MEDICARE REFORM: PROVIDING PRESCRIPTION DRUG COVERAGE FOR SENIORS

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MEDICARE REFORM: PROVIDING PRESCRIPTION DRUG COVERAGE FOR SENIORS

THURSDAY, FEBRUARY 15, 2001

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

The subcommittee met, pursuant to notice, at 10 a.m., in room 2123, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Upton, Greenwood, Burr, Ganske, Norwood, Shadegg, Pickering, Bryant, Buyer, Tauzin (ex officio), Brown, Waxman, Strickland, Barrett, Deutsch, Stupak, Engel, Wynn, Green, and Dingell (ex officio).

Staff present: Anne Esposito, professional staff member; Tom Giles, majority counsel; Kristi Gillis, legislative clerk; Bridgett Taylor, minority professional staff member; and Amy Droskoski, minority professional staff member.

Mr. BILIRAKIS. The committee will come to order.

As per committee rules, the chairman and ranking member will have 5 minutes for an opening statement. Other members of the subcommittee will be limited to 3 minutes; a solid 3, I might add.

I now call to order this first hearing of the Health Subcommittee in this, the 107th Congress. I would like to start by welcoming our witnesses and all of the subcommittee members, particularly our new members, none of whom are here, I believe. Mr. Buyer is here. I guess this is an appropriate time for me to say that since there are no votes on the House floor today, I thank my subcommittee colleagues for staying in town today to participate in this important hearing. Although when we take a look around, we don't see that too many have so far.

I am pleased to be working again with my good friend Congressman Sherrod Brown as the ranking member, and he should hear that. I also want to take this opportunity to recognize the vice chairman of the subcommittee, Congressman Charlie Norwood, whose help and support I greatly appreciate.

I am excited by the challenges before us in the current session. This subcommittee's jurisdiction includes a broad range of health concerns, as we know, including Medicare, Medicaid, health insurance, public health, food safety, and pharmaceuticals. Under the leadership of Chairman Tauzin, I am confident that the Energy and Commerce Committee and this subcommittee in particular will play a leading role in the health care debate. We have a busy year

before us. By working together, and I emphasize that, we can significantly improve the quality of health care for all Americans.

The topic of today's hearing is Medicare Reform: Providing Prescription Drug Coverage to Seniors. The title underscores a critical point; namely, that there is a clear and necessary connection between adding a prescription drug benefit to the Medicare program and broader reforms to protect and strengthen Medicare for the future.

Before we expand Medicare to provide a costly new benefit, a necessary new benefit, in my opinion, we must ensure the program is standing on solid fiscal ground. A benefit promised but not delivered, of course, is no benefit at all. I am determined to protect the long-term solvency of this very vital program.

In the last Congress, I proposed a State-based prescription drug plan to help seniors in greatest need. I remain determined that we help the poorest and sickest beneficiaries obtain the medicines they need, should broader reform efforts be delayed. But I am hopeful that there will not be delays, that the present Congress can reach agreement on a plan to reform Medicare and establish a voluntary prescription drug benefit for all Medicare beneficiaries. This hearing is the first in a series designed to lead us toward accomplishing that goal.

This is meant to be an educational hearing for members of the subcommittee and the public. We have all heard the numbers. Roughly 65 percent of Medicare beneficiaries have access to some form of prescription drug coverage.Today we will hear more about the ways in which beneficiaries are currently obtaining prescription drugs outside of the Medicare program.

Our panel will begin with Mrs. Sylvia Kessler, who has traveled from my home State of Florida to be here today. Thank you so much for joining us, Mrs. Kessler, and I wish we could welcome you and the others with better weather—although it is not as bad as it was yesterday. The panel will also include representatives from a Medicare+Choice plan, the Medigap plans, a chain drug store, an employer-sponsored plan, a State prescription drug assistance program, and the Kaiser Family Foundation. I would like to again offer a warm welcome to all of our panelists.

I look forward to a productive hearing which can shed light on how various coverage programs are structured and how they operate. By reviewing ways in which current prescription drug delivery systems are modeled, we can learn from their successes and their difficulties. However, we are not focusing, and I want to emphasize that, we are not focusing today on specific legislative proposals.

As Members know, this subcommittee has a strong record of working on a bipartisan basis to tackle difficult legislative issues, and I am hopeful that we can advance a bipartisan plan to improve prescription drug coverage for Medicare beneficiaries. By reaching agreement on an answer to this very difficult question, we can also help advance broader efforts to preserve and strengthen Medicare for the future.

In closing, I want to again thank our witnesses for their time and effort in joining us today.

I now recognize the ranking member Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. It is a pleasure to again serve with you as Chair in this 107th Congress. I am glad you are back as the chairman of the newly reconfigured Health Subcommittee. I would like to thank Diane Rowland and other distinguished witnesses for joining us today.

Access to prescription drugs is fresh on my mind because I just received a letter from a Medicare beneficiary who needs medicine for his prostate cancer. His Medicare+Choice plan made two changes effective January 1 of this year. Premiums went up $350 per year, and brand name drugs are no longer covered, period. There is no generic version of the drug that my constituent needs.

I received another letter from the frantic daughter of a woman whose Medicare+Choice plan dropped prescription drug coverage altogether. Her mother's prescriptions cost more than $300 per month. Neither mother nor daughter can afford that.

I received a letter from a woman whose employer-sponsored retiree coverage dropped its prescription drug plan. My constituent didn't know she lost her drug coverage until she tried to fill the prescription. That prescription is still unfilled.

I have heard from seniors who had to give up their Medigap coverage when premiums spiked upward, from seniors who joined the Plus Choice plan explicitly for the drug coverage, only to have that coverage ratcheted down or eliminated altogether; from seniors whose drug coverage is so skeletal they would be better served putting the associated premiums in a savings account.

These stories, which resonate with my colleagues on both sides of the aisle, are not an indictment of Medigap or of Plus Choice plans or employers or any other source of drug coverage, but they are an indictment of partial solutions. The status quo is a mishmash of partial solutions. More than a third of Medicare beneficiaries, as all of us know, have no prescription drug coverage, and even more than that, of the two-thirds that have it, more than that have coverage that simply isn't dependable and is being oftentimes scaled back.

The President's immediate Helping Hand proposal is another partial solution, and it would leave out nearly half of those who now lack prescription drug coverage.

The stories our constituents share with us are an indictment of this Congress's, of our continued failure to add prescription drug coverage to the basic Medicare benefit. Medicare is reliable, Medicare is universal, Medicare is a large enough insurance pool to accommodate the risk and manage the costs associated with prescription drug coverage.

Medicare came into being because half of all seniors in 1965 were uninsured. Now, more than a third of all seniors are uninsured, and many more underinsured for prescription drugs. Medicare prescription drug coverage as opposed to State assistance programs or private coverage for prescription drugs means stable benefits over time and means coverage that does not leave any senior worse off than that senior's neighbor in a different county or a different State or a different income bracket or a different health status.

Medicare prescription drug coverage has been demonized by many in this institution and others outside the institution as a one-size-fits-all program. This argument is spurious. The people that

make this argument, that make this assertion know that it is spurious. The kind of choice that is important when it comes to prescription drug coverage is choice of pharmacy, choice of prescription drug, choice between brand name and generic drugs, access to the right drugs, even if it is not part of the standard formulary. That is the kind of choice a Medicare drug benefit can provide to every senior, not just those lucky enough to afford a Cadillac private insurance plan.

I am confident, Mr. Chairman, that today's hearing will be informative and helpful. I am equally confident that what we hear today will reinforce the argument for a universally available Medicare drug benefit. Those of you who have observed this committee and know me probably are surprised that I haven't raised the issue of prescription drug prices or the related issues of direct-to-consumer advertising and patent extension, or tax cuts which put us in a straightjacket which makes it difficult to afford the kind of coverage that Americans deserve. In the interest of time, I will get to these issues when it is time to ask questions of the witnesses.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. And the Chair appreciates that.

I now yield to Mr. Norwood, the vice chairman of the subcommittee.

Mr. NORWOOD. Thank you very much, Mr. Chairman, and congratulations to you, as we are all pleased to follow your leadership on this very important subject. As a present to you today, I want you to know that I am here to listen and not talk, so I am going to be very brief. I know that is different, but I am grateful to all of you for coming so far, many of you, and I think that is exactly what we need to do. I want you to know we do listen to you, and what you say today will be carefully noted and help, as this is the—probably the opening salvo of the great Energy and Commerce Committee as we try to work out a prescription drug plan and help the President fulfill his campaign promises. I have great faith that this is the year we are going to get it done.

So I thank all of you for being here and give it to us, because that is what we are here to do today.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Dingell for an opening statement.

Mr. DINGELL. Mr. Chairman, thank you, and I commend you and Chairman Tauzin for beginning this Congress looking at one of the most pressing problems facing the people of the country. Millions of our seniors and disabled who depend on Medicare for their health coverage lack affordable coverage for prescription medications. The situation facing Medicare beneficiaries with respect to prescription drugs today is not unlike the situation they faced with respect to insurance coverage in 1965. Indeed, this is the one crucial reform in the Medicare program which we need to pursue.

Currently, there are a patchwork of stopgap measures available, from retiree coverage to Medigap to voluntary State assistance programs. But there is one thing clear about the whole business: None of them adequately fills the void, and our senior citizens confront a very serious and difficult problem as a result.

What we need is a uniform Medicare benefit that seniors and the disabled can depend upon; no nonsense about how we are going to give money to States, who might or might not give it to HMOs, who then might or might not pass it through. This is a formula for wasted money and loss of opportunity to help people who are in desperate need.

So the question we must examine today is how can we best do what must be done. I would like to suggest a few basic points to guide our thinking. First, the system must be reliable. Competition is a nice word, it is a buzzword, I use it, we all use it. Experience with Medicare+Choice, however, has shown that it certainly does not result in any dependable or stable product upon which seniors may rely. So unless we are willing to dump billions of dollars of overpayments into a system on an annual basis, that assuredly is not going to reach most of the people in need. This kind of idea must be rejected.

Second, the benefit has to be defined. The Congress needs to know who is getting what, who is paying for it, and what the level of benefits might be. Seniors need to know exactly what they can count on. Employers and others who provide supplemental coverage need to know exactly what they are supplementing. I will point out to all that Medicare is an intricate, involved, and essential part today of industrial retirement plans and industrial retirement health plans. It is even a part of our Civil Service retirement. States and almost every unit of government that has a retirement system includes this as a part of a wraparound program in which benefits are provided, dependent in heavy part upon Medicare.

We do not need to return to the old days of Medigap scandals when seniors were being sold a pig in a poke and when all kinds of scoundrels profited mightily at the expense of senior citizens and at the expense of the Federal Government, which was regarded as a generous giver who did not supervise.

Third, the benefit must be affordable for seniors and the disabled. That has to include premiums and cost-sharing. A benefit that no one can afford is no benefit at all. I would note also a benefit that doesn't cover adequately is also no benefit at all.

Mr. Moroni, who is assistant director of General Motors Health Plans, will tell us how GM works to ensure that a benefit is affordable to their members. Other companies in the auto industry and in the American industrial community are doing similar things, and they deserve commendations for their efforts in this matter, but they also need us to help them fill out a plan which will better not only those retirement plans, but the beneficiaries of those retirement plans.

Finally, we need to remember why we are in this business. Congress is now discussing a Medicare prescription medication benefit because there is a pressing, urgent need amongst our elderly and disabled.

It should be noted that today we regard ourselves as much more heavily dependent upon medication and prescription pharmaceuticals than we do upon medical treatment. That was unfortunately not the case in 1965 when we passed Medicare. The result was that we largely ignored that kind of benefit. In consequence,

today our senior citizens miss what is a major and essential part of good health care for them.

Any solution that this Nation devises and that this Congress designs must focus on the needs of seniors. We need to make good on the commitment that Congress made to seniors and the disabled in 1965 to provide their health care needs where the private market fell short. I am pleased that Mrs. Kessler has traveled all the way from Florida to share her experience with us as a Medicare beneficiary who lacks affordable prescription drug coverage, and we want to thank you for being here, Mrs. Kessler.

I look forward to working with you, Mr. Chairman, and with Chairman Tauzin to expeditiously address these problems this year. I hope that we won't try to swallow any snake oil of the kind I see marketed about how we are going to trust the States or the HMOs to do this. We have trusted them overlong. They have been deficient in their responsibilities, and they are now trying to perpetrate the fraud.

Thank you, Mr. Chairman.

[The prepared statement of Hon. John D. Dingell follows:]

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

I am pleased to see that Chairmen Tauzin and Bilirakis are beginning this Congress looking at one of the most pressing problems facing this country. Millions of seniors and disabled who depend on Medicare for their health coverage lack affordable coverage for prescription medications. The situation facing Medicare beneficiaries with respect to prescription drugs today is not unlike the situation they faced with respect to insurance coverage in 1965. In my mind, this is the one critical "reform" in the program that we need to pursue.

Currently, there is a patchwork of stopgap measures available, from retiree coverage to Medigap to voluntary state assistance plans. But none of them adequately fills the void. What we need is a uniform Medicare benefit that seniors and the disabled can depend on. The question we will examine today is how best to do it.

I suggest a few basic points to guide our thinking. *First*, the system has to be reliable. While "competition" might be a good buzz word these days, experience with the Medicare+Choice program has shown that it certainly does not result in a stable and dependable product that seniors can rely on, unless we are willing to dump billions of overpayments into the system on an annual basis.

Second, the benefit must be defined. Seniors need to know exactly what they can count on. Employers and others who provide supplemental coverage need to know what they are supplementing. We do not need to return to the days of the Medigap scandals where seniors were being sold a "pig in a poke."

Third, the benefit itself must be affordable for seniors and the disabled, including premiums and cost-sharing. A benefit that no one can afford is no benefit at all. Mr. Moroni, Assistant Director of General Motors health care plans, will tell us about how GM works to ensure that a benefit is affordable for their members.

Finally, we need to remember why we are in this business. Congress is discussing a Medicare prescription medication benefit because there is a pressing, urgent need among our elderly and disabled. Any solution that we design should focus on them. We need to make good on the commitment Congress made to seniors and the disabled in 1965 to provide for their health care needs where the private market fell short. I am pleased that Mrs. Kessler has traveled all the way from Florida to share her experience as a Medicare beneficiary who lacks affordable prescription drug coverage.

We look forward to working with Chairmen Tauzin and Bilirakis to move forward expeditiously and address this problem this year.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Buyer for an opening statement.

Mr. BUYER. Thank you, Mr. Chairman.

I am pleased to be a member of this subcommittee and to work with you and Mr. Brown. I come to the committee as a strong be-

liever in the private system, but we really don't have that in this country. It is sort of a quasisystem. You and I have worked together during the last 8 years with regard to the VA and its health system. I have worked for 8 years with the military health delivery system, as I chaired that Personnel Subcommittee panel, and with pride, saying I am the only Member of Congress to author and pass a prescription drug benefit that was done in the last Congress. The reason that occurred and that it received the support of the pharmaceutical manufacturers was that I insured that there was a retail out-of-network pharmacy benefit.

So I will also share a word from Mr. Dingell. I will also be very careful and I will beware of the snake oil of those who will try to operate or create systems that will take us on a path to universal health care. I don't agree with universal health care run by the government.

So what we have here, and what I recognize in Congress, are individuals of both parties who want to bring a benefit to people and help the disabled and the needy, most needy in our country, but we do have two distinct, different paths to get us there. One is make sure that we make improvements in our quasi health delivery system we have for our country and, at the same time, continue to press the bounds of the frontier of medicine and science and health. The other is that path toward incremental steps toward universal health care run by the government. So I will also be as watchful for the snake oil.

I yield back my time .

Mr. BILIRAKIS. Mr. Deutsch for an opening statement.

Mr. DEUTSCH. Thank you, Mr. Chairman. I want to add my words of thanks to the chairman for having this hearing and also the honor and the really pleasure as well of working with him during the last 6 years, and I look forward to this Congress. I know his commitment toward this issue is absolutely genuine, and hopefully this is a year we will see something happen.

As opposed to my colleague who just spoke, I would say that I would like to see America have universal health care. I think it is the wealthiest society in the history of the world, and we have citizens without health care, and we have a system which has incentives—disincentives for employees to have insurance. That is a goal that we should be talking about.

I think really the focus of where we are going is really about the universality of the prescription drug coverage. I think the benefits have to be universal. Attempts to address only low-income seniors and ignore middle-class elderly who are having a difficult time purchasing prescription drugs—and I think Mrs. Kessler will be able to directly bear witness to that case.

In Florida, there are 2.5 million seniors who rely upon Medicare. That number will increase to 5.5 million by the year 2025. Over 50 percent of the seniors in Florida are middle income who would not qualify for the low-income assistance program suggested by some of my colleagues on the other side of the aisle. That is the real issue that we are addressing here. Hopefully others and a majority of the Congress, a majority of this committee, will see it along the same lines.

I want to add quickly one other point that I know the chairman and I are both concerned about, and it is relevant to this issue that we are here today about, and that is on oncology drugs and oncologists. Currently some of the drugs are being perhaps over-reimbursed while the oncologists themselves are being under-reimbursed, and I know the GAO is conducting a study under his direction, and I look forward to the results of that.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Greenwood for an opening statement.

Mr. GREENWOOD. Thank you, Mr. Chairman.

It obviously goes without saying that every member of this committee wants to make sure that every elderly person in the country, every disabled person has access to an affordable prescription drug plan. I think it should be the No. 1 priority for this Congress. It is a subject of enormous frustration to me that we did pass legislation in the House last session and the Senate did not. Contrary to speakers on the other side of the aisle, it was not a plan that only provided a plan for prescriptions for low-income people, but made it affordable for everyone, every Medicare recipient in the country.

What is even more problematic is we are going in the wrong direction; that we have had this fall-away from the Medicare+Choice plans because of our failure, HCFA's failure, the previous President's failure to adequately fund the Medicare+Choice plans that we had, and 934,000 Medicare beneficiaries will lose access to health care benefits and choices next year as a result of these underpayments and burdensome HCFA regulations.

In my district we have—I have seniors and the disabled who were able to get into a Medicare+Choice plan, became somewhat dependent upon the availability of prescription drugs, and then for the reasons I have just cited, the premiums went up so steeply in order to get those plans that many of my constituents can no longer afford them and are in desperate, desperate straits as we speak.

I have a fellow in my district who is 45 years old, a computer guy, hit by a drunk driver, disabled, totally reliant on a painkiller, is suicidal without the painkiller, and lost access to that drug as of the first of the year. We have been desperately trying to help him ever since, and that is just one instance that repeats itself all over the country.

So I am looking forward to working with this committee and other committees, and hopefully we can get this job done and get it done soon.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Green for an opening statement.

Mr. GREEN. Thank you, Mr. Chairman.

Like all of my colleagues, I am glad you led off our first committee hearing this year with the prescription drug event public hearing. I believe addressing the need for Medicare coverage and prescription drugs is one of the most important issues that Congress will face.

Just last weekend I finished a series of town hall meetings in my own district in Houston, and in every town hall meeting over the

last month, seniors asked me to do something to help them pay for their prescription drugs. Seniors who had lost their HMO coverage for lots of reasons, and to my colleague from Pennsylvania Mr. Greenwood, BBA 97 passed this House by such an overwhelming bipartisan vote in efforts to correct it, although I am concerned that we do need to correct it, but there is lots of things that we could do with Medicare reimbursements.

When Medicare was created 35 years ago, most of the prescription medications that save and improve lives weren't even invented. Medicare, like most private insurance plans at that time, didn't cover outpatient prescription medications. Well, we know now that things have changed, and over the last 20 years there has been a surge in new drugs, more than 600 in all. Thanks to these innovations, leading causes of death have been eliminated, and life expectancy and quality of life and health has been dramatically improved. But that innovation and progress comes at a high price tag. The cost of these drugs often leaves our most vulnerable citizens, our seniors and those with disabilities, struggling to make ends meet. While some seniors have access to prescription drug coverage through private insurance, Medigap, Medicare, HMOs, or other sources, coverage is insufficient, capped, and oftentimes expensive. Fully one-third of our Medicare beneficiaries, more than 14 million seniors, have no prescription drug coverage at all.

To make matters worse, study after study has found that American seniors who live on the most limited incomes and who depend most heavily on prescription drugs are paying the highest prices for the medication that keep them in good health. Because seniors tend to have more long-term chronic conditions such as diabetes, arthritis, high blood pressure and heart disease, they are more reliant on prescription drugs. This is evidenced by the fact that more than 86 percent of Medicare's 40 million beneficiaries use prescription drugs, 86 percent. The average older American uses 18.5 prescriptions annually.

While seniors make up only 12 percent of the U.S. population, they use one-third of the prescription drugs, and this isn't just a problem for low-income seniors. Of those with incomes below 250 percent of poverty, almost 40 percent lack prescription drug coverage. An initial 5.4 million seniors who have incomes over 250 percent of the poverty level are without coverage. Hard-working seniors who worked all of their lives, who have saved for their retirement, have moderate incomes, in other words much more than Medicaid, find themselves excluded from State programs like Medicaid or other discount programs because they earn just a little too much. Many of our seniors, like Mrs. Sylvia Kessler, are forced to work so that they can afford to buy their prescriptions. Last Congress when we removed the——

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

Mr. GREEN. Thank you, Mr. Chairman. I will finish up.

Again, I appreciate this being the first hearing, and I look forward to continuing hearings. Thank you.

Mr. BILIRAKIS. As evidence of his interest in this subject, Chairman Tauzin has joined us today, and the Chair now recognizes him for an opening statement.

Chairman TAUZIN. I thank the chairman.

Let me particularly thank Chairman Bilirakis for his agreement again to serve as subcommittee chairman of this critical work of the Energy and Commerce Committee. If there has been any doubt about whether or not the new reenergized Energy and Commerce Committee would be an active player in all of the health care issues that face this Congress and the country, let there be no more doubt about it.

This first hearing on prescription drugs is just a first. Recently Mr. Bilirakis led a tour of Members to HCFA headquarters in Baltimore. We had a chance to see the operations there, and we will begin very soon very extensive hearings, along with Jim Greenwood, our O&I chairman, on HCFA and how we might reorganize that organization to better serve the needs of Americans in this country with their health care problems.

Let me also congratulate Mr. Bilirakis on his and my good friend the ranking minority member Mr. Dingell's membership on the National Bipartisan Commission on Medicare Reform.

The talent on this committee, both of its Members on both sides of the aisle and of the staffs have been accumulating a wealth of knowledge and experience for years, is going to be brought to bear on basic Medicare reform this year, and I want to thank them for their commitment to that effort.

Let me also finally say that this is not about us providing some kind of new services or better services for seniors out there. This is about us take taking care of our own families. I want to disabuse folks of a notion. When we declare national Mother's Day, it is not a Democratic mother's day or a Republican Mother's Day, it is Mother's Day. We, too, have mothers and fathers and grandparents whom we love. We, too, have children we care about. And when this Nation discusses health care issues and health care concerns, we think about mothers like my own, who is a 3-time cancer survivor, who, without the health care coverage of Medicare and without the miracle of new drugs, would not be alive today. This amazing 82-year-old woman, who still wins gold and silver medals in the Senior Olympics, get this, in discus and javelin, has survived breast cancer in 1960, lung cancer in 1980, and recently uterine cancer, and she apologized to me because she wouldn't be able to give me that little brother I always wanted. This amazing woman is just one example of the millions of Americans who depend upon this committee to get it right.

Mr. Bilirakis, I want to thank you for giving us this first, most important hearing. We are going to hear from people who are in the business of organizing and managing drug prescription plans, and we are going to learn how we might organize this country's efforts to make sure we get it right when we provide a drug prescription benefit for all of our mothers and fathers and grandparents under this new benefit program. It is not a question of whether we are going to do it. The issue is how to do it and how to do it right, and you will help us learn how to do it right today, and we thank you for that.

Mr. Bilirakis, bon voyage. You are on it, and your committee is on it, and I wish you well, and I will be with you every step of the way. This committee is going to help this Nation solve these problems this Congress.

Mr. Bilirakis, good luck to you and all of the committee members. You have my full support, sir.

[The prepared statement of Hon. W.J. "Billy" Tauzin follows:]

PREPARED STATEMENT OF HON. W.J. "BILLY" TAUZIN, CHAIRMAN, COMMITTEE ON ENERGY AND COMMERCE

Mr. Chairman, thank you for holding a hearing on this topic of utmost importance—not just to the seniors in our country, but to all Americans.

The Medicare Program affects all of us. Whether we are eligible for the program today, or have family members who are eligible, all of us have a strong interest in ensuring that the Program will meet the health care needs of a growing senior population.

Over the past few years, it has become increasingly clear that Congress needs to modernize Medicare and bring the Program into the 21st Century. Since the Program's inception in 1965, much in health care has changed. Yet many of the Program's features, as well as the design of Medicare's basic benefit package, are stuck in a 1960's style approach to practicing medicine. Prescription drug coverage is still not included in Medicare's basic benefit package and there are no caps placed on seniors' out of pocket medical expenses. No one in this room today would model a new system after Medicare's current benefit package.

This Committee is committed to addressing the issue of Medicare reform this session. Today's topic focuses on prescription drugs and the entities that currently provide a prescription drug benefit to seniors. We hope to learn how these entities administer a prescription drug benefit to seniors, as we in Congress wrestle with how best to administer such a benefit at the Federal level.

We can all agree that the question is not whether to enact a prescription drug benefit, but how. As we will hear from our witnesses, about two-thirds of our seniors have some form of prescription drug coverage, but another one-third do not. It is critical that we determine how best to improve access for all Medicare beneficiaries yet focus our efforts on those who are sickest and neediest. Additionally, when crafting a new benefit, we must be careful not to disrupt existing coverage. Our witnesses today will share with us how they provide a prescription drug benefit to Medicare beneficiaries in a cost-effective way.

Providing an affordable prescription drug benefit to Medicare beneficiaries is Just one aspect of Medicare Reform this Committee will be exploring this year. We will also be examining the role of the Health Care Financing Administration in the management of Federal health care programs. Just two days ago, Members of this Subcommittee visited HCFA's central office in Baltimore to see their operations first hand. The Energy and Commerce Committee, through both the Health Subcommittee and the Oversight and Investigation Subcommittee, intends to hold a series of hearings on HCFA's operations and their policies. We look forward to working with HCFA to remove any impediments it may face in administering health care to tens of millions Americans. More importantly, we look forward to improving the quality of health care delivered to patients through HCFA's federally administered programs.

This is an exciting time to be involved in health care and Medicare reform in particular. Our new President has expressed a strong interest in reforming Medicare. Many in the Senate have expressed a desire to move a reform package. Here on this Committee, we are honored to have two Members of the National Bipartisan Commission on Medicare Reform: Chairman Bilirakis, and my ranking counterpart on the Committee, Mr. Dingell. With our wealth of talent on health care issues, our Committee will be a strong leader in the Medicare reform debate.

Mr. Chairman, I thank you again for holding this important hearing. I look forward to listening to the testimony of our witnesses and beginning the hard work of developing a solution to this complex issue.

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

Mr. Wynn is recognized for a 3-minute opening statement.

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

I certainly appreciate the fact that you have gotten the subcommittee off to a fair start dealing with this very important issue. I don't know how much bipartisanship exists in this Congress, but I think there is consensus on the issue of Medicare reform, and prescription drugs does have considerable consensus.

As a new member of the committee, I don't have any extensive comments. I am looking forward to working with you and our ranking member Mr. Brown and learning about these issues.

I would like to take a moment, though, to make an observation, I guess. One of our colleagues mentioned in his opening statement that he was opposed to universal health care. Now, I don't subscribe to a Socialist model, but I actually do believe that we ought to be pursuing a goal of universal health care, or certainly universal access, and the fact that we have failed to accomplish that should cause us some concern. I don't think we could be content to say, well, we have failed to implement this, but at least we failed using a market-driven approach. I think we need to be receptive to all approaches that would help us achieve this objective, which is to make sure that people don't die needlessly, don't suffer needlessly, or don't have to endure economic hardship, making decisions about their lot, because we as a governmental entity have failed to implement a universal system or a universal access system.

So I am very excited about the committee's work, and I look forward to hearing the witnesses who are before us today. Thank you.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Upton for an opening statement.

Mr. UPTON. Thank you, Mr. Chairman. I am going to ask unanimous consent to put a lengthy opening statement into the record.

Mr. BILIRAKIS. Without objection, the opening statement of all members of the subcommittee may be made a part of the record. The gentleman may continue.

Mr. UPTON. I would just like to summarize it by saying this: Our Nation leads the world in the development of new drugs that enable us to effectively treat diseases and conditions, but if our folks can't afford to buy those drugs, they are useless.

I am known as an optimist, as I still root for the Chicago Cubs, and I had a gentleman at one of my town meetings last year who said, Upton, I know you are an optimist, and he came with his little white prescription bag, and he said, I like the idea that you are talking about dealing with a prescription drug bill. Can you get it done before I have to refill this prescription? I said, I am an optimist, but I am not that optimistic.

This is the Congress, this is the year that we do need to work on legislation. I commend the chairman for having this hearing, and I look forward to watching legislation move through the House, as well as the Senate, and get on the President's desk. This is a job that we need to get done, and I congratulate the chairman for holding this hearing, and I yield back the balance of my time.

[The prepared statement of Hon. Fred Upton follows:]

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

Mr. Chairman, thank you for holding today's hearing on how many seniors currently obtain prescription drug coverage. It will give us important background information that will be useful as we again set out to craft a federal benefit within the Medicare program.

It was my pleasure to serve with you on the House Leadership's Prescription Drug Task Force in the last Congress and to see the plan we crafted approved by the House of Representatives. I sought to serve on this task force because I strongly believe that no senior citizen should be forced to forego needed medication, take less than the prescribed dose, or go without other necessities in order to afford life-sav-

ing medications. Our nation leads the world in the development of new drugs that enable us to effectively treat diseases and conditions. But if people cannot afford to buy these drugs, their benefits are lost to many in our population.

Let me just quote from a letter I received last year that is all too typical of many I receive every week and of many stories that I hear at my town meetings:

"I am among those who skip my meds every other day to make it through the month. I am taking nine pills a day plus I'm a diabetic. My husband has glaucoma and high blood pressure and eye drops are very expensive. We have no prescription drug coverage, so it is a very trying ordeal for us."

Mr. Chairman, I am looking forward to working with you and my colleagues on both sides of the aisle and with the new Administration to craft a plan that can win the bipartisan support necessary to move quickly through Congress and be signed into law by President Bush. I see today's hearing as an important first step toward ensuring that my constituent and the many seniors like her no longer have to skip their meds or stretch their limited incomes to the breaking point paying for basic necessities and the prescriptions they need. We cannot allow another Congress go by without providing relief to the millions of seniors without prescription drug coverage.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Stupak for an opening statement.

Mr. STUPAK. Thank you, Mr. Chairman.

Let me just summarize. I look forward to working with you again in this Congress, and thanks for holding this hearing. Last Congress we had three main plans out there. The Democrats had their plan which made prescription drugs part of Medicare; we had the Republican plan, if you will, the insurance one where you buy a voucher and try to buy some drugs; the Allen bill was out there with the Federal Supply Service. None of them went very far. I hope this year we can do something different.

As you know, Mr. Chairman, because you have heard me speak of this before, back in 1998 we did a study up in my district from Marquette to Hancock to Gladstone, and seniors pay 91 percent more in northern Michigan for their drugs than large HMO and insurance plans.

I don't support price controls or unfairly limiting the pharmaceutical companies on what they can charge for their important lifesaving drugs, but I do believe that Medicare beneficiaries should be allowed to participate in the market the same way GM employees or any other class of employees come together jointly to purchase a product. So hopefully this year we can move forward and really put forward a true, true prescription drug plan that will help out all people; not just seniors, but all people.

Someone mentioned Medicare Choice, or Medicare+Choice. We don't have that in northern Michigan. We don't have much in the way of HMOs. So the small rural districts really do need some help. This is a really pressing problem. When I do my town hall meetings next week back in my district during the work break, that is going to be the No. 1 issue from the seniors and others who show up at the town hall meetings, not just prescription drugs, but health care reform in general.

