SENIORS' ACCESS TO PRESCRIPTION DRUG BENEFITS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

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SENIORS' ACCESS TO PRESCRIPTION DRUG BENEFITS

TUESDAY, FEBRUARY 15, 2000

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 1:10 p.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
February 8, 2000
No. HL–12

Contact: (202) 225–3943

Thomas Announces Hearing on Seniors' Access to Prescription Drug Benefits

Congressman Bill Thomas (R–CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing to examine the implications of different proposals aimed at helping seniors gain more affordable access to prescription drugs. **The hearing will take place on Tuesday, February 15, 2000, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 1:00 p.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include experts in the financing of prescription drug benefits in both the public and private sectors, as well as representatives from the senior community and the pharmaceutical industry. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

While nearly two-thirds of seniors have some insurance to help them pay for the costs of prescription medicines, an increasing number of vulnerable seniors lack access to affordable drug benefits. As a result, they are often either exposed to sizable financial risks or have their health and quality of life compromised. The origins of this problem are many. The Medicare fee-for-service program does not generally cover outpatient prescription drugs. In addition, many seniors lack access to, or find it difficult to afford, prescription drug benefits through either a Medicare+Choice or Medicare supplemental insurance (Medigap) plan. Finally, while millions of seniors now obtain drug coverage through a former employer (or a spouse's former employer), the rate at which employers are sponsoring retiree health insurance benefits is in decline. The rising cost of new drug therapies has contributed to this problem. It has also made it increasingly difficult for those without coverage to purchase the medicines they need on their own.

Last March, Chairman Thomas joined a majority of the National Bipartisan Commission on the Future of Medicare in recommending systemic reforms to Medicare. The Commission proposal would have made a variety of drug coverage options available to all seniors through a competitive insurance model similar to the one that Members of Congress enjoy. The President responded last June by proposing to expand the current Medicare fee-for-service benefit package to include a standardized prescription drug benefit. The President resubmitted his proposal to Congress this week as part of his fiscal year 2001 budget. Other lawmakers have put forward proposals that would either subsidize the purchase of drugs for those most in need, or conversely, to impose in some form price restrictions on the companies who manufacture and sell prescription drug therapies.

In announcing the hearing, Chairman Thomas stated: "As modern medicine relies more and more on drug treatments to manage chronic disease, it is essential that Congress take steps to ensure that seniors have access to affordable prescription

drugs. Last Spring, a majority of the Bipartisan Medicare Commission recommended a Medicare reform plan—a plan that expanded access to prescription drugs for seniors through market-based solutions such as group purchasing. These reforms are essential if Medicare is to remain a viable program for future generations. In working to address this growing problem this year, we will also evaluate other proposals, such as the one the President has put forward. This hearing will help us begin that process, and help us examine both the myths and realities surrounding this problem and the different solutions that have been proposed."

FOCUS OF THE HEARING:

The hearing will examine the current state of affairs with respect to seniors' access to prescription drug benefits and focus on the details of different drug proposals now before Congress. The Subcommittee will examine the implications that these proposals have for both the public and private financing of health care, their potential effects on health care choice and quality, and their relationship to the long-term needs of the Medicare program.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should *submit six (6) single-spaced copies of their statement, along with an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, with their name, address, and hearing date noted on a label,* by the close of business, Tuesday, February 29, 2000, to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, by close of business the day before the hearing.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be submitted on an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, typed in single space and may not exceed a total of 10 pages including attachments. **Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.**
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.
4. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers where the witness or the designated representative may be reached. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at "http://waysandmeans.house.gov."

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman THOMAS. If we could find our seats, please?

Since the inception of Medicare in 1965, it is pretty obvious that the practice of medicine has changed dramatically and it seems as though the farther we get away from 1965 the more dramatically it changes. Unfortunately, since Medicare has a statutorily defined structure it simply has not kept pace with the changes that have occurred. We have tried at times to try to modify, upgrade, reform Medicare. We have had several successful efforts recently and unfortunately several failures.

When the process began, drugs were a minor component of seniors' medical costs. Today they account for nearly 20 percent of the average Medicare beneficiary's health care consumption and tomorrow they are going to be even a greater percentage. Now, this increase in prescription drug utilization hasn't been for not, pretty obviously. If you were a Medicare beneficiary in 1965 and suffered a heart attack, you really had very few treatment options available to guard against recurrences. In fact, the frightening part is that some of the suggested treatments may have, in fact, been counterproductive. Instead those with the history of congestive heart failure had to rely on the hope that timely intervention of acute care would save them if they had subsequent heart problems.

However, today through the so-called miracle of modern medications, those with the history of heart problems can manage their disease by simply taking a pill every day. In fact, there are a number of things that you can do by taking a pill every day.

One of the underlying concerns as we move forward in prescription drugs is the advertising of prescription drugs as we have all become more aware in the print media and on television. You might guess this is a "People" Magazine, February 14th issue. It is a picture of Cupid hugging a blue pill which says, "Wishing you a Happy Valentine's Day", Viagra, an official sponsor of Valentine's Day.

[Laughter.]

Chairman THOMAS. Now, unfortunately, these pharmacological breakthroughs come at a price. They also come in varying categories; some primarily lifestyle, others life-saving. Prescription drugs are often expensive. The newer biotech ones are awfully expensive. Due to the years of research and intense commitments of capital necessary to find, develop and test these life-enhancing therapies. And given the fact that the traditional fee-for-service Medicare Program does not cover most outpatient prescription drugs, seniors without alternative drug coverage are forced to pay an ever-increasing share of their retirement incomes on medications.

Now, this hearing is in part to examine one, that reality; and, two, alternatives. But, clearly, if Medicare is to remain the valued entitlement program that it is today, we have to change to incorporate coverage—incorporate coverage—of these increasingly important therapies. However, as I am quite sure the witnesses will tell us, notwithstanding all of the recent revenue flowing into the trust funds in the Treasury, the underlying, fundamental Medicare Program still faces dire financial straits.

There is an inevitably about the current structure, the current benefit package, the number of retirees and the ongoing medical miracle of people living longer. If nothing is done to systematically overhaul the program before that baby boom generation begins to retire in real numbers, we either have Medicare crowding out all other fiscal discretionary spending or a significant and dramatic rollback of benefits or a significant increase in the payroll tax or a significant additional burden on the beneficiaries. Those are the options. The sooner we start the reform, the less necessary the intensity, the curve and the change needs to be.

So, the real challenge now is to begin as soon as possible to begin to deal with the options, especially for those at the lowest end of the income levels who are literally choosing between food and medicine.

If you listen to some of the direst critics, there is not a senior around receiving any kind of a Medicare and prescription drug benefit. In fact, even at the most difficult and hardest test it is still a majority. The number is usually 65 percent but clearly there is some slippage over the year, there is some in and some out. But I think you will find testimony today substantiates that it is still over 50 percent. Now, that is not bad but it is not good. Especially when you see who it is that does not have the coverage and especially when you realize that the products out there to provide that coverage are very rarely true insurance products with a stop-loss coverage. That is, those with the highest expenses, if they have coverage, almost always wind up paying for it out of their own pockets. So, our goal should be to expand coverage to those without good benefits, while not displacing private dollars with taxpayer dollars, and providing good coverage.

Now, the Medicare Commission and others have put forward a number of suggestions. We have legislation introduced by Members of Congress. Some of them deal exclusively with providing prescription drugs; others try to integrate over a longer term reform structure to shore up Medicare for future generations.

As Chairman of this Subcommittee, I am committed to bringing legislation before this Subcommittee before we adjourn. The goal will be to simultaneously advance those two goals: Reform and affordable prescription drug coverage. It is not going to be easy. I hope we can work together. I think a consensus can be found. I think we can make real progress. Even if we only make partial progress, I think it is important to begin.

My hope is that this initial hearing will start us down a cooperative path of reform. Both the inclusion of prescription drugs—and as President Clinton has said—a more competitive and quality-rated Medicare, both in the fee-for-service and in the other options are essential; not just to provide seniors with needed services but to make sure that the very program, itself, continues to be available in a modern and usable form for those retirees yet to come.

[The opening statement of Chairman Thomas follows:]

Opening Statement of Hon. William M. Thomas, a Representative in Congress from the State of California

Since Medicare's inception in 1965, the practice of medicine has changed dramatically. In 1965, prescription drugs were a very minor component of seniors' medical

costs. Today drug costs account for nearly 20% of the average Medicare beneficiaries health care consumption.

By the same token however, a senior who suffered a heart attack in 1965 had few if any preventive treatment options available to them to guard against further heart traumas. Instead, those with a history of congestive heart failure largely lived in fear of a possible reoccurrence, and hoped that the timely intervention of acute care might save them if they had a second occurrence. Today, through the miracles of modern medications, those with a history of heart problems can manage the disease by simply taking pill each day. This is just one of many incredible advances in health care that the development of new medicines have fostered.

Unfortunately, these kinds of pharmacological breakthroughs come at a price. As one of our panelists here today knows all to well, it takes years of research and intensive capital commitments to find, develop and prove these new therapies. And given the fact that the traditional fee-for-service Medicare program does not generally cover outpatient prescription drugs, seniors without alternative sources of insurance must often pay for these often expensive drugs with their own limited resources.

While the growing reliance on outpatient medications as a treatment modality has vastly improved the quality and length of life for those suffering from chronic disease, Medicare's lack of coverage for drugs has also forced seniors to spend an ever increasing share of their retirement income on medications.

Clearly, if Medicare is to remain the valued entitlement program that it is today, it must be changed to incorporate coverage for these increasingly important therapies. As the Medicare Commission recognized last year, a modern and reformed Medicare program must include affordable drug coverage.

However, as this Committee knows all to well, the current Medicare program—which includes no outpatient drug benefit—already faces dire financial straits in the years ahead. If nothing is done to systematically overhaul the program before the baby boom generation begins to retire at the end of this decade, the budget for Medicare alone will soon crowd out all other federal discretionary spending and ultimately collapse into financial insolvency.

The challenge then is how do we balance the immediate needs of some seniors who are literally choosing between food and medicine, against the equally important, longer term needs of a program that is literally the lifeline of an entire segment of our population. Last year I worked very hard on the Medicare Commission to put craft a bipartisan proposal that was designed to meet both of these needs.

This is a new year. While I remain equally committed to advancing systemic Medicare reforms, and to addressing the real needs of those seniors without access to affordable drug coverage, I am open to new ideas.

Fortunately, the problem is not as grave as some would profess. Many seniors have access to good drug benefits—often through a former employer. Others have found cost-effective coverage through a Medicare+Choice plan. I feel strongly that we should build on these successes.

Moreover, the Commission and others have put forward several good ideas that we can incorporate as we work to extend coverage for drugs while still working toward long-term reforms to shore up Medicare for future generations.

I am committed to bringing legislation before the Committee later this year that will simultaneously advance these two competing goals. It won't be easy, but if we work together, I think a consensus can be found and real progress can be made. This hearing is intended to start us down that path.

Chairman THOMAS. The gentleman from California.

Mr. STARK. Thank you, Mr. Chairman, for holding this hearing on Medicare and prescription drugs. And I, too, hope it will lead to legislation. I hope that legislation will provide an affordable prescription drug benefit to all seniors. We are going to hear differing accounts on how many seniors have or do not have prescription drugs. We will hear questions about Medicare's trust fund going broke but it is important to keep in mind that a prescription drug benefit would have no effect on the part A trust fund.

Whatever the number, we can agree that the percentage of people without prescription drug benefits is rapidly eroding and that

most of the Medigap benefits now cost more for the benefit, like $1,800 for a Medigap drug benefit that pays for only $1,250 worth of drugs, so that really the seniors are poorly advised to even buy it.

Recently I asked the CRS to analyze the tax treatment of the pharmaceutical industry. And the CRS found that tax credits contributed to lowering the average effective tax rate for drug companies so that their effective rate was nearly 40 percent lower than other major industries in the period from 1990 to 1996. At the same time numerous studies find that Americans pay the highest prices for drugs.

For these reasons, among others, I am introducing today the Prescription Price Equity Act of 2,000. Basically this bill would deny tax breaks to the pharmaceutical companies that sell their products at significantly higher prices in the United States compared to their sales in other developed countries. The purpose of this bill is to require drug companies to give U.S. consumers a fair deal in return for these significant taxpayer contributions to their industry. No drug company that charged fair prices would see any change in governmental support for research.

I am sorry, Mr. Chairman, that PhRMA is not here today because I suppose there are some questions for them. I am concerned that the American drug industry, for all the multi-billion subsidies we give them, does not do enough research and development to cure the plagues that haunt us. Today, PhRMA spends hundreds of millions of dollars telling us how much they spend on R&D and every one of those advertising and campaign contributions that amount to hundreds of millions of dollars is a dollar not spent on R&D. Those dollars spent by PhRMA disguise the fact that this pharmaceutical industry spends twice as much on sales and overhead as they spend on R&D. The profits to stockholders outstrip their R&D budgets and what is worse, the pharmaceutical industry has blocked us from knowing how much of their R&D is really research on "me-too" drugs that do nothing to advance human health.

The attachment to my statement details billions of dollars the industry could and should be spending on R&D rather than trying to bribe—and bribe is the appropriate word here—doctors to use a particular company's pills. I would like to explore with witnesses ways in which we could encourage them to do more in R&D that leads to breakthrough drugs that might prevent Alzheimer's, rheumatism, stroke, you name it.

As we debate prescription drug coverage for Medicare beneficiaries, I hope we will ask ourselves this question. Do I have taxpayer-assisted prescription drug insurance in my own life, either because I am a Federal employee or because my employer gets a tax deduction for covering me? I suspect that 99 percent of the people in this room would answer that they do. And I hope that this fact will give us the encouragement we need to be supportive now of drug coverage legislation that will help our fellow citizens who don't receive such tax subsidy.

Thank you very much.

[The opening statements of Mr. Stark and Mr. Ramstad follow:]

Opening Statement of Hon. Fortney Pete Stark, a Representative in Congress from the State of California

MEDICARE PHARMACEUTICAL BENEFIT HEARING

Mr. Chairman:

Thank you for holding this hearing on Medicare and prescription drugs.

There will be a lot of conflicting testimony today on how many seniors actually have prescription drug insurance coverage. As the AARP testimony says,

"although 65 percent of Medicare beneficiaries have **some type** of coverage for prescription drugs, this figure can be very misleading."

Whatever the number, I think we can all agree that the percentage is declining, as employers scale back retiree coverage. Medicare HMOs are dramatically reducing coverage, and we will see another round of major benefit reductions announced this summer. I think we can all agree that the three medi-gap policies that cover drugs are, frankly, a bad deal, and often cost more than the value of the drug benefit. As drug inflation soars, we can expect fewer and fewer seniors to have prescription insurance. So, whatever number we say are covered today, we know that the number will be significantly smaller a year from now.

A Medicare benefit for all enrollees would also help with the war against medical errors. Any drug benefit should be designed to detect over and under-prescribing and contra-indicated prescriptions, thus helping to reduce what we believe is a major area of medical mistakes. Establishing a well-run Medicare drug benefit may be the single best thing we can do to help improve the quality of care of our retirees and reduce the cost of medical errors.

I am pleased that PharMA is here. I am concerned that the American drug industry, for all the multi-billion dollar subsidies that we give them, does not do nearly enough R&D to cure the illnesses that plague mankind.

PharMA spends hundreds of millions of dollars telling us how much they spend on R&D-and every one of those advertising and campaign contribution dollars is a dollar NOT spent on R&D! Every one of those dollars disguises the fact that this industry spends twice as much on sales and overhead as they spend on R&D. Their profits are 50% more than their R&D budget. But what's worse, is that they have blocked us from knowing how much of their R&D is really research on 'me-too' drugs that do nothing to advance human health. It is even reported that their R&D budgets may include R&D on how to market a drug, rather than inventing a new drug. The very nature of the industry is such that they waste billions and billions in over-lapping research, and a major reason we see these huge mergers is so that research overhead can be reduced.

The attachment to my statement details the billions and billions of dollars this industry could and should be spending on R&D rather than trying to bribe-and that is the word-doctors to use a particular company's pill.

I would like to explore with the witnesses ways we could encourage them to do much more R&D to prevent Alzheimer's, rheumatism, stroke, you name it.

And I would like to ask the Comptroller General what he can do to help research

—the true costs of developing a drug;

—how much wasteful duplication there is,

—how much is spent on 'me toos,'

—whether tax credits are being claimed for marketing,

—how much of NIH's budget goes into subsidizing the basic research for the development of a breakthrough drug and whether the public shouldn't get some of that investment back when the companies profit from it, and so forth.

Finally, as we debate this issue, I hope we will all ask ourselves the moral question: do I have taxpayer assisted prescription drug insurance in my own life, either because I am a Federal employee, or because my employer gets a tax deduction for covering me? I suspect that 99%-plus of the people in this room have such prescription drug coverage. I hope that fact will give us compassion to be supportive, NOW, of helping our fellow citizens who receive no such tax subsidy.

Opening Statement of Hon. Jim Ramstad, a Representative in Congress from the State of Minnesota

HEARING ON SENIOR'S ACCESS TO PRESCRIPTION DRUG BENEFITS

Mr. Chairman, thank you for calling this hearing today to discuss access to prescription drug benefits for seniors.

As founder and co-chair of the House Medical Technology Caucus, I am well aware of the incredible advances the medical technology industry has made in recent years to treat and cure many illnesses, diseases and conditions. Similar discoveries and innovations have been made in the area of pharmaceuticals.

Sadly, however, Medicare has not kept pace with the incredible strides of American medical ingenuity. I've authored legislation to ensure seniors have access, through Medicare, to new technologies and look forward to similarly working on improving senior access to life-saving and life-enhancing prescription drugs.

I applaud the many proposals that have been issued, from the Medicare Commission, the President and Members of Congress in an attempt to address this important issue. Since anything worth doing is worth doing well, we must carefully review all proposals for their strengths and weaknesses, as well as intended and unintended consequences.

We must look for methods that will expand access to drugs without reducing access to other Medicare benefits, stifling further innovation or further complicating Medicare's already shaky financial status. The National Center for Policy Analysis (NCPA) recently released a study which found that if current Medicare dollars were used more wisely, seniors could have prescription drug coverage without the infusion of any additional federal funds.

That's why I believe we will ultimately—if Members are willing to put politics aside and work in a bipartisan, pragmatic way—design an effective and efficient ways to use scarce Medicare and surplus dollars to help seniors. Instead of cutting payments and raising taxes through fees to pay for new spending as the President's plan would do, Congress and the President should modernize Medicare to reflect the advancements in our health care system, including a targeted prescription drug proposal to cover low-income seniors without displacing the coverage and quality that a majority of enrollees already enjoy.

Mr. Chairman, thanks again for holding this hearing. I look forward to learning more from today's witnesses on how we can best address this critical issue.

Chairman THOMAS. I thank the gentleman. Our first panel will consist of one individual and I want to thank him for coming: The Honorable David M. Walker, Comptroller General of the United States, General Accounting Office. We have used you in the past. We will use you in the future. And your good offices and services are going to be invaluable in assisting us in making what are sometimes very difficult choices. I am hopeful that the choices that we make will be driven by policy and not by politics. And with that, Mr. Walker, any written testimony that you have will be made a part of the record and you can address us in any way you see fit in the time you have available.

STATEMENT OF HON. DAVID M. WALKER, COMPTROLLER GENERAL, U.S. GENERAL ACCOUNTING OFFICE

Mr. WALKER. Thank you, Mr. Chairman, Members of the Committee, it is a pleasure to be back before you again to speak on the important issue of Medicare and prescription drug coverage. I would like to briefly summarize my full statement by addressing four key issues. First, the nature of current prescription drug coverage for seniors; second, the nature, extent and timing of Medi-

care's financing challenge; third, a view to the future of our long-range fiscal outlook; and fourth, the need for comprehensive Medicare reform and care in addressing any expansion of Medicare to include prescription drug coverage.

First, current coverage statistics. Based upon 1996 data which, believe it or not, is the most recent available, approximately 31 percent of Medicare eligible beneficiaries had no prescription drug coverage. Of the 69 percent who have coverage, approximately 30 percent had coverage through employer plans, 10 percent through Medicaid, 9 percent through Medigap and 8 percent through Medicare-risk HMOs. Of those who were covered, the level of coverage and the related cost varied widely based upon their plan. In 1999, approximately 20 percent of Medicare beneficiaries incurred total drug costs of $1,500 or more. Now, that is gross cost, not net cost, out-of-pocket.

There appears to be a growing consensus that Medicare's benefit structure needs to be modernized in order to include prescription drug coverage. At the same time we must not forget that adding prescription drug coverage to Medicare could potentially exacerbate a serious financial imbalance that Medicare already faces. This financial imbalance will escalate dramatically when the known demographic tidal wave hits us around 2011.

In that regard, Mr. Chairman—this chart represents Part A. I recognize that different reform proposals would have these costs in part B, and some would have it as a Part D. It varies. In the interest of full and fair disclosure, this represents Part A—the solid line represents the trust fund balance, which starts to plummet early in the middle part of this decade, and the solid bars below show how these annual deficits will escalate in the years ahead based upon the most recent trustees' projections.

In addition, despite current and projected surpluses, our latest long-range budget simulation shows that we face serious long-range fiscal challenges in the United States in the future if we do not begin to reform entitlement programs. This chart demonstrates that the solid line that goes across is the percentage of the economy represented by taxes. Right now it is a little over 21 percent of gross domestic product represented by taxes. Obviously, taxes could be corporate taxes, individual taxes, payroll taxes, a variety of different forms. The bars represent the components of Federal spending.

What this shows is that based upon the most recent assumptions of CBO, and the Medicare and Social Security trustees, that by the year 2030 if we spend the on-budget surplus and save the entire Social Security surplus, we will serve to significantly haircut discretionary spending by year 2030. By 2050 it will be totally scalped and we wouldn't even be able to pay interest on the debt. The key point is this: We do face current surpluses and projected surpluses for a number of years, however, we are not out of the woods yet. We face serious long-range fiscal challenges due to known demographic trends which assures the sun rises in the morning, we are going to face absent meaningful reform.

In addition, while Medicare's financial imbalance may only represent 1.4 percent of taxable payroll, the combined payroll tax imbalances of Social Security and Medicare are substantial. As we all

know, payroll taxes are inherently very regressive. As you can see, based upon the trustees, Social Security and Medicare's latest projection, if you look at the combined potential pressure on Social Security and Medicare payroll taxes if the solution was to go on the revenue side alone, you can see escalating tax burdens of what is a very regressive tax and, in addition to that, history has shown that rightly or wrongly the American people have generally placed a limit as to how much they will allow themselves to be taxed in a democracy although the forms of tax, obviously, may vary.

Given these long-range fiscal challenges, we should proceed with care in addressing the prescription drug issue and the possible expansion of Medicare. We should recognize the fundamental differences between wants, which are unlimited; needs, which vary based upon individual; and affordability, of which there are very real limits. We also should recognize and acknowledge the difference between access to prescription drugs at group rates, passing on any savings associated with bulk purchasing of prescription drugs versus financial support for individuals who may not be able to afford prescription drug coverage.

Targeting is the key word in this regard, Mr. Chairman. After all, adding prescription drug coverage to Medicare will add costs to the Medicare Program and that program, according to the trustees for over 10 years, is already unsustainable in its present form. In addition, prescription drugs represent the fastest growing component of health care costs.

As a result, we clearly need to look to the possible modernization of Medicare in light of changing times and in light of bona fide needs on behalf of certain populations; at the same point in time we also have to recognize that the biggest single challenge facing the Medicare Program is its long-range fiscal imbalance. In that regard, we must deal not just with solvency, we must deal with sustainability, and we must make sure that we can deliver on the promises that have already been made as well as being able to deliver on whatever new promises might be made.

Thank you, Mr. Chairman. I would be happy to answer any questions that you or the other members may have.

[The prepared statement follows:]

Statement of the Hon. David M. Walker, Comptroller General, U.S. General Accounting Office

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss options for increasing Medicare beneficiaries' access to prescription drugs. There are growing concerns about gaps in the Medicare program, most notably the lack of outpatient prescription drug coverage, which may leave Medicare's most vulnerable beneficiaries with high out-of-pocket costs that they may not be able to afford. In 1996, almost a third of Medicare beneficiaries lacked prescription drug coverage. The remaining two-thirds had at least some drug coverage through other sources—most commonly employer-sponsored health plans. Although the proportion of beneficiaries who had drug coverage rose between 1995 and 1996, recent evidence indicates that this trend of expanding drug coverage is unlikely to continue. Moreover, the burden of prescription drug costs falls most heavily on the Medicare beneficiaries who lack drug coverage or those who have substantial health care needs. In 1999, an estimated 20 percent of Medicare beneficiaries had drug costs of $1,500 or more-a substantial sum for those lacking some form of insurance to subsidize the purchase.

At the same time, however, long-term cost pressures facing the Medicare program are considerable. There appears to be an emerging consensus that substantive financing and programmatic reforms are necessary to put Medicare on a sustainable

footing for the future. These fundamental program reforms are vital to reducing the program's growth, which threatens to absorb ever-increasing shares of the nation's budgetary and economic resources. Thus, proposals to help seniors with the costs of prescription drugs should be carefully crafted to avoid further erosion of the projected financial condition of the Medicare program, which, according to its trustees, is already unsustainable in its present form.

On the one hand, you must grapple with the hard choices involved in making the Medicare program sustainable for future generations. On the other, you are faced with the plight of many seniors who cannot afford the medical miracles that may be achieved through access to pharmaceutical advances. Expanding Medicare's benefit package could address the latter. However, a recent study suggests that such an expansion could add between 7.2 and 10 percent annually to Medicare's costs.[1] Increased spending of that magnitude would only exacerbate the tough choices that will be required to put Medicare on sustainable footing for the future.

You are considering these issues at a historic crossroad. After nearly 30 years of deficits, the combination of hard choices and remarkable economic growth has led to a budget surplus. We appear—at least for the near future—to have slain the deficit dragon. In its most recent projections, the Congressional Budget Office (CBO) shows both unified and on-budget surpluses throughout the next 10 years. While this is good news and even superior to the projections made last year, it does not mean that hard choices are a thing of the past. First, it is important to recognize that by their very nature projections are uncertain. This is especially true today because, as CBO notes, it is too soon to tell whether recent boosts in revenue reflect a major structural change in the economy or a more temporary divergence from historical trends. Indeed, CBO points out that assuming a return to historical trends and slightly faster growth in Medicare would change the on-budget surplus to a growing deficit. This means we should treat surplus predictions with caution. Current projected surpluses could well prove to be fleeting, and thus appropriate caution should be exercised when creating new entitlements that establish permanent claims on future resources.

Moreover, while the size of future surpluses could exceed or fall short of projections, we know that demographic and cost trends will, in the absence of meaningful reform, drive Medicare spending to levels that will prove unsustainable for future generations of taxpayers. Accordingly, we need to view this period of projected prosperity as an opportunity to address the structural imbalances in Medicare, Social Security, and other entitlement programs before the approaching demographic tidal wave makes the imbalances more dramatic and possible solutions more painful.

As the foregoing suggests, the stakes associated with Medicare reform are high for the program itself and for the rest of the federal budget, both now and for future generations. Current policy decisions can help us prepare for the challenges of an aging society in several important ways: (1) reducing public debt to increase national savings and investment, (2) reforming entitlement programs to reduce future claims and free up resources for other competing priorities, and (3) establishing a more sustainable Medicare program that delivers effective and affordable health care to our seniors.

My remarks today will focus on Medicare beneficiaries' access to prescription drugs and the environment in which you consider increasing that access. Two proposals before you, one offered in the President's budget and the other contained in the Breaux-Frist bill,[2] would incorporate Medicare prescription drug coverage in the context of larger Medicare reform. Other proposals that focus only on increasing access to affordable prescription drugs are also being considered. These proposals would either subsidize prescription drug coverage or lower prices faced by beneficiaries without coverage. To put these proposals in context, I will discuss the factors contributing to the growth in prescription drug spending and efforts to control that growth. I will also discuss design and implementation issues to be considered regarding proposals to improve seniors' access to affordable prescription drugs. I then will repeat my message about the Medicare program's current financial condition and its long term sustainability.

But before I turn to the specifics, let me reiterate that although people want unfettered access to health care, and some have needs that are not being met, health care costs compete with other legitimate priorities in the federal budget, and their projected growth threatens to crowd out future generations' flexibility to decide which of these competing priorities will be met. Thus, in making important fiscal decisions for our nation, policymakers need to consider the fundamental differences

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[1] M.E. Gluck, *National Academy of Social Insurance Medicare Brief: A Medicare Prescription Drug Benefit* (April 1999); p. 8. http//www.nasi.org/Medicare.medbr1.htm (4/22/99).

[2] S. 1895, Medicare Preservation and Improvement Act of 1999.

between wants, needs, and what both individuals and our nation can afford. This concept applies to all major aspects of government, from major weapons system acquisitions to issues affecting domestic programs. It also points to the fiduciary and stewardship responsibility that we all share to ensure the sustainability of Medicare for current and future generations within a broader context of also providing for other important national needs and economic growth. We have an opportunity to use our unprecedented economic wealth and fiscal good fortune to address today's needs but an obligation to do so in a way that improves the prospects for future generations. This generation has a responsibility to future generations to reduce the debt burden they will inherit, to provide a strong foundation for future economic growth, and to ensure that future commitments are both adequate and affordable. Prudence requires making the tough choices today while the economy is healthy and the workforce is relatively large.

RISING DRUG SPENDING ELEVATES BENEFICIARY ACCESS CONCERNS AND THE IMPORTANCE OF COST-CONTROL EFFORTS

Extensive research and development over the past 10 years have led to new prescription drug therapies and improvements over existing therapies that, in some instances, have replaced other health care interventions. For example, new medications for the treatment of ulcers have virtually eliminated the need for some surgical treatments. As a result of these innovations, the importance of prescription drugs as part of health care has grown. However, the new drug therapies have also contributed to a significant increase in drug spending as a component of health care costs. The Medicare benefit package, largely designed in 1965, provides virtually no coverage. In 1996, almost one third of beneficiaries had employer-sponsored health coverage, as retirees, that included drug benefits. More than 10 percent of beneficiaries received coverage through Medicaid or other public programs. To protect against drug costs, the remainder of Medicare beneficiaries can choose to enroll in a Medicare+Choice plan with drug coverage if one is available in their area or purchase a Medigap policy.[3] The availability, breadth, and price of such coverage is changing as the costs of expanded prescription drug use drives employers, insurers, and managed care plans to adopt new approaches to control the expenditures for this benefit. These approaches, in turn, are reshaping the drug market.

Rise in Prescription Drug Spending

Over the past 5 years, prescription drug expenditures have grown substantially, both in total and as a share of all health care outlays. Prescription drug spending grew an average of 12.4 percent per year from 1993 to 1998, compared with a 5 percent average annual growth rate for health care expenditures overall. (See table 1.) As a result, prescription drugs account for a larger share of total health care spending—rising from 5.6 percent to 7.9 percent in 1998.

Table 1: National Expenditures for Prescription Drugs, 1993–98

Prescription drug expenditures (in billions) Annual growth in prescription drug expenditures (percent) Annual growth in all health care expenditures (percent)

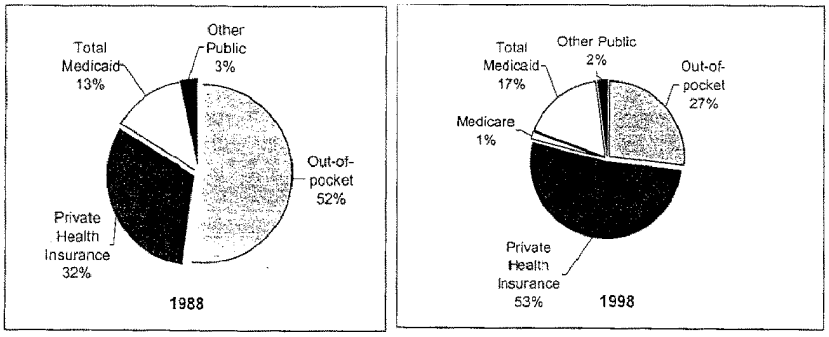
Year	Prescription drug expenditures (in bilions)	Annual growth in prescription drug expendures (percent)	Annual growth in all health care expenditures (percent)
1998	$90.6	15.4	5.6.
1997	$78.5	14.0	4.7.
1996	$68.9	12.9	4.6.
1995	$61.0	10.6	4.8.
1994	$55.2	9.0	5.5.
1993	$50.6	8.7	7.4.
Average annual growth between 1993 and 1998		12.4	5.0.

Source: Health Care Financing Administration (HCFA), Office of the Actuary.

[3] As an alternative to traditional Medicare fee-for-service, beneficiaries in Medicare+Choice plans (formerly Medicare risk health maintenance organizations) obtain all their services through a managed care organization and Medicare makes a monthly capitation payment to the plan on their behalf.

Total drug expenditures have been driven up by both greater utilization of drugs and the substitution of higher-priced new drugs for lower-priced existing drugs. Private insurance coverage for prescription drugs has likely contributed to the rise in spending, because insured consumers are shielded from the direct costs of prescription drugs. In the decade between 1988 and 1998, the share of prescription drug expenditures paid by private health insurers rose from almost a third to more than half. (See fig. 1.) The development of new, more expensive drug therapies—including new drugs that replace old drugs and new drugs that treat disease more effectively—also contributed to the drug spending growth by boosting the volume of drugs used as well as the average price for drugs used. The average number of new drugs entering the market each year rose from 24 at the beginning of the 1990s to 33 now. Similarly, biotechnology advances and a growing knowledge of the human immune system are significantly shaping the discovery, design, and production of drugs. Advertising pitched to consumers has also likely upped the use of prescription drugs. A recent study found that the 10 drugs most heavily advertised directly to consumers in 1998 accounted for about 22 percent of the total increase in drug spending between 1993 and 1998.[4] Between March 1998 and March 1999, industry spending on advertising grew 16 percent to $1.5 billion. All of these factors suggest the need for effective cost control mechanisms to be in place under any option to increase access to prescription drugs.

Figure 1: Comparison of National Outpatient Drug Expenditures, 1988 and 1998



Note: Out-of-pocket expenditures include direct spending by consumers for prescription drugs, such as coinsurance, deductibles, and any amounts not covered by insurance. Out-of-pocket premiums paid by individuals are not counted here.

Source: HCFA, Office of the Actuary.

Current Medicare Beneficiary Drug Coverage

Prescription drugs are an important component of medical care for the elderly because of the prevalence of chronic and other health conditions associated with aging. In 1995, Medicare beneficiaries had an average of more than 18 prescriptions filled.[5] This varies substantially across beneficiaries, however, reflecting the range of their needs and also financial considerations such as third-party prescription drug coverage. In 1995, an elderly person's total average annual drug costs were $600[6] compared with a little more than $140 for a non-elderly persons.[7] For some, prescription drug spending was considerably higher–6 percent of Medicare beneficiaries spent $2,000 or more.[8] A recent report had projected that by 1999 an estimated 20 percent of Medicare beneficiaries would have total drug costs of $1,500 or more—a substan-

[4] Barents Group LLC for the National Institute for Health Care Management Research and Educational Foundation, *Factors Affecting the Growth of Prescription Drug Expenditures* (July 9, 1999); p. iii.

