# INTEGRATING PRESCRIPTION DRUGS INTO MEDICARE

## HEARING

BEFORE THE

## COMMITTEE ON WAYS AND MEANS
## HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

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# INTEGRATING PRESCRIPTION DRUGS INTO MEDICARE

**WEDNESDAY, APRIL 17, 2002**

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

The Committee met, pursuant to notice, at 10:46 a.m., in room 1100 Longworth House Office Building, Hon. Bill Thomas (Chairman of the Committee) presiding.

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

# *ADVISORY*

## FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE CONTACT: (202) 225–1721
April 8, 2002
No. FC–18

# Thomas Announces a Hearing on Integrating Prescription Drugs Into Medicare

Congressman Bill Thomas (R–CA), Chairman of the Committee on Ways and Means, today announced that the Committee will hold a hearing on integrating coverage of prescription drugs into the Medicare program. **The hearing will take place on Wednesday, April 17, 2002, in the main Committee hearing room, 1100 Longworth Office Building, beginning at 9:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include Bush Administration officials and representatives of affected parties. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

**BACKGROUND:**

When Medicare was enacted in 1965, most health plans did not cover prescription drugs. Since that time, most health plans have fully integrated prescription drug coverage yet Medicare still does not cover most outpatient prescription drugs. Prescription drugs are now as important to health care as hospitals and physician services were 37 years ago.

Although seniors consume an escalating number of prescription drugs, they are more likely to be faced with high out-of-pocket costs and fewer options for private sector drug coverage. The average senior consumes 20 prescriptions a year and the Congressional Budget Office (CBO) projects that the average beneficiary will spend $2,440 for these prescriptions in 2003. Seniors comprise approximately 12 percent of the population; yet consume nearly 40 percent of all prescription drugs. While about 75 percent of Medicare beneficiaries have some type of prescription drug coverage, those without coverage are often paying the highest prices. Further, many employers through their company retirement benefit plans are paring back or dropping prescription drug coverage as costs continue to dramatically escalate.

As a result of increased utilization, new market entries and price increases prescription drug costs rose more than 17 percent last year, according to the National Institute for Health Care Management. CBO projects double-digit annual prescription drug cost growth over the next decade.

In the last Congress, the U.S. House of Representatives passed a Medicare prescription drug bill (H.R. 4680), but the Senate failed to act on the issue. The President included $190 billion over 10 years in the Fiscal Year 2003 budget, and last month the U.S. House of Representatives passed a budget resolution providing for $350 billion over 10 years for prescription drugs, Medicare modernization, and appropriate adjustments to provider payments.

"Nobody would create a seniors health care program today that excluded prescription drugs. Yet Medicare's lack of a prescription drug benefit epitomizes the most glaring reason why Medicare must be modernized. I am committed to enacting a prescription drug benefit this year as we update other parts of the program as well," stated Chairman Thomas.

**FOCUS OF THE HEARING:**

This hearing continues the Committee's consideration of the many issues surrounding the development of an outpatient prescription drug benefit within the Medicare program.

**DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:**

**Please note:** Due to the change in House mail policy, any person or organization wishing to submit a written statement for the printed record of the hearing should send it electronically to *hearingclerks.waysandmeans@mail.house.gov,* along with a fax copy to (202) 225–2610, by the close of business, Wednesday, May 1, 2002. Those filing written statements who wish to have their statements distributed to the press and interested public at the hearing should deliver their 200 copies to the full Committee in room 1102 Longworth House Office Building, in an open and searchable package 48 hours before the hearing. The U.S. Capitol Police will refuse sealed-packaged deliveries to all House Office Buildings.

**FORMATTING REQUIREMENTS:**

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

1. Due to the change in House mail policy, all statements and any accompanying exhibits for printing must be submitted electronically to *hearingclerks.waysandmeans@mail.house.gov,* along with a fax copy to (202) 225–2610, in Word Perfect or MS Word format and MUST NOT exceed a total of 10 pages including attachments. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. Any statements must include a list of all clients, persons, or organizations on whose behalf the witness appears. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers of each witness.

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

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

***NOTICE—CHANGE IN TIME***

# *ADVISORY*

**FROM THE COMMITTEE ON WAYS AND MEANS**

FOR IMMEDIATE RELEASE
April 9, 2002
No. FC–18–Revised

CONTACT: (202) 225–1721

## Change in Time for Hearing on Integrating Prescription Drugs Into Medicare

Congressman Bill Thomas (R–CA), Chairman of the Committee on Ways and Means, today announced that the Committee will hold a hearing on integrating coverage of prescription drugs into the Medicare program. The hearing, scheduled for Wednesday, April 17, 2002, in the main Committee hearing room, 1100 Longworth Office Building, beginning at 9:00 a.m., **will now be held at 10:30 a.m.**

All other details for the hearing remain the same. (See Committee Advisory No. FC–18, dated April 8, 2002.)

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Chairman THOMAS. I want to thank you all for coming. As we consider ways to modernize Medicare, it is important that we not lose sight of how Medicare has improved the lives of millions of our Nation's seniors. Yet, obviously, to carry Medicare's promise to its fulfillment, we simply can't sit on Medicare as we know it. One of the biggest issues we face is prescription drugs, and we know that, just as important to health care today as when Medicare started, is the examination of hospital and physician services.

The typical senior now takes more than 20 prescriptions a year, and we are told by the year 2005 we will spend more than $2,400 on prescription drugs. Unfortunately, seniors are, to a very great extent, the last bastion of retail drug purchasers. They pay high prices. They lack negotiating power.

Medicare has not kept pace with changes in the medicine marketplace, and, frankly, the lack of a comprehensive prescription drug benefit epitomizes just one very important way in which today's Medicare falls short.

This Congress and this Committee has held 16 different hearings examining areas where Medicare can be strengthened and improved. We have covered an awful lot of ground. We have looked at reducing Medicare's regulatory burdens, improving rural health care, securing Medicare's solvency in the long term, reforming antiquated cost sharing and Medigap programs, integrating disease management, reducing medical errors, rationalizing payments to physicians, and looking at the Medicare+Choice program.

While integrating prescription drugs is the most high-profile topic Congress faces, a comprehensive bill to strengthen Medicare and modernize it should at least address all of the issues that I just mentioned. And when we begin focusing on a prescription drug benefit, I do want to thank the Chairwoman of the Health Sub-

committee, Mrs. Johnson, and the Health Subcommittee for working on guidelines as we move forward.

Clearly, the specifics of the program are important, but the structure by which you examine options is equally important. For example, we believe strongly that you can't simply add a new prescription drug benefit to Medicare. The issues identified in those 16 hearings that I outlined, while perhaps not as politically headline-grabbing as prescription drugs, are serious, cannot be left for later, and need to be done.

Second, we really should rely on the private sector innovation in delivering the drug benefits. A strong government guarantee to all Medicare beneficiaries is absolutely essential, but what we found interesting was that the Congressional Budget Office (CBO) has certified that the private sector approach on controlling drug prices really delivers the most savings per prescription. We do have to remember that taxpayers finance the structure by which the seniors primarily receive their medicine. There is a modest amount of money out-of-pocket, but most of it is taxpayer-financed.

Third, beneficiaries really should have a choice. Competing prescription drug plans ought to be able to select actuarially equivalent coverage. A government-run, one-size-fits-some program is just not workable.

We also believe strongly that all low-income beneficiaries deserve extra help. And, frankly, it ought to be a uniform national health that low-income seniors receive. When Congress embarked on the Medicare Program, it was for seniors, not high-income seniors or moderate-income seniors. Seniors ought to be seniors first and low-income second. The program ought to be a national one and not rely on the various States and their willingness or ability to respond to low-income needs of seniors.

Fifth, the benefit should be affordable both to the seniors but also to the taxpayers. In the last Congress, the House passed a comprehensive prescription drug benefit. Unfortunately, the Senate failed to act. Last month, the House passed a budget resolution which provided, we believe, reasonable resources, some $350 billion over 10 years, to modernize Medicare and add a prescription drug benefit. We have the opportunity this spring to pass legislation to strengthen Medicare and integrate a prescription drug program.

The Speaker has asked us to have a bill on the floor before Memorial Day so that we can move it to the Senate with sufficient time for the Senate to respond. Today, this hearing is going to hear from the Bush Administration, the U.S. General Accounting Office (GAO), and a panel composed of industry groups, AARP and others, about what they believe should be done in integrating prescription drugs.

It is a pleasure to hear these people. We are all interested in the same result. Perhaps the manner by which we get there may differ. If we can keep that in mind, that providing seniors with a responsible prescription drug program is the goal, those differences ought to be able to be overcome. And prior to welcoming the Secretary to the Committee, I would recognize the gentleman from New York, the Ranking Member, Mr. Rangel, for any comments he may wish to make.

[The opening statement of Chairman Thomas follows:]

**Opening Statement of the Hon. Bill Thomas, a Representative in Congress from the State of California, and Chairman, Committee on Ways and Means**

Good morning. As we consider ways to modernize Medicare, it's important that we not lose sight of how Medicare has improved the lives of millions of our nation's seniors. Yet to fulfill Medicare's true promise, we cannot be satisfied with the status quo. Prescription drugs are just as important to modern health care as hospital and physician services were when Medicare was enacted in 1965.

The typical senior now takes more than 20 prescriptions a year, and in 2005 will spend more than $2,400 on prescription drugs. They are often paying the higher prices because they lack negotiating power. Medicare has not kept pace with modern medicine, and the lack of a comprehensive prescription drug benefit epitomizes just one way it falls short.

This Congress, the Committee has held 20 different hearings examining areas where Medicare can be strengthened and improved. We have covered a lot of ground: Reducing Medicare's regulatory burdens, improving rural health care, securing Medicare's solvency in the long-term, reforming antiquated cost-sharing and Medigap, integrating disease management, reducing medical errors, and rationalizing payments to physicians and Medicare+Choice. While integrating prescription drugs is the most high-profile topic Congress faces, a comprehensive bill to strengthen Medicare should address all of these issues.

Our guidelines for adding a prescription drug benefit:

1. We cannot simply add a new prescription drug benefit. The issues identified in our 20 hearings, while not as politically "sexy," are serious and cannot be left to fester.
2. We should rely on private sector innovation in delivering the drug benefit with a strong government guarantee to all Medicare beneficiaries. CBO has certified that the private sector approach delivers the most savings per prescription.
3. Beneficiaries should have a choice of competing prescription drug plans and be able to select actuarially equivalent coverage. A government-run "one-size-fits-some" program is unacceptable.
4. All low-income beneficiaries deserve extra help and it should be provided across the country uniformly rather than forcing them to rely on a patchwork of varying state programs.
5. The benefit should be affordable to both the taxpayers paying the bills and the beneficiaries paying the premiums.

In the last Congress, the House passed a comprehensive prescription drug benefit. Unfortunately, the Senate failed to act. Last month, the House passed a Budget Resolution, which provides ample resources—$350 billion over 10 years—to strengthen Medicare and add a prescription drug benefit. We have the opportunity this spring to pass legislation to strengthen Medicare and integrate prescription drugs. The Speaker has asked us to have a bill on the floor before Memorial Day in order to give the Senate sufficient time to respond and to maximize our chances for enactment.

Today we will hear from the Bush Administration, the General Accounting Office, AARP and industry groups about their thoughts for integrating prescription drugs into Medicare. Welcome to the Committee. I would now like to recognize the Ranking Member, Mr. Rangel.

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Mr. RANGEL. Thank you, Mr. Chairman. Let me join in welcoming the Secretary once again to this Committee. Your visits are not just important because of who you are and what you do in shaping national policy, but once we see you, we don't think we have got to see hardly anyone else as it relates to health policy or welfare policy, because it is not surprising that these bills end up on the suspension calendar and this will be our only opportunity at least to have you to share the Administration's views.

I say that because you were so persuasive as a Governor in believing that the States should have the opportunity to formulate their own policies within a national framework. And, of course, I differed with that, but I had to admit that, as Governor and as it

relates to welfare, you had done a remarkable job in your State. And other Governors have proven that they could handle it probably much better than the Federal Government.

Having said that, it just surprised me to see that the Congress would start putting restrictions on Governors and having the Governors to believe that we are now mandating that they do things, which was exactly what you said you didn't want. Well, that is welfare, and we won't be able to talk with anyone else except the Governors, who now oppose the new bill.

Now, here we are with Medicare, and my friends on the other side are going to say that this is political or that we are motivated on issues concerning the election. I don't see how it cannot be political when you are dealing with old folks that can't afford to pay for their prescriptions, and we all are looking for a solution to the problem.

Now, the Chairman has indicated that this is so important that it can't be considered a loan. Well, I know he will get back and explain why it can't, but he has got to give us a package sooner or later that is going to be very, very politically difficult to oppose. He wants to have Medicare modernization. I think he means vouchers and credits, but, you know, who knows? He wants to include provider givebacks, which means hospitals are not going to get nearly back what they have been promised, but what a good time to stick it to them in an omnibus bill. And he wants to involve other potential expenses in a package.

Well, thank God the Republicans are as honest as they are, because while my Chairman wants to do all of these things for the future, this week they are going to want to make permanent the tax cuts that they have had a couple of years ago. Which means what? It means that the fact that they never made it permanent in the budget—was for what reason, Governor/Secretary? It was because it didn't fit within the budget.

Now, you are here testifying not about how we are going to take care of senior citizens tomorrow or next month or next year. You are concerned about your legacy and what will the policies be as established by your Secretaryship after you are gone and after I am gone.

Now, you just tell me how it is going to work out that we are going to have expanded prescription benefits, Medicare modernization, provide for the givebacks, and have Americans believe that we are concerned about them, and at the same time, even though it is not in the budget, we are saying that we want to make permanent the exciting tax cuts that the President has suggested, which is, of course, the $4 trillion in the next decade, at the same time your constituents—assuming Medicare is something that you are concerned about in the future—and Social Security beneficiaries are going to be coming into massive dependency because of the Baby Boomers.

To me, it is a political shell game and that we are going through the motions here, and we had some witnesses to kind of share our view. But the new method is that the Democrat minority, we cannot have witnesses unless they are approved by the Chair. I just got back from Cuba, so I am beginning to understand that a lot better than before.

And we had a witness that was checked out by the Chair, and it found out that this lady is not only a Democrat, pardon the expression, but a candidate for the U.S. Senate. So, therefore, she was denied the opportunity to express herself on this sensitive subject.

I don't mean to make life awkward for you, but these are the people you are working with, and I just want you to know that your office has been far more cooperative with us on this and every other subject that you have jurisdiction of in terms of sharing ideas than the majority ever has. And I want to thank you for that. I hope something can come out of it, but I thank you for keeping that door open.

I yield to Mr. Stark.

[The opening statements of Messrs. Rangel, Ramstad, Nussle, and Foley follow:]

**Opening Statement of the Hon. Charles B. Rangel, a Representative in Congress from the State of New York**

I thank the Chairman for bringing us together to discuss this important topic. There is no question that there is a great need to integrate prescription drug coverage into Medicare. The only question is whether Congress is serious about doing it.

Sadly, the evidence before us indicates that the Chairman and his Republican colleagues are not serious. In order to be serious, you would have to budget sufficient resources so that premiums would be low enough and benefits would be high enough so that all seniors could benefit.

Unfortunately, the Republicans' so-called budget proposal did not set aside any money specifically for a prescription drug benefit. The money to fund any proposal sponsored by Chairman Thomas would be paid for out of a $350 billion over ten year so-called "reserve fund" that is supposed to cover not just prescription drug benefits but so-called Medicare modernization, provider give-backs, and many other potential expenses that the Republicans have not made room for elsewhere in their budget.

At the same time, the House Republican leadership is doing its best to make sure that any resources that might be there over the next ten years, will not be there beyond that by passing a bill to extend last year's tax cuts in such a way that revenues will decrease by $4 trillion in the same decade that the baby boom generation is retiring and eligible for any Medicare prescription drug benefit that Congress may enact.

The Republicans not only do not want to assist seniors with their prescription drug needs, they want to prevent us from being able to provide such assistance for the foreseeable future. At a time when, as the GAO will tell us today, the Medicare program needs to prepare for the Baby Boom generation, the Republicans' fiscal plan has made such preparation impossible.

It's pretty clear that this hearing is not real, but purely political. In fact, you have even denied a place at the witness table for the expert, former Maine Senate Majority Leader Chellie Pingree (SHELL-ee PIN-gree), that we Democrats tried to invite to testify on her plan to provide prescription drugs to seniors in Maine.

Although we had told you the name of this nationally-known expert last week, you decided yesterday that the Committee had a new policy and that because Ms. Pingree was a candidate for U.S. Senate, you would disqualify her from testifying. Although we have allowed countless members of Congress—who are candidates for re-election or sometimes election to other offices—to testify, Ms. Pingree is not allowed to offer her substantive statement because the Republican Senate Campaign Committee is worried she might make sense.

Of course, you do not really care about Ms. Pingree's success in Maine because you have no intention of actually putting together a bill that could pass the House and the Senate and be signed by the President, because you would rather use all of the money for additional tax cuts.

However, Republicans have enough polling data to know that Americans of all generations want prescription drug coverage to be provided under Medicare so here we are today pretending that you're serious.

Of course, I understand that the Chairman plans to bring a Medicare bill to the floor within a month or so. But, so far, the Chairman has made no attempt to work

with members on this side of the aisle in crafting that bill. The Chairman has not even indicated whether this Committee will have an opportunity to mark up the legislation.

Working with Committee Democrats on a truly bipartisan bill would run the risk of coming up with something that actually could pass the Senate and become law.

We should not be surprised that this is not a serious effort to address the vitally important issue of extending prescription drug coverage to America's seniors. Adding a prescription benefit would only strengthen a program that Republicans have been fighting against for decades.

Republican leaders have never liked Medicare. In 1995, Dick Armey said he "deeply resents the fact that when I'm 65 I must enroll in Medicare." Newt Gingrich said he wanted it "to wither on the vine." And Tom Delay said in 1999 that a prescription drug benefit and strengthening Medicare "don't matter to the American people."

So, I thank the witnesses for your time. I am sorry that nothing serious will happen in this Committee this year to improve Medicare or provide a real prescription drug benefit that will become law. And if Democrats were in charge, this would not just be something that we talk about, but something that we would actually do for all American seniors.

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

Thank you, Mr. Chairman, for holding this important hearing today.

Prescription drug coverage is one of the most critical issues facing this nation. This issue has moral, medical and economic implications for every American, not only current Medicare beneficiaries.

This is an issue that affects all of us, as most of us use prescription drugs at some point in our lives and all of us realize that prescription drugs will play a greater role in helping us lead active, healthy lives as we age.

The problem is that when the majority of people need prescription drugs most, in the later years of life, the largest insurer of the elderly does not provide prescription drug coverage. As a result, many seniors go without the drugs they need, dilute their prescriptions or forego other basic necessities in order to purchase vital prescription drugs. This is wrong.

Medicare must provide an outpatient drug benefit. Health care has changed and we need a system that reflects the advancements in medicine that have occurred in the past 37 years since the inception of the Medicare program in 1965. We know that seniors need prescription drug coverage and we know that the Medicare program is not meeting the needs of most seniors. It is time to modernize the Medicare program.

The Ways and Means Committee is crafting a meaningful prescription drug benefit for our nation's seniors. I look forward to hearing from our witnesses today on the best way to provide a meaning drug benefit for our nation's seniors.

Thanks again for taking up this very important issue.

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**Opening Statement of the Hon. Jim Nussle, a Representative in Congress from the State of Iowa**

Earlier this year, I visited the senior center in Independence, Iowa. At the center the very first question asked of me was about prescription drug coverage. I was not surprised in the least. Whether it's the lack of prescription drug coverage or the shortfalls in rural reimbursement rates, I receive numerous letters, phone calls, and e-mails from seniors and health care providers about Medicare problems every single day.

Because Iowa has the fifth highest population of people age 65 and over, Medicare is clearly one of the most important benefits that Iowa seniors rely upon. Unfortunately, the Medicare program has not been significantly modernized since its inception in 1965 and is not meeting the needs of Iowa seniors. Prescription drugs still cost too much for too many Iowa seniors and no senior should be forced to choose between getting a prescription filled and buying food or other basic necessities of life. If we could go back to 1965, we would have surely crafted a comprehensive drug benefit that is affordable, accessible, and completely voluntary.

While inclusion of a drug benefit is indeed important, Iowans recognize that the inequities in today's current Medicare program must be addressed before new programs are added to the system. As Chairman of the House Budget Committee I chose to include $350 billion over the next ten years to modernize the Medicare program overall; otherwise, the budget would have simply included the $190 billion requested by the Administration for prescription drug coverage. If health care providers leave the rural areas, who will write prescriptions under the new drug benefit? Who will provide the care that cannot be provided by drugs alone?

I understand that many of these problems have compounded since 1965, but rural health is on the verge of a crisis and the disparities that exist between rural and urban providers need to be resolved. I am hopeful that I can work with Secretary Thompson, Chairman Thomas, and other members of the committee to produce a comprehensive Medicare bill that not only provides comprehensive drug coverage for seniors, but ends many of the antiquated reimbursement policies that exist in the current system. I urge that the House complete consideration of comprehensive Medicare reform legislation prior to Memorial Day as it is critical to my Iowa constituents.

**Opening Statement of the Hon. Mark Foley, a Representative in Congress from the State of Florida**

I want to thank you, Mr. Chairman, for holding this very important hearing.

For years, thousands of seniors have gone without any form of prescription drug benefit. In some cases, it can cost up to $10,000 per month for the numerous types of drugs that a beneficiary may take. For those on a fixed income, this amount can mean the difference between medicine and food.

When Medicare was developed in 1965 it was designed to help seniors who were without health insurance. At the time, there were far fewer prescription drugs on the market and therefore there was not a need for a prescription drug benefit. However, times have changed and there are dozens of new prescription drugs being developed every year.

I strongly believe that, as part of our efforts to help the millions of Medicare beneficiaries who are currently suffering, we must implement a Medicare prescription drug discount card bill as soon as possible. This program, which will lead to a larger drug benefit, can be implemented more quickly than the full benefit and in the interim save seniors between 15 to 40 percent on drugs.

Again, Mr. Chairman, I commend you and Chairman Johnson for your outstanding work on this issue and I look forward to working with you to provide long overdue and critically needed help to our seniors.

Mr. STARK. I thank the gentleman for yielding, and I just wanted to follow up because there have been women throughout history who have been silenced because people in power didn't want them to be heard.

Ida Wells, an African American writer in the 1800s, wrote articles decrying lynching. She so intimidated those in town that they threatened to kill her and run her out of town.

Not so long ago, Karen Silkwood rallied against the chemical safety problems in her plant. Her campaign for safety was cut short by a tragic accident.

Today, our Chairman decided to silence the voice of another prominent woman because he doesn't want her message to reach the public. Chellie Pingree, a nationally renowned expert, an advocate for a Medicare prescription drug benefit, was denied at the very last minute the opportunity to testify today. Her work in the State of Maine for a prescription drug benefit could provide us with insight into such a program. But the Republicans apparently are afraid to hear alternatives. The Portland Press Herald News today

calls Ms. Pingree's work on the Maine drug benefit "ground breaking." And she challenges us, Mr. Secretary, to say we need Federal legislation that will do one of two things: either provide a drug benefit understand Medicare, passing on negotiated discounts to seniors, or free up the States to use innovative programs like the Maine prescription drug benefit.

This is as political as her testimony—which I would ask unanimous consent to put in the record in printed form. It says nothing about any campaign, or I don't even think it mentions her political affiliation. But it is a sad day when we can't work with our Republican colleagues to fashion a bill. It is even sadder when they are so afraid of hearing opinions that they will deny us the chance to have one witness on the grounds that they were a political candidate.

I yield back.

Chairman THOMAS. The gentleman's time has expired.

Mr. MCDERMOTT. Mr. Chairman, a point of information?

Chairman THOMAS. The gentleman from Washington is recognized.

Mr. MCDERMOTT. In the light of the decision on Ms. Pingree, if somebody has a poll in the field in their home State about the candidacy for Governor, would that preclude them from witnessing before this organization?

Chairman THOMAS. The Chair was going to respond to the statements because some people perhaps didn't fully understand what has transpired, and the Chair was going to outline a policy that I believe has been fairly longstanding, and clearly, as long as this Chairman remains Chairman, we are going to attempt to follow; and, that is, the witness was not denied the right to speak because she was a female. That is absurd on its face.

What we found out was, of all of the people in the United States who the Democrats could have chosen to be a responsible witness on a factual panel on prescription drugs, Friday at 5:00 p.m., we were told that the one that the Democrats chose just happens to be the winner of the Democratic primary in the State of Maine for the U.S. Senate.

Just as the gentleman from New York indicated that some of these activities are liable to be political, the Chair, to the best of his ability, will not allow hearings in front of this Committee to be used for political purposes.

The way in which this witness was not going to be political was couched in the most political terminology you could get. The Chair will not allow candidates for political office to be factual witnesses, whether they be Democrats, Republicans, men, women, Libertarians, Green, or others.

It may be that you are somewhat circumscribed in terms of the choices of witnesses available to us, but I believe that is a reasonable and appropriate rule, and it ought to govern. It is as difficult as it is in the current context to reach agreement. We ought to minimize the opportunity for continuing to bite at each other from a political perspective. And the Chair would briefly recognize the Chairwoman of the Health Subcommittee, the gentlewoman from Connecticut, Mrs. Johnson.

Mr. MCDERMOTT. Mr. Chairman, you didn't answer my question, though. That was: At what point is someone a candidate or using the podium for a political purpose? Do they have to be a declared candidate, or can they be exploring through a poll? Or——

Mr. RANGEL. If the gentleman would yield, the Chairman answered that. It is when——

Chairman THOMAS. Based upon——

Mr. RANGEL. He feels that it is a candidate. He answered it clearly.

Chairman THOMAS. Based upon the denial of this candidate, it is fairly clear that when the individual is on the ballot as a qualified candidate, having won the primary, that that is a clear rule. If the gentleman wishes to pursue how far back it can go, we can carry on a reasonable discussion, or the minority can continue to try to get witnesses on with more or less a shade of political leaning.

Mr. LEWIS OF GEORGIA. Mr. Chairman.

Chairman THOMAS. And we will try to make those decisions in a real-time basis.

Mr. LEWIS OF GEORGIA. Mr. Chairman.

Chairman THOMAS. And the Chair is open to either of those options.

Mr. LEWIS OF GEORGIA. Mr. Chairman, a point of information.

Chairman THOMAS. The gentleman from Georgia.

Mr. LEWIS OF GEORGIA. Would that include sitting Members of Congress?

Chairman THOMAS. Obviously not.

Mr. LEWIS OF GEORGIA. Well, we are——

Mrs. JOHNSON OD CONNECTICUT. Mr. Chairman.

Mr. LEWIS OF KENTUCKY. When we are—there's primaries and we are qualified, we——

Chairman THOMAS. I understand that.