So I look forward to working with you, Mr. Chairman. I am going on my 7th year on this committee, and I enjoy this committee, and that is why I grandfather in every year, and I look forward to working with you on health care issues. Thank you.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Pickering for an opening statement.

Mr. PICKERING. Thank you, Mr. Chairman. Let me acknowledge and commend you for the willingness and the commitment that you have made to address this issue and move this legislation. I do believe we have a great opportunity working with the new administration for this Congress, and this committee, to get something done.

Let me say, as we approach it, there are several fundamental principles that I hope will be part of the equation. First, I support a plan that provides full coverage for seniors facing serious illnesses and catastrophic out-of-pocket drug costs. Second, I favor an approach that gives seniors choices and flexibility in choosing a plan that fits their individual needs. And third, I would like to see a plan that offers prescription drug protection for rural areas, including guaranteeing the availability of at least two drug plans and allowing seniors to have the convenience of assessing medicine through a main street pharmacy, the Internet, or mail order.

Again, I believe that this is the year that we can get it done. I look forward to working with all of the members of the committee, and I look forward to hearing the testimony of the panel today.

[The prepared statement of Hon. Chip Pickering follows:]

PREPARED STATEMENT OF HON. CHIP PICKERING, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSISSIPPI

Mr. Chairman, thank you for holding this hearing today about one of the most important issues facing many people in our country, particularly seniors. As Congress begins a new year, we are in the process of shaping and focusing on our priorities. That is why today's hearing on prescription drug coverage for seniors is timely and necessary as we move forward on this issue.

Medicare is an essential health care component for America's seniors. While it is true that Medicare needs to be strengthened and modernized, there is also room under the Medicare umbrella for a prescription drug benefit for seniors who need help covering the costs of their medicines. While we will need to fund additional resources to Medicare to make it work, the fact remains that seniors should have access to affordable, voluntary prescription drug coverage that provides protection against high out-of-pocket costs.

Last year, Congress passed a bipartisan bill ensuring that prescription drug coverage is affordable, available and voluntary for all senior citizens and disabled Americans, regardless of income. Unfortunately, this legislation was not signed into law by President Clinton so we must begin again to craft legislation to address this issue. I supported this legislation last year that allowed seniors, including approximately 408,000 in my state of Mississippi, to choose from at least two competing drug plans so each person could get the plan that worked best for them, or to keep their existing coverage. The price of premiums were adjusted to reflect the income of seniors and the type of coverage each person chose to receive. The plan was designed to protects seniors from high out-of-pocket drug costs, without government price controls which would hurt research and development of new drugs and cures.

Last year, President Clinton proposed a plan that would have forced seniors into a "one size fits all" government run program with no flexibility or choice. They would pay a set monthly premium regardless of their prescription drug needs. I opposed President Clinton's proposal because it would have given the federal government too heavy a hand in controlling drug benefits, denying some seniors the right to select the coverage that best fits their needs.

This year, as we work on legislation to bring about a common sense plan to provide prescription drug coverage to seniors who need help, there are several fundamental principles I hope will be part of the equation. First, I support a plan that provides full coverage for seniors facing serious illnesses and catastrophic out-of-pocket drug costs. Second, I favor an approach that gives seniors choices and flexibility in choosing a plan that fits their individual needs. Third, I would like to see a plan that offers prescription drug protection for rural areas, including guaranteeing the availability of at least two drug plans and allowing seniors to have the convenience of accessing medicine through a main street pharmacy, the Internet, or mail order.

I am confident that working together with President Bush, Congress can develop legislation to help seniors with the costs of prescription drugs through a voluntary, affordable plan that brings lower costs and more peace of mind. I look forward to working on this important issue with all of the members of the Health Subcommittee and the entire Energy and Commerce Committee. Thank you.

Mr. BILIRAKIS. I thank the gentleman.I think we are all pleased with the fact that we have had such a good turnout considering that it is a day that we have no votes at all or the balance of the week.

Mr. Engel is recognized for an opening statement.

Mr. ENGEL. Thank you, Mr. Chairman.

When I was first elected to Congress more than 12 years ago, I spoke with my mother, who, by the way, Mrs. Kessler, is a resident of Tamarac, Florida, for the past 24 years, and said to her, Mom, what is the one thing we can do to help seniors in the country? And she said, prescription drugs, prescription drugs, prescription drugs. And that hasn't changed. We haven't moved very fast, but that still hasn't changed. When she tells me stories about her friends, people cutting down on their pills because they can't afford to take the required medication, cutting pills in half and things like that, we know that this is certainly something whose time has come.

I commend the chairman, and I am glad we are finally on the right track. This is the Congress, this is the year that we have to move with prescription drugs. The American people don't want partisan bickering or fighting, they want production, they want us to produce. We have an obligation to produce for them. Whether it is the senior citizens in my district in New York, or whether it is people in Florida, California, all across the country, senior citizens need the help now. We have to make sure that we cover all seniors; the poorest elderly, of course, but there are many, many Medicare beneficiaries without drug coverage, and more than half of them have an income of only $15,000 to $17,000 a year, and they don't qualify for Medicaid or State-run drug plans as we have in New York. So clearly today's living standards render these seniors incapable of bearing the full burden of their prescription drug needs.

I have made this a priority of mine, and I have offered legislation to establish a Medicare prescription drug benefit, and as I mentioned, we cannot wait any longer. We have to do it now.

Senior citizens are becoming more and more dependent on medication to maintain their health and quality of life. And just the way the chairman spoke about his mother and how medication kept her alive, the same thing with my mother, who has had two heart surgeries. So it is not a matter of luxury. Seniors need help with prescription drugs. As they are living longer, they need more and more help.

So I am very delighted to be part of this subcommittee and very delighted that we are finally tackling the issue so that we can help seniors like Mrs. Kessler and my mother and millions of other people across the country who are really looking to Congress for leadership.

I thank you, Mr. Chairman. I will submit my full statement for the Record.

[The prepared statement of Hon. Eliot L. Engel follows:]

PREPARED STATEMENT OF HON. ELIOT L. ENGEL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Chairman, I want to thank you for having this hearing today. Providing seniors with affordable access to prescription drugs has been a priority of mine for several years, and I am pleased we are moving forward. I have authored legislation to establish a Medicare prescription drug benefit and feel that we cannot wait any longer to provide relief to seniors who today cannot purchase the medicine they need.

The evidence is clear. The elderly are becoming more and more dependent on medication to maintain their health and quality of life. Medication has taken the place of hospital stays and surgery in many instances, and also provides a means of treatment that did not exist in the past. In essence, advancements in medical and drug technology have changed how health care is delivered. Medicare has not kept pace. We in Congress must act now to give seniors access to these new medical benefits.

We have all heard stories about seniors sitting at their kitchen table cutting pills in half to extend the life of a prescription or taking their medicine every other day to cut costs. We cannot let seniors continue to suffer financially or medically because they cannot afford the medicine they need. In many instances, not taking the proper amount of medication results in little or no benefit, leaving many in an even more precarious situation and costing Medicare more in hospital stays and acute care expenses. We must assist seniors in obtaining affordable drugs that allow them to receive the full benefit of today's medicinal technology. However, the question remains, what form should this drug benefit take?

Designing a prescription drug benefit in the context of Medicare reform is no small undertaking. There are infinite considerations and many different visions of the size and scope of the benefit. Many feel that providing the poorest elderly with a benefit is as far as we should go or that catastrophic coverage is sufficient. On the contrary, while we must provide for our poorest and most catastrophic cases, average, middle-income seniors are suffering as well and in dire need of assistance. In fact, more than half of Medicare beneficiaries without drug coverage have an average income of $15,000 to $17,000 a year. Thus, they do not qualify for Medicaid or state-run drug plans. Clearly, today's living standards render these seniors incapable of bearing the full burden of their prescription drug needs.

A question many are asking is whether or not to move forward with a Medicare prescription drug benefit now or wait to completely overhaul the Medicare program. I believe that we must act now to help our seniors. Medicare reform is certainly needed, but it is likely several years down the road. Any benefit designed today will give us invaluable experience and expertise in any reform model. I am pleased we are here today, and I await the testimony from the panel in hopes that it will set the stage to move ahead with a Medicare prescription drug benefit that will assist our seniors in meeting their health care needs.

Mr. BILIRAKIS. I appreciate that.

The longtime chairman of this subcommittee, a very active chairman in those days, Mr. Waxman for an opening statement.

Mr. WAXMAN. Thank you very much, Mr. Chairman. I plan to be active these days as well.

I am pleased that the very first hearing that you have called of this subcommittee is on the question of the need for prescription drug coverage. I think the large majority of this committee and indeed of this Congress recognize that we cannot fail to enact legislation that will provide seniors and disabled persons with the coverage they desperately need. We are going to hear some interesting testimony today.

We will hear again that seniors as a group are most dependent on prescription drugs because they are older and sicker than the population as a whole. We are going to hear again that many seniors lack coverage, and even those who are covered are finding that their coverage is eroding, whether it is retiree coverage provided by their employers, Medigap coverage which is increasingly unaffordable, or coverage through Medicare Choice plans. We will hear again that seniors without coverage end up paying the highest

prices for their drugs, simply because they do not have the advantage of group purchasing power. But even buying at discounted rates continues to be costly and beyond the means of many seniors.

Finally, we will hear again that although Medicaid makes a significant contribution in terms of drug coverage for the poor, and supplementary State-run programs to provide drugs have been tried to extend that coverage to higher-income seniors, generally those programs geared just to lower-income people have had only very limited success in even reaching their target population. We will hear again what we all know: All seniors and disabled beneficiaries need a drug benefit, and they need it to be an assured benefit, a defined benefit, and an accessible and affordable benefit.

This isn't only a problem for low income, it isn't just a problem for people in some areas of the country, it isn't a problem that will solve itself if we do not take action. Every day we delay makes the problem worse. This is the reform of Medicare that we all know we must make, and we need to do it now.

I want to congratulate you, Mr. Chairman, for holding this hearing, the very first of our subcommittee, in putting this issue right there on our agenda.

I yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Barrett for an opening statement.

Mr. BARRETT. Thank you, Mr. Chairman.

I want to join with my colleagues on this side of the aisle to thank you for holding this hearing. I think you are showing real leadership on this issue, and I appreciate that very much. I think leadership is something that is desperately needed on this issue, because I believe that President Bush's plan falls woefully short of what is needed for seniors in this country.

To suggest that seniors who make over $12,000 or couples over $15,000 are too well off to receive any type of assistance I think really is an insult to the millions of senior Americans who are struggling to get by, primarily on their Social Security checks, and are seeing double-digit inflation as they pay for the products that they need most desperately in their lives.

I also think, as I think probably every member of this panel recognizes, that this is a real world issue. I have held many, many town hall meetings on this issue, and this is the one issue where people truly are affected and really are crying out for action at the Federal level. I think it is our obligation to respond.

I am concerned, and I have to voice my concerns, although I am strongly in favor of adding a Medicare benefit for pharmacy products, I think we still have to deal with the market distortions, because I believe with the marketing structure and the pricing structure here in the United States, we are, in effect, subsidizing seniors throughout the world and others who use pharmaceutical products throughout the world because of the pricing structures that take place in other countries.

So if we were merely to transfer the cost of prescription drugs from seniors to taxpayers, we would not be dealing with that market problem, and taxpayers don't want us to be taken for a ride either. So I think, again, we have to, as Mr. Stupak was saying, be more aggressive in finding market ways to deal with this problem.

Finally, one of the problems that I have encountered in my town hall meetings throughout my neck of the woods in Wisconsin, there are currently programs that the pharmaceutical companies offer that will allow individuals with very low incomes to get some sort of pricing relief. The problem is that the companies for whatever reason have not come together to develop a common procedure to get this type of relief. In other words, if you have a senior who goes into a physician and needs three or four different products, and those products come from different manufacturers, there is paperwork, and sometimes significant paperwork, that will go along with getting that free or discounted rate from each of those pharmaceutical companies. I think if there are antitrust problems developing, as we have been told, I think that this committee should at a minimum do something quite quickly to come up with a common forum so that seniors who need these products right now can get them without having to spend hours filling out paperwork.

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

Mr. BARRETT. That's it.

Again, thank you for holding the hearing.

Mr. BILIRAKIS. Thank you, sir.

Mr. Strickland, to close the opening statements, I trust.

Mr. STRICKLAND. Thank you, Mr. Chairman. I think all of us appreciate your personal concern about this important issue.

As many of you know, I represent a rural area. The great majority of my Medicare beneficiaries have never had an opportunity to get drug coverage through a Medicare+Choice HMO, because my area is terribly unattractive to HMOs. A small minority of my constituents did sign up for an HMO that served the most populous section of my district, but many of them have been dropped by that HMO during the last 2 years.

Precious few of my constituents have incomes high enough to afford coverage through a Medigap policy. A slightly greater percentage depend on a retiree health plan. Based on my countless conversations with seniors in my district, I know that there are very large numbers of seniors who lack any drug coverage at all, and the lack of an affordable and meaningful prescription drug benefit is the most serious issue facing seniors in my district.

Every day that we delay action on this issue, we deny lifesaving medications to our constituents. For us it is very difficult to imagine the pain of having to choose between taking the medicine we need and paying our rent or buying groceries, and I doubt that any of us on this panel have ever had to make such a decision. However, that is what some of our constituents are doing every day, and while we wait, they face these circumstances.

I believe this circumstance is intolerable. Seniors are most likely to have chronic illnesses. They are most likely to need multiple prescriptions. They are among the group least likely to have adequate prescription drug coverage. They are the group most likely to be on fixed incomes, and they are the group that is paying the highest price for prescription drugs in this country. This is a moral issue. It will define whether or not we are a moral people.

I am encouraged to read in The New York Times comments by Senator Grassley, and this gives me courage, because it appears

that if they do the right thing on the Senate side and we do the right thing on this side, something good can happen. Senator Grassley is quoted as saying, I plan to work with Finance Committee members on both sides of the aisle and with our President to get something done before August. And then, drug benefits should be part of Medicare, not a freestanding supplement, and should be available and affordable to every older American, and I would hope that Senator Grassley's advice would be taken to heart by all of us as we proceed to deal with this difficult issue.

Thank you, Mr. Chairman, and I yield back my time.

Mr. BILIRAKIS. I thank the gentleman.

[Additional statement submitted for the record follows:]

PREPARED STATEMENT OF HON. LOIS CAPPS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman, I would like to thank you for holding this hearing on one of the most pressing healthcare issues facing our country today, prescription drug coverage.

When Medicare was created in 1965, seniors were more likely to undergo surgery for major health problems than to use prescription drugs. Today, prescription drugs are often the preferred, and sometimes the only, method of treatment for many illnesses and diseases.

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

Most of us here today would agree that Medicare's most glaring problem is the lack of drug coverage.

Clearly, no one would design a health insurance program for seniors today that doesn't include a drug benefit. I don't think anyone here would voluntarily choose a plan for their family that doesn't provide such coverage. And Medigap policies designed to fill this need are often expensive and inadequate.

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

And this problem is getting worse. According to Families USA, the price of prescription drugs most often used by seniors has risen at DOUBLE the rate of inflation for six years in a row.

I have been working on this issue for more than two years, and I have been frustrated by the lack of progress. As we fall to develop effective solutions the problem continues. Congress can no longer stand idly by.

As Congress considers different plans to tackle this problem, I believe that any worthy proposal would provide certain key components.

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

In the last Congress, many worthy legislative proposals were raised. There was the Allen bill, the Stark/Dingell bill, and the Pallone bill. Among others, I myself cosponsored H.R. 4607, the Medicare Prescription Drug Act of 2000 introduced by my colleague and good friend Representative Anna Eshoo.

The Eshoo bill creates a new voluntary "Part D" prescription drug benefit in Medicare that is optional and available to all beneficiaries, regardless of income.

It included a defined stop-loss benefit to prevent any individual beneficiary from being bankrupted by a single catastrophic event that causes unusually high drug costs. And it used proven market-based approaches to promote competition and drive down prices. OPM (Office of Personnel Management) would administer the plan in coordination with HCFA. I hope she will introduce this bill again in this Congress.

Mr. Chairman, Democrats have offered many different approaches to this problem, but have not seen a legitimate proposal from the other side. It would be my hope that we could work together, in a bipartisan fashion as we craft the best benefit possible for older Americans.

As I think about the countless seniors on the Central Coast of California that have shared their personal stories with me about crushingly high drug prices, I know in my heart that prescription drug coverage is not a political issue. It is sim-

ply the right thing to do, as we seek to honor our seniors and care for them as they move into the later phases of life.

I thank the Chairman for holding this hearing. I hope we can move legislation as soon as possible on this most pressing issue for our country.

Mr. BILIRAKIS. Let us go right into the panel now. I would like to introduce the panel.

Mrs. Sylvia Kessler from Tamarac, Florida, is here on behalf of the National Committee to Preserve Social Security and Medicare; Mr. John Jones, the Vice President of Legal and Regulatory Affairs of PacifiCare Health Systems; Mr. Robert Moroni, Assistant Director, Health Care Plans, General Motors Corporation; Diane Rowland, Kaiser Family Foundation; Bill Weller, Assistant Vice President and Chief Actuary, Health Insurance Association of America; Barbara Buckley, Assemblywoman from the State of Nevada; and James F. Smith, Senior Vice President of Health Care Services, CVS Corporation, and he is here on behalf of the National Association of Chain Drug Stores.

Ladies and gentlemen, I will turn the clock on for 5 minutes. If you are certainly in the middle of something, I am not going to stop you, but hopefully you would try to stay within that. Your written statements are a part of the record, as you may know, so hopefully you will complement or supplement those written statements.

We will kick it off with Mrs. Kessler. Welcome, ma'am.

STATEMENTS OF SYLVIA KESSLER, ON BEHALF OF THE NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE; JOHN JONES, VICE PRESIDENT, LEGAL AND REGULATORY AFFAIRS, PACIFICARE HEALTH SYSTEMS; ROBERT D. MORONI, ASSISTANT DIRECTOR, HEALTH CARE PLANS, GENERAL MOTORS CORPORATION; DIANE ROWLAND, KAISER FAMILY FOUNDATION; WILLIAM WELLER, ASSISTANT VICE PRESIDENT AND CHIEF ACTUARY, HEALTH INSURANCE ASSOCIATION OF AMERICA; BARBARA E. BUCKLEY, ASSEMBLYWOMAN, STATE OF NEVADA; AND JAMES F. SMITH, SENIOR VICE PRESIDENT, HEALTH CARE SERVICES, CVS CORPORATION, ON BEHALF OF NATIONAL ASSOCIATION OF CHAIN DRUG STORES

Mrs. KESSLER. Good morning, Mr. Chairman and the distinguished members of the committee. My name is Sylvia Kessler, and I am a resident of Tamarac, Florida, and a member of the National Committee to Preserve Social Security and Medicare. I am here today to share my personal story with you. My hope is that you will understand how important my daily prescription drugs are to my health, and what a prescription drug plan under Medicare would mean to someone like me.

I am an 81-year-old grandmother. I have worked very hard for my entire life to make sure that I would not be a burden to my children as I get older. The reason that I am not a burden to them is because of the Medicare program, which is there to take care of me when I get sick or have emergencies. For example, I recently demolished my only car in a bad accident and suffered several bruises and minor injuries. Thank God, with all of the cost involved in the accident, Medicare paid for the emergency care that I needed. Without Medicare, there would have been real problems. There

is no way that I could have afforded the costs of treatment on my own.

I believe that a large part of my health is due to the prescription drugs that I take every day. I take nine pills every day for a variety of conditions, including heart disease and high cholesterol. These drugs have allowed me to remain active and to contribute to my community and share in the lives much my children and grandchildren.

However, it has become more and more difficult each month to afford them. My prescription drugs cost almost $2,300 a year, which is over 10 percent of my annual income. The only way that I can make ends meet is to work two part-time jobs, one at a local flea market and the other for my local board of elections. Without these two part-time jobs and some financial help from my children, thank God, I would have to choose between food and my medications, and I don't think I could make it without either of them for very long. I worry about what will happen when I can no longer work.

So now what are my options? Well, I have tried Medicare managed care for a while, but I could not get the specialty care that I needed. I now pay for a Medigap plan that pays for some of my medical expenses, but it does not cover my prescription drugs. Now, I know that some Medigap plans offer prescription drug coverage, but I can't afford that type of coverage.

There just aren't a lot of options for people like me. My daughter, who is a nurse practitioner, she made me get off HMO and hopes to open up a clinic in the hills of Georgia and Tennessee for poor people who do not even know about Medicare and Medicaid prescriptions. They don't know anything about it.

Please don't think that I am asking for a handout. I have been a hard-working American for my entire life, and now I am in need of a little help. I am asking you, Mr. Chairman, and everybody here today to please do everything that you can to make sure that seniors can have access to their prescription drugs so that they can have healthy lives and continue to work. I hope that you and all of our elected officials from both parties can work together to provide access to prescription drugs for all seniors. I know it is the right thing to do. Thank you for your time.

Mr. BILIRAKIS. Thank you very much for your time, Mrs. Kessler.

Mrs. KESSLER. Thank you for having me.

[The prepared statement of Sylvia Kessler follows:]

PREPARED STATEMENT OF SYLVIA KESSLER

Good Morning, Chairman Bilirakis and distinguished Members of the Committee.

My name is Sylvia Kessler and I am a resident of Tamarac, Florida and a member of the National Committee to Preserve Social Security and Medicare. I'm here today to share my personal story with you. My hope is that you will understand how important my daily prescription drugs are to my health . . . and what a prescription drug plan under Medicare would mean to someone like me.

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However, it has become more and more difficult each month to afford them. My prescription drugs cost almost $2,300 a year—which is over 10 percent of my annual income. The only way that I can make ends meet is to work two part-time jobs—one in a local flea market and the other for my local Board of Elections. Without these two part-time jobs and some financial help from my children, I would have to choose between food and my medications. And I don't think I could make it without either of them for very long. And I worry about what will happen when I can no longer work.

So what are my options? Well, I have tried Medicare managed care for a while, but I could not get the specialty care that I needed. I now pay for a Medigap plan that pays for some of my medical expenses, but it does not cover any prescription drugs. Now I know that some Medigap plans offer prescription drug coverage, but I can't afford that type of coverage. There just aren't a lot of options for people like me.

Please don't think that I am asking for a handout. I have been a hard working American for my entire life and now I am in need of a little help. I am asking you, Mr. Chairman, and everybody here today to please do everything that you can to make sure that seniors can have access to their prescription drugs so that they can have healthy lives. I hope that you and all of our elected officials from both parties can work together to provide access to prescription drugs for all seniors. I know it is the right thing to do. Thank you for your time.

Mr. BILIRAKIS. Mr. Jones.

STATEMENT OF JOHN JONES

Mr. JONES. Mr. Chairman and members of the subcommittee, thank you very much for the opportunity to comment on issues related to providing prescription drug coverage for Medicare beneficiaries.

I am John Jones, Vice President of Legal and Regulatory for Prescription Solutions. I am a pharmacist, and I have been in practice for 25 years.

Prescription Solutions is a pharmacy benefit management company. It was founded in 1993 as a subsidiary of PacifiCare Health Care Systems. We serve more than 5 million individuals, including members of managed care organizations and union trusts, as well as retirees, third-party administrators, and employer groups. We fill over 2 million prescriptions per month for our Medicare beneficiaries. Our goal is to provide the highest quality drug coverage in a cost-effective manner.

Our parent company, PacifiCare, is one of the Nation's largest health care services companies. Primary operations include managed products for employer groups and Medicare beneficiaries in eight States and Guam, serving approximately 4 million members. One million of these members are in our Medicare health plan, Secure Horizons.

Prescription coverage is one of the main reasons beneficiaries support the Medicare+Choice program. We believe that the success of a pharmacy benefit program rests on many methods to provide quality and safety, along with cost management.

Now, let me tell you a few of the tools that we use. We employ a quality improvement program. This is an integrated approach to prevention or management of specific diseases that involves physicians, pharmacists and patients. These programs often encourage the use of medication and can increase the initial cost of care, but will decrease the cost of overall health care in the long term.

Our beta blocker effort is an example of such a program. National guidelines identify the importance of beta blockers in reducing the risk of a second heart attack.

Our program has succeeded in getting 85 to 90 percent of patients on beta blockers who need to be on them. The national average per use of beta blockers is only about 70 percent.

We use a strong clinically based formulary. The drug formulary, of course, is a list of drugs that have been reviewed for safety and efficacy. The list is maintained by our pharmacy and therapeutics committee, which is comprised of physicians who use the formulary to treat their own patients. Nonformulary drugs may be prescribed and covered, but they do require preauthorization. However, preauthorizations represent only 1 percent of the total paid prescriptions for Prescription Solutions.

Another tool is our on-line computer review. These reviews are made to identify inappropriate prescribing and dispensing of prescription drugs.

Provider education is also important. We regularly educate physicians and pharmacists within the network to provide up-to-date information on formulary changes and significant clinical developments in the pharmaceutical area. Keeping all providers well informed helps ensure positive outcomes for our members.

Prescription Solutions achieves its most significant savings from effective contract negotiations with manufacturers. Aggressive contracting for classes of medications that have several me-too-type drugs results in substantial discounts to the health plan. Pharmaceutical manufacturers are willing to discount drugs if the drug benefit design and formulary management results in a larger market share and increased sales.

Our mail service pharmacy is another key cost control and quality component. The fully automated pharmacy has highly trained pharmacists who oversee the system's multiple quality checks to identify and prevent errors. We employ a generic sampling program to encourage the use of generic drugs which offer exceptional value and are considered first-line therapy for a variety of diseases. With our program we supply the physician with samples of widely used and well-tested generic medications that effectively treat many diseases. The physician provides the patient with a prescription for the generic medication, along with the samples.

Finally, our real-time audit program is connected to our claims system. We have developed proprietary software which incorporates filters to identify those claims that fall outside of normal pharmacy practice. These claims pop up on our audit team's computers for immediate action.Taking immediate action allows us to follow through on claims flagged as possible errors and stop payment on those that are indeed erroneous so we don't pay them at all.

In conclusion, the tools I have described to you are just a few that are responsible for the success of our pharmacy benefit program. They are critical to making a quality Medicare drug benefit affordable.

Thank you, and I would be happy to answer any questions.

[The prepared statement of John Jones follows:]

PREPARED STATEMENT OF JOHN JONES, PRESCRIPTION SOLUTIONS

INTRODUCTION

Mr. Chairman and members of the subcommittee, thank you very much for the opportunity to comment on issues related to providing prescription drug coverage for Medicare beneficiaries. I am John Jones, Vice President of Legal and Regulatory for Prescription Solutions, based in Costa Mesa, California.

BACKGROUND

Prescription Solutions, a pharmacy benefits management (PBM) company, was founded in 1993 as a subsidiary of PacifiCare Health Systems, Inc. (PHS). As one of the leading managed care PBMs in the U.S., Prescription Solutions serves more than five million individuals, including members of managed care organizations and union trusts, as well as retirees, third-party administrators, and employer groups. Our goal is to provide the highest quality drug coverage in a cost-effective manner. Access and affordability are the cornerstones of everything we do. Our company manages over $2 billion of prescription drugs annually. With the opening of our newest mail-service facility in Carlsbad, California, we anticipate our annual prescription fulfillment volume to increase from 17,000 to approximately 45,000 prescriptions a day.

Our parent company, PHS, is one of the nation's largest health care services companies. Primary operations include managed products for employer groups and Medicare beneficiaries in eight states and Guam serving approximately 4 million members. One million of these members are in our Medicare health plan, Secure Horizons. PHS and Prescription Solutions strive to provide a high quality, cost-effective pharmacy benefit for our commercial members and Medicare beneficiaries. (Attachment A outlines the structure of our Medicare+Choice drug benefit in eleven of the markets we serve.)

Prescription benefits have been documented as one of the main reasons Medicare+Choice is so positive for eligible beneficiaries. We believe that the success of a pharmacy benefit program rests on a multitude of business functions. Today, I would like to focus on areas that we believe are the most important factors in providing a pharmacy benefit: quality and safety, and cost management.

QUALITY & SAFETY

Our processes for quality and safety encompass several elements: an overarching quality assurance program, formulary development, and various other techniques such as on-line computer review, and provider education.

Quality Initiative (QI) improvement programs are an integral part of an effective strategy for a PBM. The QI program is an integrated approach to prevention or management of specific diseases that involves physicians, pharmacists, and patients. We improve quality of care and quality of life, and at the same time reduce medical and pharmacy costs. These programs often encourage the use of medication and can sometimes increase the initial cost of care, but will decrease cost of overall health care over the long term. Two recent programs have shown that QI programs are making a difference. The use of beta-blockers after a first heart attack is strongly supported by research to prevent a second heart attack. National guidelines are in place that recognize the need for these medications. Our program has demonstrated an 85-90% compliance with this standard. The national average for the use of beta blockers is only about 70%. Another Prescription Solutions program designed to encourage the use of ACE inhibitors for patients with congestive heart failure has shown equal success. We are able to exceed the national compliance rate by identifying patients with these conditions and communicate with their personal physicians on the use of the most efficacious drugs.

Prescription Solutions' commitment to quality also is evidenced by voluntary compliance with standards set forth by the National Committee on Quality Assurance (NCQA) and with Health Plan Employer Data and Information Set (HEDIS). Currently, PBM's are not required to comply with either NCQA or HEDIS standards. However, at Prescription Solutions, we adhere to the standards and criteria to measure quality.

The use of formularies is one of our quality enhancement tools. By our definition, a drug formulary or preferred drug list is a compilation of drugs that have been reviewed for safety and efficacy. Contrary to the popular belief that formularies exist simply to control costs of an individual drug, there are many aspects to proper administration of a formulary that have more to do with quality and clinical effectiveness.

For example, in a recent case, a request for a non-formulary antibiotic medication, Vancomycin oral, was received in the prior authorization department. The physician had prescribed this drug for a serious knee infection. Due to the way this oral medication works, it could not get into the blood stream in a high enough concentration to effectively treat the infection. Subsequently, our systems identified this as a care issue, and we contacted the doctor to change the medication to an intravenous form. Notwithstanding the fact that the intravenous drug was significantly more costly than the oral medication, the latter would have had no benefit and potentially could lead to a more serious problem, including the need for surgery.

Often times, formularies are misunderstood. Requests for non-formulary drugs only represent one percent of total claims. Even then, Prescription Solutions employs prior authorization to determine approvals. In fact, of the one percent of requests for non-formulary drugs, 75 percent are approved.

With the recent advent of direct-to-consumer (DTC) advertising, demand for "newer and better" medications has dramatically increased the demand for drugs new to the market. In many cases, the physicians reviewing these products for our formulary have found that they are not always better than existing treatments.

Physicians are often approached by patients with specific requests for medications they have seen on TV or in print media. The patient may indeed have a legitimate need for a medication to treat an illness, but it is often preferable to use drugs that have a proven track record with regard to safety and effectiveness. In order to keep a patient happy, many physicians have reported that they are likely to prescribe a requested drug, unless they believe that the drug may cause harm. In many cases, the new drug is not significantly better than existing products that can be purchased at a fraction of the cost. For example, Celebrex is widely promoted for arthritis at a retail price of about $75 per month vs. generic ibuprofen or naproxen at about $10 per month. In clinical studies, these drugs have shown equivalent response in the patients tested.

Another quality control we use at Prescription Solutions is on-line computer review, known as "edits," to identify inappropriate prescribing or dispensing of prescription drugs. In many cases, on-line edits identify potential inappropriate drug interactions or possible dosing discrepancies. For reasons that can vary, physicians sometimes prescribe medications in a manner that varies from prescribing guidelines. For example, there are many drugs that are manufactured to be taken only once a day. However, if a physician orders a twice-a-day dose, our edits will notify the pharmacy of the correct dosage.

Frequent communication to physicians and pharmacists within the network provides up-to-date information on formulary changes and any significant clinical developments in the pharmaceutical arena. Warnings on new drugs, as well as drug recalls, are communicated on a regular basis. Keeping all providers well-informed helps ensure positive health outcomes for our members.

PRESCRIPTION DRUG COST MANAGEMENT

The key elements to prescription drug cost management are: formularies, provider contracts, mail services, generic and over-the-counter drug promotions, and audits.