[5] M. Davis and others, "Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries," *Health Affairs*, Vol. 18, No. 1 (Jan./Feb. 1999); p. 237.

[6] M. Davis, p. 239.

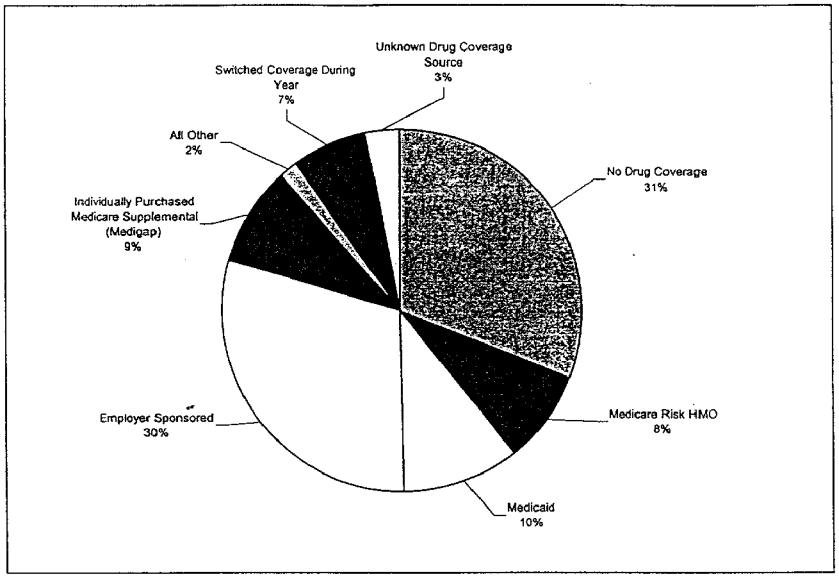
[7] Agency for Health Care Policy and Research Center for Cost and Financing Studies, National Medical Expenditure Survey data, *Trends in Personal Health Care Expenditures, Health Insurance, and Payment Sources, Community-Based Population, 1987–1995*, (March 1997); p. 10. http://www.meps.ahcpr.gov/nmes/papers/trends/intnet4d.pdf (6/10/99).

[8] J.A. Poisal and others, "Prescription Drug Coverage and Spending for Medicare Beneficiaries," *Health Care Financing Review*, Vol. 20, No. 3 (Spring 1999); p. 20.

tial sum for people lacking some form of insurance to subsidize their purchases or for those facing coverage limits.[9]

In 1996, almost a third of Medicare beneficiaries lacked drug coverage altogether. (See fig. 2.) The remaining two-thirds had at least some drug coverage—most commonly through employer-sponsored health plans. The proportion of beneficiaries who had drug coverage rose between 1995 and 1996, owing to increases in those with Medicare HMOs, individually purchased supplemental coverage, and employer-sponsored coverage. However, recent evidence indicates that this trend of expanding drug coverage is unlikely to continue.

Figure 2: Sources of Drug Coverage for Medicare Beneficiaries, 1996



Note: "All Other" includes coverage under non-risk Medicare HMOs, state-based plans, the Department of Defense, and the Department of Veteran's Affairs.

Source: HCFA, based on the 1996 Medicare Current Beneficiary Survey.

Although employer-sponsored health plans provide drug coverage to the largest segment of the Medicare population with coverage, there are signs that this could be eroding. Fewer employers are offering health benefits to retirees eligible for Medicare and those that continue to offer coverage are asking retirees to pay a larger share of costs. The proportion of employers offering health coverage to retirees eligible for Medicare declined from 40 percent in 1993 to 28 percent in 1999. This decline is at least in part due to the rise in the cost of providing this coverage, which grew about 21 percent from 1993 to 1999. At the same time, the proportion of employers asking retirees to pay the full cost of their health coverage increased from 36 percent to 40 percent.

In 1999, 13 percent of Medicare beneficiaries obtained prescription drug coverage through a Medicare+Choice plan, up from 8 percent in 1996. Medicare+Choice plans have found drug coverage to be an attractive benefit that beneficiaries seek out when choosing to enroll in managed care organizations. However, owing to rising drug expenditures and their effect on plan costs, the drug benefits the plans offer are becoming less generous. Many plans restructured drug benefits in 2000, increasing enrollees' out-of-pocket costs and limiting their total drug coverage.

Beneficiaries may purchase Medigap policies that provide drug coverage, although this tends to be expensive, involves significant cost-sharing, and includes annual limits. Standard Medigap drug policies include a $250 deductible, a 50 percent coinsurance requirement, and a $1,250 or $3,000 annual limit. Furthermore, Medigap premiums have been increasing in recent years. In 1999, the annual premium for

[9] M.E. Gluck, p. 2.

one type of Medigap policy with a $1,250 annual limit on drug coverage, ranged from approximately $1,000 to $6,000.

All beneficiaries who have full Medicaid benefits[10] receive drug coverage that is subject to few limits and low cost-sharing requirements. For beneficiaries whose incomes are slightly higher than Medicaid standards, 14 states currently offer pharmacy assistance programs that provided drug coverage to approximately 750,000 beneficiaries in 1997. The three largest state programs accounted for 77 percent of all state pharmacy assistance program beneficiaries.[11] Most state pharmacy assistance programs, like Medicaid, have few coverage limitations.

The burden of prescription drug costs falls most heavily on the Medicare beneficiaries who lack drug coverage or who have substantial health care needs. Drug coverage is less prevalent among beneficiaries with lower incomes. In 1995, 38 percent of beneficiaries with income below $20,000 were without drug coverage, compared to 30 percent of beneficiaries with higher incomes. Additionally, the 1995 data show that drug coverage is slightly higher among those with poorer self-reported health status. At the same time, however, beneficiaries without drug coverage and in poor health had drug expenditures that were $400 lower than the expenditures of beneficiaries with drug coverage and in poor health. This might indicate access problems for this segment of the population.

Even for beneficiaries who have drug coverage, the extent of the protection it affords varies. The value of a beneficiary's drug benefit is affected by the benefit design, including cost-sharing requirements and benefit limitations. Evidence suggests that premiums are on the rise for employer-sponsored benefits, Medigap policies, and most recently, Medicare+Choice plans. Although reasonable cost sharing serves to make the consumer a more prudent purchaser, copayments, deductibles, and annual coverage limits can reduce the value of drug coverage to the beneficiary. Harder to measure is the effect on beneficiaries of drug benefit restrictions brought about through formularies designed to limit or influence the choice of drugs.

Cost-Control Approaches Are Reshaping the Pharmaceutical Market

During this period of rising prescription drug expenditures, third-party payers have pursued various approaches to control spending. These efforts have initiated a transformation of the pharmaceutical market. Whereas insured individuals formerly purchased drugs at retail prices at pharmacies and then sought reimbursement, now third-party payers influence which drug is purchased, how much is paid for it, and where it is purchased.

A common technique to manage pharmacy care and control costs is to use a formulary. A formulary is a list of prescription drugs, grouped by therapeutic class, that a health plan or insurer prefers and may encourage doctors to prescribe. Decisions about which drugs to include in a formulary are based on the drugs' medical value and price. The inclusion of a drug in a formulary and its cost can affect how frequently it is prescribed and purchased and, therefore, can affect its market share.

Formularies can be open, incentive-based, or closed. Open formularies are often referred to as "voluntary" because enrollees are not penalized if their physicians prescribe nonformulary drugs. Incentive-based formularies generally offer enrollees lower copayments for the preferred formulary or generic drugs. Incentive-based or managed formularies are becoming more popular because they combine flexibility and greater cost-control features than open formularies. A closed formulary limits insurance coverage to the formulary drugs and requires enrollees to pay the full cost of nonformulary drugs prescribed by their physicians.

Another way in which the market has been transformed is through the use of pharmacy benefit managers (PBM) by health plans and insurers to administer and manage prescription drug benefits. PBMs offer a range of services, including prescription claims processing, mail-service pharmacy, formulary development and management, pharmacy network development, generic substitution incentives, and drug utilization review. PBMs also negotiate discounts and rebates on prescription drugs with manufacturers.

EXPANDING ACCESS TO PRESCRIPTION DRUGS INVOLVES DIFFICULT DESIGN DECISIONS

Expanding access to more affordable prescription drugs could involve either subsidizing prescription drug coverage or allowing beneficiaries access to discounted pharmaceutical prices. The design of a drug coverage option, that is, the scope of the benefit, the covered population, and the mechanisms used to contain costs, as well as its implementation will determine the effect of the option on beneficiaries,

[10] Certain low-income Medicare beneficiaries are dually eligible for Medicare and Medicaid.
[11] These programs are operated in New Jersey, New York, and Pennsylvania.

Medicare or federal spending, and the pharmaceutical market. A new benefit would need to be crafted to balance competing concerns about the sustainability of Medicare, federal obligations, and the hardship faced by some beneficiaries. Similarly, the effect of granting some beneficiaries access to discounted prices will hinge on details such as the price of the drugs after the discount, how discounts are determined and secured, and which beneficiaries are eligible.

The relative merits of any approach should be carefully assessed. We suggest that the following five criteria be considered in evaluating any option. (1) Affordability: an option should be evaluated in terms of its effect on public outlays for the long term. (2) Equity: an option should provide equitable access across groups of beneficiaries and be fair to affected providers. (3) Adequacy: an option should provide appropriate beneficiary incentives for prudent utilization, support standard treatment options for beneficiaries, and not impede effective and clinically meaningful innovations. (4) Feasibility: an option should incorporate such administrative essentials as implementation and cost and quality monitoring techniques. (5) Acceptance: an option should account for the need to educate the beneficiary and provider communities about its costs and the realities of trade-offs required by significant policy changes.

Adding a Medicare Benefit

Expanding Medicare coverage to include prescription drugs would entail numerous benefit design decisions that would affect the cost of this expansion as well as its acceptability. A basic design decision concerns whether financial assistance provided for the benefit would be targeted to those with the greatest need—owing to a lack of existing drug coverage, high drug expenditures, or poverty—or whether the public financial subsidies would be available to all beneficiaries. The President's proposal extends coverage to all beneficiaries, with greater government subsidies for the poor. The Breaux-Frist Medicare reform proposal incorporates optional drug coverage, which is subsidized fully for the poor and partially for others. The generosity of the benefit—the extent of beneficiary copayments, coverage limits, and catastrophic protections—will also be a major factor in assessing the impact of this benefit on the Medicare program. The President's benefit design incorporates 50 percent beneficiary copayments; an annual benefit limit; and a cap on catastrophic drug costs, which is yet to be designed. Under the Breaux-Frist approach, competing health plans could design their own copayment structure, with requirements on the benefit's actuarial value but no provision to limit beneficiary catastrophic drug costs.

Benefit cost-control provisions for the traditional Medicare program may present some of the thorniest drug benefit design decisions. Recent experience provides two general approaches. One would involve the Medicare program obtaining price discounts from manufacturers. Such an arrangement could be modeled after Medicaid's drug rebate program. While the discounts in aggregate would likely be substantial, this approach lacks the flexibility to achieve the greatest control over spending. It could not effectively influence or steer utilization because it does not include incentives that would encourage beneficiaries to make cost-conscious decisions. The second approach would draw from private sector experience in negotiating price discounts from manufacturers in exchange for shifting market share. Some plans and insurers employ PBMs to manage their drug benefits, including claims processing, negotiating with manufacturers, establishing lists of drug products that are preferred because of efficacy or price, and developing beneficiary incentive approaches to control spending and use. Applying these techniques to the entire Medicare program, however, would be difficult because of its size, the need for transparency in its actions, and the imperative for equity for its beneficiaries.

Medicaid Programs Rely on Rebates and Have Limited Utilization Controls

As the largest government payer for prescription drugs, Medicaid drug expenditures account for about 17 percent of the domestic pharmaceutical market. Before the enactment of the Medicaid drug rebate program under the Omnibus Budget Reconciliation Act of 1990 (OBRA), state Medicaid programs paid close to retail prices for outpatient drugs. Other large purchasers, such as HMOs and hospitals, negotiated discounts with manufacturers and paid considerably less.

The rebate program required drug manufacturers to rebate to state Medicaid programs a percentage off of the average price wholesalers pay manufacturers. The rebates were based on a percentage reduction that reflects the lowest or "best" prices the manufacturer charged other purchasers and the volume of purchases by Medicaid recipients. In return for the rebates, state Medicaid programs must cover all

drugs manufactured by pharmaceutical companies that entered into rebate agreements with HCFA.[12]

After the rebate program's enactment, a number of market changes affected other purchasers of prescription drugs and the amount of the rebates that Medicaid programs received. Drug manufacturers substantially reduced the price discounts they offered to many large private purchasers, such as HMOs. Therefore, the market quickly adjusted by increasing drug prices to compensate for rebates obtained by the Medicaid program.

Although the states have received billions of dollars in rebates from drug manufacturers since OBRA's enactment, state Medicaid directors have expressed concerns about the rebate program. The principal concern involves OBRA's requirement to provide access to all the drugs of every manufacturer that offers rebates, which limits the utilization controls Medicaid programs can use at a time when prescription drug expenditures are rapidly increasing. Although the programs can require recipients to obtain prior authorization for particular drugs and can impose monthly limits on the number of covered prescriptions, they cannot take advantage of other techniques, such as incentive-based formularies, to steer recipients to less expensive drugs. The few cost-control strategies available to state Medicaid programs can add to the administrative burden on state Medicaid programs.

Other Payers Employ Various Techniques to Control Expenditures

Other payers, such as private and federal employer health plans and Medicare+Choice plans, have taken a different approach to managing their prescription drug benefits. They typically use beneficiary copayments to control prescription drug use, and they use formularies to both control use and obtain better prices by concentrating purchases on selected drugs. In many cases, these plans and insurers retain a PBM's services to manage their pharmacy benefit and control spending.

Beneficiary cost-sharing plays a central role in attempting to influence drug utilization. Copayments are frequently structured to influence both the choice of drugs and the purchasing arrangements. While formulary restrictions can channel purchases to preferred drugs, closed formularies, which provide reimbursement only for preferred drugs, have generated substantial dissatisfaction among consumers. As a result, many plans link their cost-sharing requirements and formulary lists. The fastest growing trend today is the use of a formulary that covers all drugs but that includes beneficiary cost-sharing that varies for different drugs—typically a smaller copayment for generic drugs, a larger one for preferred drugs, and an even larger one for all other drugs. Reduced copayments have also been used to encourage enrollees using maintenance drugs for chronic conditions to obtain them from particular suppliers, like a mail-order pharmacy.

Plans and insurers have turned to PBMs for assistance in establishing formularies, negotiating prices with manufacturers and pharmacies, processing beneficiaries' claims, and reviewing drug utilization. Because PBMs manage drug benefits for multiple purchasers, they often may have more leverage than individual plans in negotiating prices through their greater purchasing power.

Traditional fee-for-service Medicare has generally established reimbursement rates for services like those provided by physicians and hospitals and then processed and paid claims with few utilization controls. Adopting some of the techniques used by private plans and insurers might help better control costs. However, how to adapt those techniques to the characteristics and size of the Medicare program raises questions.

Negotiated or competitively determined prices would be superior to administered prices only if Medicare could employ some of the utilization controls that come from having a formulary and differential beneficiary cost-sharing. In this manner, Medicare would be able to negotiate significantly discounted prices by promising to deliver a larger market share for a manufacturer's product. Manufacturers would have no incentive to offer a deep discount if all drugs in a therapeutic class were covered on the same terms. Without a promised share of the Medicare market, these manufacturers might reap greater returns from charging higher prices and by concentrating marketing efforts on physicians and consumers to influence prescribing patterns.

Implementing a formulary and other utilization controls could prove difficult for Medicare. Developing a formulary involves determining which drugs are therapeutically equivalent so that several from each class can be included. Plans and PBMs currently make those determinations privately—something that would not be possible for Medicare, which must have transparent policies that are determined open-

[12] OBRA 1990 allowed the states to exclude certain classes of drugs.

ly. Given the stakes involved in selecting drugs, one can imagine the intensive efforts to offer input to and scrutinize the selection process.

Medicare may also find it impossible to delegate this task to one or multiple PBMs. A single PBM contractor would likely be subject to the same level of scrutiny as the program. Such scrutiny could compromise the flexibility PBMs have used to generate savings. An alternative would be to grant flexibility to multiple PBMs that are each responsible only for a share of the market. Contracting with multiple PBMs, though, raises other issues. If each PBM has exclusive responsibility for a geographic area, beneficiaries who need certain drugs could be advantaged or disadvantaged merely because of where they live. If multiple PBMs operated in each area, beneficiaries could choose one to administer their drug benefit. This raises questions about how to inform beneficiaries of the differences in each PBM's policies and whether and how to risk-adjust payments to PBMs for differences in the health status of the beneficiaries using them.

Extending Federal Price Discounts to Beneficiaries

Another option before the Congress would allow Medicare beneficiaries to purchase prescription drugs at the lowest price paid by the federal government. Because of their large purchasing power, federal agencies, such as, the Departments of Veterans Affairs (VA) and Defense (DOD), have access to prescription drug prices that often are considerably lower than retail prices. Extending these discounts to Medicare beneficiaries, or some groups of beneficiaries, could have a measurable effect on lowering their out-of-pocket spending, although whether this would adequately increase access or raise prices paid by other purchasers that negotiate drug discounts is unknown.

Typically, federal agencies obtain prescription drugs at prices listed in the federal supply schedule (FSS) for pharmaceuticals.[13] FSS prices represent a significant discount off the prices drug manufacturers charge wholesalers.[14] Under the Veterans Health Care Act of 1992, drug manufacturers must make their brand-named drugs available to federal agencies at the FSS price in order to participate in the Medicaid program.[15] The act requires that the FSS price for VA, DOD, the Public Health Service, and the Coast Guard be at least 24 percent below the price that the manufacturers charge wholesalers.[16]

Although most federal prescription drug purchases are made at FSS prices, in some cases, federal agencies are able to purchase drugs at even lower prices. For example, VA has used national contracts awarded on a competitive basis for specific drugs considered therapeutically interchangeable. These contracts enable VA to obtain larger discounts from manufacturers by channeling greater volume to certain pharmaceutical products.

Providing Medicare beneficiaries access to the lowest federal prices could result in important out-of-pocket savings to those without coverage who are paying close to retail prices. However, concerns exist that extending federal discounts to Medicare beneficiaries could lead to price increases to federal agencies and other purchasers since the discount is based on prices determined by manufacturers. Federal efforts to lower Medicaid drug prices demonstrate the potential for this to occur. While it is not possible to predict how federal drug prices would change if Medicare beneficiaries are given access to them, the larger the market that seeks to take advantage of these prices, the greater the economic incentive would be for drug manufacturers to raise federal prices to limit the impact of giving lower prices to more purchasers.

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[13] The FSS for pharmaceuticals is a price catalog currently containing over 17,000 pharmaceutical products available to federal agencies.

[14] FSS prices are set through negotiations between VA, on behalf of the government, and drug manufacturers and are based on the prices that manufacturers offer their most favored nonfederal customers.

[15] The act covers single-source drugs, innovator multiple-source drugs, insulin, and biological products such as vaccines and antitoxins. The act does not cover noninnovator multiple-source or generic drugs.

[16] The act requires that manufacturers sell drugs covered by the act at no more that 76 percent of the nonfederal average manufacturer's price, a level referred to as the federal ceiling price. The nonfederal average manufacturer's price is the weighted average price of each single form and dosage unit of a drug that is paid by wholesalers in the United States to a manufacturer, taking into account any cash discounts or similar price reductiions. Prices paid by the fereral government are excluded from this calculation.

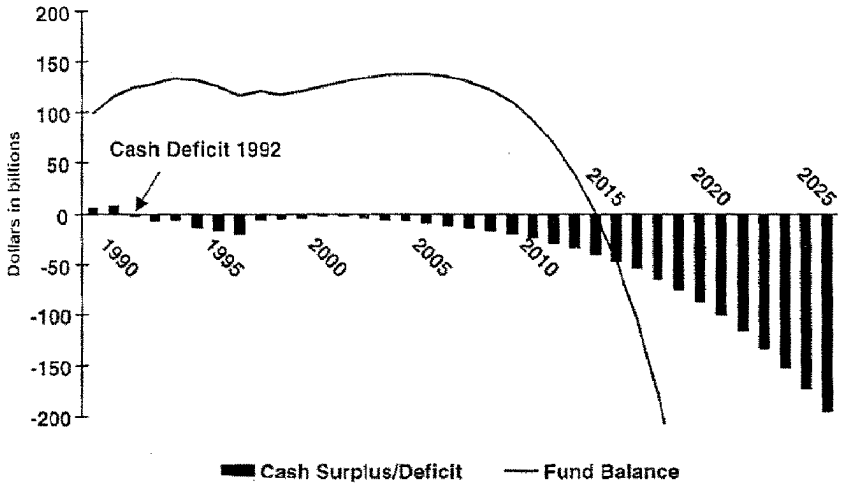
EXPANDING BENEFITS NEEDS TO BE CONSIDERED IN LIGHT OF LARGER MEDICARE FISCAL CONCERNS

The current Medicare program, without improvements, is ill suited to serve future generations of seniors and eligible disabled Americans. On the one hand, the program is fiscally unsustainable in its present form, as the disparity between program expenditures and program revenues is expected to widen dramatically in the coming years. On the other hand, Medicare's benefit package contains gaps in desired coverage, most notably the lack of outpatient prescription drug coverage, compared with private employer coverage. Any option to modernize the benefits runs the risk of exacerbating the fiscal imbalance of the programs. That is why we believe that expansions should be made in the context of overall program reforms that are designed to make the program more sustainable over the long term. Any discussions about expanding beneficiary access to prescription drugs should carefully consider targeting financial help to those most in need and minimizing the substitution of public funds for private funds. Employers that offer drug coverage through a retiree health plan may choose to adapt their health coverage if a Medicare drug benefit is available. A key characteristic of America's voluntary, employer-based system of health insurance is an employer's freedom to modify the conditions of coverage or to terminate benefits.

Medicare's Financial Condition

Unlike private trust funds that can set aside money for the future by investing in financial assets, the Medicare Hospital Insurance (HI) Trust Fund—which pays for inpatient hospital stays, skilled nursing care, hospice, and certain home health services—is essentially an accounting device. It allows the government to track the extent to which earmarked payroll taxes cover Medicare's HI outlays. In serving the tracking purpose, the 1999 Trustees' annual report showed that Medicare's HI component has been, on a cash basis, in the red since 1992, and in fiscal year 1998, earmarked payroll taxes covered only 89 percent of HI spending. In the Trustees' report, issued in March 1999, projected continued cash deficits for the HI trust fund. (See fig. 3.)

Figure 3: Financial Outlook of the Hospital Insurance Trust Fund, 1990 to 2025



Source: 1999 Annual Report, Board of Trustees of the Federal Hospital Insurance Trust Fund.

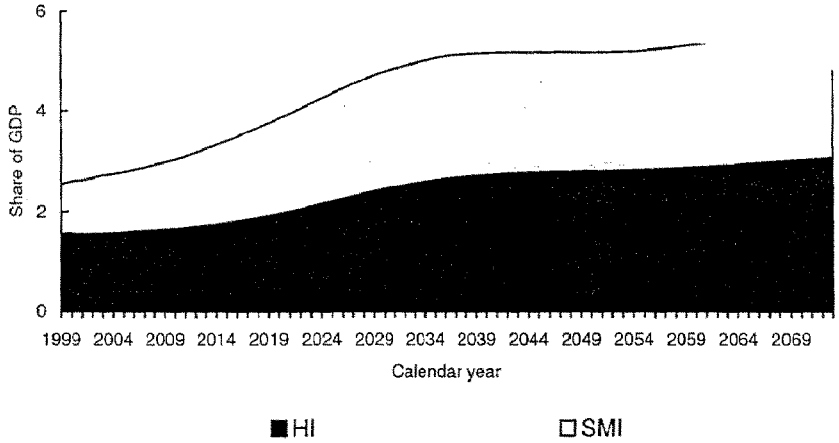
When the program has a cash deficit, as it did from 1992 through 1998, Medicare is a net claimant on the Treasury—a threshold that Social Security is not currently expected to reach until 2014. To finance these cash deficits, Medicare drew on its special issue Treasury securities acquired during the years when the program generates a cash surplus. In essence, for Medicare to "redeem" its securities, the government must raise taxes, cut spending for other programs, or reduce the projected

surplus. Outlays for Medicare services covered under Supplementary Medical Insurance (SMI)—physician and outpatient hospital services, diagnostic tests, and certain other medical services and supplies—are already funded largely through general revenues.

Although the Office of Management and Budget (OMB) has recently reported a $12 billion cash surplus for the HI program in fiscal year 1999 due to lower than expected program outlays, the long-term financial outlook for Medicare is expected to deteriorate. Medicare's rolls are expanding and are projected to increase rapidly with the retirement of the baby boomers. Today's elderly make up about 13 percent of the total population; by 2030, they will comprise 20 percent as the baby boom generation ages and the ratio of workers to retirees declines from 3.4 to 1 today to roughly 2 to 1.

Without meaningful reform, the long-term financial outlook for Medicare is bleak. Together, Medicare's HI and SMI expenditures are expected to increase dramatically, rising from about 12 percent in 1999 to about a quarter of all federal revenues by mid-century. Over the same time frame, Medicare's expenditures are expected to double as a share of the economy, from 2.5 to 5.3 percent, as shown in figure 4.

Figure 4: Medicare Spending as a Percentage of Gross Domestic Product (GDP)1999 to 2073



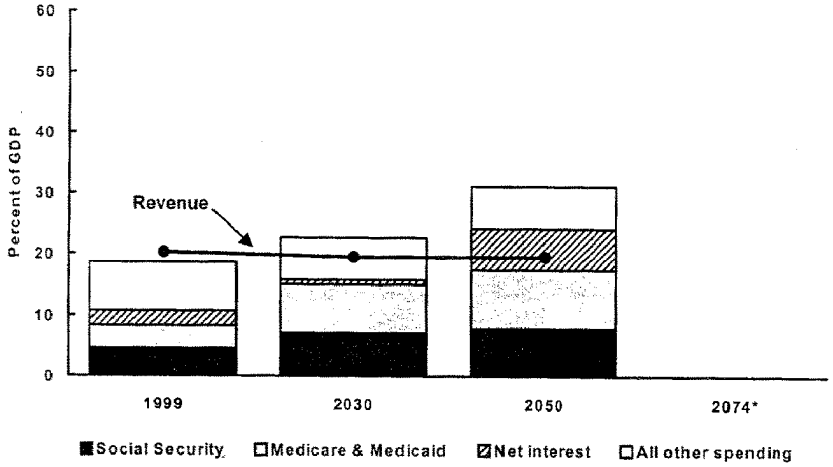
Source: 1999 Annual Report, Board of Trustees of the Federal Hospital Insurance Trust Fund and 1999 Annual Report, Federal Supplementary Insurance Trust Fund.

The progressive absorption of a greater share of the nation's resources for health care, like Social Security, is in part a reflection of the rising share of elderly population, but Medicare growth rates also reflect the escalation of health care costs at rates well exceeding general rates of inflation. Increases in the number and quality of health care services have been fueled by the explosive growth of medical technology. Moreover, the actual costs of health care consumption are not transparent. Third-party payers generally insulate consumers from the cost of health care decisions. In traditional Medicare, for example, the impact of the cost-sharing provisions designed to curb the use of services is muted because about 80 percent of beneficiaries have some form of supplemental health care coverage (such as Medigap insurance) that pays these costs. For these reasons, among others, Medicare represents a much greater and more complex fiscal challenge than even Social Security over the longer term.

When viewed from the perspective of the entire budget and the economy, the growth in Medicare spending will become progressively unsustainable over the longer term. Our updated budget simulations show that to move into the future without making changes in the Social Security, Medicare, and Medicaid programs is to envision a very different role for the federal government. Assuming, for example, that the Congress and the President adhere to the often-stated goal of saving the Social Security surpluses, our long-term model shows a world by 2030 in which Social Security, Medicare, and Medicaid increasingly absorb available revenues within the federal budget. Under this scenario, these programs would absorb more than three-quarters of total federal revenue. (See fig. 5.) Budgetary flexibility would

be drastically constrained and little room would be left for programs for national defense, the young, infrastructure, and law enforcement.

Figure 5: Composition of Spending as a Share of GDP Under "Eliminate Non-Social Security Surpluses" Simulation



*The "Eliminate non-Social Security surpluses" simulation can only be run through 2066 due to the elimination of the capital stock.

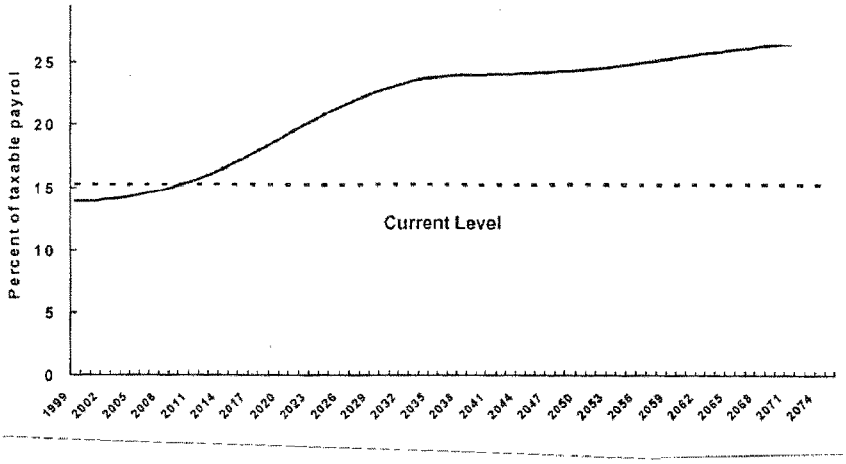
Notes:

1. Revenue as a share of GDP during the simulation period is lower than the 1999 level due to unspecified permanent policy actions that reduce revenue and increase spending to eliminate the non-Social Security surpluses.
2. Medicare expenditure projections follow the Trustees' 1999 intermediate assumptions. The projections reflect the current benefit and financing structure.

Source: GAO's January 2000 analysis.

When viewed together with Social Security, the financial burden of Medicare on future taxpayers becomes unsustainable, absent reform. As figure 6 shows, the cost of these two programs combined would nearly double as a share of the payroll tax base over the long term. Assuming no other changes, these programs would constitute an unimaginable drain on the earnings of our future workers.

Figure 6: Social Security and Medicare HI as a Percentage of Taxable Payroll, 1999 to 2074



Source: *1999 Annual Report,* Board of Trustees of the Federal Hospital Insurance Trust Fund, and *1999 Annual Report,* Board of Trustees of the Federal Old Age and Survivors Disability Insurance Trust Funds.

While the problems facing the Social Security program are significant, Medicare's challenges are even more daunting. To close Social Security's deficit today would require a 17 percent increase in the payroll tax, whereas the HI payroll tax would have to be raised 50 percent to restore actuarial balance to the HI trust fund. This analysis, moreover, does not incorporate the financing challenges associated with the SMI and Medicaid programs.

Early action to address the structural imbalances in Medicare is critical. First, ample time is required to phase in the reforms needed to put this program on a more sustainable footing before the baby boomers retire. Second, timely action to bring costs down pays large fiscal dividends for the program and the budget. The high projected growth of Medicare in the coming years means that the earlier the reform begins, the greater the savings will be as a result of the effects of compounding.

The actions necessary to bring about a more sustainable program will no doubt call for some hard choices. Some suggest that the size of the imbalances between Medicare's outlays and payroll tax revenues for the HI program may well justify the need for additional resources. One possible source could be general revenues. Although this may eventually prove necessary, such additional financing should be considered as part of a broader initiative to ensure the program's long-range financial integrity and sustainability.

What concerns us most is that devoting general funds to the HI trust fund may be used to extend HI's solvency without addressing the hard choices needed to make the whole Medicare program more sustainable in economic or budgetary terms. Increasing the HI trust fund balance alone, without underlying program reform, does nothing to make the Medicare program more sustainable—that is, it does not reduce the program's projected share of GDP or the federal budget. From a macroeconomic perspective, the critical question is not how much a trust fund has in assets but whether the government as a whole has the economic capacity to finance all Medicare's promised benefits—both now and in the future. We must keep in mind the unprecedented challenge facing future generations in our aging society. Relieving them of some of the financial burden of today's commitments would help preserve some budgetary flexibility for future generations to make their own choices.

If more fundamental program reforms are not made, we fear that general fund infusions would interfere with the vital signaling function that trust fund mechanisms can have for policymakers about underlying fiscal imbalances in covered programs. The greatest risk is that dedicating general funds to the HI program will reduce the sense of urgency that impending trust fund bankruptcy provides to policymakers by artificially extending the solvency of the HI program. Furthermore, increasing the trust fund's paper solvency does not address cost growth in the SMI portion of Medicare, which is projected to grow even faster than HI in coming decades, assuming no additional SMI benefits.

The issue of the extent to which general funds are an appropriate financing mechanism for the Medicare program would remain important under financing arrangements that differed from those in place in the current HI and SMI structures. For example, under approaches that would combine the two trust funds, a continued need would exist for measures of program sustainability that would signal potential future fiscal imbalance. Such measures might include the percentage of program funding provided by general revenues, the percentage of total federal revenues or gross domestic product devoted to Medicare, or program spending per enrollee. As such measures were developed, questions would need to be asked about the appropriate level of general revenue funding. Regardless of the measure chosen, the real question would be what actions should be taken when and if the chosen cap is reached.

Long-Term Fiscal Policy Choices

Beyond reforming the Medicare program itself, maintaining an overall sustainable fiscal policy and strong economy is vital to enhancing our nation's future capacity to afford paying benefits in the face of an aging society. Decisions on how we use today's surpluses can have wide-ranging impacts on our ability to afford tomorrow's commitments.

As we know, there have been a variety of proposals to use the surpluses for purposes other than debt reduction. Although these proposals have various pros and cons, we need to be mindful of the risk associated with using projected surpluses to finance permanent future claims on the budget, whether they are on the spending or the tax side. Commitments often prove to be permanent, while projected sur-

pluses can be fleeting. For instance, current projections assume full compliance with tight discretionary spending caps. Moreover, relatively small changes in economic assumptions can lead to very large changes in the fiscal outlook, especially when carried out over a decade. In its January 2000 report,[17] CBO compared the actual deficits or surpluses for 1986 through 1999 with the first projection it had produced 5 years before the start of each fiscal year. Excluding the estimated impact of legislation, CBO stated that its errors in projecting the federal surplus or deficit averaged about 2.4 percent of GDP in the fifth year beyond the current year. For example, such a shift in 2005 would mean a potential swing of about $285 billion in the projected surplus for that year.

