MEDICARE DRUG DISCOUNT CARD

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

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CONTENTS

MEDICARE DRUG DISCOUNT CARD

THURSDAY, APRIL 1, 2004

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

The Subcommittee met, pursuant to notice, at 2:50 p.m., in room 1100, Longworth House Office Building, Hon. Nancy L. Johnson (Chairman of the Subcommittee) presiding.

[The advisory and revised advisory announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
March 25, 2004
No. HL–7

CONTACT: (202) 225–3943

Johnson Announces Hearing on Medicare Drug Discount Card

Congresswoman Nancy L. Johnson (R–CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on the discount drug card. **The hearing will take place on Thursday, April 1, 2004, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. 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:

As part of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) (P.L. 108–173) that was signed on December 8, 2003, Congress provided for an interim prescription drug discount card program for 2004 and 2005. Approved cards will be endorsed by Medicare and available to all seniors on a voluntary basis. For up to a $30 annual fee, the U.S. Department of Health and Human Services estimates seniors will save 10 to 25 percent on the costs of their prescriptions due to the negotiated savings available through the discount cards. In addition, certain low-income seniors who are not eligible for Medicaid will receive up to $600 annually through the discount card in which they enroll to assist with purchases of prescription medicines. Considering that the typical senior will spend approximately $1,500 this year on prescriptions, the low-income transitional assistance will provide substantial support.

The drug cards will be available to Medicare beneficiaries until the full prescription drug benefit is implemented in 2006. Medicare beneficiaries will be able to enroll in approved cards in May, and discounts and transitional assistance will be available beginning in June.

In announcing the hearing, Chairman Johnson stated, "The drug discount card is the first, immediate step towards providing a full prescription drug benefit for our nation's seniors. The drug discount card will help 40 million Medicare beneficiaries save money on their medicines and will provide critical financial assistance to vulnerable, low-income seniors."

FOCUS OF THE HEARING:

Today, the Centers for Medicare and Medicaid Services announced the final list of approved drug card sponsors. Panel members at the hearing will include approved card sponsors, and testimony will focus in part on how sponsoring organizations will develop and market their discount cards to Medicare beneficiaries. The hearing continues the series of hearings held by the Subcommittee on the implementation of the Medicare Modernization Act.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person or organization wishing to submit written comments for the record must send it electronically to *hearingclerks.waysandmeans@mail.house.gov*, along with a fax copy to (202) 225–2610, by close of business Thursday, April 15, 2004. In the immediate future, the Committee website will allow for electronic submissions to be included in the printed record. Before submitting your comments, check to see if this function is available. **Finally**, due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-packaged deliveries to all House Office Buildings.

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. Due to the change in House mail policy, all statements and any accompanying exhibits for printing must be submitted electronically to *hearingclerks.waysandmeans@mail.house.gov*, along with a fax copy to (202) 225–2610, in WordPerfect or MS Word format and MUST 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. Any statements must include a list of all clients, persons, or organizations on whose behalf the witness appears. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers of each witness.

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.

*** * * Change in Time * * ***

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
March 26, 2004
HL–7–Revised

CONTACT: (202) 225–3943

Change in Time for Hearing on Medicare Drug Discount Card

Congresswoman Nancy L. Johnson (R–CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee hearing on the Medicare Drug Discount Card, previously scheduled for 10:00 a.m. on Thursday, April 1, 2004, in room 1100 Longworth House Office Building, **will now begin at 2:00 p.m.**

All other details for the hearing remain the same. (See Health Advisory No. HL–7, March 25, 2004).

Chairman JOHNSON. Good afternoon, everyone. Mr. Stark is on his way, and I am going to start with my opening statement, given the delay in this hearing and the courtesy of the various people who are going to testify in waiting around. Today, I am very pleased to Chair this hearing on the progress made in implementing the Medicare prescription drug discount card. The discount card will help millions of Medicare beneficiaries save money on their medicines and will provide critical financial assistance to vulnerable low-income seniors. These important provisions in the Medicare Prescription Drug Improvement, and Modernization Act of 2003 (P.L. 108–173), those associated with the discount card, were negotiated over several months with staff, and Members of both parties, both the majority and the minority from the Committee on Ways and Means and the other committees of jurisdiction.

The discount card proposal, as it is currently being implemented by the Centers for Medicare and Medical Services (CMS), was agreed to in a bipartisan meeting of Medicare conferees by voice vote on September 9, 2003. That is why I am glad this achievement is moving forward rapidly, with the hope that significant discounts on prescription drugs will be delivered within just a few weeks. This bill, the Medicare Modernization and prescription drug bill, was the first and only legislative initiative to provide this kind of near-term relief for our seniors. It was bipartisan. A total of 71 organizations have been selected by the U.S. Department of Health and Human Services to provide discount cards to our seniors. Twenty-seven cards will be available to all seniors across the Nation, while other cards will be available on a regional basis or through Medicare Advantage plans. Seniors will therefore have a wide range of choices in selecting the card that best meets their needs. The competition among cards will help ensure significant discounts on prescriptions.

For those seniors not eligible for Medicaid or other third-party arrangements, the Transitional Assistance Program offers up to $600 annually to Medicare beneficiaries with incomes up to 135 percent of poverty. In 2004, the typical senior will spend approximately $1,500 on prescriptions. The $600 in assistance provided to low-income beneficiaries will cover a substantial share of this amount. In addition, the annual enrollment fee charged to these individuals will be paid by the Secretary. Our witnesses today will provide us with an overview of how the discount card will operate. I am pleased to welcome Michael McMullan, Deputy Director of the Center for Beneficiary Choices within the CMS. I look forward to hearing her testimony regarding the operation of the program, the characteristics of the card sponsors that CMS has endorsed, the systems CMS has for assisting beneficiaries in selecting a card, and the plans CMS has in place for monitoring the activities of card sponsors and preventing bait-and-switch abrogations of contract obligations.

I know that we all share an interest in ensuring that our seniors have access to all of the information they need to make informed choices, and that plans deliver the benefits promised. I look for-

ward to hearing from both Aetna, Inc. and Health Net, Inc. regarding their specific drug card programs, and Aetna will be offering a national card, while Health Net will be providing a card exclusively to its Medicare Advantage enrollees in Connecticut, California, and several other States. I am eager to hear about the specific programs the two organizations will have in place to meet the need of those seniors who select their cards. Finally, we will hear from Consumers Union about their views of the program. The discount card program is the first concrete step toward making the promise of prescription drugs a reality for our seniors. I look forward to hearing more about the program today. Mr. Stark, welcome. We are ready for your comments.

Mr. STARK. Thank you, Madam Chair, for holding this hearing. You certainly picked the right day because this program—I don't think could be more of a cruel April Fools joke on the seniors than anything we could dream of. The Administration parades these Medicare-approved, as they are referred to, discount cards as a great tool for seniors to save money. However, there is nothing in the legislation that requires them to save money or states how much money they will save, if any. It is conceivable that those cards will end up costing them money.

We have never before, at least in my knowledge, used either Medicare's brand, if you will, or any government agency's brand to endorse private sector products. Given that we have asked these companies not to do very much in exchange for using Medicare's good name, I am worried that any bad behavior or disappointment in the program will reflect poorly on Medicare and that would set, I think, a bad precedent. The most efficient discount program we could have created would have been to use the purchasing power of the Medicare Program to negotiate discounts. However, your majority decided to outlaw that, and not let us do what any other private enterprise purchaser would do, and that is, get the best deal for our market power.

There is a modest help to some low-income people, although I am sure they will be confused and avoided by the discount programs, and unless we can do something to simplify the forms, I am afraid that many of the people who are entitled to that $600 won't get it. Now, why am I skeptical about these cards? First of all, the legislation and the regulations do not require discount card sponsors to pass through to consumers all discounts, rates, rebates, and other savings. There is evidence that the prices of many of the drugs used have all been pushed up by the pharmaceutical manufactures in anticipation of this new program.

So, if they increased the price 20 percent over the last year, and then give a 10-percent discount, they are still making unconscionable profits on the backs of our seniors. The current design of the program is a poster for fraudulent and manipulative practices. Medco, Inc., which I understand has been approved, is currently the defendant in a false claims act filed by the U.S. Department of Justice alleging that Medco has stolen money from our own plan under the Federal Employees Benefit Plan, that they have been canceling prescriptions and changing them without physician's orders.

I gather short-counting, and there is nothing that I know of that vets out these proposed providers to see whether they are honest, much less able to save beneficiaries any money. So, our beneficiaries also are going to have trouble choosing a discount card that is financially beneficial to them, because information is not being provided in a responsible manner. So, the needs of our seniors are being ignored, and this discount program appears just to be a fig leaf to try and cover for the inadequacy of the drug benefit, which is supposed to show up in 2006. So, I look forward to the panelists trying to explain to us what possible good this will do for our seniors.

Chairman JOHNSON. I would like to just comment, Mr. Stark, that I apologize for starting before you got here. I did it with the agreement of your staff. I regret having done it, because your opening statement is hard for people watching this hearing to integrate with the fact that the Democratic staff of this Committee, your staff, Ranking Member Rangel's staff, my staff, Chairman Thomas's staff, the staff of the Committee on Commerce from both sides of the aisle, the staff of the Senate, both sides of the aisle, all negotiated this discount card, many, many months, and consequently it does reflect the best thinking of the Members of both parties on how to deliver an advanced early benefit to seniors.

Certainly the questions you raise are legitimate questions, and I respect them. I think it is very important for the record to note that not only was this negotiated over a number of months because there are a lot of details, by both parties, but that we approved it by voice vote without dissent. The whole Conference Committee. It is one of the few portions of the bill that was totally bipartisan.

Mr. STARK. Our staff was invited for the first month. None of their recommendations were even listened to. Our staff was ignored and finally kicked out of the meeting as our Members were kicked out of the Conference. So, to suggest that our staff participated in this turkey is a falsehood.

Chairman JOHNSON. Mr. Stark, the record is clear that on this provision of the bill—and the record is clear because there was a Conference vote that was recorded, and there were no dissenters on just this passage of the bill.

Mr. STARK. There weren't any House Democrats there.

Chairman JOHNSON. That did not work on the whole bill. You did not participate in parts of it.

Mr. STARK. How could we object when we weren't allowed in?

Chairman JOHNSON. You are talking about later on in the Conference. On this provision you were there and the Democrats did vote and they agreed. The Members that were in attendance were Senators Rockefeller, Baucus, Breaux, Kyl, Nickles, and Grassley, and Representatives Thomas, Tauzin, Johnson, Bilirakis, Dingell, and Berry.

So, you were not there. Absent was DeLay, Rangel, Frist, and Hatch. So, absent were three Republicans and one Democrat. Present were the majority of the Democrats of the Committee. So, it is just simply a fact that this portion of the bill was negotiated by both parties. There was not agreement on the other parts of the bill. I respect that. I am not claiming it.

The public needs to understand that this portion was extensively negotiated with staff from both sides of the aisle, in both Chambers. Now, our job is to make it workable and work—have it work. The problems you point to are problems many of us are concerned about. Ms. McMullan, we look forward to your explanation of what CMS has done and plans to do. I am sure there will be plenty of questions. You are recognized.

STATEMENT OF MICHAEL MCMULLAN, DEPUTY DIRECTOR, CENTER FOR BENEFICIARY CHOICES, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Ms. MCMULLAN. Chairman Johnson, Representative Stark, distinguished Committee Members, thank you for inviting me here today to discuss the Medicare-approved prescription drug discount card and Transitional Assistance Program. This voluntary drug card program will give immediate relief to many seniors and disabled people covered under Medicare by reducing their cost of outpatient prescription drugs. In addition to expected savings from the drug discount card, certain low-income beneficiaries will qualify for an additional assistance of a $600 credit.

The CMS staff are working diligently so that these beneficiaries in need can begin using the cards and the credit this June. Just last week, we announced the approval of 28 general card-sponsoring organizations. Additionally, CMS approved 43 Medicare managed care applications to provide the drug card as an integrated part of the Medicare Advantage and the Medicare cost plan benefit package. These organizations will make it possible for Medicare beneficiaries nationwide to take advantage of the benefits you provided in the Medicare Prescription Drug Improvement and Modernization Act.

The CMS solicited applications from potential drug card sponsoring organizations on December 15, 2003, and these applications were due back on January 30. We evaluated each application against the requirements to operate a drug card program, and the sufficiently complete and correct applications were approved. A number of the applications were disapproved since they did not fully meet all of the key requirements. Do to the short timeframe to implementation, we are providing such applicants a 2-week window to correct such deficiencies, and we will review this information on a rolling basis to determine if these applications can also be approved.

Approved drug discount card sponsors will negotiate discounts with manufacturers and pharmacies and pass these savings on to beneficiaries who select their cards. We estimate that beneficiaries will save 10 to 15 percent on their overall prescription costs and up to 25 percent on some drugs. Just today, CMS posted on the www.medicare.gov website the names, telephone numbers, website, customer service hours, and enrollment fees on all of the approved sponsors. Enrollment fees vary within the $0 to $30 allowed range, with most managed care organizations choosing to waive the enrollment fee for their members.

The CMS anticipates posting data from the drug card sponsor with the specific price and participating pharmacies on April 29. The Medicare approved drug discount card sponsors will negotiate

with manufacturers and pharmacies for rebates and discounts off the average wholesale price for drugs covered under the drug program. The poster that I have on display outlines the process as it will work. In order to get the most competitive savings for beneficiaries, some cards will use formularies which will improve their negotiating leverage with the pharmaceutical manufacturers.

[The information was not received at the time of printing.]

For sponsors who do use formularies, they must assure that those drugs commonly needed by Medicare beneficiaries are included in their formularies. Beneficiaries will be guaranteed a percentage savings on each purchase they make with their card. While individual prices may change as the average wholesale price moves up and down, this is not different from the way the drug pricing works in the market today. In typical industry practice, a pharmacy benefit manager guarantees by contract a certain discount off of the average wholesale price to its payers. Within the universe of thousands of prescription drugs on the market, there are changes in average wholesale price (AWP) in response to price shift in labor, raw ingredients, as well as supply and demand. However, taken individually, when the AWP changes for the vast majority of drugs, these changes are by a modest amount.

Once a card is selected, beneficiaries are committed to their card for the calendar year. This is a key design feature and it allows the drug—or the prescription benefit managers to negotiate. Historically, drug discount cards have not included discounts from manufacturers because sponsors could not guarantee market share. By having committed beneficiaries, Medicare approved sponsors are able to guarantee a certain patient population. The guarantee increases their negotiating leverage with manufacturers and improves their ability to secure discounts and rebates which are passed on to the Medicare beneficiaries.

The CMS plans an extensive education effort with a special emphasis on low-income individuals to inform beneficiaries of the drug discount program, including an Internet-based comparison tool which will allow them to see precisely what price sponsoring organizations are charging for each drug they cover. This comparison tool will allow beneficiaries to identify the specific drugs they take and the cards that will result in the most savings to them. The comparison tool will show actual prices as opposed to the percent discount off of the average wholesale price, as these are more understandable to the individual. This same tool will be used by the customer service representatives at 1–800–MEDICARE, where beneficiaries can call and be walked through the decision process and be able to compare cards and we will then mail them the results of the analysis.

Beneficiaries can also obtain help from community-based organizations, such as our State health insurance assistance programs, as well as other community-based organizations that we are working with to particularly identify those individuals who have access barriers to information, such as language, literacy, or culture. It was mentioned that there was a concern about fraud. Although the drug discount program has not yet been implemented, some Medicare beneficiaries have already received calls, as well as in-person solicitations from individuals and companies posing as Medicare of-

ficials attempting to gain personal information from beneficiaries for identity theft.

In response to these complaints, CMS is coordinating information through our 1–800 number, as well as other information resources, such as our State health insurance assistance program. We have recently produced a press release to make sure that people with Medicare understand that they should never share their personal information, such as bank account numbers, Social Security number, or health insurance claim number with any individual who calls them or who solicits door-to-door. The CMS is continuing to explore methods to limit the scope of the risk to beneficiaries and to develop a process to work with appropriate law enforcement agencies to avoid further spread of this type of activity. The CMS's office of program integrity is hosting a law enforcement fraud and abuse meeting this month particularly on this issue, and we are working with the Department of Justice, the Federal Bureau of Investigation (FBI), and our own Inspector General. The CMS looks forward to continuing work on the implementation of this important program, and I thank the Committee for its time and will answer any questions that you have of me.

[The prepared statement of Ms. McMullan follows:]

Statement of Michael McMullan, Deputy Director, Center for Beneficiary Choices, Centers for Medicare and Medicaid Services

Chairwoman Johnson, Representative Stark, distinguished Committee Members, thank you for inviting me here to discuss the Medicare Prescription Drug Discount Card and the Transitional Assistance Program, which were enacted into law on December 8, 2003, as part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). In May of 2004, as an important first step towards comprehensive Medicare prescription drug coverage, Medicare beneficiaries will be able to enroll in a Medicare-approved drug card program that will offer discounts on their prescription drugs. This voluntary drug card program will give immediate relief to seniors and persons with disabilities covered under Medicare to reduce their costs for prescription drugs. In addition to the expected savings from the drug discount card, certain low-income beneficiaries will qualify for additional assistance in the form of a $600 annual credit. CMS is very proud to have a significant role in this important first step towards a comprehensive Medicare prescription drug benefit, which is slated to begin on January 1, 2006. CMS is working diligently to meet the aggressive deadline to implement the drug card and transitional assistance program. To this end, the Secretary last week announced the approval of 28 general and special cards, and 43 exclusive cards. We are confident drug card sponsors will begin marketing and enrollment efforts on May 3, 2004, with beneficiaries beginning to see discounts beginning June 1, as scheduled. We are also launching aggressive education campaigns to help beneficiaries choose the best card to fit their needs, and are planning strict monitoring efforts to ensure that card sponsors are not changing prices for unwarranted reasons.