Mr. LEWIS OF KENTUCKY. Are filing to run——

Chairman THOMAS. But you have already won, and you are participating as an incumbent, not as a challenger. And we allow Members to come up and discuss their positions, but we don't normally include Members as part of a multi-Member factual panel in discussions.

The gentlewoman from Connecticut is recognized.

Mrs. JOHNSON OF CONNECTICUT. Thank you, Mr. Chairman. And I applaud you for your policy in regard to our hearings. The factual information that is out there, the number of experts whose opinions and whose experience we can call on are really so numerous that we cannot reach them all.

The issues confronting us in providing prescription drugs to seniors are very complicated and important issues, and through seminars, through our individual readings, through working with the Administration, through working with Professors, and others throughout the Nation, we are bringing a lot of that information to the table. To imagine that there wasn't an expert that could have been called to the table on the other party's side and made points of interest to them is simply ludicrous.

And then, second, I would say—and every one of us knows this to be true—no matter how much of an expert you are at the State

level, making national policy is a very different challenge. And I would much prefer that the Democrats would have brought someone to the table that had national experience in policymaking, and particularly in the complexity of the structural delivery issues that are going to be so important to our succeeding in actually delivering to every senior across America in every little city and town a prescription drug subsidy in the years to come.

So I believe that their calling someone who is now an affirmed candidate, having won a primary, but who also is clearly not as well prepared as many other people they could have called is very concerning to me. The challenge of writing a prescription drug bill that can actually implement a policy that is sustainable, affordable and effective for our seniors is a tremendous challenge that crosses party lines, that crosses disciplines, and we all need to be extremely serious about that challenge.

So I welcome this hearing and the quality of the experts that will testify today, and it is a special pleasure to welcome the Honorable Tommy Thompson, who has been a real leader in bringing his agency to the table with practical, factual, substantive material, but also trying to reform the bureaucracy so it, too, can be more effective, practical, intelligible to the provider community and a better servant in the goal of providing a strong Medicare Program to the seniors across America.

Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentlewoman.

The Chair wants to clarify that the decision the Chair made was one based upon objective information, not a subjective one based upon the direction of the testimony. And the Chair would not exercise a subjective decision. The individual that the Democrats wished to offer would be able to present their position as how they wanted to, but that the decision was made upon the very objective criteria of an active candidate.

And, with that, it is my pleasure to welcome once again to the Committee on Ways and Means, as Mr. Rangel said, the Governor/Secretary. Mr. Thompson, your testimony will be made a part of the record that is written, and you can address us in any way you see fit in the time you have.

**STATEMENT OF THE HON. TOMMY G. THOMPSON, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Mr. THOMPSON. Thank you very much, Mr. Chairman. I appreciate the opportunity to come once again in front of the Ways and Means Committee.

Chairman THOMAS. Mr. Secretary, is our microphone on?

Mr. THOMPSON. Yes, it is.

Chairman THOMAS. Then you need to get close to it. It is very unidirectional, unfortunately.

Mr. THOMPSON. Thank you, Mr. Chairman. Chairman Thomas, Representative Rangel, distinguished Committee Members, thank you for inviting me to discuss our proposal for strengthening and improving Medicare. Medicare has provided security to millions of American seniors since 1965. But at the dawn of the 21st century, its promise is threatened by outdated and inadequate benefits, limited protection against rising medical costs, and a traditional gov-

ernment plan that often fails to deliver responsive services to recipients or ensure high quality care.

President Bush and my Department are committed to modernizing the Medicare program and strengthening it for all seniors. At the hearing of this plan is a belief that we must provide better and more efficient delivery of services and evaluate Medicare in a deliberate and thorough manner.

Medicare is in fiscal trouble, which will only deepen in coming decades unless we act now. While we all want to provide a drug benefit for seniors, it cannot be done in a vacuum. It must be accompanied by fundamental reforms that keep those benefits secure.

The framework for bipartisan legislation that the President and I have proposed includes several important principles:

First, all seniors should have the option of a subsidized prescription drug benefit as part of a modernized Medicare. Everyone benefits from new drugs that are being developed through the miracles of science. And Medicare beneficiaries should and must have greater access to life-saving therapies. But it is also clear that if we add a drug benefit without comprehensive modernization of the system we will only deepen the financial crisis Medicare faces in the coming years.

Second, modernized Medicare could provide better coverage for preventive care and serious illnesses. By preventing disease and illness to begin with, we not only save substantial financial resources, but we also save and improve the quality of lives.

Third, today's beneficiaries and those approaching retirement should have the option of keeping the traditional plan with no changes.

Fourth, Medicare should provide greater insurance options, like those available to all Federal employees.

And there are several other important principles, including strengthening the program's long-term financial security; improving the management of the government Medicare plan; updating and streamlining Medicare's regulations and administrative procedures; and encouraging high-quality health care for all seniors.

These principles are vital to quality care, and should be available to everyone in Medicare. Period. In a nation as prosperous and as compassionate as ours, it is the least that we can do.

The lack of drug coverage among America's seniors is among Medicare's most pressing challenges. Ten million Medicare beneficiaries have no prescription drug coverage at all. In fact, Medicare beneficiaries and the uninsured are really the only individuals in America today that commonly full price for prescription drugs. That is simply unacceptable. It must change.

The President is also committed to a Medicare subsidized drug benefit that protects seniors against high catastrophic drug expenses. And we must also support the continuation of affordable prescription drug coverage now available to many seniors through retiree plans and private health insurance plans.

Our budget also provides $8 billion through the year 2006 to expand drug coverage to low-income Medicare recipients. This proposal is fully integrated with the President's Medicare modernization proposal, and will enable States to take advantage of existing

structures so that seniors will be able to get help quickly. We have debated this issue long enough.

Mr. Chairman, I want to work with you and all Members of this Committee in designing this vital drug assistance program. It is so important. And I look forward to your ideas and thoughts on better serving America's neediest seniors.

We must also act now to stabilize the Medicare+Choice system, to ensure that current benefits and choices remain available to Medicare beneficiaries. We should not eliminate by inaction a program that millions of seniors enjoy.

We must come together now to take the sound, the careful and deliberate steps needed to improve the Medicare Program for today's seniors, as well as tomorrow's. And we must start this process now. These issues have been debated on and off for years, and now it is time for action. I am here today to tell you that we stand ready and willing to work with you and the other Members of the Committee and all Members of Congress, to make that happen.

I understand that the Administration and the House have sometimes differed in their numbers. While we feel that we can provide this benefit for less than the $350 billion which was proposed in the budget by this house, let me make it clear that we are committed as an administration to the principle of a prescription drug benefit, rather than to a specific figure.

Three decades from now, the promise of a financially secure retirement should continue to be a reality for America's seniors. As we join together, we can make sure that it will happen. So thank you, Mr. Chairman, Congressman Rangel, and all Members of the Committee, for this opportunity to discuss this very important topic with you today. Now I look forward to answering your questions.

[The prepared statement of Secretary Thompson follows:]

**Statement of the Hon. Tommy G. Thompson, Secretary, U.S. Department of Health and Human Services**

Chairman Thomas, Representative Rangel, distinguished Committee members, thank you for inviting me to discuss our proposal for strengthening Medicare, including prescription drug coverage. This committee obviously played a key role in creating the Medicare program. When that legislation was enacted, President Johnson said: "No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime." Thirty-six years later, President Bush believes it is time for our Nation to come together and renew that commitment. I share the President's view that we have a moral obligation to fulfill Medicare's promise of health care security for America's seniors and people with disabilities.

Medicare has provided this security to millions of Americans since 1965. But its lack of prescription drug coverage demonstrates that Medicare is not keeping up with the rapid advances in medical care. Looking ahead, medical care holds the promise of improving and extending life through countless innovations. But as we enter the 21st century, Medicare's promise is threatened by: outdated benefits; limited financial protection against high medical costs; a system that has not delivered reliable health plan options; and a traditional government plan that often fails to deliver responsive services to beneficiaries or ensure high-quality care.

The 77 million Americans who will be entitled to Medicare in 2030 are counting on Medicare's promised benefits. Yet even Medicare's current benefits are not secure for the retirement of the Baby Boom generation. Medicare's fund for hospital insurance will face cash flow deficits beginning in about 15 years and is projected to become insolvent within 30 years. Medicare's fund for its other benefits will require nearly a doubling of beneficiary premiums and infusions of general revenues to remain solvent over the next 10 years. Medicare's accounting disguises the true fiscal health of Medicare and makes it difficult to plan ahead.

**STRENGTHENING MEDICARE**

Recognizing these problems, President Bush has worked with members of Congress from both parties to develop a framework for a modernized Medicare program and for keeping Medicare's benefits secure. The President's framework includes the following eight principles:

**First, all seniors should have the option of a subsidized prescription drug benefit as part of modernized Medicare.** More specifically, the President's framework made it clear that:

- Medicare's subsidized drug benefit should protect seniors against high drug expenses and should give seniors with limited means the additional assistance they need.
- The drug benefit should give all seniors the opportunity to choose among plans that use some or all of the tools widely used in private drug plans to lower drug costs and improve quality of care.
- The drug benefit should support and encourage the continuation of the effective prescription drug coverage now available to many seniors through retiree plans and private health insurance plans.
- The new drug benefit should also be available through Medigap plans and as a stand-alone drug plan for seniors who prefer these choices.

Others may advocate a different approach, but we believe it is critical for seniors to have a choice of drug plans so that they can pick the one that is best for their needs—this is not a decision the government should make for them, just as we should not be picking their doctor or giving them a one-size-fits-all health plan. As the members of this Committee know, both the independent CMS actuaries and the non-partisan Congressional Budget Office experts fully expect private drug plans to participate in this benefit. At this point in the legislative process, with the drug benefit still subject to intense debate, it would be surprising if companies were stepping forward to say they would offer it—since they might prefer not to have to compete. But as CBO has also confirmed, giving private plans the proper incentives is the way to get the best deal for Medicare beneficiaries and the program—yielding lower drug prices and lower monthly premiums through competition. Of course, the government has a proper role to play as well, particularly in making sure seniors can get the protection against catastrophic drug costs that they need—protection which is often lacking today—and taking the steps necessary to ensure that all eligible seniors and disabled individuals get the benefits to which they will be entitled.

**Second, modernized Medicare should provide better coverage for preventive care and serious illnesses.** Medicare's current cost-sharing often imposes the highest costs on those who need the most care. Individuals who need hospital care currently face a payment of more than $800 for each spell—and they can have several spells in a year—and Medicare's coverage for hospitalizations can eventually run out. And unlike most private insurance, Medicare does not provide "stop-loss" protection to limit the financial obligations imposed on beneficiaries. At the same time, whether in Medicare itself—or in the Medigap plans that seniors buy to fill in Medicare's coverage gaps—first-dollar often coverage drives up costs and premiums for beneficiaries without yielding noticeable improvements in health. Thus we believe Medicare's coverage should be improved so that it provides better protection when serious illnesses occur and better coverage to help prevent these illnesses in the first place—like having zero co-payments on Medicare's preventive benefits while still encouraging prudent use of services and beneficiary involvement in health care decisions. Because they will encourage better use of preventive care and other services, better Medicare benefits will also help seniors and the Medicare program get the best value from the new drug benefit.

**Third, today's beneficiaries and those approaching retirement should have the option of keeping the traditional Medicare plan with no changes.** For us this is obvious—no one should be forced to accept significant changes they do not like and are not prepared for. Although we believe that a modernized Medicare program will be attractive to many current beneficiaries, we believe the choice rightly rests with them on whether to move from the existing program to the modernized one.

**Fourth, Medicare should provide better health insurance options, like those available to all Federal employees and retirees.** For too long, Medicare has been a "one size fits all" program, and we should offer options appropriate to the unique challenges various seniors face—including the kind of innovative disease management programs which this Committee has pushed for but which are threatened by chronic underpayments to private plans today. Private plans have been a critical source of drug coverage and other innovative benefits for seniors, and should remain so.

**Fifth, Medicare legislation should strengthen the program's long-term financial security.** In light of the recent Trustees' Report on Medicare one could conclude that our guiding principle should be "first, do not harm." But the President's budget recognized that strengthening Medicare would require substantial new resources—and proposed $190 billion for this important purpose. Of course we are more than willing to work with Congress this year to enact this long-overdue legislation, and we understand that there are a range of views regarding how much new spending needs to be allocated for this purpose. We believe an effective program for strengthening Medicare and including a prescription drug benefit can be accomplished within the amount the President has allocated in his Budget. Without strong measures to make the program more efficient being incorporated along with new benefits, all of Medicare's benefits will become less secure under some proposals.

For example, some have proposed a drug benefit as large as $750 billion, financed largely by surpluses generated by the Medicare Part A Trust Fund. But if the Part A surpluses literally were directed to augmenting prescription drug coverage, the consequences for Medicare's ability to provide benefits for the Baby Boom would be severe. According to the independent Actuaries, this transfer could cut the life of the Part A Trust Fund in half—causing its insolvency by 2016 and requiring its balances to be drawn down starting in 2008. Some might want to exploit the accounting gimmicks that Medicare's bifurcated Trust Fund system encourages, by creating yet another fund for the drug benefit and leaving it to future generations to figure out how to pay for it. But no accounting gimmicks can hide the fact that such a drug benefit would increase the program's long-term financing challenges by 50 to 100 percent. What costs $750 billion in the first 10 years would balloon to $2.4 trillion in the next ten, just when the Baby Boomers are counting on Medicare. Medicare spending (even after subtracting beneficiary premiums) is expected to grow from 2% of GDP today to 4% by 2030, and this drug benefit proposal would increase that share to almost 6%—which is like a tax increase on future Americans amounting to nearly 2% of our entire national product.

Thus, while we want to work closely with Congress to enact a Medicare drug benefit this year, we also want to work closely with Congress to make sure that the benefits we promise today will be there for beneficiaries tomorrow. This is also why we support changes in Medicare's Trust Fund accounting to provide a clear picture of Medicare's financial outlook. We have all seen examples of how poor accounting practices can lead to poor planning, with devastating consequences for many Americans. It is critically important that we avoid such practices in a program that is so important to all Americans.

In this context it is also important to consider the issue of provider payment reforms. Although certain provider payments may benefit from adjustment, we believe such adjustments can be accomplished without draining new funds that are even more urgently needed for improving Medicare benefits. In the context of moving forward on our shared goal of modernizing and strengthening Medicare, the Administration is willing to work with Congress to consider limited modifications to provider payment systems in order to address payment issues. In doing so, we must be systematic: all provider payment updates must be considered and any package must be budget neutral in the short and long term. Most importantly, as we all consider changes to payment systems, we need to focus on the adequacy of payment systems for providing access to care for beneficiaries, and recall that any increases in spending will be borne, in part, by beneficiaries and also have long-term implications for the security of Medicare's benefits.

**Sixth, the management of the government Medicare plan should be strengthened so that it can provide better care for seniors.** That's what we're working to do now at CMS, but we need legislation to proceed with such steps as competitive bidding so that Medicare and its beneficiaries can get better, market-based prices for the items it buys while ensuring high quality.

**Seventh, Medicare's regulations and administrative procedures should be updated and streamlined, while the instances of fraud and abuse should be reduced.** Here too we have moved aggressively but we need help from Congress and want to work with you to enact into law the kind of sensible improvements that this Committee led through the House of Representatives with unanimous bipartisan support. Regulatory reforms and simplifications are needed to reduce burdens on providers and on CMS at a time when we are implementing new benefits into the Medicare program.

**Eighth, Medicare should encourage high-quality health care for all seniors.** Recent reports from the Institute of Medicine and others have made clear the widespread opportunities for improving patient care that exist—which are likely to benefit seniors more because they use more care. These studies have also shown

that these problems are not the result of malfeasance, and made it clear that we need to change the environment for medical practice to one that encourages systematic and continuous improvements in care, not endless and costly litigation.

Looking ahead, we can and surely will continue to have a healthy debate about how we should meet these principles. The key, however, is to take action this year, and we intend to continue to work closely with Congress to implement a prescription drug benefit that Republicans and Democrats can support, and that achieves the President's principles for Medicare legislation.

**IMMEDIATE STEPS**

At the same time, the President's budget recognizes that—under all proposals—it will take several years to implement the comprehensive improvements that Medicare needs, including a prescription drug benefit and a more equitable payment system for private plans. Therefore the Budget also proposes urgently needed steps that should be incorporated into Medicare legislation: the transitional low-income drug benefit, new Medigap options, and immediate steps to help make sure that seniors who prefer private health insurance coverage in Medicare can continue to get it. We are also pushing ahead administratively with the Medicare-endorsed prescription drug card and the Pharmacy Plus waiver. These changes will both pave the way for a modernized Medicare program, and provide immediate relief including drug coverage for millions of Medicare beneficiaries before the full drug benefit can be implemented at least three years from now.

***Prescription Drug Card***

About 9 million Medicare beneficiaries have no prescription drug coverage at all. About thirty-five percent of these beneficiaries had incomes below 150 percent of poverty, or an annual income of about $18,000 for a family of two. Medicare beneficiaries and the uninsured are the only people in America today that commonly have to pay full price for prescription drugs. That is simply unacceptable and we must do something to address it. Last year, the President took the first step when he proposed the creation of a new Medicare-endorsed drug card program. The drug card is not a drug benefit and it is not a substitute for one. It is, however, an important first step in helping seniors afford the drugs they need today.

The President's proposal is pretty straightforward—it's a pooling mechanism modeled on private health insurance programs, where consumers routinely benefit from discounts of 10 to 35 percent. Private insurers, with their large numbers of customers, use their market power to secure significant rebates and discounts from manufacturers. In fact, I would venture to guess that all of us in this room, and certainly all federal employees, benefit from lower drug prices as a result of such pooling. Under the President's proposal, Medicare would endorse private drug cards that met minimum standards, allowing seniors to get the information they need to obtain manufacturer discounts and other valuable pharmacy services. These third-party plans will negotiate discounts and rebates directly from drug manufacturers and pass the savings on to Medicare beneficiaries who choose to participate.

The drug card has another important aspect: CMS has to implement it, just as it will eventually have to implement a more comprehensive drug coverage benefit. CMS knows how to pay hospitals and doctors and nursing homes, but has little experience in working with PBMs, paying pharmacists, or negotiating with drug manufacturers to run a retail drug insurance program. The infrastructure created by the voluntary drug card program and the experience CMS will gain by administering this program will be a significant advantage as CMS moves to implement whatever comprehensive Medicare prescription drug benefit is enacted. In our extensive discussions with AARP, we have found that this may be the top reason for their solid support of this concept—the desire to build the infrastructure and develop the experience needed for an effective Medicare drug benefit.

***Transitional Medicare Low-Income Drug Assistance Program***

We've been debating how to cover prescription drugs under Medicare for years. In the absence of a Medicare prescription drug benefit, many states have taken action to assist the neediest seniors. The lowest-income seniors have received drug coverage under the Medicaid program. In addition, about three-fifths of the states have set up separate prescription drug assistance programs for seniors. Yet many lower-income seniors still get no help. The President believes that Medicare legislation should take immediate advantage of existing state infrastructure, and support the integration of existing state low-income programs into the new Medicare drug benefit, by helping states provide drug coverage for low-income seniors right away.

The Administration has proposed to provide immediate support for comprehensive drug coverage for Medicare beneficiaries up to 150% of poverty—about $18,000 for a family of two. This proposal, called the Transitional Medicare Low-Income Drug

Assistance Program, would use the existing administrative structure operated by the states to identify and assist low-income seniors, and would also encourage states to use the new Medicare drug card infrastructure or similar competitive approaches to provide expanded low-income assistance. For Medicare beneficiaries up to 100% of poverty, the program would pay for expanded drug coverage at current Medicaid matching rates. As an incentive for States to expand coverage up to 150% percent of poverty, Medicare would pay 90 percent of the States' cost of drug-only coverage expansion for above 100% of poverty, leaving states responsible for covering the remaining 10%. This policy is projected to eventually expand drug coverage for up to 3 million beneficiaries who currently do not have prescription drug assistance. It would be fully integrated with the Medicare drug benefit once the reform Medicare program is implemented, through a transitional mechanism as envisioned in all major Medicare drug benefit proposals.

In addition, to make expanded drug coverage immediately available even before the enactment of the Transitional Low-Income Drug Assistance Program, states can immediately participate in a model drug waiver program called Pharmacy Plus that can cover Medicare beneficiaries up to 200% of poverty. In Illinois, for example, 368,000 additional low-income Medicare beneficiaries, up to 200% of poverty, will receive drug coverage under the waiver we approved last month. These waivers must be budget neutral to the federal government. A principal mechanism that states can use to provide this expanded coverage in a budget-neutral way is the adoption of private-sector drug benefit management tools. The savings generated from these tools in states' existing populations can be used to finance additional drug coverage.

***Reliable, Affordable Health Insurance Coverage Options In Medicare***

The President's framework for strengthening Medicare calls for a fair payment system for private plan options for Medicare beneficiaries, like the system that provides reliable health insurance options to all Federal employees in the Federal Employees Health Benefits program. Private plans have long been the preferred choice of millions of Medicare beneficiaries. This is not surprising, because the private plans allow beneficiaries to receive more up-to-date benefits than are available under traditional Medicare. The enhanced benefits can include prescription drugs, disease management programs, and better preventive care services—benefits widely available to the nonelderly and to Members of Congress and Administration officials and other Federal employees. Frequently, private plans have provided much lower cost sharing for required Medicare benefits as well.

Action is needed now to ensure that these benefits remain available to Medicare beneficiaries, because the current Medicare+Choice system for paying private plans is not giving beneficiaries the options they deserve. Since the new payment system was implemented in 1998, hundreds of Medicare+Choice organizations have left the program or reduced their service areas, adversely affecting coverage for hundreds of thousands of beneficiaries—reversing what had been an upward trend in private plan availability and enrollment. In addition, the remaining plans are offering less generous drug benefits and other coverage.

While the benefits offered by the plans that remain still provide a better deal for many seniors than fee-for-service Medicare plus an increasingly costly Medigap policy, millions of seniors who prefer private plans have been made worse off as a result of these recent changes. And without corrective legislation this situation will only get worse—just at the time when rapid advances in care will make it even more important for seniors to have these options. Indeed, based on the latest projections of the Congressional Budget Office, enrollment in Medicare+Choice will fall by more than a million over the next 10 years as a result of inadequate payment updates. Moreover, open-network plans like Preferred Provider Organizations (PPOs) and point of service plans have become popular among privately covered individuals, yet only two PPOs participate in a few counties in the entire Medicare program.

We seek to address these problems both through legislation and administrative action. For example, we just announced a demonstration project to expand health plan options in Medicare+Choice. Preferred Provider Organizations (PPOs) have been successful in non-Medicare markets and CMS is conducting the demonstration to test ways to provide more health plan options to people with Medicare. We hope to award demonstrations later this year in up to 12 geographic areas that will be available to enroll beneficiaries during the Fall open enrollment period and begin to serve enrollees next January. This demonstration program will test changes in methods of payment for Medicare services that may be more efficient and cost effective while improving the quality of services available to beneficiaries. The demonstration plans will be considered Medicare+Choice (M+C) plans and must offer all of Medicare's required benefits, but will also have the flexibility to offer greater access to drug benefits.

The President's budget also proposes to take urgently needed legislative steps toward the equitable payment system for private plans proposed in the President's framework for strengthening Medicare. These proposals would modify the Medicare+Choice payment formula to better reflect actual healthcare cost increases, allocate additional resources in 2003 to counties that have received only minimum updates in 2002, and provide incentive payments for new types of plans to participate in Medicare+Choice, including PPOs. Together these augmented payments would address the problem of persistently low payment updates to most Medicare+Choice plans, making more plan choices available and improving benefits for millions of seniors. Because these proposals would allow many plans to provide or at least maintain drug coverage in their benefit package, they also provide another means of giving seniors prompt help with their drug costs.

**New Medigap Options**

Because of the major gaps in the benefit package in the fee-for-service program, supplemental coverage—often called Medigap—is an essential part of Medicare coverage for millions of our nation's elderly and disabled. The Administration shares the concerns some have expressed regarding the rapid increases in Medigap premiums in recent years: most seniors now pay much more for Medigap than they pay in Medicare premiums. We also agree with the leaders on this Committee that we can better design both Medicare and Medigap so that seniors and people with disabilities can get more affordable coverage, and get the most for the health care dollars they spend. Clearly the existing set of options, which require beneficiaries to purchase "first-dollar" coverage for hospitalizations and even basic services like doctor's visits before they can obtain any drug coverage, has become outdated.

Yet giving seniors the option of a better benefit package, including prescription drugs, and more affordable Medigap plans to go along with it will take several years to implement. So we have also proposed that two new Medigap plans be added to improve beneficiaries' options quickly. Both of these options would be considerably more affordable that the current Medigap policies that cover drugs. They would substantially reduce cost-sharing for beneficiaries and provide much better protection against high costs. And they would increase the number of seniors with drug coverage. If we provide a one-time opt-in for current beneficiaries, we estimate that up to 1.5 million beneficiaries would choose these new policies once they are available—and that nearly half of these enrollees would be beneficiaries who do not have drug coverage now. Moreover, we can achieve this significant increase in drug coverage among seniors right away, not several years down the road, while saving money for beneficiaries and the Medicare program. Of course, as the President has made clear, seniors should be able to keep their existing Medigap coverage with no changes if they prefer it.

**CONCLUSION**

We are committed to working constructively with Congress to enact legislation consistent with the President's principles—so that we can put a prescription drug benefit into place this year. We all know that failing to act to meet these unavoidable challenges may lead to more extreme changes later, including government controls on prescription drugs and stricter coverage limits in Medicare. These changes would reduce access to needed treatments and slow the development of new technologies, such as promising new drugs for common cancers and other diseases. Instead, we must come together now to take the sound, careful, and deliberate steps needed to improve the Medicare program for today's seniors and tomorrow's. And we must take action now—these issues have been debated on and off for years, and seniors cannot afford to wait any longer. Thirty-six years from today, we should still have a Medicare program that fulfills President Johnson's promise of a secure and vibrant retirement. I thank you for the opportunity to discuss this very important topic with you today, and I look forward to answering your questions.

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Chairman THOMAS. Thank you, Mr. Secretary. I know a number of Members wish to inquire. And we always have a limited time, so the Chair will not conduct any questions, in deference to other Members. And I would urge the more senior Members, if they do not feel strongly compelled, that we allow others to participate in the questioning.

And with that, I would recognize the gentleman from Illinois for questions.

Mr. CRANE. Thank you, Mr. Chairman. Mr. Secretary, some lawmakers believe the Medicare trustees' projection of an additional year of Medicare solvency—namely, to go from 2029 to 2030—is a sign that we should not address fundamental reforms to the Medicare Program. They would rather focus on adding additional benefits to the existing program, like a prescription drug benefit.

In your opinion, if the Congress were to simply add on a drug benefit to the existing program, how would that change the solvency outlook of Medicare?

Mr. THOMPSON. It depends, really, on how that program is structured. It depends upon the total amount of the cost. If you used the $750 billion figure, then if you take $400 billion out of part A, you would reduce the solvency from 2030 to 2016. If you used it basically on payment of income taxes, at the present dollars, that would be a $2,100 tax per individual in America. So that is a comparison.