Although most would not argue for devoting 100 percent of the surplus to debt reduction over the next 10 years, saving a good portion of our surpluses would yield fiscal and economic dividends as the nation faces the challenges of financing an aging society. Our work on the long-term budget outlook illustrates the benefits of maintaining surpluses for debt reduction. Reducing the publicly held debt reduces interest costs, freeing up budgetary resources for other programmatic priorities. For the economy, running surpluses and reducing debt increase national saving and free up resources for private investment. These results, in turn, lead to stronger economic growth and higher incomes over the long term.

Over the last several years, our simulations illustrate the long-term economic consequences flowing from different fiscal policy paths.[18] Our models consistently show that saving all or a major share of projected budget surpluses ultimately leads to demonstrable gains in GDP per capita. Over a 50-year period, GDP per capita is estimated to more than double from present levels by saving all or most of projected surpluses, while incomes would eventually fall if we failed to sustain any of the surplus. Although rising productivity and living standards are always important, they are especially critical for the 21st century, for they will increase the economic capacity of the projected smaller workforce to finance future government programs along with the obligations and commitments for the baby boomers' retirement.

CONCLUDING OBSERVATIONS

Updating the Medicare benefit package may be a necessary part of any realistic reform program to address the legitimate expectations of an aging society for health care, both now and in the future. Expanding access to prescription drugs could ease the significant financial burden some Medicare beneficiaries face because of outpatient drug costs. Such changes, however, need to be considered as part of a broader initiative to address Medicare's current fiscal imbalance and promote the program's longer-term sustainability. Balancing these competing concerns may require the best from government-run programs and private sector efforts to modernize Medicare for the future. Further, the Congress should consider adequate fiscal incentives to control costs and a targeting strategy in connection with any proposal to provide new benefits such as prescription drugs.

The Congress and the President may ultimately decide to include some form of prescription drug coverage as part of Medicare. Given this expectation and the future projected growth of the program, some additional revenue sources may in fact be a necessary component of Medicare reform. However, it is essential that we not take our eye off the ball. The most critical issue facing Medicare is the need to ensure the program's long range financial integrity and sustainability. The 1999 annual reports of the Medicare Trustees project that program costs will continue to grow faster than the rest of the economy. Care must be taken to ensure that any potential expansion of the program be balanced with other programmatic reforms so that we do not worsen Medicare's existing financial imbalances.

Current budget surpluses represent both an opportunity and an obligation. We have an opportunity to use our unprecedented economic wealth and fiscal good fortune to address today's needs but an obligation to do so in a way that improves the prospects for future generations. This generation has a stewardship responsibility to future generations to reduce the debt burden they will inherit, to provide a strong foundation for future economic growth, and to ensure that future commitments are both adequate and affordable. Prudence requires making the tough choices today while the economy is healthy and the workforce is relatively large. National saving pays future dividends over the long term, but only if meaningful reform begins soon. Entitlement reform is best done with considerable lead-time to phase in changes and before the changes that are needed become dramatic and disruptive. The pru-

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[17] *The Economic and Budget Outlook:* Fiscal Years 2001–2010 (CBO, Jan. 2000).

[18] *See Budget Issues:* Long-Term Fiscal Outlook (GAO/T–AIMD/OCE–98–83, Feb. 25, 1998) and *Budget Issues: Analysis of Long-Term Fiscal Outlook* (GAO/AIMD/OCE–98–19, Oct. 22, 1997).

dent use of the nation's current and projected budget surpluses combined with meaningful Medicare and Social Security program reforms can help achieve both of these goals.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other Subcommittee Members may have.

GAO CONTACTS AND ACKNOWLEDGMENTS

For future contacts regarding this testimony, please call Paul L. Posner, Director, Budget Issues, at (202) 512–9573 or William J. Scanlon, Director, Health Financing and Public Health Issues at (202) 512–7114. Other individuals who made key contributions include Linda F. Baker, Laura A. Dummit, John C. Hansen, Tricia A. Spellman, and James R. McTigue.

Chairman THOMAS. Thank you very much, Mr. Walker.

One of the concerns that I would like to deal with right off the top is oftentimes Medicare is compared to Social Security and they are the two basic safety net entitlements for seniors.

But is it not true that the Social Security trust fund relies only on the payroll tax?

Mr. WALKER. The payroll tax, as well as some income taxes on earnings, but primarily on the—payroll tax.

Chairman THOMAS. Very small amount and that a solvency test based upon how much is coming in and how much is going out is a legitimate test of how many years you can get out of the Social Security trust fund.

Mr. WALKER. It is a signal.

Chairman THOMAS. And with Medicare: Part A being a trust fund similar to Social Security, part B being a general fund draw, that the solvency argument for part A is not really analogous to Social Security; is that a fair thing to say?

Mr. WALKER. That is fair because by definition part B is a term insurance program. It is intended to have enough reserves at the end of the year to pay claims incurred but not reported, claims reported but not paid, and you recalculate the premium and financing for general revenues every year.

Chairman THOMAS. In fact, one of the concerns that led to the Balanced Budget Act of 1997 was the then-threatened insolvency of the part A plan by 2003, 2004, which sounded farther away in 1999 but now that it is 2000 it sounds a lot closer than it used to. And that one of the component parts of the Balanced Budget Act was to take a program that had been funded under part A and move it to the general fund, thereby relieving the costs in the part A fund, but it still got paid for because it was over in part B. Could you do that without statutory change of a significant nature with the Social Security trust fund?

Mr. WALKER. In what regard, Mr. Chairman?

Chairman THOMAS. Well, what you just did was take general fund money and increase that load on the overall Medicare payment structure between part A and Part B.

Mr. WALKER. Well, there have been, as you pointed out, circumstances in the past where different types of benefits have been moved——

Chairman THOMAS. And it was home health care that was shifted from part A to Part B.

Mr. WALKER. That is correct.

Chairman THOMAS. Doesn't the President's budget this year contemplate moving that somewhat phony solvency test on part A, as though it is supposed to have some fundamental significance, from the current roughly 20/15, because the economy has the improved and the Medicare payments have been slightly less than we had anticipated, by simply taking general fund money and proposing it surplus, general fund money, moving it over to Part A?

So, that really if we wanted to play the game of Medicare being adequately funded using a part A solvency test, all we have to do is just periodically shift programs from part A to part B and/or create an open channel of moving general fund money over to part A so that it never, ever reaches the point of what a solvency test is supposed to judge: The inflow and outflow of the payroll taxes in Part A.

So, of what use is a quote/unquote solvency test on part A as a real judge of how many resources are being utilized in this area and what is the appropriate balance between a dedicated trust fund payroll tax that people pay into and the general fund which some folks may have never paid into?

Mr. WALKER. Mr. Chairman, solvency is simply not enough. Sustainability is equally or more important than solvency; solvency is nothing more than a signal. The chart that we had up before that demonstrated the burdens on the economy that are going to be associated with health care in general and entitlement programs in particular directly bears on the point of sustainability. Will we be able to deliver on our promises?

Chairman THOMAS. Excuse me. Couldn't you sustain the Medicare Trust Fund? I mean, for example, the President proposes transferring $700 billion from general revenues. Couldn't you sustain this fund by transferring $700 billion than a trillion, than a trillion and a half?

The fund could be sustained. The only limit would be the general fund's ability to put those moneys into so-called part A trust fund.

Mr. WALKER. That is the fundamental difference, Mr. Chairman. In the vernacular that I use you could end up putting more securities into the trust fund and that would extend solvency, and it would give the trust fund, the HI Trust Fund, for example, a first claim on future general revenues up and to the extent of those securities. On the other hand, it doesn't deal with the economic sustainability issue which is what percentage of the Federal budget, what percentage of the economy is represented by these programs and can we sustain that. Can we deliver on that promise? That is important and that is what this chart demonstrates.

Chairman THOMAS. So, really partly our effort here is not about the solvency of the part A trust fund. It also, in part, is not totally about adding one more benefit to a basic program but that at some point the society has to ask itself to what extent do we want to take scarce, relatively or less so, resources and, without a clear programmatic understanding of where we are going, simply transfer.

One of the concerns the Medicare Commission had was exactly that point and I do have to say that the Senator from Nebraska,

Senator Kerrey, was very instrumental in creating what, for want of a better term, we called programmatic solvency, which was to examine a percentage of the general fund that would be transferred. That, I think, is kind of a crude measure of what you are talking about; is it not?

Mr. WALKER. It is but even under that measure, for example, which the Breaux-Frist bill has, which I believe you are talking about the 40 percent——

Chairman THOMAS. Yes. That was originally a Commission idea and Kerrey was——

Mr. STARK. Even under that, you are going to hit that cap. And the question is, what will end up happening when you hit that cap? Really that is similar to what the solvency test is for the trust funds. And we need to deal with the sustainability issue, which is——

Chairman THOMAS. And we understood that at some time you would hit that cap but then it would at least trigger a public discussion of more put in by the beneficiaries, more put in by the beneficiaries to the payroll tax, a reexamination of the benefits, a reexamination of the fundamental program and the way it works or a reexamination of that 40 percent. At least it would be an event that would trigger a discussion.

And what we are trying to do is trigger that very discussion, I think, without any kind of a dramatic example of why we need to carry out that discussion. And the problem is that we hear, well, we can make it solvent to 2025, all you have to do is this. Don't worry about it. Seniors deserve everything they get and more. And that it is very difficult to create a meaningful debate over what we are really talking about which is to create a sustainable program for today's seniors—enhanced, no question, by prescription drugs which are an essential part of medical practice today—but sustainable for seniors to come.

And it is susceptible to the political siren of let us just answer the question of prescription drugs and worry about that fundamental structure later. If you don't do it over prescription drugs, what is going to be the next big event that will force us to address reform and when is it going to occur?

I believe we share that concern.

Mr. WALKER. There are two key issues here, I think, at least, Mr. Chairman. First is the issue of sustainability which we have talked about. But the other issue is flexibility. How much choice are we going to provide Generation Xers and future generations of Americans to be able to make their own choices about how the resources of tomorrow are going to be allocated. To what extent are we going to make choices for them today that will increase their burdens and reduce their flexibility to make some of their own decisions?

Chairman THOMAS. I want to underscore that point because when you talk about choices, you are not necessarily talking about them as seniors having a multitude of choices among plans all of which cost far more than the society is able to sustain. It is, in fact, taking that dollar, which ultimately is the total package available, and what portion of those resources will have been committed by our failure to make the changes today to that program which limits

their ability to make decisions in the future. Isn't that the choice question you are talking about?

Mr. WALKER. That is correct, as well as choices on discretionary spending.

Chairman THOMAS. Exactly.

Mr. WALKER. Because there are a number of important programs in discretionary spending. National defense. The judicial system. The infrastructure of the nation. Children's programs. A number of things that are in there that are going to be crowded out if we don't get on with more fundamental reforms.

Chairman THOMAS. Well, there are some individuals in some groups that believe seniors have the first call and almost total call on that discretionary dollar. And there has to be a system in which there is an open public debate about priorities. That has not occurred and it needs to.

Thank you very much for your testimony.

Mr. WALKER. Thank you.

Chairman THOMAS. Does the gentleman from California wish to inquire?

Mr. STARK. Thank you, Mr. Chairman.

I guess the other side of the coin, Mr. Walker, is that my understanding—and I don't know how close I am but I will be close enough for government work here—is that if we increase the Medicare tax by about three-quarters of a percent on both sides, the employer and the employee, that we would take care of the solvency, with everybody's estimate, for another 50 or 60 years. Is that a fair——

Mr. WALKER. For part A, 1.46 percent——

Mr. STARK. Would do it. Now, that is a tax increase, I understand, but I am trying to characterize it here just so that is the other extreme. That is as far as you would have to go to get A solvent.

Now, on the part B side, the Republicans suggested that we have an $800 billion tax cut which also comes out of general revenues; does it not? It has the same effect as part B calling on general revenues.

Mr. WALKER. That is correct.

Mr. STARK. Okay. How much can you estimate, to the closest $100 billion, how much we would have to put in to set aside to make a trust fund for Part B? That 10-year estimate was $700-and-some-odd billion. That would have solved part B for a long time; would it not?

Mr. WALKER. I don't have the exact numbers. But I think that is why you have to look at the total projected cost. Because, as you know, Mr. Stark, part B is funded 25 percent by premiums and 75 percent by general revenues.

Mr. STARK. Well, I know that. Okay. Well, I just wanted to suggest that there were options.

Now, you do, in your written testimony, mention that for a variety of factors we need an effective cost control mechanism under any option to increase access to prescription drugs. Is that your feeling?

Mr. WALKER. I think we have to be concerned with effective incentives to control utilization and I think we have to recognize the

difference between, does somebody have access to prescription drugs versus can they afford it. For those that may not be able to afford it may be possible to target financial assistance to those that are truly in need.

The other thing I think we have to recognize, Mr. Stark, is having been Assistant Secretary of Labor for Pensions and Health for a number or years and being very familiar with the private sector side, employers are looking for a lot of reasons to get out of the business of providing prescription drug coverage for seniors and we have to be aware of that. Care has to be taken to make sure that something is not done to facilitate that shift such that the government would then start picking up costs that otherwise employers might be picking up.

Mr. STARK. Are you suggesting that probably it is not such a good idea to rely on the generosity of employers to solve the problems of the uninsured or to provide pharmaceutical benefits for their retirees?

Mr. WALKER. I don't think that you can count on employers to voluntarily step it up to the plate to add a lot of burdens here.

Mr. STARK. OK.

Thank you very much.

Chairman THOMAS. Does the gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON. Thank you.

Mr. Walker, I just wondered whether the GAO has figured out what percentage of the gross national product is currently being spent on people over 65 and what will be spent on that group in 10 years and 20 years if there are no changes in current law?

Mr. WALKER. I don't have those percentages off the top of my head. I would be more than happy to go back and look and see if we have that.

[The information follows:]

U.S. GENERAL ACCOUNTING OFFICE
WASHINGTON, DC 20548
May 11, 2000

The Honorable Nancy L. Johnson
House of Representatives

Subject: Federal Mandatory Spending on the Elderly

Dear Mrs. Johnson:

I am writing to respond to a question you asked the Comptroller General at his testimony before the Subcommittee on Health, Committee on Ways and Means on Tuesday, February 15, 2000. You asked whether we had data on the percentage of the economy currently being spent on people aged 65 or over and what the percentage spent on that group would be in 10 years and 20 years if there were no changes to current law.

Since the data needed to fully answer this question are not readily available, providing a definitive answer would require extensive research. To develop information on current and future federal spending for the elderly, we contacted various federal agencies and compiled data they had available on the largest federal mandatory spending programs that provide income transfers and health benefits to the elderly. These programs are listed in the enclosure. From these data we constructed estimates of federal mandatory outlays for the elderly (that is, those aged 65 or over) for fiscal years 2000, 2010, and 2020. these estimates reflect current law assumptions and are generally based on spending projections obtained from the actuaries' offices at the responsible federal agencies. Programs for which we provide estimates encompass the major portion of federal spending for the elderly, but not all federal

spending for the elderly.[1] Our estimates and the data sources we used are provided in the enclosure to this letter.

We estimate that federal mandatory spending on the elderly for the applicable programs as a share of gross domestic product (GDP) will grow from 6 percent in 2000 to 6.5 percent in 2010. In the following decade, as the baby boom generation begins to retire, this pending will accelerate, reaching 8.4 percent of GDP in 2020. This represents a growth of about 30 percent in federal mandatory spending on the elderly as a share of GDP between 2010 and 2020. Not surprisingly, Social Security and Medicare comprise the largest share of federal spending on the elderly. Medicaid's spending on the elderly as a share of GDP is projected to grow the fastest, doubling over the next 20 years. On the other hand, our estimate show that federal spending on civilian and military retirees is projected to remain relatively constant as a share of the economy.

Future claims of the elderly in the economy are likely to be larger than indicated by our estimates. For example, our estimates do not include federal tax expenditures targeted to the elderly, such as the extra standard deduction for those elderly taxpayers who do not itemize deductions; Veterans Administration expenditures for the elderly; other federal programs targeted to or used by the elderly, including those for housing and food assistance; or spending by state and local governments. In addition, our estimates also do not include private spending on the elderly, such as pensions, prescription drugs, or long-term care including out-of-pocket costs and hours of work foregone by those caring for elderly parents.

If you have any questions regarding the estimates provided here, please call me at (202) 512–9573.

Sincerely yours,

PAUL L. POSNER,
DIRECTOR, BUDGET ISSUES

Estimates of Federal Mandatory Spending for the Elderly

Percentage of GDP	Federal year		
	2000	2010	2020
Old-Age and Survivors Insurance [a]	3.1	3.2	4.2
Medicare [a]	2.0	2.3	3.0
Supplemental Security Income [a]	0.1	0.1	0.1
Medicaid [b]	0.3	0.4	0.6
Military retirement and retiree health [c]	0.2	0.2	0.1
Federal civilian retirement and retiree health [c]	0.4	0.4	0.4
Other federal retirement [d]	0.1	[e]	[e]
Estimated federal mandatory spending on the elderly and retirees	6.0	6.5	8.4

Notes:
1. "Elderly" is defined as those aged 65 or over.
2. Spending projections reflect the largest federal mandatory spending programs that provide income transfers and health benefits to the elderly. Spending projections do not include Veterans Administration expenditures for the elderly or other federal programs targeted to or used by the elderly.
3. Column totals may not add due to rounding.
[a] Estimates for elderly share only.
[b] Estimates reflect the estimated federal share for beneficiaries who originally qualified for Medicaid at age 65 or older. Spending for beneficiaries who originally qualified for Medicaid on other grounds (e.g., disability) but are aged 65 or over in the projection year is not reflected.
[c] Estimates for federal civilian retirement reflect Civil Service Retirement System and Federal Employee Retirement System defined benefits only. Estimates for federal civilian retiree health reflect spending due to annuitants aged 65 and over who remain in the Federal Employee Health Benefits program and their dependents,including nonelderly dependents. Estimates for military retiree health reflect all spending for retirees and survivors aged 65 and over and their dependents, including nonelderly dependents.
[d] "Other federal retirement" is largely railroad retirement.
[e] Estimated to be less than 0.1% of GDP.

Sources:

Old-Age and Survivors Insurance:

Estimates are based on our analysis of long-term spending projections obtained from the Social Security Administration, Office of the Chief Actuary. These projections reflect the intermediate assumptions of the *2000 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds.*

[1] A recent report by the Senate Special Committee on Aging summarizes and analysis the many federal policies and programs that are of the most continuing importance for older persons and their families. *See Special Committee on Aging, Developments in Aging: 1997 and 1998 (2 vols.).*

Medicare Hospital Insurance and Supplementary Medical Insurance:

Estimates are based on GAO analysis of long-term spending projections obtained from the Health Care Financing Administration, Office of the Actuary. These projections reflect the intermediate assumptions of the *Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund, April 2000, and the Annual Report of the Board of Trustees of the Supplementary Medical Insurance Trust Fund, March 2000.*

Supplemental Security Income:

Estimates are based on our analysis of spending projections published in the *Annual Report of the Supplemental Security Income Program,* Social Security Administration, May 1999.

Medicaid:

For 2000 and 2010, estimates are based on our analysis of projections obtained from the Health Care Financing Administration. For 2020, estimates are based on our analysis of unpublished long-term spending projections obtained from the Congressional Budget Office.

Military retirement and health:

Estimates are based on our analysis of long-term spending projections obtained from the Office of the Actuary, Department of Defense (DOD).

Federal civilian retirement:

Estimates are based on our analysis of long-term spending projections obtained from the Office of Personnel Management, Office of the Actuary.

Federal civilian retiree health:

Estimates are based on analysis of unpublished projections obtained from the Office of Personnel Management, Budget and Program Information Division, and the Office of Actuaries.

Other federal retirement:

Other federal retirement military includes railroad retirement. The estimate for railroad retirement is based on projections published in *The Budget and Economic Outlook: Fiscal Years 2001–2010,* Congressional Budget Office, January 2000.

Mrs. JOHNSON. I would like you to provide them to the Committee. From another but credible source a year ago, was my understanding, that currently it is somewhere in about the mid-or-high thirties and that in 10 years it is going to be in the mid-or-high forties. I think all of us have the responsibility to ask ourselves what percentage of the gross economic activity we can afford to dedicate to any group, population group.

And if we are going to be getting up toward 50 percent without prescription drugs we at least need to know it because that is part of your comments that prescription drugs should be added as part of a holistic reform. Now, personally, I have been for a long time a very strong advocate of Medicare including prescription drug coverage access because, frankly, health care without medications simply is not health care any more. When Medicare was founded, you could say that.

Now, I want to get to sort of the nuts and bolts in just the short time that I have. In your testimony you say that the VA negotiates the discounted prices that are listed in the Federal supply schedule. Now, it is my understanding that this Federal supply schedule of prices is simply a formula and that formula is that the government is going to pay 24 percent less than that company sells the drug to everybody else.

Now, first of all, that keeps the company from dropping the drug price to the rest of us but a 24 percent drop is not exactly what I would call negotiations. And it is my understanding, although just superficially, that this is not the kind of process that the Federal employees' health benefit plan uses in its effort to provide drug benefits to public employees. Could you discuss those differences?

Mr. WALKER. My understanding is that the VA does an overall negotiation on behalf of itself and other federal purchasers, whereas the Federal health benefit plans, as you know, each of the plans end up negotiating their own deal as to what is going to be covered.

And part of this has to do with what is the effect of the discount? One of the great debates is to the extent that you end up basing the discount say, for example, on retail or wholesale prices, then there are certain consequences of that. The consequences of who is going to end up bearing those additional costs? And, so, there is a difference between VA and FEHBP in part because VA covers federal purchasers and the others negotiate on their own behalf.

Mrs. JOHNSON. And could you comment on the scope of drugs covered by the VA and the scope covered by most benefit plans serving Federal employees?

Mr. WALKER. As far as the benefit levels?

Mrs. JOHNSON. In other words, is the formulary more restricted? Does the VA offer drugs but only a narrower spectrum of drugs than most Federal employees health benefit plans?

Mr. WALKER. As you know, Mrs. Johnson, that since by definition there are numerous FEHBP plans, benefit plans vary as to what they offer under prescription drug coverage as compared to what VA would be.

Mrs. JOHNSON. That is the point really I wanted to bring out was that in choosing a health plan as a Federal employee—and I get exactly the same choices as the receptionist in my office, my caseworkers, everyone else who works for me, and exactly the same choices as the people who work in the Social Security offices, the air traffic controllers, all the other Federal employees, I don't get a different set of choices—but I can choose a plan that offers me access to a whole range of drugs. I can also choose a plan that offers me very big access but to a limited number of drugs. And it is my understanding that the VA offers you access to the drugs that they have on formulary.

And I think one of the really big problems we have in talking in this area is understanding the implications of formularies. And if you would just talk a little bit about that problem of health care quality and formularies. You do mention it in your testimony.

Mr. WALKER. Yes. Part of the difference is, is whether you have an open formulary or a closed formulary from the standpoint as to whether or not there is a restriction placed on which drugs you can actually get. In many cases there can be a situation where you have an incentive to select a drug from a restrictive list where the provider pays a larger share of the cost, if you pick from that preferred list.

On the other hand, you can select a drug from outside of that list if you want to but you may have to incur more costs if, in fact, you do that. So, there are differences in design.

FEHBP provides an array of choices and it empowers the individual to make the determination as to how much coverage they want and what they are willing to pay.

Mrs. JOHNSON. I would just like to put on the record that I am getting more and more complaints from my constituents about formularies, whether they are people who work for employers and get their health insurance that way or whether they are seniors using Medigap coverage or a Medicare managed care choice plan, but formularies sound good on paper. If what you need is not in that formulary, it can be a very big problem. And I think in planning this, we have to understand that formularies are a common way of controlling costs and they are very destructive to health care quality for seniors.

Thanks, Mr. Chairman, I have other questions but I will wait until there is another round.

Chairman THOMAS. Does the gentleman from Louisiana wish to inquire?

Mr. MCCRERY. Yes. Thank you, Mr. Chairman.

Mr. Walker, on your chart on the pedestal right now, you have one category for Medicare and Medicaid, so, we can't really tell the Medicare.

Mr. WALKER. Right.

Mr. MCCRERY. Do you know whether Medicare increases at a greater rate than Medicaid does during that period of time?

Mr. WALKER. Yes, it does. And the bulk of that is the combined Medicare Program.

Mr. MCCRERY. Right. OK. And we see that by 2050 Social Security and Medicare/Medicaid take up almost the entire stream of revenue if it is still 20.7 percent of GDP or there-abouts?

Mr. WALKER. That is correct and, in fact, you don't have enough to even pay interest on the national debt.

Mr. MCCRERY. Right.

So, if we make no changes in Medicare, Medicaid or Social Security, we have a big problem; don't we?

Mr. WALKER. That is correct.

Mr. MCCRERY. Unless we want to take a much bigger bite out of national income in the form of revenues to the Federal Government?

Mr. WALKER. That is correct.

Mr. MCCRERY. Now, can you tell me if your figures, that are illustrated on the board, include a drug benefit?

Mr. WALKER. No. They do not.

Mr. MCCRERY. So, those figures showing a tremendous increase in Medicare, Medicaid expenditures do not include adding a prescription drug benefit. And can you tell us what the estimate is for Medicare costs to increase if we added a prescription drug benefit to the current program

Mr. WALKER. Two footnotes. First, they don't explicitly include adding a prescription drug benefit. The cost obviously would vary depending upon how that program would be structured, who would be covered, how much subsidy there would be, and so forth. But an important footnote here, under these projections it assumes that the Social Security surplus will be saved and that the on-budget surplus will be spent either through tax cuts or spending increases.

Therefore, one could say that one of the things that could happen with that on-budget surplus is to dedicate part of those revenues to prescription drug benefits or for a variety of things.

So, no, it does not expressly consider that.

Mr. MCCRERY. Right.

Mr. WALKER. On the other hand——

Mr. MCCRERY. Well, the fact remains though if you added more spending to Medicare, whether you do it from general funds or from a new tax, that shaded area is going to go up and probably rise above the revenue line that is on your chart.

Mr. WALKER. That is correct.

Mr. MCCRERY. And I believe in your testimony you estimate that by adding a prescription drug benefit to current Medicare, current Medicare costs would increase from about 7 to 10 percent per year.

Mr. WALKER. That is what the estimate is on average.

Mr. MCCRERY. Last week you testified before the Senate Aging Committee and there you said, "Ideally the unfunded promises associated with today's program should be addressed before or concurrent with proposals to make new ones such as adding prescription drug coverage. To do otherwise might be politically attractive but not fiscally prudent."

Mr. WALKER. I think it is important that we make progress in closing the gap associated with unfunded promises based on current benefits. At a minimum, I would hope that if the Congress was going to increase prescription drug coverage it would at least not exacerbate the financial imbalance and hopefully would be coupled with reforms that would at least make a down-payment on closing the gap between promised and funded benefits for the current program.

Mr. MCCRERY. So to put it simply or try to put it simply, to paraphrase what you just said, if we add a prescription drug benefit to Medicare we ought to do it in the context of overall reform of the program?

Mr. WALKER. Comprehensive reform clearly is called for.

Mr. MCCRERY. And, finally, let me ask you about the suggestion by some that we extend the Federal supply schedule, the FSS, to Medicare. It seems to me that at some point if you keep extending that—I mean there is already I think a move to extend it to one of the programs under the FEHBP or one of the plans under FEHBP and now you are talking about including Medicare beneficiaries—at some point don't you raise the cost of drugs to those who are currently getting the discount? And if you don't do that then you certainly will reduce the number or the amount of money that drug companies have for research and development?

Mr. WALKER. Something has got to give. Either profits will give, R&D will give or prices will somehow go up and prices will be redistributed. But I think that is one of the debates that has to be had. What is the most important thing? Is access the most important? Do you want to assure access? After you have assured access then what about affordability? And then how do you want to end up allocating any financial support, whether it be tax incentives or spending or whatever else, based upon need, based upon who can't afford to pay for it?

And, so, yes, something has got to give. And there will likely be a ripple effect on others.

Mr. MCCRERY. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank you. Does the gentleman from Wisconsin wish to inquire?

Mr. KLECZKA. Thank you, Mr. Chairman.

Mr. Walker, on that exact same point, isn't the reverse true? If I and my company are not on that formulary, I am paying a higher price to subsidize those who are. That is unfair on its face.

Mr. WALKER. Unless you are a good negotiator and negotiated your own rate generally that is the case, yes.

Mr. KLECZKA. So, you have unfairness on both ends and we are going to have to strike a balance.

In your testimony you indicate that one-third of seniors have no drug benefit coverage and two-thirds do have some type of drug coverage. Some of my colleagues have said "that isn't bad. I mean two-thirds are being covered; I don't see a critical problem."

But you have indicated that the coverage for those two-thirds is very unstable. We are going to hear later this afternoon from the AARP and they indicate that while an estimated 60 to 70 percent of large employers offered retiree health coverage during the eighties, fewer than 40 percent of large employers do so today. Of those employers who offer retiree benefits, 28 percent do not offer drug coverage to the Medicare eligible retirees.

Again, you indicated that the coverage held by two-thirds of Medicare beneficiaries is unstable. Do you want to expound on that? Because I think this is the crisis and this crisis is going to grow. I think that it is incumbent upon Congress to start addressing the situation this year, this session, starting with this hearing. Could you expand on the unstableness of the current retiree coverage?

Mr. WALKER. The single largest source of retiree coverage is from employer-sponsored plans. It is about 30 percent. Of the employer-sponsored plans they are not subject to the same protections in the Employee Retirement Income Security Act. In other words, you don't vest in a benefit since it is not a pension benefit. Therefore, it is a matter of contract law.

In many cases employers have flexibility to change the nature and extent of their promises. And, quite frankly, they would like to have an opportunity to do so. And, so, yes, it is very tenuous. Yes, they can end up modifying those promises a lot easier than they can their pension promises. But I think we also have to be careful not to allow them to modify in the way where they are passing their obligations off on the taxpayers, which is one of the cares that has to be taken here.

Mr. KLECZKA. And how and why would that occur? If we mandate a benefit in Medicare, I think, would be one. Do you have any others?

Mr. WALKER. For example, if prescription drug benefits was provided to everybody under Medicare and subsidized and paid for under Medicare, and employers didn't have a contract law obligation in order to continue to provide that prescription drug coverage, then I can assure you that they would in all likelihood terminate

that coverage and say you now can be covered under the government's plan. They may or may not provide any assistance if there is a premium associated with it.

So, there are some very real ripple effects of whatever happens in this area.

Mr. KLECZKA. Okay. But, would not the employer do the same even with a voluntary benefit? Employers might think, "under contract law I don't have to do it. There is another option for my retirees. Let them get their drugs through Medicare. The company can save money, we can keep the additional profit."

Mr. WALKER. Under contract law in most cases it is deemed to be a status benefit. In most courts the way that has worked is that once you are in retirement and once you are receiving the benefit, most courts have held that that is when you are entitled to the benefit.

So, the real key is that what are they going to do for people that haven't met that status benefit yet.

Mr. KLECZKA. I have to take serious exception to that last statement, Mr. Walker. As I look at the various decisions relative to retiree health benefits, the courts in recent years have been ruling more and more with the employer. I cite for you the case in Milwaukee, Wisconsin, of the Pabst Brewing Co. wherein for years they provided decent health care benefits for the retirees. And one day, willy nilly, they woke up and just canceled those benefits. The employees took them to court but they didn't have a leg to stand on.

So, I think in a real world the reverse is happening today.

Mr. WALKER. It really depends upon the language in the applicable documents. I mean this is an area that you really can't generalize on. But I will agree with you on this: It is a tenuous promise. I will agree with you on that.

Mr. KLECZKA. Thank you very much.

Chairman THOMAS. And before I call on the gentleman from Michigan, I would like to underscore the point that was made while we were talking about employers and whether or not they have a heart, whether or not they have an interest in their employees and I believe you did say that that is the single greatest source of pharmaceutical coverage for seniors today.

Mr. WALKER. That is correct.

Chairman THOMAS. Okay. And are they required to offer it?

Mr. WALKER. They are not required to offer unless they negotiate it through union contracts or bargaining or another way.

Chairman THOMAS. Now, clearly, we want a better world but that is the current world as we discuss various people's motives.

Does the gentleman from Michigan wish to inquire?

Mr. CAMP. I do. Thank you, Mr. Chairman.

Mr. Walker, you make quite a case in your written and oral testimony here and at several points you say that without reforms Medicare spending will increase to a point that is just unsustainable by future generations. You also mention that Medicare without improvements is currently ill-suited to serve future generations. And at another point you say without reform the future of Medicare is bleak. That is pretty strong language.

You have also stated that adding a prescription drug benefit would increase Medicare annual costs, and you estimate, between 7 and 10 percent. Do you believe it is wise for Congress to take action on prescription drugs this year if there are not some significant steps toward systemic reform?

Mr. WALKER. We are on the record as saying that we believe that if Congress takes action on prescription drugs it should be coupled with enough reforms that at least it will not make the financial condition worse. And that ideally we should start making some progress on closing the unfunded gap in connection with existing promises.

Stated differently, adding a prescription drug benefit without doing anything else is going to compound our problems. It is going to take us in the wrong direction.

Mr. CAMP. And I think even a point in your testimony you go further and say, with some updated budget simulations that you would even suggest reforms to Social Security and Medicaid and Medicare because of the financial pressures.

Mr. WALKER. Realistically we can't do everything at once. But I will say this, the financial imbalance in Medicare is much, much greater than Social Security and it may well require some revenue infusion of some form as part of the solution but it clearly is going to require fundamental program reform as well.

Mr. CAMP. Given the limited resources that we have and that you have testified to and we have an extremely significant long-term financial problem looming, do you believe that we should expand access to prescription drugs in a way that does not displace the private sector, a private sector that is helping seniors with access to drugs?

Mr. WALKER. If anything, I think you would want to encourage the private sector to help and not displace private spending for public spending in this area.

Mr. CAMP. All right. Thank you.

Thank you, Mr. Chairman.

Chairman THOMAS. Does the gentleman from Minnesota wish to inquire?

Mr. RAMSTAD. Thank you, Mr. Chairman.

General, good to see you. Just to follow-up the previous line of questioning. In your testimony you stated that or in the questioning that adding a prescription drug benefit, as Mr. Camp reiterated, would increase Medicare spending 7 percent. How does that square with the study recently released by the National Center for Policy Analysis that concluded if current Medicare dollars were used more wisely seniors could have a prescription drug coverage without the infusion of any additional Federal funds. Is that why you conclude that we need to do it within the context of overall Medicare reform, and do you agree with that conclusion?

Mr. WALKER. I am not familiar with that particular study. I will say that there is no question that there are opportunities to improve the economy and the efficiency of HCFA and the Medicare Program but even if we pursue all of those, we still have a major long-range challenge and even if we pursue all of those, adding prescription drugs is going to add to the cost and it is going to add to the pressure posed by those bars.

Mr. RAMSTAD. Well, and, of course, how we do it is the key question. I think everyone or most people on this panel agree, as the Chairman said so well, that we need prescription drug coverage for seniors who can't afford prescription drugs for Medicare beneficiaries. Seniors in my district are saying, give us a targeted prescription drug coverage to cover low-income seniors without displacing the coverage and quality that those who aren't low-income currently are benefiting from, that they currently enjoy.