In addition to the quality controls referred to earlier, drug formularies are valuable tools to control costs. In today's environment, formularies have proven to be necessary to maintain affordable pharmacy benefits. On the cost management side, a formulary is designed to leverage the collective buying power of large member organizations. The list is maintained by the Pharmacy and Therapeutics (P&T) Committee, comprised mostly of practicing physicians, along with medical directors from the health plans. Decisions are made based upon the clinical expertise and experience of the physicians on the committee. This list is the basis for our pharmacy benefit and is made available to our members.

Most formularies have 1000 to 2000 medications available. The P&T Committee meets every two months to decide to add or replace medications on the list. The majority of AIDS and cancer medications are automatically added without restriction of use. New drugs are reviewed as requested by network physicians. Unique, breakthrough drugs tend to get higher priority review.

Prescription Solutions contracts with over 50,000 pharmacies nationwide. Although we provide fairly broad pharmacy access to our members, we command competitive discounts in each region where we have significant membership. However, we achieve the most significant savings from effective contract negotiating with manufacturers.

Strategic purchasing has contributed to lower drug costs and a drug benefit that is affordable. Aggressive contracting for classes of medications that have several "me-too" type drugs results in substantial discounts to the health plan. Pharma-

ceutical manufacturers are willing to discount drugs if the drug benefit design and formulary management results in a larger market share and increased sales. Deep discounts by the manufacturers are available only to those PBMs that demonstrate a value to the manufacturers in achieving those goals.

The Prescription Solutions mail service pharmacy is another key cost control component. The fully automated pharmacy is staffed with highly trained pharmacy personnel who oversee the systems' multiple checks to identify and prevent errors. Patients can order medications 24 hours a day, either by phone or on-line. With mail-service, members have the convenience of pharmacy refills delivered to their door, eliminating trips to the pharmacy and waits for their prescriptions. Our members also save money when using mail-service by paying lower co-payments. Additionally, where appropriate, our mail service pharmacists work with the patient's physician to determine if one of the plans' formulary drugs can be used if equivalent to the member's non-formulary drug. These services are especially important to our Medicare enrollees.

Pharmacists and technical personnel provide personal, high quality services in a high tech/interactive environment. Automation allows for a high degree of accuracy and efficiency. However, automation is not successful in the absence of direct member communication. Patients are provided with detailed, personalized instruction about their medication, along with a toll-free number to a Prescriptions Solutions pharmacist for a personal consultation. This service provides members a convenient and easy way to refill their prescriptions. We field up to 12,000 calls per day on our toll-free personal assistance line to help our members with their prescriptions.

This toll-free service is used by 25 percent of our Secure Horizons (Medicare) members. Seventy-five percent of all prescriptions filled by our mail service are for our Medicare members. Members that use the mail service pharmacy have stated that they are pleased with the convenience and cost-savings. Members receive a 90-day supply of medications for the price of a 60-day supply. The average Medicare member uses on average two prescriptions per month; by using mail service, they will save about eight copays per year and depending upon the market, approximately $70-100.

Generic drugs also offer exceptional benefits and are often considered first line therapy for a variety of diseases. Prescription Solutions employs a generic sampling program to encourage the use of these high value drugs as a balance to traditional sampling programs. Currently, pharmaceutical companies give providers free samples of new, branded drug products that the pharmaceutical companies are anxious to promote. In many cases, these drugs offer little or no advantage over current tried and true medications. When samples of new drugs are available, physicians are often tempted to grab a starter package for a patient to try, instead of writing a prescription for a generic medication. With our program, we will supply the physician with starter supplies of widely-used and well-tested generic medications that provide an appropriate starting point for many diseases.

Other generic or over-the-counter programs, such as our migraine management program, encourage the use of non-prescription drugs for migraine. Studies have shown that some non-prescription products are just as effective as their expensive prescription counterparts for the majority of people who use them. Promotion of programs like these helps control the spiraling cost of pharmaceuticals without sacrificing quality of care.

Fighting fraud is an ongoing battle. Each year, billions of dollars are wasted for fraudulent prescription claims. Roughly, three percent of all pharmacy claims are fraudulent. At Prescription Solutions, an organized effort to combat fraud began two years ago and recently resulted in the arrest of a pharmacist in California that may have been involved in over $1 million of fraudulent claims. In order to stop fraud, real time audits are necessary. Occasionally, incorrect claims are simply mistakes, but many times, these are deliberate attempts to defraud the system. Real time audits allow us to stop payment on erroneous claims.

Our "real time" audit program is connected to our claims system. Prescription Solutions has developed proprietary software, which incorporates filters to identify those claims that fall outside of normal pharmacy practice. These claims pop up on our audit teams' screens for immediate action. This does not hold up the payment process for normal claims that pass through the system. Taking immediate action allows us to follow-through on claims flagged as possible errors and stop payment on those that are indeed erroneous.

SUMMARY

In conclusion, our success at managing pharmacy costs is due to an integrated approach. (This approach is illustrated in Attachment B.) We target pharmaceutical

companies, physicians, members, prescription plan design and retail pharmacies. We are able to effectively forecast the cost of providing pharmacy benefits based on our experience. When necessary, benefits are flexed in response to market issues. Our strong clinical foundation means we emphasize appropriate drug utilization, which drives cost-effective care. This unique combination of clinical expertise and health plan experience is what qualifies us to effectively influence pharmacy costs over the long-term. Our primary goal is to keep pharmacy benefits accessible and affordable for all Americans well into the 21st century. We look forward to working with Congress and the Administration in the design and implementation of a drug benefit for all Medicare beneficiaries.

Attachment A

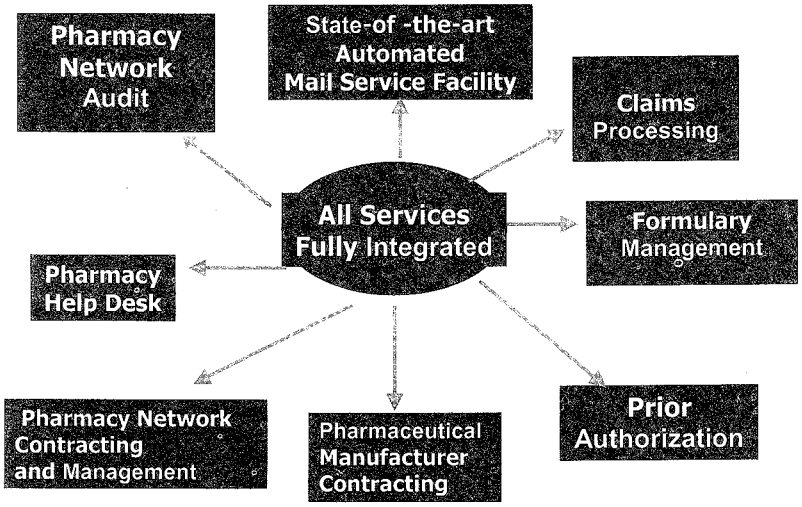
Secure Horizons (Medicare+Choice Plan)

2001 Drug Benefit Examples

Location	Secure Horizons Coverage
Dallas, Texas	$5 copay per generic drug and $25 copay per brand name drug. Coverage of generic and brand name drugs is subject to a combined annual limit of $1000. Formulary applies. Mail order available for $15 generic and $50 brand. Annual limit applies.
Denver, Colorado	$11 copay per generic drug, $30 per brand name drug, $60 per generic or brand non-formulary drug. Coverage of generic drugs is unlimited. Coverage of formulary brand and non-formulary/generic drugs is subject to an annual limit of $1300.
Houston, Texas	$5 copay per generic drug and $20 copay per brand name drug. Coverage of generic and brand name drugs is subject to a combined annual limit of $1200. Formulary applies. Mail order available for $15 generic and $50 brand. Annual limit applies.
King County, Washington	No supplemental drugs coverage.
Las Vegas, Nevada	$7 copay per generic drug and $15 copay per brand name drug. Coverage of generic drugs is unlimited. Coverage of brand name drugs is subject to an annual limit of $1500. Formulary applies. Mail order available $14 generic and $30 brand. Annual limit applies.
Los Angeles, California	$7 copay per generic drug and $14 copay per brand name drug. Coverage of generic drugs is unlimited. Coverage of brand name drugs is subject to an annual limit of $2000 per year. Formulary applies. Mail order available for $14 generic and $30 brand. Annual limit applies.
Oklahoma City, Oklahoma	$10 per generic drug and $25 copay per brand name drug. Coverage of generic and brand name drugs is subject to an annual limit of $1000. Formulary applies. Mail order available $20 generic and $50 brand. Annual limit applies.
Orange County, California	$7 copay per generic drug and $14 copay per brand name drug. Coverage of generic and brand name drugs is subject to a combined annual limit of $2000 per year. Formulary applies. Mail order available for $20 generic and $40 brand. Annual limit applies.
Portland, Oregon	No supplemental drugs coverage.
San Diego, California	$7 copay per generic drug and $14 copay per brand name drug. Coverage of generic and brand name drugs is subject to a combined annual limit of $2000 per year. Formulary applies. Mail order available for $20 generic and $40 brand. Annual limit applies.
San Francisco, California	$8 copay per generic drug and $16 copay per brand name drug. Coverage of generic and brand name drugs is subject to a combined annual limit of $1200 per year. Formulary applies. Mail order available for $30 generic and $60 brand. Annual limit applies.

Attachment B

Components of Prescription Solutions' PBM Structure



Mr. BILIRAKIS. Thank you, Mr. Jones. And we will have those questions.

Mr. Moroni, please proceed, sir.

STATEMENT OF ROBERT D. MORONI

Mr. MORONI. Good morning. My name is Robert Moroni. I am the Assistant Director of Health Care Plans for General Motors.

Mr. BILIRAKIS. Pull the mike closer, Mr. Moroni.

Mr. MORONI. Is that better?

General Motors is the largest private purchaser of health care in the United States, offering enrollees a variety of health plan options including self-insured traditional and PPO options and insured HMOs. General Motors' health plan covers 1.2 million salaried and hourly employees, retirees, surviving spouses and their families. Of the total enrollment, 75 percent, which equates to about 900,000 enrollees, are the self-insured traditional and PPO options for which General Motors pays the prescription drug directly.

In 2000, GM spent nearly $4 billion to provide health care coverage to its total population. Of that amount nearly $900 million was spent on just our self-insured prescription drug coverage. That was a 19 percent increase over our prescription drug expense for 1999.

Approximately $700 million of the $900 million was for retirees' surviving spouses and their families. Under our current design, retirees' surviving spouses and their dependents pay the same copays as their employee counterparts even though they account for proportionately more of the expense.

The current design of our prescription drug coverage is often referred to as a card program, with enrollees issued ID cards that they present to local pharmacies to obtain covered prescription drugs. The enrollee pays a copay at the time of dispensing, and the balance is billed to General Motors through our pharmacy benefit managers, also known as PBMs. GM uses two PBMs. We believe these PBMs provide some level of quality control and cost containment through a managed network of retail pharmacies and a mail order house. They have put a number of components in place to encourage medically appropriate, cost-effective prescribing and dispensing practices.

Among the tools our PBMs use are programs that encourage prescribed drugs that are safe when taken by the elderly; encourage the use of formulary medications; profile physicians; detect in real time severe drug-to-drug interactions, which are not that uncommon when patients see more than one physician; provide disease management; optimize dosing; and deliver generic substitutions when appropriate.

Although this is not an exhaustive list, it will give you a feel for some important components of a well-managed pharmacy program. But even with these comprehensive program components, we are extremely concerned about our continuing ability to provide our current level of prescription drug coverage. Prescription drugs are the most inflationary component of our health care costs. Year-to-year increases for the past 3 years have averaged more than 19

percent, and future costs are projected to increase at even more alarming rates.

Prescription drugs do not operate according to the traditional free market model. Consumerism is limited. Patients are inundated by direct-to-consumer advertising, yet they lack the full information to make fully informed decisions about the risks, benefits and cost of a particular drug. We believe it is a challenge for providers, payers and consumers to ensure that prescription decisions are clinically appropriate and cost-effective.

Other concerns regarding escalating drug costs are—ongoing of market exclusivity—pharmaceutical manufacturers' pricing practices in the U.S. which produce higher prices than in Europe and Japan and other countries in North America.

Breakthrough drug technology definitely offers the potential for increased longevity and functionality. However, new and replacement therapies for existing drugs often result in cost increases that are out of proportion with the benefits to the patient.

High drug costs have a negative impact on international competitiveness of U.S. firms that provide prescription drug coverage. It should not come as a surprise that such firms would consider implementing increasingly stringent controls or discontinuing coverage altogether.

General Motors supports the addition of a prescription drug component to Medicare. We regard this coverage as necessary not only for the treatment of illness and injury, but because in many cases prescription drugs are the most clinically appropriate and cost-effective treatment option. We believe Medicare prescription drug benefits should be universal and should employ quality control features to ensure that drugs being covered are necessary, appropriate and effective. The Medicare program should have effective mechanisms that can maintain spending at a manageable level. It should have broad-based equitable financing. And a program with less than universal coverage would be unfair to enrollees and employers who have paid into Medicare for many years, and providing coverage only for those who have no coverage through employers would penalize responsible employers who have voluntarily provided prescription drug coverage in the past.

Thank you.

[The prepared statement of Robert D. Moroni follows:]

PREPARED STATEMENT OF ROBERT D. MORONI, ASSISTANT DIRECTOR, HEALTH CARE PLANS, GENERAL MOTORS CORPORATION

Good morning. My name is Robert Moroni and I am the Assistant Director—Health Care Plans, for General Motors Corporation. In this capacity, I oversee the GM self-insured health care plans including coverage for prescription drugs. I have been employed by General Motors for almost twelve years, the last 6 of which have been in our Health Care Activity. My professional background is as a certified public accountant. I hold a Masters Degree in Health Services Administration from the University of Michigan's School of Public Health.

Background

By way of background, under our health care programs we offer enrollees a variety of health plan options, including self-insured "Traditional" and Preferred Provider Organization options and Health Maintenance Organizations (the latter being insured). General Motors' health plans cover over 1.2 million salaried and hourly employees, retirees, surviving spouses and their families. Of the total enrollment, 75% (almost 900,000 enrollees) are in the self-insured Traditional and PPO plans, for which GM pays prescription drug expenses directly. We require that the HMOs

offered to our people provide prescription drug coverage, but it varies in detail from HMO to HMO. We estimate that our HMO premiums include $300 million in prescription drug costs. Since we offer over 130 HMOs nationwide, I think you can appreciate why my comments today will be limited to our self-insured coverage which, after all, addresses the bulk of our program enrollees.

In calendar year 2000, GM spent approximately $3.9 billion to provide health care coverage for its total population. Of that amount, nearly $900 million was for our self-insured prescription drug coverage. That was a19% increase over our prescription drug expense for 1999. Approximately $700 million (or $1,289 per enrollee) of the $900 million was for retirees, surviving spouses and their families.

General Motors has been providing prescription drug coverage for its retirees, surviving spouses and their families since 1971. As noted, this group accounts for the vast majority of our prescription drug expense. Under the current design, retirees, surviving spouses and their dependents pay the same co-pays as their employee counterparts, even though they account for proportionately more of the expense.

Coverage Design

The current design of our prescription drug coverage is often referred to as a "Card Program", with enrollees issued ID cards that they present at local pharmacies to procure covered prescription drugs. The enrollee pays a co-pay at the time of dispensing and the balance is billed to GM through our carriers or pharmacy benefit manager (PBM). We pay the ingredient costs, dispensing fees and administrative fees. There are both retail and mail order options, the latter option being of particular benefit to those with long term "maintenance drug" needs and/or limited access to a local pharmacy.

There are different co-pays for our hourly and salaried programs. Currently, hourly program "Traditional" and PPO option enrollees pay flat $5 or $3 retail co-pay and enrollees of both options pay a $2 mail order co-pay for each prescription or refill. The salaried program co-pay is 25% of the prescription cost at retail with a $15 minimum and $25 maximum. If a generic drug is chosen the retail co-pay is $5. The salaried mail-order co-pay is $20 for brand-name drugs and $10 for generics. It should be noted that with mail order a 90-day supply is available, versus a 34-day supply at retail. We have what I refer to as a "preferred formulary"—actually an open formulary where we do not restrict the choice of drug dispensed but we try to influence physician prescribing behavior and/or patient selection, as I will describe shortly.

GM uses two PBMs, Merck-Medco and Blue Cross/Blue Shield of Michigan. We believe these PBMs provide some level of quality control and cost containment through a managed network of retail pharmacies and a mail order house. They have put a number of components in place to encourage medically-appropriate and cost-effective prescribing and dispensing practices. Many of these are "transparent" to the enrollee and/or voluntary, and operate on a pharmacist-to-physician interaction. Among the tools our PBMs use are:

- Partners for Healthy Aging—an enrollee/patient and physician education effort which provides information on issues of pharmaceutical safety and use among the elderly.
- Therapeutic Interchange—contacts with physicians to encourage use of formulary medications
- Physician Profiling and Peer Rating—an expansion on the above which provides feedback on quality and utilization performance.
- Severe Drug-Drug Interaction Edits—on-line, electronic feedback at the time of dispensing that prevents dispensing drugs that could represent life-threatening interactions. This situation often arises when an enrollee is seeing more than one physician and the respective physicians are not aware of all of the drugs the enrollee is taking. When one of these cases arises, the pharmacist contacts the prescribing physician and reviews the facts of the case before dispensing the potentially conflicting medication.
- Digestive Health Solutions—addressing unique concerns of patients with gastrointestinal disease. It provides educational materials to enrollees and encourages appropriate prescribing practices by physicians.
- Dose Optimization—which simplifies the dosing regiment for patients and capitalizes on cost savings of taking one pill versus two.
- Generic Substitution Component—When an appropriate generic drug is available it is dispensed unless the physician specifies "dispense as written" or the enrollee requests the brand drug. If the brand drug is dispensed at the enrollee request, the enrollee pays the difference between the cost of the generic and brand, in addition to the normal co-pay.

This is not an exhaustive list, but will give you a feel for some of what we feel are important components of a well-managed pharmacy plan.

Cost Considerations

I would be remiss if I did not tell you that regardless of the efforts discussed above, we are extremely concerned about our continuing ability to provide the kind of prescription drug coverage that our people have come to expect. Prescription drugs are the most inflationary component of our health care costs. Year-to-year increases for the last 3 years have averaged more than 19%. Future costs are projected to increase at even more alarming rates.

Prescription drugs do not operate according to the traditional free-market model. Consumerism is limited. Patients are inundated by direct-to-consumer advertising yet lack the information to make fully-informed decisions. Other practices that are a concern include unwarranted patent extensions and pharmaceutical manufacturers' pricing practices in the U.S., compared to their practices in Europe and Japan, or even other countries in North America. These factors impose unnecessary costs which, in turn, have a negative impact on competitiveness of U.S. firms which provide prescription drug coverage. It should not come as a surprise that such firms would consider implementing increasingly stringent controls, or discontinuation of the coverage altogether.

Potential Medicare Coverage of Prescription Drugs

General Motors supports the addition of a prescription drug component to Medicare. We regard the coverage as necessary—not only for the treatment of illness and injury but because in many cases prescription drugs are the most clinically appropriate and cost-effective treatment option. We believe Medicare prescription drug benefits should be universal so that access is available to all, and employ quality assurance features to assure that the drugs being covered are necessary, appropriate and effective. The Medicare program should have effective program controls or expenditure limits to ensure spending is controlled at a manageable level. It should have broad-based equitable financing. To construct a program with less than universal coverage would be unfair to enrollees and employers who paid into Medicare for many years. Further, to the extent it might provide coverage only for those who have no coverage through employers, it would seem to penalize responsible employers who have voluntarily provided prescription drug coverage in the past.

Summary

In closing, I must reiterate that General Motors is very concerned about the economics of continuing to provide prescription drug coverage. Obviously we hope to continue to provide prescription drug coverage for our employees, retirees and their families. It is our hope that a fair and equitable Medicare Program will be implemented to help seniors bear the cost of prescription drugs. Such a program should not put responsible employers, who have provided such coverage to date, at a disadvantage.

Mr. BILIRAKIS. Thank you, Moroni.

Ms. Rowland.

STATEMENT OF DIANE ROWLAND

Ms. ROWLAND. Thank you, Mr. Chairman and members of the subcommittee. I am Diane Rowland, Executive Vice President of the Henry J. Kaiser Family Foundation and Executive Director of the Kaiser Commission on Medicaid and the Uninsured.

I am pleased to be here at this hearing today to talk about the 35 million seniors and 5 million disabled Americans on Medicare who are in need of health care coverage, especially that of prescription drugs. Outpatient drug therapy has become an increasingly effective tool for managing many of the conditions faced by this population.

As Mrs. Kessler has shown you today, these needs are substantial. She represents about one-quarter of all Medicare beneficiaries who have expenditures in excess of $2,000, but live on limited and modest incomes. In fact, 40 percent of all Medicare beneficiaries today live on an income of less than 16,500 for an individual or

22,000 for a couple, and as you well know, most rely on Social Security as their main source of income.

For these beneficiaries, the need for multiple medications to manage and treat their acute and chronic illness often results in substantial and rising financial burdens and means many leave needed prescriptions unfilled. Today one-third of all Medicare beneficiaries go without any form of prescription drug coverage. About half of those live below 175 percent of the poverty level.

Lack of drug coverage disproportionately affects beneficiaries living in rural areas and the oldest old. As you will hear from the other witnesses, supplemental coverage does provide some assistance with prescription drugs to two-thirds of the elderly, but that coverage varies widely by income, is often costly, and appears to have a very unstable future.

For the lowest-income population, Medicaid has played a significant role over the years and covers today roughly 14 percent of all Medicare beneficiaries. Yet to be eligible for the Medicaid program, one must generally be eligible for cash assistance through the Supplemental Security Income program or be institutionalized in a nursing home. Medicaid does, however, cover nearly half of Medicare beneficiaries with incomes below the poverty level and covers 40 percent of the nonelderly disabled Medicare population. This population has a particularly important attachment to Medicaid because it is often—the disabled are often ineligible to obtain any kind of private-based coverage. Those eligible for both Medicare and Medicaid, the dual-eligible population, have poorer health care status and greater health care needs than other Medicare beneficiaries.

In 1998, Medicaid spent $14.5 billion for prescription drugs, representing 8 percent of total Medicaid spending. However, without the Medicaid drug rebate program, an additional $2.5 billion alone would have been spent in 1998 on prescription drugs. Within the Medicaid program, the elderly and disabled account for over 80 percent of all Medicaid spending for prescription drugs. So this is a major item in all State budgets and in the Medicaid program.

Coverage of prescription drugs, however, under Medicaid varies widely across the States. States are allowed to establish formularies that limit coverage of specific drugs and are permitted to require prior authorization before dispensing any drug. Almost all States maintain a formulary. Most place limits on the number of concurrent prescriptions, the amount of a given drug supplied at one time, or the number of refills permitted. Thirty-two States require copayments for prescription drugs ranging from 50 cents to $3 per prescription for beneficiaries with extremely low incomes.

However, many States are now struggling with the impact of rapidly rising prescription drugs on their budgets. Rising costs stem from both the increase in the average cost of drugs and from the increased volumes of drugs prescribed. As a result, many States are now looking to restrain rather than expand their coverage of prescription drugs in the future.

Building on Medicaid as well as some of the State-based pharmacy programs does provide a means to direct assistance for the lowest-income Medicare beneficiaries. However, the variations across States in existing coverage and the limited reach and scope

of both State pharmacy assistance programs as well as Medicaid would perpetuate uneven coverage for low-income Medicare beneficiaries based on where they live.

In sum, today the likelihood of having drug coverage to supplement Medicare depends largely on where you worked and whether you have retiree benefits, on where you live and whether managed care plans are available in your area, on what your income is and whether you are eligible for Medicaid or can afford to purchase coverage, and how sick you are, and whether plans are willing to enroll you if you have high drug costs. This is neither a fair nor rational way to provide health insurance coverage to our Nation's 40 million Medicare beneficiaries.

Including the drugs under Medicare would provide Medicare beneficiaries with needed coverage that is comparable to the benefits generally offered to the less—to the more healthy, nonelderly insured population. It would both help to stabilize coverage by leveling the playing field between traditional Medicare and Medicare+Choice plans, and it would serve to improve the quality of care for the Nation's Medicare population while shielding the most vulnerable from rising, potentially unaffordable prescription drug costs.

Thank you.

[The prepared statement of Diane Rowland follows:]

PREPARED STATEMENT OF DIANE ROWLAND, EXECUTIVE VICE PRESIDENT, THE HENRY J. KAISER FAMILY FOUNDATION, AND EXECUTIVE DIRECTOR, KAISER COMMISSION ON MEDICAID AND THE UNINSURED

Thank you, Mr. Chairman and members of the Subcommittee, for the opportunity to provide an overview of the Medicare population's access to prescription drug coverage. I am Diane Rowland, Executive Vice President of The Henry J. Kaiser Family Foundation and Executive Director of The Kaiser Commission on Medicaid and the Uninsured. I also serve as an Adjunct Associate Professor in the Department of Health Policy and Management at The Johns Hopkins University School of Hygiene and Public Health.

The Medicare population is, by definition, a population that is older, sicker and more dependent on prescription drugs than those not enrolled in the program. While the range and continuing proliferation of new drug treatments have made the management of the many health conditions suffered by this population possible, traditional, fee-for-service Medicare does not generally cover outpatient prescription drug costs. My testimony today will review sources of prescription drug coverage for the Medicare population, describe the scope and level of coverage offered by these various sources, and devote particular attention to Medicaid's role in providing drug coverage to Medicare's lowest-income beneficiaries.

The Medicare Population

Any discussion of Medicare benefits must acknowledge the characteristics and needs of the elderly and disabled population that Medicare serves. The Medicare population, by definition, is older and less healthy than the general population. Those who are covered by Medicare must be at least 65 years old or, if under-65, totally and permanently disabled. Because health problems increase with age, those who are covered by Medicare tend to have greater health needs than the non-elderly population. (Exhibit 1). Nearly 7 in 10 Medicare beneficiaries living in the community (69 percent) have two or more chronic conditions; many report having serious or disabling health problems, including arthritis (56 percent), hypertension (53 percent), and heart disease (36%). (Exhibit 2). Outpatient drug therapy has become an increasingly effective tool for managing many of these conditions and for delaying and even preventing the onset of more serious illnesses.

With health needs increasing with age, it is not surprising that prescription drugs are a particularly important part of the therapeutic regimen for millions of elderly and disabled Americans, and that drug use increases with age. Eight in ten Medicare beneficiaries utilize prescription drugs on an ongoing basis, filling an average of 19.6 prescriptions in 1996. Outpatient drug therapy has come to substitute for

inpatient hospital care and to help manage chronic conditions. Many expect outpatient drug therapy to play an even greater role in medical care in the future

These prescription drugs often come at a substantial cost to the Medicare population—a population that generally lives on modest, and often fixed incomes. Over 40 percent of Medicare beneficiaries—14 million people—today have incomes below 200 percent of the federal poverty level, or below $16,500 for an individual and just over $22,000 for a couple (Exhibit 3). Twelve percent of beneficiaries have incomes below the poverty level.

Not only do many Medicare beneficiaries live on modest incomes, but most rely on Social Security benefits as their main source of income. This is especially true for the 20 million low- and moderate-income elderly beneficiaries with incomes below $22,225 per year. They comprise 60 percent of Medicare beneficiaries and derive from 64 to 81 percent of their income from Social Security (Exhibit 4). Living on fixed incomes with little potential for additional earnings leaves these beneficiaries with minimal cushion to absorb additional medical costs.

Why Is Drug Coverage Important?

For many Medicare beneficiaries, the need for multiple medications to manage and treat their acute and chronic illnesses often results in a substantial and rising financial burden. Between 1996 and 2001, average total per capita drug expenses for the Medicare population increased from $798 to $1,402, while average out-of-pocket spending increased from $390 to $686 per year.

Having insurance coverage to supplement Medicare and help finance the cost of prescriptions affects individuals' financial burdens of care and use of medications. Beneficiaries without any form of prescription drug coverage tend to have higher out-of-pockets drug costs than those with some form of drug coverage (Exhibit 5). Overall, those without coverage for prescription drugs spent more than those with coverage in 1996 ($463 vs. $253 in 1996). Differences in health status do not explain these differentials. Among those in poor health, the disparities in out-of-pocket spending widened; those who lacked coverage had substantially higher out-of-pocket costs than those with coverage ($423 vs. $749 in 1996).

Beneficiaries without drug coverage incur relatively high costs because they do not have an insurer to share the cost of each filled prescription and because they tend to pay the full retail price when they go to the pharmacy. By contrast, those with prescription drug coverage are often shielded from the full effect of high and rising drug costs as they often benefit from the pharmacy discounts negotiated by their employer plan or HMO.

While lack of coverage means higher out-of-pocket costs faced by the elderly and disabled on Medicare, these higher costs do not result from greater utilization. In fact, those without prescription drug coverage fill fewer prescriptions than those with coverage, even after adjusting for health status (Exhibit 6). Beneficiaries without drug coverage averaged five fewer prescriptions per year than those with coverage in 1996. Among those in poor health, those who lacked coverage averaged 11 fewer medications filled than their insured counterparts.

Lack of coverage poses particular concerns for those with chronic conditions. For example, beneficiaries with hypertension who lacked drug coverage were 40 percent less likely than those with drug coverage to purchase antihypertensive medications, according to a recent study by Blustein. Systematic underutilization of prescribed medications poses a threat to quality of care for individuals and potentially increases costs to the system in terms of avoidable emergency room and hospital admissions, physician visits, and nursing home stays.

Who Lacks Drug Coverage?

While two-thirds of the Medicare population receive some assistance with their prescription drug expenses, nearly a third (12 million) were without any form of prescription drug coverage in 1996—the most recent year for which national data are available. About half (6 million) of those without drug coverage had incomes below 175 percent of poverty, which was $14,600 for individuals in 2000 (Exhibit 7).

Lack of drug coverage disproportionately affects beneficiaries living in rural areas and the oldest-old (Exhibit 8). Those in rural areas were substantially more likely than others to be without drug coverage in 1996 (43 percent vs. 27 percent) in 1996. Beneficiaries ages 85 and older were more likely to lack drug coverage than those between the ages of 65 and 74 (38 percent vs. 29 percent).

The near poor are at high risk of being without drug coverage. Forty percent of beneficiaries with incomes between 100 percent and 150 percent of the federal poverty level lacked coverage in 1996. By contrast, 24 percent of those with incomes above 300 percent of poverty and 32 percent of those with incomes below 100 percent of poverty, where about half received drug coverage under Medicaid.

What Are the Sources of Prescription Drug Coverage?

Most beneficiaries have supplemental insurance to help fill the gaps in Medicare's benefit package, but the nature of that coverage varies widely by income (Exhibit 9). Those with higher incomes are more likely to have broader and more comprehensive retiree benefits, while those with low and modest incomes are more likely to rely solely on Medicare for coverage. Medicaid fills in gaps for those with the lowest incomes, but only assists slightly more than half of all poor Medicare beneficiaries.

The nature of supplemental coverage has a significant impact on the scope of prescription drug coverage and the level of out-of-pocket spending. Those with employer-sponsored retiree health benefits, for example, have substantially lower out-of-pocket expenses than those with Medigap or no supplemental coverage at all (Exhibit 10).

Employer-sponsored plans, the leading source of drug coverage for seniors, assisted 31 percent of the Medicare population in 1996, generally those with higher incomes. Half of those with incomes above 200 percent of poverty had employer-sponsored supplemental coverage compared to only a quarter of the near-poor and 8 percent of the poor. Benefits offered by employers to their former employees and spouses tend to be more generous than drug benefits covered under Medigap policies or Medicare+Choice plans.

Today's workers, however, are less likely than current retirees to receive drug benefits from their employer when they retire. The number of large employers offering health benefits to retirees 65 and older has declined from 80 percent in 1991 to 66 percent in 1999. Furthermore, among those employers that continue to offer benefits to retirees, reductions in drug benefits appear to be on the horizon. Forty percent of large employers report seriously considering cutting back on drug benefits for their retirees in the next three to five years, according to a recent survey of large employers conducted for the Kaiser Family Foundation by Hewitt Associates.