If you take it out of the General Fund, the $190 billion, that the President has done, which has been reduced in other budgets, it will not in any way affect the solvency. So it depends upon how it is structured, and it depends upon how the dollars are used and where those dollars come from, Congressman.

Mr. CRANE. Let me ask you a question relating to drug therapies that Medicare does cover. I think it is safe to say that all Members of Congress, as well as the Bush Administration, want to ensure that we in Washington spend the taxpayers' dollars as prudently as possible. That is why, particularly in health care, we revisit our payment policies every year: to ensure that people have access to needed drugs and other therapies, but that we are not overpaying for services.

I have been particularly involved in working on kidney disease related issues. And your report on developing a new composite rate index for renal dialysis services will be very helpful, as it will require legislative language. When can we expect to receive that report?

Mr. THOMPSON. Congressman, I know that you are interested in this subject, and I compliment you first on your passion on it. It is a very important subject, and I appreciate your leadership.

The Congress has requested that this report be given to Congress by July of this particular year. And I can advise you today, and all Members of the Committee, that report is in the process of being compiled, and will be ready on time to you and other Members of the Committee in July of this year, as ordered by Congress.

Mr. CRANE. Thank you. Is it an accurate assumption that you envision Epogen being folded into the composite rate? And if not, does the Administration recommend that we reduce payment consistent with the Office of the Inspector General's recommendations?

Mr. THOMPSON. I didn't hear the first part of your question, Congressman.

Mr. CRANE. Is it an accurate assumption that you envision Epogen being folded into the composite rate? And if not, does the Administration recommend that we reduce payment consistent with the Office of the Inspector General's recommendation?

Mr. THOMPSON. Congressman, all of those things that you have just mentioned are going to be details that are going to be outlined in the report that will be given in July.

Mr. CRANE. Very good. Thank you so much, Mr. Secretary.

Mr. THOMPSON. Thank you.

Mr. CRANE. I yield back the balance of my time.

Chairman THOMAS. Thank the gentleman. Does the gentleman from New York wish to inquire?

Mr. RANGEL. Yes. Mr. Secretary, you are not under oath, but are you now or ever have you been a candidate for higher office?

Mr. THOMPSON. I consider Governor a higher office, Congressman, and I have been a candidate in the past, candidate for Governor. I am currently not a candidate for Governor. I am very pleased to be Secretary of Health and Human Services, one of the largest Departments of the Federal Government, supporting President Bush.

Mr. RANGEL. And you participated in no activities that will allow us to believe that you could be considered a candidate?

Mr. THOMPSON. I don't know what you are driving at, but if you think that somebody put out a poll in Wisconsin a week ago to see if I would come back, that poll was not commissioned by me, paid by me, and I didn't know anything about it until I read about it in the newspapers, the same way that you read about it and other people read about it.

I am not a candidate for Governor; do not intend to be a candidate for Governor. I intend to finish my term as Secretary of this Department, Congressman.

Mr. RANGEL. Well, I didn't know about the poll but, like the Chairman, I make this up as I go along.

Mr. MCDERMOTT. Mr. Rangel, did he say he would not run for Governor?

Mr. RANGEL. Yes.

Mr. THOMPSON. I know that is going to please a lot of Democrats in Wisconsin. I wanted to make sure that you get that on the record. Is that correct, Congressman McDermott? Because it indicates I still could win.

[Laughter.]

Mr. RANGEL. Well, thank you, Mr. Chairman, for opening up this new opportunity for us to explore our political agenda.

You had indicated more than once that you are concerned about the long-term fiscal concern of the 40 million people that have Medicare. And you are aware that in 2030 the Baby Boomers will become eligible. Do you have any idea what impact this will have on the 40 million, or what number we expect will become eligible as a result of the Baby Boomers?

Mr. THOMPSON. Congressman Rangel, our actuaries have put that into the report. I do not have that number at the tip of my fingers.

Mr. RANGEL. Some say 78 million, or double, close to 80 million.

Mr. THOMPSON. It could be. I know we included it in the report, Congressman.

Mr. RANGEL. Okay. Now, I don't know why in the budget for Medicare we did not include that area in our budget as it relates to the Tax Bill. It seems to me that the reason that we had the

sunsetting of the Tax Bill was to make certain it fit within the budget. Now we understand that this week it is going to be recommended by the majority, as did the President, that we make the tax cuts that have been enacted permanent.

Now, our people tell us that that will cost us $500 billion in this decade, and some $4 trillion in the next decade. I don't think these figures are being challenged. Have you considered this, as you project the Medicare obligations at 2030? Or is that beyond your pay level?

Mr. THOMPSON. I have not, Congressman. I do have the figure at 2030. There will be $70 million, that was the figure that was used. In regards to the tax policy, I have not considered that in our analysis of Medicare. We have based that upon the empirical data that we have within the Department and the Administration, but we have not factored in any of the tax policies. That is not in my Department, and we have not factored it in.

Mr. RANGEL. That is very helpful. So to restate your position, it is that as it relates to the future of Medicare, tax policy has not been a consideration of yours?

Mr. THOMPSON. It has not.

Mr. RANGEL. Thank you.

Chairman THOMAS. I thank the gentleman. Just so everyone understands the circumstances in terms of the tax provisions, the House last year voted on a number of tax measures. Every time the House passed a tax measure, it was permanent. The only time the tax measures were not permanent was when the House voted on the conference report, including the Senate, because of the Senate's reconciliation rules. So the only reason we don't have permanent tax structures today is because of the rules of the Senate; not because of any decision that was made in the House.

The Chair would recognize for inquiry the gentleman from Florida.

Mr. SHAW. Thank you, Mr. Chairman. I will be brief, in carrying forth your stated policy of trying to get to the junior Members before Mr. Thompson has to leave.

Mr. Secretary, in reading your written testimony, I was struck by a comment that you attributed to President Johnson, in which you said, and I quote, "No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime."

That is, I think, something that all of us should try to keep in mind. That is why we are here. That is why we are considering prescription drugs and how to modernize the Medicare Program.

You then go on to say that 36 years later President Bush believes it is time for our Nation to come together and renew that commitment. I think that coming together is something that has been too rare these days. And we have seen so much of politicking, that it is "my way, or the highway." And I think at this time that we in this Committee, and we in this Congress, come together, and we as two bodies of the Legislature come together. And I am hopeful that whatever product we will eventually come out with in this Congress, I hope that this time the Senate will move forward on

our plan, or their plan, and get us into conference. Because it is the seniors who are losing ground.

Over the last 36 years, since President Johnson made that comment, medical treatment has changed immensely. Seniors are living longer. Their quality of life is better. And much of that is due to the miracle of modern medicine and medication.

I was at Eckert Drugs in south Florida the other day, in Fort Lauderdale. And I was waiting to pick up a prescription that I had dropped off, and saw this elderly woman in front of me gathering together her prescriptions, and then having to give half of them back to the druggist because she simply could not afford it. That is not acceptable. We can do a better job, as you very aptly set forth in your comments.

I have no questions for you. I believe that your statement is comprehensive. It is complete. And I hope that all of the Members will carefully examine it, and try to govern ourselves in accordance with the framework that you set forth.

I am delighted to have you where you are. I know the good work and commitment that you have had in every field that you have been in. Whereas I can feel that you are not running in Wisconsin is Wisconsin's loss; but it is certainly this country's gain to keep you exactly where you are during the period of time that we are in now, in going back and reauthorizing welfare reform, as well as these other very, very important programs for today's seniors. Thank you, Mr. Secretary.

Mr. THOMPSON. Thank you, Mr. Shaw, for your comments. I appreciate them very much. And thank you for your leadership on welfare reform, as well as on this subject.

Chairman THOMAS. Does the gentlewoman from Connecticut, Chairman of the Health Subcommittee, wish to inquire?

Mrs. JOHNSON of Connecticut. Thank you, Mr. Chairman.

I also want to applaud your testimony, not only because it looks at modernizing Medicare by adding prescription drugs, but because it looks at better coverage of preventive health care, and will prepare the system to deal with the growing dramatic need for better ability to manage chronic illness. You are modernizing. Through your proposals, we have the opportunity to modernize Medicare as a health program, in addition to making it a far more efficient and cost effective program. I appreciate your testimony. I appreciate your work with us on making it a more errors-free program, so that there will be both less human suffering and less public cost for medical errors.

I want to ask you just one question. One of the many issues we are working on is a response to the Inspector General's and the General Accounting Office's findings that we are paying much more for part B drugs and biologicals than we should. We are currently reimbursing them at 95 percent of the average wholesale price, and these prices are much higher than the price manufacturers charge other providers.

As we look at how to fix this, we on this Committee are looking at a competitive bidding model. There are some other models out there. What is your opinion on the competitive bidding approach, versus other mechanisms to set prices in the part B area?

Mr. THOMPSON. Well, first, let me thank you for your leadership on preventive health. This is absolutely a passion of mine. I think the way we deliver health care needs to be strengthened and improved. And one of the ways is certainly in preventative health. We wait until people get sick, and then we spend lots of dollars to get them well. And we could save a lot of money by getting people healthy, and keeping them healthy, at the beginning. So I applaud you for that.

Competitive bidding is something that we support. We are somewhat concerned about if we have the sole responsibility of negotiating prescription drug prices with the drug companies, because Medicare uses up 50 percent of the drugs, and we would be the 900-pound gorilla in the market, and we would distort the market if we did that. But competitive bidding is absolutely vital. I fully and enthusiastically support it.

Mrs. JOHNSON of Connecticut. Thank you. Mr. Chairman, I yield back my time.

Chairman THOMAS. Thank you. Does the gentleman from California, the Ranking Member on the Health Subcommittee, wish to inquire?

Mr. STARK. Thank you, Mr. Chairman. And I would just like to correct the mistaken impression that the gentlewoman from Connecticut would have left when she said that State-level experts don't have experience to testify on national issues. In this particular issue, Ms. Chellie Pingree, who was first accepted by the minority and then just yesterday turned down, has testified before State legislatures in Texas, New York, Minnesota, Washington, and Arizona. She has testified before the American Association of Family Practitioners, the American Public Health Association, the American Medical Association, the AARP, the New England Regional Conference on Prescription Drugs, the Conference on Affordable Health Care, and the International Association of Machinists, if that is too political.

None of the witnesses on the schedule today, with the possible exception of the Honorable Secretary, have had any experience in running a drug program. None of the Members of this Committee have any experience running a drug program. The one witness that we went to find who wrote a drug program for a State and saw it enacted was denied.

Had the Republicans not been afraid of hearing some new ideas, they would have found that the Maine program establishes a program in which the State serves as the pharmaceutical benefits manager (PBM) for 325,000 Maine residents who don't have a prescription drug benefit.

They would have heard that Ms. Pingree's program, which she wrote when she was in the Maine State Senate, prevents profiteering and prevents the pharmaceutical companies from hindering the sale of prescription drugs in Maine. It authorizes interstate cooperation for bulk purchasing and cost saving. It provided for emergency prescription drug prices if the negotiations don't produce prices comparable to the lowest prices paid in Maine. And the Maine legislation is comprehensive. It serves as a model for more than 20 other States across the country who have a program.

And as I say, to put one's head in the sand and submit that people with this kind of expertise should not be heard before this Committee, is to prejudge in the worst kind of way what we will do to help the American public.

Now, we have the Secretary here. And I want to commend him, because recently, Mr. Secretary, you were successful in negotiating lower prices for the drug Cipro. It was needed for a national emergency, and you were able to get the government a good deal.

Would you support proposals to provide you with the power to negotiate with the pharmaceutical industry on behalf of Medicare beneficiaries to get them a better deal, given a free hand?

Mr. THOMPSON. Congressman, I am not opposed to it, in regards to negotiating that. I want to caution, however, that the problem is that Medicare is such a huge purchaser of drugs—about 50 percent—that we would more than likely, if we did that, distort the market. But if Congress gives me the authority to do that, and passes the legislation, I certainly would do it.

Mr. STARK. I, for one, Mr. Secretary, would feel very comfortable with you having that authority. You certainly wouldn't raise the drug prices and, used judiciously, it might help.

Another specific concern that many of us have—and I wonder if you or the Administration have any policy on this—but it has been suggested that the tremendous amount of consumer advertising for specific prescription drugs, one, is driving up the utilization; it is driving up the costs. And there have been several proposals to address this concern, in either making more facts available, or limiting somehow the amount of advertising that is going out to the public for classified drugs and prescription drugs.

Do you have any specific proposals or any specific concerns about this huge amount of consumer advertising for prescription drugs?

Mr. THOMPSON. As you know, Congressman Stark, we have just negotiated a new Prescription Drug User Fee Act (PDUFA) bill. That is a prescription drug utilization proposal that is going through Congress, that does require the Food and Drug Administration (FDA) to supervise and to regulate some of the advertising put out by the pharmaceutical companies. That is the first step in that arena, and it has been agreed to by the FDA and by my Department and the negotiators for the pharmaceutical industry.

Mr. STARK. Well, you are to be congratulated. And I look forward to seeing that, because I share a concern, that I am sure you had; and that is that we were just sending people off to their doctors to get pills because the pictures in four colors look pretty good. And thank you very much.

Mr. THOMPSON. Thank you, Congressman.

Mr. STARK. Thank you, Mr. Chairman.

Chairman THOMAS. Thank the gentleman. Does the gentleman from New York wish to inquire?

Mr. HOUGHTON. Thank you, Mr. Chairman.

Mr. Secretary, good to have you here. I would like to get back to this competitive bidding issue. I basically believe in competitive bidding. I think it is the right thing. It is sort of endemic to our country. We work that way. However, there are certain areas that are not particularly good for competitive bidding. And I know that, in terms of various products such as oxygen and things like that,

you have had some test cases and pilot programs; one of them being in Florida.

And the question is, have you found out anything from those projects which makes competitive bidding better, or worse? Or what is your feeling on this?

Mr. THOMPSON. We have always felt, Congressman Houghton, as you did in your business career, that competitive bids is the proper and best way to get the proper price, and you have the opportunity then to look at whether or not, not only price, but conditions, utilization, durability, all of these other things, are taken into consideration when you do that.

In the area of oxygen, I know that you and some of your constituents have some concerns. I wish I would know about those specific concerns. I will follow up on them, and find out. But as a general policy, as the Congresswoman from Connecticut pointed out, we think competitive bidding is the proper way to go.

[The information follows:]

U.S. Department of Health and Human Services
*Washington, DC 20201*

**Q: Representative Houghton: What have you found from the competitive bidding projects?**

A: Competitive bidding is a useful tool for improving and strengthening Medicare by using market forces, rather than government fee schedules, to establish payment levels. We have found that competitive bidding has been successful in reducing costs for the Medicare program, while still ensuring beneficiaries have access to needed services. Competitive bidding saves money for both the program and for our beneficiaries, who save money in their copayments.

The Balanced Budget Act 1997 gave CMS the authority to conduct bidding demonstrations for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), which we implemented in Polk County, Florida, and San Antonio, Texas. These sites are good test sites since they have a reasonably large size, relatively large numbers of suppliers, and high average spending for durable medical equipment, prosthetics, orthotics, and supplies. Savings differed by demonstration site, but the savings averaged 20 percent in the latest bids at both sites.

We also took several steps in order to meet our goal of maintaining high quality in the Medicare Program.

- We chose multiple suppliers in each category so that competition is an incentive for high quality; We developed specific quality standards for the demonstration that the suppliers must meet including a bid package with ten pages of quality standards for the product categories;
- We required winners of the bidding competition to pass site inspections and reviews by an expert panel; and,
- We hired an ombudsman for each site to solve any problems, including quality issues.

We also took steps to ensure that small businesses could compete on a level playingfield with the large suppliers. A large portion of the durable medical equipment industry is made up of small businesses. By choosing multiple winners for each product category, we were able to choose many small suppliers rather than only the largest suppliers. For example, in San Antonio, the suppliers were not required to service the entire area, but could choose to bid only for one county. As a result, approximately 90 percent of the winning suppliers were small businesses.

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Mr. HOUGHTON. Very good. Thanks.

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

Mr. COYNE. Thank you, Mr. Chairman.

Welcome, Mr. Secretary. I wonder if you could explain why the President budgeted the same amount for Medicare this year as he

did last year, and including the new benefit that he is proposing? It just seems to me that every year that we wait to adopt a drug prescription program, the costs get higher, and you can't make ends meet when you budget the same amount as you did last year.

Mr. THOMPSON. Congressman, first off, I think the President should be applauded by putting in this year after year, because he believes so passionately and strongly about refining and strengthening Medicare. That is point number one.

The second point is, we base this upon what the actuarial individuals from the Centers for Medicare and Medicaid Services (CMS) gave the Department and Office of Management and Budget (OMB). It was based upon their assumptions that we put that amount in.

And the third thing, in my testimony I also pointed out that the Administration is certainly willing to work with this Congress. We know Congress has put in the figure of $350 billion. I have communicated that personally to the Chairman, as I have to the Committee this morning, to work with that figure. If that is the figure that Congress wants, I think we can develop a bipartisan package around that figure.

Mr. COYNE. Well, by budgeting the same amount as last year, what you are saying is that doesn't mean that seniors can expect any less in the way of benefits; even though we are going to have the same budget as last year?

Mr. THOMPSON. Congressman Coyne, we attempted to look at what the actuarial study gave us. We have put that information into the budget, and that was at $190 billion. Last year, we had $155 billion; raised to $190, but we started out at $155 billion.

Mr. COYNE. Thank you.

Chairman THOMAS. Thank the gentleman. Does the gentleman from California, Mr. Herger, wish to inquire?

Mr. HERGER. Thank you, Mr. Chairman.

And thank you, Mr. Secretary, for being here to testify on this very important issue. The district that I represent in far northeastern California is very rural, heavy agriculture, 11 national forests. And we have a larger than normal percentage of seniors who live in our area. And of course, you know we even have added challenges, being in a rural area, having to do with health care.

In this area of prescription drugs, more than two-thirds of seniors have prescription drug coverage. For the other one-third with no coverage, seniors may face difficult choices between buying the prescriptions and other life essentials. One of the greatest challenges to these seniors is the high cost of these prescription drugs. And because seniors without coverage pay the highest price for drugs at the retail pharmacy, Congress has been examining ways to lower the costs of these pharmaceuticals.

In this regard, Mr. Secretary, could you tell me, what does the Administration support to reduce the costs faced by these seniors?

Mr. THOMPSON. Absolutely, Congressman, and I thank you for the question. There are several things this Administration is doing. The first thing we put in the budget is a proposal of $77 billion for transitional prescription drug coverage for low income beneficiaries. We figure that costs will be about $8 billion in the first 3 years. We expect that a fully-integrated Medicare benefit will be adopted

and implemented and effective after that time. This proposal would allow States, like California, which is close to 100 percent of poverty, to be able to use their Federal match under the Medicaid law, up to 100 percent. And then beyond 100 percent, up to 150 percent of poverty, the Federal Government would come in with 90 percent.

It is not a Medicaid, nor is it a Medicare Program. It would allow complete discretion. As Congressman Rangel has indicated, I am a big advocate of that, to give the States complete discretion to set up that program, how many drugs to be covered, and so on. That is an immediate step that, if Congress passes it, I am fairly comfortable and confident that Governors would enthusiastically endorse it and set up their programs.

The second thing, my Department has set up a "waiver," called "Prescription Plus." And this is a waiver that would allow States to set up a program up to 200 percent of poverty. A lot of States are looking at it. The State of Illinois has already adopted it. It is budget neutral. And it would allow for preventative care. And it will allow for States to have that waiver.

We have got a copy of that waiver right here that, hopefully, you would take into consideration and give to your California Governor, and maybe he would apply for it, as well.

The third thing is, we have a prescription card, that the courts have stopped. But now that we have entered a new proposed rule, we think that that is going to receive more favorable approval from the pharmacists, as well as the pharmaceutical industry. And, hopefully, we can get that passed.

So those three immediate steps; and then the final step, which is the most important one, is strengthening Medicare with a prescription drug benefit.

Mr. HERGER. Well, I thank you very much. That does sound like that would be very helpful.

Mr. THOMPSON. Thank you, Congressman.

Mr. HERGER. And Mr. Chairman, I yield back the remainder of my time.

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

Mr. LEVIN. Thank you very much. And welcome, Mr. Secretary. I just want to say, very briefly, how uncomfortable I am with the Chairman's decision about witnesses. I think really it is an unfortunate misuse of power. And I think it is indeed a slippery slope, as evidenced by Nancy Johnson's comments. I don't think we should be pre-censoring witnesses to come before this Committee.

Secondly, I just want to point out what I think, Mr. Secretary, is a deep inconsistency. There is a claim there is money in this budget for a substantial prescription drug benefit. But when you make permanent the tax cuts, I think a good portion of that money is otherwise used. And you have in the administration proposal, or it has, a provision that the Balanced Budget Act budget cuts would go into effect, hospitals and others, home health care, et cetera. Those provisions are not realistic. And we are going to have to find the money. So that $350 billion is really more imaginary than anything else.

And I just wanted to say to you, we like working with you. The problem is, Mr. Secretary, that that isn't the pattern that has been

followed in this Committee. There has really been no bipartisan effort on welfare reform, and I guess there isn't going to be on this. There will be an effort to push through a proposal; send it to the Senate. Essentially, that withdraws from you your statement that you want to work with Members of the Committee.

Let me say, fourthly, where the gentleman from California says two-thirds of the people have prescription drug benefits, as you know, at least half of that two-thirds have very inadequate coverage. So the picture is much more dire.

So let me ask you, why not place prescription drugs within Medicare cleanly, like is true for hospital reimbursement and physician and other provider reimbursement? Why not just place it in there?

Mr. THOMPSON. The problem, Congressman, is I don't think we would ever have a chance then to strengthen Medicare. I think that this Congress, if they pass the prescription drug coverage solely—there would be very little appetite to go back then and try and redo, try to fix, try to strengthen, try to make competitive, try to add a casualty loss benefit.

I don't see that happening. I may be wrong, but I don't see it happening. And that is why the President and my Department and myself, personally, feel that we have this one opportunity, with the momentum for prescription drug coverage, to do something about really improving and strengthening Medicare. And I don't think we should lose that opportunity.

In regards to bipartisan, I hope that we can work together on a bipartisan basis. I have mentioned that, Congressman, and I have mentioned that many times to you when we have discussed this.

Mr. LEVIN. No, and we appreciate that, and we are willing to do it. The problem is that people on your side in the House won't do that.

And let me just say, on your statement about prescription drugs and Medicare, essentially that means, first of all, I think it indicates a lack of trust in this Committee. And second, it holds prescription drugs hostage. If the reason not to place it in Medicare in a clean way is that you are afraid it takes the heat off other changes, you are holding it hostage. And this has been going on for years. And it sells us short. I mean, we have worked on all kinds of reforms of Medicare. We don't need to hold prescription drugs hostage. And let me just ask you quickly——

Mr. THOMPSON. Could I respond to that, Congressman?

Mr. LEVIN. Sure.

Mr. THOMPSON. I don't think we are holding it hostage. You know, that is your terminology, and not mine. What I see this is as a golden opportunity. Being a trustee of Medicare, I see the future as being very bleak. In 2016, which is not that far in the future, we are going to see a leveling off and a decline of the surpluses. And by 2030, it is going to be broke. And I think it is time for us to address this. Every year that we wait, it is going to be more difficult to fix that particular problem.

Mr. LEVIN. All right.

Mr. THOMPSON. And you have good faith. And I appreciate that. I just think we should do it now, sir.

Mr. LEVIN. The trouble is, this has been going on year after year after year. And so in essence, prescription drugs so badly needed

are held hostage because of the failure to do something else. And that isn't a good excuse, when you look in the eye seniors who can't afford prescription drugs.

Chairman THOMAS. Thank the gentleman. Does the gentleman from Iowa, Chairman of the Budget Committee, wish to inquire?

Mr. NUSSLE. Thank you, Mr. Chairman.

First, I guess, a couple of quick observations. The budget that everybody keeps referring to is the President's budget, and the budget that the House wrote and passed. I am glad everyone is referring to it, and appears willing to enforce it.

I guess my further observation would be that we still have no budget from either the Democrats or the Senate. We have no Medicare plan from the Democrats or the Senate. We have no prescription drug plan from the Democrats or the Senate. But the House did pass a budget.

Just for your information, Mr. Secretary, you had said earlier, and I just want to clarify this, if there was some confusion. It was not my intention when I wrote the budget, nor was it the House's intention when we passed the budget, to indicate that we wanted to out-bid you with regard to a prescription drug benefit.

And I worked closely with the Chairman of the Committee on Ways and Means in crafting this budget proposal with regard to Medicare. Our intention was very clear. We did not feel that prescription drugs were the only issue that we needed to address. It is a vital issue. As the gentleman from Florida indicated, Mr. Shaw, we have all had that experience, where we have been in the drug store in our district, and we have watched it firsthand; or we have had constituents come to our meetings and talk about the choices that they are having to make.

But let me just, if I could, amplify the choices that we are making in Iowa. We are eighth in the quality of health care delivery and health care services, eighth in quality. And yet, Mr. Secretary, we are 50th in reimbursement. If I bring a prescription drug benefit back to the constituents of Iowa, what will happen, if that is all I bring back, is that they will have this great new prescription drug benefit under Medicare. But my doctor will have to leave, because reimbursements are down. And we are already experiencing that. Doctors are leaving rural areas in Iowa. It is difficult to retain or to recruit new providers to our area.

So what will happen is, the doctor leaves. And of course, if the doctor leaves, and the health care provider is not providing those services in the hospital, and the hospital can't pay its bills because their reimbursement system is broken, the hospital closes. Well, now all of a sudden, all of your health care professionals leave town: a little town like mine of Manchester, 5,000, with a small little hospital that has been thriving but is now struggling. All of those folks leave town, because the Medicare system is not providing the services that they need to for seniors.

And so what happens? Now my seniors, that we have provided this prescription drug benefit to, have probably nowhere to go on Main Street to fill their prescriptions, because the pharmacist left town. Now they have to drive 50 miles down to Cedar Rapids to fill their prescription—assuming that Cedar Rapids has a hospital that is open and prescription drug benefits that can be utilized.

What I am getting at here is that we need help in rural areas. I know I am singing to the choir, because of your experience in Wisconsin. I believe you are 48, which is not too far behind Iowa. What is the Administration prepared to do to eliminate the rural/urban disparities? That is my question.

Mr. THOMPSON. Well, first off, Congressman, you made a statement at the beginning that I disagreed with you in regards to your figures. I do not disagree with you. In fact, I heartily endorse and agree with what you did in the budget. I think you did an excellent job, and I applaud you and commend you for that.

In regards to rural reimbursements, you are talking to the choir. As Governor, I fought this fight many times out here, indicating to Congress that they have to change it. The truth of the matter is that the reimbursement formula is based upon a statutory formula. And we implement the statutory formula. And the only ones that can change it are, of course, Congress. And so we are looking for you to change it. And I wish that you would, and hope that you would.