And it seems to me, to go back to your testimony, that we have two options, Congress has two options in addressing the drug issue. One, we can either devise a system to help seniors insure against the cost of drugs or intervene to make the cost of products of medicines less for seniors.

And it seems to me, given your studies and your observations of the private drug market, General, and the expanding role of so-called PBMs, the pharmacy benefit managers, in monitoring drug utilization, isn't it fair to say that the insurance approach would be better certainly in terms of driving health care quality?

Mr. WALKER. Well, I think it is difficult to say that there is a particular approach that would be better. I think frankly that the fundamental issue is severalfold. First, access. Most people believe that it is important that everybody have access to prescription drug coverage. So, therefore, we need to examine what can be done in order to assure universal access to prescription drug coverage.

Secondly, the issue of the extent to which the Federal Government might be able to leverage purchasing power to get a better deal on prescription drug prices, and to what extent might the benefit of those prices be passed on to seniors in a cost-neutral fashion to the Federal taxpayer.

The third issue is to the extent that you have got some seniors that can't afford the coverage then how do you target dollars? I think it is either through the tax system, through Medicare or otherwise, how do you target dollars to help those that need help?

Mr. RAMSTAD. But don't you agree that we should target them to low-income seniors, the prescription drug proposal should be targeted to low-income seniors?

Mr. WALKER. I think we are on record as saying that targeting would clearly appear to be the prudent course of action here especially in light of the financial imbalances this program already faces.

Mr. RAMSTAD. But you are not willing to recommend to the Congress an insurance approach with some form of a stop-loss coverage to protect seniors in terms of costs?

Mr. WALKER. I have always found that it is prudent for me to be able to provide the facts, lay out the options, talk about the pros and cons, but not recommend any particular solution, Mr. Ramstad.

Mr. RAMSTAD. So, your analysis doesn't—you haven't analyzed that vis-a-vis a discounted pricing scheme; the insurance approach versus a discounted pricing scheme?

Mr. WALKER. There are different effects. On a discounted pricing scheme what would theoretically happen is that you would end up potentially redistributing the cost among different purchasers. If, for example, you said, we want to be able to buy at 25 percent less

than average wholesale prices, then that is not saying what the price is because wholesale prices could go up. But what that would result in is a redistribution of price among different purchasers, if you will.

In addition, there are even different insurance approaches as we have heard already based upon how different Federal health plans approach this issue versus others. So, I don't think there is a universal way.

Mr. RAMSTAD. Well, in my remaining seconds I just hope that we can design an effective and efficient way to use scarce Medicare dollars in targeting a prescription drug benefit to low-income seniors. If we do nothing else this session, we need to do that in the context of Medicare reform.

Thank you very much, General, it has been very helpful testimony.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank the gentleman.

Does the gentleman from Washington wish to inquire?

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Mr. Walker, I am not an economist so I always like to know the assumptions of a graph. And I like that graph you have got up there. But I have trouble figuring out one thing about it. Where does all that net interest problem come in 2050 if we pay off the deficit. Now, where in the world are you coming up with all that net interest?

Mr. WALKER. Where it comes, Mr. McDermott, is first, the assumption in this chart is that all of the Social Security surplus will be saved——

Mr. MCDERMOTT. Like the President has suggested.

Mr. WALKER. That is correct. I think that there appears to be bipartisan, bicameral consensus on that, to save the Social Security surplus.

Mr. MCDERMOTT. On that part.

Mr. WALKER. There does not, however, appear to be any bipartisan or bicameral consensus on anything more than that. In fact, there is pent-up demand to somehow deal with the on-budget surplus, either through additional spending and/or tax cuts. So, what this assumes is that Social Security surplus will be saved and that the on-budget surplus will be spent one way or the other, either through tax cuts, spending increases or a combination.

Mr. MCDERMOTT. Well, this reflects the Republicans' plan to give a $1 billion tax cut in this country.

Mr. WALKER. No, no, absolutely it doesn't reflect anybody's plan. It reflects an assumption that whatever the on-budget surplus is that there are pent-up demands through either prescription drug pricing increases or education spending increases or tax cuts or a variety of different things. Moreover, if you assume that and if you assume that the taxation of the American public remains roughly at the current level of the economy, then that is where you start getting the haircut or the scalp.

As a result we will have deficits reemerge. I mean, for example, Social Security, itself, is going to start turning a negative cash flow in 2014 or 2015. Thus, we know that we face longer range deficits.

The other thing is that even though publicly held debt is going down, total debt is going up.

Mr. MCDERMOTT. What do we care about that? That is not our problem.

Mr. WALKER. Well, the only thing that I think that we would care about it—as an economist and I am not a Ph.D., economist but——

Mr. MCDERMOTT. I am not an economist.

Mr. WALKER. Oh, I apologize. I thought you were.

Mr. MCDERMOTT. Yes. I am not an economist. Let me get that straight.

Mr. WALKER. I apologize.

Mr. MCDERMOTT. I want to know why——

Chairman THOMAS. Let us clear this up, he is not an economist, he is a psychiatrist.

[Laughter.]

Mr. WALKER. You know, the fact is that clearly there is a difference between debt held by the public and intra-government debt that the government owes itself. At the same point in time, debt that the government owes itself, in effect, I mean the debt that is in these trust funds at some point in time has got to get paid off. And it is going to get paid off based upon future general revenues and it represents burdens that future taxpayers are going to have to bear.

Mr. MCDERMOTT. Is it fair then to characterize your testimony that it is impossible for us to do a drug benefit, given that graph——

Mr. WALKER. I do not think that it is——

Mr. MCDERMOTT. Without putting us in more fiscal difficulty than we are in today?

Mr. WALKER. I do not think it is impossible for you to do a prescription drug benefit. What I am saying is, I think that it is important that in whatever the Congress pursues in this area that it keeps in mind the long-range financial imbalance that we face in Medicare as well as the overall budget, and that whatever is done at least does not make things worse. That, by definition, would mean that somehow it would be coupled with some type of reforms that would at least break even on what incremental costs the government might have associated——

Mr. MCDERMOTT. The prescription drug benefit is held hostage to Medicare reform as one possibility. I mean we can shift enough costs off of Medicare off the government and onto individuals than we would have a little bit of money to put into a prescription drug benefit; is that what you are saying, that one scenario might work?

Mr. WALKER. I mean there a lot of ways.

Mr. MCDERMOTT. But is that one that might work?

Mr. WALKER. Potentially. I am not recommending that. I mean ultimately all that I am trying to say is this, Mr. McDermott, is that I think there appears to be a broad-based consensus that something needs to be done about prescription drugs in order to modernize the program. So, how can whatever is done be targeted to minimize the cost, to maximize the positive effect that you are designed to try to achieve without making the long-range problem on Medicare worse. That is all I am trying to say. Because right

now we have got these short-term surpluses but they are exactly that. We have got very real long-range problems that sooner or later we have got to get on to dealing with and that is all I am trying to say.

Mr. MCDERMOTT. It seems like extrapolating from that you could say that making a tax cut doesn't make any sense now; doesn't it?

I mean if we have got only short-term surpluses and we spend them where—and we wind up exacerbating the problem in 2050?

Mr. WALKER. We are on the record saying that the most prudent fiscal course is to pay down the debt.

Mr. MCDERMOTT. That is all I wanted out of you.

Thank you.

Mr. WALKER. Thank you, Mr. McDermott.

Chairman THOMAS. That assumes then that the more than $300 billion of proposed tax cuts in the President's budget falls under that same argument.

Mr. MCDERMOTT. I would go with that.

Chairman THOMAS. You would go with it in denying needy seniors prescription drugs based on your logic.

Mr. MCDERMOTT. No. The President proposed a tax and a proposal for prescription drugs.

Chairman THOMAS. Correct. He also proposed $70 billion in cuts in Medicare.

Mr. MCDERMOTT. Ah, well, you think your proposal was less?

Chairman THOMAS. No. I am just anxious to see how AARP reacts to that.

I thank the gentleman; his time has expired.

[Laughter.]

Chairman THOMAS. I sometimes like to get the full benefit of being chair.

Does the gentleman from Pennsylvania wish to inquire?

Mr. ENGLISH. Thank you, Mr. Chairman, I do wish to inquire.

General Walker, I appreciate your taking the time to participate today and I found your testimony so far very well informed and stimulating. I think you are speaking to one of the largest problems currently facing older Americans and one that to address up here, and I firmly believe we need to address this issue as soon as possible, we need to get it right.

I am a little concerned. I think the GAO performs an important role up here. Sometimes in an institution that sometimes doesn't think beyond the next election, 2 years down the road, you provide a certain institutional memory. And I wonder could you give us an insight? This prescription drug benefit would amount, even though it is an aggregation on the existing Medicare Program, it would amount to a new entitlement. Can you give us a sense of how, over time, the projections of the cost of new entitlements when they are enacted, how accurate have those projections proven to be? Or is there a case to be made that new entitlements tend to be fantastically more expensive in the long-run than initially projected?

Mr. WALKER. Without having the exact numbers in front of me, I can tell you that because of the inherent uncertainty in projecting the cost of entitlements the Social Security and Medicare trustees every year come up with three projections of the estimated cost: A high cost, a best estimate cost, and a low cost.

Historically over a number of years, the estimated costs have been closer to the best estimate cost but more toward the higher rather than the lower. So, in other words, people have tended to be more optimistic that costs weren't going to go up than, in fact, history showed.

Another point that I think is important here is that when John Kennedy was President 70 percent of the Federal budget was discretionary spending. We are now down to 30 percent roughly. We flipped it totally. And it is going to get a lot worse if we don't do something about it. And that is part of what this chart demonstrates.

Mr. ENGLISH. So, when you write, as you do in your testimony, that we believe that expansions should be made in the context of overall program reforms that are designed to make the program more sustainable over the long-term, what you are saying is, because of the unpredictability of the additional costs we have to be exceptionally careful as we add this benefit to the Medicare Program so that the entire program is going to be sustainable in the long haul?

Mr. WALKER. That is correct. I think we also have to recognize the inherent uncertainty of projections. Take CBO's latest budget projections. They now have adopted several potential alternative assumptions. Under one of their assumptions, if you go back to historical spending patterns and a 1 percent higher average annual inflation rate for health care over what they assumed, surpluses turn into deficits.

So, I think we need to proceed prudently and with caution.

Mr. ENGLISH. You also say in your summary comments that expanding beneficiary access to prescription drugs should carefully consider targeting financial help to those most in need and minimizing the substitution of public funds for private funds.

On those two critical points, how do you assess the President's proposal?

Mr. WALKER. I have not fully assessed the President's proposal. I do have a hearing scheduled for the 24th, I believe, of this month where I am going to be doing that. So, I would hesitate to say much until I have fully analyzed it.

Mr. ENGLISH. Very good. And I look forward then to your analysis. You had something else to say?

Mr. WALKER. I will say one thing. Solvency is not enough. Sustainability is not adequately addressed by the proposal. I have said that before and I expect that I will say that again on the 24th.

Mr. ENGLISH. Also, you talk about in your testimony, Federal price discounts as a potential model for price discounts through the Medicare Program. And you say that whether this would adequately increase access or raise prices paid by other purchasers that negotiate drug discounts is unknown.

Is it fair to say that there is a legitimate danger that by including Medicare drug purchases under this kind of a discount it would have a deleterious effect on the existing discounts provided to the Departments of Veterans Affairs and Defense, for example?

Mr. WALKER. It could have a deleterious effect and it also could have a ripple effect on what overall prices people pay for prescription drugs. But that is——

Mr. ENGLISH. You mean cost shifting?

Mr. WALKER. Correct. But, believe me, cost shifting is already happening in many forms in health care and one of the greatest challenges we face is how can we make the cost of health care more transparent and what can we do to provide meaningful incentives for individuals to control utilization and intensity where they need to be controlled?

We have some real challenges here, including the fact that our largest tax preference in the Code before too long is going to be for health care which may actually be fueling consumption.

Mr. ENGLISH. Thank you.

And with that pro-tax reform note, I will yield back to the chair.

Chairman THOMAS. I thank the gentleman.

Does the gentlewoman from Florida wish to inquire?

Mrs. THURMAN. I do. Thank you, Mr. Chairman.

General, let me ask you a question, philosophical question, maybe. Do you consider Medicare to be an insurance program?

Mr. WALKER. It was intended to be an insurance program. It isn't financed the same way——

Mrs. THURMAN. But basically it is an insurance program for people over 65.

Mr. WALKER. It was intended to be one, yes.

Mrs. THURMAN. So, if we look at a prescription drug benefit in all of our other private sector insurance companies that have a prescription drug benefit, do they go out and negotiate with these pharmaceutical companies for the best price to deliver to their customer?

Mr. WALKER. In many cases they do. Yes. They try to leverage purchasing power.

Mrs. THURMAN. So, why would it not be—say we don't have any money, forget the charts about what we might do to Medicare bouncing this up, doing that—why would it not just make sense for no other reason, just like we do with VA, just like the states do, just like you do with the Federal employees, at least leverage the people that we have in Medicare today or the fact that we have a Medicare Program which is an insurance program to negotiate the best customer price?

Mr. WALKER. Clearly, one of the questions to address on this issue is whether you want to leverage purchasing power to be able to get a better deal for everybody covered under the Medicare Program. On the other hand, there is going to be a ripple effect that could be——

Mrs. THURMAN. OK. However, let us talk about that ripple effect a little bit. First of all, we have two Federal programs to help low-income seniors. You may want to talk about those: SLMBs and QMBs, I believe are the two synonyms for those programs; both to help low-income seniors have access; one pays for a premium for some other kind of an insurance, another pays deductibles correct?

Mr. WALKER. Yes, that is correct.

Mrs. THURMAN. So, we do, in fact, have in place now a prescription drug benefit for low-income seniors.

Mr. WALKER. On a targeted base, right, low-income.

Mrs. THURMAN. OK. Then the second question is, do we not have a prescription drug benefit for those people——

Chairman THOMAS. I would just tell you as you go down that track and you make an absolute statement, let's make sure that when we make them that we don't mischaracterize the current structure because, frankly, there is a crazy quilt of prescription drug benefits currently available to designated seniors because Medicaid is a combined Federal/State program.

Mrs. THURMAN. Correct.

Chairman THOMAS. In some States, like Pennsylvania, they will go up to $18,000 and in other States they have virtually none or very little. Some Medicare HMOs have requirements you have got to try one of the formulary drugs and show they fail before you get a non-formulary drug.

So, when we say we have an insurance program for low-income seniors, I wouldn't want to just say, Okay, so, we have a low-income——

Mrs. THURMAN. Okay.

Mr. WALKER. The range of programs vary in many States.

Mrs. THURMAN. But in reclaiming my time, part of it is that we also don't mandate that. We just sign them up if they are in those categories of being low-income.

Chairman THOMAS. And I will tell the gentlewoman that is one of the things I am wrestling with. Why with seniors, who are low-income, do we classify them as low-income first—i.e. involved in the Medicaid Program—and seniors second? Why don't we just pull that whole program up to the Federal level and treat all seniors fairly and equally in all States?

Mrs. THURMAN. And, Mr. Chairman, do we not pay for it anyway or at least a good portion of it?

Chairman THOMAS. No. Because the prescription drugs are beyond the payment structure to a certain extent. That is one of the discussions that I hope we can get into but the gentlewoman can have the full time that this intervention caused. But as we characterize low-income I don't want anyone to think that they have got a comprehensive, uniform prescription drug package because they are low-income. In fact, because they are low-income, they are not treated equally because they are assumed to be low-income first and seniors second.

Mrs. THURMAN. General, I would be glad to hear your part of this conversation.

Mr. WALKER. Clearly there is assistance provided to low-income through the Medicaid Program. And I would have two basic comments on that. One, that exhibits targeting. It is targeting to lower income where there is a need which is an important principle I think we have to keep in mind.

Mrs. THURMAN. Which is one that you, in fact, testified about.

Mr. WALKER. Correct. And second, I don't know that I would view the Medicaid Program as an insurance program.

Mrs. THURMAN. OK.

Mr. WALKER. Both as to intent and to design and to financing and, so, but you are right, there is some coverage there. In fact, I think on our chart on page six it is 10 percent of the 65-and-over population.

Mrs. THURMAN. OK.

So, I still have a little time here, Mr. Chairman.

OK. So, let me go on to another program, one that we are all very familiar with that also provides a prescription drug benefit, and that is the Medicare choice program, correct?

Mr. WALKER. Correct, that is 8 percent.

Mrs. THURMAN. I am sorry?

Mr. WALKER. In 1995, eight percent of the 65-and-over population obtained it through Medicare Risk HMO.

Mrs. THURMAN. And has that number come down over the last couple of years because of the droppage?

Mr. WALKER. It has. I am not sure how much.

Chairman THOMAS. Actually I don't believe those are correct figures. You might want to check with Dr. Scanlon. I believe that it is more like 13, slowly moving toward 15.

Mr. WALKER. Pardon me. Dr. Scanlon, as you know, is head of our health issue areas, says that the number of enrollees are up but the relative level of coverage is down.

Mrs. THURMAN. On prescription drugs?

Mr. WALKER. Through that program. Through the program we were just talking about.

Mrs. THURMAN. Okay.

Mr. WALKER. Medicare plus Choice.

Mrs. THURMAN. So, part of our problem in all of this discussion is what is happening to the drug prices? I think that part of the droppage in coverage through the Medicare plus Choice is due to the cost of drugs. I will just give you some examples. I had Sears in last week sometime and they told me—now they are a private insurance—they said that, their drug prices alone have gone up by 34 percent. The Florida Hospitals told me that their drug costs have risen as much as 16 percent just in the last year.

So, part of what we are seeing happening out there is that we are not getting drug coverage in insurances any more because of the fact that the drug prices are going up. What can you say because I noticed you mentioned in some of your papers about some of the cost containment, looking at what we might be doing to ensure that we get a real figure about what the cost of these drugs are and what they are being sold to our customers, those being our Medicare customers.

Mr. WALKER. The single fastest growing component of the health care costs is prescription drugs. Last year they went up about 15 percent on average. If you look at CalPRS, which is the largest State with prescription drug coverage for its employees, it is the fastest growing part of their health care costs. I think part of it to control these costs is increasing the visibility of these costs, having appropriate cost sharing provisions to sensitize individuals to this cost to help them to be able to differentiate between what they might want which is unlimited and what they truly might need, and to target subsidies from a Federal standpoint and assistance to true need, financial ability to pay.

I mean I think those are some of the key principles that have to be considered by the Congress. But ultimately you are the elected representatives and you are the ones that need to make a choice.

Mrs. THURMAN. And I am sure we all have more questions but, thank you, Mr. Chairman.

Chairman THOMAS. Does anyone have an additional question?

The gentlewoman from Connecticut?

Mrs. JOHNSON. Thank you, Mr. Chairman.

Mr. Walker, you know, there are a lot of us that are thinking about this issue of volume discounts. You do want to leverage your buying power in the market to provide the lowest prices. I mean one of the things that happened with fee-for-service medicine is that prices just had no relationship to volume.

On the other hand, one of the most frustrating and painful aspects of managed care's operation in our society is the way that a big managed care company would come in and not negotiate with your local hospital, tell your local hospital what they were going to pay. And if what they were telling your local hospital was well below that local hospital's costs, the local hospital had the choice: They could either check off a whole group of patients, sometimes 25 or 50 percent of their clientele, or they could accept the price the HMO was offering.

Now, I raise this concern about HMOs because the Federal supply price is a 24 percent drop, period. The negotiations for volume go on underneath that. Now, a lot of us are supporters of the prevailing wage concept, and the prevailing wage concept in labor law is that the government, as a big buyer of labor, when it comes in to do a big project, should not pay a wage below the prevailing wage because it would pull all the wages down.

Now, we have seen this in operation in the private sector with big HMOs and we are beginning to counter that and the providers are beginning to counter that. But I think the concept of the Federal Government coming into the national market, dropping prices 24 percent plus, you know, would have a ripple effect that would have great significance.

Now, I want to put that out there. And then what would we do about the situations in which the government price doesn't cover the cost of delivering the drug? The VA price for cancer pharmaceuticals is very low. But we appropriate money to the VA so that they can do the infusion therapy that goes along with the delivery of these drugs. The Medicare price is considerably higher because it covers the cost of the drug and the delivery of that drug.

So, not only am I afraid of the government being a thousand-pound gorilla in this situation and, therefore, actually tamping down research into new drugs and, Heaven knows, the people who need the new drugs the most are the seniors because they are the ones with the long-term Alzheimer's, they are the ones with the most serious long-term consequences of diabetes and the other chronic diseases.

So, you know, I would like to hear you talk. If we can't leverage a volume benefit by using the Federal supply price, which is this 24 percent plus, then what are other ways of recognizing in any Medicare drug benefit our volume position in the market? I mean what are the other ways you could do this?

Mr. WALKER. Well, first, I think you touched on the fact that it is possible to leverage purchasing power, but there are consequences to leveraging purchasing power. For example, if you take the 24 percent discount approach, then if the Federal Government is going to come in and say, we want that same discount for this whole new population and we want to pass that on, then we can

probably get it or get a substantial discount because of the volume that we are going to do. But then the question is going to be: What is the consequence of that going to be?

In all likelihood, what the consequence is going to be is one of several things: One, the average price that others will pay may go up, the average price that employers pay or individuals pay through other circumstances will go up, or the amount of profit or R&D expenditure for the pharmaceutical industry will go down. But unlike many other circumstances where the Federal Government has come in and mandated a stated price—there is so much profit in pharmaceuticals, at least in the United States. The same potential consequences of paying people below cost is not clearly as evident here as it might be, for example, for a hospital, if you will. And part of that problem, frankly, is because we have excess capacity in many parts of the country, and so what is a reasonable cost?

Mrs. JOHNSON. That is true. Because we have excess capacity, the drop in price eliminated beds.

Mr. WALKER. That is correct.

Mrs. JOHNSON. And so if you get too big a drop in price, you will eliminate availability of others in the formulary. The formulary will diminish in size. That is one possibility, that the number of drugs that would be accessible through this price structure would diminished and then, of course, research into others.

But if you had a competitive system that was insurance based, you would still get a volume discount because every insurer would be able to say we will have a large chunk of Medicare people. But then the insurer who paid the more reasonable price would offer probably the greatest spectrum of drugs. And you would have some fail-safe against the 800-pound gorilla pressing the price so low that the market actually diminished for seniors as well as impacted the rest of us.

Thank you.

Chairman THOMAS. Does the gentlewoman from Florida wish to have a follow-up question?

Mrs. THURMAN. You have talked a little bit about the research and development part of this, and I know that Mr. Stark had talked about a piece of legislation that he might introduce.

You know, over the last several years, we have watched probably one of the only agency budgets in true dollars go up—that of the NIH. How much of our NIH budget do you know goes to the pharmaceutical companies for research and development?

Mr. WALKER. I don't know off the top of my head.

Mrs. THURMAN. Or how much money do university systems actually expend in research?

Mr. WALKER. I don't have that off the top of my head, Mrs. Thurman. I would be happy to try to get what we do have and provide it to you.

[The information follows:]

The NIH appropriation for FY 1999 was $15.6 billion. More than 80 percent, or about $13 billion, supported scientists in more than 2,000 institutions—universities, medical schools, hospitals, small businesses, and research institutions throughout the country. NIH was unable to give us information on the level of resources that may have informed pharmaceutical companies in research and development of new therapies.

GAO CONTACTS AND ACKNOWLEDGMENTS

For future contacts regarding this testimony, please call Paul L. Posner, Director, Budget Issues, at (202) 512–9573 or William J. Scanlon, Director, Health Financing and Public Health Issues at (202) 512–7114. Other individuals who made key contributions include Linda F. Baker, Laura A. Dummit, John C. Hansen, Tricia A. Spellman, and James R. McTigue.

Mrs. THURMAN. Well, I think that would be very important. And then I think if you are going to provide that, I would also like whatever tax incentives they have, and maybe Mr. Stark has that, because I think part of the problem with the cost here is the fact that they keep using that, and, quite frankly, I think it is a little bit of a red herring. First of all because based on what was the Fortune 500 list on April 26th of 1999, for return on revenues—number one pharmaceuticals; return on assets—number one pharmaceuticals; return on equity—number one pharmaceuticals. Pharmaceuticals on return on revenues was 18.5, next was commercial banks at 13.2, and telecommunications 11.9. And it is that way all the way through the list.

But what was really interesting is there is a report that was done called "Debunking the Myth of Drug Makers," I am not even sure who put this out. But just look at what some of the corporate executives were making in and across this country.

Now, you know, Mr. Chairman, you said we get the big bucks for making these decisions. I should only wish that I got some of these big bucks. I mean, you have people in here making $56 million a year. They say the average compensation for the top-paid executives from each company is $27 million. Coca-Cola realized their top direct compensation was 57, and then you go down, Bristol-Myers was $56 million, Colgate $52 million, Abbott Labs $45 million. And then the next company closest to it is Texaco, and he or she is making $6 million, AT&T $3 million, Delta Airlines $2 million.

I guess what I am really trying to get the question is, if we start leveraging as a Federal Government like we do with VA and others, do we really hurt these folks and their research and development? You talked about advertising. You talked about all of these things. It doesn't matter what kind of research we do in the future if our seniors can't afford the medicine. What good does it do them if it costs $11,000, $12,000, $13,000 a year? They will never have access to those drugs.

And then you just add all of these things, I just think there is a lot more to this issue that we need to be looking at as to why these prices are so high. Then on top of that, look at what other countries are paying for the same medicine, in Canada, in Mexico, in Britain. I mean, we can go on and on and on about the differences. And these are life-sustaining drugs.

I want you to look right back here. These are all letters from my constituents on this issue with their pharmaceutical bills—I could go through and show you life-sustaining medicines, breast cancer medicines that have jumped from $130 to $166 in one year. I mean, there is something going on here that we have got to start paying attention to because we are going to outprice life-sustaining drugs to these very people.

Mr. WALKER. Several comments. First, executive compensation. Having been responsible for that, among other things, when I was

with Arthur Andersen, the ratio of chief executive officer comp to average worker pay in this country is way higher than anywhere else in the world. We can have a long debate about whether that is appropriate or not. It is reality.

Second, there is also the issue of targeting with regard to tax incentives and support. Is it a new drug or is it a "me too" drug?

Third, you have the issue of the global ripple effect. We live in a global economy. There are many countries out there that already place price controls on what they will pay for these drugs. And, therefore, there is a ripple effect.

This is a very complicated issue, and I think this is an area where we have done some work, and, in fact, I think we are going to be asked to do some more work because it is important that the Congress get the facts, understand the options, understand the pros and cons. It is very complex. All the more reason to proceed with caution in dealing in this area.

Mrs. THURMAN. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you very much, Mr. Walker.

I just want to underscore the point that although we have been talking about Medicare and then Medicaid as the low-income aspect of Medicare—and as I think was correctly stated, Medicaid is not an insurance program—that is one of the reasons I think all of us believe that at the very least there needs to be a humanitarian, compassionate component, and we will get testimony in the next panel, as soon as we get to the next panel, about the health profile of the low-income. But just because we have focused on that doesn't mean that we aren't trying to figure out a way to get that group purchasing power into the hands of seniors, who are the last major group.

The concern, I think, that needs to be focused on is whether government does it in a displacing, rippling effect or whether we, to the best of our ability, like the FEHBP, utilize some structure of market regulation.

Now, Mr. Walker, you indicated you indicated you would be looking at the President's program, and I hope that you look at it in its entirety, especially since we discussed here today about the displacement of the private dollars already being spent, with the understanding that there is no requirement for employers to provide prescription drugs for their retirees, but, in fact, they are the single largest group. I think the President was sensitive to that because he has an inducement to try to keep the employers in up to two-thirds of the amount that they are currently paying. And I am trying to figure out why that isn't a displacement or a replacement or a substitution of private dollars for public dollars with the appearance of keeping the private dollars out there.

I mean, I do think we have to be as honest as we can be on this displacement/replacement/substitution issue. And if I were to provide 100 percent bribe for the employers to stay in, to say, see, you still got the employer market, it is where the money comes from that is the critical question.

So as you analyze it, I hope you analyze it from: One, obviously, will it work? And, two, to what extent was most of the time spent on trying to create an adequate policy to deal with this problem of prescription drugs for seniors? And perhaps to what extent was

time spent on creating a political package which, on its appearance, addresses some of the fundamental concerns that you have? But whether it is a public dollar spent up front, a public dollar spent to subsidize employers, it is the same public dollar. That is my concern is not driving out the private dollar. But you also mentioned the Tax Code and a number of other areas that we can deal with.

Do you want to get in?

Mr. MCDERMOTT. Well, Mr. Chairman, I just had a question of you because I am trying to understand something you said, and that is, you said that Medicaid is not an insurance plan. It is not a health insurance plan for poor people. I don't know what you would call it and how—I mean, I would agree that it is a bad insurance plan because we have allowed the States to have 50 different variations on it. But——

Chairman THOMAS. I think as we get into semantics, the next panel will also assist us in that, because I think while there is also a myth around the Social Security, there is maybe even a greater myth around Medicare.

The argument is that all I want out of Social Security is what I paid in with interest. Well, most retirees get that in 60 months, and most of them live many years after that. And it is, in fact, then someone else's money that is supplying the wherewithal.

In Medicare, it is even greater than that because the part B original agreement between Medicare beneficiaries and the government was that it was to be a 50-cent-on-the-dollar split. It has now slipped to 25 cents on the dollar, and, in fact, the President's plan, and others, talk about even beyond that massive transfers of general taxpayers' money to support a program.

That is not to say it isn't meritorious, but I do think we kid ourselves a bit if we talk about it, as I think most people think of insurance, as insurance. This is——

Mr. MCDERMOTT. You are talking about individual insurance that I buy on my card——

Chairman THOMAS. Or group insurance that you buy through the employer. What we are really looking at is the single largest shift of resources between generations in the history of the world. And the question is: Do we continue it and, in fact, accelerate it? Or do we begin to make adjustments in which all of us have to participate, the younger people coming along, the policymakers, the recipients of the money, and most importantly, the beneficiaries who get that final product? It is a problem for all of us. But to continue to argue it is an insurance program I think creates a veneer which makes it more difficult to get at the fundamental problems of the public policy that we have to deal with, basically who gets what, when, and how.

Mr. MCDERMOTT. Is it fair, then, to say that you don't think of Medicare as a social insurance policy? The whole country insures the health of senior citizens in the country?

Chairman THOMAS. Well, I think semantically we can turn it any way we want to, and if it creates more comfort in isolating you from the fundamental problem, and that is, there are more benefits going out because Congress gets re-elected by saying yes instead of no, and that we have completely distorted whatever insurance structure was there in the first place about an adequate inflow to

an adequate outflow, whatever gives you a comfort in terms of the pitches that you make I say is fine, as long as we understand that the basic problem is we are spending more money than the current structure provides with an inadequate medical structure for seniors, and we have to address it: One, the inadequate structure; and, two, the financing.

Mr. Walker, you wanted to get in on——

Mr. WALKER. Mr. McDermott, the reason that I responded in the way that I did with regard to Medicaid was because generally when you consider an insurance program, you have an transfer of risk in exchange for a premium. In the case of Medicaid, there is no premium. At the same point in time——

Mr. MCDERMOTT. I understand. You are describing or defining individual insurance for me. Is that correct?

Mr. WALKER. In the context of the way I articulated it.

Mr. MCDERMOTT. And my question to the chairman was: Is this another entity which we would call a social insurance policy for the entire society rather than every individual buying their own insurance policy? I understand that Franklin Delano Roosevelt sold Social Security as your individual retirement program by giving you that number and that you thought there was a drawer somewhere—I mean, people thought that. But, in fact, it was a social insurance policy by which we in the country decided old people should have a guaranteed benefit.

Mr. WALKER. Two comments on that. One, clearly, it is not traditional insurance and so, therefore, social insurance is what generally people refer to the Social Security and Medicare Programs, as social insurance. However, no matter what you call it, we still have that problem. We can call it whatever we want to call it. We still have these long-range fiscal pressures that we need to ultimately deal with.

Chairman THOMAS. Because in insurance you deal with risk adjustment mechanisms. The risk adjustment mechanism here is that Social Security worked fine as long as there were more workers than there were retirees and that their life expectancy was less than getting the payment, which was the case in 1938 when it started. We have not adjusted for the continued longevity, which is a modern miracle that we want to continue, but we also have fewer number of people paying into the program and something has got to give.

With that, Mr. Walker, the clock is giving us the need to move on, but thank you very much for outlining in a very broad-based way the problem that faces us.

Now I would ask the next panel to come forward, which will begin to look at details of a plan that they might want to articulate or at least alert us to some subsets of concerns as we try to put together a package.

First on the panel is Dr. Soumerai, Professor of Ambulatory Care and Prevention at Harvard Medical School. Dr. John Calfee is a Resident Scholar, American Enterprise Institute. Dr. Beatrice Braun, who has been with us before, nice to have you back again, Board of Directors, American Association of Retired Persons. Theodore Roth, President and Chief Operating Officer, Alliance Pharma-

ceutical Corp., on behalf of the California Healthcare Institute. And Professor Sager of Boston University School of Public Health.

Thank you all. The written testimony that you have provided us will be made a part of the record, and you can address us in any way you see fit with the time you have available. Let's start with Dr. Soumerai and move across the panel.

STATEMENT OF STEPHEN B. SOUMERAI, SC.D., PROFESSOR, AMBULATORY CARE AND PREVENTION, AND DIRECTOR, DRUG POLICY RESEARCH PROGRAM, HARVARD MEDICAL SCHOOL AND HARVARD PILGRIM HEALTH CARE, BOSTON, MASSACHUSETTS

Dr. SOUMERAI. Mr. Chairman and Members of the Committee, I am indeed very pleased to be here to talk about one of my favorite issues and a very important health issue—emphasis on health. I wish to provide strong scientific support for legislation to at least provide urgent, unlimited drug coverage for elderly and disabled people with incomes up to 200 percent of the Federal poverty threshold and catastrophic coverage to protect against high drug expenses for all Medicare enrollees.

Our research group has been studying the health effects of changes in drug coverage for over 15 years, and Medicare populations have been a part of those studies.

In an article published last year in the New England Journal of Medicine—this is one of the attachments that you have—my colleague Dr. Ross-Degnan and I reviewed the problem of inadequate drug coverage for Medicare enrollees and proposed as a first step a Federal-State insurance program that provides unlimited drug coverage to Medicare enrollees with low incomes. Since then, additional data have convinced us of the need for a catastrophic coverage program for higher-income enrollees. The evidence also indicates that high cost-sharing or capped benefits, which are part of some of the plans that are being considered, are ineffective policies for low-income chronically ill individuals because they reduce access to essential drugs among the sickest patients and increase use of expensive institutional services.

We estimated that Medicare enrollees with incomes below $10,000 and without drug coverage consume less than half of the medications taken by higher-income individuals with employer drug coverage, despite the fact that the lower income beneficiaries are twice as likely to report poor health.