Medicare supplemental insurance, known as Medigap, is another potential source of prescription drug coverage for the Medicare population. In 1996, Medigap provided prescription drug benefits to approximately 10 percent of all Medicare beneficiaries. These policies are individually purchased by Medicare beneficiaries to supplement Medicare, largely by paying cost-sharing and deductibles. Beneficiaries pay premiums to have this coverage, with premiums ranging from about $1,400 per year to as much as $4,700 per year, depending on where they live, the type of coverage they obtain, and their age.

There are 10 standard Medigap policies (Plans A-J), three of which (Plans H-J) cover some prescription drug costs. Plans H and I have a $250 deductible and cover 50 percent of drug costs up to $2,500; Plan J covers 50 percent of drug costs up to $6,000. Premiums for Medigap policies that cover a portion of prescription drug expenses have risen dramatically in recent years, by as much as 20 to 30 percent in many markets across the nation. These high premiums appear to be making Medigap drug coverage increasingly unaffordable for the large share of beneficiaries who are living on modest incomes. In fact, only 537,000 of the 6 million beneficiaries with standard Medigap policies had a plan that included prescription drug coverage in 1999, according to a new study by Chollet and Kirk (Exhibit 11). Access to Medigap drug coverage is further restricted by a provision of the law that permits insurers to deny Medigap drug coverage to the under-65 disabled on Medicare, and others who lose coverage when they disenroll from their HMO.

In addition to employer-sponsored and Medigap coverage, a growing number of beneficiaries have turned to Medicare+Choice programs for assistance with their drug costs. Medicare HMOs assisted 8 percent of all beneficiaries with their drug costs in 1996 and as many as 12 percent in 2000. In recent years, many HMOs have been able to offer supplemental benefits, such as drug coverage, because Medicare requires plans with costs below the Medicare payment level to return savings to beneficiaries in the form of additional benefits or lower cost-sharing.

While HMOs in many parts of the country have until very recently been able to offer fairly generous drug benefits to enrollees, there is some uncertainty about the future capacity of Medicare+Choice plans to provide this coverage. The number of Medicare+Choice plans participating in the program has declined in recent years, as has the share of plans offering prescription benefits to enrollees. At the same time, Medicare+Choice plans that continue to offer prescription drug benefits are moving in the direction of capping their benefits as part of a broader strategy to reign in costs (Exhibit 12).

Medicaid and state operated pharmacy assistance programs also assist many low- and moderate-income beneficiaries with their drug costs. For the lowest income population, most notably Medicare beneficiaries receiving cash assistance and those who are in nursing homes, Medicaid provides coverage to fill in Medicare's gaps.

The Role of Medicaid

In 1997, 14 percent of Medicare beneficiaries (nearly 6 million people) depended on Medicaid for supplemental insurance coverage, and most were eligible for the full range of Medicaid benefits, including prescription drugs. Although coverage of prescription drugs is optional for states, all Medicaid programs currently provide prescription drug coverage for Medicaid enrollees. Medicare beneficiaries who receive cash assistance through the Supplemental Security Income (SSI) program (known as "dual eligibles") generally qualify for Medicaid prescription drug benefits.

Medicaid covers nearly half of Medicare beneficiaries with incomes below the poverty level and 40 percent of the non-elderly disabled Medicare population. Near-poor Medicare beneficiaries with incomes between 100 and 200 percent of poverty receive more limited assistance; their incomes or assets generally exceed the low levels required to qualify for full Medicaid benefits.

The Medicare-Medicaid dual-eligible population has poorer health status and greater health care needs than other Medicare beneficiaries. Over half of all dual eligibles report their health as fair or poor compared to a quarter of other beneficiaries. They are also more likely to have ongoing chronic illness and require long-term care assistance, leaving them particularly in need of assistance with medical care and prescription drug expenses (Figure 13).

Prescription drug coverage is the second most widely utilized benefit in Medicaid, largely due to the elderly and disabled population's reliance on the program for prescription drug coverage. In 1998, Medicaid spent $14.5 billion for prescription drugs, representing 8.2 percent of total Medicaid spending. Usage and costs vary considerably by enrollee eligibility category. The disabled and elderly accounted for 80 percent of all Medicaid spending for prescription drugs (Figure 14). In 1998, the disabled alone constituted less than a fifth of enrollees but accounted for over half of Medicaid drug expenditures. By contrast, children represented over half of Medicaid enrollees and accounted for only 12 percent of drug payments.

Prior to the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), limited formularies were the main strategy used by states trying to control Medicaid drug costs. With OBRA 90, states were given a new tool—the drug rebate program, which uses the government's volume purchasing authority to get discounted prices. Under this program, in order for a state to receive federal Medicaid matching funds for a manufacturer's prescription drugs, the manufacturer must agree to rebate a portion of drug payments back to the government in return for Medicaid covering all prescription drug products manufactured by the company. More than 500 manufacturers, representing 55,000 drug products, currently have federal rebate agreements. Some states also have separate rebate agreements with manufacturers.

The rebate program influences the acquisition cost for prescription drugs (purchase of the drug itself). Medicaid regulations limit payments for acquisition costs. While payment limits are based on the cost of specific drugs, these limits only apply to aggregate spending; states may set their own payment policies for individual prescription drugs as long as total expenditures for all drugs are at or below the amount determined using the payment limits. Medicaid payments for outpatient prescription drugs also include the dispensing fee, which pays pharmacists for filling the prescription. Medicaid regulations only require that dispensing fees be "reasonable."

Coverage of prescription drugs under Medicaid varies across states. States are allowed to establish formularies that limit coverage of specific drugs and are permitted to require prior authorization before dispensing any drug. Almost all states maintain a Medicaid formulary or list of approved products. Most states attempt to control Medicaid drug costs by placing limits on the number of concurrent prescriptions (as few as three permitted in some states), the amount of a given drug supplied at one time, or the number of refills permitted. Thirty-two states require copayments for prescription drugs, ranging from 50 cents to 3 dollars per prescription for certain beneficiaries.

As a quality control, states are also required to provide prospective and retrospective drug use review (DUR) for Medicaid enrollees who get drugs on an outpatient basis. Prospective drug use review (PDUR), performed by the pharmacist or practitioner prior to dispensing a drug, is intended to reduce medication errors and adverse drug events, while retrospective drug use review (RDUR) involves the review of provider drug prescribing history to identify safety and cost problem areas.

Medicaid is a crucial source of prescription drug coverage for a significant portion of the Medicare population, but many states are now struggling with the impact of rapidly rising prescription drug costs on state budgets. Rising costs stem not only from the increased average cost of drugs, but also from the increased volume of drugs prescribed. Medicaid payments for outpatient pharmaceuticals rose from an

estimated $4.8 billion in 1990 to $14.5 billion in 1998, an increase of almost 15 percent annually, largely due to rising costs for the disabled and elderly (Exhibit 15).

Because of Medicaid's coverage for the elderly and disabled, including nursing home residents, a greater share of the Medicaid dollar is devoted to prescription drugs compared to total national health care spending. Medicaid prescription drug expenditure growth consistently outpaces the total growth of prescription drug spending. Recent reports indicate that states are now seeking larger discounts from manufacturers, restricting access to expensive brand-name drugs, and proposing that local pharmacies lower their prices. As a result, states are likely to be looking to restrain—rather than expand—their coverage of prescription drugs in future years.

At the same time, limits to Medicaid coverage and restrictive income and assets test for eligibility, coupled with variations across states in both eligibility and coverage, leave millions of low-income Medicare beneficiaries without drug coverage. Some states (26 as of January 2001) have enacted state-based pharmacy assistance program to supplement Medicaid, and these programs now provide assistance to about one million people. However, these programs are limited in their ability to fill the gaps in prescription drug coverage and vary widely in terms of structure, eligibility, and benefits. While most provide a direct subsidy to low-income seniors, other approaches include discount programs, tax credits, and private-insurance models. Most are relatively new and not widely utilized.

Building on Medicaid and the state-based pharmacy assistance programs provides a means to direct assistance toward the lowest income Medicare beneficiaries. However, the variations across states in existing coverage and the limited reach and scope of most state pharmacy assistance programs perpetuates uneven coverage for low-income Medicare beneficiaries based on where they live.

Conclusion

Prescription drug use and expenditures are not evenly distributed among the Medicare population. Among Medicare's 40 million beneficiaries, nearly a third (30%) will incur drug expenses of less than $250 per year. In contrast, eight percent of beneficiaries will experience drug costs of $4,000 or more this year and account for over a third (36%) of the $50 billion in drug spending attributed to Medicare beneficiaries (Exhibit 16). These striking variations in spending within the Medicaid population underscore the importance of pooling the risk for coverage broadly.

Today the likelihood of having drug coverage to supplement Medicare depends largely on where you worked and whether you have retiree benefits, where you live and whether managed care plans are available in your area, what your income is and whether you are eligible for Medicaid or can afford to purchase coverage, and on how sick you are and whether plans are willing to enroll you if you have high drug costs. This is neither a fair nor rationale way to provide health insurance coverage to our nation's 40 million Medicare beneficiaries.

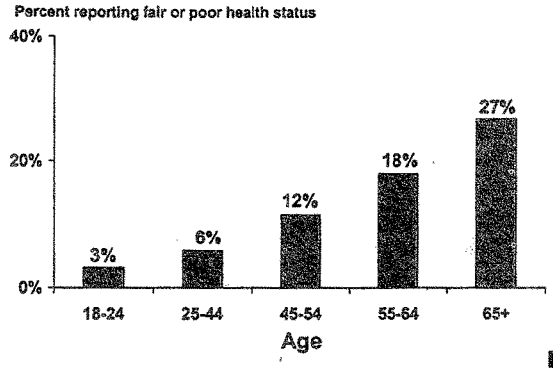
Use of prescription drugs to maintain functioning and promote well-being is an integral part of medical treatment today and should be an integral part of the health care coverage as well. Inclusion of prescription drugs into the Medicare benefit package would help to assure basic coverage for millions of our most vulnerable citizens and help to stabilize their coverage in either the traditional Medicare program or managed care plans. Broadening Medicare to cover prescription drugs would also help stabilize the current erosion of retiree health benefits and level the playing field between managed care plans and the traditional program, thus helping to both modernize Medicare and secure adequate future coverage.

Medicare has served the nation's elderly and disabled population well for more than 35 years. Much progress has been achieved through Medicare in alleviating disparities in access to care and bringing life saving medical advances to our elderly and disabled citizens regardless of income or residence. Our challenge now is to build on the strengths of Medicare by addressing its gaps and securing its financial viability.

I look forward to working with the Subcommittee to address this challenge. Thank you.

Exhibit 1

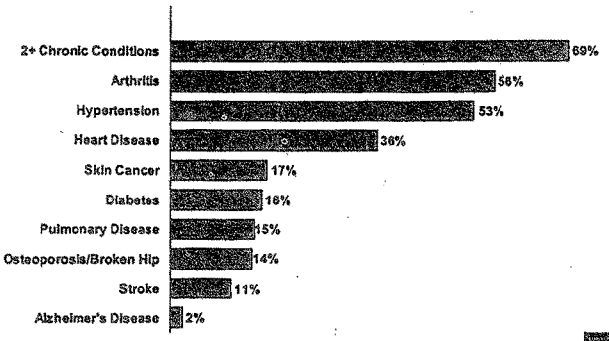
Health care needs increase with age



SOURCE: US DHHS, NHIS, 1998.

Exhibit 2

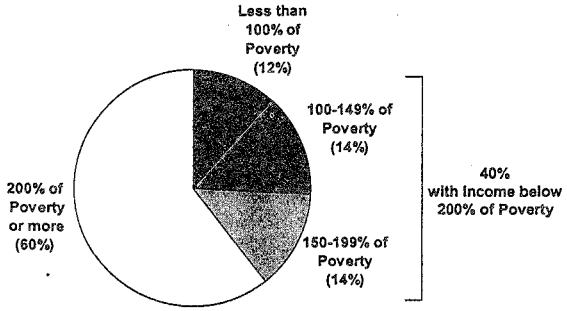
The Medicare population has substantial health needs



SOURCE: 1997 Medicare Current Beneficiary Survey.
Note: Data are for beneficiaries living in the community.

Exhibit 3

Four in ten Medicare beneficiaries have incomes below 200% of poverty

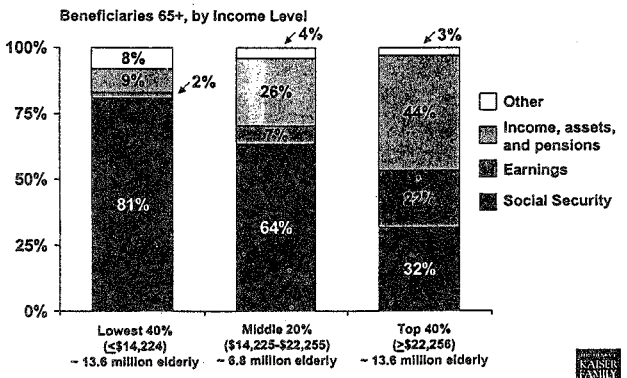


Total = 36 Million Medicare Beneficiaries

Source: Urban Institute estimates based on 2000 Current Population Survey.
Note: Reflects income from all household family members. If income from household family members other than spouse were excluded, 17% would have incomes below poverty. 1999 federal poverty was $8,240 for individuals; $11,060 for couples.

Exhibit 4

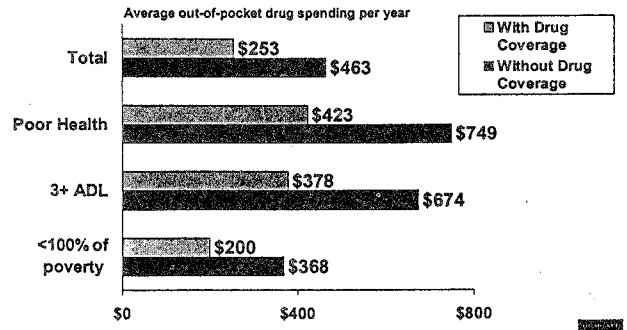
Most seniors rely on Social Security for the majority of their income



Source: Social Security Administration, March 2000.

Exhibit 5

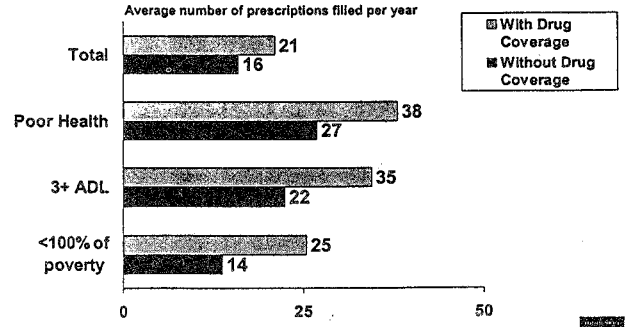
Medicare beneficiaries *without* drug coverage face higher out-of-pocket drug costs



Note: ADL = Activity of Daily Living
SOURCE: Poisal, J.A. and Chulis, G.S., *Health Affairs*, March/April 2000.

Exhibit 6

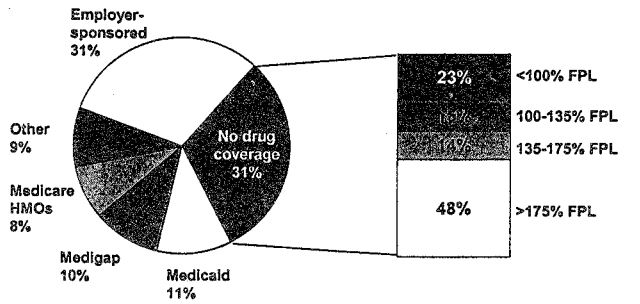
Medicare beneficiaries *without* drug coverage fill fewer prescriptions



Note: ADL = Activity of Daily Living
SOURCE: Poisal, J.A. and Chulis, G.S., *Health Affairs*, March/April 2000.

Exhibit 7

Nearly a third of all Medicare beneficiaries lack drug coverage, about half of whom are low-income



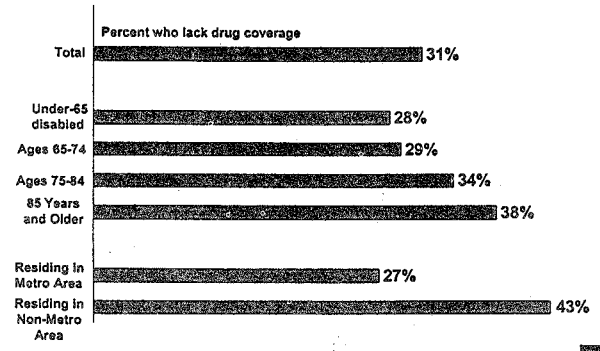
Total = 37.2 million beneficiaries

Total = 11.6 million beneficiaries without drug coverage

Source: Poisal, J.A., and G.S. Chulis, *Health Affairs*, March/April 2000.
Note: Data are based on the noninstitutionalized population.

Exhibit 8

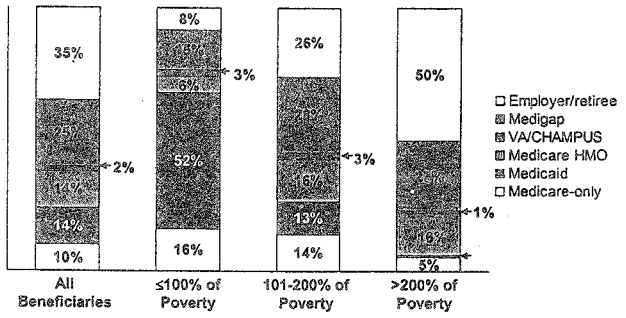
The oldest-old and those living in rural areas are most likely to lack prescription drug coverage



SOURCE: Poisal, J.A., and G.S. Chulis. *Health Affairs*, March/April 2000.

Exhibit 9

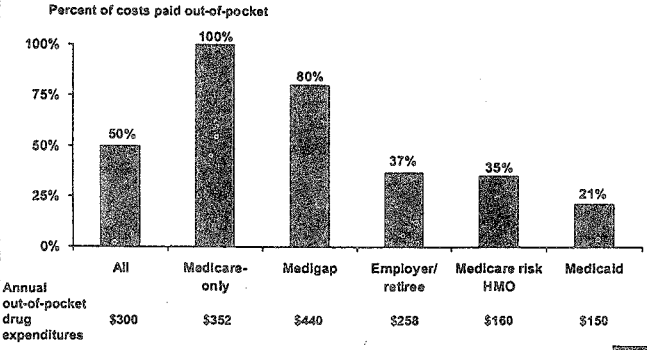
Supplemental insurance varies by income



Note: Columns may not sum to 100%; other sources of public coverage not shown.
Source: Urban Institute analysis of 1997 Medicare Current Beneficiary Survey.

Exhibit 10

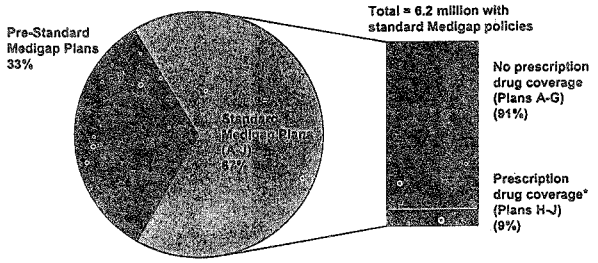
Out-of-pocket prescription drug costs vary by source of supplemental coverage



SOURCE: Davis, et al., 1999.

Exhibit 11

Medigap provides prescription drug coverage to fewer than 9% of Medicare beneficiaries with standard policies

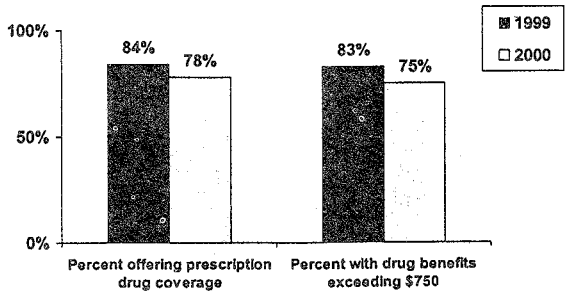


Total = 9.3 million Medigap policy owners, 1999

* For example, Plan I's drug benefit includes a $250 deductible, 50% co-insurance, and is capped at $1,250 per year.
Source: Chollet, D., and A. Kirk. "Medigap Insurance: Industry Structure, Change, and Implications for Medicare." Report to ASPE, DHHS (January 2001).

Exhibit 12

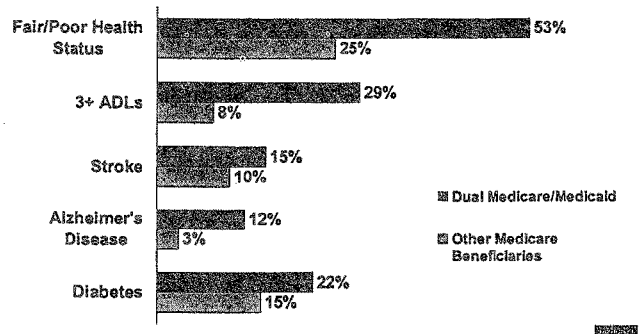
Prescription drug benefits offered by Medicare+Choice plans declined between 1999-2000



SOURCE: Mathematica Policy Research, Inc., analysis of Medicare Compare database 2000 for The Commonwealth Fund. (Benefit caps apply to prescription drug benefits in basic plans.)

Exhibit 13

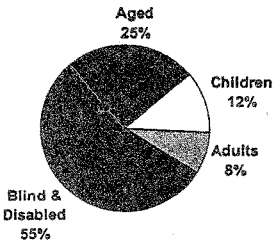
Medicare beneficiaries eligible for Medicaid are more likely to have serious health conditions



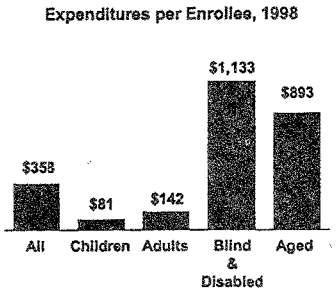
SOURCE: Medicare Current Beneficiary Survey, 1997.
Note: ADLs = Activities of Daily Living

Exhibit 14

The aged and disabled account for 80% of Medicaid prescription drug spending



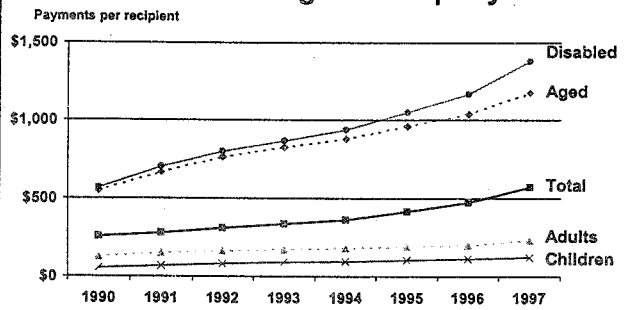
Total = $14.5 billion, 1998*



SOURCE: Urban Institute Estimates, 2000.
* 8.2% of total Medicaid spending on services.

Exhibit 15

Medicaid prescription drug payments for the aged and disabled are higher and rising more rapidly

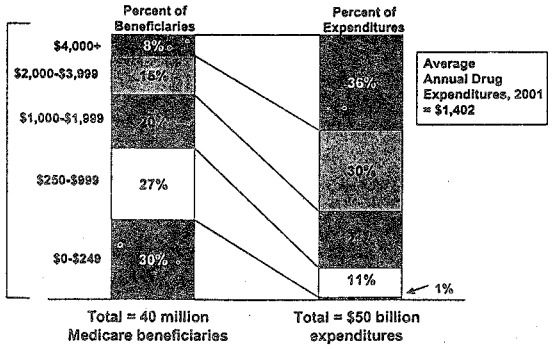


Source: Baugh, et al. Trends in Medicaid Drug Utilization and Payments, 1990-97 *HCFA Review*, Spring 1999.

Exhibit 16

Medicare prescription drug spending is skewed

Nearly a quarter of beneficiaries have drug expenses of more than $2,000 per year



SOURCE: Actuarial Research Corporation, January 2001.
Note: Based on '95 and '96 MCBS, adjusted for under-reporting and the exclusion of the institutionalized population, and projected based on CBO baselines. Numbers may not add to 100% due to rounding.

Mr. BILIRAKIS. Thank you very much, Ms. Rowland.

Mr. Weller. Please proceed, sir.

STATEMENT OF WILLIAM WELLER

Mr. WELLER. Thank you, Mr. Chairman, members of the committee. I am Bill Weller, Assistant Vice President and Chief Actuary of the Health Insurance Association of America. I appreciate the opportunity to testify on this important issue. I arrived at HIAA just after OBRA'90 passed and have assisted the HIAA members who offer Medigap products as well as Medicare+Choice plans since then.

Our members, including national Medigap writers, have a strong interest in meeting the needs of seniors. Medicare supplements are very popular with seniors; 90 percent have some type of additional coverage. HIAA is therefore concerned with any proposals to change these products. Changes designed to be improvements, if all the implications are not well understood, can create a worse situation for seniors, many of whom have no option other than Medigap.

In addition, as an actuary I have been involved with studies of Medigap experience for the American Academy of Actuaries. The academy's reports can be a valuable resource to Congress. These reports provide insight into the effects, positive and negative, of various ideas. HIAA believes it is very important to take steps now to help seniors better afford needed prescription drugs, yet changes must be made carefully to avoid disrupting private coverage millions now rely on.

I would like to take most of my time this morning comparing the principal factors I believe are needed for viable private drug coverage with the current rules and limitations of Medicare supplement, in particular the 10 Medigap standardized plans. But first, let me note that all seniors when they become eligible for Medicare have the right to purchase a Medigap plan which includes coverage of prescription drugs, plan H, I or J. Medigap carriers cannot deny coverage or charge these people an extra premium, for example, based on their poor health. However, the vast majority do not purchase drug coverage. It is expensive, and most are still healthy at that time.

The additional cost of Medigap plans H, I and J reflects both the cost of the drugs and the higher use of medical services by these people. The added cost from both appears to about equal the maximum amount of reimbursement for drug benefits alone within those plans.

Surveys document a high level of satisfaction among seniors with the Medigap coverage they maintain. Seniors recognize the value of this coverage if they need significant medical care. This can change if the Medigap policies that seniors buy quickly become unaffordable. Viable plans, public or private, that cover prescription drugs need to adequately address the following factors. They are discussed more fully in the written testimony.

Insurance costs. Successful private insurance plans, as you have already heard, have adopted formularies, encouraged generic substitution and used PBMs as important tools to maintain quality and control costs. Copayments in the past several years have been

changed to make insureds more aware of the substantial difference in costs for different drugs.

On the other hand, Medigap is generally not allowed to use restrictive networks and cannot change copays after issues.

The loss ratio standards in OBRA'90 are unlikely to leave enough margin for the cost of administering a modern drug benefit with these necessary tools.

Future trends. Everyone is aware of the increases in cost of prescription drugs. Projections for the future are also worrisome. Managing an insurance program which includes drug coverage entails updating formularies, adjusting copays, et cetera, not just increasing premiums. Even determining an insurance company or employer's willingness to continue the coverage is an issue. However, Medigap carriers, by law, cannot change anything except the premium. For example, in force policies could not be changed to require a higher copay for a brand name drug when there is a generic equivalent. And once a Medigap policy is issued, the carrier must continue the coverage.

Sources of revenue. Subsidies are generally considered necessary to generate high levels of participation in health plans. All the major drug proposals from the last Congress, whether relying on public or private insurance, included such a subsidy. A subsidy for added drug benefits within a Medigap plan where other benefits are not subsidized will have less perceived value. Thus, there is a lower likelihood of achieving satisfactory levels of participation.

Finally, adverse selection. I suspect that you are weary of actuaries raising this concern. Unfortunately it is real, and it must be controlled. Most employer-based groups control adverse selection by requiring continuous coverage of retirees. If the retiree drops coverage, they can't get it back. Medigap, because of expansions to open enrollment, has become easy to get back into.

Open enrollment is causing increases in rates for Medigap plans without drug coverage, and the effect would be even worse for new Medigap plans with drug coverage.

In closing, I can state that HIAA shares the concerns of many about the issue of drug coverage for seniors. We believe the ultimate solution will provide meaningful drug benefits as part of changes to the underlying Medicare program. But if changes are made before broad restructuring takes place, we need to move with extreme caution. Changes to Medigap and Medicare+Choice without changes to Medicare itself could harm the private coverage seniors now rely on. It could also reduce the coverage choices for future seniors like me.

Thank you.

[The prepared statement of William Weller follows:]

PREPARED STATEMENT OF WILLIAM WELLER, ASSISTANT VICE PRESIDENT AND CHIEF ACTUARY, HEALTH INSURANCE ASSOCIATION OF AMERICA

INTRODUCTION

Mr. Chairman, distinguished members of the Subcommittee, I am William Weller, Assistant Vice President and Chief Actuary of the Health Insurance Association of America (HIAA).

HIAA is the nation's most prominent trade association representing the private health care system. Its 290 members provide health, long-term care, dental, disability, and supplemental coverage to more than 123 million Americans.

During the past 10 years with HIAA, I have been involved in the actuarial aspects of Medicare Supplement products starting with the implementation of the changes required by Omnibus Budget Reconciliation Act of 1990 (OBRA'90). Prior to joining HIAA in 1990, I worked in the insurance industry for 25 years. I received my fellowship in the Society of Actuaries in 1971 and became a member of the American Academy of Actuaries in 1972. During the past several years, I have been a member of the Academy's Medicare Supplement Insurance Work Group, reviewing the causes of premium increases on Medicare Supplement (or Medigap) plans. Their final report (Medigap Report) was presented to the National Association of Insurance Commissioners in June 2000.

I am very pleased to be here today to speak with you about how the current Medigap market works, special challenges relating to the three Medigap plans that include prescription drug coverage, the impact of increasing costs and regulation on the premiums that seniors now pay for Medigap coverage, and the higher costs they would be asked to pay in the future if prescription drug coverage were to be expanded.

In the last section of my testimony, I will address the differences between Medigap and other products that provide drug coverage, and the implications for actuarial models used to estimate the price of each such product.

It is worthwhile to note the importance of the broad spectrum of Medicare Supplement products and the key role of Medigap plans within that spectrum. Because Medicare requires beneficiaries to pay deductibles and coinsurance amounts that can add up to substantial annual out-of-pocket expenses and because it does not cover the cost of care for truly catastrophic illnesses, 90 percent of seniors maintain additional, supplemental coverage.

Approximately 20 million seniors have some Medicare Supplement coverage, either through an employer-sponsored plan for retirees (11 million beneficiaries) or through an individually purchased Medigap plan (nine million beneficiaries). Many other seniors have supplemental coverage through Medicare+Choice or Medicaid. It is the nine million seniors who pay the total cost of supplemental coverage themselves by purchasing an individual Medigap plan who would have the biggest problem finding the resources to pay for new, mandated expanded coverage of prescription drugs.

Surveys conducted bi-annually by the Inspector General of the Department of Health and Human Services continue to show a high level of satisfaction among seniors with Medigap and with their choices including options with and without outpatient prescription drug coverage. These surveys also note the importance seniors attach to having these choices include a wide range of premium levels to allow affordable options. Even with this range, the most popular Medigap plans cover the beneficiaries' obligations under Parts A and B but do not include drug coverage.

SENIORS SHOULD HAVE EXPANDED ACCESS TO NEEDED PHARMACEUTICALS

Pharmaceuticals have become a critical component of modern medicine. Prescription drugs play a crucial role in improving the lives and health of many patients, and new research breakthroughs in the coming years are likely to bring even greater improvements. As older Americans become an ever-increasing percentage of the overall United States population, the need for more outpatient medicines, including maintenance drugs for this sector of the population, is growing rapidly. There is continuing emphasis on new pharmaceuticals to treat diseases typically associated with aging. Over 600 new medicines to treat or prevent heart disease, stroke, cancer, and other debilitating diseases are currently under development. Medicines that already are available have played a central role in helping to cut death rates for chronic and acute conditions, allowing patients to lead longer, healthier lives. For example, over the past three decades, the death rate from atherosclerosis has declined 74 percent and deaths from ischemic heart disease have declined 62 percent, both due to the advent of beta blockers and ACE inhibitors. During this same period, death rates resulting from emphysema dropped 57 percent due to new treatments involving anti-inflammatories and bronchodilators.