BACKGROUND

Currently, Medicare beneficiaries who lack outpatient drug coverage pay among the highest prices for prescription drugs, as much as 20 percent higher than people with drug coverage according to a study of drug pricing prepared by the Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation. Under the Medicare Prescription Drug Discount Card Program, we expect beneficiaries to save an estimated 10 to 15 percent off the retail price on their overall prescription drug costs, and up to 25 percent on some drugs. The drug card will pass savings on to beneficiaries in the form of price concessions. While not a drug benefit, the voluntary drug card program is an important first step in providing Medicare beneficiaries with the tools they need to better afford the cost of prescription drugs.

SPONSOR SOLICITATION

CMS has already begun implementation of the drug card program. We received 106 applications by the January 30, 2004, deadline. Five applications were withdrawn or merged by the applicants, leaving a total of 101. To be considered for the program, organizations were required to complete a detailed application concerning their qualifications and the design of their proposed drug discount card program. Applicants that did not receive our approval have a right to request a reconsideration within 15 days from the notice of initial determination. Any reconsideration determination will be final and binding on the parties and not subject to judicial review.

CMS solicited applications by potential drug discount card sponsoring organizations on December 15, 2003, and applicants were due back on January 30. We evaluated each application against the requirements to operate a drug card program, and the sufficiently complete and correct applications were approved. A number of the applications were disapproved if, for example, they did not fulfill entirely a key requirement, such as providing a contract or letter of agreement (signed by both parties) when the sponsor indicated a plan to contract out a key function such as administering the $600 credit. Because of the short timeframe to implementation, we are providing such applicants with a two-week window to correct such deficiencies, and we will review this information on a rolling basis to determine if these applications can be approved.

We have approved 28 general card applications (of the 55 general applications considered). As approved sponsors can offer more than one card program, this results in 28 national approved programs and 19 regional approved programs. Twenty-seven potential sponsors were rejected based on failing to completely satisfy fundamental requirements of the solicitations, including liabilities exceeding assets and the failure to demonstrate the capacity to manage transitional assistance. CMS also approved 43 (of 44) exclusive card applications, associated with 84 Medicare managed care organizations, to provide the drug card as an integrated part of the Medicare Advantage benefit package available to beneficiaries enrolled in those plans. The recommended approvals allow for a manageable number of cards from which people with Medicare will select, and reflects the high standards attributed to the use of the Medicare name. The 28 general card applicants represent card programs that would be administered by insurers, pharmacy chains, and pharmacy benefit managers. We expect that beneficiaries can begin to enroll in these card plans in May and begin using their drug cards in June 2004.

We also awarded a "special approval" to: three applicants to provide access to the $600 credit through long-term care pharmacies; two applicants to provide discounts to residents of the territories; and one applicant to service Federally recognized Indian tribe and tribal organization pharmacies. The MMA requires CMS to have one additional contractor for the tribal pharmacies. We have re-issued a solicitation to receive additional applications to meet this requirement, and several organizations have responded with a notice of intent to submit a proposal.

All applications of contractors that currently administer State pharmacy assistance programs will receive a Medicare approval, covering: IA, IL, KS, MA, MD, MI, NH, NY, OH, OR, PA, RI, SC, VT, and WV. States have the ability to exclusively contract with a Medicare approved card program. If a state's current contractor did not apply for an approval, the state may work with another (approved) card sponsor.

To ensure that beneficiaries have convenient access to their neighborhood pharmacies, card sponsors will not be permitted to limit their services to mail-order programs. Instead, all approved cards must include an extensive national or regional network of retail pharmacies, which must meet minimum requirements. For example, in urban areas, at least 90 percent of Medicare beneficiaries must live within two miles of a participating pharmacy. In suburban areas, 90 percent of Medicare beneficiaries must live within five miles, and in rural areas, 70 percent of beneficiaries must live within 15 miles of a participating pharmacy.

Drug card sponsors will be required to provide information to beneficiaries on the program's enrollment fee, which cannot exceed $30 per year, and to publish discounted prices available through their cards. In addition, Medicare will ensure that beneficiaries have at least two choices of approved general cards in each state, with the state being the smallest service area permitted under this program. If a card sponsor's service area includes additional states, the entire additional state must be included. Medicare will also provide reliable, easy-to-compare information that will show beneficiaries which programs are in their area, and allow beneficiaries to choose the discount card program that best meets their needs. Medicare will also inform enrollees that prescription drug card sponsors must protect personal and medical information consistent with the privacy requirements of the Health Insurance Portability and Accountability Act.

BENEFICIARY ELIGIBILITY

To qualify for the drug discount card, Medicare beneficiaries must be entitled to or enrolled under Part A and/or enrolled under Part B, but may not be receiving outpatient drug benefits through Medicaid, including 1115 waivers. The Federal Government will also pay the full annual enrollment fee, which is not to exceed $30, for these cardholders.

To enroll, beneficiaries will submit basic information to the selected approved discount card sponsor of their choosing about their Medicare and Medicaid status. Those beneficiaries requesting the $600 credit also must submit income and other information about retirement and other health benefits to the card sponsor, and attest to truthfulness of the information. CMS will verify this information and notify the approved discount card program of the beneficiary's eligibility and enrollment outcome. If a beneficiary is found to be ineligible for a drug card, the card sponsor will send written notice to the beneficiary explaining why he or she was found to be ineligible. For beneficiaries who are eligible, sponsors will send a welcome package, including their new drug card, so that they can begin obtaining discounts and, if receiving the $600 credit, using these funds to purchase prescription drugs, upon receiving their cards. Individuals found to be ineligible for either the discount card or the $600 credit may request reconsideration if they still believe they qualify.

An eligible beneficiary can enroll in an approved discount card program at any time. After the initial election in 2004, beneficiaries will have the option, for 2005, of choosing a different card program during the second election period between November 15 and December 31, 2004. In addition, a beneficiary may change cards under certain circumstances if, for example, the beneficiary enters a long-term care facility, moves outside of the area served by the beneficiary's approved program, or enrolls in or drops a Medicare managed care plan that is also providing an exclusive drug discount card program in which the beneficiary was enrolled.

TRANSITIONAL ASSISTANCE PROGRAM

In addition to providing a discount off the price of prescription drugs, MMA creates the Transitional Assistance program, which provides up to $600 in an annual credit for Medicare beneficiaries whose incomes do not exceed 135 percent of the federal poverty level ($12,569 for individuals, $16,862 for couples for 2004). When applying the $600 toward prescription drug purchases, beneficiaries at or below 100 percent of poverty will pay 5 percent coinsurance, and beneficiaries between 100 and 135 percent of poverty will pay a 10 percent coinsurance. The credit, in conjunction with the discount card, will give these most vulnerable beneficiaries immediate assistance in purchasing prescription drugs they otherwise may not be able to afford. For example, Medicare beneficiaries without prescription drug insurance on average would pay about $1,300 for prescription drugs in 2004. The expected savings of approximately 10 to 15 percent translates to $140 to $210. This savings added to the $600 credit will be of substantial help to those who need it most.

EDUCATION

To help explain the drug discount card to beneficiaries and help them navigate among cards to choose the card that best fits their needs, CMS has a number of education and outreach efforts underway. Print, radio, and television advertisements will highlight the upcoming changes to the Medicare program, including the addition of the drug discount card. The advertising campaign—presented in both English and Spanish—also includes Internet-banner ads and a 10-minute pre-recorded informational radio interview to educate beneficiaries about the upcoming drug discount cards.

These advertisements will direct beneficiaries to 1–800–MEDICARE and Medicare's website, www.medicare.gov, for more information. CMS is working to ensure that customer service representatives at 1–800–MEDICARE have up-to-date information on the drug card, as well as other CMS programs. Based on our analysis, we estimate 1–800–MEDICARE will receive 12.8 million calls in FY2004. This compares to an FY2003 call volume of approximately 5.6 million calls. The 12.8 million calls include an estimated increase of 5.5 million calls as a result of the new Medicare law and 7.3 million calls for routine 1–800–MEDICARE call topics. We plan to increase our CSR level at 1–800–MEDICARE in May 2004 to handle the expected increase in call volume.

An additional feature of the website will be a new price comparison tool, Medicare Price Comparison. Under the drug card program, card sponsors will negotiate drug discounts with both pharmacies and drug manufacturers. The new comparison tool will give beneficiaries, or their representatives, the capacity to find the sponsor-negotiated price for each drug or all their drugs at pharmacies in their area. Pricing information will be available for brand name, generic, and mail-order prescriptions

offered through each card sponsor's program. Drug card sponsors will be able to update the drug pricing information on a weekly basis. Starting in late April, beneficiaries will be able to use the comparison tool by going to *www.medicare.gov* or by calling 1–800–MEDICARE. Customer service representatives at 1–800–MEDICARE also will be able to answer questions about the program, help them compare drug cards on price and network pharmacies, and refer callers to other appropriate resources. They will also mail the results of the comparison to seniors.

CMS also has a number of beneficiary publications planned for 2004 to explain changes in the Medicare program. For example, HHS has prepared a detailed "Guide to Choosing a Medicare-Approved Drug Discount Card" for beneficiaries that explains the program, including eligibility and enrollment information, and provides step-by-step guidance for comparing discount cards and choosing one. The booklet currently is posted at *www.medicare.gov*, and printed copies will be available for free through 1–800–MEDICARE. CMS also will publish a small pamphlet with an overview of the drug card program and an introduction to the discount cards and the $600 low-income credit. In addition, a brief document that introduces beneficiaries to the discount cards and the Medicare-approved seal will be mailed directly to beneficiary households. This mailing, which will correspond with the television information campaign, is scheduled for late April 2004. Also, as required by MMA, CMS will work with its partners at the Social Security Administration to facilitate a mailing targeted toward low-income Medicare beneficiaries detailing the drug card and transitional assistance program.

To assist in beneficiary education and outreach, CMS increased funding to State Health Insurance Assistance Programs' (SHIPs) grants and REACH from $12.5 million last year to about $21.1 million for fiscal year 2004—a 69 percent increase above the fiscal year 2003 total. In addition, HHS' budget plan for fiscal year 2005 allocates $31.7 million to SHIPs—more than double the amount awarded in fiscal year 2003. With the new funding, SHIPs will be able to expand their efforts to work with and reach even more Medicare beneficiaries and increase and enhance their volunteer staff through additional training and resources.

To educate providers and pharmacists, as well as the States and other stakeholders, CMS will sponsor conferences and conduct a number of teleconferences to make the information available nationwide. For example, in-person training will take place at the CMS-sponsored drug card conference, which is scheduled for April 7–8. CMS staff will be available to provide technical assistance and support as the program begins.

COVERAGE

The discount card and $600 in transitional assistance can be used to purchase nearly all prescription drugs available at retail pharmacies. Syringes and medical supplies associated with the injection of insulin, such as needles, alcohol, and gauze, are also included. It is anticipated that many approved programs will use formularies to obtain deeper discounts on prescription drugs. If an approved discount card program uses a formulary then the drugs most commonly needed by Medicare beneficiaries must be included. At a minimum, each program must offer a discount on at least one drug in each of the 209 therapeutic categories of prescription drugs. However, even if a prescription drug is not on the sponsor's formulary, the $600 must still be applied to all the covered prescription drugs available at the pharmacy if the beneficiary uses the discount card toward the purchase. Drug card sponsors also may choose to offer discounts on over-the-counter (OTC) drugs, but the $600 cannot be used toward the purchase of OTC drugs. CMS made public on April 1, 2004 the enrollment fee for each drug card on the PDAP website, and the discounted prices will be posted at the end of April.

Medicare approved drug discount card sponsors will negotiate with manufacturers and pharmacies for rebates and discounts off the average wholesale price (AWP) for drugs covered under the drug card program. In order to get the most competitive savings to beneficiaries, some cards will use formularies, which can improve the negotiating leverage sponsors have with pharmaceutical manufacturers.

Beneficiaries will be guaranteed a percentage savings (or discount) on each purchase they make with their card. Individual prices may change, as AWP moves up and down, but the discount rate to which the card entitles them will not move, unless the sponsoring organization can satisfactorily report to CMS a good cause for such a move. The attached chart outlines how this process works. CMS expects to receive detailed information from program sponsors concerning specific discounts in the near future.

It is true that drug prices under the drug card may change. But this is not different from the way drug pricing works in the marketplace today. In typical industry practice, a pharmacy benefits manager guarantees, by contract, a certain dis-

count off of the average wholesale price (AWP) to its payers. Within the universe of the thousands of prescription drugs on the market, there are changes in AWP in response to price shifts in labor and raw ingredients, as well as to supply and demand. However, taken individually, the AWP for the vast majority of drugs either does not change or changes several times a year by a modest amount.

Once a card is selected, beneficiaries are committed to their card for the calendar year (with a few exceptions). This is a key program design feature to improve the discounts to beneficiaries under a drug discount card. Historically, drug discount cards have not included discounts from manufacturers because sponsors could not guarantee market share. By having committed beneficiaries, Medicare approved sponsors are able to guarantee a certain patient population. This guarantee increases their negotiating leverage with manufacturers and improves their ability to secure discounts and rebates, which are passed on to the beneficiaries. Because approved programs will be competing for Medicare beneficiaries to be able to increase their negotiating power, the programs will have an incentive to pass negotiated savings along to the beneficiaries in the form of the lowest possible drug prices.

While approved discount card programs may update their prices and lists of offered drugs on a weekly basis, CMS will monitor drug price changes to ensure that prices do not deviate from expected market changes, such as those in average wholesale price. While we do not anticipate that sponsors will be changing prices for unwarranted reasons, CMS will nonetheless closely monitor changes in prices over time for each drug that a card sponsor offers:

- If a card sponsor's drug prices change in an amount that is not consistent with the expected change due to AWP, then the sponsor must report it and provide a rationale.
- Also, CMS will routinely check for price changes from week to week compared to what is expected, based on changes in AWP. Price changes that are not expected will be flagged and evaluated.
- If the price change is not due to legitimate changes in their operating environment, such as losing a manufacturer contract, or unexpected costs of operating the call center, then a card sponsor could be sanctioned by CMS.
- Sanctions could include prohibiting further marketing and enrollment, monetary penalties, and terminating the card program.

FRAUD

Although the drug discount card program has not yet been implemented, some Medicare beneficiaries have already received calls as well as in-person solicitations from individuals/companies posing as Medicare officials attempting to gain personal information from beneficiaries for identity theft.

A beneficiary should NEVER share personal information such as their bank account number, Social Security number or health insurance card number (or Medicare number) with any individual who calls or comes to the door claiming to sell ANY Medicare related product.

Beneficiaries who are contacted by these false card companies should remember that Medicare-approved cards will not be available until May. The names of approved card sponsors have been made public and the companies will begin to market their cards through commercial advertising and direct mail beginning this month. Medicare-approved card sponsors will not market their cards door-to-door or over the phone.

In response to these complaints, CMS is coordinating information with customer service representatives at 1–800–MEDICARE, the call centers at the Medicare contractors and the State Health Insurance Assistance Programs (SHIPs). CMS has already informed the public through a press release about how to protect themselves from fraud. OIG referrals have been made for two complaints where we had specific enough information to make a fraud referral.

CMS is continuing to explore methods to limit the scope of these scams and develop a process to work with the appropriate law enforcement agencies to avoid further spread of this type of activity. CMS' Office of Program Integrity is hosting a law enforcement fraud and abuse meeting this month. The primary participants will include the Department of Justice, Federal Bureau of Investigation, and the DHHS' Office of the Inspector General. Participants from other agencies that have dealt with issues of Prescription Drug fraud will also be invited. The primary topic of this meeting will be the discussion of the drug discount card program and how to prevent and deter fraud, waste and abuse in this area.

CONCLUSION

Thank you again for the opportunity to testify today about this new important transition toward a prescription drug benefit for Medicare beneficiaries. This vol-

untary drug discount card program will provide immediate assistance in lowering prescription drug costs for Medicare beneficiaries until the new Medicare drug benefit takes effect on January 1, 2006. We recognize the importance of the discount cards and the low-income credit to Medicare beneficiaries, who, for too long, have gone without outpatient prescription drug coverage. We at CMS are dedicated to meeting the deadlines set out in the historic Medicare Prescription Drug, Improvement and Modernization Act of 2003 and are working expeditiously to satisfy the May 3 and June 1, 2004, effective dates for enrollment and implementation, respectively. Thank you again for this opportunity, and I look forward to answering any questions you might have.

Chairman JOHNSON. Thank you very much. Could you go into some further detail about how you plan to monitor the prices that companies put up on their website? I am very pleased that they have to put up a price, and that there will be some people to help seniors determine which plan is best for them.