I am going to focus on several relevant studies on the impacts of two successive policy changes affecting low-income patients enrolled in the New Hampshire Medicaid Program: First, a change from unlimited coverage to a three-prescription-per-month coverage limit or cap; second, replacement of this cap with unlimited drug coverage. You can think of this also as taking away catastrophic coverage, and then returning it.

This natural experiment allowed us to study the impacts of both reducing and increasing drug coverage in low-income populations, and these large controlled studies were published as three consecutive reports in the New England Journal of Medicine.

The first report, Attachment 2, showed that limited coverage caused use of essential life-saving drugs, like insulin for diabetes,

to decline substantially. See the figures in these reports, even if you don't have time to read them in their entirety, because they really are striking in terms of the effects. After drug coverage was restored, use of these drugs rebounded to baseline levels.

In the second study, we focused on chronically ill elderly and found that the limited drug coverage resulted in a 35-percent decline in use of essential drugs such as insulin and cardiac meds; a twofold increase in institutionalization in nursing homes that was usually permanent and increase hospital admissions; increased government costs for institutional care, which was about 20 times the drugs savings in this population; and a cessation of these adverse outcomes after restoration of drug benefits.

Based on these data, we have estimated that a low-income coverage program would save State and Federal insurers at least one-third of the cost of drugs provided.

In our third report, on patients with disabling mental health problems, which is Attachment 4, limited coverage caused a 15 to 49-percent decline in use of essential psychoactive drugs such as antidepressant agents and lithium; a 50-percent increase in mental health visits; large increases in symptoms, emergency mental health services, and day hospitalizations; and government costs for treating destabilized patients that were at least 17 times higher than the drug savings.

In a new study led by Dr. Alyce Adams in our research group, we examined the effects of different types of drug coverage on drug consumption in 1995 for 3,000 Medicare patients with hypertension. We found that drug coverage was indeed significantly associated with consumption of potentially life-saving drugs for high blood pressure. Enrollment in a state program for low-income seniors was associated with a 36-percent increase in use of these agents; employer coverage, with a 20-percent increase; and Medigap coverage, with only an 11-percent increase in use of these blood pressure drugs. The small effect of Medigap coverage that was alluded to earlier is consistent with the high levels of cost sharing, limited benefits, and barriers to enrollment in these plans.

In conclusion, Mr. Chairman, these data argue for a set of core principles for action.

First, we believe that all beneficiaries should have access to prescription drugs, but available solutions are controversial and compromise may take time.

Second, poor, near-poor, and low-income elderly have an urgent clinical need for an immediate benefit. We have heard similar stories all around the country.

And third, no one should become impoverished by their medical need for essential drugs. From the standpoints of public health and equity, a stop-loss protection provision should be the second highest priority for action by the Congress.

Thank you.

[The prepared statement follows:]

Statement of Stephen B. Soumerai, Sc.D., Professor, Ambulatory Care and Prevention, and Director, Drug Policy Research Program, Harvard Medical School and Harvard Pilgrim Health Care, Boston, Massachusetts

Mr. Chairman and Members of the Committee:

I am very pleased to have been invited to speak here about this important public health issue. I offer strong support—on scientific, clinical, and economic grounds—for legislation to provide urgent prescription drug coverage for elderly and disabled individuals with incomes up to 200% of the federal poverty threshold, and catastrophic coverage to protect against high drug expenses for all Medicare beneficiaries. Currently, I direct the Drug Policy Research Program at Harvard Medical School and Harvard Pilgrim Health Care and have been studying the health effects of changes in drug coverage among Medicare patients for over 15 years.

In an article published last year in *The New England Journal of Medicine* (Attachment 1, selected pages from: Soumerai SB, Ross-Degnan D. Inadequate drug coverage in Medicare: A call to action. N Engl J Med 1999; 340: 722–8.), my colleague, Dr. Ross-Degnan, and I reviewed the problem of inadequate drug coverage for Medicare enrollees and proposed, as a first step, a federal-state insurance program that provides unlimited drug coverage to Medicare enrollees with low incomes. Since then, additional data have convinced us of the need for catastrophic coverage for higher-income enrollees. The evidence also indicates that high cost-sharing or capped benefits are ineffective policies for low-income chronically-ill, because they reduce access to essential drugs among the sickest patients and increase use of expensive institutional services.

Almost half of all Medicare enrollees do not have adequate access to essential drugs. We estimated that Medicare enrollees with incomes below $10,000 and without prescription drug coverage consume less than half of the medications taken by higher-income individuals with employer drug coverage -despite the fact that the lower-income beneficiaries are twice as likely to report poor health. In 1998, 10% of elderly low-income participants in the New Jersey Pharmacy Assistance Program consumed an average of $4900 for generally essential medications—clearly out of reach of low-income seniors in other states.

I will focus on several relevant studies on the impacts of two successive policy changes affecting low income patients enrolled in the New Hampshire Medicaid Program—first, a change from unlimited coverage to a three-prescription per month coverage limit (cap); second, replacement of the cap with unlimited drug coverage again. This natural experiment allowed us to study the impacts of both reducing and increasing drug coverage in low-income patients. These large, controlled studies were published as three consecutive reports in *The New England Journal of Medicine* (NEJM).

The first report (Attachment 2, Abstract of: Soumerai SB, Avorn J, Ross-Degnan D, Gortmaker S. Payment restrictions for prescription drugs in Medicaid: Effects on therapy, cost, and equity. *N Engl J Med* 1987; 317:550–6.) showed that limited drug coverage caused use of essential life-saving drugs like insulin for diabetes, furosemide for congestive heart failure, bronchodilators for asthma, and lithium for bipolar illness, to decline substantially. (See figures in *NEJM* report). A key finding is that immediately after drug coverage was restored, use of these drugs rebounded to baseline levels.

In the second study, reported in the NEJM (Attachment 3, Abstract of: Soumerai SB, Ross-Degnan D, Avorn J, McLaughlin TJ, Choodnovskiy I. Effects of Medicaid drug-payment limits on admission to hospitals and nursing homes. *N Engl J Med* 1991; 325(15):1072–1077.), we focused on chronically-ill elderly, and found that the limited drug coverage resulted in:

- a 35% decline in use of essential drugs, such as insulin, and cardiac medications;
- a twofold increase in institutionalization in nursing homes, that was usually permanent, and increased hospital admissions;
- increased government costs for institutional care of $311,000, which was about 20 times the drug savings in this population;
- a cessation of these adverse outcomes after restoration of drug benefits.
- based on these data, we have estimated that a low-income coverage program would save state and federal insurers at least one-third of the cost of drugs provided.

In our third NEJM report on patients with disabling mental health problems (Attachment 4, Abstract of: Soumerai SB, McLaughlin TJ, Ross-Degnan D, Casteris C, Bollini P. Effects of limiting Medicaid drug-reimbursement benefits on the use of psychotropic agents and acute mental health services by patients with schizophrenia. N Engl J Med 1994; 331:650–655.). Limiting coverage caused several important adverse effects which also began to disappear when drug coverage was restored. These included:

- 15 to 49% decline in use of essential psychoactive drugs, such as antidepressant agents and lithium
- a 50% increase in mental health visits

• large increases in symptoms, use of emergency mental health services and day hospitalizations.
• an additional 1.3 treatment episodes per patient each month.
• government costs for treating destabilized patients were at least 17 times higher than the drug savings.

These estimates of increased government costs are conservative, because they do not consider unquantified costs of pain and suffering and risks of suicide.

In a new study (see Attachment 5) led by Dr. Alyce Adams in our research group, we examined the effects of different types of drug coverage on drug consumption in 1995 for 3,000 Medicare beneficiaries with hypertension. Controlling for differences in health and socio demographic characteristics, we found that drug coverage was significantly associated with consumption of potentially life saving antihypertensive medications. State drug coverage for low income seniors was associated with a 36% increase in use of antihypertensives; employer coverage, with a 20% increase; and Medigap coverage with only a 11% increase in use of these blood pressure drugs. The small effect of Medigap coverage is consistent with the high levels of cost sharing, limited benefits, and barriers to enrollment in these plans.

What are the implications of this research for national pharmaceutical policy? First, we have found that even relatively small changes in drug coverage can have substantial effects on the quality and costs of care, especially for low-income, chronically ill patients.

• Our data indicate that coverage of medications in these groups can:
  • prevent major acute illness;
  • control chronic illnesses;
  • and maintain independence of frail elderly and disabled people in the community.
• Medications are inadequately covered for many low-income and chronically-ill elderly in the majority of states who may not be able to afford treatments that are, from a societal perspective, clearly cost-effective.

In conclusion, these data argue for a set of core principles for action:

• All beneficiaries should have access to prescription drugs but available solutions are controversial and compromise may take time.
• Poor, near-poor, and low-income elderly have an urgent, clinical need for an immediate benefit.
• No one should become impoverished by their medical need for essential drugs. From the standpoint of public health, a stop-loss protection provision should be the second highest priority for action by the congress.

[Attachments are being retained in the Committee files.]

Chairman THOMAS. Thank you, Doctor.
Dr. Calfee?

STATEMENT OF JOHN E. CALFEE, PH.D., RESIDENT SCHOLAR, AMERICAN ENTERPRISE INSTITUTE

Mr. CALFEE. Mr. Chairman, I would also like to thank you for inviting me. I am honored to be here. I have provided some written remarks, and I will provide a brief summary here.

I think the starting point is the simple fact that the reason these hearings are being held in the first place is because pharmaceutical research has been so successful in the last 5 or 10 or 15 years and has provided benefits which are really quite impressive, and I think that you could summarize it by saying that the reason that people are so excited about pharmaceatical issues is precisely because both physicians and patients are finding new drugs to be so useful.

Expenditures have been going up very rapidly, but what the research shows is that it is not price increases that are driving up the expenditures but, rather, the adoption of new drugs and the greater use of existing drugs. In this research enterprise, the cen-

tral motivation has been the profit incentive. I think that when you think about what it takes to gather the kinds of intellectual resources and financial resources that are necessary to solve problems that, in fact, had defied solutions for decades or centuries, it is clear that it is the lure of profits that has brought together that constellation of resources and abilities.

This suggests that in thinking about and in constructing a Medicare drug benefit, I would submit that the single most important principle is not to do anything that would interfere with continued success in pharmaceutical research. In other words, it would be a tragedy if a drug benefit were constructed that in some way impeded or retarded or curtailed the ongoing pharmaceutical revolution.

With this background, we can think a little bit about what a drug benefit might entail. I would suggest that there are three points, at least from my perspective, that are essential. The first of these is the necessity of avoiding any form of control over pharmaceutical prices. There is no surer or more certain disincentive to research than price controls.

Unfortunately, there are two reasons why a Medicare drug benefit would be particularly and unusually prone to price controls. One is the fact that pharmaceuticals themselves invite price controls. That is because the cost of manufacturing and distributing drugs is small compared to the cost of developing pharmaceuticals. Anyone who has control over prices—a government agency in particular—faces a strong temptation to push down prices, keeping them above the cost of manufacturing and distribution, but not necessarily above the cost of doing the research that is necessary to create those drugs.

In addition, the Medicare system itself is susceptible to price controls. Medicare has traditionally been a fee-for-service program, and I think it is fair to say that virtually every medical or health care product that has been covered by Medicare has eventually been enveloped in pervasive price controls. So there are reasons to think that a Medicare drug benefit would be prone to price controls, and this suggests that we should very much beware that possibility when putting together a Medicare drug benefit.

A second principle, which is discussed rather infrequently but I think could be very important as we get into the details of a Medicare drug benefit, is that it is essential to maintain the freedom for the elderly to purchase whatever drugs they wish to purchase, even if those drugs are not covered by Medicare, even if they are beyond Medicare's limits, even if patients are paying a price that is greater than the price that Medicare has specified. We don't want a situation like we have in other parts of Medicare where the elderly are simply prohibited from purchasing services that Medicare does not cover.

Finally, a Medicare drug benefit should respect the basic economic principles of insurance. We have had a lot of experience with insurance, especially health insurance. We know something about how health insurance programs work. This experience suggests that, first of all, there should be substantial deductibles for a drug benefit. It makes no sense to put all pharmaceutical purchases through an insurance program or through a government program.

There should be substantial copayments because we need to maintain some kind of linkage between consumer willingness to pay and pharmaceutical research and development and pharmaceutical uses.

We should maintain as far as possible private markets for pharmaceutical benefits, not only because private plans are more efficient but also because of the importance of maintaining a diversity of choices for the elderly. Not everyone is going to want the same kind of program.

Finally, it would make sense to have some kind of stop-loss provision, and some form of means testing, so that the resources can be devoted to the most essential task of maintaining a safety net.

Regarding specific Medicare proposals, I only have a few comments. There is a consensus among most of observers that it would be best to reform the Medicare system itself before adding a drug benefit. That may not be feasible. There is certainly no inherent reason why it is impossible to have a drug benefit without reforming Medicare, but as I mentioned before, extreme care would be necessary.

The White House has announced a plan, which has been discussed earlier today. That plan is open to a number of very important criticisms. For example, It has no deductible. More important, the White House plan would essentially create purchasing monopolies for each region of the country. This would invite some forms of price controls. Even more important is the fact that under the Clinton plan, Medicare beneficiaries who have exceeded the benefit limits of the plan would still be able to buy drugs at the prices specified by the plan. Essentially, that would extend Medicare prices beyond Medicare itself to essentially encompass the entire pharmaceutical market for the elderly. That would be a de facto regime of price controls.

The fact that the administration's budgeting for their plan entails—or predicts—expenditures that would be probably on the order of one-third less than the current trends in pharmaceutical expenditures for the elderly strongly suggests that the administration is, in fact, counting on price controls and expenditure controls to reduce drug costs.

I will also mention that other proposals, specifically those coming out of the Breaux-Thomas commission and some of the other plans, such as the Snowe-Wyden plan, are quite different. They would not involve price controls, although the danger of price controls might well be there. And they would permit competing market-generating pharmaceutical benefits which, again, I think would be a good idea.

That concludes my remarks. Thank you, Mr. Chairman.

[The prepared statement follows:]

Statement of John E. Calfee, Ph.D., Resident Scholar, American Enterprise Institute

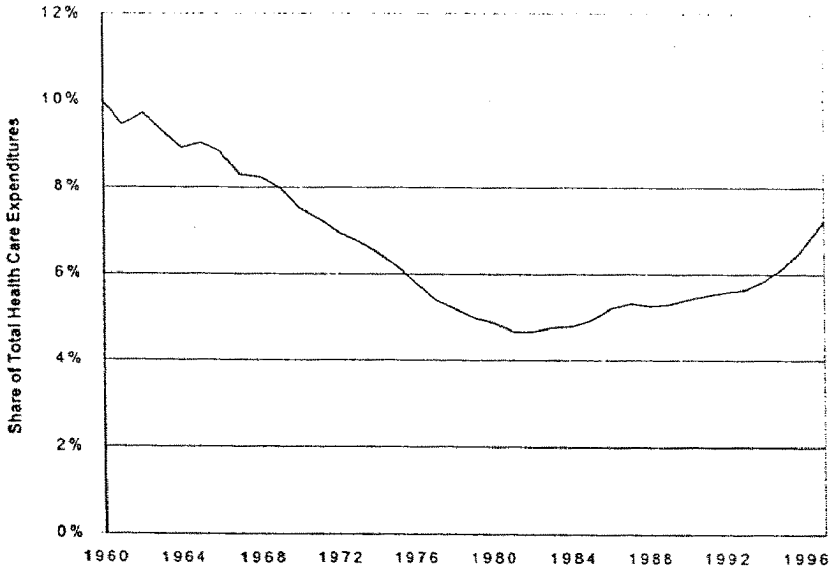
Mr. Chairman, I thank you for inviting me to testify today on seniors' access to prescription drug benefits. I am an economist who has devoted considerable attention to health care markets and the pharmaceutical industry. Most of what I wish to say today is drawn from my recently published book, *Prices, Markets and the Pharmaceutical Revolution* (AEI Press). That book is available from the publisher, AEI Press, and is also downloadable from the American Enterprise Institute website (www.aei.org).

Pharmaceutical Costs in Perspective

Outpatient expenditures on prescription drugs (with inflation taken into account) almost doubled between 1990 and 1998, and increased an additional 12.3 percent in 1998.[1] The elderly have consistently accounted for about 30 percent of those expenditures (Medicare Current Beneficiary Survey, HCFA). Pharmaceuticals are also claiming an increasing share of the U.S. health care budget. This is a relatively recent phenomenon, however. Prescription costs as a proportion of health care expenditures actually declined for many years after 1960, with the trend reversing in the early 1980s. Even today, the share of spending on pharmaceuticals is far below the levels of the early 1960s, despite climbing from 4.9 percent of health care costs in 1985 to 7.2 percent in 1997 (see Figure 1).

Figure 1:

PRESCRIPTION DRUGS AS A PERCENTAGE OF U.S. NATIONAL HEALTH EXPENDITURES, 1960–1997



SOURCE: HCFA 1999

Other advanced economies have also seen rapid increases in pharmaceuticals expenditures.[2] In fact, the 7 percent of health care costs allocated to prescription drugs in the United States today is barely half the corresponding proportions in Canada (12.5%) or Germany (12.5%) and even further below the levels in France (16.7%), the United Kingdom (17.3%), and Japan (20.0%) (OECD Health Data 1998).

Why Pharmaceutical Expenditures Have Been Increasing

Increased drug expenditures are partly offset by reduced expenditures on other forms of health care. The medical literature is full of studies documenting health cost savings from drug therapies for ulcers, schizophrenia, depression, congestive heart failure, asthma, strokes, migraine headaches, kidney disease, AIDS, and other illnesses and conditions.[3] Nonetheless, expanded uses of pharmaceuticals tend to in-

[1] Barents Group 1999, p. i, citing data from the Health Care Financing Administration in the U.S. Department of Health and Human Services, and for 1998, from Scott-Levin Source Prescription Audit.

[2] IMS Health, *Drug Monitor,* December 1998, August 1999 and September 1999.

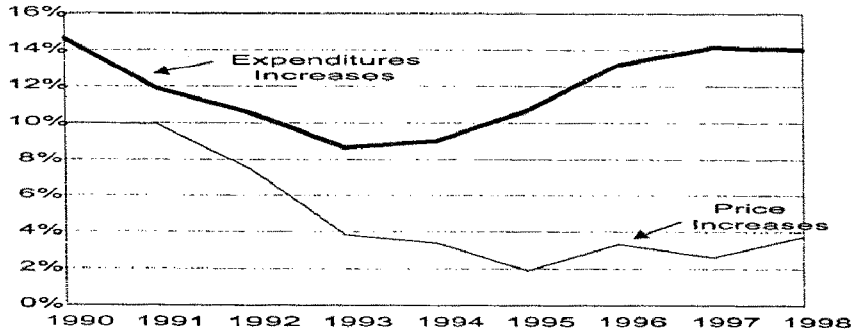
[3] See the following sources. Ulcers: Vakil 1996. Schizophrenia: *Hospital and Community Psychiatry,* v. 41, n. 8, 1990, and Glennie 1997. Depression: Frank 1999. Congestive heart failure: *Managed Healthcare,* April 1998, and SOLVD Investigators 1991. Strokes: Fagan, et al. 1998,

crease total health care expenditures for the simple reason that they lengthen lives and treat conditions that formerly were not treated at all.

Price increases are not the main reason for increased pharmaceutical expenditures. Prescription drug prices between 1993 and 1998 increased at less than 4 percent annually, only slightly above the general inflation rate and far below the rate at which prescription drug expenditures increased (see Figure 2).

FIGURE 2

Prescription Drug Price Increases versus Total Expenditures Growth



Sources: Expenditures Increases from HCFA 1999; Price Increases from Bureau of Labor Statistics, CPI, All Urban Consumers, Prescription Drugs and Medical Supplies.

Surveys have accordingly found that higher prices for existing drugs account for less than one-fourth of expenditure increases. The bulk of the increases come from increased volume and, especially, a shift toward more expensive drugs, which are usually newer on the market.[4] Even this modest role for price increases is exaggerated because measurements of pharmaceutical price changes are upwardly biased, as pharmaceutical price indices fail to adjust for the higher quality of new drugs and the increased benefits from new uses for old drugs (see Triplett 1999, especially chapter 3 by Frank, Berndt and Busch).

Physicians are prescribing more pharmaceuticals primarily because there are so many valuable new drug therapies. New drugs are treating conditions that formerly were undertreated or even underdiagnosed (see Calfee 2000a for citations and additional material). Such conditions include high blood pressure, elevated blood cholesterol, obesity, diabetes, depression and other mental illnesses, and osteoporosis. Many of the new treatments are especially important for the elderly. The dramatic reduction in mortality from heart disease in the past 30 years, for example, is almost certainly due primarily to improved medical treatments including "clot-busters" and other innovative drug therapies.[5] We have also seen great progress in reducing pain and suffering, as a result of better pain relievers, drugs with fewer debilitating side-effects, pills that replace injections, and treatments for migraines and osteoporosis. Examples include the "Cox-2 inhibitors" for treating arthritis pain, and newer anti-depressants. So-called "lifestyle" therapies such as those for mild obesity, mild depression, allergies, hair loss and impotence are also of enormous value to consumers. Finally, such remarkable developments as improved hypertension treat-

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and NIH 1998. Migraine headaches: Legg, et al. 1997a and 1997b. Kidney disease: Showstack, et al. 1989.

[4] See Health Industry Association of America 1999, figures 1 and 2, showing that drug prices have increased at less than four percent annually while drug expenditures have increased in double digits. Also see Pharmaceutical Research and Manufacturers of America 1999, p. 49, figure 4–11, which breaks down prescription drug expenditure increases into price versus volume, etc., showing that price increases accounted for about one-fifth of the expenditure increases in 1997 and 1998. These data are from IMS Health 1999, *Retail and Provider Perspective,* various issues.

[5] A recent summary of progress against heart disease is contained in Center for Disease Control, Aug. 6, 1999. On the impact of medical treatments, see Cutler, McClellan, and Newhouse 1999, especially their description of a forthcoming study by Heidenriech and McClelland.

ments and the statin class of cholesterol-reducing drugs are saving lives by preventing heart attacks.

All this is flowing from what is widely regarded as a revolution in pharmaceutical research and development. This revolution is very much market-driven. Its power comes from combining scientific research and faster FDA regulation with burgeoning market institutions that include managed care with its disease management techniques and massive data sets, a revamped clinical trials industry, the computer revolution, venture capital for biotechnology, flexible labor markets, and innovations in advertising and marketing research.

This research revolution is still in its early stages, as scientists rush to decode the human genome and open up new research areas. A crucial task in constructing a pharmaceutical benefit for Medicare is to permit this revolution to continue uninterrupted.

The greatest threat to further progress would be controls over prices. The profit motive is what has brought us the new drugs that physicians and patients want to use. The expectation that the government will control the prices of new drugs—an HHS-dictated price for a breast cancer cure, for example—would force firms to constrain their research investments, causing many of our most talented scientists and entrepreneurs to turn to the many other areas in the U.S. economy that offer handsome returns for intelligence and hard work. Price controls would be a powerful disincentive for pursuing the expensive and risky explorations necessary to solve such stubbornly resistant problems as devising preventatives and cures for Alzheimers, diabetes, osteoporosis, arthritis, heart disease, and cancer (cf. Calfee 1999).

Price controls would also introduce overwhelming complexity into health care, create vested interests for those parties that benefit from controls (there are always some who do), and inhibit the market adjustments necessary for a dynamic research enterprise. And once in place, price controls are extremely difficult to dismantle. Advanced nations with pervasive pharmaceutical price controls, such as Japan, have for decades denied innovative drugs to their citizens (Thomas 1994).

Potential Dangers in a Poorly Conceived Medicare Drug Benefit

Medicare is predominantly a fee-for-service arrangement. History shows that Medicare's fee-for-service reimbursement mechanism leads to pervasive price controls—despite the fact that the original proponents of Medicare vociferously promised that the system would never lead to price controls for physicians, hospitals and other essential components of health care for the elderly (Hoff 1998). This history also demonstrates that an arrangement in which medical technology and services can be purchased only at Medicare prices leads to endless disputes, much gaming of the system, and highly arbitrary and unpredictable prices that are often dominated by political considerations.

If a drug benefit is simply folded into an unreformed fee-for-service Medicare system, price controls over pharmaceuticals would be inevitable. That is one reason why many informed parties have advocated reforming Medicare to bring it closer to a competitive private market before adding a drug benefit. A majority of the Breaux-Thomas Bipartisan Commission on Medicare Reform, for example, proposed to reform Medicare by bringing it more in line with the methods developed by private enterprise, and encouraging drug benefit plans similar to those in private health insurance rather being part of the obsolete fee-for-service arrangement now prevailing in Medicare (National Bipartisan Commission 1999).

This does not mean that it is impossible to add a useful drug benefit to Medicare. But it is essential to avoid the error of constructing a benefit plan that would do more harm than good, by curtailing the very research enterprise that has made prescription drugs essential to health care for the elderly.

Essential Elements in a Well-Designed Medicare Drug Benefit Plan

Two crucial questions immediately arise in any Medicare reform. The first, of course, is whether the plan would permit or encourage price controls on pharmaceuticals. The adverse consequences of price controls are so great that leaving pharmaceuticals out of Medicare altogether would be preferable to constructing a drug benefit that controlled prices. A Medicare drug plan would therefore have to be designed so as not to invite the progressive implementation of price controls, a fate that has met all other health care activities funded by Medicare. The Breaux-Thomas recommendations, which would provide defined contributions for health care plans but would not specify prices, presumably would not involve price controls. But what factors would enter the process for approving health care plans? The theoretical power to specify prices can easily evolve into a mechanism for price controls.

A second, equally important question about any Medicare reform is whether the elderly would be free to purchase medical services, including pharmaceuticals, out-

side their plan's limits. If they could, market incentives would continue to yield pharmaceutical advances. But if Medicare patients could not purchase pharmaceuticals outside the system—just as they now cannot purchase nonreimbursed medical care except under onerous conditions—the effect would be to create de facto price controls (Hoff 1998).

A Medicare drug benefit should also respect the basic economics of insurance. One of those principles is that insurance should not cover events that involve little or no financial risk. Here we must note the emerging role of pharmaceuticals for the elderly. Many people today can expect to lead relatively healthy and enjoyable lives through their eighties and perhaps into their nineties. In doing so, they will almost certainly make liberal use of pharmaceuticals, which are now attacking the most common illnesses and disabilities of old age and very old age. It makes sense for consumers to prepare for a lengthy retirement that includes pharmaceuticals along with recreation, travel, special living arrangements, good dining, and all the other products and services that are already finding huge new markets among the elderly. There is no individual or social benefit to selecting one component of these *expected expenses*—pharmaceuticals—and processing it through an insurance system, with its attendant administrative costs and debates over "health" compared with "lifestyle" products.

A related principle from the economics of insurance concerns financial limits. Deductibles should be substantial. Passing all pharmaceutical purchases through insurance, instead of only those exceeding, say, $500–1,000 per year, would create unnecessary administrative costs and would remove incentives for reasonably careful use of pharmaceuticals. Conversely, insurance should provide coverage for catastrophic costs, with limits on out-of-pocket expenses. Co-payments are essential to maintain a link (albeit an imperfect one) between what drugs cost and what they are worth to consumers. All of this can be means tested so as to provide a safety net for the impoverished elderly (Pauly 1999).

Private insurance is invariably more efficient and less susceptible to political manipulation than is insurance provided by the government. It would also permit the introduction of competing plans at varied prices, which is essential to avoid forcing Medicare beneficiaries to pay for plans that offer either far less or far more than what beneficiaries are willing to pay for. A voucher system, which is essentially what the Breaux-Thomas Commission recommended, would therefore be far superior to an insurance plan run directly by Medicare. The special problems of bringing pharmaceuticals into the Medicare fold—along with the simple fact that doing so involves new legislation and a new administrative mechanism—suggest that something akin to Breaux-Thomas might be adopted for pharmaceuticals even if the rest of Medicare were left untouched. That action would, among other things, provide important new evidence to inform the larger debate over Medicare reform.

Even such a modest system would be far from foolproof. It would be difficult to solve the problem of adverse selection (i.e., the tendency for those most in need of expensive treatments to choose the most generous insurance plan, thus driving up costs and causing the less-sick to choose leaner plans, which raises costs yet more). Adverse selection can cause premiums to climb so high that insurance plans for sicker participants provide little financial benefit. Also, a catastrophe benefit could raise difficult problems in deciding which new therapies (offered with the expectation of full government coverage) would be worth their cost. Nonetheless, a market-oriented Medicare reform could permit the pharmaceutical revolution to continue (cf. Calfee 2000b).

Problems with the Clinton Medicare Drug Benefit Proposal

The President described in July 1999 a new Medicare drug benefit proposal, which was slightly altered in January 2000 (see Office of the President 1999). Unfortunately, the President's plan would create many of the very problems that a Medicare drug benefit should avoid. The plan would pay for half of purchases up to an annual limit, starting at $2,000 in 2002 and increasing to $5,000 in 2008. There would be no deductible. Annual premiums, set to provide a 50% subsidy, were estimated to start at $288 in 2002 and reach $528 by 2008. (The White House recently indicated that these numbers were being adjusted upward, but the essential features of the plan remain in place.) Prices would be negotiated by regional purchasing monopolies, administered by a single pharmaceutical benefit manager selected by HCFA. These prices would apply to purchases by Medicare beneficiaries even after the benefit limits had been exceeded, thus extending the HCFA-negotiated prices to non-Medicare reimbursed prescription drug purchases. This would amount to price controls.

The White House estimated that total spending on prescription drugs for the elderly in its plan, including the patients' share, would start at $30 billion annually

in year 2002 and increase by 5 percent per year to roughly $31.5 billion in 2003, $33 billion in 2003 and so on. But prescription drug expenses for the elderly are already running at about $33–35 billion, and are expected to increase to a minimum of $45 to $50 billion by year 2002, with further increases likely. The Clinton plan would therefore cut pharmaceutical expenditures for the elderly by over one-third in 2002, and even more in later years. This illustrates the central role that price and expenditure controls are expected to play in this plan.

The President's plan would also create the inefficiencies that invariably arise when there is no deductible, as even the most routine prescription drug purchases would go through the Medicare bureaucracy. The plan would also prohibit competing formularies or other competitive tools. Such an enforced uniformity would work to the disadvantage of most Medicare beneficiaries.

Other Proposals

I have not reviewed the details of other leading Medicare drug benefit proposals. I note, however, that the majority recommendations of the Breaux-Thomas Bipartisan Commission would avoid most of the problems with the White House plan. In particular, the Breaux-Thomas approach (the details of which would be set by a special board) would presumably involve deductibles, an avoidance of price controls, and competing plans with varied formularies. Much the same appears to be true of the Snowe-Wyden proposal (S. 1480).

Such plans at least offer hope for a Medicare drug benefit that would permit the pharmaceutical research revolution to continue, bringing yet more life-saving and life-improving therapies whose nature we can now only imagine.

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Chairman THOMAS. Thank you very much, Doctor.

Dr. Braun, it would be my usual pleasure to welcome you once again, but I think since the last time you were here, we have had an addition to the Health Care Subcommittee, and so for a more direct and personal introduction, your Representative. The gentlewoman from Florida, your constituent.

Mrs. THURMAN. Dr. Braun, I just wanted to officially welcome you and let you know that all of us in Hernando County are very proud of the work that you have done in the past and the work that you are doing today. And I am just glad you are here.

STATEMENT OF BEATRICE BRAUN, M.D., MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS

Dr. BRAUN. Thank you very much, Congresswoman. As you have heard, I am Bea Braun. I come from Springfield, Florida, and I am a member of the AARP's Board of Directors.

Chairman THOMAS. Dr. Braun, as usual, these microphones are very unidirectional, and you need to have it right in front of you and talk directly so we can all hear you.

Dr. BRAUN. Thank you, Mr. Chairman.

Since it was enacted, Medicare has provided access to affordable health care and kept many older people out of poverty. But there are a lot of challenges facing the program, as we have heard this morning. As a retired physician, I have seen the practice of medicine change dramatically, particularly in the area of prescription drugs. Simply stated, prescription drug coverage is smart medicine.

Yet, while most employer plans include drug coverage, Medicare does not. We are pleased that Congress, the Administration, and the drug industry recognize that prescription drug coverage must

be a part of a strengthened Medicare Program. The question is how to do it.

AARP believes that a Medicare prescription drug benefit must be available to and affordable for all beneficiaries. The benefit should be voluntary, allowing people the option of keeping the coverage that they have, and the benefit must be affordable for all beneficiaries, not just for those with low incomes.

The benefit needs to ensure that it helps middle-income beneficiaries handle mounting prescription costs. Equally important, it needs to ensure enough participation in the benefit to avoid risk selection.

One of Medicare's greatest strengths has been its success in pooling the risk of nearly 40 million beneficiaries. This has let Medicare avoid the cherrypicking that exists in today's under-65 health insurance market. The broadest pool must be sustained in order to keep Medicare strong and affordable.

While 65 percent of beneficiaries may have some type of coverage, as we have heard this morning, employer-based retiree coverage is declining rapidly, Medigap coverage is expensive and it is limited in what and who it covers, and managed care coverage has proven unstable, as the last 2 years of increased prices and pullouts have demonstrated.

I am not attempting today to give a full review of the prescription drug proposals before Congress. That will take a lot more hearings. But as Congress undertakes this effort, I would like to raise the following fundamental questions that need to be answered about any drug proposal.

First, will the proposed prescription drug coverage be affordable to beneficiaries and assure a viable risk pool for the program? These go hand in hand.

Second, how would insurers be prevented from cherrypicking beneficiaries?

Third, how would beneficiaries with very high costs for drugs be protected?

Fourth, does the proposed benefit meet the needs of current and future beneficiaries?

The AARP is reserving judgment on current proposals until these and other questions about their impact on beneficiaries and the program itself are answered.

How to provide Medicare beneficiaries with affordable prescription drugs is a huge challenge. We urge the Congress, the drug industry, and consumers to engage in a serious debate on the merits of the full range of approaches. The success of any drug benefit proposal as well as broader changes in Medicare depend on a clear understanding on the part of public and policymakers alike of the changes being contemplated. This will require not only extensive dialog, but also a thorough analysis of how the proposal would affect current and future beneficiaries.

In fact, if legislation is pushed through too quickly before the effect on beneficiaries and the program is known, AARP would be compelled to alert our members of the dangers in such legislation and why we could not support it.

Mr. Chairman, thank you for your efforts to examine the high costs of prescription drugs for older Americans like myself. AARP

is committed to working with the Members of Congress on a bipartisan basis to advance this debate over prescription drug coverage and to carefully explore the best options for securing all of Medicare's future.

Thank you.

[The prepared statement follows:]

Statement of Beatrice Braun, M.D., Member, Board of Directors, American Association of Retired Persons

Mr. Chairman and members of the Committee, I am Beatrice Braun, a member of AARP's Board of Directors. I want to thank you for your interest in the issue of the high cost of prescription drugs and the difficulties older Americans have in paying for needed medications. AARP appreciates this opportunity to share our perspective on the need for a Medicare prescription drug benefit and some of the broader issues involved in reforming the Medicare program.