You have to take into consideration that 73 percent of the reimbursement formula is based upon wages, and that is how the reimbursement formula was set up. And so if you are going to change the formula, you have got to address the wage issue. Because the wages in New York are higher than they are in Cedar Rapids, Iowa, and higher than they are in Elroy, Wisconsin. But that comprises 73 percent of how the formula is structured.

So if we are going to reimburse differently, we are going to have to change the formula and take in factors like the rural health incidence, like the declining populations, like the fact that health care providers are leaving rural areas—rural Iowa and rural Wisconsin. Those kinds of factors should be built into a reimbursement formula to make it more equitable.

And that is something that the Chairman, Chairman Thomas, is working on; on the provider payments. But the only way you are going to change it is to change the reimbursement formula, and that requires congressional action, not administrative action.

Mr. NUSSLE. And will the Administration support action similar to that? I know you haven't seen the proposal yet, but you would be willing to support it?

Mr. THOMPSON. I haven't seen the proposal, but it is something that I, personally, have been involved in for a long time. And I can't imagine that I could, in good faith, not support it.

Mr. NUSSLE. Thank you.

Mr. Chairman, just for the good of the order, there have been some comments, too, about somehow making tax cuts permanent not fitting within the budget. We have a budget. The CBO has scored the provisions to fit within the budget, and it does so.

There was a gentleman who made a statement, something about, "I think it makes it more difficult." Well, that is fine, but CBO and OMB have scored it, suggesting it does fit. So whether you think it fits or not, we have our score keepers telling us that in fact it does. Thank you, Mr. Chairman.

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

Mr. CARDIN. Thank you, Mr. Chairman, Mr. Secretary.

Mr. THOMPSON. Thank you, sir.

Mr. CARDIN. I would hope that, in regards to reimbursement for needed preventive health care services and benefits, that we would not delay action because of other objectives that we are trying to achieve.

I remember very well Chairman Thomas' help when he was Chairman of the Health Subcommittee, when we expanded Medicare to include a whole host of new preventive health care services. That was the right decision we made, when we included those services, and we didn't wait until everything could be done in everyone's definition of "reform." And to me, prescription drugs falls into the same category.

You and I both know that seniors need to take their medicines in order to stay healthy; that if they don't take their prescription medicines, they are more likely to have a stroke, or more likely to need an amputation, or more likely to be disabled and not even able to get around. And that is just going to add to health care costs. We shouldn't say, well, this is the sugar for making some of the other changes in Medicare that are needed. I would just hope that our inability to agree on an overhaul of Medicare does not prevent us from adding a benefit within the Medicare system that is desperately needed by our seniors and our disabled population.

We should debate how to implement a prescription drug benefit. It is costly. It does cost the system money, certainly in the short term. But I must tell you, the actuaries have said that the Medicare trust fund is in its best shape since we have been making these projections. And the actuary actually said that he thinks that these figures are more reliable this year than they have been in any previous year. So I think we do have some elbow room to work with within the current Medicare system.

Let me just point out four factors I hope we could agree on, and I would like to get your reaction to them: That a prescription drug plan, first, should be voluntary, because there are some seniors who have good health care benefits today that include prescription medicines, and they shouldn't be required to sign up for a program they don't need.

Second, that it should be a benefit available to all seniors. It shouldn't be means tested. It should be available to all of our seniors. And I think the leadership on both sides of the aisle are committed to that point.

Third, that the benefit needs to be a guaranteed amount. As Mr. Levin said, there shouldn't be any difference between a prescription drug benefit and the benefit for physicians services. Seniors should know that it is going to be covered. Now, if you get a better plan out in the private sector or in Medicare+Choice, fine. But at least you know that there is a guaranteed benefit level, by statute, that every senior is going to be able to receive.

And then fourth, we have to put enough subsidy into the program that we don't have adverse risk selection. And I know the current Chairman of the Health Subcommittee has been very strong about that point.

I would hope that, at least as a starting point, we could agree on those four principles. And I would appreciate your response.

Mr. THOMPSON. Well, first, let me respond to your basic premise about the need to strengthen Medicare. I have been a trustee now for a little over a year. And all of the actuaries and all of the studies indicate that Medicare is going to go broke. Last year it was 2029, and it is extended this year to 2030. But they still look at the underlying assumption that by the year 2016 the amount of money is going to be going down.

Mr. CARDIN. But Medicare has always been projected, ever since we have done these projections, to be going broke. So this is nothing new. We have never made a commitment to long-term solvency.

Mr. THOMPSON. But when you add a benefit like prescription drugs, which is going to be expensive, depending upon how you pay for it, it is going to more than likely be a drag on the longevity of that particular plan. Therefore, it seems prudent to look at the overall strengthening of Medicare now, when you put in the prescription drug benefit. That is what the President feels. That is what I feel. And that is what the Department feels.

And we have this opportunity. And I am not questioning your good intentions. I am not questioning anybody's intentions. I am just looking at the overall opportunity to strengthen Medicare. I think it is now with prescription drugs. And I don't see that opportunity availing itself in the future. That is why I think we should do it now.

In regards to the four principles, I have no difficulties with your four principles. But I also want you to know that you are going to have to look into the dollar amount—the dollar amount—that you come up with for prescription drugs, and how you pay for it. You have got about five indicators that you can ratchet up or down to meet that. And so you can't get locked in with a dollar amount at this particular point in time, but the principles are solid.

Mr. CARDIN. Let me just in conclusion point out that we wouldn't have colorectal screenings, or prostate cancer screenings, or osteoporosis bone density screenings today, if we would have required those improvements to wait until we got everything done. I hear your point, but these are important preventive health care services. You have been a leader on this. We have got to get it done. Thank you, Mr. Chairman.

Mr. THOMPSON. Thank you, Congressman Cardin. Thank you for your leadership on welfare, as well.

Chairman THOMAS. I thank the gentleman, although perhaps our memories are becoming more selective the farther we are getting away from that period. Because I recall that the cooperative attempt between the gentleman and myself was called H.R. 15, which was clearly the nucleus, or the core, around which a number of significant changes to the Medicare Program were made which finally became the Medicare Reform Act in 1997. So there were a number of other items that were attached to it, as well. They didn't travel the lonely journey by themselves.

Mr. CARDIN. Just very quickly, Mr. Chairman, I agree with you. So we have already fixed the system. Now we can put the prescription drugs in.

Chairman THOMAS. The problem was, the fixes were forced under an Administration that was hostile to the competitive ideas. This Administration is receptive of the competitive ideas. And we are

going to continue to build on the future successes the gentleman from Maryland has participated in. And I look forward to his enthusiastic participation in the latest round.

Does the gentlewoman from Washington wish to inquire?

Ms. DUNN. Thank you very much, Mr. Chairman.

It is good to see you, Mr. Secretary. Thanks for coming before us this morning. I enjoyed your interchange with Mr. Nussle on the topic of the problems we have in rural America, because I have some of that type of territory in my home State of Washington. And it is terribly important for us to get some of these problems ironed out. Part of the thinking behind one of my proposed pieces of legislation has to do with making accessibility easier for people in rural areas.

I wanted to make a brief statement, and then ask you a couple of quick questions. You are currently drafting a policy that will address the issue of Medicare coverage of drugs that are usually administered by a physician. My legislation, as you know, provides coverage for self-injected biologics that people can provide to themselves, in Medicare part B, so that patients can have equal access to these drugs; as well as to assist in encouraging choice and competition between infused and self-injected drugs.

So two questions: When do you plan to make a decision on the self-Administration policy, and how expansive, in terms of the drugs covered, will your policy be? I would like to know the answer to that.

And second, I would like to get your thought on giving seniors access to self-injected biologics that would be covered under Medicare.

Mr. THOMPSON. I am sorry, could you just mention the last question again?

Ms. DUNN. The second question was, I would like to get your perspective, what your thoughts are, on Medicare's coverage of self-injected biologics.

Mr. THOMPSON. First off, I thank you for your comments on rural Washington. It affects rural Iowa, rural Michigan, the rural Dakotas, and rural Wisconsin.

In regards to the self-injection, as you know, my office has been in communication with you, Congresswoman. And that report is coming out relatively quickly. You will be receiving it. I will be talking to you about that in the future.

In regards to the details, I am not at liberty to discuss those details right now. Those details will be coming forth to me. I will be briefed on it, I believe, week after next. And those details are still being worked on, so I cannot go into the finite details at this point in time.

With the third thing, it depends upon the cost; it depends upon the drugs; it depends upon the equipment. All of these things have to be taken into consideration. But overall, my basic principle is to support you and the kind of legislation you have introduced.

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

Mr. COLLINS. Thank you, Mr. Chairman.

Thank you, Mr. Secretary. I appreciate the fact that you are here offering some proposals for the modernization of Medicare. I enjoy

traveling throughout the Third District of Georgia, and I ask many times for the opportunity to speak with senior groups. I also like to inform them that there is a lot of rhetoric that comes out of Washington when it pertains to their health insurance. And it is in my opinion—and I ask if it is in yours—that Medicare is a health insurance program for seniors and disabled. It is an entitlement program that is incorporated in provisions of law. Is that not true?

Mr. THOMPSON. That is correct. You are absolutely correct, Congressman.

Mr. COLLINS. And Mr. Secretary, that health insurance program is funded with particular provisions of law that are non-discretionary to the Congress. Is that not true?

Mr. THOMPSON. That is correct.

Mr. COLLINS. So therefore, when you discuss any other provisions of law that bring revenue into the Federal Treasury, you are actually not directly referring to the health insurance for seniors and disabled, because there are specific provisions of law that require that those health insurance provisions and coverage be paid. Is that not true?

Mr. THOMPSON. Yes.

Mr. COLLINS. So what you are proposing actually is changes to policy that will directly affect the benefit structure of that health insurance.

Mr. THOMPSON. Yes.

Mr. COLLINS. You are not making any proposals that will directly or indirectly affect, or have an effect, on changes of tax policy.

Mr. THOMPSON. That is correct.

Mr. COLLINS. Because by law, it has to be paid, whatever policies that Congress accepts——

Mr. THOMPSON. That is correct.

Mr. COLLINS. And the President will sign. In your comments—and I hear it oftentimes—that the cash flow of Medicare, or a portion of that cash flow, is referred to as "surplus." But in essence, in your comments on the second page, you refer to it as I do.

Mr. THOMPSON. As what?

Mr. COLLINS. As I refer to it. And that is as a cash flow. Truthfully, there is no surplus.

Mr. THOMPSON. There is no surplus.

Mr. COLLINS. Because a surplus is when you have funds beyond your liability. In the long-term liability of this program, based on the policy, there is no surplus.

Mr. THOMPSON. That is correct.

Mr. COLLINS. It is all cash flow. Now, in consideration by the Congress of funding these non-discretionary provisions, we are the ones that will have to take into consideration at some point in time the policy that governs that cash flow, so that we effectively can have the funds available to pay for those provisions that are by law to cover the health insurance.

Mr. THOMPSON. That is correct, and that certainly is something that the trustees are concerned about.

Mr. COLLINS. So therefore, any consideration that we give to changes in policy with future liabilities, we must not only consider those who are being affected by that policy as far as a direct ben-

efit, but as a Congress and as the Administration, the portion of the Administration who deals with tax policy, we must consider how it will affect those who actually are responsible for paying the tax—and that is the working people of this country—to cover that benefit structure; based on the fact that we are a pay-as-you-go system. Is that not true?

Mr. THOMPSON. Yes.

Mr. COLLINS. So I commend you for coming forth with, I think, reasonable ideas that you offer to the Congress that we can do and we can take into consideration and actually adopt, that will help the coverage for those who do need coverage.

And as we move forward with accepting those proposals, I urge my colleagues to take into consideration those who actually will be paying for the benefit; and that is working America.

It kind of reminds me of a song I heard the other day, you know, that there are certain people who get to dance, but it's always the working man who pays for the band. And that is what we are discussing here today. We are discussing those who actually will benefit from the program. But as a Congress, we must consider those who are actually paying for the benefit.

Thank you for your consideration, your common sense approach, the fact that you are sticking with the proposals that deal with the policy and you will leave the long-term policies to the Congress that actually will effect the payment of those non-discretionary portions of law. Thank you, Mr. Secretary.

Mr. THOMPSON. Thank you, Congressman Collins, for your questions, and thank you for your positions.

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

Mr. KLECZKA. Yes, Mr. Chairman. Thank you very much.

I think my colleague, Pete Stark, resolved one of my dilemmas this morning, when he referred to the witness as "Governor/Secretary," because I always have a problem figuring out what to call you, Tommy. So I think we will use "Governor/Secretary."

Looking at your testimony today, you indicate to the Committee that there are five points that we should be, as a Congress and as the Administration, talking about when we address the Medicare Program. And the first, you start out with giving seniors the option of a subsidized prescription drug benefit. I think we for the most part agree with that. We have tried to do that in the past, and we haven't succeeded. Hopefully, with your help we can succeed this time.

Second, you talk about better preventive care. Over the last few years, we have added one or two or three benefits to accomplish that goal. Clearly, there is more to be done. And so I agree with that second point, also.

The third, you talk about providing that the beneficiaries have the option of keeping the traditional Medicare plan. None of the colleagues on my side of the aisle have any proposals that would change that, so I am sort of scratching my head as to why that is here. The Medicare Program, as it is incepted, is available to all seniors 65 or older, and so that one I have a little question about.

Fourth, you talk about providing better health care options, similar to what is available for Federal employees. And this has come

up time and time again, and it makes for a pretty good 30-second commercial. But I just don't really know if it is appropriate for what we are talking about, and that is a Medicare program for the seniors.

If, in fact, we provide a guaranteed benefit of a health insurance program for the seniors, they don't need a potpourri of 20 plans to choose from. If it is a decent, affordable, comprehensive plan, like I think the Medicare Program has the structure to do, then they don't need 20 more choices. Okay?

And then, the last option you talk about is the legislation should strengthen the program's long-term security. And that, we all agree to.

Okay, with that being said, Mr. Secretary, what do you envision as far as a subsidized drug benefit, given the limited dollars that we have set aside for this expansion? Do you view that this additional benefit should be part of the Medicare program, like physicians' care and hospital care currently are?

Mr. THOMPSON. Yes, I do. I would like to respond to items three and four in my statement.

Mr. KLECZKA. Sure.

Mr. THOMPSON. Three and four actually go together. Your position is that you do not believe there should be competition, that there should not be the opportunity for a senior to be able to pick and choose which program is the best.

Mr. KLECZKA. Well, I make that statement because what we did a couple of years prior to you becoming Secretary, we tried this thing, which I will term an "experiment," called "Medicare+Choice."

Mr. THOMPSON. That's right.

Mr. KLECZKA. And I think it has been a total failure, especially in the State that I happen to come from and the people that I have to represent. You indicated that millions of people have opted to take Choice. But the other side of the coin is, millions of people have already canceled it. All right? They have got out of it. Because once many benefits were proposed, the actual companies offering the policies canceled those benefits. And in fact, the recent situation in Milwaukee, Wisconsin and in southeastern Wisconsin was one of the Medicare+Choice plans which initiated their coverage at a zero deductible for hospital stays announced this year that it is going from $0 to $365 a day. Okay? And so my seniors don't need those types of bad choices.

And the basic fee-for-service program works. Let's just make that better, instead of searching around for ways to complicate the lives of senior citizens who, like many other individuals in the country, are not very informed on life insurance, they are not very informed on health insurance and things of that nature. So let's make it simple, but make it good.

Mr. THOMPSON. Let me respond, if I might, Congressman. Because I know full well of the Milwaukee case, because you contacted me. And you also contacted CMS, and we were able to reduce it.

Mr. KLECZKA. And through your intervention, that increase was somewhat decreased. And we thank you for that. Right.

Mr. THOMPSON. Somewhat decreased, and they still pulled out. And that is a problem. The reimbursement formula for

Medicare+Choice has been such that the companies have not been able to make a profit. They have pulled out. And a lot of people have been left without their coverage.

But we also have done a survey, through CMS, Congressman Kleczka. And those individuals that still have Medicare+Choice like it, and would like to be able to maintain it and continue it. And that is why the President has put in an additional 6½-percent increase for reimbursement, to stabilize Medicare+Choice.

We also feel as an Administration that a senior—and we believe seniors are very intelligent, very good shoppers—would be able to choose, pick and choose the best program. And that is why we think the Federal health insurance program is a proper model to look at, and go back to that.

We also in the Administration—and that is point number three of my statement—indicated that seniors should have the opportunity, if they so desire, to pick a new plan, or remain in the fee-for-service program that you are advocating; that every senior should have that right. And that was the principle number three.

Chairman THOMAS. The gentleman's time has expired.

Mr. KLECZKA. I would love to, but I don't have the time.

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

Mr. PORTMAN. Thank you, Mr. Chairman.

A prescription benefit under Medicare is long overdue and, Mr. Secretary, we appreciate your personal commitment to this issue, and also your practical approach to actually getting it done. And even in a political year, an election year like this one, we hope we can move forward on a bipartisan basis to get that done.

I have got a couple of questions for you. I think they are related. But the first one is with regard to costs of prescription drug coverage. Because of increased utilization, because of new market entries, because of just the cost of prescription drugs alone, we are told by the National Institute for Health Care Management that there was a 17-percent increase last year in prescription drug costs. The CBO I think is projecting double-digit inflation, sort of as far as the eye can see.

My question would be to you, in your opinion, what impact can Medicare modernization and a prescription drug policy in Medicare have on these cost increases?

Mr. THOMPSON. Congressman, we think several things. Number one, we think the competitive bidding that Congresswoman Johnson indicated is certainly going to lower and stabilize prescription prices.

Second, we think the competitive opportunity—that individuals would be able to choose their plan and have the difference between just a Medicare fee-for-service or a more competitive kind of plan like the Federal employees have—is going to be the biggest one single factor in holding down the costs of prescription drugs in the future.

And those two things are reasons, I believe, that this Congress should go ahead, streamline, strengthen Medicare, and put in a prescription drug benefit. I think we could do it on a competitive basis, and I think the free enterprise system would work to the advantage of the seniors, as well as to the taxpayers.

Mr. PORTMAN. Thank you. I assume you also believe that your prescription drug discount card would be effective; just the volume discount of that would result, and in how competition would work, in lower costs?

Mr. THOMPSON. Those are the three immediate things we talked about earlier and that I answered to the previous question. One, we have the prescription drug card that we think is going to be beneficial to hold down prices.

The second one is allowing States to set up their own individual prescription drug program, using the Federal match from Medicaid up to 100 percent, and then a 90/10 match from the Federal Government up to 150 percent of poverty. That is immediate. We think that would be very helpful.

And the third one, of course, is the waiver that we are allowing through the Department of Health and Human Services, Prescription Plus. Several States are interested. The State of Illinois has already been the first State to set it up.

Those three things are immediate, and they would also hold down on the costs of drugs across America.

Mr. PORTMAN. It is the responsible thing to do, as we offer this benefit, which we should have done a long time ago: to be sure that we are also addressing the cost issue. And I agree with you. I think we will.

Another issue that is out there in the real world is the sort of abuse of prescription drugs, or complications that arise because of misuse of prescription drugs. Many seniors don't comply with the directions from their doctor, or the directions from a pharmacist, on how to use them. They sometimes forget to take a dosage. Sometimes they mix drugs. Sometimes they stockpile drugs, and then share them with friends and family, when it has expired or an inappropriate drug.

I don't know what the costs are of this, but there are estimates out there that it is a huge cost driver; maybe $150 to $200 billion a year. Certainly, by improving that compliance with prescription drugs and medication in general, we would be able to improve people's health; but we would also be able to get at some of the cost drivers.

What steps do you think we can or should take to ensure that seniors are encouraged or incentivized to use prescription drugs more effectively? How can we incorporate best practices under the Medicare reforms?

Mr. THOMPSON. I think through the information. I think CMS has got a program right now that we are advertising. We are going to have a $35 million program explaining in more details about Medicare. We are also putting out a very good prevention agenda by the Department, advising people on the proper use of drugs, and why they should be used properly.

The third thing is that we are setting up ways in which we are communicating better, through CMS, to doctors, to hospitals, across America, advising them not only of this particular subject, but many other subjects about quality of health.

We have also got the Agency for Healthcare Research and Quality, which is the research component of the Department of Health and Human Services, that is really looking at quality, issues on

prescription drug uses, how to use it, and proper usage. FDA also has got a program set up in regards to this.

All of these things coming together hopefully will be of some assistance in making sure that seniors use the proper dosage, and use the correct amount.

Mr. PORTMAN. I appreciate that, Mr. Secretary. I think that is extremely important. And as to compliance packaging, other more innovative ways to kind of let seniors see in very simple terms what the right dosage is, when they are supposed to take it, and so on, I think that would go a long way. And I hope we can address that issue as well as the cost issue while we provide this important benefit. Thank you, Mr. Chairman.

Mr. THOMPSON. Thank you so very much for your questions and your comments, Congressman. You are always right on target.

Mr. PORTMAN. Thank you, sir.

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

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I was pleased to hear, Mr. Secretary, that you are going to be with us for the foreseeable future.

Mr. THOMPSON. Thank you, Congressman, for your endorsement, my friend.

Mr. MCDERMOTT. I don't want you to leave us just here in the lurch, because we're in problems.

I hear you talking about strengthening Medicare, and doing a Medicare benefit for prescription drugs. And I keep wondering where the money comes from. Because even somebody like Gail Wilensky, who used to run what then was called "HCFA," doesn't think there is an adequate amount of money available to give a real prescription benefit, which is probably going to be somewhere around $350 billion, and do what people call strengthening Medicare. There is an implied savings in this strengthening of Medicare. That is what it sounds like to me you are saying when you say we are going to strengthen Medicare.

What I should hear is, we are going to save money by doing some kind of changes. Am I hearing wrongly, or do you have some other source of money beyond the $350 billion that was in the budget resolution which should go for an adequate drug benefit? Or do you think the drug benefit shouldn't be that much?

Mr. THOMPSON. Well, as you know, Congressman, the Administration put in our budget $190 billion. Congress has seen fit to raise that to $350 billion. And I came here today to indicate to you that the Administration wants to work with that latter number, in order to come up with a comprehensive prescription drug coverage.

Secondly, we also are looking into strengthening it, putting in a casualty loss for seniors that we think is important.

We also think a preventive benefit is important, in order to hold down the costs. As you well know, Congressman—you and I have discussed this—we need to do more in the area of prevention. We think that that is going to be a cost saver. We think that we can save money if an individual goes in for a mammography, a colorectal examination, or any other kind of preventive health; that might save in the future more expensive health care. And we think that is important.

Fourth, we think that the spend-down on prescription drugs—a lot of people are spending down their assets in order to get on Medicaid, in order to get the prescription drug coverage—we think if we have some preventive areas in here to strengthen it, that will prevent that.

We think that the Medigap insurance, to allow for three new policies to add just prescription drugs and not first-dollar coverage, will allow that to take place.

Mr. MCDERMOTT. All those could be done with——

Mr. THOMPSON. And finally, we think competition——

Mr. MCDERMOTT. No additional money?

Mr. THOMPSON. We think that those things are cost savers, Congressman.

Mr. MCDERMOTT. Okay.

Mr. THOMPSON. And we think that the competition—If you as a senior have the opportunity to be able to choose between one fee-for-service plan versus 10 other plans, like a Federal employee is able to, we think that is going to be much more productive, much more cost-efficient.

And finally, we think having the competitive bidding process put in, that we will hold down on the purchase price of drugs, like we did for Cipro; that we would be able to save some dollars.

These are the cost savings that we think will be able to strengthen Medicare, improve Medicare, and at the same time allow for prescription drug coverage, Congressman.

Mr. MCDERMOTT. So if I understand—And we are holding our breath, waiting for your plan to be rolled out up here. I remember when Mrs. Clinton was coming with her plan, and there was a lot of bated breath. Well, we have got bated breath up here for your plan.

But we were not allowed to hear a witness who has a proposal in Maine, which I would like to hear you comment on. Because the Federal Government negotiates, the Veterans Administration negotiates with the drug companies, and this State Senator, Ms. Pingree, said, "Why don't we have the State of Maine negotiate with the pharmaceutical companies to get good prices?" That is her proposal.

Now, would you be opposed to a program where Medicare, using its enormous financial power, would negotiate with the pharmaceutical companies for better prices? I mean, if the Veterans Administration can do it, and the State of Maine can do it, why would it not be a good idea for us to use the 30 million people who are in Medicare as a buying power to drive down the price?

Mr. THOMPSON. Congressman, three things: Number one, the State of Maine case is in litigation right now. The district court ruled one way; the court of appeals has ruled another way. It is now being petitioned for certiorari in front of the U.S. Supreme Court. Whether or not they are going to take jurisdiction, I can't tell you. But that case is being questioned in the legal system.

In regards to that, we set up a model waiver, Congressman, called "Pharmacy Plus." And I have got a copy of that waiver here. And Maine is interested in this particular program, as are approximately 13 to 15 other States. Illinois has already enacted this particular waiver, and we have approved that, to give them up to 200

percent of poverty, based upon their prescription drug coverage. It allows those States to negotiate directly with the particular pharmaceutical companies.

That is in the model waiver. And we think the model waiver may be superior to the State of Maine. And this is a waiver that came up out of the Department of Health and Human Services, that we developed, that we would like to have you take a look at.

Mr. MCDERMOTT. I don't know if everybody has a copy of it.

Mr. THOMPSON. I just brought it, and it is there. A lot of States are doing it. And we think it is superior to the State of Maine. And I just would like to point out, it came from the Department, sir.

And finally, in regards to negotiating, the only problem with Medicare is that we are such a huge purchaser of the thing in the market that we would more than likely distort the market if we negotiated directly with a pharmaceutical company on the purchase of drugs.

Therefore, we think—and I mentioned that to Congressman Stark—that if Congress gives me the authority, I will do it. But I think a better approach is competitive bidding, which will accomplish pretty much the same thing, as well as the model waiver. And I think that is a better approach than having a way to distort the market, Congressman.

Chairman THOMAS. The gentleman's time has expired. However, the Chair would like to sympathize with the gentleman from Washington on the preventive care, as he well knows. Something as useful as the early detection, education, and treatment of diabetes, which would significantly reduce end-stage renal disease, was listed when we wanted to offer it as a program as a "coster," rather than a money saver. And if the Department would help us in collecting statistics about early detection and prevention programs that we put in place, to show that they actually save money, we could do even more of that, by offering other programs out of the savings of the preventive programs that we have.

But under our current budgetary structure and rules—which the Chair thinks are rather absurd—those wind up as "costers" because we look at 5-year windows for cost, rather than over a 10- or a 20-year period in which we fundamentally are able to alter behavior. That is one of the problems that we live with, with the artificial budgeting structure that we have, including comments about tax cuts or any other provisions in the artificial world in which we live.

Does the gentleman from Pennsylvania wish to inquire?

Mr. ENGLISH. I certainly do, Mr. Chairman. And for what it is worth, I will stick to 5 minutes.