If they put up the price, and you join the plan and then they double the price, to me that will represent failure. I know that represents failure to you, too. You have done a lot of thinking about how you prevent that kind of bait-and-switch activity by plans. First of all, would you tell us what in the contracting language prohibits them from indulging in this kind of behavior, and then what kind of oversight will you have and what kind of penalties will you impose?

Ms. MCMULLAN. The contract requires them to provide us with a percent discount off of the average-wholesale price. If they need to change the percent discount, it has to be for cause. The cause would be something like losing a manufacturer contract or something else in the business part of the relationship in getting the rebates or the discount.

So, there has to be cause for them to change the percent discount. Without any cause, then they guaranteed a percent discount off of the average-wholesale price. We will monitor those prices to ensure that they are doing that. We get the pricing files from all of the drug card sponsors. We have a monitoring mechanism in place to evaluate these, to make sure that they stay within the expected range of prices, and we review them. We will review them for any kind of trends and patterns that we do not expect. In addition, our program integrity contractor will be looking carefully for any potential issues that have been identified through the complaint process or the grievance process to ensure that the contractors are doing what they have committed to do in the contract.

In addition, there is the power of the marketplace, and the fact that we have these prices on the website so people can see what other card sponsors are offering and ensure that the card sponsor that they have elected is staying within the market price and that feedback will come to us and we will also be responding to any concerns that are raised to us. So, we have an extensive analytic process to look at all of those drug—all of the drug data, to review it for any kinds of patterns. In addition, we will be doing regular monitoring type of reviews with contractors.

Chairman JOHNSON. If you discover behavior you think is not in conformance with the contract agreement, then what?

Ms. MCMULLAN. The contractor would then be required to cure the error. They could be subject to sanctions with the ultimate sanction being the termination of their contract.

Chairman JOHNSON. Thank you. Mr. Stark.

Mr. STARK. Is there any guaranteed or minimum discount in this plan?

Ms. MCMULLAN. There are guaranteed discounts. The guaranteed discount is exactly what we are contracting for.

Mr. STARK. What is the minimum discount that you accept? What is the lowest discount? Five percent? Three percent? Two percent? What?

Ms. MCMULLAN. I am not familiar enough with each of the contracts to tell you that. We anticipate the discounts to be between—the overall discounts to be between 10 and 15 percent and as high as 25 percent on an individual drug.

Mr. STARK. Don't you have any comprehensive list? That wasn't established before you granted the license to these companies? There was no established discount?

Ms. MCMULLAN. There was no established discount.

Mr. STARK. So, it could be anything. It could be 2 percent, or 1 percent or 100 percent?

Ms. MCMULLAN. It could be.

Mr. STARK. Is there anything that sets the discount other than these plans?

Ms. MCMULLAN. Our anticipated level——

Mr. STARK. I don't care what you anticipated. Is there anything in the law or the regulation that requires a discount to be a certain amount?

Ms. MCMULLAN. We anticipated—we asked them to do it within the market. We anticipated——

Mr. STARK. What if they don't? What if they don't do it? What if they all come in at 2 percent?

Ms. MCMULLAN. Well, we do not see that happening.

Mr. STARK. I know you don't see it happening. You don't have a crystal ball. In the free market you don't have any control. So, what happens if they all come in at 2 percent?

Ms. MCMULLAN. They will all come in——

Mr. STARK. Somebody just gave you a note. She may know what happens. Do you know, lady, whoever it was that handed her the note? What does the note say?

Ms. MCMULLAN. The drug card sponsors were given an idea of what we were looking for. We—in our impact analysis, we told them about our anticipated——

Mr. STARK. So, what you are telling me is there is no discount set?

Ms. MCMULLAN. What they have to——

Mr. STARK. Just a second. I don't want to hear this. I am going to let her finish. I want to know if there is a number. Is there a number that I can see to look forward to, Ms. McMullan? Is there a number?

Ms. MCMULLAN. We believe——

Mr. STARK. Yes or no?

Ms. MCMULLAN. We believe between 10 and 15 percent.

Mr. STARK. If that isn't there, what are you going to do?—there is no guarantee, is there? There is no guarantee of it, is there?

Ms. MCMULLAN. The percentage discounts that come in——

Mr. STARK. Stop. Is there a guarantee that it will be between 10 and 15 percent?

Ms. MCMULLAN. No.

Mr. STARK. All right. That is what I want. It took you a long time to get there, but thank you for your answer. Now, is there any guarantee that a drug will not be dropped once someone signs up and they have to stay in the program for a year, is there any guarantee that a drug that their physician has prescribed will not be dropped from the program?

Ms. MCMULLAN. The——

Mr. STARK. Yes or no?

Ms. MCMULLAN. A drug card sponsor can drop a drug. However——

Mr. STARK. So, that is it. I—Hello, Mrs. Chairman. Let me finish talking. If you want to inquire you can——

Chairman JOHNSON. The witness will not respond until the gentleman has finished talking. Then the gentleman will not interrupt the witness until the witness has finished talking.

Mr. STARK. The Chairman won't interrupt me on my time. Thank you very much. Now, would you like to tell me, if you know, Ms. McMullan—or if you are willing, is there anything that guarantees that a drug will not be dropped from a program. Yes or no?

Ms. MCMULLAN. No.

Mr. STARK. That is what I thought. So, there is no guarantee that once somebody signs up for a year, that their drug which they need and has been prescribed by their physician may not be dropped, and there is no guarantee of any particular size of discount. So——

Ms. MCMULLAN. The market will act and ensure that the drug card sponsors——

Mr. STARK. What do you know about the market, Ms. McMullan? Have you ever had a job in private industry? Do you know anything about the market?

Ms. MCMULLAN. The——

Mr. STARK. What do you know about the market? Could you explain your knowledge of the market?

Ms. MCMULLAN. The analysis that went into the development of this program, included an analysis of how the market works. The market will provide the incentives to the drug card sponsors to provide the kinds of discounts that——

Mr. STARK. However, there are no guarantees. So, if you don't think the analysis is any good, there is no guarantee.

Ms. MCMULLAN. We have no——

Mr. STARK. Madam Chairman——

Mrs. JOHNSON. You have interrupted her three consecutive——

Mr. STARK. You have interrupted more often than anybody has. If you would be quiet on my time, we could get this done.

Chairman JOHNSON. Luckily your time is about to expire.

Mr. STARK. That is right. If I start interrupting you, the way you have been interrupting me, you would be unhappy.

Chairman JOHNSON. I am asking for common courtesy.

Mr. STARK. I don't care what you are asking for. I have the time.

Chairman JOHNSON. I had her let you finish. I asked you to let her finish, in response.

Mr. STARK. Look, ma'am, I can interrogate a witness in any manner that I choose. If you can find something in the rules to change that, I would be glad to listen. If you would just let people have their time instead of interrupting them.

Chairman JOHNSON. The gentleman's time has expired. Mr. McCrery.

Mr. MCCRERY. I thank the Chairman. In listening to the gentleman from California's remarks, his point of view is perfectly legitimate. He has expressed it many times over the years that I have been on this Committee. He doesn't often have a lot of confidence in the market to provide benefits to consumers, and I understand that. That is a legitimate point of view. That is why we do have some government regulations and so forth to try to make sure that markets do work. In the case of a discount card, I think there is already a lot of experience in the market for discount cards. For example, my stepmother, prior to my purchasing a discount card for her in the open-market, admittedly, I am paying $28 a month for this card, but still it is an open-market creation, it is a free-market creation, her drug bills were close to $8,000 a year.

Now, they are about $5,000 a year. That is a significant savings for my stepmother she got through the free market by purchasing a discount card. They, I am sure, are using the very same principles that these companies that have asked to qualify for Medicare discount cards are going to use. Now, they may not be able to do quite as good a job because they are not going to be charging as much, $30 a year as opposed to $30 a month. Still, I expect they will be able to use their purchasing power and the allure of a long list of member Medicare seniors to attract discounts. So, there is some proof in the market that this concept can work. Is there any guarantee it will work? No, sir, there is no guarantee. Some of us do have a little more faith in the markets than my colleague from California, and we hope we are right. We think we will be. No, there is no guarantee. I don't think that is so bad. Now, Ms. McMullan, there is going to be a lot of choices for seniors, 28 national cards, 28 different cards. What plans does CMS have to help beneficiaries make sure that they pick the best card that is available, or that they know everything about the various cards that are going to be out there?

Ms. MCMULLAN. We are doing a substantial amount of education about the availability of drug cards, including a direct mail to all Medicare beneficiary households telling them about the card, and telling them that they can get assistance by calling 1–800–MEDICARE, or by going to www.medicare.gov. The tool that I mentioned in my testimony will provide either the individual themselves, if they are an Internet user, or by calling 1–800–Medicare, or by going to a local community-based organization, the opportunity to compare drugs on the issues that are important to them, including the availability of pharmacies within a geographic area, within 5 miles of their home, or if they want a particular pharmacy

that they use, they can specify the pharmacy on the corner that they are accustomed to.

We will then ask them for the drugs that they are using and the dosage, and all of that information will be fed into a screening tool that then presents back to them the available drug cards that meet their specifications, and will show their aggregate savings in descending order from the most savings to the least, and then they can go in and look at the exact savings on a drug-by-drug basis. So, they can use that information in evaluating what is more important to them, and maybe more important to them that the pharmacy is closer to them, or the amount of savings. We will narrow the number of pharmacies that they have to consider, the pharmacy of the drug card plans that they will have to consider.

Mr. MCCRERY. Now, some have criticized the ability of these plans to change their prices and formularies during the course of the year. Why should we allow them to change their prices and formularies?

Ms. MCMULLAN. Well, the changes will reflect any changes in the average-wholesale price. These changes can go up and they can go down. As I said, they are reflected to changes in the manufacturers cost and of supply and demand. So, they can go down as well as going up.

As far as what is included in the formulary, again, we don't anticipate that they are going to change them in any kind of wholesale way. We have asked the drug card sponsors to include those drugs that are most commonly used by the Medicare population, and there are strong incentives for these drug card sponsors to give the beneficiaries what they need, because they want to keep the loyalty of these individuals into the 2005 year, and also many of these drug card sponsors are positioning to become part of the Part D benefit, and so all of this, they want to have good will and good faith of the members of their drug card plans.

Mr. MCCRERY. Thank you. Thank you, Madam Chair.

Chairman JOHNSON. Thank you. Mr. Cardin.

Mr. CARDIN. Madam Chair, I think Mr. Doggett was here first. Thank you, Madam Chair. Thank you for the courtesy of allowing me to ask these questions. Ms. McMullan, I appreciate the reference in your opening comments to the fraud that we are discovering with telemarketers who are alleging that they are Medicare-approved discount card sponsors, getting information from beneficiaries. We believe their goal is identity theft, and perhaps also to get money out of beneficiaries.

I have a concern about implementation of this new program. You plan to permit the approved plans to contact Medicare beneficiaries who are already very sensitive about being contacted by telephone. We should restrict marketing to means other than via telephone, which, I think, is somewhat threatening to handle for many elderly persons. On February 24, I wrote a letter to Secretary Thompson about this. I urge you to develop a code of conduct for the approved plans, as to how they can contact seniors, obtain and update information, et cetera, so that we don't encounter abusive behavior by these now-approved plans.

Ms. MCMULLAN. We have published some of the marketing guidelines. We continue to refine those, and will take your concerns

into consideration in making sure that they are as tight as possible in protecting the Medicare population. We are very aware of this and very concerned that we don't expose people with Medicare to any of this risk. Currently, our approach is to only allow calls that the beneficiary seeks the caller or agrees to get a call.

Mr. CARDIN. I think that would be an improvement, if there is an express consent to the call. This still raises the fact that, it is hard to document what occurs during a phone call. Whereas, if it is done by mail or e-mail, we know that we have some documentation which is useful for us to be able to monitor conduct. If there is a specific request from a beneficiary to handle the transaction by telephone, then obviously that would be fine. Just be cautious in this area. Let me just return to the point that was mentioned earlier, Mr. McCrery mentioned it and Mr. Stark mentioned it. There are discount cards out now today, obviously not Medicare-approved.

I understand your point about market share—trying to lower the cost by locking in a beneficiary for a year. The concern that has been expressed, though, is that because the plan can change the drugs that are covered on a weekly or bi-weekly basis, and beneficiaries are locked in for a long period of time, although the drugs can change, we know that pharmaceutical prices are going up well beyond the cost of inflation and discounts are not guaranteed.

All of that put together, we are not exactly sure how much impact these cards will have on the actual out-of-pocket costs for Medicare beneficiaries, particularly those who do not qualify for low-income assistance. That is our concern. We would hope that while these plans are in effect, there will be some way to monitor exactly what is happening with plans dropping drugs, and why are they dropping drugs.

Was it a come-on to get people to enroll in the program, and then after they are enrolled to go to a different drug on which they can make a greater profit? I don't know. These are some of the concerns that many of us have, because this is new for the government to be involved in this type of program. We ask you to monitor this very carefully and very closely, and report back to this Committee and to Congress as to what is happening as far as the approved plans, dropping drugs, or changing the discount levels, knowing that the beneficiary is locked in for a year.

Ms. MCMULLAN. We intend to do that. We have a pretty sophisticated analysis of the different drug offerings, plan to look at both the changes in formularies and in the changes in prices. Again, we do not believe that the incentives are there to do that, and the contract also requires these companies to provide the drugs that are most usually needed by people with Medicare. So, we don't anticipate that we are going to see this, because it doesn't set them up very appropriately. We will monitor for it. If it does occur, we will act upon it.

Mr. CARDIN. Let me just challenge that statement. Having a particular drug in your formulary may be very important for marketing, but you may not have a particularly good relationship with the manufacturer. You may use it as a marketing tool, but later drop it from your formulary because of the profit level. So, I think you need to monitor that practice. Just don't assume that plans will have and continue to offer all those drugs.

Ms. MCMULLAN. We will.

Chairman JOHNSON. Mr. Camp.

Mr. CAMP. Thank you, Madam Chair.

Ms. McMullan, I appreciate your testimony. I have had a chance to look at the written portion of it. If you could tell me, it appears as though there will be 28 various drug cards, discount drug cards being offered or prescription cards. Can you tell me, how will seniors keep track of the fact that the discounts and benefits can vary among those cards? How will seniors follow that and be aware of that?

Ms. MCMULLAN. We are going to be ensuring that individuals with Medicare—they will receive a direct mail. We are also doing advertising too, to let them know that they can all call 1–800–MEDICARE, or go to the website to get information about the drug cards that are available to them in their area. We will then use—we have a tool that we have on the website that our customer service representatives will use. We are also training community-based organizations to use this tool, like State health insurance assistance programs and others. What that tool does is asks the individual for a set of eligibility information, asks them what is important to them, like are they interested in retail pharmacy, mail order pharmacy, how close would they like a pharmacy to be to them? What drugs do they take? If they have a particular pharmacy that they want to use, they can specify that pharmacy.

Using all of that information, we then present to them the drug cards that are available that meet those parameters. We list those in descending order by the lowest price to the highest price. They can see both the aggregate savings as well as the per-drug savings that each of those cards offers, and then each individual makes the decision that is best for them based on what their evaluation is, whether it is convenience of pharmacy, lower cost, and—but we will narrow the field to those that meet the parameters that the individual has specified.

Mr. CAMP. Any senior not enrolled in Medicare Advantage would be eligible to receive one of those cards?

Ms. MCMULLAN. Yes.

Mr. CAMP. Is there any chance that a beneficiary could be worse off financially with any of the available cards than they are today?

Ms. MCMULLAN. The target for the drug discount card are those people who don't have drug—outpatient prescription drug coverage now. So, that is a significant number of people. Within that, the advantage of the $600 credit for those people who are below the 135 percent of poverty. So, the target for this card are people who don't have discounts now, who pay cash prices at the register, and the people who have the opportunity to get $600 against their $1,400 on average drug cost a year. So, the target is going to be advantaged.

Mr. CAMP. I think just for people that are watching, the poverty rate really means for a married couple an income level of $16,862, and then for a single it would be an income of $12,569. Those income levels and below, they would be able to be eligible for the $600 discount?

Ms. MCMULLAN. Yes.

Mr. CAMP. What—if you can tell me, there has been some concern that there may be fraudulent cards in the marketplace, that may be marketed. What are you doing to ensure that some beneficiaries may not enroll in the wrong kind of card program?

Ms. MCMULLAN. We have, as I mentioned, we are doing a direct mail that will go out at the end of April and the beginning of May that gives beneficiaries information about the drug cards. In this, we tell them to look for the Medicare approved seal which has to be on one of these cards in order to make them an authentic approved Medicare card. In addition, we have a booklet that we will make available, it is on the website now, and can be ordered through 1–800–MEDICARE, that gives them much more detailed information. Again emphasizes the fact that in order for it to be an authentic card, it has to have the Medicare approved seal on the card. So, we are using our different educational channels to make sure that people get this information and engaging as many community partners as we can to make sure that people at a local level also get this information.

Mr. CAMP. Thank you. Thank you, Madam Chairman.

Chairman JOHNSON. Mr. Doggett.

Mr. DOGGETT. Thank you, Madam Chairman. Like my colleagues, Mr. Camp and Mr. Cardin, and Ms. McMullan, I am concerned about the potential for fraud with these cards, the reports that are already out. What is the approximate dollar value of the additional resources that the agency has allocated to combating fraud with much greater potential for fraud with these cards?