For over thirty years Medicare has provided older and disabled beneficiaries with dependable, affordable, quality health insurance. I live in Florida, which has one of the largest beneficiary populations in the nation. As a retired physician, I have seen first hand how Medicare has made a difference in the lives of older Americans. Medicare has been instrumental in improving the health and life expectancy of beneficiaries in Florida and across the nation. It has also helped to reduce the number of older persons living in poverty.

Medicare's promise of affordable health care extends beyond the current generation of retirees. Now, more than ever, Americans of all ages are looking to Medicare's guaranteed protections as part of the foundation of their retirement planning. AARP believes that in order for Medicare to remain strong and viable for today's beneficiaries, and for those who will depend on it in the future, we must confront the key challenges facing the program.

Foremost among these challenges is ensuring that Medicare's benefits and its means of delivering care remain dependable even as they are updated to keep pace with the rapid advances in health care. The practice of medicine has changed dramatically since the Medicare program was created. We are now living in a time of amazing breakthroughs in medical technology. Among the most striking are the advances in the area of prescription drugs. Drug therapies that were not available when Medicare began are now commonly used to prevent and treat virtually every major illness. In many cases, new drugs substitute for or allow patients to avoid more expensive therapies such as hospitalization and surgery. In other cases, drugs facilitate treatment or provide treatment where none existed before, improving the quality and length of life for the patient. As a result, prudent reliance on prescription drugs now goes to the very core of good medical practice.

Ironically, while older Americans typically need more medications than younger people, most employer plans include and rely on prescription drug coverage as an essential tool for medical management, but Medicare still does not. Consequently, high prescription drug prices impose significant financial hardship on the millions of Medicare beneficiaries who have inadequate or no insurance coverage for prescription drugs. It is important to remember that beneficiaries without coverage pay top dollar for their prescriptions because they do not benefit from discounts negotiated by third party payers as do most younger persons. AARP believes prescription drug coverage must be part of an improved Medicare program. Simply stated, prescription drug coverage is smart medicine.

The second challenge facing Medicare is our nation's changing demographics. The retirement of the baby boom generation will nearly double the number of Medicare beneficiaries in the program. Medicare's financing and delivery systems must be capable of serving this enormous influx of beneficiaries whose health care circumstances, needs, and expectations will be similar in some respects to those of today's beneficiaries, but very different in others. Just as important, longer life spans are already causing rapid growth in the very old population. Medicare must be prepared to handle the unique health care needs of a growing number of older Americans who reach 85, or even 100.

To meet these challenges, the program's long-term financial solvency must be secure. AARP supported the Balanced Budget Act of 1997 as a first step towards securing Medicare's long-term solvency. The strong economy we now enjoy, and the Medicare Trustees' projection of solvency to the year 2015 are good news. But, this does not mean we can afford to become complacent or that we can delay the debate over how best to strengthen Medicare.

The deliberation over Medicare's future must be ongoing. It will take a sustained effort to update and improve Medicare. Changing a program that millions of Americans depend on for their health care is no small task. There must be a careful and thorough examination of the full range of issues—prescription drugs being only one issue among them—and a similarly careful effort to make sure that policy makers and the public alike understand the trade-offs that will be necessary.

AARP believes that it would be a serious mistake for anyone to hinder debate on reform proposals. By the same token, it would be an error for the Congress to rush to judgment on any reform option before policy makers and the public understood the proposed changes and their anticipated effect on beneficiaries, providers, and on the Medicare program in general. As we all learned over the recent BBA revisions, earlier experiences with the Catastrophic Coverage Act in the late 1980s, and from the health care reform debate of the early 1990s, unless the American public understands the trade-offs they are being asked to make and the changes that they will face, initial support can erode quickly.

The Need for a Medicare Prescription Drug Benefit

AARP is pleased that the Subcommittee has begun to examine ways to make prescription drugs more accessible and affordable for older Americans. It is our hope that today's hearing will help focus attention on the need for an affordable Medicare prescription drug benefit for all beneficiaries, as well as on other Medicare reform issues.

As new prescription drugs are becoming available to treat and even prevent more and more serious conditions and life-threatening illnesses, reliance on these drugs has become especially significant for older Americans. Eighty percent of retirees use a prescription drug every day. While older Americans comprise only 12 percent of the U.S. population, they account for one-third of prescription drug spending. In fact, after premium payments, prescription drugs account for the single largest component of health care out-of-pocket spending, for non-institutionalized Medicare beneficiaries age 65 and older. On average, these beneficiaries spend as much out-of-pocket for prescription drugs (17 percent of total out-of-pocket health care spending) as for physician care, vision services, and medical supplies combined. By contrast, inpatient and outpatient hospital care each accounts for about 3 percent of older beneficiaries' total out-of-pocket health spending.

High use, high drug prices, and inadequate insurance coverage pose serious problems for today's Medicare beneficiaries. A chronic health problem necessitating some of the newest, most expensive prescription drugs can deplete a retiree's financial resources. Some beneficiaries are forced to choose between food and their medications. Others do not refill their prescriptions or take the proper dosage in order to make their prescriptions last longer. A new international health care survey of the elderly by the Commonwealth Fund reports 7% of adults age 65 and over did not even fill a prescription due to cost.

Because of Medicare's current lack of prescription drug coverage, many beneficiaries must pay for prescription drugs completely out-of-pocket. While some beneficiaries may have employer-based retiree coverage, or be able to purchase private supplemental coverage that assists with costs, or join a Medicare HMO that offers a prescription drug benefit, these coverage options are inadequate, limited, expensive, and unstable. For instance, a new study by the Commonwealth Fund, reports that many Medicare beneficiaries do not have continuous prescription drug coverage. In 1996, just 53 percent of beneficiaries had prescription drug coverage throughout

Although 65 percent of Medicare beneficiaries have some type of coverage for prescription drugs, this figure can be very misleading. In fact, the majority of Medicare beneficiaries—not just those with low incomes—need drug coverage in Medicare. Why?

First, Medicare beneficiaries' current prescription drug coverage does not protect them from high out-of-pocket expenses. AARP estimates that 25 percent of Medicare beneficiaries spent over $500 out-of-pocket on prescription drugs in 1999, and over half of these beneficiaries had some type of coverage. Forty-two percent of beneficiaries who spent $1,000 or more on their prescription drugs (excluding insurance premiums) had some type of drug coverage. For example, some beneficiaries buy Medigap policies that provide a drug benefit. Two of the three Medigap policies that cover prescription drugs have an annual cap of $1,250 on drug coverage; the third policy has a $3,000 cap. All three Medigap policies that have a prescription drug benefit require the beneficiary to pay 50 percent coinsurance. It is interesting to note that while Medigap prescription drug coverage is quite limited, the premiums on these policies exceed $1,000. Other beneficiaries choose to enroll in Medicare HMOs that offer some prescription drug coverage. Yet, this year 32 percent of Medi-

care HMOs offering drug coverage have a $500 cap that applies to brand or to brand and generic drugs, and average copays in these plans have increased dramatically from last year—an estimated 21 percent for brands and 8 percent for generics.

Second, current prescription drug coverage available to Medicare beneficiaries is limited. Private Medigap policies may be the only option for obtaining drug coverage for beneficiaries who do not have access to employer coverage or Medicare+Choice plans. Yet, because almost all Medigap policies with drug coverage exclude beneficiaries based on pre-existing conditions once they have passed the first six months of their Medicare eligibility, and because not all three Medigap policies that include prescription drugs are not offered everywhere, many Medicare beneficiaries desiring such coverage cannot obtain it. Additionally, although Medicare HMOs are prohibited by law from underwriting the coverage they offer, such plans are not available in all parts of the country.

Third, current drug coverage options are not stable. For example, beneficiaries who obtain prescription drug coverage from their former employer are finding that coverage to be unstable. Retiree health benefits that include prescription drug coverage are becoming more scarce. While an estimated 60 to 70 percent of large employers offered retiree health coverage during the 1980s, fewer than 40 percent do so today. Of those employers who offer retiree benefits, 28 percent do not offer drug coverage to Medicare eligible retirees.

Further, beneficiaries who have drug coverage through Medicare HMOs cannot depend on having this coverage from year to year as plans can change benefits on an annual basis or even terminate participation in Medicare. For example, this year many beneficiaries in Medicare+Choice plans are living through abrupt changes in their prescription drug coverage that they did not foresee when they enrolled. Some of the most visible of these changes include:

• Increasing premiums—Over the past few years, more and more Medicare+Choice plans are charging premiums for their coverage, and those premiums are climbing. This year 207,000 beneficiaries must pay over $80 per month to enroll in a Medicare HMO. This compares to 1999 when only 50,000 Medicare beneficiaries enrolled in Medicare HMOs had a premium above $80 per month.

• Higher cost-sharing—For the first time this year, *all* Medicare HMOs that provide prescription drug coverage are charging copays for those prescription drugs, and the average beneficiary copay has increased significantly.

• Decreasing benefit—The annual cap on the typical Medicare+Choice drug benefit has decreased. While in 1999 only 21 percent of Medicare HMOs had an annual cap of $500 or less on their drug benefit, this year 32 percent of plans will have a $500 cap.

• Loss of benefit—This year some Medicare+Choice plans dropped their prescription drug benefit entirely. Although Medicare+Choice has provided beneficiaries with an opportunity for drug coverage, the volatility of the Medicare+Choice market has made that coverage unpredictable and unstable from year to year.

Issues Surrounding Adding Prescription Drugs to Medicare

AARP is committed to the creation of a voluntary, affordable Medicare prescription drug benefit that would be available to all beneficiaries, so that they may benefit from longer, healthier lives, fewer invasive medical procedures, and reduced health care costs. We appreciate the Subcommittee's interest in this issue and look forward to working with the Congress and the Administration to assure that a prescription drug benefit that is available and affordable to all Medicare beneficiaries becomes part of Medicare's defined benefit package. To that end, we have identified principles that we believe are fundamental to the design of a Medicare prescription drug benefit:

• A Medicare prescription drug benefit must be **availableto all** Medicare beneficiaries. First, the benefit should be *voluntary* so that beneficiaries are able to keep the coverage that they currently have, if they choose to do so. A Medicare prescription drug benefit should not be an incentive for employers to drop or cut back on retiree health coverage. Second, the benefit needs to be *affordable* to assure enough participation and thereby avoid the dangers of risk selection. To this end, the government contribution will need to be sufficient to yield a beneficiary premium that is affordable, and a benefit design that is attractive to beneficiaries. In other words, this is not simply a matter of beneficiary affordability, but equally important, the fiscal viability of the risk pool. Medicare Part B is a model in this regard. The Part B benefit is voluntary on its face, but Medicare's contribution toward the cost of the benefit elicits virtually universal participation.

• Prescription drugs should be part of a defined benefit package. It is critical that beneficiaries understand what is included in their benefit and that they have de-

pendable and stable prescription drug coverage. In addition, defining the drug benefit would reduce the opportunity for risk selection.

- The benefit must assure beneficiaries have access to medically appropriate and needed drug therapies.
- The benefit must include quality improvement components to reduce medical errors and mismedication and to help reduce overall health care costs.
- The benefit must include meaningful cost-containment mechanisms for both beneficiaries and Medicare. This should include drug-purchasing strategies that enable Medicare beneficiaries and the program to take advantage of the aggregate purchasing power of large numbers of beneficiaries.
- The benefit must provide additional subsidies for low-income beneficiaries to protect them from unaffordable costs and assure that they have access to the benefit.
- The benefit must be financed in a fiscally responsible manner that is both adequate and stable. AARP believes that an appropriate amount of the Federal budget surplus should be used to help finance a prescription drug benefit.
- A new prescription drug benefit should be part of a strong and more effective Medicare program. Prescription drug coverage must be integrated into the program in a manner that strengthens Medicare by improving the program's ability to support modern disease management and prevention strategies. Many of these strategies hold promise to both improve health outcomes and lower program costs.

Prescription Drug Proposals Before the Congress

The need to modernize the Medicare program to address the lack of prescription drug coverage has become a major issue for the 106th Congress. Several types of policy approaches for easing the financial burden that high prescription drug prices can impose on older Americans have been introduced. At this time, AARP has not taken a position on any of the proposals before Congress. As these plans continue to be refined, we have reserved judgment until further questions can be answered. We have not attempted in this testimony to undertake an extensive review of all of the prescription drug proposals introduced and the full range of questions that they raise. That essential step will require many more hearings, close review by a range of experts, and careful assessment of the impact of the proposed changes on beneficiaries, plans, providers, and the program itself. However, we have tried to summarize the major types of policy approaches before the Congress and the fundamental questions that must be answered about each.

President Clinton's Proposal

The approach put forward by President Clinton requires Medicare to pay for 50 percent of beneficiaries' prescription drug costs. This Medicare benefit would be available to all beneficiaries, but would be voluntary. Benefit management would be contracted out to private entities, such as pharmacy benefit managers (PBMs). This approach would allow market forces to reduce drug prices for beneficiaries because the contracted third parties could negotiate the same types of discounts from manufacturers and pharmacies for Medicare as they currently negotiate for health plans and HMOs. The government would be distanced from the role of determining prices under this approach. Additional financial assistance would be provided to low-income beneficiaries and financial incentives would be offered to employers to ensure that they retain current retiree health benefits. The Administration has now also suggested a new catastrophic benefit, although the details have not been spelled out. While AARP is pleased that the President's proposal includes prescription drug coverage for all beneficiaries, details of his plan are forthcoming and there are still unanswered questions about how a Medicare-based proposal would work. For instance:

- Will this prescription drug coverage be affordable to beneficiaries?
- Are the proposed benefit package and subsidy sufficient to attract a large number of beneficiaries?
- How would the President's new additional benefit to protect those beneficiaries with extremely high drug costs work?

The Kennedy-Stark-Dingell bill takes a similar Medicare-based approach as the President's, but would provide a different and more generous benefit structure. Although the bill's proposed benefit would include a deductible of $200, the beneficiary's coinsurance would be 20 percent rather than 50 percent, as proposed by the President. In addition, the Kennedy-Stark-Dingell bill would include a cap on the benefit of $1700 and stop-loss protection after the beneficiary has $3000 in out-of-pocket prescription drug expenses. This proposal raises the following questions:

- What happens to beneficiaries after they have exceeded the benefit cap but before they are eligible for stop-loss protection?

• Would beneficiaries support this type of benefit structure?
• Does this type of benefit meet the need of most current and future beneficiaries?

The Breaux-Frist Proposal

The approach introduced by Senators Breaux (D–LA) and Frist (R–TN) provides some subsidy to all beneficiaries interested in purchasing prescription drug coverage. Unlike the President's plan, this approach would not create a defined prescription drug benefit; rather, it allows entities, such as insurance companies or health plans, to offer any type of benefit so long as the benefit is equal to a certain actuarial value. Plans would compete by varying their drug benefit design. AARP is pleased that the Breaux-Frist bill improves upon earlier versions of the proposal in that it would include some form of subsidy for all beneficiaries who choose to purchase a "high option" plan. However, we have several questions that relate to our belief that the benefit must be affordable and avoid risk selection. These questions include:

• Is the prescription drug benefit affordable? Is a 25 percent premium subsidy enough to create a viable risk pool and make the benefit affordable for most beneficiaries?
• How would insurers be prevented from "cherry picking" beneficiaries since the drug benefit would be pegged to an actuarial cost and not to a particular benefit design?
• What will be the effect on quality of care and on beneficiaries or program cost of having a prescription drug that is administered separately rather than as part of the rest of Medicare? Will this lack of integration lead to cost-shifting or poorer quality care?
• Will prescription drug insurance that is offered through private entities be more expensive for beneficiaries and for the Medicare program than a benefit administered by Medicare because Medicare does not have to make a profit and has lower administrative overhead costs?
• Will stop-loss protection extend to the prescription drug benefit? How would beneficiaries with very high drug costs be protected?

The Bilirakis Proposal

Another approach, illustrated by Representative Bilirakis' (R–FL) bill, is to create a state-based approach for low-income beneficiaries, while expanding Medicare's benefits to include stop-loss protection so that the program would cover prescription drug costs once a beneficiary's annual out-of-pocket expenses reached a specified threshold. This approach would rely on the states to develop mechanisms for reducing prescription drug costs for low-income beneficiaries. While AARP opposes a Medicare prescription drug benefit for low-income beneficiaries only, the approach of providing low-income drug assistance *outside* of the Medicare program deserves further review. However, a state-based approach with accompanying Medicare stop-loss protection raises the following types of questions:

• How would the state low-income drug assistance program work? Would all states offer a low-income program?
• What processes would be established for enrollment and outreach in the state-based low-income prescription drug programs?
• Will there be any incentives for Medicare+Choice plans to keep offering a drug benefit or to offer wrap-around coverage?
• Would receipt of Medicare stop-loss protection be conditioned on the purchase of private sector insurance?

The Allen Proposal

Another approach, reflected in Representative Allen's (D–ME) bill, attempts to lower prescription drug prices by limiting the prices that manufacturers could charge beneficiaries. This approach does not involve the creation of a Medicare prescription drug benefit, but rather would lower drug prices by legislatively tying the prices paid by retail pharmacies for drugs sold to Medicare beneficiaries to the best prices paid by the government. Although it does not provide a Medicare benefit, the Allen approach has helped focus attention on the inequity of prescription drug pricing and merits review. However, a prescription drug discount approach raises the following types of questions:

• Will manufacturer discounts be passed on to Medicare beneficiaries?
• Will manufacturers engage in cost-shifting?
• Will—as the industry has threatened—a lower return on pharmaceuticals taken by beneficiaries discourage manufacturers from further research and development of drugs mainly used by older Americans?

Options for Medicare Reform

The above policy approaches for dealing with the high cost of prescription drugs illustrate one challenge we face in modernizing Medicare. The President's Medicare reform proposal, the plan introduced in the Senate by Senators Breaux and Frist, and proposals that will likely emerge from the House, provide opportunities for furthering debate about Medicare's future. We urge the Congress to carefully examine the different reform options and begin to answer some of the most critical issues surrounding broad changes to Medicare, including:

- How, and to what extent, would Medicare's long-term solvency be improved?
- Would all beneficiaries—regardless of the area of the country in which they live—have access to the same set of defined Medicare benefits?
- Would fee-for-service Medicare remain an affordable option for beneficiaries of all incomes?
- Would a prescription drug benefit be affordable and available to all beneficiaries?
- Would the level of the government's contribution continue to assure adequate choice for beneficiaries over time, without regard to where they live?
- How would beneficiaries be protected from high out-of-pocket costs?
- Would the entity responsible for administering Medicare be accountable to Congress and to beneficiaries?
- How would Medicare reforms be financed?

Key Principles That Should Guide Broader Medicare Reform

As this Committee also examines the broader issue of reforming Medicare, AARP urges you to consider the fundamental principles that, since Medicare's inception, have helped to shape it into such a successful program. We believe strongly that these principles must be the basis of any viable reform option.

Defined Benefits Including Prescription Drugs

All Medicare beneficiaries are now guaranteed a defined set of health care benefits upon which they depend. A specified benefit package that is set in statute is important for a number of reasons. First, it assures that Medicare remains a dependable source of health coverage over time. Second, a defined benefit package serves as an important benchmark upon which the adequacy of the government's contribution toward the cost of care can be measured. Without this kind of benchmark, the government's contribution could diminish over time, thereby eroding Medicare's protection. Third, a benefit package set in statute reduces the potential for adverse selection by providing an appropriate basis for competition among the health plans participating in Medicare. And finally, a defined benefit package provides an element of certainty around which individuals, employers, and state Medicaid programs may plan.

As was laid out earlier in this statement, because prescription drugs are central to the delivery of high quality health care, Medicare should be like most other health insurance plans and include prescription drugs as part of Medicare's defined benefit package offered by all participating plans—including traditional fee-for-service.

Adequate Government Contribution Toward the Cost of the Benefit Package

It is essential that the government's contribution or payment for the Medicare benefit package keep pace over time with the cost of the benefits. Currently, payment for traditional Medicare is roughly tied to the cost of the benefit package. If the government's contribution were tied to an artificial budget target and not connected to the actual cost of the benefit package, there would be a serious risk of both the benefits and government payment diminishing over time. The effect of a flat government payment—regardless of the plan cost—could be sharp year-to-year premium and cost-sharing increases for beneficiaries. It could also mean significant differences in what beneficiaries would have to pay for different Medicare plans.

Out-of-Pocket Protection

Changes in Medicare financing and benefits should protect all beneficiaries from burdensome out-of-pocket costs. Medicare beneficiaries age 65 and over, spent on average, about $2,430—nearly 20 percent of their income—out-of-pocket for health care expenses in 1999, excluding the costs of home care and long-term nursing care. In addition to items and services not covered by Medicare, beneficiaries have significant Medicare cost-sharing obligations: a $100 annual Part B deductible, a $776 Part A hospital deductible, 20 percent coinsurance for most Part B services, a sub-

stantially higher coinsurance for hospital outpatient services and mental health care, and significant coinsurance for skilled nursing facility care and very long hospital stays. Currently, there is no coinsurance for Medicare home health care.

AARP believes that Medicare beneficiaries should continue to pay their fair share of the cost of Medicare. However, if cost-sharing were too high or varied across plans, Medicare's protection would not be affordable, and many beneficiaries would be left with coverage options they might consider inadequate or unsatisfactory.

Viable Fee-for-Service

Medicare beneficiaries must continue to have access to a strong and viable fee-for-service option. Managed care is not yet established as a fully satisfactory choice for many beneficiaries. In addition, many beneficiaries live in areas of the country where managed care plans are not available or likely to become available. Without an affordable fee-for-service option, these beneficiaries could end up paying as much or more out-of-pocket for health care coverage that does not meet their needs.

Protecting the Availability and Affordability of Medicare Coverage

Medicare should continue to be available to all older and disabled Americans regardless of their health status or income. Our nation's commitment to a system in which Americans contribute to the program through payroll taxes during their working years and then are entitled to receive the benefits they have earned is the linchpin of public support for Medicare. Denying Medicare coverage to individuals based on income threatens this principle. Similarly, raising the age of Medicare eligibility would have the likely affect of leaving more Americans uninsured. Thus, in the absence of changes that would protect access to affordable coverage, AARP would oppose efforts to raise the eligibility age for Medicare. Analogies to Social Security's increasing age of eligibility simply do not apply. Social Security's early retirement benefits—though actuarially reduced—start at age 62, and most retirees today begin to collect benefits at age 62 not at age 65.

Quality of Care

Medicare beneficiaries have come to depend upon quality care in Medicare. Quality standards have been a hallmark of the program and have often served as a model for the private sector. Systematic data collection and analysis, careful quality monitoring, as well as new techniques for promoting quality outcomes, must remain a part of any reformed Medicare system.

Administration of Medicare

Effective administration of the program remains essential. The agency or organization that oversees Medicare must be accountable to Congress and beneficiaries for assuring access, affordability, adequacy of coverage, quality of care, and choice. It must have the tools and the flexibility it needs to improve the program—such as the ability to try new options like competitive bidding or expanding centers of excellence. It must ensure that a level playing field exists across all options; modernize original Medicare fee-for-service so that it remains a viable option for beneficiaries; ensure that all health plans meet rigorous standards; and continue to reduce waste, fraud and abuse in the program.

Financing

Medicare must have a stable source of financing that keeps pace with enrollment and the costs of the program. Ultimately, financing sources will need to be both broadly based and progressive. Additionally, because health care costs are rising faster than productivity, AARP supports using an appropriate portion of the on-budget surplus to secure Medicare's financial health.

Conclusion

The Medicare program needs to be ready to meet the unique challenges it faces now and in the future. Foremost among the challenges is ensuring that, even as the program adjusts to ensure its future financial soundness, it must also adjust to keep pace with the rapid advances in medicine. Therefore, AARP believes that an affordable Medicare prescription drug benefit that is part of Medicare's defined benefit package and available to all Medicare beneficiaries is essential to any Medicare reforms.

How to provide Medicare beneficiaries with affordable prescription drugs is a huge challenge before us. AARP urges all stakeholders—government, industry, and consumers—to engage in a serious debate on the merits of the full range of approaches. The success of any drug benefit proposal as well as broader changes to Medicare depend on a clear understanding—on the part of the public and policy makers

alike—of the changes that are being contemplated. This will require not only extensive dialogue, but also a thorough distributional analysis of how the proposed changes would affect the full range of current and future beneficiaries.

If legislation is pushed through too quickly, before there has been a thorough examination of the effect on beneficiaries and the program, and before there is an emerging "public judgment" about the changes, this would be a very serious mistake. In such a circumstance, we would be compelled to alert our members to the dangers in such legislation and why we could not support it.

We thank you for your efforts to examine the high costs of prescription drugs for older Americans. AARP looks forward to continuing to work with members of this Subcommittee and the Congress to advance the debate over prescription drug coverage, and to carefully explore the best options for securing Medicare's future.

Chairman THOMAS. Thank you, Doctor. Cost and availability. Mr. Roth?

STATEMENT OF THEODORE ROTH, PRESIDENT AND CHIEF OPERATING OFFICER, ALLIANCE PHARMACEUTICAL, SAN DIEGO, CALIFORNIA, ON BEHALF OF THE CALIFORNIA HEALTHCARE INSTITUTE

Mr. ROTH. Mr. Chairman and members of the subcommittee, thank you for giving me the opportunity to testify today on the important issue of Medicare and prescription drugs for seniors. I would also like to commend you for demonstrating commitment to this issue and the broader topic health care policy. How we deal with this subject has great implications for the physical and emotional health of our Nation's older citizens and the financial health of America's biomedical research and development enterprise.

My name is Ted ROTH. I am president and chief operating officer of Alliance Pharmaceutical, a biopharmaceutical company based in San Diego. We employ about 300 people engaged in developing unique therapeutic and diagnostic products that are based on the company's expertise with perfluorochemicals, surfactants, and pharmaceutical manufacturing processes. Our drugs and medical devices are intended mainly for use in critical and acute care situations, including surgical, cardiology, and respiratory indications.

Today I am testifying on behalf of the California Healthcare Institute, representing approximately 200 companies and academic institutions. During the past generation, California has become the world headquarters for biotechnology and medical innovation. Altogether this statewide enterprise employees well over 200,000 California who are pursuing hundreds of research and development projects to cure and prevent disease. It is no exaggeration to say that such that such research represents our only hope of conquering the terrible diseases that predominantly affect our older citizens: Alzheimer's and stroke, as well as cancer, heart disease, and depression.

With respect to the Medicare population, the central challenge we face is twofold: How can we make sure that biomedical research companies continue to produce the new medicines that patients so desperately need and, at the same time, ensure that these medicines are available to all our senior citizens who need them?

Ironically, we confront this question to a great degree because pharmaceuticals have been so effective. A century ago, Americans' average age at death was 47 years. Most of the diseases that accompany older age today were rare. And at the dawn of the new millennium, thanks in large measure to vaccines and other pharmaceuticals, the average life expectancy in the U.S. is 76 and rising. In fact, today more than 1.4 million Americans are in their 90s.

To a large extend, the costs associated with prescription drugs and biioltyechnology products are an indications of just how much innovative science has transformed health care. Increasingly, drugs and biologic are saving the lives of people who would have died without them and are displacing less desirable surgical procedures and treatments. In other words, breakthrough medicine has changed the nature of health care, and in doing do, they inevitably represent a growing share of medical costs. Patients and physicians generally view this as a positive trend. For instance, curing ulcers with a drug is vastly preferable to surgery, and rating depression on an outpatient basis with a compound that regulates the brain's neurotransmittes is immeasurably better than confining a severely depressed patient in a psychiatric hospital.

A recently study of nearly 2,000 members in a managed care program for congestive heart failure showed that pharmacy costs increases by 60 percent, or $250,000, but hospital costs, in fact, decreased by 78 percent, and the total savings exceeded $9 million.

The free market economy of medicine in America has produced the most technologically advanced drugs and biologics in the world. Nationally, there are about 30 biotechnology products in Phase Ii or Phase III clinical trials, a high percentage of which will be approved for patient use within the next few years, and much of this innovative has taken place in small, entrepreneurial; biomedical companies, as Exhibit 1 to my prepared remarks indicate, the California biomedical companies and the products that they are working on:

To meet the high standards of safety and efficacy demanded by the Food and Drug Administration for commercialization, the average new drug requires an investment of nearly $500 million over a period of 12 years. The biotechnology revolution we are experiencing is only possible because an unprecedented amount of private capital has flowed into small startup companies during the past 20 years, enabling them to fund the long and arduous process of transforming an invention into a product for patients. In 1998 along, biotechnology companies invested almost $10 billion in R&D. Since most of these companies have yet to generate commercial sales, let along profits, their net operating loss of 1998 amounted to $5.1 billion.

At Alliance Pharmaceutical, which is a typical company in this regard, we have exploited every available avenue for financing—venture capital, public equity, corporate partnerships, and so forth—to support our key development programs.

Naturally, investors are concerned about whether or not they can earn a return on invested capital that is commensurate with the risk involved with developing a new drug. Bear in mind that the entire research and development work, including obtaining FDA

approval, must be completed before realizing the first dollar of sales from each product. By and large, investors are comfortable with assessing the inherent risks of science and the marketplace. What makes them uncomfortable is the prospect of Government intervention in the form of price controls, direct or indirect. If Congress imposes price control mechanisms in changing Medicare, the most serious unintended consequence will be to reduce the rate of private investment in biomedical research and, as a result, the research itself.

I would just like to present four areas that we think should be incorporated into any legislation for prescription drugs: number one, help the neediest first; two, rely on market mechanisms, not price controls; three, focus on the total health care costs, not individual components; and, finally, incorporate pharmaceuticals into broader Medicare reform.

Thank you for this opportunity to present to you.

Statement of Theodore Roth, President and Chief Operating Officer, Alliance Pharmaceutical, San Diego, California, on behalf of the California Healthcare Institute

Mr. Chairman, Members of the Subcommittee, thank you for giving me the opportunity to testify today on the important issue of Medicare and prescription drugs for seniors. I'd also like to commend you for demonstrating commitment to this issue, and the broader topic of health care policy. How we deal with this subject has great implications for the physical and emotional health of our nation's older citizens and the financial health of America's biomedical research and development enterprise.

My name is Ted Roth and I am president and chief operating officer of Alliance Pharmaceutical, a biopharmaceutical company based in San Diego, California. We employ about 300 people engaged in developing unique therapeutic and diagnostic products that are based on the Company's expertise with perfluorochemicals, surfactants, and pharmaceutical manufacturing processes. Our drugs and medical devices are intended mainly for use in critical and acute care situations, including surgical, cardiology and respiratory indications.

Today I am testifying on behalf of the California Healthcare Institute (CHI), representing approximately 200 companies and academic institutions. During the past generation, California has become the world headquarters for biotechnology and medical innovation. Altogether this statewide enterprise employs well over 200,000 Californians who are pursuing hundreds of research and development projects to cure and prevent disease. It is no exaggeration to say that such research represents our only hope of conquering the terrible diseases that predominantly affect our older citizens: Alzheimer's, stroke, as well as cancer, heart disease and depression.

With respect to the Medicare population, the central challenge we face is twofold: How can we make sure that biomedical research companies continue to produce the new medicines that patients so desperately need and, at the same time, ensure that these medicines are available to all our senior citizens who need them?

Ironically, we confront this question to a great degree because pharmaceuticals have been so effective. A century ago, Americans' average age at death was 47 years. Most of the diseases that accompany older age today were rare. At the dawn of the new millennium, thanks in large measure to vaccines and other pharmaceuticals, the average life expectancy in the U.S. is 76 and rising. This is truly remarkable—in a 100-year period, we have added 30 years to the average length of life. In addition, the quality and productivity of those years has been greatly improved. Every five years since 1965, medicines have helped add one year to average life expectancy. Today more than 1.4 million Americans are in their nineties.

To a large extent, the costs associated with prescription drugs and biotechnology products are an indication of just how much innovative science has transformed healthcare. Increasingly, drugs and biologics are saving the lives of people who would have died without them and are displacing less desirable surgical procedures and treatments. In other words, breakthrough medicines change the nature of healthcare, and in doing so they inevitably represent a growing share of medical costs. Patients and physicians generally view this as a positive trend. For instance, curing ulcers with a drug is vastly preferable to surgery. Treating depression on an outpatient basis with a compound that regulates the brain's neurotransmitters is

immeasurably better than confining a severely depressed patient in a psychiatric hospital. A recent year-long study of nearly 2,000 members in a managed care program for congestive heart failure showed that pharmacy costs increased by 60%, or $250,000, but hospital costs decreased by 78% and total savings exceeded $9 million.

The free-market economy of medicine in America has produced the most technologically advanced drugs and biologics in the world. Nationally, there are about 300 biotechnology products in Phase II or Phase III clinical trials, a high percentage of which will be approved for patient use within the next few years. And much of this innovation has taken place in small, entrepreneurial biomedical companies. As exhibit I shows, California's biomedical companies are working disproportionately on the maladies that afflict senior citizens. Significantly, most of these products in development have yet to reach the market.

To meet the high standards of safety and efficacy demanded by the Food and Drug Administration for commercialization, the average new drug requires an investment of nearly $500 million over a period of 12 years. The biotechnology revolution we are experiencing is only possible because an unprecedented amount of private capital has flowed into small startup companies during the past twenty years, enabling them to fund the long and arduous process of transforming an invention into a product for patients. In 1998 alone, biotechnology companies invested almost $10 billion in R&D. Since most of these companies have yet to generate commercial sales, let alone profits, their net operating loss for 1998 amounted to $5.1 billion. At Alliance Pharmaceutical, which is a typical company in this regard, we have exploited every available avenue for financing—venture capital, public equity, corporate partnerships, and so forth—to support our key development programs.

Naturally, investors are concerned about whether or not they can earn a return on invested capital that is commensurate with the risk involved with developing a new drug. Bear in mind that the entire research and development work, including obtaining FDA approval must be completed before realizing the first dollar of sales from each product. By and large investors are comfortable with assessing the inherent risks of science and the marketplace. What makes them uncomfortable is the prospect of government intervention in the form of price controls, direct or indirect. If Congress imposes price control mechanisms in changing Medicare, the most serious unintended consequence will be to reduce the rate of private investment in biomedical research, and, as a result, the research itself. This outcome would be particularly tragic in view of our industry's promise and the increasing rate of public sector investment in basic life sciences research through the National Institutes of Health and other federal agencies. Government investment in academic science remains inert unless private investors are willing to capitalize the development of that research into commercially viable products. In fact, the development phase (after characterization of the biopharmaceutical product) represents by far the greatest amount of time and money to bring these products to patients. Government agencies are not prepared to conduct this work—the private sector has demonstrated that it can most effectively perform this function.

Still, we must face the question of how to ensure seniors' access to affordable medicines, once they are developed. Here I would like to focus on a few principles that, no matter the details of any particular approach, are essential to balancing the goals of expanding access and continuing innovation.

