach this year, but I believe it will continue to be our goal to make sure that we reach it in the not-too-distant future.

I hope that the stand alone drug effort is a step in the right direction. It is not a solution to the problem, but I do not believe it is a step in the wrong direction.

Clearly, we did not expect to find consensus today and clearly every member will leave with additional questions that I hope will find answers as we move through whatever markup process, whatever floor activity process we go through, but I am confident of one thing: that this subcommittee, both Republican and Democrat, is engaged in this issue and is willing to learn.

For those who feel shorted from today's opportunity to testify, please take the opportunity to go see those Members and educate them further. It will contribute to a much more accurate debate as we move to House activities.

Let me once again thank all of you for your willingness to be here today. This hearing is now adjourned.

[Whereupon, at 3:37 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

PREPARED STATEMENT OF JAMES L. MARTIN, PRESIDENT, 60 PLUS ASSOCIATION

Mr. Chairman, on behalf of the 60 Plus Association, I commend you and the Subcommittee on Health and Environment of the House Commerce Committee for holding this hearing on a topic very important for all seniors, a prescription drug benefit under Medicare.

The 60 Plus Association is a national, nonpartisan senior citizens advocacy group with 500,000 members nationwide, an average of 1,000 per Congressional District. We are supported by the voluntary contributions of our members. We have never in the past nor presently receive federal grants or contracts and we have a policy that we do not seek or would we accept federal grants or contracts.

As senior citizens are living longer and healthier lives, the issue of prescription drugs becomes a major issue for their health and their budget. Years ago seniors lived into their 60s and 70s; now we have seniors living beyond those years, with an increasing population in their 80s, 90s, and even 100 years and beyond. The rational TV weather forecaster, Willard Scott, has a growing number of individuals each year from whom to select to honor on their 100th birthday.

I am not here to endorse any specific piece of legislation but mainly to highlight important principles, which should be included in any prescription drug plan.

First of all, we are very concerned with the proposal pushed by President Bill Clinton. The president's plan is a big government, "one size fits all" proposal that will enlarge government, promises much but delivers little, places decision-making in the hands of federal bureaucrats, and will do little to meet the diverse needs of our senior citizens. The proposal may have great political appeal in this election year but little common sense appeal to those of us who have studied it. A closer study of the proposal demonstrates that it is a bad program for senior citizens and for the American taxpayer. If we believe we have problems with financing Social Security and Medicare, let us adopt this Clinton proposal and we will have an even bigger financial disaster down the road.

We at the 60 Plus Association are pleased that a bipartisan group is working in the House and the Senate to put forward a proposal, which will really help seniors.

We believe that the essential features of any successful proposal must be a rejection of a big government role and especially one that will lead to price-fixing or price controls by the federal government. Throughout history, price controls have led inexorably to rationing. That's the major reason the Canadian health system is considered by 80 percent of seniors to be in a state of crisis. Rationing leads to long lines in emergency rooms and prompted the Canadian Minister of Health to travel to the United States a few years ago for treatment of his heart ailment.

The United States has one of the greatest pharmaceutical industries in the world. Billions are being spent to develop new drugs, many of which help our seniors live a life with less pain, a higher quality, a longer life, and assist in avoiding surgery. Price controls, especially from an entity with the power of the federal government, could bring such research progress to screeching halt. We would be killing the goose that lays the golden egg. Seniors in order to receive a lower price on a drug today would be risking the opportunity for pharmaceuticals to develop other significant

drugs which may help them not only in years ahead but other seniors in future years.

Speaking of the American pharmaceutical industry, it is often used as a whipping boy. For those who participate in this approach, I would like to cite an article, which appeared in Parade magazine, September 12, 1998 authored by former House and Senate member Paul Simon. He noted that a heart scan had revealed that he was headed for a heart attack or stroke, even though he had not the usual symptoms of a heart problem such as chest pain or shortness of breath. He underwent a six-way heart bypass operation. He noted that the heart scan developed by research was responsible for him being alive today. He added "Pharmaceutical companies do an excellent job in research" and noted that they had increased their spending from \$2 billion in 1980 to \$20 billion in 1998. Senator Simon attributed his survival to the research performed by pharmaceuticals.

Seniors are a diverse group. We believe assistance should be provided to those seniors, namely low-income seniors, who need such assistance. We oppose any program that will encourage companies or other health plans to drop their current prescription drug coverage for seniors, a clear and distinct possibility under the Clinton plan. We will be risking some of the great benefits in our current health system for a real shot in the dark by a very risky federal health initiative.

And finally, we should consider the element of choice. We must give seniors this option, and not pass the entire decision-making and funding process on to federal bureaucrats. Seniors must be able to make their voices heard and their decisions known in the marketplace. Seniors will lose this voice if it stifled by a federal bureaucracy under the control of a plan, which has great political appeal (such as the president's) but dire consequences for the financial health of our country and the best interests of our senior citizens.

I urge the House Commerce Committee to adopt a bipartisan plan, which will really help seniors, and not penalize them with new government entitlement programs of dubious benefits, costly mandates, and excessive regulations. Thank you.