Ms. MCMULLAN. I don't know the dollar value. I will be happy to provide that for the record. We are taking this issue very seriously. We are engaging with our partners in the law enforcement area, as I mentioned earlier. We are sponsoring a meeting among the Department of Justice, the FBI, and the Inspector General to ensure that we are all working together on identifying both the risks to individuals as well as the opportunities to prevent those risks. We are taking very seriously the reports that we have gotten thus far and will continue to monitor that.

[The information was not received at the time of printing.]

Mr. DOGGETT. I believe there are some more precise figures that you have for fraud with reference to the media campaign to promote this system. I believe that is a campaign that the U.S. General Accounting Office has found to, quote, "have notable omissions and other weaknesses." It is still investigating the legality of the video news releases that are a part of that campaign. Am I correct that the approximate cost of the promotional campaign is about $12 million on broadcast media that fill our airwaves and about $10 million on the flyer you have sent out to all Medicare recipients?

Ms. MCMULLAN. That—those numbers are correct.

Mr. DOGGETT. That is a contract that was given to the same public relations firm that is handling the Bush-Cheney 2004 campaign, isn't it?

Ms. MCMULLAN. The prime contractor for our ad work is Ketcham & Associates.

Mr. DOGGETT. The same firm that is handling the President's reelection campaign, right?

Ms. MCMULLAN. I don't know that.

Mr. DOGGETT. Was that a Halliburton sole source contract, or how was that contract awarded?

Ms. MCMULLAN. It was competitively awarded.

Mr. DOGGETT. In what way? By what standards and when?

Ms. MCMULLAN. One of the mechanisms that we use in the Federal acquisition is something called an indefinite delivery indefinite quantity contract. We competed those contracts, the contracts to do beneficiary communications and customer consumer research fully, and then we have a stable of contractors that we do limited competitions among. We did a limited competition among that group of indefinite delivery indefinite quality contracts, and Ketcham & Associates is the prime contractor that was awarded the contract.

Mr. DOGGETT. It was awarded under what you referred to as a limited competition. So——

Ms. MCMULLAN. A limited competition after a full and open competition.

Mr. DOGGETT. Have they done any work for the agency previously?

Ms. MCMULLAN. Yes, they have. I can't tell you exactly what work. However, yes, they have.

Mr. DOGGETT. On the—are they—I just had one other question and then I will yield back my time. Go ahead.

Chairman JOHNSON. I wanted her to clarify the difference between a general open competition.

Ms. MCMULLAN. In order to create the smaller group that you can do a limited competition among, you have to do a full and open competition, which is the broad competition, to get down to the smaller number, and then qualify for a limited competition. It is a two-stage process. We have a list of four contractors that are within that stable of contractors that then qualify for a limited competition. They won in both the large contract to be listed among the four, and then won within the limited competition.

Mr. DOGGETT. On a different topic, the transitional assistance, the $600, I believe the plan is that you have to certify the enrollees before they will qualify for the conditional assistance. How do you plan to certify the applicants so that they get that benefit as soon as possible?

Ms. MCMULLAN. We have worked very hard during the months leading up to this to enter into agreements to get information from the Internal Revenue Service (IRS), from the Office of Personnel Management (OPM), for the Federal employees, from the U.S. Department of Veterans Affairs (VA), and from the Railroad Retirement Board in order to get the information that we need to assure that when people attest to their—that they qualify for these cards, that they are qualified. Then we can enroll them.

Mr. DOGGETT. When would you expect that the first assistance would be available?

Ms. MCMULLAN. June 1.

Mr. DOGGETT. On the flyer that was sent out to Medicare recipients, was that prepared with the—in consultation with the same firm that did the television ads?

Ms. MCMULLAN. I don't remember if we did any consultation with them on that at all. That was done mainly within the Federal staff. Then we printed it using the U.S. Gvernment Printing Office.

Mr. DOGGETT. Thank you very much. Thank you, Madam Chairman.

Chairman JOHNSON. To follow up on a preceding question. Would you clarify who can get a discount card. If you are already on Medicaid, if you are already qualified under the VA system, can you get a card? If you are qualified under a State drug subsidy program, can you get a card? If you are a senior that just already has a private card, can you get a card?

Ms. MCMULLAN. The only people with Medicare who are not able to get a card are people with Medicaid. The transitional assistance is not available to people who already have outpatient prescription drug coverage. So, a card, anyone with Medicare who does not also have Medicaid, full outpatient prescription drug coverage under Medicaid, or an 1115 waiver, they do not qualify for the card. Anyone other than that can get a card. Those people who, in order to qualify for the $600 transitional assistance, you may not have other outpatient drug coverage, such as Federal Employees Health Benefits Program (FEHBP), TRICARE, or employer group coverage.

Chairman JOHNSON. You can have another discount card?

Ms. MCMULLAN. Yes.

Chairman JOHNSON. A private discount card?

Ms. MCMULLAN. Yes.

Chairman JOHNSON. So, all of those people not eligible for Medicaid in the 38 States that define Medicaid as 75 percent of poverty, of the Federal poverty income, are under. So, all of those people that are in between 75 percent of poverty income and 135 percent of poverty income, in all of those 38 States, they all will get the $600 and have the discount card, and if they already have a discount card, they can have two, so they can select the one that gives them the most discount on whatever drug they intend to buy?

Ms. MCMULLAN. Yes. You asked about State pharmacy assistance programs. Members of State pharmacy assistance program plans may also get the card, and if they qualify on income, the transitional assistance.

Chairman JOHNSON. Well, that is very interesting. Since, some of the State pharmacy assistance programs have very high deductibles. So, they can effect that high deductible by using their discount card. Are there other questions of the CMS representative? Thank you very much, Ms. McMullan, for being with us. I appreciate your hard work to get this launched, and the good attention that you have paid to helping seniors with their choices. There was—I am sorry. There was one thing that needed to be clarified. You have identified the cards at this time. Have the cards negotiated their prices yet?

Ms. MCMULLAN. In order—we notified the card sponsors that we were going to approve them. They are now finalizing their contracts. They will start sending us the pricing information during the month of April, and we will have that information on the website by April 29.

Chairman JOHNSON. So, you actually don't know at this time. You just approved their structure, and the fact that they could do the job, and so on?

Ms. MCMULLAN. Also discount——

Chairman JOHNSON. We don't know what kind of prices they are going to be able to negotiate from the manufacturers. The seniors themselves, before they sign up, will know the prices at their nearest pharmacy, or they can ask the lowest price in their area, so the—but by the time this goes into effect, those negotiated prices will be known, but they are not known now?

Ms. MCMULLAN. Correct.

Chairman JOHNSON. That is part of the reason why you can't say whether they will be 10 percent across the board, 15 percent across the board, or they will be 40 percent here and 1 percent there in the same plan for different drugs. Thank you for clarifying that. Now, let's turn to the second panel, if they will come to the dais, please.

I would like to welcome Susan Rawlings, the Vice President and head of Retiree Markets of Aetna. I would like to welcome Steven Nelson, the Senior Vice President, Senior Products Division, Health Net. I would like to welcome Gail Shearer, the Director of Health Policy Analysis of the Consumers Union. Thank you very much for being here. I apologize for having kept you so long this afternoon. Ms. Rawlings.

STATEMENT OF SUSAN RAWLINGS, VICE PRESIDENT AND HEAD OF RETIREE MARKETS, AETNA, INC.÷ ÷

Ms. RAWLINGS. Thank you. Good afternoon, Madam Chairman, Congressman Stark, and Members of the Subcommittee. My name is Susan Rawlings, and I am the Vice President and head of Retiree Markets for Aetna. I am very pleased to be here this afternoon to talk with you about Aetna's role as one of the carriers selected to issue a prescription drug discount card to America's seniors.

I want to begin by emphasizing that Aetna strongly supports the Medicare Modernization Act, and I would like to highlight for you the immediate impact of this law passed just 3 months ago on seniors. As a result of the increased payments under the new law, Aetna has revised its existing coverage effective March 1, 2004. We applied 50 percent of the new money to reducing member premiums and lowering costs, 30 percent of the new money was applied to increasing benefits and preventive care, and the remaining 20 percent of the money was applied to improving our provider networks. My written statement includes these details and the enhancements we made to our product portfolio.

Aetna's participation in Medicare dates all of the way back to the beginning, when we paid the very first Medicare claim on July 9, 1966. Today we serve more than 105,000 beneficiaries through health plans that we offer in 5 States. As we look to the future, we are evaluating several options to expand our participation in the Medicare program. For example, the disease management demonstration project, for which we are immediately and intimately waiting for the request for proposals that we expect to get at any moment. We are very excited about that. Providing an even broad-

er range of health plan choices down the road, including potential Medicare Advantage service area expansions in 2004 and 2005, and participation in the regional preferred provider organization (PPO) and Medicare Part D coverage that are authorized by the Medicare Modernization Act beginning in 2006.

Now, we would like to talk in more detail about the Aetna Rx savings card. Effective June 1, beneficiaries will receive further assistance under another important initiative established by the Medicare Modernization Act, the Medicare approved prescription drug discount card. At Aetna, we are proud that we have been approved as a national card sponsor. In order to better understand the needs of eligible beneficiaries who might seek this card, we wanted to talk directly with them. We conducted focus groups in California, Colorado, and Florida in early March of this year. We sought the opinion of these beneficiaries in order to gauge their understanding of the discount card program, how they viewed the value of the program, and in what manner they would prefer to receive information.

These discussions and the insights received will enable us to better communicate with seniors and allow us to implement the program to best serve their needs. Aetna's card will be available to all Medicare beneficiaries, eligible Medicare beneficiaries in all 50 States, which will enable Aetna to support the intent of the Medicare Modernization Act by increasing access to more affordable prescription drugs. Eligible beneficiaries include all enrollees in the original Medicare fee-for-service system, enrollees in Aetna's Medicare's advantage plans, and enrollees in other Medicare Advantage plans that do not sponsor the exclusive drug cards.

The Aetna Rx savings card includes a number of standard features supplemented by several features unique to Aetna that will enable beneficiaries to receive maximum value from the discount card program. For example, the card will give enrollees access to Aetna InteliHealth, our online consumer health information resource. This website contains the Ask the Pharmacist feature and offers health information that consumers in consultation with their health care professionals may use to take an active role in their health care decisions. Additionally, our discount card will also enable enrollees to receive discounts on over-the-counter vitamins and nutritional supplements through our Vitamin Advantage program. Our card will be an open formulary card. Instead of adopting a closed formulary, the Aetna savings card will offer discounts on all prescription drugs that are allowed by CMS. We do not intend to limit the prescription drugs available for discount.

Based on focus groups we conducted, we gained insights that will help us provide information on how to enroll for the card. In early May Aetna will launch a new website to provide beneficiaries with answers to frequently asked questions and other educational information on the card program. This website will include instructions to help beneficiaries enroll in our drug card through an online enrollment form. We also plan to work with our provider network to help identify needy beneficiaries who might qualify for the transitional assistance benefit. Furthermore, we plan to share information on the Aetna Rx savings cards with the 13 million medical members of Aetna's health plans so that they can be equipped with

the knowledge of the card's benefits and how it might be of value for their Medicare-eligible family and friends.

Beneficiaries who choose the Aetna Rx savings card will be aided by customer service representatives who have received specialized training on how to effectively communicate with seniors and respond to their questions. Aetna will begin making information available to Medicare beneficiaries as soon as possible. Enrollment should start in early May with an effective coverage date of June 1. The Aetna Rx savings card will use private sector pharmacy benefit management tools and techniques such as negotiated discounts on brand-name drugs, the option to use mail-order pharmacies, and programs that encourage the use of generic drugs. These tools will increase beneficiaries' access to prescription drugs, and reduce out-of-pocket costs, and form a bridge to the Part D program in 2006.

In conclusion, I would like to thank the Subcommittee Members for your interest in the Medicare-approved prescription drug discount program and for closely monitoring its implementation. Please be assured that Aetna is strongly committed to making this program work for Medicare beneficiaries. We believe that our plan to make information available to beneficiaries will help minimize the confusion while they are choosing their prescription drug discount card. We are confident that this card will maximize access to and the affordability of prescription drugs seniors need. Thank you very much.

[The prepared statement of Ms. Rawlings follows:]

Statement of Susan E. Rawlings, Vice President and Head of Retiree Markets, Aetna, Inc., Hartford, Connecticut

Good afternoon, Madam Chairwoman and Members of the Subcommittee. I am Susan Rawlings, Vice President and Head of Retiree Markets for Aetna. I appreciate having this opportunity to testify about Aetna's longstanding commitment to meeting the health care needs of Medicare beneficiaries, as well as our enthusiasm about serving beneficiaries through the new programs that were authorized by the Medicare Modernization Act of 2003 (MMA).

I want to begin by emphasizing that Aetna strongly supports the MMA. Throughout the 2003 Medicare debate, we played an active role in encouraging Congress to enact legislation to provide Medicare beneficiaries with access to high quality health care and the widest range of choices. The MMA advances these goals in several ways: by immediately increasing funding for the health benefits of Medicare health plan enrollees; by establishing a new regional PPO program in 2006; by providing beneficiaries with short-term prescription drug assistance in 2004 and 2005; by establishing a permanent prescription drug benefit in 2006; and by expanding beneficiary access to preventive services and disease management services that were pioneered by the private sector. We applaud Congress for enacting this historic legislation to improve choices and benefits for Medicare beneficiaries.

Aetna's participation in Medicare dates all the way back to July 1966 when we paid the first claim in the history of the Medicare program. In the intervening years, we have expanded our involvement by providing comprehensive health coverage through Medicare's private health plan program, which is currently known as Medicare Advantage. Today, we serve more than 105,000 beneficiaries through health plans we offer in five states: California, New Jersey, New York, Pennsylvania, and Maryland. This includes active participation in the Medicare+Choice point-of-service plan offered under the demonstration project announced in 2002 by CMS.

Looking to the future, we are eager to further expand our participation in Medicare by sponsoring Medicare-approved prescription drug discount cards and we will evaluate offering beneficiaries a broader range of health plan options, including the regional PPOs that are authorized by the MMA beginning in 2006. We are prepared to carefully review the CMS proposed regulations that we anticipate will provide the industry with further guidance in late spring.

Improvements in Medicare Advantage

Although the Medicare-Approved Prescription Drug Discount Card Program is the official topic of today's hearing, I want to begin by highlighting the benefit enhancements and cost savings that our Medicare Advantage enrollees are already receiving as a direct result of the additional funding the MMA provided for the Medicare Advantage program in 2004.

In late January, Aetna submitted revised 2004 benefit packages—also known as adjusted community rate (ACR) proposals—to the Centers for Medicare and Medicaid Services (CMS), specifying how we proposed to use the MMA funding to improve benefits and lower costs for our Medicare enrollees. Our revised benefit packages were subsequently approved by the agency and, since March 1, beneficiaries have seen numerous improvements in Aetna's Golden Medicare Plan HMO™ and in Aetna's Golden Choice™ POS Plan, such as:

- Reduced Member premium or enhanced benefits—and sometimes both—in every market we serve;
- Generic prescription drug coverage available in every county we serve;
- The addition of brand name prescription drug coverage in many counties, including all of our service areas in Pennsylvania and Maryland;
- Reduction of co-payments for inpatient hospital care by 50 percent—from $200 to $100 per day—in several counties in New Jersey and New York; and
- The elimination of co-payments for a broad range of preventive services including routine physicals, bone mass measurements, colorectal screening exams, prostate screening exams, mammograms, pelvic exams, and routine hearing and vision exams.

Across our services areas, our members and providers benefited directly from the passage of the MMA. 50% of the MMA dollars were applied in the form of member premium reductions, 30% in benefits enhancements and 20% in network development because of the passage of the MMA. I have attached a sample communications package on our new benefits and premiums (as of March 1, 2004) to demonstrate just how thorough and comprehensive we are when it comes to communicating with seniors. We will prepare and distribute similar communications materials to seniors as needed to implement the discount card program.

Similar coverage improvements have been adopted by Medicare Advantage plans all across the nation. CMS recently reported that the 2004 funding increase for the Medicare Advantage program has resulted in improved benefits for 3.7 million beneficiaries, lower cost-sharing for 2 million beneficiaries, and reduced premiums for 1.9 million beneficiaries. These improvements are clear evidence that the MMA is providing significant value for seniors and disabled Americans, less than four months after the President signed this measure into law.

The Aetna Rx Savings Card℠

Beginning June 1, beneficiaries will receive further assistance under another important initiative established by the MMA: the Medicare-Approved Prescription Drug Discount Card Program.

In order to meet the needs of eligible Medicare beneficiaries we conducted focus groups in California, Colorado and Florida in March 2004. We sought the opinion of these beneficiaries in order to gauge their understanding of the discount drug card program, how they viewed the value of the card, and in what manner they would prefer to receive information. These discussions will enable us to better communicate and allow us to implement procedures to serve their needs.

Aetna strongly supports the steps this program will take to provide beneficiaries with discounted prices on prescription drugs and, at the same time, provide up to $600 annually in added assistance for those with low incomes. On March 25, CMS announced that Aetna has been approved as a general card sponsor on a nationwide basis, meaning that our Aetna Rx Savings Card will be available to all eligible Medicare beneficiaries in all 50 states which enables Aetna to support the intent of the MMA by broadening access to more affordable prescription drugs through the country. Eligible beneficiaries include all enrollees in the Medicare fee-for-service system, enrollees in Aetna's Medicare Advantage plans, and enrollees in other Medicare Advantage plans that do not sponsor drug cards.