Mr. Secretary, I want to thank you for coming here and testifying today. And on behalf of those of us who think $350 billion is serious money—perhaps naively—I want to congratulate you for also exploring ways of delivering the same package of Medicare services more efficiently, in a more modern way. And if that generates cost savings, I don't think you would need to apologize for it.

My sense is that one of the most important things you have touched on in your testimony is the need for seniors to have a flexible package of benefits under whatever we do. And I wonder if you

could elaborate, very briefly, on your testimony. The notion of flexibility has been characterized here, strangely, as complicating seniors' lives. Yet for many seniors, in very different circumstances, a different package of benefits would mean different things.

And I wonder if you could elaborate on the importance to seniors of giving them at least a variety of options for how they might take a subsidy in supporting their prescription plans.

Mr. THOMPSON. I think, first off, let me thank you for your pointing out the efficiencies. And I would like to thank you and the Committee for passing our contracting reforms. I know the House has passed it, and it is over in the Senate. Hopefully, the U.S. Senate will pass it. Because the contracting reforms are going to allow us to build in quality, efficiencies, and save money, and deliver a better product. And that is what you want, and it is what the taxpayers want. And we are hopeful that the Senate will pass it, so we can do that.

In regards to choice, as we know, seniors like Medicare+Choice, because it gives them the opportunity to look at something else besides just fee-for-service. We think also of the Medigap plans; there is "A" through "J." This Administration is asking for three more, three that do not require first-dollar coverage, and one that will allow only for prescription coverage. So that seniors will be able to pick and choose from Medigap programs to decide which one is the best suited for their particular needs.

The third thing, and the most important one, is if we go with the change of strengthening it, allowing Medicare recipients to have the same choices as Federal employees, we are fairly confident that the seniors will embrace that enthusiastically and will be able to pick and choose which plan best suits them and their insurance needs.

And that is why we think it will be a cost saver, because you will have competition; you will hold down on expenses; and you will allow seniors to have the same choices that you and I have when we pick our health insurance program. And we think that is good public policy.

Mr. ENGLISH. And I know you know from your experience as Governor that Wisconsin has not been the only source of policy innovation at the State level. And I know you are aware that Pennsylvania has a Program of All-Inclusive Care for the Elderly (PACE)——

Mr. THOMPSON. That is correct.

Mr. ENGLISH. That has been in place for many years. It is perhaps the most comprehensive of the State programs available—perhaps of less interest at this hearing, because PACE doesn't afford one of the factions in Congress an opportunity to highlight one of their candidates. But it is certainly one of the most successful programs.

In Pennsylvania seniors currently have access to a limited prescription plan under PACE. We would like to see a program that would fit into that existing benefit, if anything could be wrapped around it. Do you feel that that is an important priority, and that we should encourage the States that are doing things already in prescriptions to be able to continue to offer those benefits; and not,

as the minority plan from the last Congress did, require seniors to choose one or the other?

Mr. THOMPSON. Thank you, Congressman English, and thank you for your comments about our innovation in Wisconsin. And I appreciate that. I am not going to get into an argument with Governor Ridge which one of us was the most innovative, because Governor Engler would also like to have a dog in that hunt. But I thank you so very much. And I compliment the Governor and the legislature in Pennsylvania for coming up with the PACE program.

And that is why the President came in with his immediate program to allow for States like Pennsylvania that have taken a lead to be able to use this new program, up to 100 percent of poverty, to get their Federal match, and then up to 150 percent of poverty, to get a 90/10 match. That would help Pennsylvania, probably more than any other program. And we are hoping that you will support that.

In regards to that innovation of States, this is something that I believe very passionately about. That is why we set up this model waiver for States to use. And it is called "Pharmacy Plus," and allows States to take a look at this opportunity for themselves to set up their own individual drug program, one in which the States and the Federal Government would be in partnership. And we are hoping that States like Pennsylvania take the lead and do that.

Mr. ENGLISH. Thank you.

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

Mr. WELLER. Thank you, Mr. Chairman.

And Mr. Secretary, it is good to have you here again.

Mr. THOMPSON. It is always a pleasure, Mr. Weller.

Mr. WELLER. Particularly, someone from the neighboring State of Wisconsin.

Mr. THOMPSON. Yes. And we love people from Illinois coming to visit Wisconsin.

Mr. WELLER. I know. A lot of my neighbors do. And again, I appreciate your time and your leadership, and particularly your leadership on modernizing Medicare for the 21st century with prescription drugs.

And I also want to commend the President on his leadership in the war-time balanced budget he has offered the Congress, which was mirrored in what we passed out of the U.S. House of Representatives, that includes prescription drug coverage for seniors as part of Medicare.

One thing I would note, in the House-passed war-time balanced budget we provide about $350 billion for the purpose of modernizing Medicare, including prescription drug coverage. And my hope is it will be legislation similar to what this House passed 2 years ago, which was voluntary and affordable for all seniors who qualify under Medicare. And thanks to the leadership of Chairman Thomas and Nancy Johnson and others, this House led. And unfortunately, the Senate failed to act. And we could have had prescription drug coverage for seniors today, had the Senate acted, rather than doing nothing.

The question I have, Mr. Secretary, is, in your testimony you note that there are about 9 million Medicare beneficiaries that

have no prescription drug coverage today. About one-third of those have incomes of $18,000 or less, lower-income seniors. And of course, they are the ones who struggle the most in meeting the cost of providing prescription drug coverage.

There are two questions I have. One is that I find as I travel throughout the district that I represent, the south side of Chicago and the south suburbs, towns like Joliet and Park Forest and that, many seniors already have prescription drug coverage, about two-thirds do.

Mr. THOMPSON. Seventy-three percent.

Mr. WELLER. Seventy-three percent. And I find across the board there is support for including prescription drug coverage. And they appreciate what the House majority has done, the leadership that has come out of the House.

One concern they have, though, is they are concerned that if we provide prescription drug coverage under Medicare that it may jeopardize the coverage they already have, that as part of their retirement benefits they are provided what they feel is a pretty good program covering prescription drugs. And they have a fear that if the government were to provide it through Medicare that they would lose it as part of their retirement benefits.

And I was wondering, Mr. Secretary, if you can just share your concerns, as we move the legislation through this Committee, on how we can best ensure that prescription drug coverage will not only be affordable, but voluntary. If you have better coverage available from another source that you prefer to have, there is no reason to jeopardize it.

Mr. THOMPSON. I really think that we can take care of that in the overall proposal that this Committee will be marking up. I think that there is no question that 73 percent of seniors have their own prescription drug coverage. Some of it is not as adequate as it should be, and they will be certainly benefiting from a prescription drug coverage in Medicare.

We think overall that the prescription drug coverage benefit for seniors under Medicare is important. But we do not want to crowd out. And that is something that some individuals are fearful of, some of your constituents, that if we put prescription drug coverages, employers say, "Well, you've got it. As a senior you don't need it in the employer's proposal." And that is a big block, of those individuals that are covered by employer-owned policies.

And so therefore, we want to make sure that we take that into consideration. But we think that it can be handled quite nicely.

Mr. WELLER. Yes. And building on that, the proposal that we passed out of the U.S. House of Representatives in the last Congress was a public-private partnership, and enlisted the private sector in helping provide Medicare prescription drug coverage, and legislation that obtained bipartisan support.

My hope is that the legislation we move through this Committee will have bipartisan support as well, because both parties claim they are for prescription drug coverage. And we no longer want it to be a political issue. We actually want to provide a solution and get the job done.

And I was wondering, from your perspective, there are kind of two schools of thought. One is that there should be no private sec-

tor involvement in providing Medicare prescription drug coverage; and the other is that we should enlist the private sector. And fundamentally, can you argue the merits of what the President has discussed, which is enlisting the private sector?

Mr. THOMPSON. The President feels strongly that the seniors should have options. If they want to retain the current Medicare fee-for-service program, they should have that opportunity, and nobody should abrogate that opportunity.

But at the same time, like we have for Medicare+Choice, like Medigap, there are many different programs out there that seniors like to be able to pick and choose. We think that is good public policy, for several reasons. It gives the senior a better opportunity to devise his or her best insurance coverage; whether it be prescription drug coverage, whether it be first-dollar coverage, whether it be a casualty loss coverage, whether it be preventative health. Allow the senior, with consultation with family Members, with their doctors, to pick the best health insurance program.

That is why we think a mix is good, with the understanding that that senior should be able to pick or choose, if he or she wants to; but at the same time, if they want to maintain their existing plan, they should have that right, as well.

Mr. WELLER. Thank you. Thank you, Mr. Secretary.

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

Mr. LEWIS of Georgia. Thank you very much, Mr. Chairman. Welcome, Mr. Secretary. Mr. Chairman, I won't take my 5 minutes, but I do want to say from the outset this reminds me of another period in our history about 40 years ago, in 1964, when another person was denied, an attempt was to deny a person for testifying. But this particular woman, by the name of Fannie Lou Hamer, was able to testify. And in testifying, she educated and sensitized the Nation; not about health care, but about voting rights. And she said, in that classic statement, "I am sick and tired of being sick and tired."

Since I am a candidate for reelection to Congress, and since our witness was denied the right to testify, I don't think I should inquire, Mr. Secretary. So I want to thank you for being here.

Mr. THOMPSON. Do you want me to comment on that?

Mr. LEWIS of Georgia. If the spirit moves you to talk.

Chairman THOMAS. The Chair would observe we are well within the 5-minute period.

Mr. THOMPSON. I don't know how I could comment.

Mr. LEWIS of Georgia. Well, you don't have to, Mr. Secretary. I just wanted to make a statement for the record, sir.

Mr. THOMPSON. Thank you, Congressman Lewis.

Chairman THOMAS. Thank the gentleman very much. Does the gentleman from Florida wish to inquire?

Mr. FOLEY. Thank you very much, Mr. Chairman. Let me just commend you on the rules of engagement on bringing witnesses forward. And we may disagree, but I could think of a number of reasons why I would like Elizabeth Dole here to talk about the Red Cross, or Mayor Norm Coleman to talk about some issue. But I think it is important that we talk to people who have direct-line experience and are here today.

Let me also comment for the record that I found the Democratic response to the savings possible under the retail pharmaceutical cards, if you will, 11.4 percent discounts, to be paltry, to be not worth the time and effort that we are endeavoring to create this legislation.

So it begs the question of why Wal-Mart is the most popular consumer stop in America, why people spend $25, $35 to join Costco or Price Club, and why so many millions of Americans enjoy the benefits of an AARP card. Largely because they provide a discount in some form or fashion.

Now, Chuck Hagel, Senator Hagel, and I have been working for quite some time on the discount card that has been enunciated by the President. And let me commend first the President for taking the leadership. And let me also suggest, during the prior testimony people were asking you specifically where we would find the money to initiate prescription drugs and a discount card mechanism.

Let me underscore, yesterday in this very hearing room the Honorable Reuben King-Shaw, formerly of Florida, now a member of your Administration, was speaking specifically about areas that you have articulated and are talking about. Wellness models: Sander Levin and I are working on the wellness model, which in the long term will actually reduce costs to Medicare and allow us to transition a healthier society into providing the benefits for those most needed.

My question is, Mr. Secretary, obviously, it is because of a lawsuit requiring Congress to act and give statutory authority to implement the prescription drug card program. How quickly do you believe you can get it up and running, if we can provide you, if you will, with the legislative authority?

Mr. THOMPSON. Thirty to sixty days.

Mr. FOLEY. In 30 to 60 days the seniors who live in Palm Beach County of the 16th Congressional District can actually access the kind of savings, potentially upwards of 11, maybe more, depending on the competition? But what we are saying today, right here, is that within 60 days seniors could have benefits of actual cash savings, rather than political rhetoric.

Mr. THOMPSON. We have done a lot of the preliminary work already, Congressman. So we can move very rapidly.

Mr. FOLEY. And isn't it correct that the Administration is not willing just to have a discount card; that they actually have an enunciated policy on providing pharmaceutical drugs to seniors 65 and over?

Mr. THOMPSON. That is correct. You are absolutely correct.

Mr. FOLEY. Let me also caution those that see Medicare as being the primary, if you will, place to have the pharmaceutical drug program, having had experience as a State legislator, I caution those that expect miracles out of an agency to be the one-size-fits-all, that when we tried to do that in Florida we actually had to create a formulary list. We had to deny a number of drugs, because of the cost of those drugs. That is why I applaud what you are doing. It is to provide, if you will, an opportunity to provide prescription drugs, but to keep a free market concept and principle in place.

Mr. THOMPSON. We think it would be very effective. We think seniors, who are very intelligent, would be able to pick and choose

the best insurance program for themselves, as well as prescription drug coverage for themselves and their families.

And that is why we think it would be cost-effective, good public policy, and be able to be more efficient. And just like the Federal employees' insurance is right now, you have that option, I have that option. And I think we should allow the seniors to have the same option to develop their own insurance program.

Mr. FOLEY. Your work in your home State is legendary. As Governor, you were able to squeeze savings out of programs by implementing, if you will, preventative care, whether it was in truancy, whether it was in juvenile detention. So you see that same opportunity federally now, as we are talking about Medicare and wellness, to do the same kind of cost savings through implementations of health models, if you will?

Mr. THOMPSON. Absolutely. And that is why we think this "Pharmacy Plus" waiver is a giant step forward, to allow States to set up their own innovative plans in partnership with the Federal Government.

We also think the $8 billion that the President has put in his budget to allow States to develop their own insurance program, their own pharmaceutical plan, as well as with Federal tax credits to develop their own health insurance program using the pooling process, is going to save a lot of dollars and allow a lot of uninsured individuals to be covered. We expect 6 to 8 million people could be covered by just the Federal tax credit program, if Congress passes it.

Mr. FOLEY. Thank you. I yield back.

Chairman THOMAS. Thank you. Does the gentleman from California, Mr. Becerra, wish to inquire?

Mr. BECERRA. Thank you, Mr. Chairman.

Mr. Secretary, thank you very much again for coming before us and providing testimony.

Mr. THOMPSON. Good to see you, Congressman.

Mr. BECERRA. Good to see you, as well. I am a little disturbed by the fact that the President did not increase funding for his prescription drug plan and Medicare overall from his previous budget of last year; especially when you take into account that the Medicare prescription drug bill that was presented to this House by Chairman Thomas and the Republican majority in this House a year ago or so was projected by the Congressional Budget Office, or the non-partisan Accounting Office—it was budgeted to cost about $154 billion over 10 years. That was an estimate last year.

Today, the same CBO is telling us that that same bill—same bill, no changes—today is going to cost about $41 billion more, or about 25 percent more than their previous projection of last year for that same 10-year window.

So given that we all know—and seniors know this better than we do—that the cost of health care, including prescription drugs, continues to rise, I am somewhat disturbed—in fact, very disturbed—that the President didn't include more money there. And I hope that, as some of my colleagues have mentioned previously, you will take that back to the President; that if we really want to do this in the right way, we can't do it on the cheap.

Mr. THOMPSON. Could I respond, Congressman?

Mr. BECERRA. Certainly.

Mr. THOMPSON. Okay. Thank you very much. First off, point number one is that the President did increase the budget, from $153 billion to $190 billion. That is point number one.

Point number two is that we have our own actuaries out at the Department of Health and Human Services and Division of Centers for Medicare Services. They came up with the figures for OMB. The OMB put those figures and plugged them in.

Third, in my testimony this morning, as well as in answer to several questions, I indicated that we are willing to work with the $350 billion figure that Congressman Thomas has indicated is necessary, and also which Congressman Nussle has put in the budget which was approved by the U.S. House of Representatives.

Mr. BECERRA. Secretary, thank you for that. And actually, before I turn to my next question, I do want to make sure that it is clear. The OMB is the President's arm that does its budget numbers, which has always been a little less accurate than the Congressional Budget Office.

And second, the President may have increased the numbers he put in there for Medicare, but that does not take into account the fact that the prescription drug bill by itself would have increased by $41 billion. Your plan, the President's plan for Medicare talks about all sorts of things, not just prescription drugs.

Mr. THOMPSON. That is correct.

Mr. BECERRA. So let's be sure we are talking apples and apples, and not apples and oranges, and not let seniors believe that because the President increased the entire amount, that it will be taken care of.

Mr. THOMPSON. But I am also——

Mr. BECERRA. But he doesn't try to leave out the fact that just for prescription drugs it would be a lot more. Let me ask a question——

Mr. THOMPSON. But I also understand, Congressman, that $350 billion that is in the budget bill also is looking at streamlining and strengthening Medicare, as well.

Mr. BECERRA. Right.

Mr. THOMPSON. So those are apples and apples.

Mr. BECERRA. Absolutely. And that is good. Let's just hope that the streamlining doesn't mean reduced benefits for seniors in the process.

Mr. THOMPSON. Well, let's hope that we can come up with a very good, comprehensive, bipartisan plan. And I want to work with you to accomplish that, Congressman.

Mr. BECERRA. I am glad you are willing to work with us on a bipartisan plan, because the leadership in the House on the Republican side has not taken any time to sit down with us to talk about a bipartisan plan. So perhaps, working together, we can get the Republican majority to do that with us, as well.

The point I wanted to make with regard to funding——

Mr. THOMPSON. Yes, sir.

Mr. BECERRA. You mentioned in your testimony, and I will quote you, "We have a moral obligation to fulfill Medicare's promise of health care security for American seniors and people with disabilities." I can't agree with you more.

And to me, that means that, to fulfill that promise, you have got to have the money in hand, ensuring that the government dollars that we are collecting from those who are working, in their Medicare contributions, is available to them. It seems to me that the more we see an Administration proposed budget that not only spends money not in Medicare but in other areas, and specifically with regard to tax cuts that are going to benefit mostly the well-to-do in this country along with corporations, not Medicare beneficiaries. It seems to me that we are spending those Medicare trust fund dollars not on Medicare over the next 10 years, but on things that are unrelated to Medicare.

And I know the General Accounting Office will present its testimony in just a moment, but there is a chart that the GAO provided us. And again, the General Accounting Office is the non-partisan watchdog for the Federal Government. And what they are telling us is that by the year 2050, the last bar, you can see the costs we will have.

Spending, non-Medicare; Medicaid spending; and non-Social Security spending are the green portion of the bar. The red is Medicare-Medicaid; which, as you can see, has grown over the years, because we know the Baby Boomers will be retiring and using Medicare.

Mr. THOMPSON. Sure.

Mr. BECERRA. And the cost of medicine is going up. Social Security in yellow. And then Net Interest in blue. The portion of the bar that has grown the most is the portion in blue, which means that the cost of paying the debt—just the interest on the debt, not the principle, just the interest on the national debt—is growing fastest.

If we were to save the moneys that we have from the Medicare trust fund for Medicare by paying down the national debt, we could reduce the size of that blue portion of that bar so that we can, hopefully, in some point in the future not just meet the needs of our seniors with Medicare, but also try to meet the needs of all Americans, including our kids, to educate and to do the right thing.

So I just fear that in having a budget from the President that spends all of the Medicare trust fund on things other than Medicare, that that is sending us down the wrong path. I thank you for being here.

Mr. THOMPSON. Thank you, Congressman, for your questions and your comments. I appreciate that.

Chairman THOMAS. The gentleman's time has expired. Does the gentleman from Texas wish to inquire?

Mr. BRADY. Yes, Mr. Chairman.

Thank you, Mr. Secretary, for your testimony today. I appreciate the increase the President has proposed for health care all across the board, and would note that only in Washington are major increases in spending often described as cuts, drastic cuts. The fact is, more money helps. We appreciate your and the President's support doing that.

Listening to your testimony, I am thinking that there is one woman in Kingwood, Texas, who would be thrilled to hear your goal to make all seniors have access to affordable prescription drugs. I was at a townhall meeting the other day at the Rosemont

Assisted Living Center in Kingwood. This woman—she called herself not a senior citizen, but an "experienced citizen"—has a monthly drug for one medicine, $1,204 a month for one prescription. She tried generic drugs. It didn't work. The pain returned. Thankfully, she has a husband who is able to go back to work, and she is able to afford it. But there are a lot of people like that in the country.

And I think the fact of the matter, that you are working so hard to try to help the sickest and the poorest among us first, is really the responsible approach. As I see it, you have taken the approach: Let's create a short-term drug plan this year to help the sickest and the poorest of our seniors. And then, as we work together to modernize Medicare once and for all, then create a broader plan that is affordable and voluntary, and is paid for. And I think that is really key. Because I think in the past Washington has got itself in trouble by over-promising——

Mr. THOMPSON. That's right.

Mr. BRADY. And under-delivering; passing on the financial burden of programs; doing it for an election year, and then passing it down to future generations. Your plan rejects that type of old-fashioned thinking, thank goodness.

And I think you are exactly right when you say the plan should strengthen the solvency of Medicare, rather than accelerate its bankruptcy. Putting in a huge plan we can't pay for right now would be like going on a spending spree when your credit cards are all maxed out. And fixing Medicare once and for all is really key.

I guess my point to you is that I think the biggest challenge to modernizing Medicare isn't the numbers. I think it is partisan politics. It seems to me that the only way we are going to be able to get all this done is if both parties to work together. If we just put aside the interests of our election year ambitions, and put our seniors first.

Mr. THOMPSON. That's right.

Mr. BRADY. It seems to me that we all have a real stake in helping our seniors. And I would just like you to comment on that as being a major obstacle.

Mr. THOMPSON. Congressman Brady, I couldn't agree with you more. I think that is one of the most intelligent statements that I've heard, in regards to making sure that we take care of our seniors first.

We have an opportunity this year on a bipartisan basis to strengthen Medicare, improve it, and at the same time add a prescription drug coverage, a casualty loss coverage, as well as more preventive care, which is a passion of mine. I think it is absolutely necessary to take a look at how we deliver medical services in the United States, and try and find ways in which we will be able to hold down on future costs by allowing seniors as well as other Americans to take care of their health up front, and use the money more propitiously in regards to that.

In regards to your statements on a bipartisan basis, I hope that we can. I think it is the right time. And people say it is an election year, therefore it can't be done. I think it is just the opposite. I think the election year is going to drive a decision to be made on prescription drug coverage, therefore, we have an opportunity.

I believe—and I am cautiously optimistic of that—that we can get a reformed, strengthened, and improved Medicare plan passed with prescription drugs this year through both Houses, signed by the President.

Mr. BRADY. Right. Thank you, Mr. Secretary and Mr. Chairman.

Chairman THOMAS. Thank the gentleman. Does the gentlewoman from Florida wish to inquire?

Mrs. THURMAN. Thank you, Mr. Chairman.

Thank you, Mr. Secretary, for being here. First of all, just a couple of comments on the question that Mr. Crane asked. As it has been noted in this hearing, it sounds like we may be moving our date up until Memorial Day. And if we could get any of that information, particularly on the bundling and the composite rate, before we go into this markup, that would be most appreciated. Because it doesn't do us any good after the bill has already gone.

Mr. THOMPSON. I will see what I can do to expedite it, Congresswoman Thurman. And I think your point is well taken.

Mrs. THURMAN. Secondly, I just want to say, I know that Mr. Shaw is not here, but in his conversation about the woman, all of us see that in Florida all of the time. But I might add one of the things that concerns me and why some of us who would like to work in a bipartisan way do believe that all seniors should be included.

Because in Florida, as you well know, we already have a medically needy program under Medicaid. So if what you say in your statement is that it gives seniors with limited means, I am not sure that we would be adding any more for the woman that Mr. Shaw was talking about. But I do want to go to something that——

Mr. THOMPSON. No, no, I think you are misreading my statement.

Mrs. THURMAN. No, not yours.

Mr. THOMPSON. Okay.

Mrs. THURMAN. Yours says, "Medicare subsidized drug benefits should protect seniors against high drug expenses, and should give seniors with limited means the additional assistance they need." And so I was just pointing out that we do have a medically needy program, so I am not sure that this woman would still be taken care of. But let me go to a couple of other issues——

Mr. THOMPSON. But I want to point out, I want it to cover all seniors.

Mrs. THURMAN. Okay.

Mr. THOMPSON. But I think that we have to subsidize in certain cases low-income Americans, make sure that they get the adequate coverage.

Mrs. THURMAN. Well, I appreciate that clarification. The other issue, though, that does concern me—and I know you may not have had the opportunity to look at the AARP testimony——

Mr. THOMPSON. No, I have not.

Mrs. THURMAN. But I do want to bring up some things. In your last statement, under the fourth, "Medicare should provide better health insurance options, like those available to all Federal employees and retirees," it says the last is, "Private plans have been a critical source of drug coverage and other innovative benefits for seniors, and should remain so."

However, if you go and look at the AARP report, what they are showing is that there are choices; that they have been doing this, that the principal sources of coverage that offer prescription drug benefits—employer-based retiree coverage, private supplemental coverage, or Medicare health maintenance organizations (HMOs)—they are finding that they have been inadequate, they are limited, they are expensive and, more importantly I think, unstable, which is what we have found throughout the country, particularly with the Medicare HMOs.

But let me go on to say that it also says that a study was released that reported that nearly 42 percent of the beneficiaries lacked drug coverage at some point in 1998. And a new study published by Health Affairs reports that nearly 40 percent of Medicare beneficiaries had no drug coverage in the fall of 1999.

So what they did is, they laid out and they illustrated for some middle-income people the difficulty that they are having in obtaining affordable and dependable drug coverage. And I am just going to read these very quickly:

A retired couple has significantly saved for retirement, and has an income of $40,000 a year. Both take prescription drugs for heart disease and high cholesterol. The wife also needs medication for breast cancer and osteoporosis. They do not have access to retiree health benefits from a former employer. There are no Medicare+Choice plans available in their area. And a Medigap plan offering some drug coverage would cost each of them $260 a month. There is a private option for them. They can't afford it.

A retired couple has an income of $30,000 a year, significantly above the threshold for Medicaid and most State and private pharmacy assistance programs. They have prescription drug coverage through a Medicare HMO. This year they have learned, however, that the HMO plans to terminate its contract with Medicare, effective December 31st. There are no other Medicare HMOs in the area. And while they can afford supplemental insurance and are guaranteed access to certain Medigap plans, "A," "B," "C," and "F," none of these plans would include their drug coverage.

And then the last one is about a 75-year-old widow who is enrolled in a Medicare HMO that offers drug coverage. She currently has prescriptions for cholesterol-lowering medication, at $97.51 a month, and an allergy medication of $46.94 a month. While initially her drug coverage was quite generous—and we are finding this over and over—this year her drug benefit is capped at $300 a year. As a result, she basically will have no drug coverage for three-quarters of the year.

So I know we don't have a lot of time to discuss this right now, but I would like to, one, have the opportunity to discuss some of these issues with you; but secondly, because of the lack of time that we have sometimes in this Committee, if we could get your staff to kind of respond to us as to how you think these private plans that are already in place—how you think you can better them through the modernization that you are talking about.

Mr. THOMPSON. Thank you very much, Congresswoman. We will be more than happy to work with you on that particular subject, more than happy to get back to you with our staff.