- *Help the neediest first.* Cost is the reason we do not have a Medicare prescription drug benefit today. One in three seniors have already arranged coverage for drugs in the private insurance market. Any plan that simply adds an expensive new benefit onto a program already beset by cost problems is unwise. We should begin with providing benefits to lower-income seniors and disabled citizens.
- *Rely on market mechanisms, not price controls.* The private market has demonstrated a robust ability to contain healthcare costs, including the cost of drugs. By exploiting private sector cost-containment and healthcare management systems already in place, and encouraging competition, Medicare has the best chance of controlling its budget without imposing government price controls.
- *Focus on total healthcare costs, not individual components.* In many instances, pharmaceuticals are replacing more expensive clinical alternatives such as surgery or hospitalization. Beyond improving patients' quality of life, prescription drugs often produce substantial cost savings.
- *Incorporate pharmaceuticals into broader Medicare reform.* The National Bipartisan Medicare Commission identified a direction for Medicare in the future, with seniors selecting from various competing private sector plans those options that best met their needs. A drug benefit should be integral to a modernized Medicare program, not an afterthought merely added to a faulty structure.

Mr. Chairman, as you consider the best way to improve drug access for Medicare beneficiaries, we urge you and your colleagues to remember the crucial role that

smaller biotechnology companies play in meeting the unmet medical needs of seniors and, ultimately, of everyone. The reason California leads the world in biomedical progress is that we have enjoyed a free market that rewards risk-taking and successful innovation. This free market is the envy of the world. It must not be constrained by the visible hand of government intervention. We share your goals of making the fruits of innovation available to all, and we look forward to working with you to achieve the best solution.

Chairman THOMAS. Thank you, Mr. Roth.

Dr. Sager?

STATEMENT OF ALAN SAGER, PH.D., PROFESSOR, BOSTON UNIVERSITY SCHOOL OF PUBLIC HEALTH, BOSTON, MASSACHUSETTS

Mr. SAGER. Thank you, Mr. Chairman, and thank you for inviting me.

We can make all needed medications affordable for all Americans and build a durable financial foundation under drug research.

Over 70 million of us lack insurance for drugs today. Some 17 percent of Americans and 42 percent of uninsured Americans report not filling prescriptions for financial reasons. What good is drug research if people can't afford the product?

Yet our drug spending per person is the world's highest, and total prescription drug spending will be over $120 billion this year, or 10 percent of health care costs.

We face three choices: Many of us could suffer and die for lack of needed drugs, but that is intolerable; we could spend more on drugs, but that is both unaffordable and unnecessary; or we could secure more drugs from manufacturers for what we already spend.

Why are medications unaffordable for many?

First, because of high U.S. drug prices;

Second, our Government does not fight for lower prices for all citizens. Americans pay some $20 to $50 billion extra for the drugs we buy. That is because other wealthy nations don't pay their fair shares of drug makers' costs. This amounts to badly targeted, private, and invisible foreign aid to rich nations; and

Third, the drug makers paralyze government action by claiming that high U.S. prices and profits are needed to finance research, and that prices and profits are products of a free market. False.

During the nineties, the nation's big drug makers' returns on equity were over double that of all industries for the entire decade. High profits, decade after decade, mean that drug makers' risk is much less than they claim. Drug makers claim, falsely, that they set prices to cover research costs. They do set prices to try to maximize profits as stakeholders expect and demand.

Profits don't finance research. Profit is what is left over after paying for research and other costs. Drug profits were over 50 percent greater than research in 1998. Drug makers won't identify a ceiling on profits above which no more research money is needed, and they won't identify a level below which research would suffer. They just want more.

In a free market, that would make sense. Sadly, there is little of a free market here. Lacking either a free market or effective gov-

ernment action, we have anarchy. Anarchy allows the strong to earn unwarranted profits. PhRMA spreads a fog of fear to try to paralyze public action and to preserve profits by threatening collapse of research if Government protects patients.

Drug makers themselves are the real threat to research. Their unnaturally high prices and profits, while patients suffer, could lead an angry future Congress to legislate harsh controls. Moderate action today will protect both patients and research tomorrow.

But what solutions are possible? Bills to lower drug prices for seniors and offer Medicare drug benefits have been filed. We should weave these approaches together because helping people will be very costly without restraints on spending.

Private restraints, such as formularies and higher copays, will fail in costly, bureaucratic, and irritating ways. Instead, we should build on the blessings of at least four rich opportunities:

First, we already spend enough to buy all needed drugs;

Second, we generate some one-quarter to one-third of the world's drug revenues;

Third, once research is performed and factories are built, the added or marginal cost of making more pills is very low. We estimate it at 5 cents on the retail dollar. That means that manufacturers can make drugs worth $20 billion to Americans, at retail, at an added cost to themselves of about $1 billion; and

Fourth, lower prices may not hurt drug makers. Merrill Lynch says that a 40 percent price cut for Medicare patients would result, at worse, in a 6-percent loss of revenue, or even in a slight revenue gain.

How to seize these four opportunities? Internationally, by negotiating a drug price treaty. All wealthy nations should pay the same fair prices for prescription drugs and to subsidize poor nations.

Domestically, either we could fight for years over drug prices, profits, and coverage—with substantial name calling. Anger would grow. Stock prices would wobble.

Or we could make a package deal for patients, payers, and drug makers that could include at least three elements:

First, payers and drug makers negotiate returns on equity adequate to finance research and retain capital, but with big rewards for breakthrough drugs;

In exchange, drug makers produce and distribute enough medications to meet all the need. Low marginal costs make this very inexpensive;

Finally, to make the deal real, set lower drug prices in the private market, use public money to buy drugs for people unable to afford the lower discounted prices, and assure that drug makers obtain enough private plus public revenue to reach negotiated profit and total revenue targets.

Thank you for the chance to present these views.

[The prepared statement follows:]

Statement of Alan Sager, Ph.D., Professor, Boston University School of Public Health, Boston, Massachusetts

Mr. Chairman and members of the Subcommittee on Health—

Good afternoon.

My name is Alan Sager and I am a professor at the Boston University School of Public Health. I am honored by your invitation to appear before you today.

Together, we face two challenges.

• making all needed medications affordable for all Americans, while
• building a durable financial foundation under drug research and delivery in the U.S.

I am convinced we can do both of these. One reason is that we already spend enough money to do so. But not if we continue business as usual.

What is the nature of the problem?

Many Americans can't afford needed prescription drugs because they lack insurance, suffer low incomes, and can't afford high American prices.

Today, 70 million Americans of all ages have no insurance for prescription drugs. Additional millions have skimpy coverage. Yet American prescription drug spending per person this year will be the world's highest. And total prescription drug spending will be over $120 billion this year, or about ten percent of overall U.S. health spending.

Worse, people without insurance typically pay the world's highest prices for prescription drugs. That's because average American prices are highest in the world, and uninsured Americans pay prices above the average.

So it is not surprising that 17 percent of all Americans—and 42 percent of uninsured Americans—reported not filling prescriptions for financial reasons.[1]

And these are the economy's fat years, to paraphrase what Joseph told Pharaoh.

The drug cost problem will probably worsen. Drug spending in the U.S. has been rising about three times as fast as overall health care spending.

Perhaps 1,000 new drugs are in the overall pharmaceutical pipeline.[2]

If too few of these medications work, we will have a lot of disappointed investors.

But what if a great number of them do work?

Then, many more patients will have to choose between their money and their lives. And still other patients will not even have this choice, because they will lack the money.

Will medical miracles be affordable for all or merely profitable for some?

If we fail to make vital drugs available to all who need them, how great will be the public fear and anger? Reasonable action today will prevent over-reaction tomorrow.

Together, we face three choices:

• Many of us could suffer and die for lack of needed medications, but that is intolerable.
• We could spend more public or private money—or both—to buy needed drugs, but that is both unaffordable and unnecessary.
• We could secure more drugs from manufacturers for the amount we already spend.

What are the causes of the problem of unaffordable medications?

To make sense these problems and to devise solutions to protect the biotechnology industry specifically, we must examine the prescription drug industry generally.

1. High U.S. drug prices make drug insurance unaffordable for many.

2. U.S. prices are high mainly because, alone in the world, our government does not protect us from the world's drug makers. This year, Americans will pay between $20 and $50 billion extra for drugs. This is an invisible subsidy to other rich nations that don't pay their fair shares of the drug makers' costs. It constitutes the world's least-well-targeted foreign aid.

3. The drug makers paralyze government action by claiming
• that today's prices and profits are legitimate products of a free market;
• that high U.S. prices and profits are needed to finance vital research; and
• that even moderate restraint on prices or profits will collapse the drug makers' fragile financial house of cards.

These three claims are false. The drug makers' prices and profits can't be sustained at current or hoped-for levels.

During the 1990s, the nation's big drug makers' returns on equity were two and one-quarter times the average for all U.S. industries. It is unrealistic to expect that American patients can or will continue to pay prices high enough to sustain these profits.

The United States government emphatically rejects PhRMA's claims by taking a 40 percent (or so) price discount for medications for the V.A. and military, and by

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[1] Karen Donelan, Robert J. Blendon, Cathy Schoen, Karen Davis, and Katherine Binns, "The Cost of Health Care System Change: Public Discontent in Five Nations," Health Affairs, Vol. 18, No. 3 (May–June 1999), pp. 206–216, exhibit 6.

[2] Neil Munro, "Technology: Frontier Ethics," National Journal, 4 June 99.

taking an 18 percent (or so) price cut for the Medicaid program. This is the sort of thing foreign governments have long done for all their citizens.

But unlike governments elsewhere, our government has protected only itself alone. In so doing, it leaves the drug makers free to raise prices on the rest of us in order to reach their revenue targets.

The drug makers claim they set prices to cover research costs. That is not true. They set the prices that they believe will maximize profits, and that's what their stockholders expect. In 1998, the drug makers' profits averaged more than one and one-half times their research costs.

And the drug makers are unwilling to identify any ceiling whatsoever on their profits—the level of profit beyond which no more money is needed to finance vital research. Similarly, the drug makers are unwilling to identify any floor on their profits—the level of profit below which vital research would suffer. Their position is simple: more is better. That would make sense only if the drug makers operated in a competitive free market.

The drug makers' returns are unnaturally high and are not justified by legitimate market forces. Sadly, few signs of a living free market can be detected in the drug industry—outside the retail pharmacy sector. (The evidence for this position is detailed in the July 1999 report to the U.S. House of Representatives Prescription Drug Task Force that I co-authored with my colleague, Deborah Socolar.) Without either functioning free markets or effective government action, we have only one thing—anarchy. And anarchy allows the strong to earn unwarranted profits.

That is why PhRMA, the drug makers' trade association, spreads a fog of fear—PhRMA's Fog of Fear—to try to paralyze public action and to preserve anarchy.

But the drug makers themselves sometimes pay a price for this anarchy. Some individuals connected with the biotech and prescription drug industries have worried aloud about the instability of biotech stock prices in 1993–1994 and again in recent months. They have condemned legislative efforts to contain prices or improve coverage, claiming that these efforts would impede the flow of capital to the industry. But their position amounts to condemning a symptom. As long as many Americans cannot afford needed medications, we will see repeated attempts to lower prices and improve coverage. The industry cannot wish away this simple reality. Unless all patients win equitable and affordable access to medications, investors will be denied relaxed enjoyment of drug profits. The challenge is to win both.

Drug makers claim that sky's-the-limit prices and profits are needed to finance drug research. But excessive prices and profits are more likely to damage the very research the drug makers profess to care about.

Insisting on unnaturally high drug prices and profits—in a nation where growing numbers of patients suffer for lack of needed medications—could lead an angry future Congress to legislate harsh price and profit controls. And that is the real threat to sustained research funding. Moderate action and compromise today will protect both Americans and our vital drug research community tomorrow.

What solutions are possible—to win affordable medications for all Americans?

Some drug makers' magical solution is to promise that new drugs will reduce costs of hospital and doctor care. That's easy to promise but hard to deliver, on average. Some short-run savings may be possible in some instances. While preventing or treating one disease is a blessing, doing so will inevitably expose patients to other diseases. This means that any dollar savings are one-time only.

Prudence demands that we plan against the contingency that drug breakthroughs will fuel higher spending.

Legislation to mandate lower drug prices for seniors has been introduced, as has legislation to offer prescription drug benefits under Medicare. We need to weave these two approaches together because helping vulnerable people will be very costly unless it is coupled with restraints on spending. And no market will restrain spending safely or adequately. Recall the experience that an unrestrained Medicare program had with hospital and physician spending in the late 1960s and early 1970s.

We can protect all people without spending more money, and in ways that provide fair and adequate financing for research to develop new and effective drugs.

We can do so because we are blessed with at least four rich opportunities.

First, U.S. drug prices and drug spending per person are the highest in the world. This means that all of us together already spend enough to buy the medications all Americans need.

Second, Americans together generate between one-quarter and one-third of the world's drug makers' revenues.

Third, once the research is performed and the factories are built, the marginal cost of manufacturing additional volumes of medications—more capsules, pills, and

suspensions—is very low. We estimate it at 5 cents on the retail dollar. That means that manufacturers can make drugs worth $20 billion to Americans (at retail) at a cost to them of only $1 billion.

Fourth, the price elasticity of demand for medications may be very substantial. For example, researchers at Merrill-Lynch estimated last year that even a 40 percent price cut for Medicare patients would result in only a 6 percent loss of revenue—or even a slight revenue gain.[3]

Several specific approaches could be used to meet these capitalize on these opportunities. Here are a few:

I. Internationally, negotiate a drug price peace treaty. All wealthy nations would agree to pay the same fair prices for prescription drugs, and to subsidize sick people in poor nations. Our government would have to take the lead. This is probably worth doing no matter what domestic approaches are taken.

II. Domestically, I see only two alternatives. Either:

A. We could engage in years or decades of increasingly mean-spirited and fragmented fights over drug prices, profits, and coverage. Anger and threats would be the highlights. So would corporate stock price instability.

OR

B. We could sit down to negotiate a comprehensive package deal. By focusing on the two real bottom line issues—affordable medications for all plus fair returns on invested equity and adequate financing for research, this approach could short-circuit angry trench warfare fights about the details. The package could include these eight elements:

1. Private and public payors and drug makers negotiate fair returns on drug makers' equity. This would be the rate adequate to finance needed research and retain needed capital. Adequate overall profits would be combined with generous rewards to those who develop valuable medications.

2. In exchange, drug makers produce and distribute enough medications to fill all prescriptions written by physicians for Americans. Drug makers would find it inexpensive, on average, to provide the increased volumes (higher than today's production levels) required to protect all Americans. That is because drug makers face high fixed costs but very low marginal or incremental costs to make additional amounts of most medications.

3. To make the deal real:

- Drug prices would be lowered in the private market.
- Public money could be used to buy medications for people unable to afford even the discounted prices.
- The drug makers would win enough total revenue to achieve negotiated profit and total revenue targets.
- The targeted total spending on prescription drugs this year would be pegged at about the expected $120 billion-plus.

4. To make medications more affordable, drug makers would be encouraged to cut wasteful marketing and advertising costs.

5. Physicians need better evidence on each drug's benefits and costs. Studies to obtain this information should be financed, compiled, and disseminated by objective parties, not by industry.

6. To encourage better use of medications, patients deserve improved information about proper drug use.

7. To protect patients, pharmacists need to be assured of payments adequate to cover the time of both patient counseling and accurate dispensing.

8. It may also be desirable to target scarce public and private research dollars down paths that are more likely to develop medications that are both effective and affordable for all.

Evidence supporting the findings and conclusions presented in this testimony is found in Alan Sager and Deborah Socolar, Affordable Medications for Americans: Problems, Causes, and Solutions, presented to the Prescription Drug Task Force, United States House of Representatives, 27 July 1999. It is available from *www.house.gov/berry/prescriptiondrugs/*. Refer to "studies of interest."

(A summary of that report is incorporated into this testimony; it appears on the following pages.) [

Thank you for the opportunity to present these views. I will be happy to respond to your questions, either today or subsequently.

[The summary is being retained in the committee files.]

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[3] Merrill Lynch, Pharmaceuticals: A Medicare Drug Benefit: May Not Be So Bad, 23 June 1999.

Chairman THOMAS. I thank all of you.

Dr. Sager, do you have a timeframe in which that plan would run? Would it be like a 5-year plan?

Mr. SAGER. I think that—

Chairman THOMAS. Or a 10-year plan?

Mr. SAGER. I think it should be incremental and American, sir.

Chairman THOMAS. No, but I mean the number of years. So once you put it in place, it has to be monitored constantly in terms of the dollar flows, so it wouldn't be for a set number of years.

Mr. SAGER. I think we would have to see as we got into it.

Chairman THOMAS. All of us are concerned that we need to do what we need to, accessibility and affordability. The concern is that we might do some of the things that you don't want us to do. So quickly, on a list of do's and don'ts, I think I heard clearly that the program ought not to be capped in some way. How does that reflect over to formularies? There are choices and sometimes providing restricted choices gives you ultimately more than open-ended choices. Any reaction to that?

Dr. SOUMERAI. Yes, in terms of caps, caps really hurt the people with multiple chronic illnesses. The data clearly point that way.

There are a lot of private systems and public systems that make formularies, if they are good formularies, work. And I could give you some papers that we and others have written that show examples of good policies that have said, for example, that all non-steroidal anti-inflammatory agents are about equally effective. And the expensive ones are discouraged.

Chairman THOMAS. Well, part of the problem is the incremental benefit from an incredible increasing cost in some of the newer drugs, and someone needs to deal with the tradeoff in that area.

I assume New Hampshire put the caps on to, quote-unquote, save money?

Dr. SOUMERAI. Yes, as well as about a dozen other States.

Chairman THOMAS. One of the things that this Committee did, to its credit, was to destroy the myth that a 5-year budget plan reflects reality and that in the area of preventive care, you can invest money and that over the long haul, not even just measuring the quality of life, but actually produce savings. So is it fair to say that if we were not going to do the things that are, quote-unquote, cost savers, like caps and the rest, that it also would be reasonable that as benefits are given, there might be some reasonable reduction of choice? Now, maybe, Dr. Calfee, that is to you, because if you look at, for example, some of the AARP requirements, it means you cannot build a plan because you have to maximize choice, you have to provide full coverage, you have to have reasonable costs, meaning virtually no increase in anything, and at some point you have got to deal with the realities of the situation.

Is it a reasonable tradeoff to require formularies but restrict choice? Or is it better to maximize choice and then let people pay out of pocket? Which gets to the next level: Deductibles, good or bad? I know it depends on how high they are. But as a concept, should we include deductibles if they are reasonable?

See, the President's plan has no deductibles whatsoever. Now, let's——

Dr. BRAUN. I think that is something that we need to talk more about. We certainly have evidence of what beneficiaries would like, they would like first-dollar coverage. And, of course, one of the advantages of that is that you are more apt to have more people buy into it if it is a voluntary situation and you want to get your risk pool as big as you can.

Chairman THOMAS. Well, you have to give it away free. You have first-dollar coverage, you are going to get more people participating. But then you have got an enormous cost on your hand.

Dr. BRAUN. But you want some of the people who have low cost——

Chairman THOMAS. I understand that.

Dr. BRAUN [continuing]. To come into the risk pool; otherwise, you are going to have nothing except high ones, and then you can't afford the premium.

Chairman THOMAS. I understand that, but at some point maybe we need to talk about government as the insurer of last resort or a reinsurance concept, given how few those high-costers are which skew the entire risk pool.

Dr. BRAUN. That is right.

Chairman THOMAS. Rather than create an open-ended, front-loaded, everybody gets in to guarantee a larger risk pool. Managing that risk pool might be a responsible role.

Dr. BRAUN. I think that stop-loss idea, whether it is reinsurance or whatever, is very——

Chairman THOMAS. Well, stop-loss is very critical for some. But, Dr. Braun, just to give you an example of the difficulty with the way in which the testimony once again has been presented by AARP, although it certainly is far-ranging, when I try to distill it down in terms of getting any direction or assistance or guidance, I find that you have pointed to a number of things, but have not taken a position on anything.

Dr. BRAUN. No, Mr. Chairman. We realize that there needs to be more discussion and there have to be some tradeoffs in this, and speaking of the first-dollar situation, you know, maybe deductibles are going to work out better. I don't think we have made any decision on that situation.

Chairman THOMAS. OK. At the bottom of page 17, it says, "AARP urges all stakeholders—Government, industry and consumers—to engage in a serious debate."

Dr. BRAUN. Yes.

Chairman THOMAS. You say slightly above that, under financing, that AARP supports using an appropriate portion of the on-budget surplus. How much is appropriate?

Dr. BRAUN. I don't think we have determined how much is appropriate. I think that is another thing that needs to be discussed as the plan is developed to see what is going to be necessary.

Chairman THOMAS. OK. On page 16, you say that Medicare should continue to be available to all older and disabled Americans, regardless of their health status or income. That means you don't want any income test at all, no means test for any of the benefits, right?

Dr. BRAUN. No, not means testing for benefits, no.

Chairman THOMAS. OK.

Dr. BRAUN. But there may be some income-relating or some differences in premium or there certainly needs to be subsidies for the low-income group, and that is going to depend——

Chairman THOMAS. Well, I am thinking more about the high-income, not the low-income. I think you heard general agreement here that we ought to take care of the low-income.

You say that our Nation's commitment to a system in which Americans contribute to the program through payroll taxes during their working years and then are entitled to receive the benefits they have earned is the linchpin of public support for Medicare.

Are they entitled to the benefits greater than what they earned or just what they earned? What does that mean? I don't think anyone here argues that they should not get what they put in plus interest. The concern is that if you say that they deserve benefits they have earned——

Dr. BRAUN. Well, first of all, you need—you would certainly have to look at it in terms of what the money was worth in the time, plus, as you say——

Chairman THOMAS. Certainly buying power, no question we would give——

Dr. BRAUN. But I think it has been very difficult in the past to foresee what kind of payroll tax was going to be necessary to take care of the population that we have now. I think you need to face the fact that it is probably true for the future. Are people paying in now going to be able to pay for what is going to be available when they come——

Chairman THOMAS. So it really isn't that they are entitled to what they earned. It is entitled to what it costs to provide them with the reasonable health care——

Dr. BRAUN. A good health care benefit——

Chairman THOMAS [continuing]. Far beyond what they paid in, which is the current situation.

Dr. BRAUN. Not for everybody. Some people do die young.

Chairman THOMAS. If that were the solution, we wouldn't be here today.

Dr. BRAUN. No. That is right.

Chairman THOMAS. Because that is changing as well.

Finally, on page 15, you say, "AARP believes that Medicare beneficiaries should continue to pay their fair share of the cost of Medicare." Is that the original 50 cents on the dollar of the part B premium, or is 25 cents on the dollar, which is what we currently pay, a fair share? You don't want to go back to the original statute of 50/50.

Dr. BRAUN. I think that is another thing that needs to be discussed, that whole area of Medicare financing and what is the fair share. We simply want to say that the beneficiaries need to do their share in reforming Medicare and not expect everybody else to do it.

Chairman THOMAS. Does AARP have a position on the President's 20 percent copay for clinical labs in his budget? Is that a fair-share payment by a beneficiary?

Dr. BRAUN. AARP hasn't taken any position on any of the proposals as yet. We still want some more information. We have got questions about each of them.

Chairman THOMAS. What about the President's proposal to index deductions on the part B premium, which has never been changed since it was put in effect? Obviously, everything has gone up, as you indicated, but the deduction hasn't gone up at all. So would indexing of things be a reasonable approach, as the President offered?

Dr. BRAUN. I think we have to look at that as part of the whole picture, but I think we have an indexing problem all over the place.

Chairman THOMAS. See, this is part of my problem as I go through. You have got testimony once again in which on the one hand and on the other, but what I get out of this is although people are supposed to engage in a serious debate over this, you folks don't take a position, you don't offer assistance, and you are the single largest group that would create a positive factor for change.

If you would step forward and say we are willing to assume *x* percentage of the load, we are willing to say that if we get value, we are willing to trade choice, but what you want is value and choice and more. And it is exceedingly difficult to try to deal with an organization as large as you are when you give us a set of principles which, if we honored all of them, the only way you could honor them is to contradict others. You can't do everything that you said you wanted as a principle and produce a real-world product. That is the difficulty with this kind of testimony, Dr. Braun.

Now, I know that you are a representative of AARP, but at some point, I would hope that we could engage some of the principals in AARP so that as we begin to make difficult choices, we would at least have the opinion of the single largest group that represents or purports to represent seniors.

For example, AARP is one of the largest Medigap insurers. Do you believe that seniors who buy the AARP Medigap insurance are getting value for a dollar when the first dollar goes to buy down deductibles and copays instead of going, for example, for prescription drugs, which you say is the highest cost for seniors other than premiums? Would that be a good change in the law, to let people write Medigap that had first-dollar coverage for prescription drugs instead of deductibles and copays?

Dr. BRAUN. Medigap needs some changes. I don't think there is any question but that it needs changes. And it may need more changes as we get into Medicare reform. I think it would be nice if we didn't need Medigap, if we simply had an insurance which would obviate——

Chairman THOMAS. Well, I would love to engage the organization in that conversation as well. But at least if there are some areas for change or fundamental reform which would preclude the need for Medigap, but at some point I would love to have you folks engage us in a conversation in which you simply do more than tell us we have to engage in serious dialog, that you actually provide some—

Dr. BRAUN. I hope, Mr. Chairman, that they are frequently talking with you, and we want to continue to talk with you because—

Chairman THOMAS. I guess my frustration is that what they say behind closed doors is exactly what you are delivering in your testimony, and at some point we need to engage. And I appreciate your appearance once again.

Dr. BRAUN. That is fair enough, and I understand your frustration, Mr. Chairman.

Chairman THOMAS. Well, it is difficult. We need to go to a vote. I apologize. But I do believe the other members would very much like to ask the panel some questions. Would you be willing to remain so that we can come back after the vote? Is that possible for the panel members?

We will be back no later than 10 of 4 . The Subcommittee stands in recess.

[Recess.]

Mrs. JOHNSON [presiding]. The hearing will come to order. The chairman is unable to return, so we will proceed.

I would like to just pose a question to Mr. Roth and Dr. Sager, and there are others on the panel who may not have been able to stay who might want to comment on the same question.

It is unusual for us to have panelists who directly contradict one another. And you are saying diametrically opposed things about what the impact would be of the government setting prices on the pharmaceutical industry.

So are you talking about different segments of the market? Have we had any experience that we can look at in the past as to what has happened to pharmaceutical investments and research when there have been government discussions of price setting?

Mr. Roth, if you would like to comment, or, Dr. Sager, if you would like to comment? And then some of the others of you may want to comment as well.

Mr. ROTH. Well, I think that in the 1993–94 timeframe we saw an example where proposed legislation that would have included price controls, particularly on innovative drugs, had a profound impact on our ability to raise capital at that time. The Wall Street investment essentially shut down because of the fear that the health care plan that was proposed at that time would result in the inability of the firms that were taking this risk of them getting an eventual return on their investment at such time as the products were commercialized.

Mrs. JOHNSON. Dr. Sager?

Mr. SAGER. I think as long as prices are so high in this country, so much higher than they are elsewhere, and as long as so many Americans are unable to afford the medications we require, there will be pressures to make medications more affordable for more people, and that will make the industry nervous.

The industry is blaming the symptom. government is not the cause of their problem. The cause of their problem is unaffordable medications. The symptom is government trying to respond in some way by proposing measures to make medications more affordable for all us.

Until, like every other wealthy nation in the world, we devise a method of making medications affordable for all of us, the stock markets will be made nervous every few years and investors will be frightened every few years.

Mrs. JOHNSON. So you believe that government would set a price that would assure a level of profitability that would allow the kinds of companies that Mr. Roth has been associated with to recoup their investment and make a reasonable profit? You believe that?

Mr. SAGER. If they produce medications that benefit us. Obviously, the taxpayers can't throw money down a black hole to finance research that doesn't work.

Mrs. JOHNSON. Well, of course, that is a given, and that happens in today's market. The question is what would happen in tomorrow's market, and you are saying you believe the government would set a reasonable price.

Mr. SAGER. Well, I think it needs to be negotiated. One of the questions that the drug makers and their representatives consistently refuse to answer is what profit level is required to finance needed research. Is it the 39.4 percent on equity that they earned in 1998? Is it 20 percent on equity? Is it 80 percent?

Mrs. JOHNSON. See, the problem with your figures, Dr. Sager, if I may interrupt, is that they are across the board. The companies Mr. Roth is talking about have no profit. I don't know what percentage of the research on new drugs is being done by startups and what percentage is being done by the Pfizers of the world. And I don't know whether the Pfizers of the world are satisfactory in terms of our future needs in terms of research, but certainly there isn't any way Mr. Roth's group could survive under your regimen, in my estimation. And if you look at what happened just last year—look at what happened to the equity markets for nursing homes because we sent levels of nursing home reimbursement that made it very clear that they couldn't possibly repay their mortgage.

Now, you look at Medicaid. And what is happening in Medicaid? I mean, I had an elderly physician say to me just a few weeks ago, when Medicaid paid usual and customer fees, it was a great program. It pays now whatever the government negotiates, and what the government negotiates depends a lot on what they want their tax policy to look like. And I have sat on both the tax Committees and the reimbursement Committees, and it is not as if we set prices according to costs and probability and all these great things that you think. We don't set prices for that reason. We set prices, and then we say but if the volume goes up too much—it doesn't matter whether the volume goes up because people need health care, whether seniors need to see the doctors. If the volume goes up too much, we cut your price again.

And Medicare just last year, over the last 3 years, withheld $3 million from physicians for reimbursements just because they didn't bother to adjust a reimbursement for them—they had the power to readjust—because they didn't want the additional money to go out. So I think you are naive in thinking that we can set this price accurately.

But I do want to go on to one other issue, and that is this business of the lower prices for American drugs in foreign markets. I think the fastest thing we could do to really help here is to repeal the law that prohibits the importation of pharmaceuticals from other countries. Would you support that?

Mr. SAGER. Do you mean there the reimportation of—

Mrs. JOHNSON. Yes, the reimportation.

Mr. SAGER. Well, I think that is a very useful partial solution, and I also agree with you that the profit margins would need to take into account the size of the firm and the extent of risk that it runs. Greater risk entitles a firm to greater reward.

We may not know how precisely to do that sitting here this afternoon, but we are not stupid, either, and we can think this one through.

Mrs. JOHNSON. Well, I certainly would agree that repealing the law that prohibits the importation of pharmaceuticals from abroad would be a partial solution, but at least it would be immediate. At least we would certainly have American entrepreneurs who would rush down to Mexico and get the same drug for the same amount—for the cheap amount and bring it back in.

So I think that is the kind of thing that we can do immediately. I would have to say that there has been very strong opposition to that approach in the Congress from the other side of the aisle, and that is the kind of thing that we would have to talk about and get together on. But at least it is something that we could do promptly.

I am not as optimistic as you are that we could set different prices for different companies. What we have done in Medicare for people, senior citizens going to see physicians, to prevent the government from paying for a short visit the same way we pay for a long visit, is to have five levels of office visit, each one with a different documentation in the record. Nobody is really talking about the intrusion into privacy that this represents. We just don't talk about it because there is no other way to do this. But you talk to any internist, and you talk to them about what happens toward the end of the year, and the government codes down all his visits so he gets less than plumber in my district for a long visit that he is supposed to get three times that amount for.

So there are problems with the government setting the price, and then there are problems with the government paying the price.

So I want to leverage. I want to do something about price and volume. But I think the idea of looking at the experience that we have had in the private sector of competitive pricing by plans has a lot more to offer. And then if we back it up with the right to import low-cost drugs from abroad and things like that that we might have—we need a variety of things that will enable us through the market to lower prices.

Mr. SAGER. Well, I think the main concern there would be that the mechanisms themselves wouldn't add up to enough to substantially lower prices for Americans.

Mrs. JOHNSON. Well, see, then in that case, what you are advocating is the kind of mechanism in the Federal supply system. That is a 24 percent cutoff right off the top, and negotiations thereafter. I would not want to guess that any company that Mr. Roth has worked with can survive that.

Mr. SAGER. I think what we have to do, ma'am, is to start with the objective of making sure that all Americans can afford their medications, and doing that in a way that doesn't throw money recklessly at industries that earn extravagant profits.

One of the very useful things about your point on mentioning the reimportation of medications from foreign countries is that this has finally smoked out the drug industry's mistaken argument that the

drug prices in the United States are not extraordinarily high. For years, they have denied that American prices were extraordinarily high. And I think if we look point by point through the things they say—medications cost $500 million each to develop and the rest—we really need supporting evidence. And I think that supporting evidence is largely lacking.

The drug makers say they expend more than $20 billion a year on research. Where is the evidence? Where is the standard accounting and financial reporting to back that up? How much of that is market research? How much of it is "Me, too" drug research? The drug industry——

Mrs. JOHNSON. I am hopeful——,

Mr. SAGER [continuing]. Has for years purveyed information without substantiation.

Mrs. JOHNSON. I certainly am hopeful that through the discussion in the next few months we can get better information on the table. But I would have to say that I consider the concrete evidence that the government can and will set fair values to be lacking.

Before I conclude, let me just ask particularly Dr. Braun: My colleague, Pete Stark, a dear colleague, he is urging us all to sign on to a discharge petition that would bring his bill and the Allen-Turner bill to the floor immediately.

Now, in your testimony you say that we shouldn't push legislation too quickly. Do you think it is a good thing to sign that discharge petition, or is it premature?

Dr. BRAUN. I think we stand by what we say, that we don't think that things should be pushed too quickly until there has been sufficient time for discussion.

Mrs. JOHNSON. Thank you. I would interpret your testimony to say that as well.

Mr. Stark?

Mr. STARK. I thank the gentle lady. I believe our discharge petition is just to open the rule so we could debate any bill, which is fine with me.

Also, I think the Chair stated that the Democrats opposed importing pharmaceuticals from Europe, and that is hardly the case. Congressman Berry has a bill, H.R. 1885. If you want unanimous consent to allow us to import from Europe, Canada, or Mexico, we can do it right now. I will ask unanimous consent that we approve the bill and report it out.

We have long been for taking any restrictions or harassment away from folks who import the same drugs that the manufacturers ship out of the country and we can't ship them back at the same price. That hardly seems fair.

But I would just like to suggest that all these people here on the panel understand free enterprise. I presume—well, certainly Mr. Roth has made a lot of money in the free enterprise system, and probably Dr. Calfee has, too. But Lehman Brothers and Merrill Lynch indicated recently that they think that these bills wouldn't hurt. It is the old saying, I guess, about an increase in volume, and you say, gee, yes, but you cut the margin, you can't make any money. Lehman and Merrill Lynch disagree. They suggest that the benefits of increased volume of sales would offset any suspected cut in price through any kind of regulation.

Further, in 1988, not many people remember that marvelous catastrophic bill, which, if the PhRMA group had not surreptitiously moved to get it repealed, we would have a drug benefit today and we would not have to worry about Medigap. But, according to the Lehman report, after the passage of the act, "the drug sector outperformed the S&P significantly because investors anticipated additional volume gains as a result of the legislation"—that is a quote—and that R&D increased 16.2 percent in 1988, well above the average for the nineties. So it is not necessarily a universal agreement among the freest of the free enterprisers that some kind of a pharmaceutical benefit would be bad. Even if a drug benefit, in fact, lowered prices, the lowering of the prices would have an effect of increasing volume. That maybe works, maybe it doesn't.