The Aetna Rx Savings Card includes a number of features—and is supplemented by several Aetna initiatives—that will enable beneficiaries to receive maximum value from the discount drug card program. For example:

- The Aetna Rx Savings Card will give enrollees access to "Aetna InteliHealth®," an online consumer health information resource. This website includes an "Ask the Pharmacist" feature and offers health information that consumers, in con-

sultation with their health care professionals, may use to take an active role in their health care decisions.

- Our discount drug card will also allow enrollees to receive discounts on over-the-counter vitamins and nutritional supplements through the Vitamin Advantage™ program.
- Aetna will begin making information available to Medicare beneficiaries as soon as possible. Approval to market is expected in early May 2004 and we expect our first members to be effective June 1. Aetna is committed to communicating quickly and thoroughly on changes such as these, as evidenced by the recent communications supporting the Medicare Advantage improvements March 1 (an example is attached as exhibit 1).
- Instead of adopting a closed formulary, the Aetna Rx Savings Card will offer discounts on all prescription drugs that are allowed by CMS. We do not intend of limit the drugs available for discount.
- When drug card enrollment begins in early May, Aetna will launch a new website to provide beneficiaries with answers to Frequently Asked Questions (FAQs) and other educational information on the discount card program. This website will also include instructions to help beneficiaries enroll in our drug card through an online enrollment form.
- Beneficiaries who choose the Aetna Rx Savings Card will be aided by customer service representatives located in service centers in the United States. These representatives have received specialized training on how to effectively communicate with seniors and respond to their questions.
- The $30 annual enrollment fee for beneficiaries who qualify for low-income assistance under the discount drug card program will not apply, as this fee will be paid by CMS.

Value of Private Sector Tools and Techniques

The discount card program, along with other key components of the MMA, establishes an important role for the private sector. We believe this is good news for beneficiaries, considering that the private sector has a strong track record of providing high value under the Medicare program.

The Aetna Rx Savings Card will use United States based private sector pharmacy benefit management tools and techniques such as negotiated discounts on brand name drugs, the option to use mail-service pharmacies, and programs that encourage the use of generic drugs. These tools will increase beneficiary access to prescription drugs by reducing out-of-pocket costs.

A number of studies have demonstrated that the use of these techniques by private sector health plans is beneficial to enrollees in public programs. For example, a 2003 study, conducted by Associates and Wilson[1] on behalf of America's Health Insurance Plans (AHIP), found that the PACE program in Pennsylvania—the largest state pharmacy assistance program in the nation—could save up to 40 percent by adopting the full range of private sector pharmacy benefit management techniques.

In addition, the General Accounting Office (GAO)[2] has reported that pharmacy benefit management techniques used by health plans in the Federal Employees Health Benefits Program (FEHBP) resulted in savings of 18 percent for brand-name drugs and 47 percent for generic drugs, compared to the average cash price customers would pay at retail pharmacies.

These findings demonstrate that Aetna and other private sector companies are well-positioned to use our experience and capabilities to make prescription drugs more affordable for a broader range of Medicare beneficiaries. With respect to both the quality and affordability of health care, the private sector has a strong track record that bodes well for its involvement in the discount card program as well as longer-term Medicare reforms.

Conclusion

In conclusion, I want to thank Subcommittee Members for your interest in establishing the Medicare-Approved Prescription Drug Discount Card Program and for closely monitoring its implementation. Please be assured that Aetna is strongly committed to making this program work for Medicare beneficiaries.

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[1] *Prescription Drug Benefit Management: Improving Quality, Promoting Better Access and Reducing Cost*, Associates & Wilson, October 2003.

[2] *Federal Employees' Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies*, U.S. General Accounting Office, January 2003.

We plan to make information available that will help minimize the confusion of Medicare beneficiaries while they are choosing their prescription drugs and maximize their access to the prescription drugs they need.

We are confident that a strong public-private partnership will enable the discount card program to fulfill its potential to provide beneficiaries with more affordable prescription drugs over the next two years and lay the groundwork for the Medicare prescription drug benefit that will be implemented in 2006.

Chairman JOHNSON. Thank you, Ms. Rawlings. Mr. Nelson.

STATEMENT OF STEVEN H. NELSON, SENIOR VICE PRESIDENT, SENIOR PRODUCTS DIVISION, HEALTH NET, INC., WOODLAND HILLS, CALIFORNIA

Mr. NELSON. Thank you. Good afternoon, Chairman Johnson, and Congressman Stark and Members of the Subcommittee. I am Steve Nelson, head of Medicare programs for Health Net, Inc., and I appreciate the opportunity to testify about Health Net's participation in this important program. I will offer specific examples of how our programs are working and the value they bring to beneficiaries. For more than 10 years, we have been proud to serve Medicare beneficiaries. My message to the Subcommittee today is what Congress passed, and was signed in December, has already had a tangible positive impact. We look forward to our participation in the drug discount program. We have been providing pharmacy benefits to most of our senior members, and this new program will make sure their dollars go farther. Congress' decision to provide transitional benefits to low-income seniors means that a number of our beneficiaries will get a $600 subsidy to help them purchase prescription drugs.

Since the passage of the Medicare Modernization Act, Health Net has made significant improvements to the benefits we provide our Medicare members. These include lower premiums for more than 65 percent of our members, lower copayments for more than 90 percent, enhanced benefits for approximately 20 percent, and a drug discount card for every single member. That is really all within the last 3 months. This is all compelling evidence that our 171,000 beneficiaries are better off today than they were just 3 months ago. Before we made these improvements, we conducted focus groups and listening sessions to gain new insights into our seniors' health care needs. In California, we learned that our beneficiaries wanted lower premiums and a better drug benefit. So, in one California county, for example, members now have no monthly premium compared with a $40 monthly premium last year, unlimited generic drug coverage, and $500 annual brand drug benefit compared to no drug benefit at all last year. In Connecticut they wanted lower out-of-pocket costs. Now copayments have dropped by as much as 50 percent.

Two months from today, on June 1, our Medicare beneficiaries will see another significant improvement in their benefits when our drug card goes into effect, giving them discounted prices on prescription drugs. We have been approved to offer a card exclusively to enrollees in our health plans, and we will waive the annual enrollment fee of $30. With the card our beneficiaries will see immediate savings of up to 25 percent on the cost of their medications.

We have launched a companywide effort to provide more support for seniors with the following goals in mind: one, providing easy-to-understand information; two, lowering prescription drug costs; three, integration of the drug card with existing pharmacy benefits; and four, expanding our care coordination programs.

Health Net is implementing a series of educational initiatives that assist beneficiaries in navigating through the program with easy-to-follow instructions, answers to frequently asked questions, and pertinent information about transitional assistance. As part of our ongoing education effort, beneficiaries will also receive a brochure on our drug discount card and related information in our summary of benefits and our evidence of coverage documents. We are also publishing new webpages to support the Medicare drug discount card program and updating Health Net's Medicare website to include new Medicare prescription benefits. In addition, we have enlisted our physicians and pharmacy partners in an education campaign for beneficiaries. In fact, just this week Health Net volunteered to participate in a pilot test run by CMS where beneficiaries will be invited to review our materials and participate in practice calls to our customer service representatives.

To make things simple and effective for beneficiaries, we are doing the following things. We are working closely with our pharmacy partners to assure that members will receive the lowest cost at the time the medication is dispensed by simply presenting their Health Net Medicare drug discount identification card. We are enhancing our patient safety programs to reduce potential drug errors. We are improving customer service capacity to help members take full advantage of the new programs, including transitional assistance. We will improve patient support by encouraging members to call health coaches, who are experienced clinical nurses, to discuss any significant medical event, chronic therapy, or symptom concern. Health Net is making every effort to ensure our beneficiaries receive the greatest possible value for their drug card. Our goal is to ensure access to an affordable drug benefit for all our Medicare members. I am pleased to have had this opportunity to share with you our ideas for making this program a success, and would be happy to answer any questions.

[The prepared statement of Mr. Nelson follows:]

Statement of Steven H. Nelson, Senior Vice President, Senior Products Division, Health Net, Inc., Tempe, Arizona

Good afternoon, Chairwoman Johnson, Congressman Stark and distinguished Members of the Subcommittee. I am Steve Nelson, Senior Vice President, Senior Products Division of Health Net, Inc. I appreciate the opportunity to discuss Health Net's participation in the Medicare Prescription Drug Discount Card and Transitional Assistance Program.

Health Net's HMO, insured PPO and government contracts subsidiaries provide health benefits to approximately 5.3 million individuals in 14 states through group, individual, Medicare, Medicaid and TRICARE programs. Health Net's subsidiaries also offer managed health care products related to behavioral health and prescription drugs.

Introduction

Health Net is strongly committed to serving the health care needs of Medicare beneficiaries. For more than ten years, we have participated in the Medicare health plan program—through Medicare+Choice, and now Medicare Advantage.

Currently, our Medicare Advantage HMO plans provide coverage to 171,000 beneficiaries in 44 counties in Arizona, California, Connecticut, New York, and Oregon.

Health Net offers a Medicare Advantage Preferred Provider Organization (PPO) product, called Health Net Options Plus, in 21 counties in Arizona, Oregon, and Washington. We are offering this PPO plan under a demonstration project the Centers for Medicare and Medicaid Services (CMS) launched in late 2002.

Looking forward, we are excited about expanding our participation in Medicare under the new programs authorized by the Medicare Modernization Act of 2003 (MMA), including the discount card program that is the focus of today's hearing. We commend Congress for enacting this important legislation that enhances choices and benefits for current and future generations of Medicare beneficiaries.

Medicare Advantage: Enhanced Benefits and Lower Costs

Although my testimony will focus primarily on the discount card program, I will briefly review another component of the MMA that is providing real and meaningful value to millions of Medicare beneficiaries. Specifically, I am referring to the additional funding that Congress provided, beginning in 2004, for the health benefits of Medicare Advantage enrollees. These urgently needed funds enabled Health Net to reduce out-of-pocket costs and expand benefits for enrollees in our Medicare Advantage plans.

Here are a few examples of how Health Net's Medicare Advantage enrollees have seen their coverage improve, effective March 1, as a result of the MMA:

- more than 65 percent of our Medicare Advantage enrollees have had their plan premiums either reduced or completely eliminated;
- more than 90 percent have lower copayments for physician and hospital services, with hospital copayments reduced by more than 40 percent in some cases; and
- approximately 20 percent now have access to enhanced benefits.

For enrollees in our Medicare Advantage plans—and for millions of other beneficiaries all across America—these coverage improvements are extremely important. Because we serve a disproportionately large share of low-income beneficiaries—as do many Medicare Advantage plans—the 2004 funding increase makes a huge difference in the lives of many seniors and disabled persons who rely on Medicare Advantage.

The Discount Card Program: Lower Drug Prices and Low-Income Assistance

Two months from today, on June 1, beneficiaries will see another significant improvement in Medicare when the drug discount card program goes into effect, giving them discounted prices on prescription drugs. This program will also give low-income beneficiaries as much as $600 annually in transitional assistance to apply toward the purchase of prescription drugs.

On March 25, CMS officially approved Health Net to offer a drug discount card exclusively to enrollees in our Medicare Advantage health plans and our PPO demonstration plans. Although the MMA allows card sponsors to charge an annual enrollment fee of $30, we will not charge any fee for our card. We anticipate that our enrollees will see immediate savings of 10 to 25 percent on the cost of their medications.

Exclusive Sponsorship: Integration of Drug Card With Existing Drug Benefits

As an "exclusive" card sponsor, our program differs from general card programs. First, our drug discount card is available only to beneficiaries covered by our Medicare Advantage plans. Second, as required by MMA, beneficiaries covered by our Medicare Advantage plans are not permitted to choose any other Medicare-approved drug discount card while they are Health Net members. These rules allow us to integrate our drug discount card with our current prescription drug benefit thus making the program simpler for beneficiaries.

For example, in cases where beneficiaries receive transitional assistance, Health Net will allow the $600 to be applied to the Health Net drug benefit co-payments and deductibles. As long as their transitional assistance is available, members who use Health Net drug benefits will have minimal out-of-pocket drug expenses up to our benefit limits.

Beneficiary Education Initiatives

Health Net is implementing a series of education initiatives based on CMS requirements and model materials, to ensure that beneficiaries are fully informed about our drug discount card. As a starting point, we have developed educational materials that will assist beneficiaries in navigating through the program with easy-

to-follow instructions, answers to frequently asked questions (FAQs), and pertinent information about the transitional assistance.

Health Net also will provide all of our enrollees information about the program, prior to its initiation, through:

- a member notification letter,
- a member handbook,
- discounted price information about the top 100 prescription drugs, and
- an application form for transitional assistance.

As part of our ongoing education effort, beneficiaries will also receive a brochure on our drug discount card and related information in our summary of benefits and our evidence of coverage documents. We are also publishing new webpages to support the Medicare Drug Discount Card Program, and updating Health Net's Medicare website to include new Medicare prescription benefits.

In addition, we are developing a two-phased approach to our customer service operations. During the program's start-up phase, customer service and call center representatives are being trained to respond to initial questions about what the program does and give detailed guidance to Medicare beneficiaries about how to enroll and apply for transitional assistance. Beneficiaries are also being referred to the 1–800 Medicare call center. Once the program is underway, Health Net will adjust these messages on an ongoing basis and conduct refresher training as we learn more about how beneficiaries use their discount cards to obtain prescription drugs. Finally, our pharmacies and physicians will receive the same Medicare-approved outreach materials that our enrollees will receive in recognition of the important role they have in beneficiary education.

Health Net assigns a high priority to ensuring that beneficiaries are fully educated about this program. Accordingly, we are one of three drug card sponsors that have volunteered to participate, beginning this week, in a pilot test run by CMS. Under this pilot test, Medicare beneficiaries will be invited to take part in a review of our proposed materials, as well as in mock customer calls to our customer service representatives. With this review, we believe that CMS and Health Net will receive firsthand information about the adequacy and clarity of our materials and the capabilities that our customer call centers must have to meet the information needs of interested Medicare beneficiaries.

Serving Our Low-Income Beneficiaries

Health Net believes it is imperative that all of our members who meet the income eligibility requirements receive transitional assistance. As an exclusive card sponsor, Health Net Medicare members will be able to use their transitional assistance to complement the drug benefits they receive under their Medicare Advantage plan. By using transitional assistance for copayments or coinsurance, Medicare members will be able to conserve limited income. In addition, with transitional assistance, beneficiaries are far more likely to comply with drug regimens—a critical factor in maintaining health status. Members will not have to make the awful choice between the rent and their prescriptions.

It is important to note that each member with transitional assistance will use these funds on a dollar-for-dollar basis for any drug they purchase. If the beneficiary does not use his or her transitional assistance dollars, these amounts will not accrue to Health Net.

Start-Up Requirements

Launching a drug discount card under the MMA program requires a significant commitment from card sponsors. To qualify as an approved exclusive card sponsor, Health Net completed an application that demonstrated our capability to undertake the program according to the regulatory requirements. As an organization, Health Net reviewed the requirements, developed operational plans, and identified and overcame obstacles to provide an application that was fully responsive to CMS.

Operational Requirements

Health Net's preparation for participating in the drug discount card program has been extensive. These preparations affect almost every area of our Medicare Advantage plans and their operations. The time period for implementation of the program is extremely short given the number of systems, safeguards, and communications necessary for its operation.

Moreover, requirements of the new program impact a significant number of Health Net operational areas. As a result, Health Net has made extensive operational changes, including updating existing processes or creating new procedures for operational areas such as enrollment, billing or customer service. Health Net has also made extensive enhancements to all business systems to support this new pro-

gram. System updates have been adopted to help facilitate communications between Health Net business systems and CMS, thus allowing accurate and timely data exchanges and reporting. Health Net is also working very closely with our pharmacy claims processing vendors to implement major system enhancements to administer the beneficiary discounts and the transitional assistance, along with the integration of the current prescription drug benefits.

Implementation Activities

In spite of the complexities we have described, Health Net has engaged in companywide activities in the following areas to make the program as simple as possible for the beneficiaries. These are all steps Health Net is taking to ensure implementation results that (1) minimize confusion for the beneficiaries; (2) lower prescription drug costs for the beneficiaries; and (3) integrate the drug discount card with existing pharmacy benefits.