My only quick rejoinder is that the Federal system works very well. We have 10 plans, 10 to 12 plans, that Federal employees can pick and choose from. We think the same advantage could be given to seniors. They could maintain their current plan, if they so desire. But having the opportunity to pick and choose from other just as good, or sometimes better, plans would be better.

In regards to Medigap, that is why we are adding three more plans. Because none of them really deal with prescription drug coverage very well, so we are adding three more. Hopefully, Congress will approve them, and get away with the first-dollar coverage which is a problem and an impediment for giving an expansive prescription drug coverage.

So with three new Medigap plans, with 10 different Federal plans that seniors could pick and choose from, we think seniors would be better served. And that is why we believe it is good public policy.

Chairman THOMAS. Thank the gentlewoman. And also, the Chair will say that, in terms of the honest request to work in a bipartisan way, the Chair has a clear record of working with Members in a bipartisan way: the gentleman from Maryland, in health care and pension areas, the gentleman from Tennessee, the gentleman from Louisiana, and a number of others.

To the degree the work product is approached in an atmosphere of accommodation and compromise, the Chair has no problem. To the degree "bipartisan" is defined as making non-negotiable demands, and failure to succumb to those non-negotiable demands, the Chair doesn't believe that is bipartisan. So the Chair will respond in the way in which the Members wish to enter into a working relationship.

Does the gentleman from Texas, Mr. Doggett, wish to inquire?

Mr. DOGGETT. Thank you, Mr. Chairman.

Secretary Thompson, you have indicated that you are opposed to greater use of government to——

Mr. THOMPSON. I am sorry, I didn't hear that.

Mr. DOGGETT. You have indicated that you are opposed, as I understand it in response to two queries today, to greater use of government bargaining power to lower prices for Medicare recipients, because you say it will distort the market. Is that correct?

Mr. THOMPSON. No, that is not what I said.

Mr. DOGGETT. All right, then what——

Mr. THOMPSON. I said that if Congress approved——

Mr. DOGGETT. You would implement it. But you think that it is not——

Mr. THOMPSON. But I cautioned you——

Mr. DOGGETT. Yes.

Mr. THOMPSON. About the possibility of distorting the market when you are such a huge purchaser of 50 percent of the drugs.

Mr. DOGGETT. And so that is why I said you are opposed to the idea, because you think it will distort the market.

Mr. THOMPSON. No, I cautioned you about that particular problem. I said I think a far superior one is competitive bidding, which I think would accomplish your objective, as well as not distort the market.

Mr. DOGGETT. I guess some of the people that are faced with these soaring drug prices down in my neck of the woods think the market is already pretty distorted for them.

You have also cited this model waiver agreement, which I hope you are going to leave with us today. The model waiver agreement does not add any new money to the States; does it?

Mr. THOMPSON. No, it does not.

Mr. DOGGETT. So if you have a State that cannot provide an adequate level of prescription drugs through its Medicaid program at present to those people that are serving it, the waiver is really worthless. If they can't cover the people they are covering now, it doesn't give them the resources to cover any additional people on their prescription drugs.

Mr. THOMPSON. That is not true.

Mr. DOGGETT. Why not?

Mr. THOMPSON. Because it allows for the States, under the waiver, as long as they are budget-neutral, to use their Federal match to be able to set up this prescription drug coverage, which is a tremendous help to States.

Mr. DOGGETT. Well, if they are using all of their Federal match, if a State is theoretically using all of its Federal match at present, and not able to meet the needs that it is currently covering, then getting a waiver to do more is not going to assure anyone any additional prescription drugs, is it?

Mr. THOMPSON. Well, the truth of the matter is that States can use their Federal match in different ways, and become very innovative, and can allow this to be able to be used for prescription drug coverage. And that is why so many States are applying for it, looking at it, and seeing whether or not they could use it in their particular States. And I will be more than happy to leave a copy——

Mr. DOGGETT. I appreciate it.

Mr. THOMPSON. With any Member of the Committee.

Mr. DOGGETT. I would like to get a copy. This model waiver agreement does not contemplate States negotiating with pharmaceutical manufacturers in any way similar to what Maine has done?

Mr. THOMPSON. It certainly allows them to do that.

Mr. DOGGETT. It doesn't prevent them, but it doesn't authorize them to do that in any way, or encourage them to do it, does it?

Mr. THOMPSON. Well, there are certain States that are doing that right now, Congressman.

Mr. DOGGETT. Right. And with reference to the States——

Mr. THOMPSON. And there is nothing to prevent them. And States should be doing that.

Mr. DOGGETT. Oh, I am glad to hear you say that, because I wanted to get a clarification on that. You are certainly correct that the Maine program is in litigation. The pharmaceutical manufacturers have done everything they could to prevent it from being implemented, and I am sure they will continue to do so until it reaches its final appeal. Does the Administration support programs like that that Maine has initiated?

Mr. THOMPSON. That is why we set up the model waiver, that is why I instructed that it be adopted and implemented, because it gives States some guidance. We think it meets the guidelines and

will not end up in litigation. We think it is something that States can do. And we think it is probably superior to Maine, in regards to the fact that it will not cause litigation.

Mr. DOGGETT. But you are supportive of the kind of effort that Maine has made?

Mr. THOMPSON. Absolutely. That is why I put forth the model waiver, Congressman.

Mr. DOGGETT. With reference to the legislation that is contemplated that you are here today on, as well as the welfare reauthorization legislation that you made a quick appearance here on in the Subcommittee last week, does the Administration support imposing any unfunded mandates on the States?

Mr. THOMPSON. Say that again?

Mr. DOGGETT. With reference to either—the legislation you are here on today, or the welfare reauthorization—does the Administration support imposing any new, unfunded mandates on the States?

Mr. THOMPSON. Well, Congressman, I have testified on both the welfare reform proposal many times in many different Committees of this Congress, as well as on Medicare.

Mr. DOGGETT. Right.

Mr. THOMPSON. And we believe very strongly that this is a partnership between the Federal and State Governments, on welfare reform, as well as on Medicare.

Mr. DOGGETT. Yes, sir. I understand that. So are you opposed?

Mr. THOMPSON. I mean as far as welfare. Medicare is a Federal program.

Mr. DOGGETT. On both of these, you are opposed to any new unfunded mandates on the State, are you not?

Mr. THOMPSON. It depends upon how you describe them, Congressman, because in certain things——

Mr. DOGGETT. Well, we have got a law on it.

Mr. THOMPSON. We set guidelines, we set certain goals which States have to meet as far as welfare reform. We think that's good public policy. I negotiated, when I was Governor and Chairman of the National Governors Organization in 1995 and 1996, the first welfare bill with Congress. And I said at that time, "You set the goals high; just give us the flexibility under those goals to meet those obligations." And we did it, across America. Governors did it, Republicans and Democrats.

We feel the same thing, and the next welfare reform proposal will accomplish the same thing, by setting the goals high, but giving States the flexibility underneath there to do so. Now, if you want to say that those goals are unfunded mandates, then I will have a difference of terminology with you. But overall, we have given States extreme flexibility as far as welfare reform is concerned.

Mr. DOGGETT. Thank you.

Chairman THOMAS. The gentleman's time has expired. Does the gentleman from Wisconsin wish to inquire?

Mr. RYAN. I do.

Governor, it is nice to see you again.

Mr. THOMPSON. Thank you, Congressman.

Mr. RYAN. Great to have you back. When we talk about improving and strengthening Medicare, which has been often questioned here, what we mean is right now Medicare isn't adequate to give seniors comprehensive benefits along the lines of the year 2000 medicine. And the hope is that 10 years from now we are not scratching our heads, thinking, "Gosh, all the seniors get is year 2002 medicine, and we need to get them the year 2012 medicine." So we have to make sure that the law is modernized and that it is allowed to evolve with the changes in health care.

And when we talk about strengthening Medicare, that means making it solvent for the Baby Boomer generation, so the promise of benefits can be met when this next new wave of retirees occurs.

So in that vein, I, too, represent southeastern Wisconsin, which you know very well. And it has been said that, "Fee-for-service is working fine. Why add an alternative? Why give seniors other private-sector alternatives?" In my experience, when we did have workable Medicare+Choice, people loved it. In 1997 and 1998, when we had Primecare Gold and all of those other ones, it worked very well. People enjoyed it. They flooded to it.

The problem that we experience—and you know this all too well—is the adjusted average per capita cost, AAPCC, reimbursement rate structure for Medicare+Choice was an abysmal failure. It didn't work well. And the last Administration did not do a good job of implementing Medicare+Choice.

And in the new version of this, or in reforming this program, is it your intention to switch from that kind of reimbursement system to a bid structure reimbursement system like what we have with the premium support Federal employee health benefit plan?

Mr. THOMPSON. That is what we want to do, because we think, Congressman, that it gives seniors the opportunity to pick the best program. And you are absolutely correct. When Medicare+Choice is in a particular area, seniors flock to it.

Mr. RYAN. Yes.

Mr. THOMPSON. But the reimbursement formula has got to be there so that the companies can make a profit, in order to stay in there and offer the services. We think, with competition with the Federal health employers system, that there are going to be many plans out there that seniors are going to be able to pick and choose. Some will want to stay with the current fee-for-service, and rightly so. And they should have that right. But others will want to be able to pick and choose, like you do, like every one of us around this table does. Seniors should have the same opportunity.

Mr. RYAN. I think that is right. Seniors who have employer-sponsored Medigap plans are pretty satisfied, because their employers, by virtue of their past employment, provide that. But most seniors in our area don't have Plus Choice, don't have employer-sponsored Medigap, and are stuck with the bill. So when we hear these comparisons between fee-for-service and Plus Choice, when it works what you see left out in this debate is that Plus Choice gives you comprehensive benefits. You don't have to go out and buy a supplemental when you have a comprehensive Plus Choice plan. That is the benefit of moving to a choice-based system, which I think is lost here.

One other thing that I think is being lost in this debate, that will be really helpful from your Administration, is the demonstration of the cost saving that occurs when competition occurs. The CMS and CBO have historically and repeatedly scored savings in the Medicare system when premium support is put into place. When competition and choice occur, quality goes up, costs go down, people are happier. And what ends up happening is, over the long run, the system saves money——

Mr. THOMPSON. Radical ideas. Radical ideas.

Mr. RYAN. These are radical ideas?

Mr. THOMPSON. Costs go down, quality goes up.

Mr. RYAN. And that is how we get to the issue of not just improving Medicare by giving people a comprehensive list of benefits so they don't have to go purchase these large supplementals, but we get to that issue of saving money in the long run in the system so that we can restore solvency to the system so that that promise of benefits, of evolved modern benefits, can be there for the next generation. And I think it would be helpful to have CMS share with us how those cost savings are achieved.

One last quick question. The waiver: Did Wisconsin apply for the waiver or not, under your new waiver?

Mr. THOMPSON. Wisconsin has applied.

Mr. RYAN. OK. Thanks.

Mr. THOMPSON. And first, let me just congratulate you and thank you for doing such a great job for Wisconsin, Congressman Ryan.

Mr. RYAN. Thanks, Governor.

Chairman THOMAS. Mr. Secretary, I want to thank you very much. I know you have been overly generous, and you have had a helicopter waiting for you. But the Members are interested, and do want to inquire. And we appreciate your willingness to provide the time for full inquiry. It is difficult to do. We will try not to overburden you.

But we want to thank you very much for your presence, for your testimony, but most importantly, for your leadership, as we move forward in trying to make changes in this most sensitive but important area.

Mr. THOMPSON. Thank you, Congressman Thomas. And let me congratulate you on your leadership of this Committee. And hopefully, we can come up with a proposal that is going to pass both Houses and be signed into law. It is badly needed, as you know. And I thank you for your leadership in this area.

Chairman THOMAS. Thank you. That is our goal, and I hope we succeed.

Mr. THOMPSON. Thank you.

Chairman THOMAS. And to the other witnesses, we do want to thank you for your patience. It is kind of like that little sign in the store which says, "If you are waiting, understand that when it is your turn we will provide you with the same opportunities."

It is now my pleasure to welcome once again to the Committee only the seventh Comptroller General of the United States. Mr. David Walker assumed the position in 1998. And it is one of those jobs that are absolutely critical because the General Accounting Office, for more than three-quarters of a century, has provided the kind of accountability, based upon requests and their own initi-

ation, that allows us to do the kinds of things to make sure that the taxpayers are getting a return on their investment. It isn't always pleasant, but it is always necessary.

And so, thank you once again for appearing before us. Your written testimony will be made a part of the record, and you can address us in any way you see fit.

**STATEMENT OF THE HON. DAVID M. WALKER, COMPTROLLER GENERAL OF THE UNITED STATES, U.S. GENERAL ACCOUNTING OFFICE**

Mr. WALKER. Thank you, Mr. Chairman, Members of the Committee. Thank you for entering my statement into the record, and I will move now to summarize it.

I am pleased to be here today to discuss options for increasing Medicare beneficiaries' access to prescription drugs. There are growing concerns about gaps in the Medicare Program, most notably the lack of outpatient prescription drug coverage, which may leave Medicare's most vulnerable beneficiaries with high out-of-pocket costs.

At the same time, however, the short-term and long-term cost pressures facing the existing Medicare Program are considerable. Many of these same pressures are being experienced by other government and private sector employers. For example, earlier this week, CalPERS, the second largest purchaser in the Nation of health insurance behind the Federal Government, announced a record 25-percent increase in health insurance premiums for the year. This increase was fueled in large part by increased costs associated with prescription drugs.

As I have noted previously, substantive financing and programmatic reforms are necessary in order to put Medicare on a sustainable fiscal footing for the future. In fact, Madam Chair, it was 10 years ago this year, when I was a trustee of Medicare, and along with Stan Ross, who was the other public trustee at the time, that we said publicly for the first time that the current Medicare program is unsustainable in its present form, and that has been repeated by every set of trustees since that point in time.

Thus, any proposals to help seniors with the cost of prescription drugs should be carefully crafted to avoid further erosion of the current projected financial condition, which is already precarious for Medicare and it is already unsustainable in its present form. We are going to have a very difficult time delivering on promises that have already been made.

We must also be mindful that fiscal pressures created by the retirement of the Baby Boom generation and rising health care costs are just over the horizon. As the first chart shows, Madam Chair, our Nation's fiscal flexibility has already decreased as spending for Social Security, Medicare, and Medicaid have absorbed an increasingly large share of the Federal budget. Reductions in defense spending have helped accommodate the growth in these entitlement programs. However, reductions in defense spending can no longer be used as a means to help fund other claims on the budget. Indeed, spending on defense and homeland security will grow as we seek to combat threats to our Nation.

As you can see, between 1982 and 2002, the percentage of the Federal budget spent on Medicare and Medicaid doubled and those percentages are only going to go one way under our current system, even without prescription drug costs, and that is up.

In recent years, Medicare's trustees have reinforced what Stan Ross and I said 10 years ago, that the Medicare Program is already unsustainable in its present form. The GAO's long-term budget simulations, which were referred to previously, show that the aging of the Baby Boom generation and rising per capita health care spending will, absent meaningful reform, lead to massive fiscal challenges in future years.

Assuming, for example, that last year's tax reductions were made permanent and discretionary spending keeps pace with the economy, by mid-century, spending for the current Medicare Program without an addition of a drug benefit is projected to account for more than one-quarter of all Federal spending. In addition, absent fundamental reform of entitlement programs, the Nation is likely to face an unprecedented degree of tough fiscal choices in the years ahead, and this is the chart, Madam Chair, that was shown previously.

The huge budgetary pressures that we are sure to face in the coming years require that we set priorities so that benefit expansions are in line with available resources. In this regard, the application of basic insurance principles to any proposed benefit could help moderate the cost for both beneficiaries as well as taxpayers. Under these principles, beneficiaries receive protections against the risk of catastrophic medical expenses while remaining conscious of the cost of care. At the same time, it is important that the benefit expansion proposals include targeting mechanisms to assure that Federal support is directed at the beneficiaries with the greatest financial need.

Nevertheless, as I have said previously, no matter how well designed the new benefit may be, adding benefits without fundamentally reforming the existing program may merely hasten the exhaustion of Medicare's HI Trust Fund, hospital insurance trust fund and the further draining of Federal revenues associated with the supplemental medical insurance (SMI) program. As a result, any benefit expansion will also serve to make our long-range fiscal challenge even greater. Ideally, Medicare reforms should be designed to improve our long-range fiscal situation. At a minimum, it should be designed to not make our long-range fiscal situation worse.

Madam Chair, I will be more than happy to answer any questions that you or other Members of the Ways and Means Committee may have. Thank you.

[The prepared statement of Mr. Walker follows:]

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

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss options for increasing Medicare beneficiaries' access to prescription drugs. There are growing concerns about gaps in the Medicare program, most notably the lack of outpatient prescription drug coverage, which may leave Medicare's most vulnerable beneficiaries with high out-of-pocket costs. Recent estimates suggest that, at any point in time, over a third of Medicare beneficiaries lack prescription drug coverage. The rest have at least some drug cov-

erage through various sources—most commonly employer-sponsored health plans—although recent evidence indicates that this coverage is beginning to erode.

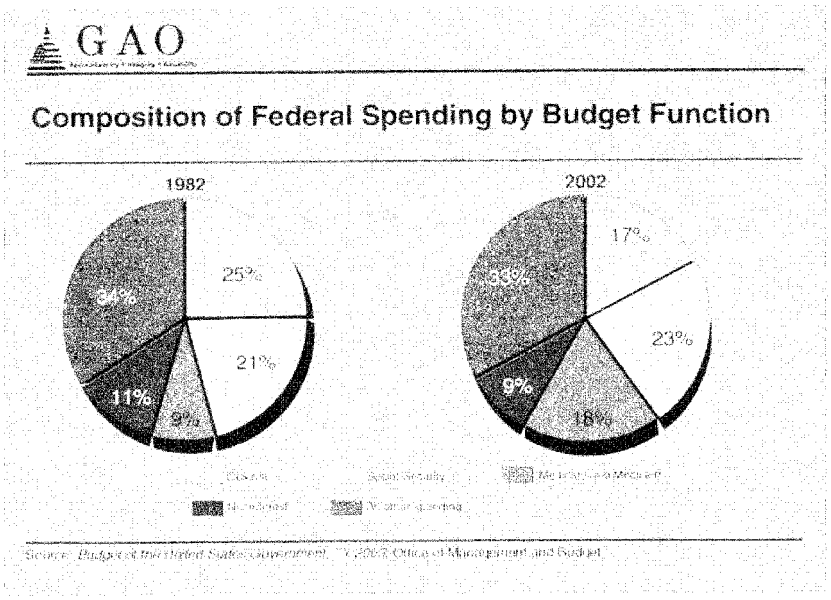
At the same time, however, the short-term and long-term cost pressures facing the existing Medicare program are considerable. After a brief slowdown in the late 1990s, Medicare spending growth has recently accelerated. In the last fiscal year, growth in program spending reached nearly 9 percent, with spending on certain services increasing much more rapidly. For example, spending for home health grew about 30 percent and spending for skilled nursing facility care grew slightly over 20 percent.

As I have noted previously, substantive financing and programmatic reforms are necessary to put Medicare on a sustainable footing for the future. These fundamental reforms are vital to reducing the program's growth, which threatens to absorb ever-increasing shares of the nation's budgetary and economic resources. Thus, any proposals to help seniors with the costs of prescription drugs would need to be carefully crafted to avoid further erosion of the projected financial condition of the Medicare program, which is already unsustainable in its present form.

We must also remain mindful that the fiscal pressures created by the retirement of the baby boom generation and rising health care costs are just over the horizon. Between now and 2035, the number of people who are 65 and older will double. Federal health and retirement spending are expected to surge as people live longer and spend more time in retirement. In addition, advances in medical technology are likely to keep pushing up the cost of providing health care. Moreover, the baby boomers will have left behind fewer workers to support them in retirement. Absent substantive reform of the entitlement programs, a rapid escalation of federal spending for Social Security, Medicare, and Medicaid beginning less than 10 years from now is virtually certain to overwhelm the rest of the federal budget.

As figure 1 shows, fiscal flexibility has already decreased as spending for Social Security, Medicare, and Medicaid have absorbed an increasingly large share of the federal budget. Reductions in defense spending have helped accommodate the growth in these entitlement programs. However, reductions in defense spending can no longer be used as a means to help fund other claims on the budget; indeed, spending on defense and homeland security will grow as we seek to combat threats to our nation.

**FIGURE 1: COMPOSITION OF FEDERAL SPENDING BY BUDGET FUNCTION.**



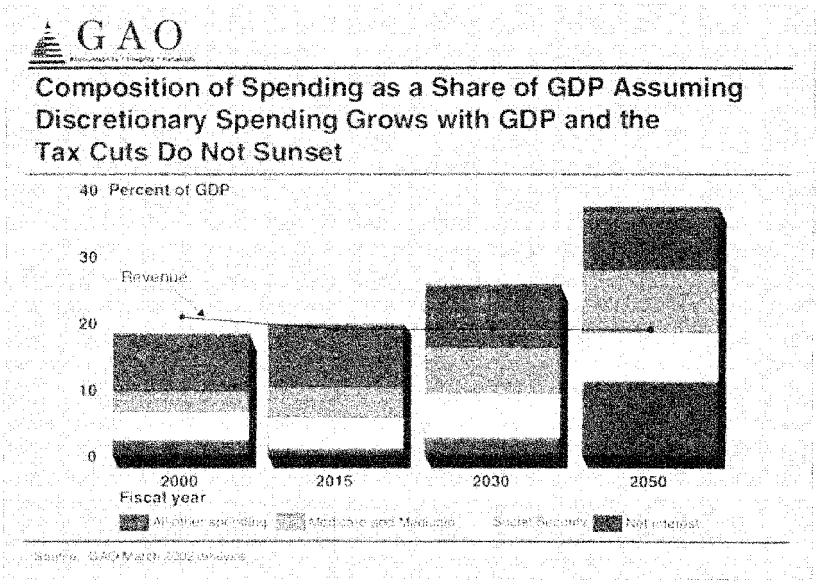

Note: 2002 data based on OMB current services estimate.

Today my remarks will focus on (1) the access and affordability issues that underlie the interest in a Medicare prescription drug benefit, (2) the financial challenges Medicare faces to meet its current obligations, and (3) key considerations in light of the tension between benefit expansions and budgetary pressures.

In summary, intentions to add prescription drug coverage to Medicare's benefits come during a period of rapid growth in national spending for pharmaceuticals. Between 1995 and 2000, spending for prescription drugs rose more than 2 ½ times faster than spending for health care overall, and this dramatic growth is expected to continue in the coming years. In the absence of a drug benefit in the Medicare program, many beneficiaries obtain coverage from other sources, including health plans, public programs, and the Medigap insurance market. But the price, availability, and level of such coverage vary widely, leaving substantial gaps and exposure to high out-of-pocket costs for hundreds of thousands of beneficiaries.

Despite the various pressures to adopt a prescription drug benefit, the rapidly escalating cost of meeting current obligations for present and future beneficiaries argues for careful deliberation and extreme caution in crafting any benefit expansion. Medicare's trustees have indicated in recent years that the Medicare program is already unsustainable in its present form. GAO's long-term budget simulations show that the aging of the baby boom generation and rising per capita health care spending will, absent meaningful reform, lead to massive fiscal challenges in future years. Assuming, for example, that last year's tax reductions are made permanent and discretionary spending keeps pace with the economy, by mid-century, spending for the current Medicare program—without the addition of a drug benefit—is projected to account for more than one-quarter of all federal revenues. In fact, federal revenues may only be adequate to pay Social Security and interest on the federal debt. As a result, massive spending, tax increases, or some combination of the two would be necessary to obtain balance. (See fig. 2.)

**FIGURE 2: COMPOSITION OF SPENDING AS A SHARE OF GROSS DOMESTIC PRODUCT (GDP) ASSUMING DISCRETIONARY SPENDING GROWS WITH GDP AND THE TAX CUTS DO NOT SUNSET.**




The huge budgetary pressures that we are sure to face in the coming years require that we set priorities so that any benefit expansions are in line with available resources. In this regard, the application of basic health insurance principles to any proposed benefit could help moderate the cost for both beneficiaries and taxpayers. Under these principles, beneficiaries receive protections against the risk of catastrophic medical expenses while remaining conscious of the cost of care. At the same

time, it is important that benefit expansion proposals include targeting mechanisms to ensure that federal support is directed at the beneficiaries with the greatest financial risk. Nevertheless, as I have stated previously, no matter how well designed a new benefit may be, adding benefits without fundamentally reforming the existing program will merely hasten the exhaustion of Medicare's Hospital Insurance (HI) trust fund and the draining of general revenues. Any benefit expansion will also serve to make our long-range fiscal challenge even greater. Ideally, Medicare reforms should be designed to improve our long-range fiscal situation. At a minimum, they should be designed so as not to make our long-range fiscal challenge worse.

**Rising Drug Spending Elevates Beneficiary Access Concerns**

Extensive research and development have led to new and improved prescription drug therapies that, in some instances, have replaced other health care interventions. For example, new medications for the treatment of ulcers have virtually eliminated the need for some surgical treatments. As a result of these innovations, the importance of prescription drugs as part of health care has grown. However, not all new drug therapies serve to reduce the need for more invasive and expensive medical procedures. Some new drug therapies are substitutes for already existing, less expensive, ones and may not appreciably improve efficacy or reduce side effects. Others may be used more for making lifestyle enhancements than for extending life or treating a serious medical condition. Spending on the new drug therapies, along with the mass media advertising of prescription drugs, serves to significantly increase total drug spending as a component of health care costs.

The Medicare benefit package, largely designed in 1965, provides virtually no outpatient drug coverage. Beneficiaries may fill this coverage gap in various ways. All beneficiaries have access to individually purchased supplemental policies—Medigap—when they first become eligible for Medicare at age 65. Those policies that include drug coverage tend to be expensive and provide only limited benefits. Some beneficiaries have access to coverage through employer-sponsored policies or Medicare health maintenance organizations (HMO). In recent years, coverage through these sources has become more expensive and less widely available. Beneficiaries whose income falls below certain thresholds may qualify for Medicaid or other public programs.

**Prescription Drug Costs Continue to Rise Rapidly**

In recent years, prescription drug expenditures have grown substantially, both in total and as a share of all heath care outlays. Prescription drug spending grew an average of almost 15 percent per year from 1995 to 2000, well more than double the 5.6 percent average growth rate for health care expenditures overall. (See table 1.) As a result, prescription drugs account for a growing share of health care spending rising from 6.1 percent in 1995 to 9.4 percent in 2000. By 2011, prescription drug expenditures are expected to account for almost 15 percent of total health expenditures.