These advances have not come without a price. Rapid cost increases for prescription drugs are a major concern of our nation's seniors. We are using more drugs, and the average price for the drugs are rising. As a result, prescription drug spending has outpaced all other major categories of health spending over the past few years. For example, while hospital and physician services expenditures increased between 3 percent and 5 percent annually from 1995 through 1999, the Academy of Actuaries' Medigap Report showed Medigap claim costs growing at 11 percent annually (twice the rise in Medicare expenses) for the plans without drug coverage. The Academy also reported an increase of 16.5 percent per year for a plan in one state

that included extensive coverage of drugs and more frequent guarantee issue options.

A study completed in 2000 for HIAA and the Blue Cross and Blue Shield Association by the University of Maryland's School of Pharmacy found that drug spending will increase at an even faster pace than the government had been predicting. The University of Maryland researchers project that the nation's expenditures for prescription drugs will increase at a rate of 15-18 percent per year over the next five years, more than doubling annual drug spending from $105 billion in 1999 to $212 billion by 2004. According to the lead author of the study, Dr. C. Daniel Mullins, 60 percent of those expenditures will be caused by increases in the price and use of drugs already on the market today, while 40 percent will be attributable to the cost of drugs still under development—so-called "pipeline" pharmaceuticals.

These statistics all demonstrate the increasing proportion of seniors' overall medical costs, which are for outpatient prescription drugs. Probably as a result of this fact, roughly two out of every three seniors have some type of insurance coverage for pharmaceuticals—either through employer-sponsored retiree health plans, private Medicare+Choice plans, Medicaid or, in limited instances, individual Medigap policies. Yet, HIAA recognizes the concerns for those without any coverage, as well as those in fear of losing the coverage they currently have.

Whatever path Congress chooses to follow to bring expanded drug coverage to Medicare beneficiaries, it is vitally important not to jeopardize the supplemental coverage that seniors now have, whether or not it includes coverage for drugs. Seniors rely heavily on their supplemental plans since Medicare now pays just 50 percent of their medical costs. As already noted, seniors are highly satisfied with their supplemental coverage and value the range of choices now available to them in supplemental plans.

DETAILS OF THE CURRENT MEDIGAP MARKET AND ISSUES WITH EXPANDING DRUG COVERAGE

The existing Medigap market provides 10 standardized plans, three of which include some prescription drug coverage (plans H, I, and J). A "high deductible" option is also available with two plans (plans F and J), but has not proved popular with seniors. Except for the high deductible addition, these plans have not been changed since developed immediately following OBRA'90. The attached chart showing the benefits provided by the various Medigap standard plans is very familiar.

The Medigap market also includes the Medicare SELECT option that allows the insurer to provide benefits through a network of health care providers who agree to provide care at discounted rates in return for a higher volume of patients. Certain Medigap benefits are not paid for out-of-network care. Medicare SELECT has grown steadily since the program was first authorized and is now allowed in all states.

There are now a number of open enrollment opportunities for Medicare beneficiaries to purchase new or replace existing coverage with a Medigap plan. OBRA "90 established a six-month open enrollment period for Medigap coverage beginning when a beneficiary is age 65 or older and enrolls in Part B. A beneficiary applying for a Medigap plan during this period may not be denied coverage and cannot be charged a higher premium because of poor health. All Medigap plans, including those with prescription drug coverage, are available during this open enrollment period.

From 1991 through 1997, there was a small amount of expansion in open enrollment under laws enacted in a few states. Since then, federal legislation (BBA, BBRA and BIPA) has expanded the open enrollment opportunities and states have frequently gone beyond the federal open enrollment standards.

ISSUES WITH EXPANDING MEDIGAP DRUG COVERAGE

HIAA believes that Medigap is not a good starting point for legislative proposals to expand drug coverage for seniors. In addition to a host of other problems with this approach, which are discussed below, several studies show that adding a drug benefit to Medigap plans that currently do not include such coverage would increase premiums dramatically. Seniors who today have chosen to purchase Medigap policies that do not provide a drug benefit would be forced to pay an additional $600 or more a year (assuming a $250 deductible for expanded drug benefits), according to HIAA estimates.

Revising the existing Medigap market to include expanded coverage of prescription drugs would need to address three key participants in the market—Insurance Regulators, Medicare Beneficiaries and Medigap Writers.

Regulators—The National Association of Insurance Commissioners (NAIC) would likely have to develop standards for new Medigap plans. State regulators

would have to approve new policy forms before they could be sold, as well as scrutinize their initial rates and any proposed rate increases. Even relatively straightforward product changes based on proven design formulas can take several years to progress from the design stage through the regulatory approval process and, finally, to market.

The requirement that Medigap policies must be "guaranteed renewable" (GR) would exacerbate problems with creating insurance that reflects modern drug benefits. If the NAIC were to standardize a new set of GR plans with greater drug coverage, as some have proposed, it could impose unworkable limitations on the use of pharmacy benefit managers (PBM) or formularies. Once coverage is issued, insurance carriers would be prevented by contract from increasing co-payments and deductibles as drug costs continue to skyrocket. Effective cost management would be extremely difficult. On the other hand, allowing needed flexibility, including PBMs and formularies, would destroy the standardization of Medigap that Congress and the NAIC have worked so hard to achieve during the past decade.

The states would also need to create a set of transition rules that are fair to both beneficiaries and companies with existing policies and that do not run afoul of the guaranteed renewability requirements for Medigap policies. Establishing and administering such rules would be a very difficult task.

Medicare Beneficiaries—Surveys show that there is considerable recognition of the current plans among seniors. Thus, changes to the standard plans are likely to create some confusion. In addition, open enrollment opportunities for viable products with expanded drug coverage would need to be limited to avoid severe adverse selection. Finally, the level of initial premiums for Medigap plans and the size of premium increases over time will both need to rise substantially if there is expanded drug coverage. Even if proposed premium increases were consistent with state law parameters, seniors and state regulators would be likely to resist approving the magnitude of increases it will take to sustain an insurance policy as drug prices grow rapidly.

Medigap Writers—Insurance carriers attempting to offer Medigap plans with expanded drug coverage for seniors would have to address difficult business decisions and cost issues:

- costs of development, marketing and administration of the new plans;
- costs of new processes for drug benefits (e.g. PBM interface and formularies);
- increasing and volatile cost of drugs to be reimbursed;
- reflecting the value of any government subsidy to some or all seniors for their drug coverage; and
- estimating the impact of adverse selection.

Premiums for the new Medigap form would have to reflect these costs. However, one substantial barrier is that the expense margin limitations insurance carriers must meet under OBRA "90 (which are a function of the dollars paid to Medigap insured) are too small to support the expected administrative costs of expanded drug coverage. Finally, premium increases for Medigap plans would become even larger, generating further adverse selection with the potential that the product may not remain viable.

In our view, the combined weight of these problems would doom any attempt to focus on private Medigap plans as a principle source of expanded drug coverage to seniors.

PRIVATE INSURANCE OPTIONS WITH DRUG BENEFITS

As already noted, a significant number of Medicare beneficiaries already have insurance for their prescription drug expenses from the private market. In addition, Medicaid as a public option provides insurance for many low-income beneficiaries.

The vast majority of the private options rest on four characteristics to maintain a viable insurance product:

1. The full cost of the drug program is not expected to be paid by the individual.
2. The drug benefits are part of comprehensive, coordinated care management so that the risk taker for the full set of benefits will receive any offset from lower required use of other medical services.
3. The drug benefit is managed and, if necessary, modified to control growing costs, by utilizing formularies, generic substitution, and other cost saving opportunities, consistent with good medical care.
4. The option is structured to avoid adverse selection by giving beneficiaries strong incentives to maintain coverage even when their expected drug costs are low.

Employer-based coverage is the primary source of existing drug coverage for seniors. Most employer-sponsored plans incorporate the "viability" factors listed above or are rapidly moving to incorporate them. Yet, even these plans are finding the pri-

vate option increasingly expensive. Recent surveys indicate that employers are contemplating several changes for their retiree health care plans over the next several years, including increasing premiums and cost-sharing (81 percent of respondents to a 1999 Hewitt Associates survey sponsored by the Kaiser Family Foundation) and cutting back on prescription drug coverage (40 percent).

Medicare+Choice plans, the second most utilized option for prescription drug coverage, have used the savings they have achieved through efficient total care management to offer drug benefits. Unrealistically low increases in government payments to Medicare+Choice plans, however, are having the effect of reducing drug coverage for many seniors enrolled in these plans and threatening the very continuation of the Medicare+Choice program.

Medigap plans H, I, and J (which cover drugs) are subject to underwriting, except during open enrollment. The ability to underwrite these plans is the only one of the four "viability" factors currently available to insurers offering these plans. Even so, studies have shown that these plans experience higher use of part A and B services. As a result, costs of non-drug Medigap benefits for plans H, I, and J are higher than the same benefits within Medigap plans A through G. These are major reasons why the cost of plans H, I, and J is often prohibitive.

There is a growing use of "drug discount cards." These non-insurance programs provide access to discounted drug prices. However, drug discount card programs do not spread the cost of prescription drugs as with insurance products. Instead, these cards provide seniors with significant discounts to retail prices at designated pharmacies. The vast majority of Medigap writers offer such opportunities where not restricted by state regulation. Some of these drug discount cards are now being advertised on television, reflecting their growing attractiveness to seniors as a viable alternative to the increasingly expensive insurance options for drug coverage.

MODELING A PRESCRIPTION DRUG BENEFIT FOR SENIORS

Insurance products rest on actuarial models to estimate the future benefits, costs, and revenues necessary to support the product. Modeling coverage of prescription drug benefits involves:

- projecting costs for different subgroups of the insurable population (minus the portion to be paid by the insured);
- adjusting these base year costs for periodic cost increases (trend) and shifting patterns of care;
- approximating government provided payments, if any;
- reflecting the expected willingness of these various subgroups of the population to purchase the coverage; and
- allowing for the chance that new, higher premiums will cause healthier Medicare beneficiaries to discontinue their coverage.

Costs for drug coverage for seniors, prior to any of the other adjustments, are projected to rise by 15 percent each year. A table in another Academy of Actuaries report, *Medicare Reform: Providing Prescription Drug Coverage for Medicare Beneficiaries,* shows the effect of various cost-sharing provisions on this base rate of increase. The table (Table 3 is attached) demonstrates that premium rates for universal coverage would need to increase more than 15 percent to keep pace with rising drug costs. For example, the impact of a deductible increases insurance costs at a faster rate than the cost of the underlying benefits (e.g. a $500 deductible would require an 18.8% increase to offset the effects of "deductible leveraging" when all costs increase by 15%).

If the "benefit maximum" were changed to an "out-of-pocket maximum" to include stop-loss or catastrophic coverage (part of many of the proposals from last year), this feature, along with the others, could generate premium increases of 25 to 30 percent per year for the first few years. Products that contractually cannot adjust benefits (e.g. Medigap) can only increase premiums. Rate increases of this magnitude would create additional problems.

Volatility in pharmaceutical cost trends also makes private drug coverage difficult to price. While there has been relative stability in the rate of increase of hospital and physician costs during the past two decades, pharmaceutical costs have been more difficult to predict. In March 1999, for example, HCFA estimated that prescription drug expenditures would reach $171 billion by 2007. Just six months later in September, HCFA was forced to revise these projections and the new prediction was that prescription drug spending will reach $223 billion by 2007, which is a 30 percent increase over the previous estimate.

Several legislative proposals in the past have included some government contribution to eliminate the "individual pay-all" problems when using voluntary programs. It was often stated that this subsidy would result in almost universal acceptance

of any offer to provide coverage. However, many actuaries do not believe 25 percent or even 50 percent subsidies are sufficient to achieve 70 percent acceptance, much less universal acceptance. These actuaries point to the increasing unwillingness by some employees to pay the required employee contribution for employer-sponsored coverage as evidence.

In addition, the ability of government contributions to maintain a consistent share of the costs of a private option over 20 years is hard to imagine. Errors in cost assumptions, changes in patterns of including drugs in comprehensive medical care, and other budgetary dictates could reduce the level of subsidy. The insurers' obligations to Medicare beneficiaries are not likely to be reduced simply because of a shortfall in the percentage of costs contributed by the government.

Appropriate oversight of the use of PBMs and/or formularies will likely be a part of any successful legislation that includes a government subsidy for prescription drug coverage. Actuaries will look to existing examples of this oversight to estimate its likely effect and cost to be included in the price of the new coverage. The two representative examples are the oversight of employer-plans and Medicare+Choice Organizations. Medicare+Choice Organizations are subject to more restrictive controls, so there is a higher level of administrative cost to meet the control requirements. The employer-based market has lowed costs and flexibility to quickly adjust to changing circumstances.

The most difficult factor to model, however, will be "adverse selection." Adverse selection, which tends to drive up premiums, occurs because those who expect to receive the most in benefits from the policy will purchase it immediately, while those who expect to have few claims will forego purchasing it. When people with low drug costs choose not to enroll in coverage while those with high costs do enroll, insurance carriers are forced to charge higher premiums to all policyholders. The more opportunities there are for enrollment, the greater the risk of adverse selection.

Adverse selection is and will be a very real problem for private insurers, particularly those selling coverage on an individual basis. Using cost estimates for the year 2000, one-third of seniors (even if all had coverage for outpatient prescription drugs) would have drug costs under $250 per year, with the average cost estimated at $68 annually. These seniors are unlikely to purchase any type of private drug coverage without almost a complete subsidy of the cost, given that the premium for such coverage would be at least 10 times higher than their average annual drug costs. Of the two-thirds who might buy the coverage, many would be doing little more than dollar trading without a significant subsidy. Some may actually end up much worse off: a person with $500 of drug expenses could have premium, deductible, and coinsurance costs of about $1,000 or twice the actual costs of drugs. Consequently, many relatively healthy seniors are not likely to purchase the product, resulting in further premium increases for those that do.

Employer plans control this type of adverse selection by limiting eligibility to employees and spouses at the time they retire. In addition, beneficiaries with coverage must maintain the coverage continuously, even in years when their expected use of the insurance coverage is low. Re-enrollment is not permitted.

Medicare+Choice Organizations cannot directly control adverse selection due to the annual open enrollment requirement. This has caused Medicare+Choice Organizations to be very concerned that rich drug benefits would lead to disproportional enrollment of those with high drug costs. Offsetting this risk to some extent has been the ability of Medicare+Choice Organizations to manage the entire medical and pharmacological risk. But the manner in which the Health Care Financing Administration is implementing risk adjustment sharply reduces the value of this offset since there is no risk adjustment factor attributed to drug benefits.

As previously noted, Medigap has seen considerable expansion of open enrollment opportunities. Actuarial models would likely anticipate a similar expansion for drug coverage even if the legislation only provided a single eligibility period initially.

The expansion of Medigap open enrollment opportunities is generally felt to be one of the causes of above average increases in Medigap costs since 1996. The American Academy of Actuaries Medigap Report to the NAIC noted:

> "While it is too early to evaluate the quantitative effects of the 1997 Balanced Budget Act requirements for the guaranteed issue of certain Medicare Supplement plans to individuals who lose Medicare+Choice health coverage, this requirement may provide opportunities for anti-selection. The level of anti-selection will be affected by individuals' health status, by whether Medicare+Choice alternatives exist, and the ease [for beneficiaries] to move in and out of plans (e.g. in Massachusetts, there are virtually no limits on individuals moving in and out of plans).

In the other Academy report on prescription drug coverage, they address this issue as well:

"Seniors (many of whom are on drug therapies for chronic medical conditions) can more easily predict the level of their out-of-pocket drug costs than is the case with their other health costs. They also frequently know the specific drugs they will need. Accordingly, adverse selection presents a greater technical obstacle for programs with voluntary elements; for example, when there are different choices in the levels of coverage (e.g., different deductibles or annual maximums) or in the particular drugs covered (e.g. formularies). Similarly, the overall level of both prescription and other expenditure required by beneficiaries who use a specific drug is more predictable than the case with other acute health care services"

Illustrating the concern, Table 2 (attached) from this last report shows that seniors with at least an average of three prescriptions per month make up 40 percent of seniors. Their costs are over 3.5 times the average costs of the other 60 percent. In addition, the table notes that these more frequent users, reflecting greater incidence of maintenance drugs, have a lower rate of using generic drugs.

Adverse selection is considered within actuarial models when coverage must be offered in open enrollment situations. It is also considered when insurers must increase premiums by 20-30 percent each year to cover rising costs. Policyholders will compare the higher premiums to their current and expected costs. Those who expect to receive relatively little in benefits (generally due to low actual use of drugs in the prior year) are much more likely to lapse their existing coverage (citing unaffordability as their reason) than those who recognize that their insured drug costs have been more than the premiums they have been paying.

Drug discount card programs are not likely to suffer from adverse selection because, unlike insurance programs, there is no spreading of costs. At present, they have no method to provide any subsidy beyond the discounts provided by the pharmacies in their network.

CONCLUSION

There is no question that seniors, especially seniors with low incomes, need help with the cost of the prescription drugs vital to their health. However, the likely effects of any new policy proposal must be carefully examined to ensure that unintended consequences do not erode the private coverage options that beneficiaries rely on today to meet their health care needs. Actuarial models have significant value in projecting the implications of proposals on the premium costs for various groupings of likely insureds. More important, these models also address the impact of potential ongoing changes—legislative, economic and insurance related.

HIAA shares the concerns of many public voices today calling for measures to help seniors better afford prescription drugs. HIAA developed a proposal in 2000 which, we still believe, represents an immediate and workable step that will provide meaningful relief for seniors before addressing needed changes in the underlying Medicare program.

HIAA is extremely concerned with proposals that would require Medicare supplement insurance or Medicare+Choice plans to cover the costs of outpatient prescription drugs without the addition of prescription drug coverage as a Medicare covered benefit. Mandating all Medigap policies to include a drug benefit would not be popular with seniors—who would experience diminished choice of policies, higher prices, and in some cases, loss of coverage.

HIAA stands ready to work with the members of this Subcommittee, and all in Congress and the Administration, to ensure that all seniors to have access to affordable prescription drugs.

ATTACHMENT A

Benefits Covered By Standard Medigap Plans

Covered Benefits	Standard Medigap Plans									
	A	B	C	D	E	F**	G	H	I	J**
Core Benefits*	P	P	P	P	P	P	P	P	P	P
Part A Deductible	.....	P	P	P	P	P	P	P	P	P
SNF Coinsurance	.....	.....	P	P	P	P	P	P	P	P
Foreign Travel Emergency	.....	.....	P	P	P	P	P	P	P	P
At-Home Recovery	.....	.....	.....	P	.....	.....	P	.....	.....	P
Part B Deductible	.....	.....	P	.....	.....	P	.....	.....	.....	P
Part B Excess Charges	.....	.....	.....	.....	.....	P	1	.....	P	P
Prescription Drugs	.....	.....	.....	.....	.....	.....	.....	2	2	3

Benefits Covered By Standard Medigap Plans—Continued

Covered Benefits	Standard Medigap Plans									
	A	B	C	D	E	F**	G	H	I	J**
Preventive Medical Care	.....	.....	.....	.....	P	.....	.....	.....	.....	P

*Core benefits include Part A co-payment for days 61-90 in the hospital, Part A co-payment for each lifetime reserve day in the hospital, up to 365 additional days of hospital coverage after Medicare coverage is depleted, the first three pints of blood used under Part A or Part B, and the 20-percent coinsurance for Part B services after the Part B deductible has been met.

**Plans F and J also have a high deductible option. The high deductible, which is adjusted for inflation, is $1,530 in 2000.

[1] Medigap policy pays 80 percent of balance billing charges.

[2] After $250 deductible, policy covers 50 percent of prescription drug costs to a maximum of $1,250.

[3] After $250 deductible, policy covers 50 percent of prescription drug costs to a maximum of $3,000.

Table 2—Distribution of Prescription Expenditures for Seniors

Scripts per Year	Percent of			Relative to Population Average		Generic Drugs	
	Members	Scripts	Costs	Scripts	Cost	% of Scripts	% of Cost
0 to 12	21.9	4.4	2.1	0.20	0.10	69	41
12 to 24	20.0	11.0	7.1	0.55	0.36	58	30
24 to 36	18.2	16.2	12.6	0.89	0.69	54	27
36 to 54	20.3	26.4	24.5	1.30	1.21	50	24
54 or more	19.5	42.0	53.6	2.15	2.74	47	21

Source: Data provided by a national Medicare+Choice Health Plan

Table 3—Annual Rates of Increases in Prescription Drug Insurance Plan Costs Per Capita Assuming 15 Percent Per Year Increases in the Cost of Drugs

Cost Sharing Feature	Annual Rate of Increases	
	Through CY 2005	Through CY 2020
A. Fixed Dollar Amounts		
Co-payments ($10 Generic/$20 Brand)	18.5%	15.5%
50% Coinsurance with annual deductibles of:		
$100	15.7%	15.0%
$500	18.8%	15.4%
$2,000	29.2%	16.9%
50% Coinsurance with benefit maximums of:		
$2,500	10.9%	2.4%
$5,000	13.6%	4.3%
B. Amounts Adjusted for 2.5% annual increases in CPI		
Co-payments ($10 Generic/$20 Brand)	17.9%	15.6%
50% Coinsurance with annual deductibles of:		
$100	15.6%	15.0%
$500	18.2%	15.5%
$2,000	27.1%	17.3%
50% Coinsurance with benefit maximums of:		
$2,500	11.9%	5.4%
$5,000	14.0%	7.6%

Note: Trend in per capita spending assumed to be 15 percent per year. Per capita expenditures trend comprised of prices (3 percent), mix of drugs (8 percent) and volume (3.5%).

Mr. BILIRAKIS. That is a good way to finish.

Ms. Buckley to tell us about Nevada.

STATEMENT OF BARBARA E. BUCKLEY

Ms. BUCKLEY. Thank you, Mr. Chairman, members of the committee. For the record, my name is Barbara Buckley. I am serving my fourth term as the assembly representative for district 8 in Clark County, Nevada, which is Las Vegas. I also serve as the majority leader for the Nevada Assembly. I have served on the com-

merce and labor committee for four terms, and on the health and human services committee for three terms.

In my tenure in the Nevada Legislature, I have worked extensively on health care issues, sponsoring our Nevada patients' bill of rights in 1997 and expanding our work by creating an cabinet level ombudsman for patients in 1999.

In 1999, I was also part of the assembly leadership team that fought to ensure our tobacco dollars were earmarked for health care, senior programs, and programs to prevent tobacco use in our State. I am proud to say that those efforts were successful, and as a result, 60 percent of our funds were earmarked for these purposes.

Like most legislation enacted in Nevada and indeed everywhere, our tobacco legislation was a result of compromise between both parties with divergent opinions on how best to achieve our goals. We were committed to securing a portion of the funds to promote independent living programs for seniors as well as establishing a prescription drug plan.

When our Governor asked that we try an insurance-based prescription drug plan for seniors, many of us were skeptical about whether such a plan could work, but agreed to try the plan to ensure that all of our goals for our tobacco legislation were met. And so with the unanimous support of the 1999 Nevada Legislature, we began our experiment with an insurance-based senior prescription drug plan.

The statute sets forth the details of our plan. A senior is eligible for a subsidy from our tobacco funds based on their income level. Generally from zero to $12,000, they are eligible for a 90 percent subsidy. It goes up to $21,500, and at that income level a senior is eligible for 10 percent subsidy. The maximum amount of subsidy that could be awarded to a senior is capped at $480 per year. $4.2 million was set aside to begin our program. It was estimated that 10,000 seniors could be served.

Implementation of our program was left to the Department of Human Resources. They issued a request for proposal to hundreds of insurance companies. Only one unlicensed insurance company bid. The RFP was reworked, relet. At that time six insurance companies bid, and one was selected.

The successful bid resulted in our senior RX program. As you can see from the testimony and the handouts, there are two programs contained in this, a blue and a silver program. The premium for a blue program is approximately $75 a month or $900 a year. There is a $100 calendar year deductible. A managed formulary is utilized. Generic drugs cost $10; preferred drugs cost $35 or 50 percent of the cost of the drug, whichever is greater. Nonpreferred drugs are not covered, and there is a $5,000 maximum annual plan benefit.

There is also a silver program which costs approximately $99 a month. Generic drugs are $10; preferred brands are $25; nonpreferred brands are $40 or 40 percent of the cost of the drug. There is also a $5,000 cap on that program as well.

As of January 26, 2001, 1,400 applications have been received, and 124 seniors were enrolled. I learned from our Governor yesterday we have had 65 people enroll. Almost 700 people are eligible

for the subsidies, but have not yet chosen to sign up for the benefits or pay their share of the premiums.

Reviews of the program are decidedly mixed. I am pleased that the Nevada Legislature and the Governor felt that establishing a drug program was important for our State. I am also pleased that our State chose to go forward instead of waiting for Congress to act. No offense meant.

The program, though, has a number of shortcomings. First, the program only covers 10- to 12,000 seniors who earn less than $21,000. That means there are over 100,000 additional seniors earning below 21,000 who are unable to take advantage of our program due to funding limitations. Seniors who earn 21,000 or more are not eligible at all. These excluded seniors should not have to choose between paying their power bill and affording prescription drugs, a very real choice today.

For those that are offered coverage, the insurance model does not result in an affordable prescription drug model for many. I have attached charts showing sample seniors. In one, a senior must pay $35 a month in premiums and still $327 in copays. If her income is $12,000 a year, she is still spending 34 percent of her income for drugs.

It is also difficult for seniors to figure out how the program works, and it also excludes all Medicaid beneficiaries who are not seniors. In March of 2001, the Nevada Legislature is going to begin hearings on a number of different alternatives that other States are considering, and I have outlined those in my testimony, and I am sure you are very familiar with them. I know this committee has been studying this issue for some time and has great expertise.

In conclusion, I will offer a couple of observations from my vantage point some 3,000 miles away. A private insurance plan is not successful in helping our seniors if it is unaffordable. At this point, for many, our plan is unaffordable. And even if we had the lowest-cost plan in the Nation, we would only cover 10,000 people when hundreds of thousands need help.

I believe we need to add a prescription drug benefit to Medicare so that everyone in need can be helped. Our State resources are strapped in implementing new programs. A uniform program passed by this Congress that would apply to all seniors would be most effective in helping our Nevada seniors in need.

My experience with this insurance-based approach is that its elements are often confusing for seniors, and if the insurance companies find that they cannot make money, they withdraw from the market, again leaving our seniors without help.

Thank you.

[The prepared statement of Barbara E. Buckley follows:]

PREPARED STATEMENT OF BARBARA E. BUCKLEY, ASSEMBLYWOMAN, STATE OF NEVADA

Mr. Chairman, members of the Committee, for the record my name is Barbara E. Buckley. I am serving my fourth term as the Assembly representative for District 8 in Clark County, Nevada. I also serve as the Majority Leader for the Nevada Assembly. I have served on the Commerce and Labor Committee for all four terms and served on the Health & Human Services Committee for the previous three terms.

In my tenure in the Nevada Legislature, I have worked extensively on health care issues, sponsoring the Nevada Patient's Bill of Rights in 1997 and expanding on our

work by creating a cabinet level position of Ombudsman for Health Care Consumers in 1999.

In 1999, I was part of the Assembly leadership team that fought to ensure our tobacco dollars were earmarked for health care, senior programs, and programs to prevent tobacco use in our state. I am proud to say that those efforts were successful and that Nevada dedicated 50% of its tobacco dollars to these programs.

Like most legislation enacted in Nevada, and indeed all 50 states, our tobacco legislation was the result of compromise between elected officials of different parties with divergent opinions on how to accomplish what is best. The Assembly leadership was committed to securing a portion of the funds to promote independent living programs for senior citizens as well as establishing a prescription drug plan.

When our governor asked that we try an insurance-based senior prescription drug plan, many of us were skeptical about whether such a plan could work but agreed to try the plan so as to ensure our other goals in the legislation were met. And so, with the unanimous support of the 1999 Nevada Legislature, we began our experiment with an insurance-based senior prescription drug plan.

The statute sets forth basic details of the insurance-based prescription drug plan. A senior would be eligible for a subsidy depending on his or her income. The attached chart reflects the subsidy available:

Income	Subsidy
$0-$12,700	90%
$12,700-14,800	80%
$14,800-17,000	50%
$17,000-19,100	25%
$19,100-21,500	10%

The maximum amount of subsidy that could be awarded to an individual was capped at $480.00 per year. $4.2 million was set aside to begin the program; it was estimated that approximately 10,000 seniors could be assisted.

Implementation of the program was left to the Nevada Department of Human Resources. The department decided to initiate a request for proposals to all insurers for participation in the Senior RX program. They decided at the outset to set few, if any, parameters on program design. For example, it did not require compliance with any sort of affordability design for co-payments or deductibles; it did not require adherence to any sort of appeal process if the insurer were to use a formulary. The administration wanted to ensure that it received as many bids as possible and left program design to the insurance companies.

In March of 2000, Nevada released its first request for proposals. The results were disappointing; only one insurance company applied and it was not licensed in the State of Nevada. The request for proposals was redesigned and re-released. Five companies submitted a bid and in the fall of 2000, Fidelity Security Life Insurance Company was selected.

The successful bid resulted in the Senior Rx Program. Attached to my testimony is its outline. As you can see, there are two programs—a blue and a silver.

The premium for blue program costs $74.76 a month or $897.12 a year. There is a $100 calendar year deductible. A managed formulary is utilized. Generic drugs cost $10.00; preferred drugs cost $35 or 50% of the cost of the drug, whichever is greater. Non-preferred drugs are not covered. The maximum annual plan benefit is $5,000.

The premium for the silver plan's premium is $98.31 a month or $4,179.72 a year. Generic drugs are $10.00; preferred brands are $25. Non-preferred brands are $40 or 40% of the cost of the drug, whichever is greater. The maximum annual plan benefit is also $5,000.

As of January 26, 2001, 1,457 applications for the program have been received; 124 are enrolled. Almost 700 people are eligible for the subsidies, but they have not yet chosen to sign up for the benefits or pay their share of the premiums. They have 60 days to do so.

Reviews of the program are decidedly mixed. I am pleased that the Nevada Legislature and the Governor felt that establishing a prescription drug program is a high priority for our state. I am pleased that our State chose to go forward instead of waiting for Congress to act. However, our program has many serious shortcomings.

First, the program only covers 10,000-12,000 seniors who earn less than $21,500. That means there are over 100,000 additional seniors earning below $21,500 who are unable to take advantage of the program due to funding limitations. Seniors who earn $21,501 and higher are not eligible at all. These excluded seniors should

not have to choose between paying their power bill and affording prescription drugs—a very real choice right now.

For the few that are offered coverage, the insurance model approach does not result in an affordable prescription drug model for many. For example, if Mary Smith earns $12,000, and needs two generic drugs, one preferred drug, and one non-preferred drug, (NAME THEM) and selects the Blue plan, she must pay the following:

$417.12 a year on premiums
$100 annual deductible
_____CO-pays

As you can see, the program penalizes Medicare beneficiaries who need brand name drugs by charging unaffordable co-payments, even though there may not be generic drugs that are medically appropriate for them.

On the other end of the user extreme, if John Doe uses _____, _____, and _____, and he earns _____ a year, he will be required to pay _____ in premiums, a $100 deductible and _____ in co-payments. Purchasing the drugs without any insurance would cost only _____. (CONTRAST WITH SENIOR USING JUST ONE OR TWO GENERICS)

The prescription drug program also excludes Medicare beneficiaries with disabilities. These beneficiaries are likely to be poorer, sicker, and have less access to alternative sources of payment for drugs such as Medigap or Medicare HMOs.

In March, 2001, the Nevada Legislature will begin hearings on prescription drug issues. I believe that the Governor and the Legislature is committed to making whatever changes are necessary to improve our program for our seniors. The Task Force for the Fund for a Healthy Nevada, chaired by myself and Assemblywoman Vivian Freeman, requested bill drafts which will be considered at that time.