- **Information & Outreach:** To ensure an accurate and consistent message, we have synchronized the timing and message of our announcements about the program with CMS' announcements. CMS is widely advertising this program and has developed an extensive library of outreach and membership materials. To minimize confusion, we want our information to be consistent with the agency's message and we are therefore adopting the CMS materials to the greatest possible extent.
- **Prescription Benefits Management & Pharmacy Operations:** Health Net is working closely and extensively with our pharmacy claims processors to assure that the necessary design and programming is accomplished, in order to ensure that members will receive the lowest cost at the time the medication is dispensed at the pharmacy, by simply presenting their Health Net Medicare drug discount identification card.
- **Care Management Programs:** As a result of having prescription data available for all medications filled by the beneficiaries under the drug discount card program, our health care management programs will be enhanced. These programs integrate pharmaceutical and medical care, help to reduce potential drug errors, avoid drug-to-drug and drug-disease interactions, and enhance the overall use of medications by our beneficiaries.
- **Call Centers & Customer Services:** Health Net is enhancing these capabilities focused on the eligibility requirements for the discount card and transitional assistance, the timing of marketing and enrollment activities, helping beneficiaries complete the drug card and transitional assistance enrollment forms, and helping them understand the information and outreach materials they will receive from CMS and from Health Net.
- **Enrollment & Membership:** Health Net is integrating enrollment processes for the drug card into our existing Medicare Advantage enrollment processes. This enables us to utilize the same trained staff that has been successfully processing Medicare health plan enrollments and disenrollments for the past 10 years.
- **Disease Management:** Our drug discount card will also be integrated with Health Net's Decision Power^{SM} disease management program. One key component of this program allows members to contact Health Coaches by phone to discuss any significant medical event, chronic therapy, or symptom concern. With Decision Power^{SM}, Health Net engages our members as active participants in making decisions about their health care.

Working With CMS

Health Net believes this program brings considerable value to our Medicare members and we are proactively engaged with CMS to make this program available to beneficiaries as rapidly as possible.

CMS has provided necessary direction and flexibility to enable sponsors to develop programs for beneficiaries. Given the timeframes and the complexities of this program, CMS has conducted an implementation program that is unprecedented to meet these challenges. These include

- establishing a specific drug sponsor website with technical and operational questions and answers, systems and file specifications, member materials, conference presentations, and much more;
- conducting frequent sponsor calls to discuss technical and operational issues;
- granting waivers and extending deadlines to make the process successful;
- providing computer software and connectivity for sponsors to communicate enrollments and reports electronically; and
- reviewing marketing materials on a flow basis.

We believe that the combined efforts of CMS and Health Net will result in a very successful and timely launch of this program. Every effort is being made to ensure that beneficiaries will be fully informed about the program and that they will receive discounted prices on their prescription drugs—just as the MMA intended.

Conclusion

Health Net is committed to working with the government in the spirit of public-private partnership to meet the health care needs of America's seniors and individuals with disabilities. Our company vision is to add value to the lives of the people we serve by delivering:

- access to quality health care that helps people achieve improved health outcomes;
- understandable, reliable and affordable products; and
- service that exceeds expectations.

Looking ahead, the Medicare Prescription Drug Discount Card and Transitional Assistance Program is an important step toward providing beneficiaries with the prescription drug benefit scheduled to start in 2006. This program is providing an opportunity to build on our extensive experiences in administering prescription drug programs for Medicare beneficiaries, as well as communicating with beneficiaries about how to make the best use of prescribed medications. We believe this experience will be helpful to our organization, our health care providers, CMS—and most importantly—to all Medicare beneficiaries.

As we begin to implement the drug discount card program, Health Net is making every effort to ensure that our beneficiaries receive the assistance and tools they need to understand how to receive the greatest possible value from our drug discount card—to help achieve our ultimate goal of ensuring access to an affordable drug benefit for our Medicare members. I am pleased to have had this opportunity to share with you our ideas for making this program a success for our beneficiaries.

Chairman JOHNSON. Thank you, Mr. Nelson. Ms. Shearer.

STATEMENT OF GAIL SHEARER, DIRECTOR, HEALTH POLICY ANALYSIS, CONSUMERS UNION

Ms. SHEARER. Thank you, Madam Chairman and Members of the Committee. Thank you so much for providing Consumers Union the opportunity to testify today. American consumers are desperate for relief from the high prices they are charged for prescription drugs. Consumers Union is not optimistic that the new discount drug card program enacted as part of the Medicare Modernization Act will provide the level of relief needed. We are concerned that Medicare beneficiaries will be confused by the new program and will be at risk of being victimized by companies who will seek to take advantage of their confusion.

We believe that the challenge of making prescription drugs affordable to all consumers deserves immediate focus by Congress. The costs of failing to do so are high. Recently there were reports in the press that 23 million Americans are not taking statins to lower their high cholesterol level even though they are recommended for them because they cannot afford them. These press reports came to light in the wake of new research that shows the high effectiveness in terms of reduced heart attacks and mortality of using cholesterol-reducing medicines. If just 5 percent of those unable to afford statins suffer negative health consequences, then more than 1 million consumers in this country will be victims of our failed health care policies. We urge you to consider the reality that medicines that are unaffordable mean dire consequences for those who cannot take them.

In my testimony, I will highlight key concerns that we have with the new discount drug card program. Seniors and the disabled will be confused about how to choose and whether to choose a discount drug card. We don't need elaborate surveys about discount drug cards when we are able to poll our mothers to quickly discover that there is already a high degree of confusion and anxiety about the choices that they will soon face regarding discount drug cards.

It is important to remember the characteristic of the population that will be eligible. An estimated 23 percent have cognitive impairments and are likely to be overwhelmed by the task of selecting a card. One of the lessons of the Medigap market in the 1970s and 1980s, and I know that the Members here today will remember that, is that complicated choices in the health insurance marketplace can result in fraudulent schemes that victimize a vulnerable population. It is important that CMS aggressively police against fraud. Congress must provide resources and make a commitment to help consumers sort out the confusion.

The CMS must be vigilant in curbing marketplace behavior that complicates the market and creates financial burdens for beneficiaries who choose the wrong discount drug card. Centers for Medicare and Medicaid Services must guard against bait and switch or other market manipulation. If price changes are large and frequent, or if the drug list changes frequently and drugs are dropped, then CMS should consider revoking the approval for a card while protecting existing enrollees. In addition, this type of practice should disqualify a company from serving as a prescription drug plan when the Medicare drug benefit begins in 2006.

The CMS should aggressively expand the role of generics in the marketplace and police against discount drug cards that steer beneficiaries toward brand-name drugs. For example, we would like the Medicare website to automatically include comparative pricing information for generic drugs whenever they are available, even if they are not available through the discount drug card offer. The CMS should compare the discounts available from all discount drug cards with a standard pricing basis such as the Federal Supply Schedule to help consumers compare cards. If prices are rising at a rate of 10 percent to 15 percent per year, then a discount of 10 percent would not provide substantial financial relief. The CMS should establish a reliable measure of the discounts.

The CMS and Congress should pay particular attention to the use of formularies, drug lists by the discount drug card companies. Formularies are basically lists of prescription drugs, in this case for which the discount drug card company will negotiate a discount on behalf of enrollees. Formularies in the eventual Medicare prescription drug benefit have a far-reaching impact since they will determine whether the drug is covered by the enrollee's insurance coverage and whether any out-of-pocket costs count toward reaching the catastrophic benefit. It is unclear what the benefits for consumers are of having scores of different formularies—drug lists—for each discount drug card. Whether formularies, as determined by companies offering discount drug cards, serve the best interest of consumers should be monitored carefully throughout this program.

In light of the fact that high prescription drug prices are denying millions of Americans access to needed prescription drugs, Congress should take steps to lower prescription drug prices for all, including those not eligible for Medicare. We urge you to fund Section 1013 of the Medicare Modernization Act that calls for synthesis of medical evidence about the comparative clinical effectiveness of alternative prescription drugs by the Agency for Health Care Research and Quality. When implemented, this provision will provide consumers and government programs with a scientific basis and analysis to make sound decisions based on evidence, reducing the impact of the decisions that are based on an incomplete picture that is often presented in direct consumer advertising.

In conclusion, the challenge of assuring that Medicare beneficiaries and all Americans have access to affordable prescription drugs is daunting. The Congress and the Administration should take steps to reduce confusion, police against fraud, guard against marketplace manipulation, encourage the use of generics, provide a standard basis for evaluating discounts offered, and aggressively pursue other steps to help all Americans have affordable—have access to affordable, safe medications. Thank you.

[The prepared statement of Ms. Shearer follows:]

Statement of Gail Shearer, Director, Health Policy Analysis, Consumers Union

Summary: Consumers Union Testimony on Discount Drug Cards

Consumers of all ages are in dire need of relief from the high cost of prescription drugs. The discount drug card program that is about to begin may offer modest relief to some low-income Medicare beneficiaries, but Congress needs to do much more to provide meaningful discounts for Medicare beneficiaries and relief for non-beneficiaries as well. Ten of Consumers Union's concerns about the program are outlined below.

1. Seniors and the disabled will be confused about how to choose—and whether to choose—a discount drug card.
2. One of the lessons from the ***medigap*** market in the 1970's and 1980's is that complicated choices in the health insurance marketplace can result in fraudulent schemes that victimize a vulnerable population.
3. Congress must provide resources and make a commitment to help consumers sort out the confusion. The need for this is demonstrated by the fact that even the Federal Government is providing "guidance" that could lead to some beneficiaries enrolling in programs that do not offer the most savings for them.
4. The Centers for Medicare and Medicaid Services (CMS) must be vigilant in curbing marketplace behavior that complicates the market and creates financial burdens for beneficiaries who choose the "wrong" discount drug card.
5. The CMS should aggressively ***expand*** the role of generics in the marketplace, and police against discount drug cards that steer beneficiaries toward brand name drugs.
6. The CMS should compare the discounts available from all discount drug cards with a standard drug-pricing basis such as the federal supply schedule to help consumers compare cards.
7. The CMS and Congress should pay particular attention to the use of formularies (drug lists) by the discount drug cards.
8. The CMS and Congress should apply additional lessons (e.g., the reliance on evidence-based, scientific findings; changing coverage, changing prices; harm due to consumer lock-in) to refine and improve the Medicare prescription drug benefit scheduled to begin in 2006.
9. The government should aggressively reach out to all those eligible for the $600 subsidy to assure that all who are eligible receive the subsidy, when that's the best deal for them.
10. In light of the fact that high prescription drug prices are denying millions of Americans access to needed prescription drugs and contributing significantly

to the high cost of health insurance, Congress should take steps to lower prescription drug prices for all, including those not eligible for Medicare.

Introduction

American consumers are desperate for relief from the high prices they are charged for prescription drugs. Consumers Union [1] is not optimistic that the new discount drug card program enacted as part of the Medicare Modernization Act will provide the level of relief needed. Indeed, it seems like a missed opportunity. We are concerned that Medicare beneficiaries will be confused by the new program and will be at risk of being victimized by companies who will seek to take advantage of their confusion. Even some of the government's efforts to educate consumers could deepen the level of confusion. We urge Congress to take further steps to achieve meaningful relief for all consumers, to police against market practices that could harm consumers, and to study and apply lessons from the discount drug program to the Medicare prescription drug program that begins in 2006.

The potential for savings from the discount drug program are limited. CMS estimates that only 19% of Medicare beneficiaries will enroll, and about two thirds of enrollees will do so largely to get the $600 subsidy.

We believe that the challenge of making prescription drugs affordable for all consumers deserves immediate focus by Congress. The costs of failing to do so are high. Recently, there were reports in the press that 23 million Americans do not take statins to lower their cholesterol level—even though they are recommended for them—because they cannot afford them. These press reports came about in the light of new research that shows the high effectiveness (in terms of reduced heart attacks and mortality) of using cholesterol reducing medicines. If just five percent of those unable to afford statins suffer negative health consequences (and I believe this figure is an underestimate), then more than one million consumers in this country will be the victims of our failed health care policies. Because these are "statistical" health consequences and deaths—and not discrete events—they have not captured the attention of policymakers and the public. But we urge you to consider the reality that medicines that are unaffordable do mean dire consequences for those who cannot take them. This crisis demands your attention.

In our testimony below, we explore ten key areas of concern regarding the discount drug care program.

1. Seniors and the disabled will be confused about how to choose—and whether to choose—a discount drug card.

We don't need elaborate surveys about discount drug cards when we are able to poll our mothers and senior friends to quickly discover that there is already a high degree of confusion and anxiety about choices that they will soon face regarding discount drug cards. Should I get a discount drug card? Which one is best for me? Will I still be able to use other discount drug cards? Will the prices change? Will the drugs that I need continue to be covered? What if I want to change to a different card? These are not easily answered questions, especially in light of the possibility that prices and drugs on the list could change as often as once a week, but beneficiaries will be locked into the card that they select. A further complication is uncertainty about how the discount drug cards will work with existing state discount programs and existing prescription drug company subsidy programs.

It is important to remember the characteristics of the population that will be eligible for a discount drug card. These are not federal employees who are used to annual open enrollment decisions, with assistance from human resources staffs and Washington Checkbook. Instead, they are people 65 and over, and younger adults with disabilities. The Kaiser Family Foundation estimates that 36 percent of Medicare enrollees need assistance with at least one activity of daily living. An estimated 23 percent have cognitive impairments. The challenges of sorting out the best discount drug card for those who are cognitively impaired, for those who may have difficulty reading fine print, may be overwhelming. Yet the importance of making the right choice could be of great importance to them.

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[1] Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about goods, services, health, and personal finance. Consumers Union's income is solely derived from the sale of *Consumer Reports*, its other publications and from noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, *Consumer Reports*, with approximately 4.5 million paid circulation, regularly carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions that affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

We have questions about whether the modest anticipated discounts (especially compared with other options that Congress has rejected) justify this program which will be confusing for beneficiaries and will require a huge resource commitment by senior health insurance counselors in order to help beneficiaries make a decision that will provide very short-term benefits for them.

2. One of the lessons from the *medigap* market in the 1970's and 1980's is that complicated choices in the health insurance marketplace can result in fraudulent schemes that victimize a vulnerable population.

As you know, the CMS has expressed concern about recent illegal activities. Individuals are incorrectly indicating that they are offering government-approved discount drug cards. Apparently, scam artists have made telephone calls and went door-to-door in Alabama, Georgia, Idaho, Nebraska, Oklahoma, New York, Rhode Island, and Virginia, peddling phony discount drug cards while indicating they were from the government.[2] They tried to obtain personal information.

Recently, according to SCAMS—Senior Counselors Against Medicare Swindlers—the California Medicare Patrol Project, the consumer complaint website, http://ripoffreport.com/ reported having received 700 e-mails complaining about a website called pharmacycards.com that claimed to offer 80 percent drug discounts, listing an address in British Columbia. This company was withdrawing cash from checking accounts from people who had never even heard of the site. While this scandal may be unrelated to the discount drug card issue before you today, it is a reminder that the lure of deep drug discounts, the increasing use of the Internet, and the potential to tap into seniors' checking accounts, can combine to set the stage for possible abuses in the future.

Members of this Committee may remember similar problems that arose in the Medicare supplement insurance (medigap) market in the 1970's and 1980's, prior to the landmark reforms of OBRA 1990. Insurance agents preyed on the fears of vulnerable seniors (and sometimes represented that they were affiliated with the Medicare program) and this often resulted in abuses such as selling one person multiple duplicative policies. When seniors—many of whom have visual or cognitive impairments—are confused and overwhelmed with the choices that they face, this opens the door to predators in the marketplace who are out to make a quick buck at the expense of the vulnerable victim. It is important the CMS aggressively police against this type of preying on the nation's seniors and disabled.

3. Congress must provide resources and make a commitment to help consumers sort out the confusion. The need for this is demonstrated by the fact that even the Federal Government is providing "guidance" that could lead to some beneficiaries enrolling in programs that do not offer the most savings for them.

Will CMS educational materials be part of the solution or part of the problem? Recent materials offered as part of the CMS educational campaign raise serious concerns. On January 8, 2004, CMS released a document called: "Better Benefits—More Choices: Good News About the Medicare Prescription Drug, Improvement and Modernization Act of 2003!"[3] The sheet explains how the Medicare Endorsed Prescription Drug Discount Card will help those who need it most. The final bullet provides this example:

> Beneficiary A needs to fill a prescription for Celebrex. In 2002, an estimated retail price for 30 tablets of Celebrex (200 mg) was $86.28. For a low-income senior, the Act could mean a savings of nearly $22 a month off the retail price and this could be covered by the $600 in assistance. This example is based on a 20% discount off the retail price.

Unfortunately, there are several problems with this advice:

- The government is making no attempt to help people compare the Medicare card savings against other discount options like the Pfizer Share card, for which anyone eligible for the low-income assistance would qualify. In effect, by encouraging beneficiaries to sign up for the discount drug card coverage (instead of other discount programs), the government is benefiting drug companies (who will have lower costs for their subsidy programs) at the expense of taxpayers (who will be bearing the cost of the $600 subsidy).
- In addition, by failing to provide information about lower cost drug alternatives, the government is missing an opportunity to encourage consumers to consider lower-cost non-brand options. The state of Oregon recently conducted an in-

[2] *Phony Medicare drug cards*, Consumer Reports, May 2004.
[3] http://www.cms.hhs.gov/medicarereform/issueoftheday/01082004iotd.pdf.

depth evidence-based drug review for non-steroidal anti-inflammatory drugs (NSAIDSs) for arthritis and pain. The review concluded that "all of the medicines listed [list includes Ibuprofen, Celebrex, and Vioxx] are ***equally effective*** in treating arthritis.[4] The monthly cost of Celebrex was estimated (by AARP) to be $104, while the monthly cost of Ibuprofen (generic) $19.[5] We believe that CMS should help consumers identify lower cost alternatives that are equally effective.

4. The CMS must be vigilant in curbing marketplace behavior that complicates the market and creates financial burdens for beneficiaries who choose the "wrong" discount drug card. CMS must guard against "bait and switch" or other market manipulation.