**Table 1: National Expenditures for Prescription Drugs and Health Care, 1995–2000.**

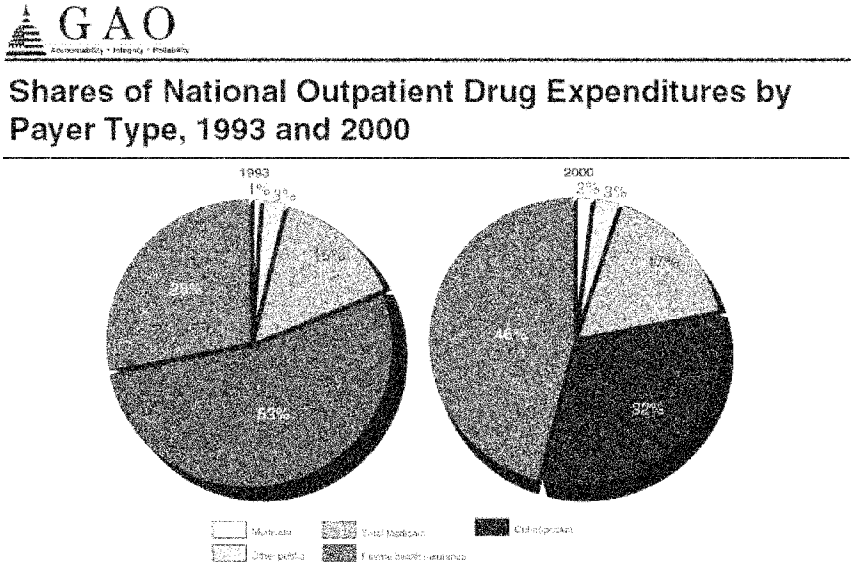
| Year | Prescription drug expenditures (in billions) | Annual growth in prescription drug expenditures from previous year (percent) | Annual growth in health care expenditures from previous year (percent) |
|---|---|---|---|
| 2000 | $121.8 | 17.3 | 6.9 |
| 1999 | 103.9 | 19.2 | 5.7 |
| 1998 | 87.2 | 15.1 | 5.4 |
| 1997 | 75.7 | 12.8 | 4.9 |
| 1996 | 67.2 | 10.5 | 5.0 |
| 1995 | 60.8 | 11.2 | 5.7 |
| Average annual growth between 1995 and 2000 | | 14.9 | 5.6 |

Source: Centers for Medicare and Medicaid Services, Office of the Actuary.

Total drug expenditures have been driven up by several factors. Drug coverage by private insurance has likely contributed to the rise in spending, because insured consumers are partially insulated from the costs. In the years from 1993 to 2000, the share of prescription drug expenditures paid by private health insurers rose from more than a fourth to almost a half. (See fig. 3.) The development of new, more expensive drug therapies—including new drugs that replace old drugs and new drugs that treat disease more effectively—also contributed to the growth in drug spending by boosting the volume of drugs used as well as the average price for

drugs used. Similarly, biotechnology advances and a growing knowledge of the human immune system are significantly shaping the discovery, design, and production of drugs. Advertising pitched to consumers has also served to increase the demand for prescription drugs. A recent study found that, in 2000, the 50 drugs most heavily advertised directly to consumers were responsible for nearly half of the roughly $21-billion increase in retail spending on prescription drugs from 1999 to 2000.[1]

**FIGURE 3: SHARES OF NATIONAL OUTPATIENT DRUG EXPENDITURES BY PAYER TYPE, 1993 AND 2000.**




Source: *Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.*

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

**Drug Coverage for Medicare Beneficiaries Is Becoming More Expensive and Less Available**

In 2001, CBO estimated that the average Medicare beneficiary would use $1,756 worth of prescription drugs. This is a substantial amount considering that some beneficiaries lack any drug coverage and others with coverage may have less than in previous years. Moreover, significant numbers of beneficiaries have drug expenses much higher than those of the average beneficiary. CBO also estimated that some 10 percent of Medicare beneficiaries would have expenditures of $4,000 or more.[2]

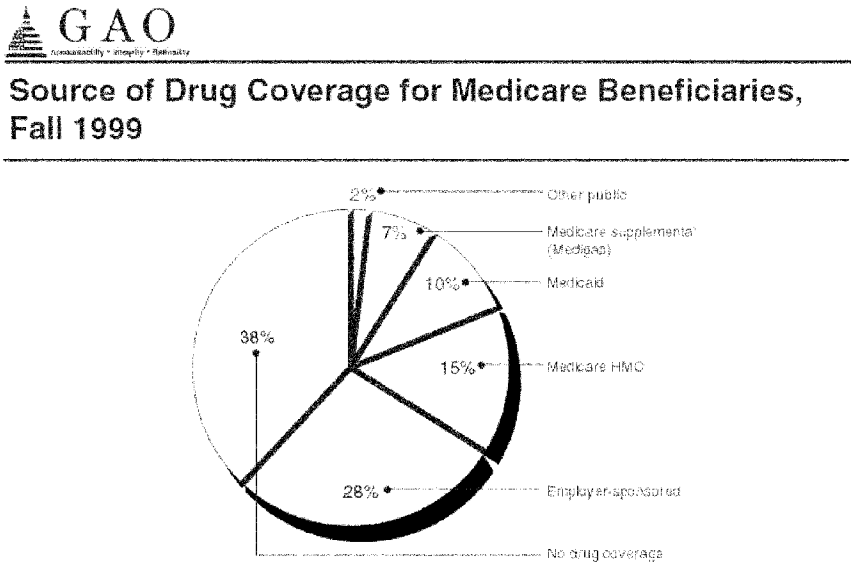
According to a recent survey, in the fall of 1999, nearly two-thirds of Medicare beneficiaries had some form of drug coverage from a supplemental insurance policy, health plan, or public program. More than one-third reported that they lacked drug coverage altogether.[3] (See fig. 4.)

[1] The National Institute for Health Care Management Research and Educational Foundation, Prescription Drugs and Mass Media Advertising, 2000 (Washington, D.C.: Nov. 2001).

[2] CBO estimates reported in Michael E. Gluck and Kristina W. Hanson, Medicare Chart Book (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, fall 2001).

[3] Mary A. Laschober and others, "Trends in Medicare Supplemental Insurance and Prescription Drug Coverage, 1996 to 1999," Health Affairs, www.healthaffairs.org (Feb. 27, 2002).

**FIGURE 4: SOURCE OF DRUG COVERAGE FOR MEDICARE BENEFICIARIES, FALL 1999.**




Source: *Barents Group analysis of 1996 through 1999 Medicare Current Beneficiary Survey Access to Care Data.*

Employer-sponsored health plans provide drug coverage to the largest segment of the Medicare population with coverage. However, there are signs that this coverage is eroding. Fewer employers are offering health benefits to retirees eligible for Medicare, and those that continue to offer coverage are requiring retirees to pay a larger share of costs. The proportion of large employers offering health coverage to retirees eligible for Medicare declined from 31 percent in 1997 to 23 percent in 2001. At the same time, the proportion of large employers requiring Medicare-eligible retirees to pay the full cost of their health coverage increased from 27 percent to 31 percent.[4]

In March 2001, 10 percent of Medicare beneficiaries obtained prescription drug coverage through a Medicare HMO, down from about 15 percent in 1999. Medicare HMOs have found drug coverage to be an attractive benefit that beneficiaries consider when choosing to enroll. However, owing to rising drug expenditures and their effect on plan costs, fewer Medicare HMOs are offering a drug benefit. In 2002, 50 percent of Medicare beneficiaries have access to a Medicare HMO with drug coverage, down from 65 percent in 1999. The drug benefits the plans do offer have become less generous, increasing enrollees' out-of-pocket costs and limiting their total drug coverage.

About 7 percent of beneficiaries purchase Medigap policies that provide drug coverage. These policies have shortcomings: they tend to be expensive, involve significant cost-sharing, and do not provide protection against catastrophic out-of-pocket expenses. In 1999, average premiums for standard Medigap policies that included drug coverage ranged from about $1,400 per year to $1,700 per year.[5] Beneficiaries remained responsible for a $250 deductible for drugs and 50-percent coinsurance. The drug benefit was capped at an annual limit of $1,250 or $3,000. Furthermore, Medigap premiums have been increasing in recent years. One recent study reported that, from 1999 to 2000, premiums for the Medigap plans offering prescription drug

[4] William M. Mercer, Incorporated, Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans, 1997 (New York, N.Y.: 1998) and Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans, 2001 (New York, N.Y.: 2002).

[5] U.S. General Accounting Office, Medigap: Current Policies Contain Coverage Gaps, Undermine Cost Control Incentives, GAO—02—533T (Washington, DC: Mar. 14, 2002).

coverage rose the most—by 17 to 34 percent—compared to 4 to 10 percent increases for Medigap plans without prescription drug coverage.[6]

All Medicare beneficiaries who qualify for full Medicaid benefits receive drug coverage that may include some limits, such as restrictions on the number of prescriptions that can be filled per month, depending on the state's Medicaid plan. Individuals with low incomes who are not eligible for full Medicaid benefits may have access to some drug coverage through a state pharmacy assistance program. As of April 2002, 26 states and the District of Columbia had such a program in operation.

Access barriers to prescription drugs may be particularly acute for Medicare beneficiaries who lack drug coverage and have substantial health care needs. In 1998, among beneficiaries in poor health, those without drug coverage had drug expenditures that were $910 lower than those with drug coverage and they filled 14.5 fewer prescriptions. The difference in expenditures and use between the two groups suggests that the lack of drug coverage may impose barriers to health care.[7]

**Expanding Benefits Needs to Be Considered in Light of Larger Medicare Fiscal Concerns**

The current Medicare program, without improvements, is ill suited to serve future generations of seniors and eligible disabled Americans. Although the need to modernize Medicare's benefit package is compelling, the program is already fiscally unsustainable in its present form, and the disparity between program expenditures and program revenues is expected to widen dramatically in the coming years.

**As Currently Structured, Medicare Is Fiscally Unsustainable**

On March 26, 2002, the trustees of the Medicare trust funds reported on the current and projected financial status of the program over the next 75 years. The report stated that, while the near-term financial condition has improved slightly since last year's report, Medicare continues to face substantial financial challenges in the not-too-distant future that need to be addressed soon.

Medicare's fiscal health is often gauged by the projected solvency of the HI trust fund, which pays for inpatient hospital stays, skilled nursing care, hospice, and certain home health services and is financed by payroll taxes. The gap between income and costs can best be expressed relative to taxable payroll (the HI trust fund's funding base). This year, under the trustees' 2002 intermediate estimates, the 75-year actuarial deficit is projected to be 2.02 percent of taxable payroll—an increase from last year's projected deficit of 1.97 percent. This means that to bring the HI trust fund into balance over the 75-year period, either program outlays would have to be immediately reduced by 38 percent or payroll tax income immediately increased by almost 70 percent, or some combination of the two.

The trustees' report also projected that the trust fund for Medicare's HI component would remain solvent until 2030. However, the projection that the HI trust fund is not facing imminent insolvency does not mean that we can or should wait until 2030 to take action. Although HI revenues currently exceed HI outlays, the March 2002 trustees' report projects that cash deficits will reemerge in 2016 and grow larger with each passing year. (See fig. 5.) Unlike private trust funds that can set aside money for the future by investing in financial assets, the Medicare HI trust fund is essentially an accounting device. It allows the government to track the extent to which earmarked payroll taxes cover Medicare's HI outlays. While the U.S. Treasury securities in the HI trust fund are backed by the full faith and credit of the U.S. government, they essentially represent an unfunded promise to pay, which will require tough fiscal choices in future years.

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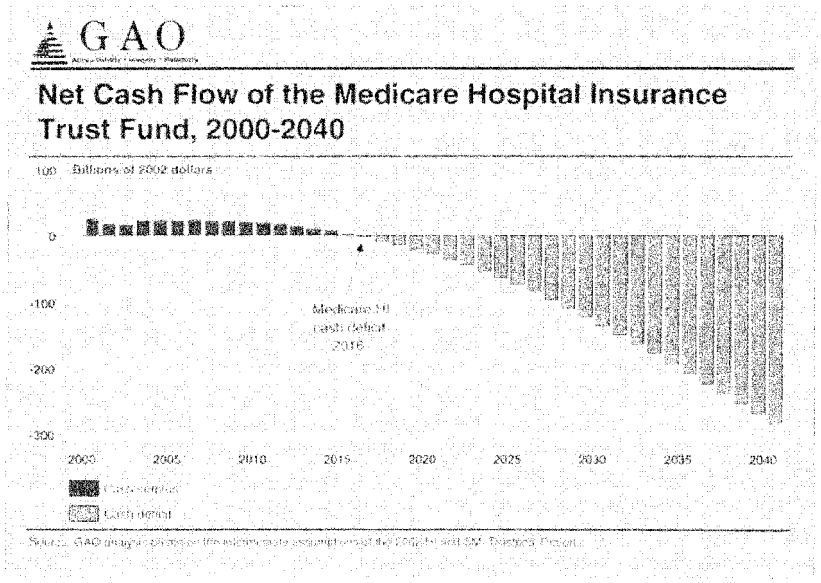
[6] Weiss Ratings Inc., "Prescription Drug Costs Boost Medigap Premiums Dramatically," http://www.weissratings.com/NewsReleases/Ins_Medigap/20010326Medigap.htm (Palm Beach Gardens, Fla.: Mar. 26, 2001).

[7] John A. Poisal and Lauren Murray, "Growing Differences Between Medicare Beneficiaries With and Without Drug Coverage," Health Affairs vol. 20, no. 2 (March/April 2001).

**FIGURE 5: NET CASH FLOW OF THE MEDICARE HOSPITAL INSURANCE TRUST FUND, 2000–2040.**




To finance its cash deficits, the HI trust fund will need to draw on the special-issue Treasury securities acquired during the years when the program generated cash surpluses. The negative cash flow will place increased pressure on the federal budget. In essence, for HI to "redeem" its securities, the government will need to obtain cash through some combination of increased taxes, spending cuts, increased borrowing from the public (or correspondingly less debt reduction than would have been the case had cash flow remained positive).

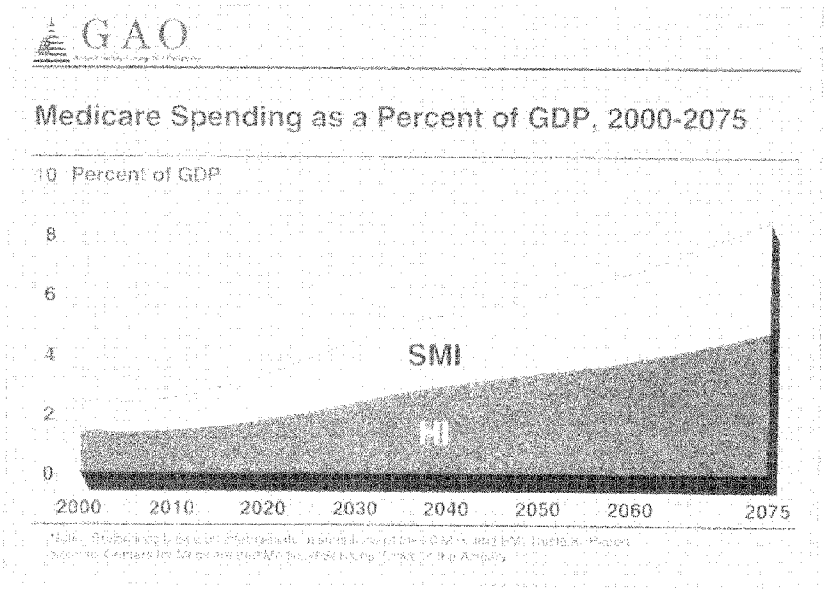
A focus on HI solvency alone, however, does not provide a complete picture of the Medicare program's expected future fiscal claims. The Supplementary Medical Insurance (SMI) portion of Medicare, which covers physician and outpatient hospital services, diagnostic tests, and certain other medical services, is not reflected in the HI solvency measure. SMI is largely funded through general revenues and its outlays are projected to grow even faster than HI outlays in the near future.

**Bleak Outlook for Medicare's Long-Term Sustainability Increases Urgency for Program Reform**

Without meaningful reform, the long-term financial outlook for Medicare is bleak. Together, Medicare's HI and SMI expenditures are expected to increase dramatically, rising from about 11 percent of federal revenues in 2001 to more than one-quarter by mid-century. Over the same time frame, Medicare's expenditures are expected to more than double as a share of the nation's economy, from 2.4 to 6.0 percent, as shown in figure 6. Moreover, relatively fewer potential workers will be available to shoulder Medicare's financial burden. In 2000 there were 4.9 working-age persons (18 to 64 years) per elderly person, but by 2030, this ratio is projected to decline to 2.8.[8]

[8] For the HI portion of Medicare, in 2001 there were 4 covered workers per HI beneficiary. Under their intermediate 2002 estimates, the trustees project that by 2030 there will be only 2.4 covered workers per HI beneficiary.

**FIGURE 6: MEDICARE SPENDING AS A PERCENTAGE OF GDP, 2000–2075**




The progressive absorption of a greater share of the nation's resources for health care is in part a reflection of the rising share of the population that is elderly. Medicare's rolls are expanding and are projected to increase rapidly with the retirement of the baby boomers. Today's elderly make up about 12 percent of the total population; by 2030, they will comprise 20 percent. Medicare growth rates, however, reflect not only a rapidly increasing beneficiary population, but also the escalation of health care costs at rates well exceeding general rates of inflation.

When viewed from the perspective of the entire budget and the economy, the growth in Medicare spending will become progressively unsustainable over the longer term. Our updated budget simulations show that to move into the future with no changes in federal health and retirement programs is to envision a very different role for the Federal Government. Assuming, for example, that last year's tax reductions are made permanent and discretionary spending keeps pace with the economy, spending for net interest, Social Security, Medicare, and Medicaid consumes nearly 50 percent of federal revenue by 2015 and more than three-quarters of federal revenue by 2030, leaving little room for other federal priorities including defense and education. (See fig. 2.) By 2050, total federal revenue is insufficient to fund entitlement spending and interest payments, resulting in deficits that are escalating out of control.

Our long-term simulations illustrate the magnitude of the fiscal challenges associated with an aging society and the significance of the related challenges the government will be called upon to address. As I have stated previously, early action to reform Medicare and other programs would yield the highest fiscal dividends for the federal budget and would provide a longer period for prospective beneficiaries to make adjustments in their own planning.[9] Waiting to build economic resources and reform future claims entails significant risks. First, we lose an important window during which today's relatively large workforce can increase savings and enhance productivity, two elements critical to growing the future economy. Second, we lose the opportunity to reduce the interest burden on the federal budget, thereby creating a legacy of higher debt. Third and most critically, we risk losing the oppor-

[9] U.S. General Accounting Office, Budget Issues: Long-Term Fiscal Challenges, GAO–02–467T (Washington, D.C.: Feb. 27, 2002) and Medicare: New Spending Estimates Underscore Need for Reform, GAO–01–1010T (July 25, 2001).

tunity to phase in changes gradually so that all affected parties can make the adjustments needed to adequately plan for the future.

Unfortunately, our long-range challenge has become more difficult, and the window of opportunity to address the entitlement challenge is narrowing. It remains more important than ever to return to these issues over the next several years. Ultimately, the critical question is not how much a trust fund has in assets, but whether the government as a whole can afford the promised benefits now and in the future and at what cost to other claims on scarce resources.

**Private Health Insurance Principles Should Guide Reform Efforts**

Given the current federal fiscal environment, we cannot afford to ignore the difficult policy choices that must be made to keep the Medicare program on a sustainable footing. Adding prescription drug coverage to the Medicare benefit package would require balancing competing concerns about program sustainability, federal obligations, and the hardship faced by some beneficiaries. The addition of a benefit that has the potential to be massively expensive should be focused on meeting the needs deemed to be of the highest priority. This focus would entail targeting financial help to beneficiaries most in need and, to the extent possible, avoiding the substitution of public for private coverage. I continue to maintain, that, optimally, benefit expansions should be made in the context of overall program reforms that are designed to make the program more sustainable over the long term.

Several basic principles of health insurance provide a framework for keeping any new prescription drug benefit more affordable for both beneficiaries and the taxpayers. First, as health insurance is intended to protect individuals against large, or catastrophic, expenses, a well-designed benefit should limit beneficiaries' liability for out-of-pocket expenses. Second, a benefit should be designed to include reasonable cost-sharing to encourage the appropriate use of services. Third, the benefit should include features to avoid adverse selection, that is, avoid covering only beneficiaries who will use the benefit. Including the individuals who may not currently need the benefit—but may need it in the future—can spread the risk and help keep the cost down for everyone.

Leading proposals to integrate prescription drug coverage into the Medicare program, to varying degrees, incorporate these principles. For example, the proposals commonly limit a beneficiary's financial liability for prescription drug costs. They seek to restrain inappropriate spending, in part by requiring cost-sharing in the form of a deductible and coinsurance. To make drug coverage attractive to a broader spectrum of beneficiaries, the proposals subsidize the beneficiary premium. To further encourage beneficiaries to sign up for prescription drug coverage when they are healthy, the proposals include provisions that discourage delayed enrollment. Finally, because even modest cost-sharing amounts might prove too burdensome for some individuals, the proposals include targeting mechanisms to help prevent low income from becoming a barrier to obtaining prescription drug coverage.

Although the leading prescription drug coverage proposals share certain key design features, they differ in important details, such as the amount of required cost sharing and the limit on beneficiary out-of-pocket costs. These differences reflect trade-offs in cost-control mechanisms, benefit generosity, and protections for beneficiaries with high needs. Careful debate about the different trade-offs is important, because both the overall design of a new benefit and the associated details determine the likely impact on both beneficiaries and taxpayers. Frankly, we know that incorporating a prescription drug benefit into the existing Medicare program will add hundreds of billions of dollars to program spending over the next 10 years. For this reason, I cannot overstate the importance of adopting meaningful financial reforms to ensure that Medicare remains viable for future generations.

**Concluding Observations**

Updating the Medicare benefit package may be an important step in addressing an aging society's legitimate expectations for health care. Expanding access to prescription drugs could ease the significant financial burden some Medicare beneficiaries face because of outpatient drug costs. However, it is essential that we not take our eye off the ball. The most critical issue facing Medicare is the need to ensure the program's long-range financial integrity and sustainability. Care must be taken to ensure that any potential expansion of the program be balanced with other programmatic reforms so that we do not worsen Medicare's existing financial imbalances. The program needs to include adequate fiscal incentives to control costs and should be carefully targeted to meet genuine needs while remaining affordable.

This generation has a stewardship responsibility to future generations to reduce the debt burden they will inherit, to provide a strong foundation for future economic growth, and to ensure that future commitments are both adequate and affordable.

Changes need to be considered as part of a broader initiative to address Medicare's current fiscal imbalance and promote the program's longer-term sustainability. Balancing these competing concerns may require the best from government-run programs and private sector efforts to modernize Medicare for the future. Medicare reform and modernization are best done with considerable lead-time to phase in changes and take action before the changes that are needed become dramatic and disruptive.

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

**Contacts and Acknowledgments**

For future contacts regarding this testimony, please call William J. Scanlon, Director, Health Care Issues, at (202) 512–7114 or Laura A. Dummit, Director, Health Care—Medicare Payment Issues, at (202) 512–7119. Other individuals who made key contributions include Linda Baker, James Cosgrove, Hannah Fein, James McTigue, Jennifer Podulka, and Lisa Rogers.

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Mrs. JOHNSON OF CONNECTICUT. [Presiding.] Thank you very much, Mr. Walker.

I am going to turn first to Mr. McCrery, and we will get through as many questioners as possible before we have to go vote.

Mr. MCCRERY. Thank you, Madam Chair.

Mr. Walker, I thought your testimony was excellent, and it attempts to ring the bell that we need to pay attention. I have said several times in this Committee room that I think Congress is fiddling while the budget is burning. You try to underscore that in your testimony and I appreciate that.

One thing you say, though, that I think may leave with some the wrong impression, you say that assuming the 2001 tax cut is made permanent, then by 2050, Medicare, Medicaid, Social Security, and interest on the debt will consume all Federal revenues. One might hear that and think, gee, this tax cut, if made permanent, will reduce revenue so much that we will not have enough to pay for everything, and in fact, if you look at the chart that you have up right now, there is a thin black line that is hard to see for the Members, but if they look closely, they can see a thin black line that goes across the chart and it is entitled, "Revenues," and it is expressed as a percent of the gross domestic product (GDP). If you look closely, you can see that even if the tax cut is made permanent, that revenues as a percent of our National income remain steady. I cannot tell exactly, but it looks like it is somewhere around 18 to 19 percent of GDP, is that correct?

Mr. WALKER. About 19 percent, roughly, of GDP, that is correct.

Mr. MCCRERY. And historically, Mr. Walker, what have revenues to the Federal Government been as a percent of GDP?

Mr. WALKER. The highest that it has ever been, I believe, Mr. McCrery, was just under 21 percent of GDP, and I think your point is excellent, and that is no matter what happens with regard to the tax system, whether or not the current tax changes are made permanent or not, our imbalance is so huge that we need to begin to reform the base. We need to not only look at entitlement programs. We also have to look at discretionary spending to find out what is working and what is not working because the numbers just do not add up and we are not going to be able to deliver on our promises unless we make some fundamental changes.

Mr. MCCRERY. Exactly, but I wanted to underscore that your assuming the 2001 tax cut is made permanent is not a criticism of making the tax cut permanent and your conclusion is not that revenues will dip as a result of that. You are just trying to paint a scenario that you think is a realistic one, because most of those tax cuts eventually will be made permanent, we think, most people think.

Mr. WALKER. I did it this way for several reasons. One, I know that is how the House passed the bill.

Mr. MCCRERY. Right.

Mr. WALKER. And secondly, by showing it this way, you can see that even if the tax cut is not extended, we still have a huge problem. So by doing it this way, you can see both ways, because otherwise what you would do, Mr. McCrery, as you properly pointed out, you would just extend that black line all the way across. It would not dip as it does between 2000 and 2015. It would not dip. In any event it is still way out of balance.

Mr. MCCRERY. Right. Twelve or thirteen years ago when I was on the Budget Committee, I asked Chairman Greenspan, who was appearing before the Budget Committee, if he was concerned that as we raised revenues to meet these obligations and we started to take in 23, 24 percent of GDP or higher for revenues, did that disturb him as an economist in terms of the nature of our economy, the nature of our society, and he responded yes, that it did. If we allow the Federal Government to take in too high a percent of what we produce as a country, that it could very well change the nature of our society.

And I am concerned about that, too, but I think we have to start talking about these kinds of choices in an honest, straightforward way, and we have not done that, so I appreciate very much your pointing these things out.

Mrs. JOHNSON OF CONNECTICUT. Mr. Walker, if I may, we only have 5 minutes before we must actually leave to vote. I am going to forego my questions, and I am very pleased that my colleagues here are going to try to fit their time in so that then you can leave, and we can convene the last panel as soon as the next three votes are over.

Mr. Becerra?

Mr. BECERRA. I thank the gentlelady for yielding the time, and I will try to be brief in my remarks and hope my two colleagues have an opportunity, as well, to question.

Mr. Walker, first, thank you very much for being here. I want to make sure we are clear on something here. As much as some people might want to portray this as a "sky is falling" situation for Medicare, in fact, Medicare has never found itself in a better position when it comes to surviving over the next several years, is that not correct?