One bill will create a state-administered prescription drug plan similar to those run by 26 other states with more affordable co-payments. Another makes improvements to the existing insurance based program, such as the right of a senior to pay the lower price when a generic drug is not recommended by the their physician and the right to appeal a denial of a certain drug.

On a broader level, we will also hear testimony on the price of prescription drugs and approaches other states have taken in examining these price increases. We will no doubt hear from individuals who go to Mexico to purchase drugs cheaper than they are in the United States.

Finally, the Nevada Legislature will consider measures recently adopted by other states—requiring pharmacies to honor Medicaid prices for prescription drugs needed by individuals on Medicare (with a state established dispensing fee) and the use of bulk purchasing to lower the price of drugs.

The Legislature will also examine a recent University of Boston study by Alan Sager and Debbie Socolar entitled "A Prescription Drug Peace Treaty: Cutting Prices to Make Prescription Drugs Affordable For All and to Protect Research: State by State Savings". Sagar and Socolar argue that the marginal cost of production for producing more pills once they have been developed is only 5% of retail price. They argue that Wall Street analysists concur that drug companies could make up for price cuts by selling more medications and suggest that if drug prices are set at the Federal Supply Schedule price, government could subside all necessary drug costs for people who cannot afford the discounted price. This study notes that there are 557,000 people in Nevada without any drug coverage at all. This includes 75,000 seniors without any drug coverage, 398,000 uninsured people, and 84,000 privately insured people with no drug coverage. Our State ranks 4th highest among the states in the percentage of people without drug coverage. This study indicated that Nevada could have saved $186 million dollars this year alone by purchasing drugs at the Federal Supply Schedule utilized by the Veterans Administration. Hearings will be held on this study in Nevada.

I know that this Committee has been studying these issues for some time and has great expertise in this area. I would offer a few observations from my vantage point three thousand miles away in Nevada. A private-insurance plan is not successful in helping our seniors if it is unaffordable. At this point in time, for many, our plan is unaffordable. Even if we had the lowest cost plan in the nation, we would cover only 10,000 people when 150,000 need help.

I believe we need a prescription drug benefit added to Medicare so everyone in need can be helped efficiently and effectively. I believe that block-granting to the states would be inefficient—it would require 50 different administrations to struggle the way Nevada did while seniors wait for help. It also taxes a state's already strapped human resources.

For example, it has taken the Nevada Department of Human Resources three years to increase the number of insured children in our Nevada Check-Up program—the CHIP program—from 1,400 to 16,000. Nevada's Medicaid waiver pro-

gram for individuals with disabilities is still not off the ground even though it was approved by the 1997 Legislature. This is not because they do not want to help children or people with disabilities—it is a resource issue. To add yet another program to be implemented to the State's taxed resources is not efficient when the Medicare program exists and could be improved. It would also allow us to use our scarce state resources and help other programs in need. One that immediately jumps to mind is the need to help those on fixed incomes with assistance in paying their utility bills—our electric bills alone will jump 60% by 2003 and gas rates have also climbed.

Thank you for the opportunity to share a few thoughts on Nevada's experience and I would be happy to answer any questions.

Mr. BILIRAKIS. Thank you very much, Ms. Buckley, for sharing with us the experience of Nevada in this area.

Mr. Smith.

STATEMENT OF JAMES F. SMITH

Mr. SMITH. Mr. Chairman and members of the subcommittee, I am Jim Smith, senior vice president of health care services of CVS Pharmacy. As the largest pharmacy provider in the Nation, CVS operates 4,126 community pharmacies in 27 States. CVS operates 278 pharmacies in districts of this subcommittee's members.

I am also here on behalf of the National Association of Chain Drug Stores. NACDS represent about 170 chain pharmacy companies that operate about 33,000 retail pharmacies all across the United States. We very much appreciate this opportunity to testify before the subcommittee today.

We believe that Congress should develop a pharmacy benefit for seniors, not just a prescription drug benefit. Because seniors take so many more prescription medications than younger individuals, they need ready access to community pharmacy-based education, counseling, and medication therapy management so that they can take their medications appropriately to achieve the intended medical outcomes.

Mr. Chairman, we especially applaud your leadership in recognizing the essential nature of these services by including a comprehensive medication therapy management benefit in your legislation, H.R. 5151. It is absolutely critical that any Medicare prescription drug benefit that Congress approves includes coverage for these services.

About 69 percent of seniors have some form of prescription drug coverage through a variety of sources. About 31 percent of the seniors do not have any form of prescription coverage and pay for their prescriptions out of pocket. What can pharmacies do to help those seniors without coverage who pay for their prescription drugs? First, our pharmacists work with patients and their doctors to try to maximize the use of lower-cost generics when they are available on the marketplace. The savings for using generics are remarkable and unmistakable. At CVS the average brand of prescription price is about $65, while the average generic prescription price is about $15, difference of 333 percent.

With billions in dollars in brand names drugs coming off patents over the next few years, we believe it is critical that any Medicare drug benefit includes incentives to encourage greater generic use. We are concerned, however, about some of the tactics being used by brand name companies that may delay the availability of many

of these lower-cost generics and thus increase costs for all prescription drug users.

Second, many of our pharmacies already offer discounts to seniors on prescription drug purchases. These discounts are usually about 10 percent, but each pharmacy has its own policy on discounting their prices for seniors. We are a fiercely competitive industry as evidenced by our 2 percent net profit margins. If you don't like the price at one pharmacy, you can go to another. Many pharmacies will match their competitor's prices. And, yes, retail pharmacy prices do vary from store to store, reflecting differences in cost of doing business, loss leaders, and other factors. The fact is, however, consumers can and should shop around for prices.

We believe that two good principles for the committee to keep in mind when developing senior drug benefits are, first, don't overpromise to the seniors; and second, make sure that you understand how all the pieces fit together in the pharmacy marketplace.

Having said this, we are concerned about policy approaches that would seek to control or target retail prescription prices as the solution to the high cost of prescription drugs for seniors. Here is why: Almost 80 percent of the cost of the average retail prescription price represents the cost, the pharmacy's cost, of acquiring the drug product from the manufacturers, over which we have no control. The remaining 20 percent of the prescription price represents our operating costs, such as heat, light, rent, salaries, computers, counseling and overhead expenses. Currently our salary budgets are experiencing significant upward pressure as a result of the critical pharmacy shortage.

We look forward to working with you this year, Mr. Chairman, on alleviating this shortage and ensuring that an adequate supply of pharmacists exists to serve all Americans.

Given these facts, any initiatives that seek to control and limit our retail charges do nothing to affect our cost of buying the drugs. For example, these so-called cash discount card programs essentially require pharmacies to provide a discount on the retail prescription price without lowering the cost of providing the product. In other words, the pain doesn't flow upstream.

We also believe that these prescription cash discount cards create unfulfilled promises for seniors. If a senior cannot afford a drug at $100, it is very unlikely that this senior can afford it at $90.

Second, some say you may be able to obtain better prescription prices for the elderly by pooling their purchasing power so they can get the same volume discounts obtained by other pharmaceutical purchases. Be wary of this line of argument. The pharmaceutical marketplace does not work that way.

Let me give you a case in point. If volume purchasing drove manufacturer discounts, then why do some of the largest pharmaceutical purchasers, such as CVS, other large drug chains, as well as many independent pharmacies that belong to a large buying group, pay higher prices for brand name drugs than smaller pharmaceutical purchasers who buy less volume? Insurance plans and PBMs say that they can volume purchase and get lower prescription prices for seniors. All this really means is they require the pharmacy to give a discount to the seniors without passing along

to the seniors any of the manufacturers' discounts, rebates or other financial incentives being given to the plan.

We also believe that the subcommittee should take a good hard look at the use of competitive-based premium support models and pharmaceutical benefit managers, also known as PBMs, in providing any new Medicare drug benefit. For example, how did PBMs achieve most of their savings? In 1998, CBO said much of the savings that PBMs achieve appear to come from the lower drug prices paid to pharmacies rather than rebates offered by drug manufacturers.

So then what works for seniors in terms of providing them a meaningful pharmacy benefit? First let me say we support the establishment of a meaningful voluntary pharmacy benefit program for all seniors that need and want it. For the short term we believe that the best course that Congress can take is provide Federal funds to States to help low-income seniors obtain this pharmacy benefit. Many States already have these programs in place, like New York, Pennsylvania, New Jersey, Illinois, and they work. Almost every State is now considering enacting or developing some sort of prescription assistance program for seniors. For that reason we believe that States are in good position right now to help those most in need. For the long term we believe that any new drug——

Mr. BILIRAKIS. Would you finish up, please, Mr. Smith.

Mr. SMITH. I am summing up right now.

For the long term we believe that any new drug benefit for seniors should promote the utilization of generic drugs, provide seniors with access—with meaningful access to community-based medication therapy management, give seniors access to the community-based pharmacy provider of their choice; not economically coerce seniors to using prescription delivery mechanisms such as mail order, not include price controls on retail pharmacy prices including cash discount cards, and assure that the community pharmacies are adequately compensated and providing services to meet the needs of our seniors.

We look forward to working with you and the committee on these issues. Thank you.

[The prepared statement of James F. Smith follows:]

PREPARED STATEMENT OF JAMES F. SMITH, SENIOR VICE PRESIDENT, HEALTH CARE SERVICES, CVS CORPORATION

INTRODUCTION

Mr. Chairman and Members of the Subcommittee. I am Jim Smith, Senior Vice President of Health Care Services of CVS Corporation. As the largest pharmacy provider in the nation, CVS operates 4,126 community pharmacies in 27 states. In 2001, we will provide an estimated 320 million prescriptions. CVS operates 278 pharmacies in districts of this subcommittee's members.

I am also here on behalf of the National Association of Chain Drug Stores (NACDS). NACDS represents about 170 chain pharmacy companies that operate about 33,000 retail pharmacies all across the United States. Chain pharmacy is the single largest segment of pharmacy practice. We filled about 60 percent of the 3.1 billion prescriptions provided across the nation last year. NACDS operates 2,112 stores in the districts of this subcommittee's members.

We very much appreciate this opportunity to testify before the subcommittee today. We believe that our experience in delivering and managing pharmacy benefits can be of value to the subcommittee as you begin your important work this year in determining what works, and doesn't work, for seniors in helping them obtain their vital prescription medication and pharmacy services.

DEVELOP A PHARMACY BENEFIT, NOT ONLY A "DRUG" BENEFIT

Today, when a patient arrives at their local community pharmacy, be it a chain pharmacy or an independent, they come into contact with one of the most accessible and trusted providers in the entire health care system. It is estimated that 95 percent of Americans live within five miles of a retail community pharmacy.

Thus, the vast majority of Americans are never far from a highly trained health professional that can provide medications or advice on a wide range of health care issues. Convenient access to community pharmacies makes us a critical part of society's health care safety net.

Prescription medications are the most widely used and cost-effective health care interventions used by patients today. Modern prescription drugs have extended and improved the lives of millions of Americans and saved millions of dollars through shortened length of illnesses, increased productivity, and reductions in hospitalization and medical procedures. Community pharmacy is proud of the role we have in assuring the safe and effective use of these therapies.

That is why we believe that any new program to expand prescription drug coverage to seniors should be a pharmacy benefit, not just a prescription drug benefit. Too often, we think of a prescription drug benefit as only providing a "drug product" to seniors. We believe that this is a serious mistake. Seniors take so many more prescription medications than younger individuals. For that reason, seniors need ready access to community-pharmacy-based education, counseling, and medication therapy management, in addition to the drug product, so they can take their medications appropriately to achieve the intended medical outcomes.

We believe that insurers, payors, pharmaceutical manufacturers, and seniors themselves can agree that these important community-based pharmacy services help make better use of prescription products. To play off a popular catch-phrase, "pharmacy doesn't make the drugs, but pharmacy does make the drugs work more effectively."

We applaud forward thinking members of this House who supported inclusion of medication therapy management services in various prescription drug proposals introduced last year. Mr. Chairman, we especially applaud your leadership for recognizing the essential nature of these services by including a comprehensive medication management benefit in your legislation, H.R.5151. It is absolutely critical that any Medicare prescription drug benefit that Congress approves includes coverage for these services.

EXISTING PRESCRIPTION COVERAGE SOURCES FOR SENIORS

Now let me turn to our perspectives on the various approaches being used to provide prescription drug benefits to seniors, and what pharmacies already do to help uninsured seniors obtain their prescription medications. As the Committee knows, about 69 percent of seniors have some form of prescription drug coverage through a variety of sources.[1]

About 50 percent of seniors obtain their coverage through private sector sources, such as employer-sponsored retiree plans, Medigap plans, and Medicare managed care plans. The remaining seniors obtain their prescription coverage from public-sector sources, predominantly Medicaid and state-based pharmaceutical assistance programs.

About 31 percent of seniors do not have any form of prescription coverage and pay for their prescriptions out of pocket. Clearly, we see first hand that many seniors without prescription drug coverage, and even those with it, struggle to pay their prescription drug bills.

What do pharmacies do to help these seniors obtain their prescription drugs? First, our pharmacists work with patients and their doctors to try to maximize the use of lower-cost generics when they are available on the market. The savings from using generics are unmistakable. At CVS, the average brand name prescription price is about $65, while the average generic prescription price is about $15, a difference of 333 percent.

Obviously, if a generic substitute is not available, we will try and work with the doctor to see if the patient can, in fact, take a generic version of another drug. With billions of dollars in brand name drugs coming off patent over the next few years, we believe that it is critical that any new Medicare drug benefit have both patient and pharmacy incentives in order to encourage greater generic use. We are concerned, however, about some of the tactics being used by brand name companies

[1] Kaiser Family Foundation, "The Medicare Program", Issue Brief, October 2000.

that may delay the availability of many of these lower cost generics, and thus raise costs for all prescription drug users.

Second, many of our pharmacies also offer discounts to senior citizens on their prescription drug purchases. These discounts are usually about 10 percent, but each pharmacy has its own policy on discounting their prices for seniors. Consumers already reap the benefits of the highly-competitive retail pharmacy marketplace. We are a fiercely competitive industry, as evidenced by our 2 percent net profit margins. If you don't like the price at one pharmacy, you can go to another. Many pharmacies will match their competitors' prices. And yes, retail pharmacy prices do vary store to store, reflecting differences in cost of doing business, loss leaders, and other factors. The fact is, however, consumers can and should shop around for prices.

Third, we can help the poorest seniors access the patient assistance programs that pharmaceutical manufacturers have established. Clearly, these programs provide a short-term benefit to some low income seniors, but they are not an adequate solution or appropriate substitute for meaningful, long-term prescription drug coverage.

DON'T OVER PROMISE SENIORS AND UNDERSTAND THE MARKET

Regardless of how seniors obtain for their prescription drugs, whether through public or private prescription programs, or pay out of pocket, community retail pharmacies are in a good position to help evaluate for the Committee the effectiveness of various options for prescription drug coverage. In other words, because we are at the point of service where the "rubber meets the road", we can help determine what works and what doesn't.

When considering approaches to prescription drug coverage, we believe that two good principles for the Committee to keep in mind are: first, don't over promise seniors; and second, please make sure that you understand how all the pieces fit together in the pharmacy marketplace.

For example, many of you often receive mail from constituents asking the simple question: "Why do my drugs costs so much?" Well, pharmacy economics 101 is not that difficult to understand. Reimbursement for almost 85 to 90 percent of all our prescriptions is set by third party plans, such as insurance companies, HMOs or PBMs. Third party plans keep squeezing down reimbursement rates in order to control exploding costs, but these policies do little to control escalating expenditures. Under these plans, most patients simply pay a copay for these prescriptions. Patient copays have been increasing over the last few years also because of the escalating costs of prescription benefit programs.

Having said this, we are concerned about policy approaches, both at the Federal level and the state level, that would seek to target retail prescription prices as the solution to the high cost of prescription drugs for seniors. Here's why. The Committee should be aware that almost 80 percent of the cost of the average retail prescription price represents costs to the pharmacy over which we have absolutely no control (See Attached). These are predominantly the cost of acquiring the drug product from the manufacturer, which is passed through to the consumer, and thus reflected in the retail price charged.

The remaining 20 percent of the prescription price represents our operating costs, such as heat, light, rent, salaries, computers, counseling, and other overhead expenses. Currently, our salary budgets are experiencing significant upward pressures as a result of the critical pharmacist shortage. We look forward to working with you this year, Mr. Chairman, on alleviating this shortage and assuring an adequate supply of pharmacists exists to serve all Americans, including Medicare beneficiaries.

With this as background, let me now talk about some of our perspectives and cautions on other approaches that you may consider this year.

PRESCRIPTION DRUG "CASH DISCOUNT CARDS": UNFULFILLED PROMISE

We have no upward negotiating leverage with brand name drug manufacturers, so any initiatives that seek to control or limit our retail charges do nothing to affect our cost of buying the drug. For example, these so-called "cash discount" card programs essentially require pharmacies to provide a discount on the retail prescription price, without lowering our cost of providing the product. In other words, the pain doesn't flow upstream.

We also believe that these prescription cash discount cards create unfulfilled promises for seniors. If a senior cannot afford a drug at $100, it is very unlikely that the senior can afford it at $90. In addition, as stated above, many of our pharmacies already give senior citizen discounts, which reduce the retail price essentially to the price that the senior would pay under the cash discount card. Finally, many of these cash discount card programs also often use out-of-state mail order

as an incentive to steer patients to certain drugs that may be inappropriate for the senior. Mail order also takes the senior out of the neighborhood pharmacy setting.

On this topic, we'd like to draw your attention to a recent report from the Massachusetts Institute of Technology that said, "the individuals who face the greatest burden lack insurance coverage for prescription drugs are in relatively poor health with severe chronic conditions, have relatively low income, and do not qualify for existing state prescription drug coverage programs. These individuals need benefits that far exceed the savings attainable from a pure discount card program."[2]

THE MYTH OF VOLUME PHARMACEUTICAL PURCHASING

Some may say that you can obtain better prescription prices for the elderly by "pooling their purchasing power" so that they can get the same volume discounts obtained by other pharmaceutical purchasers. What I am here to tell you is be wary of this line of argument—the pharmaceutical marketplace doesn't work that way. Volume purchasing does not drive pharmaceutical manufacturers to give discounts—you have to move a manufacturer's "market share" to obtain these discounts.

Let me give you a case in point. If "volume purchasing" drove manufacturer discounts, then why do the largest pharmaceutical purchasers, such as CVS and other large chain pharmacies, as well as many of the independent pharmacies that belong to large buying groups, pay higher prices for brand name drugs than smaller pharmaceutical purchasers who buy less volume?

Here's what the proponents of "volume purchasing" for seniors don't and won't tell you. All this really amounts to is simply discounting the retail prescription price that seniors pay at their pharmacy, without affecting our cost of buying the drug or without requiring the insurance plan or PBM to "pass through" to the senior any and all of the financial incentives that are given to them by the manufacturer. If these plans were required to pass through all the discounts that they negotiate, both pharmacy discounts and manufacturer discounts, the senior would truly benefit from lower prescription drug prices. Without these other "pass throughs", the entire burden of so-called "volume purchasing" falls squarely and unfairly on the shoulders of community pharmacies.

We also believe that some of the estimates being made of the size of the discounts that volume pharmaceutical purchasing would attain for seniors are unrealistic and will create serious unfulfilled promises. For example, there were several numbers floating around last year that indicated that private sector entities, or PBMs, would be able to lower retail prescription prices paid by consumers by 25 percent, with some estimates as high as 30 to 39 percent.[3]

We do not know where these numbers come from or how they are calculated. The only remotely conceivable way that this discount size could be attained is if the PBM is required to pass along to the consumer any and all financial incentives (e.g. rebates or discounts) that they negotiate with pharmaceutical manufacturers. I am here to tell you that this does not happen today in the marketplace and is creating false and unrealistic expectations.

"DRUGS ONLY" PLANS AND INSURANCE-BASED MODELS

We understand that there is support among Members for creating "drugs only" insurance-based models to provide prescription drug coverage to seniors. Recent experience in Nevada should tell us that, just because you "build it", doesn't mean that "seniors will come." In a genuine effort to help seniors obtain prescription drugs, Nevada embarked upon establishing an insurance-based model to provide prescription drug coverage to seniors. After several attempts to finally find a company that wanted to administer the program, reports are that only a handful of seniors have signed up because of the high premiums and cost sharing in the program.

We are concerned about a similar fate if such an approach is tried at the Federal level. In general, these programs are subject to significant "risk selection", and tend only to attract those seniors that need protection against high prescription drug bills. Many seniors will not see the benefit in obtaining this coverage because of the significant deductibles and premiums that have to be paid before any benefit is derived from the coverage. Thus, because the cost will keep many seniors out of the "risk pool", premiums will keep increasing for those remaining in the pool, making it less and less affordable for those that need the coverage.

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[2] Massachusetts Institute of Technology, The HOPE Plan and the Section 271 Discount Drug Purchase Program for Massachusetts: An Economic Analysis. December 21, 2000.

[3] Price Discounting Practices for Pharmaceuticals in the U.S. The Lewin Group, April 2000.

Moreover, the cost of these private-sector insurance plans can also be prohibitive, as was reported last week in the *New York Times*. The premiums for Medigap plans with prescription drug coverage, the model on which these insurance-based programs are based, will increase 31 percent in New York, 26 percent in Illinois, 24 percent in Wisconsin, 16 percent in Arizona, and 14 percent in Ohio.[4]

"PREMIUM SUPPORT", CAPITATION AND PBMS

We also believe that the subcommittee should take a good, hard look at the use of the competition-based "premium support" model and pharmaceutical benefit managers, also known as PBMs, in providing any new Medicare drug benefit. For example, how do PBMs achieve most of their savings? By focusing on squeezing pharmacy reimbursement or negotiating rebates and discounts from drug manufacturers?

The track record of PBMs in being able to manage pharmaceutical costs was called into question by CBO in a 1998 study, which said: "*Much of the savings that PBMs achieve appear to come from the lower prices paid to pharmacies rather than from the rebates offered by drug manufacturers.*"[5] The study found that 50 percent to 70 percent of the drop in the plans' spending on prescription drugs resulted from lower retail prescription prices. Only 2 to 21 percent of the savings resulted from manufacturer rebates that the PBMs shared with the health insurance plans.

This study reflected the experience of the three largest PBMs that manage the 9-million member Federal Employees Health Benefits Program (FEHBP). Members of Congress should be aware that this program, which is being talked about as the basis for a future Medicare "premium support" model, has been experiencing double-digit increases in prescription drug expenditures over the last several years, 22 percent for 1998 alone.

In announcing significant health premium increases for the 2000 FEHBP plan year, a significant percentage of which was to account for escalating prescription drug costs, Office of Personnel Management (OPM) Director Janice LaChance said that "it is clear that competition in the marketplace has not effectively slowed the growth in FEHBP premiums."[6]

We believe that the experience of FEHBP should be instructive to Members of Congress as they consider the "premium support" model for Medicare. Please note that these prescription drug cost increases are occurring in a population that is not representative of the Medicare population. FEHBP generally serves a younger population that uses fewer prescription drugs than the Medicare population. More significant increases are likely to occur in an older, Medicare-based population.

Moreover, some of the proposed "premium support" models would pay a fixed, "capitated" rate to providers of the pharmacy benefit. Past experiences is using capitation models for pharmacy benefits have been unsuccessful. There is no reason to believe that they would be any more successful today, given the impact that manufacturer direct-to-consumer advertising has had on fostering increased prescription drug use. We are concerned with this model and the impact that it would likely have on the health of Medicare beneficiaries and on the economic viability of community pharmacies.

SO . . . WHAT WORKS FOR SENIORS?

What works for seniors in terms of providing them a meaningful pharmacy benefit? First, let me say that we support the establishment of a meaningful, voluntary pharmacy benefit program for all seniors that need and want it.

For the short term, we believe that the best course that Congress can take is to provide Federal funds to states to help low income seniors obtain this pharmacy benefit. We know that there are many mixed feelings among Members of Congress about this approach. However, given that almost every state is now considering enacting or developing some form of prescription assistance program for seniors, we believe that states are in a good position, right now, to help those most in need.

And data indicate that 60 percent of those seniors without prescription drug coverage, or about 7.2 million seniors, have incomes of less than 200 percent of poverty.[7] We see many of these seniors in our pharmacies every day, struggling to pay

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[4] Insurers Push Rates Higher for Medicare Supplement. Milt Freudenheim, *New York Times,* February 8, 2001.

[5] Congressional Budget Office, *How Increased Competition from Generic Drugs Has Affected Prices and Returns in the Pharmaceutical Industry*, July 1998, p 8.

[6] U.S. Office of Personnel Management, "Plan to Control Health Premiums for Federal Employees and Retirees announced with Release of Premium Increases for 2000. September 20, 1999.

[7] Kaiser Family Foundation. "The Medicare Program" Issue Brief, October 2000.

their prescription bills. For them, they just want some help to get them their medications.

For the long term, we want to work with this Committee, the rest of the Congress, and the Administration to achieve long term reform of the Medicare program to provide the type of quality pharmacy benefit that seniors need and deserve.

We believe that this benefit should:

- promote the utilization of generic drugs when appropriate;
- provide seniors with access to meaningful, community-based medication therapy management services with appropriate compensation for pharmacies;
- give seniors access to the community-based pharmacy provider of their choice;
- not economically coerce seniors to use other prescription delivery mechanisms, such as out-of-state mail order;
- not include price controls on retail pharmacy prices, including prescription cash discount card programs; and,
- assure that community pharmacies are adequately compensated in providing services to meet the needs of our nation's seniors.

We look forward to working with you and the Committee on these issues, and that you for the opportunity to testify today.

Mr. BILIRAKIS. Thank you very much, Mr. Smith.

I will start the questioning. Mr. Smith, I will start with you.

In your testimony you state that it is important for Members of Congress to understand how all of the pieces fit together in the pharmacy marketplace. God knows, that certainly is true. And you have touched on that, but not in very much detail. I wonder if you could help me understand the chain that takes place as a prescription drug tablet journeys from the manufacturing plant to the medicine chest of a senior citizen. I appreciate the fact that you represent the chain drugstores, but take into consideration in addition to the chain drugstore the little family drugstore, which there aren't many left out there. Could you do that for me?

Mr. SMITH. Sure. There are many parts to this, but in essence the delivery—the distribution system, is that what you are interested in? It comes from the pharmaceutical——

Mr. BILIRAKIS. I am interested in the distribution system, but also your opinion. And you touched on this in terms of the costs of that particular tablet as it goes through the system.

Mr. SMITH. I will give it to you from the chain perspective. And today most independents form buying groups, and they operate very similar to a chain, so I think you can use that model for everyone.

Mr. BILIRAKIS. Do most——

Mr. SMITH. Most independents, and as you said there are fewer of them today, but they are actually stabilizing out there and are much stronger today than they were in previous years. So we do have a very strong community-based system out there. But most of them buy by either of two mechanisms. They buy directly from the manufacturers where that is permitted, or they buy from a wholesaler.

Mr. BILIRAKIS. Who is that wholesaler?

Mr. SMITH. Wholesaler could be somebody like Cardinal Health or McKesson or somebody like that, and they will have daily deliveries. The bulk of what we purchase in dollar volume is usually purchased through a manufacturer directly. Now, we warehouse that in certain warehouses across the Nation, or stores order that medication and is delivered to the stores. But obviously you can't be in supply of every medication every day, so we use wholesalers on a daily basis to supplement our inventories.

Mr. BILIRAKIS. Are these wholesalers, the warehouses that you are referring to, are some of those CVS warehouses?

Mr. SMITH. Yes. We have CVS warehouses across the Nation where our stores are located, which supplies not only on pharmacy items, but also over-the-counter items. We also have wholesalers located geographically which we use a primary wholesaler and generally a backup wholesaler.

Mr. BILIRAKIS. Can you take the cost of that tablet——

Mr. SMITH. The cost of a tablet, and I will break it to the brand side and generic side. If we go and we buy from pharma company A, whatever the medication we are buying, whatever class it is, we are going to pay on the brand side the exact same price as our competitor from Rite Aid, Walgreen's, or Eckerd's or the independent buying group. On the brand side there is no volume purchasing.

Mr. BILIRAKIS. That is if you purchase it from the manufacturer?

Mr. SMITH. Manufacturer or wholesaler.

Mr. BILIRAKIS. All right then. Or wholesaler. So if it goes from the manufacturer to, let's say, one of your warehouses, then what does your warehouse do? Does the warehouse purchase that tablet from the manufacturer?

Mr. SMITH. The warehouse is just a holding point to distribute the medications to the individual pharmacy stores.

Mr. BILIRAKIS. So it doesn't really—it doesn't purchase it and then resell it?

Mr. SMITH. We purchase centrally from our home office in Woonsocket, Rhode Island, and we have it delivered to our distribution centers, which then distribute it to the stores. We also use—the individual stores on an as-needed basis will order daily from a wholesaler to get medications which they are out of stock on and they have to get to the store. Those are preset prices on contracts or arrangements. But as I said on the brand side, those prices are relatively the same across the industry. There are some volume purchase arrangements on the generic side. So the larger you are, the better you can buy some of those products. So there is a little bit of slight advantage on buying generics, although the bulk in dollars of what we buy is obviously on the branded side.

Now, what we sell those—what we sell in medications is certainly dependent on the plan which we have. And CVS, 90 percent of the business we do from pharmacy is through some type of third-party arrangement. And we negotiate with that third-party plan whether it is a Medicaid or whether it is a private PBM or HMO. Each one of those are different contractual arrangements based on administrative costs.

Mr. BILIRAKIS. Did you say 90 percent?

Mr. SMITH. Ninety percent of CVS business, higher than most of the industry. Most of the industry is somewhere in the 80's. But 90 percent of our business is done through some type of third party, and those arrangements are all separate. And once again, the arrangements there are done from the HMO, PBM to the plan, so they arrange on rebates or whatever else they do. So the financial gain there would be from the PBM or the insurance agency, not to the retailer pharmacy.

Matter of fact, just the opposite really occurs at the retail because we are the ones who end up administering the care, admin-

istering the formulary or whatever. So additional costs end up being promoted at the retail setting because our pharmacists are required to explain, try to explain to plan design why they can't get the medication they have been taking for 20 years.

As you all hold your town meetings next week and on a regular basis in your district, I also visit our pharmacists in each of the locations, and we hold town meetings, and the one thing that they tell me is, please take away the administrative burden of filling a prescription. Give me the ability to do what I have gone to school for 6 years for. Let me talk to my patients and my customers, explain to them the medications they are taking.

Right now as we try to——

Mr. BILIRAKIS. Well, my time has expired, Mr. Smith. I will tell you, as we will announce when we finish up, there will be questions that will be submitted to all of you, and I plan to go into some of the details regarding my questioning in more detail to you.

Mr. SMITH. I would love to do that.

Mr. BILIRAKIS. I appreciate that.

Mr. Brown.

Mr. BROWN. Thank you.

The chairman in his opening statement linked Medicare reform and prescription drug coverage, that this Congress perhaps or maybe likely will pursue them together. I think the more critical link is between prescription drugs and the $1.6 trillion proposed tax cut.

If you look at the cost of prescription drugs, one plan that we considered last year was $80 billion over 5 years, which is—under Medicare, which is adequate, but hardly as generous as many of us would like. A plan with more of an 80/20 split that would be—would really, I think, better meet the needs of Medicare beneficiaries would be at least half again as expensive as that.

Then you also consider in the years ahead, 30 years from now, the projections of the Medicare population, today 40 million will then be some 80 million beneficiaries, and the huge burgeoning of costs that come with that.

Ms. Rowland, if you have done any analysis, if Kaiser has done any analysis on this, or if you haven't, if you would, just draw on your knowledge and experience of how this all collides in the next couple of decades if we pursue the $1.6 trillion tax cut and we pursue a good prescription drug benefit, at least the $80 billion over 5 years; understanding the increased costs will cost later and the burgeoning numbers of Medicare beneficiaries in the next couple or three decades, sort of where we go and what happens.