As you know, companies that offer discount drug cards will be allowed to change both the prices they charge for various medications and the list of drugs that are offered as often as once a week. At the same time, consumers are locked into the card that they select, and are allowed to switch cards only once (during a short period at the end of 2004). This raises the troubling possibility that a diligent consumer will carefully complete worksheets comparing their savings from various discount drug cards, will commit to one card because it offers discounts on the drugs that he/she needs, and then will find that the company offering the card drops the drugs the individual needs from their list of covered drugs. Some have raised the prospects of large-scale "bait and switch" operations. Any consumer who loses discounts on the drug that they need is likely to be justifiably upset about this program. It is essential that CMS monitor the price changes and the drug lists carefully and take appropriate steps. If price changes are large and frequent, or if the drug list drops drugs frequently, then CMS should consider revoking the approval for a card (while protecting existing enrollees). In addition, this is the type of practice that should disqualify a company from serving as a prescription drug plan when the Medicare drug benefit begins in 2006.

5. The CMS should aggressively ***expand*** the role of generics in the marketplace, and police against discount drug cards that steer beneficiaries toward brand name drugs.

We have questions about whether the discount drug card program will adequately encourage the use of generics instead of high-priced brand name drugs. CMS has established 209 drug categories. Generics must be offered in 55 percent of these categories (which, according to CMS, represents 95 percent of the drugs for which generics are available).[6] This means that there will be only brand-name drugs available in 94 categories. We are concerned that the large number of drug categories may unnecessarily limit the inclusion of generic drugs. The Academy of Managed Care Pharmacy argues that fewer categories would have allowed larger discounts; similarly, fewer categories may have allowed for greater reliance on generics.[7]

We are concerned about the potential for drug manufacturers to manipulate the discounts that they offer in these categories to ensure a place on the sponsors' formularies, possibly through large discounts on these brand name drugs. The end result could be patients locked into brand-name drug therapy. We urge the CMS to carefully monitor whether the program in fact steers enrollees to brand name drugs when generics (possibly in other related categories) would be appropriate. We note that manufacturers have supported the CMS approach, while pharmacy benefit managers (PBMs) and pharmacies have opposed it. We would hope that the Medicare website would automatically include comparative pricing information (possibly at reputable websites) for generic drugs *whenever* they are available, even if they are not available through the discount drug card offered.

6. The CMS should compare the discounts available from all discount drug cards with a standard drug-pricing basis such as the federal supply schedule to help consumers compare cards.

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[4] Oregon Health Resources Commission. The review notes that "patients with recent history of bleeding ulcers should avoid using aspirin, NSAIDS **or** COX–2 inhibitors, and that "compared to other NSAIDS, Vioxx and Celebrex may be *less* likely to cause bleeding ulcers in seniors." *See:* http://www.oregonrx.org/OrgrxPDF/One%20Page%20Summaries/OHPR%20factsheet%20NSAIDs1.pdf.

[5] http://www.aarp.org/or/rx/Articles/a2003-10-02-or-rx-arthritustable.html.

[6] p. 69853, Federal Register notice, Medicare Program; Medicare Prescription Drug Discount Card, 42 CFR Part 403, CMS–4063–IFC. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

[7] "Drug Makers Split with PBMs, Insurers Over Coverage of Drug Card," InsideHealthPolicy.com, February 4, 2004.

One troubling reality of the new discount drug care program is the failure of Congress and CMS to establish base reference prices against which the discounts are measured. Families USA has pointed out that "there are also no rules that prevent base prices from increasing substantially quickly." [8] Between January 2002 and January 2003, prices for the top 50 drugs increased at a rate of almost three-and-one-half times the rate of inflation, according to Families USA.[9] Not only should CMS establish a base price for comparison purposes, but it would be helpful if CMS also provided information about how the discount card prices compare with other prices. Beneficiaries who are a short bus trip away from Canada may well be interested in Canadian prices. People who are not eligible for federal programs (such as Medicaid and veterans' benefits) would not be able to benefit from the same low prices for prescription drugs in these programs. Still, they would be interested to know how their prices compare with the prices available to federal purchasers (i.e., the federal supply schedule), and to the VA to cover veterans' drugs (though of course veterans pay modest cost-sharing for this deeply discounted price). These programs can demonstrate to the public the benefits of negotiating for deep discounts and using bulk purchasing power saving money for consumers and taxpayers.

7. The CMS and Congress should pay particular attention to the use of formularies (drug lists) by the discount drug card companies.

Formularies are basically lists of prescription drugs, in this case, for which the discount drug card company will negotiate a discount on behalf of enrollees. (Formularies in the eventual Medicare prescription drug benefit have more far-reaching impact since they determine whether the drug is covered by the enrollee's insurance coverage, and whether any out-of-pocket costs count toward reaching the catastrophic benefit.) One of Consumers Union's concerns about the ultimate implementation of the Medicare Modernization Act of 2003 in the year 2006 is the model that relies on participation by hundreds of insurance companies and health plans in providing the benefit, and their use, in turn, of possibly hundreds of formularies that determine which drugs are covered for enrollees. The intent of the legislation is that these formularies be evidence-based. It is unclear to us, given that all formularies are meant to be constructed based on objective scientific evidence, why there should be scores or hundreds of alternative formularies. In 2006, this will mean that a Medicare beneficiary on one street could have in effect different drug coverage than a beneficiary on the next street. More formularies do not necessarily result in more choice for beneficiaries, who remain at the mercy of decisions of the prescription plans to enter the market in their region. It is unclear what the benefits for consumers are of scores of different formularies/drug lists by each discount drug card. Whether formularies, as determined by the companies offering discount drug cards, serve the best interests of consumers should be monitored carefully throughout this program.

8. The CMS and Congress should apply additional lessons from the discount drug program (e.g., the reliance on evidence-based, scientific findings; changing coverage, changing prices; harm due to consumer lock-in) to refine and improve the Medicare prescription drug benefit that begins in 2006.

Throughout this program that will last approximately one-and-one-half years, there will be issues that may have implications for the drug benefit that begins in 2006. We urge Congress—and CMS—to carefully consider the implications of this program for the future drug benefit. In addition to the use of formularies, Congress should consider whether additional limits should be placed on changes in formularies; prices charged; implications of consumers being locked-in to the plan they choose; the adequacy of choices available in different regions; the affordability of the coverage, and many other elements. This learning period will also be important for the discount drug card companies, many of which are participating with the intent of gaining experience (and market share) that will benefit them when the 2006 benefit begins.

9. The government should aggressively reach out to all those eligible for the $600 subsidy to assure that all who are eligible receive the subsidy, when that's the best deal for them.

Low- and moderate-income Medicare beneficiaries need all the help that they can get to make prescription drugs affordable. It is important that CMS take aggressive steps to be sure that these seniors and disabled enroll in the program that is best

[8] The New Medicare Prescription Drug Discount Card: A Very Flawed Program, at www.familiesusa.org.

[9] Dee Mahan, *Out of Bounds: Rising Prescription Drug Prices for Seniors*, Families USA, 2003.

for them, while minimizing costs to the taxpayer. (As noted above, shifting costs from pharmaceutical company programs to the taxpayers, without extra relief for beneficiaries, is not a good idea). We would hope that the government would minimize the enrollment hoops demanded of beneficiaries, as these restrict access to the programs. For example, we urge Congress to encourage CMS to automatically enroll all current Medicare Savings Program beneficiaries (QMB, SLMB, and QI–1 individuals) in the transitional assistance and special transitional assistance programs without requiring a separate enrollment process.

10. In light of the fact that high prescription drug prices are denying millions of Americans access to needed prescription drugs, Congress should take steps to lower prescription drug prices for all, including those not eligible for Medicare.

In enacting the Medicare Modernization Act of 2003, Congress rejected other pricing models that have successfully saved money for consumers and taxpayers. A 1998 CBO study found that federal facilities paid 58 percent of the average invoice price paid by retail pharmacies for 100 brand-name drugs in 1994, compared with 91 percent for hospitals and 82 percent for HMOs.[10] In other words, federal facility prices were 29 percent lower than HMO prices, a substantial savings. More recently, through the use of an evidence-based formulary and volume discounts, the Department of Veterans Affairs is able to achieve discounts well below the federal supply schedule prices, which are already among the lowest prices in the market.[11]

Another high priority for prompt Congressional attention (and the topic of an FDA task force) is the issue of legalization of reimportation of prescription drugs from other countries. Consumers Union believes that in light of the urgent need for relief from high prices and the reality of reimportation that is underway, Congress has a responsibility to help ensure the quality and safety of these medications in order to protect those consumers who are reimporting drugs. The lower prices from reimported drugs make the difference between many consumers being able to get needed medications and going without. The use of licensed brokers, with strict quality controls, as currently done successfully within Europe, is one model that should be carefully considered. Congress and the Food and Drug Administration should move forward expeditiously to make safe and fairly priced drugs available to U.S. consumers.

At the same time, it is important that the Congress recognize its responsibility in using market forces where possible to provide better value to taxpayers and consumers for prescription drug values. Oregon has done pioneering work that studies the scientific evidence about clinical effectiveness as a basis for the selection of drugs in its Medicaid program. The Medicare Modernization Act of 2003 includes a provision in section 1013 that calls for further synthesis of medical evidence about the comparative clinical effectiveness of alternative prescription drugs by the Agency for Healthcare Research and Quality. This important provision should be funded promptly and implemented soon to provide consumers and government programs with the scientific basis, and analysis, to make sound decisions based on evidence, reducing the impact of decisions that are based on an incomplete picture that is often presented in direct-to-consumer advertising.

Conclusion

The challenge of assuring that Medicare beneficiaries (and all Americans) have access to affordable prescription drugs is daunting. The discount drug card program that will soon go into effect may offer beneficiaries modest relief (especially for those eligible for the $600 subsidy). However, the program is fraught with potential problems: beneficiaries will be confused and bad actors will try to take advantage of their confusion. The Congress and the Administration should guard against marketplace manipulation, encourage the use of generics, provide a standard basis for evaluating the discounts offered, monitor the use of formularies, and aggressively pursue other steps to help all Americans have access to affordable, safe medicines.

[10] p. 25, *How Increased Competition From Generic Drugs has Affected Prices and Returns in the Pharmaceutical Industry*, Congressional Budget Office, July 1998. *See also:* p. 155–156, and footnote 17, Huskamp, et. al., "The Impact of a National Prescription Drug Formulary on Prices, Market Share, and Spending: Lessons for Medicare?" *Health Affairs*, Vol. 22, No. 3, May/June 2003.

[11] Description and Analysis of the VA National Formulary, Institute of Medicine, 2000.

Chairman JOHNSON. I thank the panelists very much. Ms. Shearer, I think your idea that we watch these plans and learn from them and draw some standards for those who participate in 2006 is a very worthy comment. Surely if we see plans getting in and actually moving their prices a lot, that may very well not be a plan we want to be a permanent participant in the drug plan. So, I am sure you will be active in helping us watch performance. Certainly, what you do is more important than what you say, and we do need to watch carefully the performance of the plans as we look to the more permanent plan of 2006. It certainly is too bad that 23 million aren't taking statins they should. That is part education. These discounts will help. When the big plan comes in place, it is not just discounts, it is also a 75 percent subsidy for the majority of seniors. So, we should be making very good progress in that direction.

I am not quite as concerned as you are about the senior confusion because I have watched literally every senior center in my district learn exactly how to order drugs from Canada in a hurry. So, there will be a lot of good resources out there. I am sure every congressional office will work in their area as long as the—as well as the federally funded educators. I think the development of comparative pricing capability is very important in the long run, and we did make a step forward in this bill in that direction. I think your organization and others can help us on that as we go through this, and we can look back and then see what are the additional tools we need.

Mr. Nelson, let me just ask you a comment briefly, or ask you—I am really impressed that, first of all, the changes in the bill have had such a beneficial effect for your participants in your Medicare formerly Choice Now Advantage Plan, but I am particularly interested that you are using the discount card to give people access to other portions of your plan. Now, as I understand it, the discount card is only eligible to the people in your plan.

Mr. NELSON. That is correct.

Chairman JOHNSON. So, presumably they did have access to these things beforehand.

Mr. NELSON. Actually, the drug benefit programs that we offer with our Medicare Advantage plans vary by county. So, for example, in Oregon, and one county in Washington, we have a demonstration PPO plan. We have about 4,000 members there. However, a drug benefit is not available to them through this—through our demonstration PPO product.

Chairman JOHNSON. So, this will give a uniform access all across your plans except in those plans that already have the richer benefit.

Mr. NELSON. Correct. However, the transitional assistance program will apply to individuals in our plans where a drug discount, or where a drug benefit does exist. It will help with the copays, out-of-pocket expenses, and then it will also help when they reach their limit, which a lot of our drug benefits have.

Chairman JOHNSON. I do want to comment on the fact that you are hooking them into this Decision Power Disease Management Program, because I think that kind of advice, and you describe it as a coach, is extremely important. If now your seniors have access

not only to health care, but to prescription drugs and have a chronic illness, using that coach, they will be able to really dramatically improve their health and reduce their costs. So, I was very glad to see that connecting up so early. So, by June, many will have much, much better access to disease management. Ms. Rawlings, I really am impressed with the research you have done and the quality of the product you are putting out there. I don't quite understand—can you tell us anything about what the average discount will be? Is there some goal you have? Will it vary tremendously per drug?

Ms. RAWLINGS. I think the best way to explain it is this. Our discounts, in terms of the specific question on the range, I think that public information we have discussed is ranges between 10 and 25 percent on different drugs during—through different processes it may be even a little bit higher. We are not sharing specifics just because we will be in a competitive environment, and until we are ready to launch, we frankly would like to keep our position a little secure. We chose to offer this card nationally to offer broader access to the millions of people who do not have an existing benefit today, and we felt by offering compelling discounts as I just mentioned, that we can expand access and create greater awareness of the drugs that are available and make them more affordable for people to receive them.

Chairman JOHNSON. I also understood in your testimony that you mentioned that the General Accounting Office has reported that pharmacy benefit management techniques, which this bill does allow, used by health plans in the FEHBP have resulted in savings of 18 percent for brand-name drugs and 47 percent for generic drugs. So, we can, I believe, hope that these discount cards, which is only the first step and doesn't involve quite as many price-cutting tools as the full bill allows, in this first step, because of the competition, there are multiple plans, that we will see discounts that will be 10 percent and much deeper.

I would—I think it didn't come out clearly earlier when we talk about the market, what we are really saying is that if a senior calls up and they find out that this company gives them a 1 percent discount at this drug store, they are unlikely to sign up with that company. So, your job will be to make sure—make clear to seniors kind of what general discount they get across the drugs, and then which particular drugs they get a really good deal with you, and to make sure that that discount gets down to the local pharmacist in their area that they choose to deal with. Is that a fair statement?

Ms. RAWLINGS. Yes, it is. If I might add, Madam Chair, I—our plan, the way our network—we have a national network in place to support this card, and they are negotiated. The discounts are negotiated on a pharmacy basis and apply to all drugs that would be purchased through that particular pharmacy all around the country.

I think it is an important point to note that—and you mentioned this a moment ago—that this particular program is an excellent first step toward moving to 2006 when the Medicare Advantage program offers broader choices and hopefully much broader participation around the country which will enable companies like Aetna

to more fully integrate our disease management and care management programs across the country.

Chairman JOHNSON. Your card, unlike Mr. Nelson's card, is not available just to those who participate in some of your senior integrated care plans, but to all seniors, correct?

Ms. RAWLINGS. That is correct.

Chairman JOHNSON. Inside and outside of that network.

Ms. RAWLINGS. That is correct. If I could also add one point to that. When we did the research and did the focus groups in the three States that I mentioned, the probably most significantly shocking thing to me was that most folks were not all that aware of reform, which surprised me. Secondarily, they were all acutely aware of what they were spending on their pharmaceuticals. The majority of the folks in the room were on varying types of insurance or on traditional Medicare, and all seemed to be quite conscious of the fact that they would weigh the premium, whether there is one or not or what the level is, versus what discounts they would be able to achieve with that card and make a decision that was a very individual one.

I think the fact CMS mentioned they would have the pricing tool available on the web, I agree with you on making a clear comparison between brand and generics is an excellent service for these folks. I think all of the—my colleagues and competitors and all of us will have every interest to make sure that these folks feel like they are able to make a good, clear decision for what is right.

Chairman JOHNSON. It is disappointing when a senior can bring to you, who has done comparative shopping, something that shows that one pharmacy was going to cost them $93 for exactly the same prescription that someone else was going to charge them $20 for in the same shopping area. So, it is going to be important not only for people to understand what your discounts are, but what the price effect is going to be, because 40 percent off of $93 is not as good a deal as 40 percent off of $20. So, thank you. Mr. Stark.

Mr. STARK. Thank you, Madam Chair. Ms. Shearer, in your opinion, how much of a discount might Medicare enrollees receive, and how—again, in your opinion—do you suppose the Medicare discount cards will compare with discount cards that are already out in the market, which many seniors already have. Pfizer Inc. has one if your income is below $28 thousand, I think, for certain drugs. How will this proposed Medicare drug card compare with what is already out there?

Ms. SHEARER. Congressman Stark, I wish I could give you a definitive answer. Let me just talk briefly about the cards that are on the market. When Consumer Reports has looked at them, and I am thinking really about the general discount drug cards, we have found that for the most part people are better off just doing some pretty aggressive shopping around. They don't save additional money; that the potential savings are very limited. I can't really estimate what the level of discount will be under this program.