But, Mr. Roth, you don't want any price controls, and however you feel about what it might do to the world, those of us who spend the taxpayers' money, directly or indirectly, some of us, feel we have a responsibility to spend it wisely. And there are some cases—now, you could probably tell me many more, such as Amgen and Epo. We are the sole purchasers of Epo, for all practical purposes. It goes to people with dialysis, and it might be life-threatening for them not to have it. And right now we have to pay whatever Amgen decides to charge.

The same thing is true, I think, of Beta Seron. It is marketed as—if I can find the quote here—it has some other brand name. But it costs about $11,000, the protocol, say $1,000 a month for somebody with MS. And it received $4.6 million in government aid to develop this drug, but basically is uncontrolled. And, you know, $1,000 a month for somebody to lay out for a drug is pretty rough.

How is the free market going to keep those charges in control where you have a sole source for preventing a life-threatening occurrence? What is to prevent the manufacturer from charging what, let's assume, reasonable people would say is an outrageous amount because they have basically had the sick person over a barrel? How do we deal with that? How does the free market set that price?

Mr. ROTH. May I respond to your comments first?

Mr. STARK. Sure, please.

Mr. ROTH. The Lehman and Merrill Lynch reports that you refer to, I am not familiar exactly with them, but I believe that what they said was that they feel that prescription drug coverage for seniors is important and it will happen. And I think that is what we are saying, but it is the method that it happens. Is it going to be done in a way that allows competition, or is it going to be government mandated? I believe——

Mr. STARK. I just want to know how competition, Mr. Roth, works for Epo. How about——

Mr. ROTH. OK. I will get to that, sir.

Mr. STARK. Yes, that is the key. How does competition work there?

Mr. ROTH. Amgen has been probably the biggest reason that our industry has been able to exist. It has shown that one can take an idea, develop a product around that, and deliver it to people in a way that allows them to live more productive lives. And what we are seeing is that there are more companies that have followed,

and they are trying to develop additional products that will compete with epo, and that is where you will see—

Mr. STARK. Only because Uncle Sam picks up the cost. Now, take the Beta Seron. How do you anticipate that the free market—let's say that Uncle Sam stopped paying for Epo—how do you suppose the free market is going to set a price that would make that drug reasonably available to dialysis patients, most of whom are getting Social Security disability?

Mr. ROTH. The free market, there will be additional products that will come that will compete with that if you allow the system to work.

Mr. STARK. But if there aren't—and there are many cases, Mr. Roth, where there aren't other products—there is no replacement for Epo. I don't know if there is one for Beta Seron or not.

Mr. ROTH. There are at least three products that are being developed for treatment of multiple sclerosis.

Mr. STARK. And what do you do while you wait for them to be developed? Croak? What do you do if you can't get Epo? Turn yellow and die?

Mr. ROTH. That is part—you know, if what you are saying is that it is taking too long to develop drugs, we would agree with that. We are doing all that we can—

Mr. STARK. How does the free market limit what the taxpayers would be responsible for—I mean, you haven't told me. How does the free market work here? It is not working now. There is no control. Patents work effectively to deny any other entry.

Mr. ROTH. You know, Mr. Stark, I would disagree with you, respectfully—

Mr. STARK. Okay.

Mr. ROTH—and say that the free market is working. We have value. We are delivering value to people in the United States better than any other country. And, you know, I sit here and listen to people talk about——

Mr. STARK. You are selling in Canada for a third less and in Mexico for half. Why is Canada getting a better deal than I am?

Mr. ROTH. If you feel that other countries are taking our products and imposing improper price controls, then it is incumbent upon our government to see that those types of trade barriers are not allowed to exist.

Mr. STARK. This is not a trade barrier. It is your industry that is selling it for less in these countries.

Mr. ROTH. Mr. Stark, what I am saying is that we are providing value to the American citizens through our industry. It is an industry that there has been a lot of discussion today where people have talked about exorbitant profits. I am proud to be a member of this industry. I am proud to be working in something that is helping mankind, that is investing money, that—yes, there is going to be a return, but that is what—there is nothing wrong with profits in our economy.

Mr. STARK. Nobody is suggesting that there is anything wrong with profits. All I am suggesting is that the government, which is spending your money, whether you like it or not, tends to bid. We go buy automobiles for the FBI to drive around in. We just don't go down to the local Chevy dealer and pay list price. You know, we

don't pay sticker price. We get some bids. The automobile dealers aren't complaining that we are not letting the free market work. It is only the drug manufacturers who say we don't want the government doing any of this.

Now, we buy guns to arm our soldiers. We buy paper, we buy computers, we buy all of those things. I don't hear Microsoft complaining because I get the Federal GSA rate for my Windows. They are happy to sell it to the government at a government-negotiated rate.

What is so—I mean, why should the pharmaceutical industry not behave like every other high-tech industry that deals with the government? What is wrong with that?

Mr. ROTH. I don't think anyone has said that there is anything wrong with it.

Mr. STARK. Okay.

Mr. ROTH. We are saying that it should be done in a competitive manner.

Mr. STARK. So you would be willing to let the government accept bids, then, for pharmaceuticals to use for its constituents?

Mr. ROTH. I am saying that if the prescription drug benefit is put in place in a competitive manner that that is something that our industry would support.

Mr. STARK. Just say that one more time. Let's say there is a drug benefit for Medicare beneficiaries, you would have no objection to the Federal Government running a bidding process to let the free market bid on how much they would sell it to the beneficiaries for. Is that correct?

Mr. ROTH. Yes, and if you will see my testimony, which I would refer you to, we also feel that it should be part of overall structural Medicare reform and not done in a piecemeal fashion.

Mr. STARK. OK. Mr. Calfee, do you buy that?

Mr. CALFEE. Well, there are great dangers of the Federal Government as the sole purchaser of a product as important as drugs that are used by the elderly.

There are a couple things that came up in the previous exchange that I think—

Mr. STARK. Nobody is suggesting it would be the sole purchaser. I am just saying for this particular benefit, which we assume, like part B, would be voluntary. So if people don't want it, they don't have to sign up for it.

All I am suggesting is where there is a Federal benefit, would you object to some kind of a bidding structure so that we can assure that people, where there is a competitive drug, could get the best price?

Mr. CALFEE. A lot depends on how it would be done. My fear is that if we have a program in which HCFA simply purchases pharmaceuticals for the elderly directly, they would have such extraordinary power over pricing that what they would be tempted to do and what experience shows they almost certainly would do, I would be to push those prices down, leaving them above the marginal cost of producing the drug, but less than what is necessary to induce research and development. Just as other nations have——

Mr. STARK. Doctor, we currently spend over $1 billion a year on epo, one drug, and we have never even raised the issue. What evidence do you have—

Mr. CALFEE. Actually——

Mr. STARK —Where we buy drugs——

Mr. CALFEE. Actually, in my reading about the relationships between Amgen and Medicare over the EPO drug, there have been long and tortured negotiations between Amgen and Medicare, and there has been a lot of—I am not sure it has ever reached the point of litigation, but certainly there have been a lot of discussions about the pricing of that drug——

Mr. STARK. As well there should be.

Mr. CALFEE [continuing]. Because the government is the sole purchaser. But the reason it is sole purchaser is because the government undertook to become the sole purchaser of that drug.

But I would also remind you that it was the free market that produced that drug in the first place.

Mr. STARK. Look, I have got no quarrel—as I said earlier—I would like the free market to do more research and less advertising and less money with PhRMA, and we would all be better off. But, you know, they spent $11 billion last year on spiffs to doctors. They gave free merchandise and trips and all kinds of junk to physicians to con them into using one drug or another—$11 billion. Now, that is money that could have gone into research, and I bet Mr. Roth could use that kind of dough in his company and not have to go to these guys—a pretty nice chunk of money, wouldn't it be? For venture capital, it costs you a lot.

So why should we give that to doctors in terms of commissions and free golf bags and stuff like that to use a product? I mean, this free market has some warts on it, my friend, as well as it may or may not do. You know, there are as many members of the free market in Federal penitentiaries as there are Congressmen. So this cuts both ways, and don't think that anybody is exempt from having their scalawags.

I am just trying to find out how the free market could contain—it wasn't able in Medicare to contain hospitals or physicians. We are forced into time—Madam Chair, Mr. Thomas inquired for 20 minutes, and you did for 10, and out of order, I might add.

Mrs. JOHNSON. And you have for 12, and the reason I went ahead and inquired was that it was my understanding that I was next. We do have two other members, and there are people here who have to make a 5 o'clock plane. So I would like——

Mr. STARK. Thank you. Thanks for your usual fairness, Madam Chair.

Mrs. JOHNSON. Mr. English of Pennsylvania.

Mr. ENGLISH. Thank you, Madam Chair, and my inquiry will be shorter than the State of the Union address. Thank you.

Mr. Roth, I want to follow through and maybe get you to summarize some of the things you have suggested. In your testimony, you mentioned that in 1998 the biotechnology industry invested almost $10 billion in R&D on 300 biotechnology products currently in development, and most of the companies have yet to generate commercial sales. So the industry experienced in that loss, as I understand it, of $5 billion in 1998.

To put this into context, a few other 1998 statistics regarding R&D. Research-based pharmaceutical companies spent 20 percent of sales on R&D, electrical and electronic industry spent 7.6 percent on R&D, telecommunications spent 5.1 percent on R&D, aerospace and defense spent 3.7 percent on R&D. So, clearly, pharmaceuticals firms like yours are very much R&D-intensive.

I wonder what would be the effect on your industry's ability to raise venture capital for R&D to produce cures for tomorrow if price control legislation such as the Waxman-Allen bill would become law? And beyond that, what would be the impact of a monopolistic government structure with 85 percent of the seniors' market dictating formularies and prices with biotechnology and pharmaceutical companies?

Mr. ROTH. I think we would see access to the capital markets close drastically and most likely permanently.

Mr. ENGLISH. Dr. Sager called you a threat to research. Is that fair?

Mr. ROTH. Called me what?

Mr. ENGLISH. Called your industry a threat to research in his testimony; is that fair?

Mr. ROTH. No, that is not fair.

Mr. ENGLISH. Okay. Dr. Soumerai, you have been quiet. Let me ask you, you recommend providing comprehensive prescription drug coverage for individuals up to 200 percent of poverty and protection against high drug expenditures for everyone. Under the President's proposal, comprehensive prescription drug coverage phases out at 150 percent of poverty and at that point individuals have to pay 50 percent cost-sharing on a capped benefit. Therefore, an individual with an income of $12,360 would have to pay 50 percent of their drugs, a $24 monthly premium and 100 cents on the dollar for drug costs above $2,000 when first implemented.

Do you think this is a good benefit structure and a wise use of scarce taxpayer dollars?

Dr. SOUMERAI. Our concern is exactly for those vulnerable populations at low-income and——

Mr. ENGLISH. Like the people in my district.

Dr. SOUMERAI. Well, I have to agree with the tenor of your question that for those people between 150 and 200 percent of poverty they can't pay those kinds of bills. We know from our research, for example, that in the lowest income populations close to the poverty level that even a $1 co-pay inhibits compliance with the doctor's prescription regimen. It may be a 10 or 12-percent reduction for a $1 copayment. So, that kind of excessive cost-sharing is unacceptable.

And, actually, I would say that it would inhibit appropriate use of effective medications. Many of the proposals out there do not protect that for the low-income populations.

Mr. ENGLISH. Dr. Calfee, I represent a district up on the Canadian border so, obviously, we have a great sensitivity to the differential prices between those in our local drugstore versus how much pharmaceuticals cost in Canada, right over the border.

I wonder what is your explanation for that difference? And beyond that, assuming that the Canadians have put in place a way of leveraging through lower prices, what impact does that have on

the U.S. consumer in terms of potentially having to absorb higher prices? For example, the Comptroller General made the point that when you squeeze at one end the costs tend to go up some place else. Are American consumers being hung out to dry? And would that problem be addressed by allowing re-importation legislation to go through?

Dr. CALFEE. Several questions there. Let me take a shot at it. The reason it happens, of course, why we have the disparity in the first place, is that they have price controls in Canada. I think everyone understands that.

I think that the idea that if drugs could be freely imported from Canada to the U.S. that that would simply reduce U.S. prices to the Canadian prices, I think that idea is on the whole a mirage. I think that what would happen is that a pharmaceutical firm, if they are selling to the Canadian market and if they know that everything they sell to the Canadian market can move right across the border, not just to your district but also places like Detroit and other, you know, large metropolitan areas immediately across the border, if they know that is what is going to happen with their drugs they are going to take that into account as part of their pricing policy. They will say to the Canadian authorities we are not just selling to you, we are selling to all of the Northern United States and we are going to price accordingly. And either the Canadian authorities would have to adjust their prices drastically or they would no longer be able to purchase drugs as they have in the past.

In fact, I would predict that if the Allen legislation becomes law and it becomes very easy to re-import drugs from Canada, I would predict that the first thing that will happen is that the Canadian authorities would undertake measures to try to keep those drugs from being re-imported back to the U.S. because they would quickly realize they would lose their capability of extorting the prices that they are now getting.

So, I don't think the Allen bill is really going to provide the solution that a lot of people think that it will.

As far as the burden on American consumers, there may be a small burden from Canadian prices but the main consequence of that is a long-run burden. That is that the Canadians are contributing relatively little to the research enterprise and this is slowing down the research enterprise to some extent. And we would all benefit from faster drug research if the market, if a freely competitive market were larger than the one there is right now.

I hope that answers some of your questions.

Mr. ENGLISH. It does and I will yield back the balance of my time.

Mrs. JOHNSON. The gentlelady from Florida.

Mrs. THURMAN. Thank you, Madam Chairman.

Dr. Calfee, in your testimony and I sometimes think we are up here doing a Breaux-Thomas rah-rah session right now because everybody keeps talking about reform of Medicare. However, I am going to point to something that you said. For example, proposals to reform Medicare by bringing it more in line with the methods developed by private enterprise and encouraging the inclusion of

drug benefit plans similar to those in private health insurance rather than being part of the obsolete fee-for-service.

We do that under the Allen bill. That is exactly the proposal; to allow us to negotiate a fair price for a drug just like you do in any private insurance or at least that is the intention of it. So, that we could go out there and, in fact, negotiate just like anybody else does.

So, in fact, from your testimony we could say that you want Medicare to be more like private insurance because private insurance does, in fact, go out and negotiate a price; is that correct?

Dr. CALFEE. I don't know the details of the Allen bill, that is for sure.

Mrs. THURMAN. But don't private insurances negotiate the best price for their customer?

Dr. CALFEE. Competing private insurance firms negotiate the prices and in doing that they have to negotiate over various elements including the nature of their formularies and other things. So, that if one firm, for example, were to pay extremely low prices for drugs and, therefore, would have to have a very restrictive formulary because they couldn't buy a lot of drugs, they would have to compete against other firms that charge higher prices but have better formularies and they might well lose out. It is the competition that is essential.

Mrs. THURMAN. But we would be in a competitive market at that point because we would have been negotiating as well for the best price available.

Dr. CALFEE. Again, I don't know what the Allen bill does. By, we, do you mean the entire Medicare system as just one buyer?

Mrs. THURMAN. Yes. Because you would be negotiating.

Dr. CALFEE. Yes.

Mrs. JOHNSON. Would the gentlelady yield?

I thought the Allen bill simply required that drug companies make drugs available in America at the same price that they make them available in other countries.

Mrs. THURMAN. No. It would be based on the VA system where we negotiate a fair price for veterans in our VA system. So, I believe what it does is to allow us to go out and negotiate the best price just like we do for Medicaid or like we do for like the Veterans Administration. It is a very similar situation to the health benefits we have.

Mrs. JOHNSON. The way it is described in your "Dear Colleague" is that it says simply that the drug companies—they would have to make their products available to seniors at the same low prices that companies give the Federal Government and other of their favored customers.

Mrs. THURMAN. Correct. And, so, that would also allow Blue Cross/Blue Shield to negotiate for their services.

Mrs. JOHNSON. So, they would have to make the Medicare available to Medicare recipients at the same price as their lowest customer. So, if there was a Federal plan that had lower prices than the VA it would be the lowest.

Mrs. THURMAN. Correct. Because we are assuming that, as I assume and believe, Medicare is a government insurance program. I

mean we are the administrators of that program. So, I think that——

Mrs. JOHNSON. I think the difference between you and Dr. Calfee is this issue of whether there would continue to be multiple negotiations and multiple producers in the market. If one person gets that big a market, would there be other companies there the next time you want to negotiate?

When we did this in the defense area, we ended up having to support two producers because otherwise we would have only one producer and then we would have nobody to competitively bid with and that is a big problem in this area.

Mrs. THURMAN. But I would think that we would not want to take the competition out because that would be the way we would get our lowest price is to make sure that we have——

Mrs. JOHNSON. But see then you don't actually do it to the lowest prices; you do it to several of the lower priced. And, so, those are the kinds of issues. I think that is what Pete was trying to get at and what you were struggling with.

He was attempting to say do you mind the bidding processes? And I think the question is how do you structure it so you always have multiple actors in the bidding process and that is the difficulty here.

Mrs. THURMAN. But I think that is something that we can get around if we can provide a benefit under Medicare and cut the cost for prescription drugs, which could be as much as 40 percent.

And Dr. Sager, let us go back to your testimony because obviously you and I think a lot alike on this issue so I appreciate everything that you said and particularly regarding the Merrill Lynch study. I found that really very interesting compared to all of the other testimony and conversations that have been going on about this issue.

And where they say—and they, in fact, use the Drug Fairness Act which is the Allen bill which is one that I think is the toughest proposal on the table—that would reduce drug industry sales revenue by about just 3.3 percent because of volume increases. And that is important. I am going to say something to Dr. Braun here, but I would like you to talk about that a little bit because obviously you have done some research in that area. That is an amazing number compared to what we are hearing.

Mr. SAGER. There is a range of numbers out there and that is at the optimistic end, but it is a product of one serious effort. At some time we may have to take, "yes" for an answer. We are torturing ourselves. A $120 billion really is enough to buy all the medications we need. We can't afford to throw money recklessly at any industry, however deserving it might think it is. We can't afford to throw the money. We have to protect people. And the drug makers can, indeed—owing to this price elasticity of demand, as use goes up because prices go down, through a combination of that and their astonishing low marginal cost of making more pills produce all the medications Americans require for the $120 billion we already spend.

Mrs. THURMAN. Dr. Braun, I hope I am going to characterize this right. Is it safe to say that the seniors that you represent are basically saying to us, look, we have got to get this under control? We

want something. We don't want to engage in the bipartisan debates, we don't want to take a stand because what we really want is a benefit?

Dr. BRAUN. We need prescription drug coverage for seniors. That is what our AARP members and all seniors really want and that is what we need and that is what we need to keep focused on. We need coverage available for all Medicare beneficiaries just as it is available for most of the rest of you in the room.

Mrs. THURMAN. And I think you said something that really was also substantiated by Dr. Soumerai in the idea which you called smart medicine.

Dr. BRAUN. Right.

Mrs. THURMAN. Why did you use that terminology?

Dr. BRAUN. Because I think it doesn't make any sense if you spend your money for the doctor to examine you and tell you what you need, and write you a prescription, and then you don't have any money to pay for the prescription so you don't get the prescription. So, next week he has to put you in the hospital because you didn't get better. I think that is why it is smart medicine.

Mrs. THURMAN. So, we use up a lot of our Medicare dollars where this same person could go into the hospital and get the medicine and it is charged to Medicare but when they walk out there after they have been stabilized they can't afford it.

Dr. BRAUN. That is right. And they can't continue their medicine so in another month or two they are back in again.

Dr. SOUMERAI. An interesting corollary to that is that we pay through Medicare for physician and hospital care. We don't pay for the most ubiquitous and effective treatment in medicine which is pharmaceuticals for chronic illnesses suffered by the elderly. It is just such an incredible thing when you think about that.

Mrs. THURMAN. Mr. Roth, and I have to tell you I am very pleased with the research that gets done in this country. I probably have a husband who is alive because of research and a mother who is alive because of research that is done in this country. And none of us want to see that taken away and I know you may not believe that based on some of the statements that we have made today. I mean that is absolutely not true. And we also believe it is good for our economy.

We understand that we need to keep this economy moving and one of the ways we do is through innovation. But I have to tell you, I don't know how to explain this to people. We have talked about Canada and Mexico, we have had a little bit of discussion about that. But what do I say to constituents of mine—and if you want to look at some of those letters and answer them for me, I would be happy for you to do that. But, you know, to somebody who comes to me and tells me that on 5–28–99 they could get breast cancer medicine—for $130.22. Okay? Then on 12–20, they get that same medicine for $166.59. How do I answer that question as to why this has gone up?

I mean it is the market. It is producing revenue back. And it is doing, you know, all the things that we think when we put something out there that has been researched and developed but the price keeps just going up which is just the exact opposite of what we see in other parts of our economy. Computers were very high

when we got them out there. Now, people are buying them and the price has come down.

I don't know how to answer this question.

Dr. ROTH. I am not able to answer specifics either other than to say that, you know, the research that will continue to be done is going to develop new and innovative products that will hopefully allow other treatments for those diseases which, will in turn, bring the cost to the consumer, to the patient down from what it is.

Mrs. THURMAN. But it takes a long time for that to happen. I mean not just the research and the development but once it hits the market. I have been going through this immuno-suppressant issue that costs $15,000 a year for a patient to take it. They can't afford it. I mean it is about $1,100 a month. They can't afford it. We are trying to make sure that it gets covered under Medicare because we think that is smart medicine, to keep people off dialysis, keep them out of the hospital, all the kinds of things that we think are smart medicine.

And that is the problem. I can't answer that question. So, the question that then comes back to me is, well, why can't you negotiate a price for us? Why can't you give us the same benefit that somebody under a preferred customer rate would get?

I mean we are part of an insurance. And seniors are seeing their costs much higher than a preferred customer sometimes being 189 percent more, all the way up to a 1,500 percent difference.

And I don't know how to explain this, especially when they come to me and tell me it is a life-sustaining drug. It breaks my heart. I mean these people have heart problems and they write me these letters and tell me: I have got to cut my medicine in half.

I have a letter from, a daughter that said her father is saying that he is going to quit taking his medicine so that his wife can have the medicine. I have people who told me similar stories. I mean these are real issue for these folks and they are life-sustaining issues.

My seniors probably pay, on average, $2,400 a year for the cost of medicine. This is what seniors are concerned about this month. Another couple wrote to me that they both have to go to the doctor. They both have to pay their deductibles this month, because it is the first time they are going to be back to the doctor since after the first of the year.

All of a sudden their Medicare deductible has become a burden. I mean they have to pay it. So, they are going to go in and they are both going to pay, you know, $50 or $100 and they can't pay it—and that is going to go back to the problem of them buying drugs or turning down their heat or not being able to go to the grocery store to buy food. These are the kinds of stories that I am hearing at home.

Now, I have to tell you my district is about 188,000 Medicare, Social Security recipients. It is also the second highest senior district in the State of Florida. These are the people that I represent. Their stories are very compelling and I don't have a good answer for them other than that I am trying to find a way to fix this.

And I wish you could give me an answer.

Mrs. JOHNSON. Yes. I thank the gentlelady from Florida. They are difficult questions that are hard to answer to our constituents.

It is also true and I represent an old manufacturing area in which there are a lot of people getting by on just Social Security. But many of them also are in drug coverage plans that they don't want disturbed. Many of our employers did provide good retirement coverage and they don't believe that if we provide it, it will be as good. And I cannot assure them looking at Medicaid that what we do will be as good for them as what they are currently in.

So, we are getting a lot of contradictory input from our seniors just as AARP is. And this is a difficult area. We thank you very much for your input.

As you leave, I just want to bring up one thing that is very dear to my heart. We have a new Institute of Medicine study on the value of nutrition, nutritional counseling, nutritional considerations. And not only do I have a bill to have Medicare cover nutritional counseling but I think to open up a prescription drug medication benefit without better integrating it with nutritional education would be the loss of a tremendous opportunity because more and more we are realizing that there are things we are medicating for that actually if we help people change their diet, their lifestyle that they actually wouldn't need the medicine and they would be much wholer and healthier.

So, any thoughts you have about how we could link nutritional education with any prescription program I would be very interested in.

I know some of you have to leave so I do feel compelled to close this hearing down but thank you for your input. If there is one thing that came out loud and clear it is that it is important for us all to think through very carefully—I mean Dr. Sager has a nice little list of what to do but other people also have real concerns of what might be the consequence and experience gives us the clear information that the unintended consequences are going to be far greater than the intended consequences. And if we can't even define the intended consequences we do have to gain more input and more understanding before we can move with any confidence.

But it is my hope and I know it is the chairman's hope that we will pass a prescription drug bill this session and my goal is, at the very least, target it to those who need it most and stop loss for those so that everyone will, no one will be subject to bankruptcy as a result of medication needs.

Thank you very much for your input. We invite your follow on thoughts and I particularly invite your thoughts on how nutritional counseling could be integrated with any prescription benefit.

Thank you very much.

[Whereupon, at 4:48 p.m., the hearing adjourned.]

[A submission for the record follows:]

Statement of Michael F. Ovellette, TREA Senior Citizens League, Alexandria, VA

Mr. Chairman, The TREA Senior Citizens League (TSCL) appreciates the opportunity to submit testimony to your committee concerning ways to make prescription drugs more affordable for senior citizens and to offer proposals to establish a prescription drug benefit program for senior citizens. In this regard, TSCL appreciates and will take the opportunity to offer a number of insights and several proposals for consideration. Finally TSCL will make specific recommendations for general application to any Medicare Prescription Drug Benefit eventually passed by Congress that would be both beneficial to and accessible by the League's membership.

TSCL is a non profit, issues advocacy organization representing over 1.5 million members and supporters and is dedicated to serving its members by defending and protecting their earned retirement benefits. The League is registered to conduct grassroots fundraising, public education and lobbying activities in nearly every state, and does not solicit nor accept any money from the federal government. As a matter of information, over 39,006 of our members are constituents of members of this subcommittee and are looking for your bi-partisan help in assuring that a Medicare Prescription Drug Benefit or some alternative to high-cost medications are finalized this year.

Although TSCL has formally supported the Administration's Medicare Reform proposal we also support S. 1895 by Senators John Breaux (LA) and Bill Frist (TN). We applaud their efforts at being the first in the Senate to present a logical and well though-out piece of legislation. TSCL is equally grateful to Representative Pete Stark (CA) for his introduction of H.R. 1495 and to Representative Tom Allen (ME) for his introduction of H.R. 664, The Prescription Drug Fairness for Seniors Act. TSCL also wants to thank the members of this subcommittee for the decision to hold a hearing on this critically important issue this early in the legislative year.

Mr. Chairman, the hardships for seniors caused by the increasing cost of prescription drugs has spurred the Congress to include the issue among the highest legislative goals and objectives to be considered during the 2nd Session of the 106th Congress. Prices for the 50 prescription drugs most often used by seniors rose 6.6 percent in 1998—four times faster than the year's 1.6 percent overall inflation rate, according to a recent study. These rising costs are putting medicine out of reach of a growing number of older Americans, particularly the 35 percent of Medicare recipients without prescription drug insurance. Government figures released in July 1999 projected that senior spending on prescription drugs would grow about 11.2 percent annually during 1999 and 2000. Yet industry figures released in September 1999 showed that prescription spending increases for 1999 already exceeded that amount, up 12 percent with four months remaining in 1999. Additionally, many Medicare recipients that belong to Health Maintenance Organization (HMO's) will have to pay three times as much in monthly premiums in 2000 and will find HMO's far less willing to pay for Doctor-prescribed medicines. In sharp reversal of recent trends, no HMO that accepts Medicare patients next year will cover the full cost of a patient's medicine. Sadly, many HMO's across the nation are dropping seniors, who depended on this protection, from coverage at an alarming rate. Particularly hit hard are those seniors residing in rural areas. Faced with the situation just described, many seniors are being forced to travel to Canada or Mexico to purchase prescription medicines at not always affordable rates, but far less cost than if purchased in the United States. Sadly, when forced to choose between paying for medication or food, older Americans have no choice other than to explore any avenue that provides financial relief because they must have both to survive.

THE ADMINISTRATION'S MEDICARE REFORM PROPOSAL

In June 1999, President Clinton introduced a plan that would offer a voluntary prescription drug benefit to all Medicare beneficiaries. There would be no deductible and a 50 percent co-payment. Premiums would start at $24 per month in 2002, rising gradually to $44 per month by 2008. The plan would match a beneficiary's drug costs up to $1,000 in 2002, rising to $2,500 by 2008. It would also exclude premiums and co-payments for individuals earning less than $11,000, or couple earning less than $15,000. The Administration estimated this proposed drug benefit would cost $118 billion over ten years. The non-partisan Congressional Budget Office (CBO), however, estimated the cost of the program at $168 billion ($50 billion more).

TSCL has supported this proposal because it was the first solid effort to address the prescription drug problem being faced by its members and supporters. TSCL does not believe that the proposal offers older Americans who have earned a government sponsored benefit, the kind of comprehensive and affordable protection plan that one would reasonably expect would be offered to the older Americans whose efforts during their lifetimes have brought this Country to where it is today.

THE PRESCRIPTION DRUG FAIRNESS FOR SENIORS ACT (H.R. 664)

Another proposal that TSCL supports and which drew a substantial amount of support last year is H.R. 664, introduced by Representative Tom Allen (ME). This legislation has a companion bill in the Senate (S.731). The bill would assure that Medicare beneficiaries receive the same reduced drug prices that drug manufacturers currently give their favored customers, such as the federal government and large HMOs. Estimates are that the more favored prices would cut drug costs by as much as 40 percent. A senior citizen spending $150 a month on prescription drugs could save over $700 annually under the legislation. The appeal of this legislation is the

offer of some protection to Medicare prescription drug consumers without huge costs to finance the program. The downside of this proposal is the fear professed by powerful drug lobbies that it creates "price controls" on the industry and would mean less money for research and development, weakening the industry's ability to create new drugs and improve existing ones. Again, TSCL supports this legislation because if passed would be of benefit to senior citizens. Ultimately though, TSCL believes that the prescription drug costs situation being faced by older Americans should be solved by the government and not referred to the pharmaceutical industry for resolution.

ACCESS TO PRESCRIPTION MEDICATIONS IN MEDICARE ACT OF 1999 (H.R. 1495)

While TSCL has not to date supported H.R.1495, we wish to extend our appreciation to Representative Pete Stark (CA) and the other members of the House of Representatives who are responsible for its introduction. TSCL is encouraged by their pro-active efforts to act in an expeditious manner by presenting legislation to significantly reduce the burdens of older Americans and to seek wide public debate on Medicare reform. In keeping with our commitment to support any legislative efforts to improve the lives of older Americans, TSCL should be eager to support H.R. 11495, but has not done so yet. This can be attributed directly to the overall confusion produced by all of the recently introduced pieces of legislation. With the understanding that it appears the bill has been crafted by experts, it simply is not readily understandable and is virtually impossible to clearly and succinctly define the bill to our members and supporters so they will be able to understand the impact on their "pocketbooks." At first glance, the Administration's proposal is understandable as is H.R. 664. However, H.R. 1495 is no less difficult to understand that the Senate's primary prescription drug proposal, S. 1895. This subcommittee is urged to consider action to direct the re-crafting of H.R. 1495 in understandable language so that older Americans, many who have never had access to a prescription drug benefit of any kind, will be able to understand the bill in order to allow them to make an educated decision.

TSCL'S VISION OF A PRESCRIPTION DRUG BENEFIT

Very simply, TSCL will lend its full support and urge the grassroots efforts of its members and supporters to a proposed Medicare prescription drug benefit with the following characteristics:

Universal:

Any benefit that becomes law would be the same for all Medicare-eligible beneficiaries to include an age 62–65 and age 55–62 Medicare buy-in options.

Targeted:

Provides additional assistance for low-income beneficiaries.

Voluntary

Older Americans participation in a government-sponsored plan would be voluntary and give them the choice of remaining with any current supplemental plan that they currently possess and maintain confidence. Such a condition would generate a need to field a government-sponsored plan that encourages participation by the vast majority of Medicare-beneficiaries.

Affordable:

Would require reasonable monthly premiums, cost-sharing or co-pays with an annual likewise reasonable benefit maximum intended to reduce catastrophic out-of-pocket expenses for the most seriously ill beneficiaries.

Responsible:

Would discourage irresponsible or over-utilization of the benefit.

Modernizes Medicare

Like other modern insurers, Medicare would use a benefit manager to negotiate lower drug prices.

Partners with the Private Sector

Would provide incentives to employers to develop and retain retiree drug coverage by possibly paying the entire or portion of the retirees' monthly premium.

Understandable

Any plan considered must be clearly understandable by those who make an enrollment decision.

TSCL believes the Administration's proposal meets the majority of the aforementioned preferred characteristics and is one where support is justifiable. However, the League contends that there are very attractive portions of virtually all Medicare prescription drug benefit legislation introduced to date. The complexity of H.R.1495 appears to be a major shortfall that needs significant improvement.

TSCL is of the opinion that the 50 percent cost-sharing requirement of the Clinton proposal and the 20 percent cost-sharing requirement of H.R. 1495 should be changed to a $10 co-pay per prescription even if other provisions of the plan were increased. A flat-dollar co-pay requirement would make the plan much more understandable and therefore much easier for older Americans to be able to establish or adjust their monthly prescription drug out-of-pocket costs. Therefore, TSCL recommends to this committee that if H.R. 1495 were to be re-crafted to incorporate a recommended $10 per prescription co-pay, we could support H.R. 1495 assuming the required monthly premium was affordable. TSCL also encourages this committee to debate this issue in a totally bipartisan manner, understanding that that the important question to be answered is not whether older American need a prescription drug benefit, but rather how soon it can be made available. For far too long our parents, friends and neighbors have needed some kind of Medicare Drug Benefit. Now is the time to put aside partisan politics and make the lives of these deserving Older Americans more comfortable and dignified.

As an additional comment, TSCL believes that in the absence of a comprehensive prescription drug program under Medicare, one other alternative would be to pass legislation that would make generic equivalent drugs more readily available to older Americans and prevent the extensions of patents on name-brand medications. This would be one way that Congress could increase the affordability of prescription drugs to seniors with no insurance protection.

Senior Citizens League

TSCL Members	In District
Representative William M. Thomas, Chairman	3,467
Representative Fortney Stark, Ranking Member	2,571
Representative Nancy L. Johnson	2,571
Representative Jim McCrery	1,713
Representative Philip M. Crane	2,537
Representative Sam Johnson	1,842
Representative Dave Camp	4,537
Representative Jim Ramstad	2,822
Representative Philip S. English	3,894
Representative Jerry Kleczka	3,753
Representative John Lewis	1,415
Representative Jim McDermott	2,867
Representative Karen Thurman	7,949

Thank you

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