Ms. ROWLAND. Well, clearly as you look at the expanding Medicare population, as you look at the history that we have just laid out today of the rising cost of prescription drugs, but also the increased need of the population for the use of prescription drugs, we have no way to really anticipate what additional drugs will come onto the market over the next 10 years. So I think we can really look at this area as one that is going to grow, and the cost is going to grow. Some estimate that a comprehensive drug benefit under Medicare could cost as much as $300 billion over the next 10 years. Obviously when you begin to use the surplus for prescription drugs,

it requires then a substantial commitment of that surplus. A substantial tax cut would really leave that fairly limited.

So I think you really need to look at the fact that if you are going to do a meaningful drug benefit, it is probably going to be expensive. It is going to grow in cost over time, and you are either going to have to commit what resources the surplus offers or additional tax revenue.

Today the elderly pay about 20 percent out of pocket on drugs. That is expected to rise to about 30 percent by 2025. So we are kind of on a collision course here of increasing costs for a very needed medication and the need to pay it down through either increased commitment of Federal revenues through the surplus or whatever means.

Mr. BROWN. Ms. Rowland, let me go in a different direction for a moment, too. Some are advocating—in Congress are advocating a drug proposal to specifically target low-income individuals. What is your research showing us about coverage, who doesn't—about who has coverage, who doesn't, and where the real need is?

Ms. ROWLAND. Well, the very poorest of the population obviously receive coverage through the Medicaid program. Those who are basically receiving cash assistance through Supplemental Security Income are also eligible for coverage under Medicaid, which today includes a prescription drug benefit. So it is really the near poor and the modest income that have the greatest need for prescription drug coverage, although the other thing that one needs to look at is within the Medicare population, income and need for drugs are not directly related. And so when we look at those with the highest drug expenditures and those who don't have coverage today, it crosses all income spectrums. In fact, people, for example, in rural areas have particular problems. They are less likely to have access to HMOs, less likely to have worked in a situation giving them retiree benefits. So we really see that the need for prescription drug assistance, I think, is fairly universal.

Mr. BROWN. So if someone is 200 or 250 percent of poverty, and our program is targeted to those at 175 or below, we really are missing out at helping a good number of people who won't get help otherwise and will face pretty——

Ms. ROWLAND. Right. Like a third of Medicare beneficiaries without prescription drug coverage today. About half of them have incomes below 175 percent of poverty, so you inevitably leave out 6 million people above that who today go without drug coverage.

Mr. BROWN. Mr. Chairman.

Mr. NORWOOD [presiding]. There are so many of us here, happily, today that I am going to keep us on the 5-minute schedule, but hopefully we will have time for another round because I am absolutely certain that everybody up here has lots of questions, and that includes myself, who happily is next.

Mr. Weller, I would like to ask you some quick questions of which I hope, you know, I can get fairly quick answers and then go on to Mr. Moroni. Of the 9 million people who purchase individual Medigap coverage today, H, I and J, I believe, all of those are the prescription drugs, how many of the 9 million actually purchase those Medigap policies?

Mr. WELLER. I believe that the 9 million includes both of the prestandardized plans, many of which had some prescription drug coverage, as well as the 10 standardized plans. Studies have shown that less—less than—around 10 percent, I guess, of people purchase H, I or J, one of those three.

Mr. NORWOOD. Could you compare the price for me real quickly as to what perhaps an H or I Medigap policy might cost with drug prescription drug benefits versus one that doesn't?

Mr. WELLER. It appears that those policies cost about $1,000 more, 1,000 to 1,200. It is very close to the amount of the maximum drug benefit in those plans, which is 1,250 and $250 deductible. As I noted, the difference in cost is because of the difference in other—utilization of other services as well as the drugs.

Mr. NORWOOD. How many seniors in these plans actually hit their caps? Can you give me some percentage of that?

Mr. WELLER. I have not seen any study that had a good distribution of that.

Mr. NORWOOD. You can get back to me.

Mr. WELLER. I will try.

Mr. NORWOOD. I was pretty startled to read that seniors electing the drug coverage option, they actually have a higher A and B cost than those seniors that are in non-drug plans. Is that true?

Mr. WELLER. Yes, that is true.

Mr. NORWOOD. Mr. Moroni, I particularly wanted to ask you a couple of questions because I think GM is a pretty good model. You guys do a lot of things right and have a lot of information in terms of the numbers of people that you insure. My understanding from what you said was that as you look at your coverage for your employees, you are finding that prescription drug costs are rising or escalating. Is that still—that is a true statement?

Mr. MORONI. Yes, at approximately 19 percent annually.

Mr. NORWOOD. Do you believe that cost is because your seniors are actually taking more medications because more are available, or do you believe that cost is up there because there is an increase in the price of the medications that you are buying?

Mr. MORONI. It is obviously a combination of both. I mean, we do have an aging population, like all groups, so part of it is that people are taking more drugs. However, you also see different factors there; not just more drugs, it is inflation, and it is trading up of drugs. So it is really both. And I guess I would comment that you want your seniors on the right drugs. You know, you want them on hypertension, heart medication, whatever it is they need. You also want everything that they need to be appropriate and nothing more.

Mr. NORWOOD. Tell me, do you see—I mean, as we are taking or prescribing more medications, there are a couple of reasons that may be true, but one of which is—I hope is that people are healthier; in other words, it can be preventative in nature. Are you seeing any decrease at all in your health care treatment costs as you are seeing an increase in your prescription drug costs?

Mr. MORONI. That is a question we get asked often in various forms, and we have seen no decrease in our—we call it hospital surgical medical, everything other than the drug costs, as the drug costs have increased. So——

Mr. NORWOOD. Is the medication a quality of life issue or extending life issue more than fewer costs in actual treatment? That is an important question. I don't mind you getting back to me either if you want to. But that is—if you can know that, it would be helpful for us to know.

Now, you said in your statements that you support a universal drug benefit with Medicare. Does your company then—if and when we do some form of that, do you believe that your company would then drop drug benefit coverage for your employees because then they could use Medicare?

Mr. MORONI. I think what we would like to do is have the option to see what Congress enacts and then decide how we may want to wrap around or provide coverage, you know, within the coverage that is enacted. Today we provide wraparound coverage for the nondrug benefits to Medicare. So it is all dependent.

Mr. NORWOOD. Has there been any discussions with UAW about that, any talk about, well, if Congress actually furnishes a Medicare coverage, then what General Motors might want to do with their plan?

Mr. MORONI. Not that I am aware. I mean, that conversation just hasn't occurred that I am aware of.

Mr. NORWOOD. Is that a reasonable concern for people to believe that if we go to a full Medicare coverage, that people such as yourself that are offering benefits might get out of that totally, particularly in view of the rising costs?

Mr. MORONI. I guess the way that I would—I think the best way to answer that without seeing what might be enacted is that we hope that it is a universal type of coverage, that——

Mr. NORWOOD. Well, you support universal. Let's presume that it is universal.

Mr. MORONI. You know, I think it would be our hope that such coverage as universal coverage, it has good controls, and it might help some of the employers, whoever they are, whether it is General Motors or other employers providing retiree benefits, continue to maintain the benefits they are providing. I think it is a challenge today for people to do that.

Mr. NORWOOD. I will get back with that on the next round. I have a minute or so left.

Mr. Smith, in your purchasing—time is up? Well, my time is up. I will get back to you next time. I would like to give the time to my good friend John Dingell all the way down at the end.

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy.

Mr. Jones, welcome to the committee. What percent of the counties in the United States have HMOs within their borders?

Mr. JONES. I am not sure. That is not something I would know.

Mr. DINGELL. Is it all or part?

Mr. JONES. I would say it is not all. It is part.

Mr. DINGELL. Would you submit that for the record?

My information is that 38 million Medicare beneficiaries live in areas where there are no HMOs, and that 68.1 percent of the beneficiaries live in a county with at least one HMO. Now, do you agree with that?

Mr. JONES. Again, that is not my speciality.

Mr. DINGELL. What would the statement be with regard to PacifiCare?

Mr. JONES. We operate in eight States.

Mr. DINGELL. Eight States. All right. Now——

Mr. JONES. And not all counties of those eight States. There are some counties we don't have HMO benefits in or health plan benefits.

Mr. DINGELL. Usually you don't do business in rural counties because there aren't enough people there, right?

Mr. JONES. It is hard to get physicians to——

Mr. DINGELL. So usually the HMOs stay out of the rural counties. Yes or no?

Mr. JONES. Rural counties are difficult, yes.

Mr. DINGELL. So you stay out of the rural counties.

Now, what criteria do you have at your HMO for going into a particular county or staying out of it?

Mr. JONES. I am a pharmacist, and I don't make those decisions. I am not——

Mr. DINGELL. So you don't know.

Mr. JONES. I don't know.

Mr. DINGELL. But it would be fair to assume you go where you make money, right?

Mr. JONES. I assume.

Mr. DINGELL. I assume.

Now, what did your HMO do with the money that was given to the HMOs in the last Congress? What percentage of it went to beneficiaries, and what percent went to profits, and what percent went to dividends, and what percent went to the corporate officers in salaries or bonus?

Mr. JONES. Seeing that I am not a financial officer of the company——

Mr. DINGELL. The answer is you don't know.

Mr. JONES. I don't know.

Mr. DINGELL. So if I made the statement that you folks cut a fat hog on that, and that the rest of the industry did, you would not be able to deny it, would you?

Mr. JONES. I wouldn't be able to comment.

Mr. DINGELL. Well, I am going to make the statement. You cut a fat hog on it, and nobody but you and the HMOs got anything out of this.

Now, having said that, what commitment did the HMOs make with regard to the administration bill? This bill, as you note, gives money to the States, who are then supposed to give it to the HMOs in the somewhat dubious expectation that that money will then flow forward and through to the HMO patients. Do the HMOs make any commitment on this matter, or do you just intend to pocket that fine generosity which flows through from the Federal Government?

Mr. JONES. As I understand, and again, the pharmacy part of our company, our parent company, does other things, but as I understand, the money flowed through to providers, paid providers.

Mr. DINGELL. Now, I note here that in some 66 counties the maximum benefit is $1,000 under most of the HMO prescription pharmaceutical benefits. I note that the copay is 50 percent, and I note

that in most instances the plan premium per month is somewhere between $29 and $75 a month. Do those figures sound right to you?

Mr. JONES. We don't have percentage copays for our—not at our company.

Mr. DINGELL. As a matter of fact, this is interesting. My staff informs me that this is your company, and that you do have a copay.

Mr. JONES. We have copays, but not percentages. They are individual copay amounts.

Mr. DINGELL. It says brand mail order copay percentage 50 percent. And this is in Oklahoma: Creek County, Grady County, Lincoln County, Logan County, McClain County, Nowata County, Okfuskee County, Oklahoma County, Osage, Pottawatomie, Rogers, Tulsa, and so on. Is this a surprise to you?

Mr. JONES. I don't know every single county and every single State of our eight States; however, the vast majority of our business, in fact——

Mr. NORWOOD. Mr. Jones, go ahead and complete the answer, and that will end the questioning for Mr. Dingell and yourself. We will come back.

Mr. DINGELL. I feel sad about this because I know Mr. Jones has been enjoying this questioning.

Mr. NORWOOD. I feel sad about it, too, but I was sad about my 5 minutes, too.

Mr. JONES. I would say that greater than 90 percent of our copays are fixed. Again, I wasn't aware—you may be entirely right.

Mr. DINGELL. I notice that you have a copay——

Mr. NORWOOD. Thank you very much, Mr. Dingell. I am sorry to interrupt you.

Mr. Buyer, you are next.

Mr. BUYER. Mr. Weller, I want you to know that I agree with your comments that you made that we should not add a prescription drug benefit without doing some structural reforms in Medicare, and I think that we should make it as part of a comprehensive plan would be my position, so I want to agree with your comments.

Second, to the gentleman from General Motors, I recall in the early 1990's when there was this euphoria over Clinton care, the major automobile manufacturers supported a provision that permitted the government to assume the health care costs for your retiree population 55 and older. You wanted to trigger them on to the taxpayers; is that correct?

Mr. MORONI. I can't comment on that. I was not—but that would not be my understanding of the triggering on to the taxpayers, no.

Mr. BUYER. Well, I don't know who else was going to pay for it if you wanted to trigger them into the universal Clinton government health care system. One of the biggest concerns that many of us had was when the Big 3 came in, they negotiated a lot of different contracts, and then the escalating costs, they were very eager to sort of dump retirees onto the government. Who is the government? It is the taxpayers.

So you got my attention here today and so has Ms. Rowland in her testimony. I pick up her testimony and she says that "40 percent of large employers report seriously considering cutting back on drug benefits for their retirees in the next 3 to 5 years, according

to a recent survey of large employers conducted for the Kaiser Family Foundation by Hewitt Associates." So I want to continue with the questions of earlier.

You have some negotiated benefits with union employees. You also now have retirees that are nonunion, whether they are administrative or white collar. My fear is that while the unions are going to put up a really big fight if you think you are going to trigger them into some type of plan, they are in a comfort zone; but you have a lot of employees, independents, widows who may not have that coverage or protection like the union retiree may have, and my fear is you are going to trigger them into something different.

So will you please—what do you tell the retirees—I used to have a GM facility, a lot of retirees in Kokomo, I have some in Marion. What do you say to them? They are on fixed incomes right now.

Mr. MORONI. You know, I think the best way to look at this from our perspective is the way to ensure that employers continue to provide some sort of retirement benefit, the responsible employers that there are right now; to make sure that Congress swiftly enacts a type of broad-based universal prescription drug Medicare, either program or supplement.

So I think it just has to be viewed that there are a lot of responsible employers out there right now that are still providing health care coverage, drug coverage and whatever, that probably want to continue to provide such coverage, and they are looking for different avenues to help them through the challenges of trends that we are seeing. So I think the best way to make sure that that continues is by Congress swiftly moving toward some sort of universal Medicare coverage. That is what will help in our opinion, that is what will help the employers who are being responsible right now to continue to be responsible.

Mr. BUYER. Do you have sort of an idea of what the cost of prescription drugs are added to the price of an automobile?

Mr. MORONI. You know, I should. That is not one figure I have with me.

Mr. BUYER. Is the General Motors executive sort of looking at this and saying that the dollar is fungible, that someone out there in America is going to be paying for this, and if you have this 19 percent increase in cost, well, we can't eat it, so we add it to the price of automobiles and the consumers pay, or we wrap them into some systems that we create here, and the general population pays?

Mr. MORONI. I guess—could you redirect something more specific to me, because I really think that what we are really trying to say is that we are feeling very pressured by the type of trends that we are seeing. We still want to be a responsible employer. We are looking for all avenues to be able to, you know, still provide comprehensive coverage. We are also seeing that there are gaps, and that a universal type of plan by Medicare will help offer——

Mr. BUYER. Let me——

Mr. NORWOOD. I am sorry, Mr. Buyer. Your time is up.

Mr. Green, you are next.

Mr. GREEN. Thank you, Mr. Chairman. Again, hopefully we will have a second round for those of us who can stay around.

Let me first start off by saying that in 1965, if we could have created Medicare without covering doctors or hospitals, we would have thought it was crazy. And here we are in 2000 where we have seen over the years our prescription costs, both for seniors, but for the private sector has gone up, compared to—along with other costs, but it is so much more a part of our health care dollar today than it ever was. So I think if we recreated Medicare here today, we would have prescription drugs as part of it.

I thought it was interesting, the adverse selection concern, Mr. Weller, because that is why Medicare was created. Insurance is there for adverse selection. You want—insurance companies have to make a profit. They don't want people—all their claimants—to claim, so they can make that profit. They couldn't make a profit in 1965, and so that is why Medicare was created, or really 20 years before that, because that is when the bills were introduced.

So that is what troubles me about trying to have the private sector provide for a prescription drug benefit and make a profit on it without a great deal of subsidization that we would have to do.

Mr. Jones, we work with PacifiCare a great deal in Houston, because after all, the other HMOs, Secure Horizon stayed in the Houston market and I appreciate that, and I appreciate Secure Horizon working with my staff on individual constituent cases, and really good to work with. NICARE, 65 withdrew from the Houston market last year, along with about 60 percent of our seniors—they covered 60 percent of our seniors, NICARE did, and they withdrew.

We do have two new companies that just announced coverage in Houston, one a PPO and one an HMO. The HMO will not cover prescription drugs, and the other one, the PPO will, but they are charging $85 per month premiums in addition. National Medicare+Choice plans are dropping their drug benefits, lowering payment caps, imposing stiff premium surcharges, and the portion of Medicare+Choice plans with a payment cap of $500 or lower has increased by 50 percent in the last 2 years since 1998—3 years. Nearly three-quarters of the Medicare+Choice plans have capped benefits at $1,000. I know, I think Secure Horizon's prescription drug benefit in Houston, at least Harris County, is $1,200.

How can seniors rely on Medicare+Choice plans to provide coverage that they need when we see what is happening in the market?

Mr. JONES. It is a challenge for Medicare+Choice plans. We do what we can to manage the pharmacy benefits to where people can continue to afford them. Increasing costs are a continued challenge for us and we have to come up with methods of dealing with the increasing cost of drugs, increasing utilization. We do all of that, and we do it in a fairly flexible manner. We try to change with the changing times. But reimbursement is always an issue for us.

Mr. GREEN. How many—what percentage of Secure Horizon's customers do you think—has your company done any research—joined your HMO because of prescription drug benefit?

Mr. JONES. I am sure there are figures, and I could certainly get back to you on that.

Mr. GREEN. I would appreciate it, because just again, nonscientific in my own district, a huge percentage of our seniors joined

an HMO simply because they didn't have any options, they needed some type of prescription drug benefit.

Mr. JONES. I don't doubt it.

Mr. GREEN. Mr. Moroni, you state in your testimony that prescription drug cost increases for GM have averaged 19 percent annually for the last 3 years.

Mr. MORONI. Correct.

Mr. GREEN. And you expect them to continue to rise, and you also reference that 80 percent of the prescription drug costs for your retirees are for your retirees, surviving spouses and their family. Eighty percent of the drug costs that GM pays for are for retirees, surviving spouses and their families?

Mr. MORONI. Correct.

Mr. GREEN. So only 20 percent is for current GM employees?

Mr. MORONI. Correct.

Mr. GREEN. That is an amazing percentage. I mean it shows that the older you get, the more medicine we need, which is, again, seems like it should be given.

Mr. NORWOOD. Thank you, Mr. Green. I am new at this. I forget to turn the microphone on. Thank you very much, Mr. Green. You have 5 seconds and I wanted to say you are getting into a long, lengthy question.

Mr. GREEN. Let me just ask to Mr. Moroni, both—GM is trying to curb costs and however you can answer it, if you have to get back, but what is GM doing to solve the problem of adverse selection that we heard from other witnesses?

Mr. NORWOOD. Mr. Moroni, if you would submit that in writing, please. I have to go to Mr. Greenwood, and now it is his turn.

Mr. GREENWOOD. Thank you, Mr. Chairman.

I would like to direct some questions to Mr. Jones and Mr. Weller, and anyone else who would like to comment, it would be helpful.

I want to focus on Medicare+Choice plans. It is sort of interesting that we get two completely different perspectives, depending upon who we are listening to, about how Medicare+Choice plans operate. In listening to Mr. Dingell, it sounds like the Medicare+Choice plan is some sort of carnivore that wanders into a region and gets fat on profits and, after fattening up, gluttonly wanders off for some strange reason, as if it doesn't want to eat anymore. The way it looks to me is that the Medicare+Choice plans go out there, and we started feeding them well enough when we started out with 95 percent of the average area per capita cost, and they could provide a nice, full plate of all of the regular Medicare benefits, plus, plus. There was the plus. The prescription drugs and the dental and hearing benefits and so forth. And then we stopped—we stopped feeding them. We didn't pay them enough to keep up with the costs. So after they got down to skin and bones, they wandered out and said, we are not going to starve to death.

That is a bit of an exaggeration, but it seems to me that those are the prevailing perspectives on how Medicare+Choice plans are operating. I wondered if you could comment on—I mean, to me, we have, as I said in my opening statement, we have a lot of work to do to try to provide a prescription drug benefit, but at least for a while there, the Medicare+Choice program seemed to be a great op-

tion. It certainly was for my mom and dad. They didn't have to buy Medigap anymore, they got their prescription drugs, they got good health care, everything was going fine.

Now, in my district, what has happened is A, we didn't keep up paying these plans, the premiums that they needed; and B, we have a screw-up, because in Philadelphia, which is not in my district but borders my district, there is a zero premium prescription plan. But in my district, it is very expensive to get exactly the same package.

I wonder if you could comment on what I have just said in terms of really what has been driving the Medicare+Choice plans and what their options have been, and these two perceptions.

Mr. JONES. I think that this industry has been fairly competitive among the various players, and where there was fairly reasonable reimbursement in a region, they would enrich their benefits to attract members into their plans. As the reimbursement levels were reduced, so was the richness of the benefits that were offered. And everyone needs to be able to break even or show a profit in order to continue their business. It has been unfortunate for seniors because they did get used to companies competing for their attention and trying to get them into their programs, which included very reasonable benefits for a pharmacy. There were no caps in some programs, the competition was such.

That has all changed. I certainly empathize that we have done whatever we could to keep that benefit there, but there have been caps put on it, higher copays, more cost-sharing by the seniors, and it is a difficult situation we are all put in.

Mr. GREENWOOD. Is there a Medicare beneficiary in the country that you wouldn't cover with a very nice Medicare+Choice package, including a nice prescription drug package, if you were paid by HCFA an annual premium for that patient that—for that beneficiary that allowed you to, on average, actuarially cover your costs and earn what—fill in the blank—and what percent profit?

Mr. JONES. Our profits last year were 2.3 percent. It is not a large profit. But no, we took all comers.

Mr. GREENWOOD. So 2.3, 3 percent, that range of profit, just do the math, the Federal Government pays your company and any other Medicare+Choice company enough to cover the benefit, plus prescription drug benefit and make 2 to 3 percent profit, you cover everybody in the country, right?

Mr. JONES. I can't speak for our parent company and its goals, but that has been traditionally where we are.

Mr. NORWOOD. Thank you very much, Mr. Greenwood. Now we go to Mr. Engel.

Mr. ENGEL. Thank you, Mr. Chairman.

Mrs. Kessler, since you are the only one on the panel that actually is a consumer and has experienced some of these programs, we have people on the panel from a number of different groups that provide prescription drugs for Medicare beneficiaries. You have heard, Medicare Choice plans, Medigap plans, employee retirement plans, a State program and a pharmacy program. I believe that while these programs provide assistance for some seniors, not all can benefit from them, and I am wondering—you alluded in your

testimony, and I am wondering if you could give us some more detail about your experiences with these types of programs?

Mrs. KESSLER. Well, I was on HMO and I was not very happy with it. Of course, I have been well practically all of my life, and then all of a sudden, it caught me. So my daughter, who is a nurse practitioner, made me get off HMO, and I got on to AARP, and of course, I pay for my drugs. I get a little percentage here and there, but that is about it. And there are plenty of senior citizens like me who really couldn't afford all of these medicines that I take, that they take. We save all of our money all of our lives and then all of a sudden we get sick, and we are afraid that the money that we have saved would have to go for the drugs, which scares the heck out of us.

Mr. ENGEL. Well, it seems that now there is a patchwork of options, but what you are saying is none offer the safety and security of a comprehensive Medicare benefit. So you are actually saying that a uniform universal benefit for everyone in Medicare is really the way we should go?

Mrs. KESSLER. Yes, definitely so.

Mr. ENGEL. Now, the Florida program that is similar to New York covers seniors over age 65 who are duly eligible for both Medicare and Medicaid with an income of under $11,000 per year. So obviously a lot of seniors are left out of that. The State, I understand in Florida, has a discount program which allows a discount on the cost of drugs at pharmacies, but you and others don't qualify for that because you have a program through AARP?

Mrs. KESSLER. Yes.

Mr. ENGEL. So many seniors actually get lost in the shuffle and find that they don't have the care that they need; is that an accurate statement?

Mrs. KESSLER. That is right. That is right.

Mr. ENGEL. Thank you very much.

I want to raise an issue that Charlie Norwood had mentioned before. I wonder if Ms. Rowland or Mr. Moroni could comment.

When you talk about the increasing cost of prescription drugs, it would seem to me that on the other end of it, Medicare would save money because of beneficiaries getting the proper medication at the proper dosage as opposed to taking a half dose or going without certain drugs due to cost. So I am wondering, Ms. Rowland, if you could comment about—are there any real numbers that measure potential savings due to proper drugs which will lead to decreased hospital stays and fewer acute care conditions as a consequence of a prescription drug benefit? And also, after that, if Mr. Moroni can mention if you have noticed a decline in costs of other areas of care as you initiated the prescription drug benefit?

Ms. ROWLAND. We don't have any hard statistics on what happens when individuals cut their prescriptions in half and only take half of what they need. We do know when we look at some experience in the Medicaid population, that when cost-sharing was imposed on some of the lowest-income Medicaid beneficiaries, they went without their drugs and ended up more often in nursing homes. So we in the State of New Hampshire, for example, the cost of nursing home care increased when they imposed additional cost-sharing for prescription drugs.

There is a new study just out from Canada looking at the imposition of cost-sharing for low-income elderly and disabled people in Canada, showing a greater use of emergency rooms as a result of lack of taking proper medications.

So while we don't have a lot of studies in the U.S., we do have a lot of stories about people who don't take their medications properly, and we know that for many of the medications that the elderly take today, lack of taking them on a regular basis can really lead to complications.

Mr. ENGEL. And more expense.

Ms. ROWLAND. And more expense.

Mr. ENGEL. Thank you. Mr. Moroni.

Mr. MORONI. From our data, we have not seen a decrease in the hospital-surgical-medical side of the expense due to the—or I should just say in conjunction with the higher drug costs. So I think you would have to think about although there may be certain hospitalizations you avoid, with the trend of just your normal hospital-surgical-medical coverage, and then on top of that, you put on something like as high a trend as 19 percent, and actually, in 1999, it was actually 23 percent, it just averaged out.

Mr. ENGEL. Can you comment, Mr. Moroni, on PBMs to manage the drug benefit? Some of the Medicare drug proposals would rely on PBMs to provide a drug benefit. Could you talk about some of the things they do for GM to manage the pharmacy benefit like reducing cost and providing quality assurance?

Mr. MORONI. Yes. Actually, we do think that our PBMs help kind of optimize cost and quality. Most importantly, I would say our PBMs look for drug-to-drug interactions on a real-time basis, which you do fine. Especially, as I said, when people see multiple physicians. We also have programs like, you know, a preferred formulary that our PBM has assigned to hopefully optimize some of the costs. Their dosing authorization programs, generic substitution programs, disease management programs—all of which we think has helped us save costs, and that was part of my testimony—that even with the extensive programs we have in place, both on a quality side and a cost side, our costs are still at 19 percent. Actually, safety is another major issue that I cannot really leave out of there, because there are specific drugs actually cited in a GAO report that our PBMs make sure that our elderly people are not on it, they are safe for the elderly.

Mr. NORWOOD. Thank you, Mr. Moroni and Mr. Engel. Now, Mr. Shadegg.

Mr. SHADEGG. Thank you, Mr. Chairman. I want to commend you for holding this hearing today.

It is very obvious that in this country we need to be looking at how we make sure seniors get the drugs they need to be able to care for themselves. No one wants a Nation where people have to make a decision between paying rent or buying groceries and taking the medicines they need.

By the same token, I have to say that I think to a certain degree, a lot of the discussion and a lot of the focus on how we create the right program to do this, in the context in which we are not looking at the cost of doing this, the staggering cost of doing this is literally whistling past the graveyard and missing a huge issue. I think, Mr.

Moroni, your testimony drives that point home pretty clearly. I can imagine that General Motors would be in favor of a universal drug benefit if General Motors for the past years has seen an average of a 19 percent increase in its prescription drug program.

Now, I hope everyone in this panel and everyone in this Congress understands that if we, in a well-intentioned fashion, create a universal drug benefit and we face the kind of escalating costs GM has faced over the past 3 years of 19 percent per year, we are in deep trouble. So I would like to focus on what foundation we need to be looking at in terms of drug pricing and drug costs before we jump into creating this program. Because I have not seen anything in the discussion of the shape of the program or the structuring of the program, whether you favor one over the other, that is going to address the issue of cost. And in looking at these facts, I want to point out that the more things change, the more they stay the same.

In 1959, the Senate Judiciary Subcommittee on Antitrust and Monopoly, led by Estes Kefauver of Tennessee did a study, a 2½ year study of drug pricing in America, and you will be surprised to learn that they found almost exactly what we are finding today. They found, for example, that Eli Lilly was selling 100 tablets of an antibiotic called V-Cillin, and they are selling it in England for $6.50, in Australia for $10.75, and in the United States for $18. So the pricing in the United States was roughly three times the price in England. For 100 capsules of Tetracycline, the production cost for Bristol Myers was $1.67. Its price to druggists was $30.60, and consumers paid $51.

You then come flash forward to today. Here is a study done by Life Extension Network, on the most outrageously high-priced drugs in America, one called Premarin. For 28 capsules of 6 milligrams, the U.S. price is $14.98; the European price is subsidized, $4.25. For Coumadin, which is a blood thinner that my mother-in-law takes, for 25 10-milligram capsules of Coumadin, the U.S. price is $30.25, the European price is $18.50.

Another study done by USA Today in November 1999, I will just pick a couple, there are many on here, and I would like to put both of these in the record—for Prozac, the U.S. price, $2.27; in Canada, less than half of that, $1.07; in Britain, $1.08; and in Australia, 82 cents. Zocor for high cholesterol, U.S. price $3.16; Canadian price $1.47; British price $1.73; Australian, $1.75. Again, we are more than twice. Claritin, everybody hears about Claritin; it is one that is a demand pull drug, and I want to talk about demand pull in a moment; U.S. price, $1.96; Canadian price a little closer, $1.11; British price, 41 cents; Australian price, 48 cents.

[The information referred to follows:]

10 Best-Selling Prescription Drugs in the USA Cost less in Other Countries

(Retail Price of the most commonly prescribed dose of each drug, converted to U.S. dollars)

Rank	Drug	Condition	U.S.	Canada	Britain	Australia
1	Prilosec	Heartburn/Ulcer	$3.31	$1.47	$1.67	$1.29
2	Prozac	Depression	$2.27	$1.07	$1.08	$0.82
3	Lipitor	High colesterol	$2.54	$1.34	$1.67	$1.32
4	Prevacid	Ulcer	$3.13	$1.34	$0.82	$0.83
5	Epogen	Anemia	$23.40	$21.44	$27.48	$29.24

10 Best-Selling Prescription Drugs in the USA Cost less in Other Countries—Continued

(Retail Price of the most commonly prescribed dose of each drug, converted to U.S. dollars)

Rank	Drug	Condition	U.S.	Canada	Britain	Australia
6	Zocor	High colesterol	$3.16	$1.47	$1.73	$1.75
7	Zoloft	Depression	$1.98	$1.07	$0.95	$0.84
8	Zyprexa	Mood disorder	$5.27	$3.39	$2.86	$2.63
9	Claritin	Allergies	$1.96	$1.11	$0.41	$0.48
10	Paxil	Depression	$2.22	$1.13	$1.70	$0.82

Source: USA Today, November 10, 1999

Outrageously High Drug Prices

Drug (Quality/Potency)	U.S. Price	Euro. Price
Premarin	$14.98	$4.25
Synthroid	$13.84	$2.95
Coumadin	$30.25	$2.85
Prozac	$36.12	$18.50
Prilosec	$109.00	$39.25
Claritin	$44.00	$8.75
Augmentin	$49.50	$8.75
Zocor	$96.99	$45.00
Prempro	$23.49	$4.75

Source: Life Extension Network.

Mr. SHADEGG. I would like to ask Mr. Moroni and Mr. Jones a series of questions, and if others of you would like to comment, I would be happy to do that.

Have any of you, since you buy large quantities of drugs, done a study of your own to try to find out why drug prices in the U.S. are so much higher than they are in other countries?