I am concerned, though when you look at the numbers, CMS is estimating about 7.3 million enrollees in the first year and 7.4 million in the second. If there are about 100 companies—I realize there could be somewhat less—it comes to about 700,000 per card.

I just question the economic analysis that leads to the conclusion that this kind of purchasing is the bulk purchasing that can lead to really significant discounts. Just in summing up, I am reminded of back in the days of the Kassebaum-Kennedy bill (P.L. 104–191) when that was enacted with great fanfare, that an estimated 25 million people were going to benefit, and now I am hearing words like up to 25 percent. Honestly, I am skeptical about the savings on average. I mean, I think we would be lucky if they were 10 percent on average.

Mr. STARK. Kaiser has about 600,000 or 700,000 enrollees in my county in California, and they don't anticipate that they can provide significant discounts as big as they are. Had I been able to talk some more with our previous witness, I would have pointed out that the Secretary is supposed to require that card sponsors have business integrity in the contracting regulations, and Medco isn't here, but they have paid settlements of $2 million and $45 million for improper business practices. Aetna, some time ago was part of a class action that forced physicians to enter into economically unfavorable contracts, imposed unnecessary administrative burdens on providers, improperly denied claims in whole or in part, and did not pay their claims in a timely manner, or did not pay them at proper rates. I am just curious, Ms. Rawlings, how did the Secretary determine that your company had good business integrity, given that record?

Ms. RAWLINGS. Well, I can't speak for them. I will give you my view. I think first and foremost we have settled that lawsuit and have changed our leadership over the last several years to build strong relationships in the communities with our physician and hospital partners, and I think have made significant progress in reestablishing ourselves.

Mr. STARK. So, you have changed.

Ms. RAWLINGS. We have changed.

Mr. STARK. Good. Mr. Nelson, then let me ask you just one question, and my time will expire. Tell me if I am wrong, but it is my understanding that you are not going to charge the $30 enrollment fee.

Mr. NELSON. Correct.

Mr. STARK. So, you are not going to make any money on that.

Mr. NELSON. Correct.

Mr. STARK. If you get a million enrollees, and you are one of the bigger providers, using the Consumers Union estimates of 700,000 enrollees per card, you may get a couple million people, how are you going to make any money? Where does your profit come from, if you don't charge the fee for enrolling people? You have to get some kickback or share in the discounts which you keep and don't pass through to the cardholders; is that not correct?

Mr. NELSON. That is not correct.

Mr. STARK. How can you make a profit in this?

Mr. NELSON. The idea of adding additional benefits for our beneficiaries is, believe it or not, very exciting to us. It is an opportunity to do three things: extend a drug benefit to all of our enrollees; to offer the opportunity to participate in transitional assistance; and then, third, at least—or last but not least important is the opportunity to connect them into our pharmacy management

system so we can interact with them and do all the things that our industry and our company is—has become very skilled at over the years.

Mr. STARK. So, only your existing members can join your card.

Mr. NELSON. That is correct.

Mr. STARK. Aetna, how will you make a profit, with your card being open to anyone who wants to enroll?

Ms. RAWLINGS. That is correct.

Mr. STARK. Where does the revenue come in? Mr. Nelson will get it through outreach and perhaps marketing, but where will your profit come from? How do you make money on this?

Ms. RAWLINGS. Well, our view on this card is something I mentioned earlier, is that it is a tool for Aetna to demonstrate to the broader country, if you will, our commitment to the Medicare program and our desire to broaden prescription drug access.

Mr. STARK. Okay. In the past both of you have dropped members from your managed care plans when you weren't making money on them. So, I don't suspect that you are going to operate a plan that doesn't make money over time.

Ms. RAWLINGS. Well, I think the way I would explain it is simply, and being conscious of your time as I can, is that we have every interest in broadening our participation in the Medicare program, and we feel, as I mentioned earlier, that the Medicare Modernization Act made significant changes to the program around aligning costs with trend that enables us to stay in.

I think secondarily, because of the strains that have been on the program over the last several years, and you just mentioned this, the industry and Aetna specifically have gotten much, much greater understanding of how older consumers access care and how we can best serve them. A lot of that is through disease management and care management programs that we offer as part of our basic package. The Medicare prescription drug discount card is a means by which Aetna can launch a card and serve hopefully as many millions of beneficiaries who would like to enroll, at the same time learn about them, contribute to the value of their pocketbook and enable them to learn about Aetna and the new programs available for 2006.

Mr. STARK. Do you ever anticipate that you will be able to deliver managed care for less than the fee-for-service fees that we pay for the Medicare standard benefit?

Ms. RAWLINGS. Well, it is a hard question to answer clearly because the fees move all over the place. What I can tell you is that we believe with an integrated approach that it involves disease management and care management, understanding where people have risk, and bringing them into the system, which is contrary to normal, or to some opinion, that you can actually balance the scales and lower costs over time while creating greater value. So, I can't really answer it specifically, but we do believe we bring the industry and us specifically brings great value through the integration of the health care system.

Mr. NELSON. Congressman Stark. If I might add to that, we are very proud of what we do and what we contribute to the health outcomes of the seniors that we serve. There is plenty of evidence out there that we provide additional choices, lower-cost care and

better outcomes than the fee-for-service counterpart. So, I don't think there is really a question that we are capable of delivering better results.

Mr. STARK. We will see, I hope. You may be right. Thank you, Madam Chairman.

Chairman JOHNSON. Thank you, Mr. Stark. Mr. McCrery.

Mr. MCCRERY. Thank you. Ms. Shearer, I understand and recognize that your organization doesn't think that the legislation we passed last year goes far enough or provides enough help to seniors with their prescription drug needs. I think that is pretty close to what you stated in your testimony. However, don't you think that the legislation will provide significant assistance to a large number of seniors?

Ms. SHEARER. Well, there is no question——

Mr. MCDERMOTT. I am not talking about the 2006 program. I am talking about this drug card and the transitional assistance.

Ms. SHEARER. The $600 subsidy is a significant subsidy to those who will get it. I am not optimistic that the discount drug cards are going to yield the kind of savings that you would like, we would all like to see. I am happy to talk about other issues, but I think you really wanted me to limit it to the discount drug card.

Mr. MCDERMOTT. The $600 transitional assistance.

Ms. SHEARER. Yes.

Mr. MCCRERY. I mean, the drug card, we don't know what level of discount those are going to produce, and I admit that. Based on my own personal experience and the free market that is out there right now, I can tell you that there are significant very large discounts available from retail. You said, well, we have found or research has found that in most cases seniors can just do smart shopping and do just as well as buying one of these discount cards. Well, that was not my experience. We tried to do smart shopping. We were somewhat limited. My stepmother lives in a small town, and so our choices were limited at least in that geographic area, but we did try. This card that I ended up getting her into has just been a godsend to her. It has saved her a huge amount of money. So, my personal experience does not comport with your research, at least not as you described it today.

Ms. SHEARER. If I could just say, Congressman, I would really urge the Committee to make sure that CMS does careful analysis, because I think we all would like to know what the savings are, and the methodological challenges of measuring the savings are not very easy, because there are lots of different prices you could measure against. I think we need to design that study very carefully. I think we would all be interested in knowing just what level of savings are achieved.

Mr. MCCRERY. Yes. No, there is no question that it is hard to pinpoint a price in this market, as large as it is and as many points of delivery as there are. There is no question that is very difficult, if not impossible. I will be glad to give you the list of my stepmother's drugs, which were extensive, and tell you what she was paying at the drugstore and now what she is paying with her discount card. It is pretty plain to see the savings. Then the $600 subsidy to low-income seniors clearly is a very good benefit. It may not be enough, but it is certainly enough to provide those low-income

seniors who need a statin with a statin at retail. Never mind any discount they might get. Retail. They can get a statin, these days, for $600 a year. They can get two maybe.

Assuming that you agree with me that this legislation does help seniors to at least some degree, my question is, what is Consumers Union going to do to let seniors know what is out there, what is available, what to be wary of in the market, those kinds of things, or are you going to do anything to help seniors take advantage of this help that is now going to be available to them?

Ms. SHEARER. We have some possible projects under development. Like any organization, we need to figure out what the business model is, how we are going to produce them, who would do them. We are considering various things. I can't really say more, but we would like to help get the word out about just what the choices are in the marketplace. It is not clear exactly where that will all lead, but we are considering things.

Mr. MCCRERY. Okay. Good. Do you have anything already on the books? Since we only have 2 months until the seniors can start making choices. Have you done anything yet?

Ms. SHEARER. No. No, we have not. I mean, we are an organization a little bit different than many that are helping. We produce Consumer Reports. We have a Washington office. We do advocacy. We don't have a large niche in the marketplace to help seniors get this kind of information. So, this is a new area for us to consider. So, we are——

Mr. MCCRERY. Oh, I see press reports all the time citing Consumer Union. You could do a lot. You could hold a press conference. You could put in your Consumer Reports magazines, all kinds of things that you could do. I hope that you will help seniors, because your organization does claim to be looking out for the interest of consumers and regular folks, and so I hope that you will use all of that power to inform people and help them.

Chairman JOHNSON. Thank you, Mr. McCrery. I thank all the panelists. I would say, it could be very helpful to us, Ms. Shearer, if your organization—you worked with us. I have reviewed a number of things you have said about the bill, and they are quite factual and accurate, so, I would like to work more closer together so that you are working from, I think, more substantial data about the bill, because we can do our seniors in America no greater harm than confusing them, and some who could get really good benefits won't. Others will make poor choices. There isn't anyone—first of all, this is all voluntary. There isn't anyone who is going to do worse with one of these cards than without any card. So, what we need to do is help seniors understand what their options are and how important shopping is, just like it is important in food or any other area. So, I would very much like to work with you, having relied on Consumers Union some periods of my life quite heavily. I would have to say that I have been distressed as I sit and review materials that you put out that there is a lot of factual inaccuracies, and so I would like to work with you at the beginning and not at the end.

It is very nice to have you here to talk about your concerns, which are real, and legitimate, and the depth of research that the companies have done to get into this market, and I would say noth-

ing was more discouraging than to watch some of the Choice plans withdraw, because they invested big money to get in. It is hard to put a product on the market and then not have it do well. I think everyone has the intention of making this all work, and I think working together, communicating aggressively to our seniors, helping them understand this isn't everything, this is merely a step, but I think together we can make a significant difference in the costs of drugs and the availability of medicines for other seniors in the next few weeks. I am pleased that this bill has had a near-term as well as a long-term impact for our seniors. Thank you all for participating today.

[Whereupon, at 4:30 p.m., the hearing was adjourned.]

[Submission for the record follows:]

Statement of AARP

On behalf of AARP's more than 35 million members, we thank you for holding this hearing on the new Medicare-endorsed prescription drug discount card program. AARP has consistently supported a discount card program as a building block for a full Medicare drug benefit. The discount card program will provide some help with drug costs right away by providing modest discounts for people who now pay full retail costs. It will provide additional help to those who need it most by providing a $600 credit on the cards in 2004 and 2005 for those with limited incomes. We are pleased to see this process now underway.

As we move forward, it is clear that we face significant challenges in educating beneficiaries and helping them to enroll in this program. This is especially true for those with limited incomes who qualify for the card programs' $600 annual transitional assistance. AARP is working through a broad coalition—the Access to Benefits Coalition for Prescription Drugs—to conduct hands-on, grassroots outreach efforts.

We believe success of the transitional assistance program could be greatly enhanced by removing regulatory barriers that were not mandated by the statute. Removing these barriers could expand eligibility and ease or even guarantee enrollment of many eligible people.

Education and Enrollment Challenges

Educating beneficiaries and helping them to enroll in this program is a significant challenge. There will be many cards to choose from, each with different discounts, formularies, enrollment forms, and marketing campaigns. The challenge is not one of lack of communication but of information surfeit. The potential for confusion and miscommunication is substantial.

We will need to explain honestly to beneficiaries that the discounts provided by the cards are expected to be modest, averaging probably 10 to 15 percent off of full retail brand prices. Many beneficiaries already receive discounts of that magnitude, and it will be important to help people evaluate whether they would benefit additionally from the card program.

Those who can benefit will need help in determining which card would help them the most. Some cards may have tightly limited formularies that provide greater discounts on a smaller number of drugs and thus may be better for those who rely on a limited number of those specific medications. Other cards may have broad or open formularies that provide discounts on a wide range of drugs, which is an option that some beneficiaries may prefer. And each card will have its own network of retail pharmacies, requiring beneficiaries to determine whether they can use a given card in their neighborhood or at a favorite drug store.

Medicare is launching a broad education campaign and will be providing individual assistance through its 1–800 Medicare hotline and through a web-based tool to help individuals evaluate specific card options. These are valuable tools for assisting people in understanding the program and their specific options. However, they will bring beneficiaries only up to and not through the enrollment process. Beneficiaries will need to take an additional step on their own in finding, filling out, and submitting the right enrollment form for the card of their choice.

Transitional Assistance is a Special Challenge

Perhaps the greatest opportunity—and challenge—is reaching those eligible for the $600 annual transitional assistance credit. People eligible for this program have

limited incomes—below 135 percent of the federal poverty limit—and in most cases no other drug coverage. These are the people who most need help with prescription drug costs.

Outreach may be particularly challenging for beneficiaries in this population, as they may face the greatest barriers to learning about, understanding, and enrolling in the drug card program. Previous efforts to reach these same people have had very limited success. For example, virtually all of those eligible for transitional assistance are eligible for one of the Medicare Savings Programs (known separately as the QMB, SLMB, and QI1 programs) that help pay Medicare cost-sharing requirements. Yet less than two thirds of those eligible for these programs are enrolled.

It is clear that simply doing the kind of outreach that has been done before probably will not be enough to ensure broad enrollment.

ABC Coalition

Because the challenge in reaching those eligible for transitional assistance is so great, we are working through a broad coalition—the Access to Benefits Coalition for Prescription Drugs—to target them through hands-on, grassroots outreach efforts.

The Coalition includes more than 40 groups representing beneficiaries, providers, and others that can help find, educate, and enroll eligible people in the program. The goal of the Coalition will be to ensure that all low-income beneficiaries know about and benefit from the discount card, as well as other available resources, for saving money on prescription drugs.

Coalition plans include a national media campaign and production of toolkits to help outreach workers explain and assist in enrollment. We also will organize, analyze and share knowledge about best practices and cost effective strategies that overcome barriers in reaching this important population.

Removing Regulatory Barriers

In addition to grassroots outreach efforts, odds for success of the transitional assistance program could be greatly enhanced by removing regulatory barriers. Specifically, we believe the following changes in regulations issued by the Centers for Medicare and Medicaid Services (CMS) should be made:

- *A universal enrollment form* should be authorized. Currently each card sponsor will have two different application forms, one for those who do not qualify for transitional assistance and another for those who do. This means local community outreach workers providing one-on-one help in evaluating cards and completing the application forms will need to carry around dozens of different forms. That will be unmanageable, with great potential for confusion and error. A universal application form that could be used to apply for different drug cards by checking off a box for the chosen card sponsor would greatly increase their ability to be effective.
- *Automatic enrollment for people in Medicare Savings Programs* should be conducted. People eligible for transitional assistance are by definition eligible for these programs. They are very difficult to reach through traditional outreach efforts, as experience has proven with less than two thirds of all eligibles enrolled. Automatically enrolling people in Medicare Savings Programs into the discount card transitional assistance program if eligible beneficiaries do not choose a card after a specified time period, while still giving them an option to decline or change enrollment if they wish, would ensure that millions of difficult-to-reach people will receive this benefit.
- *State pharmacy assistance programs* should be allowed to directly enroll their members when they already have the information necessary to determine eligibility. Many of these state programs already have income data telling them which of their enrollees qualify for transitional assistance. These state programs also are eager to maximize enrollment in transitional assistance—again while giving individuals the option to decline or change enrollment—because it will help stretch their own resources in these continuing times of state budget shortfalls.
- *Family size definitions* should include entire household size. The legislation authorizes transitional assistance for beneficiaries below 135 percent of the federal poverty level. However, CMS regulations exclude many people who are below 135 percent of poverty by stipulating that income eligibility be based only by whether a beneficiary is married or single. They do not take into consideration any dependent children or grandchildren that may also be a part of a beneficiary's household, even though these dependents can be a significant drain on a low-income family's resources, and as part of the household increase the amount of income that falls below 135 percent of poverty. For example, a mar-

ried couple raising two grandchildren under the new 2004 poverty guidelines can have an income of up to $25,448 and be under 135 percent of poverty, which is substantially greater than the $16,862 allowed for this same household to qualify for transitional assistance under the CMS regulation.

Conclusion

The Medicare-endorsed drug discount card program is important as a bridge to the overall effort to enact a comprehensive Medicare drug benefit. The transitional assistance component for those with limited incomes is particularly important because these are the people who most need help. Yet some program complexities could create significant amounts of confusion.

We believe that the changes outlined in our statement will help to make the program run more smoothly. Educating and enrolling people—especially those eligible for transitional assistance—will be a substantial challenge. Simply engaging in traditional outreach methods—particularly for a program designed to last only 18 months—will likely fall short. It is critical that we all work together to conduct the outreach efforts and take the regulatory steps that are essential for this program to be a success.