I don't want to run out of time. Let me give you the other questions. Have you studied demand pull marketing? Because I saw from your expressions you haven't done the other. Demand pull marketing is kind of a new phenomenon in the United States where we are telling the American people hey, there is this prescription drug that will go out and solve every problem you have. I would suggest to General Motors that part of the reason you are facing a 19 percent increase in your drug prescription—prescription drug program—is demand pull marketing, and I wonder if anybody has looked at that.

I want people to get the drugs they need, but I am not certain that—I talk to a lot of doctors back in Phoenix, Arizona who tell me patients are watching television, coming in demanding the drug. The doctor has to talk them out of that drug.

Mr. NORWOOD. Thank you very much, Mr. Shadegg, and remember the question, because the second round we need to have an answer for that.

Now I think it is Mr. Strickland's turn.

Mr. STRICKLAND. Thank you, Mr. Chairman. To follow up on my friend's comments, I would like each of you to respond to these two questions and I think you can do it in one or two words.

Do you think that the issue described by my colleague regarding Americans being charged so much more than other citizens in other countries is a serious problem in terms of the costs of prescription drugs in this country? And I think you can do that with a yes or no. And then I would like for you to say, hopefully with a yes or

no, if you think it would be appropriate for this Congress to consider some legislation to deal with this price inequity. Two questions. Would you mind beginning here and just going down the table?

Mrs. Kessler, what is your opinion there?

Mrs. KESSLER. Yes, I would say that that would be a good idea, that that should be a question about the drugs, why it is so high here, definitely so. This should be one of the requirements to judge so that we can get all of our prescriptions paid.

Mr. STRICKLAND. Thank you. Mr. Jones?

Mr. JONES. The differentials between our prices and those abroad is a very complex issue which we have not taken a very——

Mr. STRICKLAND. Do you think it results in Americans being charged more, regardless of the complexity of the reasons?

Mr. JONES. Drugs cost more here, there is no question about it.

Mr. STRICKLAND. Do you think drugs would cost less here if there wasn't this price disparity?

Mr. JONES. Again, therein lies the complexity of an international market.

Mr. STRICKLAND. Okay. Second question. Do you think we should address this disparity problem legislatively?

Mr. JONES. I think that it is one that will bedevil Congress. It is one that will probably have to be looked at one way or the other.

As far as a poll marketing, we have a very aggressive physician education campaign to counter some of that type of marketing, and we understand that people are subject to it.

Mr. STRICKLAND. Okay. Could we go ahead?

Mr. MORONI. As I said in our testimony, we do believe that the pricing practices are a concern and we do feel that they affect some competitiveness of U.S. industry.

Ms. ROWLAND. I think you should clearly look at the pricing policies, and I think in looking at this examination you might also want to take a look at the current Medicaid program which has a drug rebate provision that allows Medicaid to at least get a discounted price in some of the States for that.

Mr. WELLER. I would agree with Mr. Jones that it is a complex issue, but as a straight question of does it cost more, clearly, yes. What Congress should do, we believe that you need to restructure and reform Medicare, the entire program; that has as part of that, you need to deal with prescription drugs and you need to deal with the cost of them to the Federal Government, to the beneficiaries.

Ms. BUCKLEY. Yes, there are clearly price inequities; yes, Congress should look at it and look at it in a comprehensive way to ensure research and development is not hurt, and to look at ways we can cover everyone, increase sales to pharmaceutical companies so that they can lower costs.

Mr. SMITH. Eighty percent of the price of a prescription is bound in product cost. If you can reduce that product cost, the price will absolutely come down.

Second, I do believe Congress should look at those inequities and try to find out why and try to alleviate those problems.

Mr. STRICKLAND. Thank you. The comment was made that we should have the restructuring of Medicare, and the concern I have there is because I think this may be a euphemistic way of saying

we should basically destroy Medicare as we know it and go to a system that would be quite different than Medicare.

Ms. Rowland, I serve a rural area. You know, I think, that the people who live in rural areas do not have the same opportunities and access. Can you speak a little bit more about that and what you think we can do as we try to plan a fix to this terrible situation that we all know exists?

Ms. ROWLAND. We know that around a quarter of all Medicare beneficiaries live in rural areas, but we also know that those in rural areas are more likely to go without drug coverage. Roughly 40 percent are without drug coverage today.

That is largely due to the fact that many of the Medicare+Choice plans aren't out there in rural areas, and I think with the withdrawals, you are not likely to see a large increase in rural areas in the near future.

Second, many of the people living in rural areas have not worked for some of the large employers that offer the retiree benefits, so they are the most likely to go without the more comprehensive retiree wrap-around benefits to Medicare that do include prescription drugs, and they tend to have lower and more fixed incomes. So even when a Medigap policy may be available, the ones that include prescription drugs are largely unaffordable. I think that is one of the reasons why one needs to really look at providing a comprehensive benefit within Medicare so that people get the same benefits under Medicare, whether they live in urban or rural areas, just as they do with physicians' services and hospital care today.

Mr. STRICKLAND. Thank you.

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

The vice chairman of the committee, Mr. Burr.

Mr. BURR. Thank you, Mr. Chairman.

Let me take this opportunity to thank all of our witnesses today. I am not going to ask you any questions, so I will relieve you of that burden. But I did want to thank you for the information that you brought to the committee. I assure you that it will be extremely helpful as we proceed on.

This is a very talented committee. The members as well as the staff have spent a tremendous amount of time understanding the complexities that each of you brings with your testimony. They understand the scope of the population that is covered under the proposed benefit that we all seek. We understand the geographical challenges that we have. We also understand that it is a population that needs it today. I am convinced, more so than I was last year, that because of the passion and the talents of this committee, we can achieve a legislative proposal that benefits patients. And that is ultimately where we have to keep our focus.

I would tell you that there are 3 major components: .

Access. Some do, some don't today; all should. I think that every member of this committee would agree with that statement.

Affordability. Affordability sometimes is a function of competition. We have certainly seen that in private sector areas. And I would tell you that when you look at this population because of the size, when you find a way to negotiate based upon the size of the population, you find better pricing. It is what you referred to, Ms. Rowland, as it related to Medicaid, even though that was a legisla-

tive mandate. But clearly, we have seen the private sector markets respond the same way relative to a population large enough that you can negotiate on their behalf, brings you levels of pricing we never dreamed of 10 years ago in health care. So we have to understand that component.

The third piece is voluntary. We can't force anybody to participate, nor should we. We should not discourage employers from extending that benefit to retirees; we should find ways to support it even greater than we do today. But the reality is, over time, as we incorporate a benefit, if we don't make a component of that the ability for employers to fit into it, to piggyback onto it, to dovetail into some section of it, we will allow them to remove that forever as a benefit that they extend to retirees.

We need your help. We will need your continued help. No matter who the new Administrator is at HCFA, I am convinced that if the support of Congress dries up or the support of those individuals who are really the brain trust of this issue is not there to support them as well as the American people, they will not accomplish the structural changes that I personally believe have to be made in HCFA, nor will they accomplish a drug benefit that can withstand the test of time and money that we all know it goes into.

Let me suggest that we are not here just considering this benefit for today. Our focus should be for tomorrow. We have heard a number of examples of meds that were mentioned and prices and individuals who were covered and weren't covered, and it was broken down in whatever way it was advantageous to those that either asked it or answered it. We have to get past that. We are headed into an age, with the completion of the Human Genome Project, where we will talk about medications that cure, for the first time, diseases that we have maintained or treated up to this point. We will have to go through a whole new cultural change of assessing medications based upon not their value at the beginning, but their cost-savings because they are now available.

Somewhere in that component, hopefully first on my mind, but every member will have to make that up on their mind, will be the quality of the patients. We will offer in many cases the ability to relieve what is a constant chronic or terminal case for what is now 35-plus million Americans and 15 years from now will be 70 million Americans: my parents, your parents, somebody's grandparents.

This is an important thing. It is the most important thing for this subcommittee today. I am confident that we can accomplish it, Mr. Chairman, with our friends on the other side of the aisle, with the support of the brain trust that is willing to come up and share their information with us. It won't be easy, but we can come up with a plan.

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

Mr. BURR. The gentleman is finished. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Mr. Ganske.

Mr. GANSKE. Mr. Chairman, I am juggling simultaneous hearings on high energy costs and high prescription drug costs and unfortunately, we do have people in the country who are having to make decisions on whether to pay their power bills or whether to buy their medicines, and that is a problem.

Mr. Chairman, I need to speak briefly about an arcane item called adverse risk selection. I have felt like a voice crying in the wilderness in my floor speeches late at night on this issue, but in my opinion, it is the single most important issue that we need to face as we are talking about this additional benefit.

The designers of many Medicare prescription drug proposals recognize this problem. Some try to address it by saying that if a beneficiary doesn't sign up for the drug insurance program on an initial registration for Medicare, then, thereafter, when he or she wants to sign up for the drug insurance program the program would be quote, "experienced-based," and potentially more costly. The theory is that the threat of higher premiums would act as an inducement for seniors with no or low drug costs to sign up initially.

But, Mr. Chairman, if everyone had already acted with such prudence, we wouldn't be here today, because the low participation in the current voluntary Medigap programs indicates that unless seniors must sign up initially, a large number won't. They will wait until they need drugs and then they will complain vociferously to Congress about their high premiums and we will be right back here where we started. And since other seniors will have a prescription drug benefit, there will be enormous pressure on legislators to further subsidize the seniors who are tardy in signing up for a drug program. That, of course, will significantly increase the cost of the program.

Now, another way to control adverse risk selection is to try to devise a risk adjustment system. This committee has been involved in that many times. We will wait eagerly for the day to show that we can actually devise that type of program in other parts of Medicare.

Now, another way would be a similar benefit package to help control that. Consumers would then be able to select plans based on price and quality rather than benefits, but if plans are allowed wide variation in benefits, some plans, I guarantee you, will be more likely to attract low-cost beneficiaries and we will again see adverse risk selection.

Now, a sure way to avoid adverse risk selection would be to mandate enrollment, and that was the approach in 1988 with the Catastrophic Coverage Act, and we saw what happened to that law. And to say, Mr. Chairman, that mandatory enrollment today has little appeal to policymakers is an understatement, to say the least. All they have to do is remember the Grey Panthers jumping up and down on Dan Rostenkowski's car.

Now, finally we could avoid adverse selection for a voluntary prescription drug benefit if we subsidized this benefit so much that seniors won't have much cost, and with that huge subsidy, the benefit would then become cost effective for the vast majority of seniors. But, Mr. Chairman, we are then likely facing a $400 billion or $500 billion subsidy.

That reminds me of an article by Dan Rostenkowski in the Wall Street Journal, who said, "The problem was, and still is, a lack of money." And yes, we have a surplus, but the 10-year cost of a more highly subsidized drug coverage could, in my opinion, easily double

or triple the cost, and that is where I am in line with Congressman Shadegg who just spoke about this.

So what do we do? Well, it is clear that there are seniors that really need the help right now, and there are seniors who are getting the help in the State Medicaid drug programs. And those programs are in every State, and they are, as Ms. Rowland pointed out, getting discounts from pharmaceuticals.

My proposal is that we build on that, that we try to get something done on this at a cost that we can absorb right now, and the way to do that would be to add the qualified Medicare beneficiaries and the select low-income beneficiaries up to 175 percent of poverty, give them their little Medicaid card, tell the Governors, we are going to pay for it from the Federal side; and this provision can be implemented immediately and it will help take care of the large number of beneficiaries who need that help right now, and we can move on to a comprehensive Medicare benefit in terms of prescription drugs in the context of a comprehensive Medicare bill.

Mr. BILIRAKIS. The gentleman is granted 2 additional minutes, without objection.

Mr. GANSKE. Thank you, Mr. Chairman.

Mr. BILIRAKIS. And we will not have a second round, but we will grant everyone an additional 2 minutes if they like.

Mr. GANSKE. I very much appreciate that, Mr. Chairman, because I wanted to get to your and my feelings on this, and that is that you have advocated a similar approach in terms of block grants to States who have in some cases set up programs to help subsidize citizens in those States with prescription drugs.

I think that, Mr. Chairman, you and I are closer to each other on this than we actually were to either the Democratic or the GOP bill last year. I have some concerns with the block grant, because I have some concerns about how you control fraud and abuse with the block grant program and I have concerns that in some cases they aren't set up in any of the States; you have some variability, and I believe for that reason that tying this in with Medicaid could be accomplished immediately, and there are controls already built in for fraud and abuse in those programs, and that this is something we should look at.

Mr. Chairman, as I pointed out, you and I are much closer together on this than we are far apart. And I just look forward to, Mr. Chairman, working with you on this issue, because this is something that we could do now and not have another 2 years go by and have that widow who isn't so poor that she is in Medicaid, that she is a dual-eligible, but who is just above that margin who is really scraping by on her energy bills and her prescription drug bills, and we could give her help right now and it would be a simple thing to do. And that is what I think this Congress should look at.

In addition, we ought to look at fixing the drug reimportation bill that we passed last year to close some of the loopholes, particularly on labeling, and that should be part of it too. I thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman. Mr. Brown, for 2 additional minutes.

Mr. BROWN. Just a couple of comments rather than questions. I very much appreciate the panel's insight and I want to thank you all for that. There was some talk earlier of the amount of—how we have overfed and then starved or something—the metaphor—some Medicare+Choice. There is a GAO report of August 2000, and I want to enter one page into the Record, page 3, and I want to site that paragraph real quick. "In addition, the combination of spending forecast areas built into plan payment rates and BBA payments cause an additional $2 billion, or 8 percent, excess payments to plans. Instead of paying less for health plan enrollees," this is from the GAO, "we estimate that aggregate payments to Medicare+Choice plans in 1998 were about $5.2 billion, 21 percent, or about $1,000 per enrollee more than if the plan's enrollees had received care in the traditional fee-for-service program."

[The information referred to follows:]

...In addition, the combination of spending forecast errors built into plan payment rates and BBA payment provisions caused an additional $2.0 billion, or 8 percent, in excess payments to plans. Instead of paying less for health plan enrollees we estimate that aggregate payments to Medicare+Choice plans in 1998 were about $5.2 billion (21 percent) or approximately $1,000 per enrollee, more than if the plans' enrollees had received care in the traditional FFS program....

Mr. BROWN. So I think that we—people in this institution have sort of tried to convince others that we have overpaid—that we have underpaid HMOs and that they have been starved, and there really is no evidence for that.

Second, I appreciate the comments of Mr. Shadegg about the cost of prescription drugs in the United States and overseas, and it begs the question, obviously, of why, and the answer. And I appreciate his siting.

I saw an article recently in the Post, I saw some of those numbers that were there that he had, but every other country in the world has a legislature which has stood up to conservative politicians and prescription drug lobbyists and actually passed legislation that does something about the cost of prescription drugs.

I don't know that Mr. Moroni, when he talks about the costs that GM is almost buried by, and that all of you see with health plans or whatever, that you understand that this is going to be awfully difficult to afford any of these Medicare prescription drug plans unless we do something about cost, compulsory licensing. That article talked about and was tried by Senator Kefauver, defeated in the Senate again, because the hordes of prescription drug lobbyists were all over the Capitol then as they are now. And until we do something about compulsory licensing or reimporting, which country after country after country around the world has done, it injects competition, not price controls, but competition in this whole morass of prescription drug price gouging, and it clearly is the way to go to explore these kinds of alternatives.

Mr. Chairman, I am well beyond my 2 minutes.

Mr. BILIRAKIS. Mr. Shadegg, 2 minutes.

Mr. SHADEGG. Thank you, Mr. Chairman. Let me just say that I am not going to ask you today to answer any further questions. I am going to give you a little more information from the Kefauver study and then ask, if you would, to answer two questions for us in writing after we finish today.

First of all, let me make it clear, I do not favor drug price controls mandated by the government. What I want to look at is competition in the drug industry and make sure that the industry is, in fact, competitive and that we are not suffering because it is not competitive.

Interestingly, one of the findings of the Kefauver committee study that went on in this industry said that of the 22 largest pharmaceutical manufacturers, those firms were spending, on average, 24 cents out of every dollar on promotion. Now, interestingly, that was before demand pull marketing of prescription drugs began in America, because this was, remember, 1959, and I believe it was also before the lavish marketing to doctors that goes on today. I can tell you, you can read about them, and I have an article here about the dinners that doctors are taken to, the gifts that they are given, the golf outings that they are taken to.

I have been told by doctors in Phoenix, Arizona that they will be taken for a night of entertainment out by a drug firm and they will be taken first to a cigar shop where they can walk in and pick out anything they want in the entire cigar shop. They are then taken to a florist where they can pick out any flowers they want for their spouses, no holds barred; then they are taken to a restaurant, the highest end restaurant and fed a lavish dinner. And we have all heard those stories.

So I am concerned and I am not an advocate of government regulation or government price controls, but I am concerned.

The three questions I would like you to answer are——

Mr. BILIRAKIS. Please ask the questions. I don't think we will have time for the responses now.

Mr. SHADEGG. No, no. That is why I say answer them in writing.

First, have you or your organization studied or analyzed the effect or the phenomenon of these very high U.S. drug prices versus low foreign prices of drugs, prescription drugs? That is question one.

Two, do you think the Congress should do that before it enacts a comprehensive Medicare drug benefit?

Third, have you studied demand pull marketing and its effect on drug prices in the United States? And if you have or haven't, do you think the Congress should do that before—and we will get you these in writing, we will type them and send them to you—do you think the Congress should do that before it enacts a comprehensive drug benefit?

And then the third is, have you or your organization studied the marketing practices of the drug, some of these parties, golf outings, et cetera, to see the effect of those marketing strategies on drug pricing in the United States? And if you have or haven't, do you think the Congress should study those again when it enacts a comprehensive Medicare drug benefit?

Mr. BILIRAKIS. As I indicated, there will be questions submitted to you and this is among them. Sooner rather than later, it would be very helpful.

Mr. SHADEGG. I appreciate your time.

Mr. BILIRAKIS. Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman. I would like to follow up.

Mr. Moroni, if you could tell the committee or GM could tell the committee of the concern of overutilization, today's National Journal talks about our Republican Majority Leader saying that when you have the coverage, you will use it more. And I know there is a way that that can be dealt with, if you would get that to the committee.

Ms. Buckley, to follow up on my colleague's questions, I know Nevada is trying to put together a bipartisan collaboration. Do you think—what do you think about every State having to take the responsibility, 50 different States, each coming up with some way to address the issue of financing prescriptions for seniors? And also, does the Nevada plan cover the disabled like Medicare does?

Ms. BUCKLEY. Thank you, Mr. Chairman. I do not think it would be effective or efficient for seniors to have all 50 States struggle to develop their own programs. It has taken us 2 years to develop our program, and numerous RFPs, and so far benefits are still unaffordable. I think it would create a patchwork of ineffective programs when Medicare can be utilized.

Mr. GREEN. The concern I have, Mr. Chairman, if we do the block grant that is proposed, is that the fear of most seniors is that there are some Members of Congress who fear that we would block grant all of Medicare in a Medicare reform, and again we would end up with 50 States trying to provide senior citizen coverage not just for prescriptions, but for Medicare in general. And our example with the Medicaid, the diversity of the benefits under Medicaid is just outrageous. And I can talk about my own State of Texas. It provides very little Medicaid coverage compared to other States. So Medicare is a Federal program and we should coverage prescriptions under the Federal program.

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

Mr. GREEN. Can I just get a——

Mr. BILIRAKIS. Yes or no. Who did you ask that of?

Mr. GREEN. Ms. Buckley.

Mr. BILIRAKIS. Ms. Buckley.

Ms. BUCKLEY. Yes, we would like Congress to act so that it is a more uniform program. States don't have the resources to provide effective senior prescription drug programs for seniors. We would like to take our senior prescription drug money and help seniors with utility bills that they can't afford.

Mr. BILIRAKIS. Mr. Engel may inquire for 2 minutes.

Mr. ENGEL. Thank you, Mr. Chairman. I want to thank the whole panel, and again, Ms. Buckley, I couldn't agree with you more. I think that we cannot have a hodgepodge of different States with different programs. We have the EPOC program in New York which is a pretty good program, and yet there are literally hundreds of thousands of seniors that are not covered. I think Mrs. Kessler is a perfect case in point. Someone who worked hard all of her life, does not ask for a handout, a middle class person, and she is just above the threshold for this and above the threshold for that and gets very, very little help.

We have to help those seniors. I think it should come down in this Congress. We should not wait for total Medicare reform. We need to deal with the prescription drug problem now. I know that the chairman—under his leadership, we are dealing with it now.

The bill that was passed in the Congress, the last Congress, I think is woefully inadequate. Private industry doesn't want it. Very few seniors would be covered by it. I think, quite frankly, it is a way of killing real reform in helping seniors with prescription drugs, and I think that is not a path that we should go down in this Congress again. I still maintain that if we provide prescription drug coverage for seniors, ultimately health care costs in many areas will go down because preventive care helps do that, and if people are getting the medication that they need, they will be less sick later on.

So again, thank you, Mr. Chairman. I look forward to dealing with all of these issues, and again, I hope we can deal with this in this Congress so that seniors like Mrs. Kessler and my mother who reside in the same place, and millions and millions of seniors all over this country, can get the health coverage they deserve.

Mr. BILIRAKIS. I thank the gentleman. I would just merely say in closing that first of all, Mr. Barrett, I believe it was, said it well when we were talking about the cost of drugs in some of these foreign countries versus the cost here. And he said something about the Americans are subsidizing the cost of drugs there, and when you stop to think about it, he said it well there. Now, what is the solution to that is the difficult part.

But I would say, Mr. Engel brought up—I mean, there are an awful lot of good arguments against doing something now. There is concern, there is a fear that if you put some temporary fix in place to help the needy and the sickest now, that that means that prescription drugs as a part of Medicare is just something that is not going to be addressed by this Congress, because the immediate solution, so to speak, would be considered the final solution.

I don't believe that. I think that Mrs. Kessler is hurting now and I think that if we help Mrs. Kessler now—I mean there is no sin in that—but at the same time, continue to work toward prescription drugs in Medicare. I feel very strongly that we have to have prescription drugs in Medicare. I daresay there aren't many Members of Congress who don't feel that way. It is just a case again of how you go about it all. And also it is the complexities of these partnerships that enters the picture, turf fights enter the picture, all sorts of things that can.

Can we do it in this Congress? God knows, we have to do it in this Congress, but we may not; and that means another 2 years plus for Mrs. Kessler to continue to have problems with her prescription drugs when, in fact, we could probably help Mrs. Kessler and Mrs. Tauzin and Mrs. Engel and whatnot now and in the meantime, so to speak.

So I don't know. There are a lot of arguments certainly against doing anything other than universal. I realize that. But common sense dictates to me that our job is to help people now, not necessarily say we will help you 3 or 4 or 5 years from now.

Well, having said that, we have kept you here a long time and I really appreciate your patience and your willingness to be here and to help out, and you have helped. We will be submitting questions to you, and hopefully all of us working together, if we can toss aside demagoguery and partisanship for a change, we can get the job done. Thank you very much. The hearing is——

Mrs. KESSLER. May I say something? I want to thank all you gentlemen. You have reaffirmed my faith in the U.S. Government.

Mr. BILIRAKIS. Isn't that nice.

Mrs. KESSLER. And I know I am going to go back and tell this to everybody. So I know I would like to see this happen before I die.

Mr. BILIRAKIS. And this comes from a Floridian, I want you to know, Mr. Brown. Thank you very much. The hearing is adjourned.

[Whereupon, at 1 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

KAISER FAMILY FOUNDATION
March 19, 2001

Hon. MICHAEL BILIRAKIS
Chairman
Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives
Room 2125, Rayburn House Office Building
Washington, DC 20515-6115

DEAR CHAIRMAN BILIRAKIS: Thank you again for the opportunity to testify before the Subcommittee on Health on February 15, 2001 regarding "Medicare Reform: Providing Prescription Drug Coverage for Seniors." I received the follow-up questions and am submitting the following information for the record.

Pharmaceutical Company Marketing:

What effect does direct-to-consumer advertising have on utilization? What effect does pharmaceutical company marketing have on health care providers? What is your experience with pharmaceutical prices in other countries versus the United States? If there is a difference, can you explain why?

Spending by drug manufacturers on direct-to-consumer (DTC) advertising has increased substantially in recent years, from $266 million in 1994 to $1.3 billion in 1998. However, I am unfortunately not aware of any systematic analysis of the effect of direct-to-consumer advertising on utilization. We are beginning such a study in conjunction with researchers at Harvard University, and I would be happy to forward the results to you when they are completed.

Indications of the extent to which DTC advertising has reached consumers can be found in a September 2000 survey we conducted with *The Lehrer Newshour*. The survey found that 91% of Americans say they have seen or heard a drug advertisement in the past 12 months, and over a third of those who had been exposed to an ad talked to their doctor about the drug that was advertised. I have enclosed a copy of the toplines and the summary chartpack from that survey.

While there has been substantial public focus on the growth in DTC advertising for prescription drugs, marketing targeted to physicians remains a much larger share of pharmaceutical promotional activities—drug manufacturers spent an estimated $7 billion on professional promotion in 1998 compared to $1.3 billion for direct-to-consumer advertising. This difference is not surprising given the fact that physicians must prescribe a medication in order for a consumer to have access to it. We are in the process of conducting a survey of physicians that includes some questions about drug advertising and would be happy to also forward those results to you when they are available.

I have enclosed a copy of our *Prescription Drug Trends* chartbook for your reference. This publication provides information about the trends in prescription drug coverage, spending, prices, use, and industry structure, and contains additional data on pharmaceutical company marketing efforts. In addition, the office of the Assistant Secretary for Planning and Evaluation (ASPE) at the Department of Health and Human Services is planning a conference to examine and develop research designs to explore the impacts of direct-to-consumer pharmaceutical advertising on health care costs and patient outcomes. The conference will be held on May 30, 2001 in Washington, DC and is likely to produce additional information on this topic.

Finally, our research has focused primarily on domestic pharmaceutical issues, so I am unfortunately unable to provide any information on drug prices in other countries. I would be happy to provide the Subcommittee with suggestions for other possible sources of information if that would be helpful.

Delivery of Prescription Drugs Under the Medicaid Program

Please explain the chain that takes place as a prescription drug tablet journeys from the manufacturing plant to the medicine cabinet of a senior citizen who gets prescription drug coverage from you.

Every state's Medicaid program operates in a different way, and, even within a state's Medicaid program, delivery of prescription drugs may vary depending on beneficiaries' enrollment in a managed care plan. However, there are general rules and processes that all states share in delivering prescription drugs to Medicaid beneficiaries.

Each Medicaid program has a formulary consisting of drugs that are available to all beneficiaries eligible for prescription drug coverage. The formularies are determined, in large part, by which manufacturers have agreed to participate in the federal Medicaid drug rebate program. Participating manufacturers agree to rebate a set amount of payments for their products, and, in return, the Medicaid formulary includes all participating manufacturers' products. A few formulary exclusions are permitted, such as for products with a high risk of abuse or products that the FDA has determined to be ineffective. In addition, a state can require the prescriber to seek prior authorization before a particular drug can be dispensed—a strategy often used for more costly medications.

When a Medicaid beneficiary receives a prescription, he or she has it filled at a participating pharmacy that gets its stock either directly from manufacturers or through wholesalers. Many states have provisions that require or encourage the use of generic substitutes when available. Medicaid beneficiaries can face limits to the number of prescriptions they may fill, quantity of medication dispensed at any one time, or dollar amounts on the cost of the prescription. Beneficiaries may also be charged a nominal co-payment for their medications.

I hope that this information is useful to the Committee as it considers options for extending prescription drug coverage among Medicare beneficiaries. Please do not hesitate to contact me if you need any additional follow-up information. Thank you.

Sincerely,

DIANE ROWLAND, *Executive Vice President,*
The Henry J. Kaiser Family Foundation
Executive Director, The Kaiser Commission on Medicaid and the Uninsured

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PRESCRIPTION® SOLUTIONS
COSTA MESA, CA 92626
March 23, 2001

Questions for witnesses of February 15, 2001
Energy and Commerce Subcommittee on Health
Hearing on Medicare Prescription Drugs

Question 1. What effect does direct-to-consumer advertising have on utilization?

Direct-To-Consumer (DTC) advertising provides information about diseases and drugs that treat those ailments. DTC advertising has been shown to increase utilization of specific drugs according to a report published in the Journal of Family Practice, December 2000. Physicians admit to prescribing drugs that patients request even though there are other less expensive drugs that achieve comparable results. In the same article, Dr. Richard L. Kravitz, Director of the UC Davis Center for Health Services Research in Primary Care, has stated "these ads are designed to encourage patients to request the advertised drugs from physicians. In some cases, the request may be appropriate, but the ads can also result in doctors prescribing drugs they don't deem necessary." For Prescription Solutions, utilization (based on number of prescriptions/member/year) has increased 17% over the past 3 years.

Question 2. What is your experience with pharmaceutical prices in other countries versus the United States? If there is a difference, can you explain?

There have been reports of pricing disparities regarding the cost of drugs in other countries, but Prescription Solutions has no direct experience in the pricing of foreign drug products. This subject is complex since access to certain pharmaceuticals and drug price controls vary by country and it is difficult to speak generally regarding the international markets.

Question 3. What effect does pharmaceutical marketing have on health care providers?

Physicians are susceptible to marketing pressures much as any other segment of society. Pharmaceutical marketing to providers may take the form of advertising and visits by sales representatives but is often in the form of drug samples. According to a *New York Times* article, November 15, 2000, some physicians that have re-

sponsibility for pharmacy budgets believe that the ready availability of samples in medical offices increases inappropriate drug utilization. In the article, Dr. John B. Chessare, chief medical officer at Boston Medical Center, states that his hospital was strongly discouraging its doctors from accepting free drug samples. Health care administrators also assert that the samples are helping to inflate their drug costs.

Focus groups conducted by Prescription Solutions have demonstrated an interest by physicians in generic drug sampling that would encourage use of appropriate and cost effective therapies. A generic sampling program has been initiated to help physicians counteract the effect of pharmaceutical samples of new, branded drugs.

MEDICARE REFORM

Question 1. Please explain the chain that takes place as a prescription drug tablet journeys from the manufacturing plant to the medicine cabinet of a senior citizen who gets prescription drug coverage from you.

The diagram below shows the "high level" flow of a prescription drug from the manufacturer to the patient. It doesn't account for all areas of interaction, however. There are negotiations with the manufacturer for discounts and rebates on formulary drugs selected. There are also computer systems that support the insurance eligibility of the patient, check for drug interactions, and price the prescriptions so the pharmacy can be paid. The patient also has a choice of pharmacies between either a retail pharmacy (patient picks up the prescription) or a mail service pharmacy (prescription is delivered to patient's home).

A patient visits their doctor and may receive a prescription for a medicine, which they will take to the pharmacy to be filled. If the drug is on the health plan formulary, it will be dispensed to the patient with instructions for proper use and storage of the medication. The patient pays a co-pay that is predetermined according to their benefit and then takes the medication home for use. If the medication is not on the formulary, the physician will be contacted. The physician will call in the request or fax a form for the request of a nonformulary drug. Clinical guidelines have been established for the use of nonformulary drugs. If the patient meets those criteria, approval will be given, and the drug will be dispensed by the pharmacist. If approval is denied, the physician will often be given formulary options to use that will be therapeutically equivalent to the requested drug.

Non-formulary drugs are reviewed via a Prior Authorization process for medical necessity. Guidelines have been established by the Pharmacy & Therapeutics Committee for the appropriate use of non-formulary drugs. Drugs are chosen for the formulary based on safety and efficacy. There are more than 1600 drugs on the formulary, and 24 million prescriptions filled annually for our Medicare members. Occasionally, medications are requested that are not on the formulary and must be evaluated on an individual basis. About one percent of all prescriptions require prior authorization before being filled, and of these cases, 75% of the prescriptions written are approved without further action. Approximately one-fourth of one percent of all prescriptions are denied.

Question 2. To the extent that you or the organization you work for, have experience with the purchase and supply of prescription drugs abroad, please identify any differences you are aware of in the international systems.

We are a domestic company. Since we are subject to the drug importation laws, we do not buy drugs from foreign countries.

Thank you for the opportunity to provide clarification on these questions.

Sincerely,

JOHN JONES, R.PH., J.D.
V.P. Legal and Regulatory