Mr. WALKER. Yes, but I think we have to be very careful. Medicare has never been in a good financial condition.

Mr. BECERRA. We have never been at a point where we can say that we can see it extending for 75 years, but——

Mr. WALKER. Right.

Mr. BECERRA. Today, the projection is that we can see it at least going for the next 28 years, and we have never, over the history

of Medicare, been able to say that we have been able to project that it would be able to survive 28 years with things as they are. I am not trying to imply that that is good. I am just trying to make sure it is clear that it is better than it has been before and we now have to address the fact that with the Baby Boom generation and the high cost of medical care, we do need to do something.

Let me ask a question, because I know I want to be brief and give my colleagues some time. That chart, I think, is very telling that you provide to us, and over the next 40 to 50 years, we can see, assuming these projections are correct, where we will be spending our Federal dollars. According to your chart, the biggest expenditure we are going to have within that bar, the four blocks that you show, Social Security, Medicare, Medicaid, and other domestic programs and interest on national debt, the largest is the interest on the national debt, in essence, moneys that will never benefit any particular person, will do nothing to improve a program, because it is just going to pay a debt, and not even the principal on that national debt but just the interest we owe on that debt.

Now, in a previous chart, you show in the last 10 years, we have actually decreased the interest payments that we have been making on the national debt and that is because of the prosperity that we saw over the last 8 to 10 years before we hit this recession within the last couple of years. But let me ask you this. If I were to give you $400 billion right now and say, over the next 10 years, I can give you $400 billion and let us spend it on reducing the interest payments on the national debt, would the size of that blue block within that final bar for 2050 be as big?

Mr. WALKER. Well, it would go down, obviously. If you end up paying down debt held by the public, then obviously you are going to pay less interest, and over time, the power of compounding is very significant.

Mr. BECERRA. So if we could take the $400 billion that it is estimated we are going to take in within the Medicare trust fund in surplus money, in other words, money that the Medicare system does not need to use to pay out for benefits, if we were to take that surplus money in the Medicare trust fund and put it into paying down the national debt as opposed to what the President has proposed in his budget over the next 10 years, of spending it on things, including another tax cut, would we not be able to reduce the size of the national payment on interest?

Mr. WALKER. Well, you would, but you would have to cut the other spending that the money is associated with.

Mr. BECERRA. Absolutely. You would have to make some hard choices. Let me stop there and yield the remainder of my time.

Mrs. JOHNSON OF CONNECTICUT. Let me recognize Congresswoman Thurman from Florida.

Mrs. THURMAN. Just very quickly, and probably to that point, because I think it was a very big concern for some of us when Secretary Thompson told us that the Federal tax policy is not taken into consideration when the Administration considers the Medicare prescription drug benefit, so I would ask you as the Comptroller General, is that wise fiscal policy, for us to ignore the financial im-

pact of tax policy when planning for other Federal spending like Medicare?

Mr. WALKER. We look at the bottom line, and the bottom line is basically the difference between the revenues and the expenditures. What I am trying to do here is to not get in the debate about whether or not to extend the tax cut——

Mrs. THURMAN. But your bottom line would be based on spending?

Mr. WALKER. It would be a——

Mrs. JOHNSON OF CONNECTICUT. If I may, we only have 2½ minutes left. Mr. Doggett, would you——

Mr. DOGGETT. Thank you. Thank you for your service, particularly when some last year wanted to give a blank check to the airlines. I appreciate the role that your office played in looking at that problem.

With reference to the predicament that you described here today and in trying to look toward the best policy answers, the one that has been discussed here today perhaps the most is Medicare+Choice. Has GAO not done some studies of Medicare+Choice that suggest that it is not a panacea?

Mr. WALKER. It is not a panacea, but part of the issue is the way Medicare+Choice was designed, the reimbursement rate was such that, in fact, it turned out not saving the Federal Government very much money. What ended up happening is that the providers wanted, in order to be able to attract individuals to their plans, to provide additional benefits as an incentive for them to be able to come into the plans, which they did. They also wanted to be able to make a profit margin, which is appropriate. But the problem is that the numbers did not add up. There is no question that choice can help to control cost and to improve quality, but it has to be designed carefully.

Mr. DOGGETT. One of those GAO studies, for example, showed that the payment increases that we approved here in Congress have not led to increased benefits or availability for seniors, did it not?

Mr. WALKER. I would have to look at the detailed study.

Mr. DOGGETT. And did not another one——

Mrs. JOHNSON OF CONNECTICUT. Mr. Doggett, if I may, we have about 30 seconds left to vote.

Mr. DOGGETT. Last question.

Mrs. JOHNSON OF CONNECTICUT. They are going to hold it open a couple of minutes.

Mr. DOGGETT. Did the GAO not also find that Medicare+Choice plans are generally overpaid compared to traditional Medicare?

Mr. WALKER. In some cases, yes, we did, and——

Mrs. JOHNSON OF CONNECTICUT. I would just like to add on the record that the Medicare+Choice plans did not receive anywhere near the increases that the fee-for-service plan received, and also that these rosy estimates of how healthy Medicare is are based on incredibly faulty assumptions. They assume that we can cut physicians 5 percent several more years, an absolutely unsustainable assumption. We will have no doctors in the program if we do that.

So we are talking big picture issues. I think the issues that have been raised here have been very legitimate, but do not for a minute think that there is anything rosy about the financial circumstances of Medicare, particularly as we face the need for prescription drugs amongst our seniors and better ability to manage chronic illness.

Thank you very much, Mr. Walker.

Mr. WALKER. Thank you.

Mrs. JOHNSON OF CONNECTICUT. We will return in about 15 minutes for the last panel.

Mr. WALKER. Thank you, Madam Chair.

[Recess.]

Mrs. JOHNSON OF CONNECTICUT. If the panel will seat itself. Mr. Bruce Bradley, Director of Health Plan Strategy and Public Policy of General Motors; Ray Gilmartin, President and chief executive officer of Merck; William Novelli, the Executive Director and Chief Executive Officer of AARP; John Rector, the Vice President of government Affairs and General Counsel for the National Community Pharmacists Association; and Mitchel Sayare, President and Chief Executive Officer of ImmunoGen.

Thank you for your patience today. My apologies for your having to wait so long to testify, but we do welcome you to this hearing and consider this a very important part of educating ourselves to write the quality policy that we need to provide prescription drugs to seniors.

Mr. Bradley, if you will start, and we will move right across the panel.

**STATEMENT OF BRUCE E. BRADLEY, DIRECTOR, HEALTH PLAN STRATEGY AND PUBLIC POLICY, GENERAL MOTORS CORPORATION, DETROIT, MICHIGAN**

Mr. BRADLEY. Madam Chairwoman. I am Bruce Bradley, Director of Health Plan Strategy and Public Policy at General Motors (GM). It is a real honor for me to testify before this historic Committee as you work to design and to pass a Medicare prescription drug benefit.

As we have heard, there are few issues more important to seniors and other Medicare beneficiaries than filling the coverage gap represented by the absence of a Medicare drug benefit. But the enactment of a meaningful Medicare drug benefit is just as critical to employers, both public and private, who are struggling to provide retiree health coverage while facing double-digit increases in health insurance premiums and particularly pharmaceutical costs.

We at GM commend the Ways and Means Committee for addressing this issue. My testimony will focus on the challenge GM faces in the delivery of our pharmaceutical benefit, how we manage it, and what our priorities would be for a Medicare drug benefit.

The GM provides coverage to over 1.2 million workers, retirees, and their families. We are the largest private provider of health care coverage in the country. The GM spends over $1.3 billion a year on prescription drugs for these beneficiaries. Despite our aggressive management, the current 15 to 20 percent annual growth rate is still more than quadruple the general inflation rate. Although GM's Medicare-eligible population represents a third of our

covered population, it accounts for nearly half of our drug costs, or $508 million a year.

The current financing challenges posed by our Medicare-eligible population will only grow worse as the Baby Boom generation starts to retire. Prescription drug costs literally threaten the ability of many U.S. companies to compete in a global marketplace.

The GM's response to the multi-faceted challenge of rising drug costs is comprehensive, with a focus on assuring the best medical outcomes and value. We have a great deal of experience in administering a drug benefit and believe that our management techniques have made a positive difference in the quality and value of the benefit we offer.

First, we have a full-time doctorate-level clinical pharmacist on our staff who oversees our team and the Pharmaceutical Benefits Manager, or PBM. We have utilized PBMs to help effectively purchase medications and have ensured that our beneficiaries and that the company receive the benefits of their negotiations through very explicit performance standards.

Our contracts with the PBMs encourage medically appropriate and cost effective prescribing and dispensing practices. This includes consumer and health care professional education programs, incentives to utilize high quality, cost effective generic drugs, appropriate dosing, physician profiling, severe drug-to-drug interaction avoidance, and other safety processes. We are also engaged in many community-based prescription drug initiatives.

Notwithstanding our concerns about drug costs, we believe that all Medicare beneficiaries should have access to an affordable, meaningful drug benefit. It is quite clear that in many cases, prescription drugs are the most clinically appropriate and cost effective treatment. We, therefore, believe that any Medicare drug benefit should include the following four components.

First, the Medicare drug benefit should be universal in nature. All beneficiaries should have the choice of an affordable drug benefit. Virtually every private insurer for the under-65 population recognizes that this is an essential element to have a drug benefit for quality medical care today. Moreover, the distribution of seniors without prescription drug coverage is not limited to low-income populations. In fact, about half of those seniors without coverage have incomes of over 200 percent of the poverty level.

Second, the drug benefit should be affordable to beneficiaries and taxpayers yet provide significant coverage. This will require a significant investment of Federal dollars. We well recognize, however, that Congress has to achieve a bipartisan consensus around what level of Federal dollars are available for such an investment, and clearly, resources are not infinite. These limited financial resources underscore the importance of a well managed, cost effective prescription drug benefit.

Third, the design of the Medicare drug benefit must be oriented to achieve positive medical outcomes and value. To that end, the benefit should be designed to encourage appropriate use of high quality, cost effective generic medications, require cost sharing that guards against excessive and inappropriate utilization, and integrate state-of-the-art pharmacy management techniques.

Finally, a drug benefit should provide incentives for employers who are already financing prescription drug coverage for Medicare-eligible individuals to continue to do so. We recognize that the Congress may not be able to afford the same level of benefits that many leading corporations now provide, but Medicare should offer a much-needed floor of protection. As such, it should ensure that employers and health plans currently providing drug coverage can design benefits to wrap around Medicare, or alternatively, Medicare should provide these entities with direct financial subsidies that are equivalent to the value of the underlying Medicare benefit. Such policies avoid penalizing employers who have voluntarily provided such coverage and slow the trend of companies withdrawing benefits for the Medicare population.

In conclusion, GM well recognizes your design, financing, and other challenges. We hope that our experience as well as our support can help you develop and pass a long-overdue Medicare drug benefit. We look forward to working with you in the days and months to come. Thank you.

[The prepared statement of Mr. Bradley follows:]

**Statement of Bruce E. Bradley, Director, Health Plan Strategy and Public Policy, General Motors Corporation, Detroit, Michigan**

Mr. Chairman, Ranking Member Rangel, and distinguished Committee members, I am Bruce Bradley, Director of Health Plan Strategy and Public Policy at General Motors (GM). It is an honor to testify before this historic Committee as you work to design and to pass a Medicare prescription drug benefit.

There are few issues more important to seniors, eligible people with disabilities, their families—and employers—as filling the coverage gap represented by the absence of a Medicare prescription drug benefit. Moreover, a meaningful prescription drug benefit is critically important to employers, who are struggling to provide retiree health coverage while facing double-digit increases in health insurance premiums and pharmaceutical costs.

GM faces extraordinary financing and delivery challenges in the Administration of our prescription drug benefits, particularly as it relates to the benefits we provide to our retirees. We have a great deal of experience in administering drug benefits and well recognize the challenges you face in attempting to design a workable and meaningful drug benefit for the Medicare program.

We commend the Ways and Means Committee for addressing this issue. My testimony will focus on the challenge GM faces in the delivery of our pharmaceutical benefit, how we manage it, and what our priorities would be for a Medicare prescription drug benefit. It is our hope that the lessons we've learned can be useful to this Committee as it takes critical steps towards achieving a bipartisan agreement on a meaningful and universal Medicare prescription drug benefit.

**Prescriptions Drug Cost Challenges Facing GM**

GM insures 1.2 million workers, retirees and their families. We are the largest private provider of health care coverage. GM spends over $1.3 billion a year on prescription drugs for its current and retired workforce and their families. Despite our aggressive management of our prescription drug benefit and associated costs, the current 15–20 percent annual growth rate still more than quadruples the general inflation rate, and clearly represents a troubling trend.

From our perspective, these drug costs are driven by a multitude of factors, including increased utilization (both appropriate and inappropriate), and price. While we are attempting to manage these costs through a number of interventions that will be outlined later in this testimony, we do not see significant potential to reduce the trend without assistance from the federal government. More specifically, only the federal government can pass legislation to increase coverage by enacting a Medicare drug benefit.

Although GM's Medicare-eligible population represents only 33 percent of our covered population, it accounts for about nearly half of the prescription drug cost or $508 million. The current financing challenges that our Medicare-eligible population poses will only grow worse as the baby boom generation starts to retire less than ten years from today. The growing financial burden posed by prescription drug costs

literally threatens the ability of many U.S. companies to be effective competitors within the world marketplace. If we do not get a handle on these costs in short order, companies will have to make undesirable choices that may limit access or shift costs to current and retired workforce. Faced with overwhelming retiree health cost challenges, many other companies have actually chosen to drop health benefits for this population. In fact, between 1994 and 2001, there was a 43 percent decline in firms offering retiree coverage.[1]

**GM Management of Drug Benefit Plans**

GM has responded to the multi-faceted challenge of rising prescription drug costs with a multi-faceted management response, with a mind to assuring the best medical outcomes and value. We have a great deal of experience in administering a drug benefit and believe that our management techniques have made a positive difference in the quality and value of the benefit we offer, and could be applied to the design of a Medicare drug benefit.

We have utilized pharmacy benefit managers (PBMs) to help effectively purchase medications, and have ensured that the company receives the benefits of their negotiations through very explicit performance standards. Our contracts with PBMs encourage medically appropriate and cost-effective prescribing and dispensing practices. 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:** Addresses unique concerns of patients with gastro-intestinal disease. It provides educational materials to enrollees and encourages appropriate prescribing practices by physicians.
- **Dose Optimization:** Simplifies the dosing regimen for patients and capitalizes on cost savings of taking one pill versus two.
- **Encourage High Quality, Cost-Effective Generic Drug Use:** 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.

**GM's Priorities for a Medicare Benefit**

GM believes that all Medicare beneficiaries—both seniors and eligible people with disabilities alike—should have access to an affordable, meaningful Medicare drug benefit. Notwithstanding our concerns about prescription drug costs, we regard such coverage as necessary because in many cases, prescription drugs are the most clinically appropriate and cost-effective treatment.

We therefore believe that any Medicare drug benefit should include the following four components:

- First, a Medicare drug benefit should be universal in nature. All Medicare beneficiaries should have the choice of an affordable drug benefit. The Medicare program has largely been a great success, representing the only population in this nation with the benefit of universal coverage. Virtually every private insurer for the under-65 population recognizes that it is essential to have a prescription drug benefit for quality medical care today.
- Moreover, the distribution of seniors without prescription drug coverage is not limited to low-income populations. In fact, fully half of those seniors without coverage have incomes over 200 percent of the poverty level. Further, of those seniors who do have coverage today, many have extremely limited coverage or are at risk of losing their good coverage because of cost. Addressing this problem effectively, therefore, means designing a universal benefit.

[1] William P. Mercer. Health Benefit Costs Up 11.2% in 2001—Highest Jump in 10 Years. National Survey of Employer-Sponsored Health Plans 2001. New York: William P. Mercer, Inc.

• Second, a Medicare prescription drug benefit should be meaningful and affordable to both beneficiaries and taxpayers. To ensure a stable and accessible drug benefit that is voluntarily chosen by all beneficiaries, it will be necessary to design a substantive benefit that has an affordable premium. This will require a significant investment of federal dollars. We well recognize, however, that Congress has to achieve a bipartisan consensus around what level of federal dollars are available for such an investment, and clearly resources are not infinite. This underscores the importance of a well-managed, cost-effective prescription drug benefit.

• Third, the design of the Medicare prescription drug benefit must be oriented to achieve positive medical outcomes and value. Just as important as designing an affordable, meaningful, and universal drug benefit is managing it well. It would be irresponsible for the Congress to pass a drug benefit without significant attention towards ensuring that the benefit is cost-effectively designed and managed. To that end, the benefit should be designed to encourage appropriate use of high-quality, cost-effective generic medications, require cost-sharing that guards against excessive and inappropriate utilization, and integrates state-of-the-art pharmacy management techniques that ensure the use of high-quality, high-value pharmaceuticals.

• Lastly, a prescription drug benefit should provide incentives for employers who are already financing prescription drug coverage for Medicare-eligible individuals to continue to do so. We recognize that the Congress may not be able to afford the same level of benefits that many leading corporations provide to their beneficiaries, but it should provide a much-needed floor of protection. As such, it should ensure that employers and health plans currently providing drug coverage can design benefits to wrap around Medicare. Or, alternatively, Medicare should provide these entities with direct financial subsidies that are equivalent to the value of the underlying Medicare benefit. Such policies would appropriately avoid penalizing firms who have generously and voluntarily provided such coverage and slow the recent trend of companies withdrawing their benefits for these populations.

**Conclusion**

GM well recognizes the design, financing, and other challenges the Congress faces in constructing and passing a Medicare prescription drug benefit. There are few domestic policy issues that are more important to successfully address. We hope that our experience, as well as our support, can help you develop and pass a long-overdue Medicare drug benefit. We look forward to working with you in the days and months to come.

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Mrs. JOHNSON OF CONNECTICUT. Thank you very much, Mr. Bradley. Mr. Gilmartin, it is a pleasure to see you.

## STATEMENT OF RAYMOND V. GILMARTIN, CHAIRMAN, PRESIDENT, AND CHIEF EXECUTIVE OFFICER, MERCK & CO., INC., WHITEHOUSE STATION, NEW JERSEY

Mr. GILMARTIN. Thank you, Madam Chairwoman and Members of the Committee. I am pleased to have this chance to appear today to discuss Medicare prescription drug coverage.

At Merck, we believe it is not enough to just discover medicines, we have to make sure these medicines get to those who need them. Medicines change lives and increase lifespans. Medicines can now control common illnesses in later life that once meant certain death, such as diabetes and heart disease. Work in Merck laboratories today holds great promise for creating tomorrow's medicines, and these are medicines we need to prevent and treat Alzheimer's disease, HIV/AIDS, cancers, depression, and other illnesses that can rob us of our independence and prematurely take our loved ones from us.

Sadly, for those seniors and disabled persons without good drug coverage who cannot afford the medicines they need, the promise of medicines is unfulfilled. These people also lack the coordination of care that comes with good coverage. Consequently, they may take medicines in dangerous combinations or dosages that actually jeopardize their health and quality of life.

Our seniors deserve better, and that is why Merck is so strongly committed and supports action this year to add prescription drug coverage to Medicare, along with other changes to the Medicare Program to improve its Administration and competitiveness, as well as better coordinate care around the patient.

All Medicare beneficiaries should have a choice of private sector comprehensive health plans that include drug coverage. Those choosing to remain in the traditional Medicare Program should be able to get drug coverage through competing private sector prescription drug plans.

We understand that a critical question facing this Committee is how best to deliver a quality prescription drug benefit while containing its costs. As a pharmaceutical company, we hear the concerns of employers, governments, and ordinary citizens about the cost of medicine. As a provider of pharmaceutical benefits to more than 65 million Americans, including more than 8 million seniors through our subsidiary Merck-Medco, we also understand the challenges of cost containment.

We believe that the answer to cost containment and that question has profound implications, not only for taxpayers and Medicare beneficiaries, but also for the future health of patients and America's research-based pharmaceutical industry.

Merck supports allowing providers of Medicare prescription drug benefits to use a full range of clinically appropriate cost containment strategies. Specifically, Merck supports giving competing private prescription drug plans the ability to engage in tough price negotiations with pharmaceutical companies. Plans must have the ability to encourage the use of the most cost effective, appropriate medicine, whether that medicine is a brand or a generic.

We also believe that prescription drug benefit providers who serve Medicare beneficiaries should have financial incentives that ensure that they fully use these cost containment strategies. The best way to accomplish this, first, is to have prescription plans compete with each other to enroll beneficiaries based on quality and premium cost, and second, to put these plans at some financial risk to contain costs. These strategies will subject our medicines to tough scrutiny and ensure that their price reflects their value in treating disease and improving health.

We are encouraged that the major proposals under consideration for providing prescription drug coverage to Medicare beneficiaries have rejected the alternative path for cost containment, government price controls. Having government officials determine which medicines will be available and at what price through price setting, reference pricing, mandatory rebates, or other bureaucratic tools is a sure path to impeding pharmaceutical research. Throughout the world, price controls have proven ineffective in controlling overall costs or improving patient health.

Madam Chairwoman, we hope that the Committee will look to the work of the bipartisan Medicare Commission as the best guide to needed Medicare modernization. We also support the ideas contained within the Breaux-Frist plan, this Committee's own H.R. 4680, and President Bush's Medicare proposals. These are strong building blocks for action.

At Merck, we believe it is possible to craft a Medicare prescription drug benefit that meets the needs of our Nation's seniors and persons with disabilities while maintaining an environment that rewards success in new drug discovery. Such an environment will allow Merck and others to continue to lead the world in discovering the medicines that improve and save lives.

Thank you again for this opportunity to present our views and I look forward to your questions.

[The prepared statement of Mr. Gilmartin follows:]

**Statement of Raymond V. Gilmartin, Chairman, President, and Chief Executive Officer, Merck & Co., Inc., Whitehouse Station, New Jersey**

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Thank you again for this opportunity to present our views and I look forward to your questions.

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Mrs. JOHNSON OF CONNECTICUT. Thank you, Mr. Gilmartin. Mr. Novelli?

**STATEMENT OF WILLIAM D. NOVELLI, EXECUTIVE DIRECTOR AND CHIEF EXECUTIVE OFFICER, AARP**

Mr. NOVELLI. Thank you, and thank you for inviting AARP to address the need for a Medicare prescription drug benefit.

Comprehensive prescription drug coverage in Medicare this year is an urgent priority for our 35 million Members and for virtually all Americans. Prescription drug coverage options are increasingly limited, expensive, unstable, or unavailable. Our Members and their families need a meaningful Medicare benefit that is affordable and available to all beneficiaries. Many beneficiaries must pay for all or some of their prescription drugs out of pocket, and those without coverage must pay top dollar for their drugs.

The challenge of crafting a voluntary Medicare drug benefit is considerable. To succeed, it must be a workable program, and that is it needs to attract enough enrollees to spread risk and to be viable. It needs to ensure adequate protection for those with high drug costs, include assistance for low-income seniors and the disabled, and provide strong cost containment measures to help keep the program affordable and sustainable over time.

We clearly recognize the budget constraints, and they are greater than last year, but a comprehensive drug benefit will require a major funding commitment. People are not looking for a free ride. They know they will have to pay their share. But a realistic drug benefit must be adequately funded. A program with meager benefits and high premiums will not succeed because not enough beneficiaries will voluntarily enroll. At this point, it is not clear what an affordable benefit will ultimately cost, but we do know that the proposals offered last year were not embraced by the public.

As you are aware, it will be difficult to develop a workable package that fits within the House budget allocation, but we intend to look at what this Committee proposes as well as other proposals

with an open mind. We will bring these proposed programs to our Members to get their reactions and responses. We will continue to listen carefully to their expectations. We will inform our members about what seems to be realistic and possible, and we will share their views with you.

There are two additional components to our prescription drug position. First, we recognize that cost containment is an important part of Medicare drug coverage. For a benefit to be affordable and sustainable over time, there must be mechanisms in place to control the rapidly rising costs of prescription drugs.

In order to contribute to cost containment, we are launching this week a national education program through our own publications, the general media, and at the community level, aimed at our Members and the public. This program will stress the wise and safe use of medications with an emphasis on generic drugs.

I would like to call your attention to that print ad on the easel over there. I am sure you cannot read it from where you are sitting, but it says, "Before you take your medicine, take this advice," and then as you go down, the top one says, "Important, take exactly as directed, but first, call around and compare drug prices." The one underneath that, "Avoid paying too much for your prescriptions. Generics may work as well as brand names." And then, "Tell your physician and pharmacist everything you are taking. Some medicines do not interact well." And finally, "Do not let advertising sell you on drugs you do not need. Check up on your prescriptions."

In addition, we intend to become actively involved in litigation that can make lower-price generics more available and that can assist in other ways to contain costs.

Our final point is that we are not in favor of funding for a provider giveback package before agreement is reached on a Medicare prescription drug benefit. We believe that providers should be paid fairly, but it is not appropriate to increase provider payments without first ensuring that older Americans get the drug coverage they need.

We stand ready, and we pledge to provide assistance in every possible way that we can. We recognize that congressional support is needed from both sides of the aisle and from the Administration to achieve a meaningful Medicare drug benefit for all beneficiaries. The needs of older and disabled Americans who lack adequate drug coverage can no longer go unmet. We are asking Congress to act now. Thank you very much.

[The prepared statement of Mr. Novelli follows:]

**Statement of William D. Novelli, Executive Director and Chief Executive Officer, AARP**

Mr. Chairman and members of the Committee, I am Bill Novelli, Executive Director and CEO of AARP. On behalf of our organization and its 35 million members, I want to thank you for convening this hearing and for continuing your efforts to consider approaches for adding a much needed prescription drug benefit to the Medicare program.

As AARP looks toward building retirement security for today's older Americans and the baby boom population, we believe no person is economically secure without adequate medical insurance. The structure of retirement security is no longer simply the "three-legged stool" of Social Security, private pensions, and personal sav-

ings, but rather four pillars consisting of: Social Security, pensions and savings, earnings, and, importantly, stable, affordable and adequate health insurance.

Consequently, now more than ever, Americans of all ages are looking to Medicare's guarantee of affordable health care coverage as part of the foundation of their retirement planning. But there is a serious gap in Medicare's protection—the absence of reliable prescription drug coverage.

While modern medicine increasingly relies on drug therapies, the benefits of these prescription drugs elude more Medicare beneficiaries every day. Drug costs continue to rise unabated. Employer-based retiree health coverage is eroding. Managed care plans in Medicare have scaled back their drug benefits. The cost of private coverage is increasingly unaffordable. State programs provide only a limited safety net. Therefore, the need for a Medicare drug benefit for *all* beneficiaries will only continue to grow.

Given the prominence of drug therapies in the practice of medicine, if Medicare were being designed today—rather than in 1965—not including a prescription drug benefit would be as absurd as not covering doctor visits or hospital stays. That is one of the reasons why ensuring that prescription drug coverage is included in Medicare's defined benefit package is AARP's number one legislative priority this year. Our members and their families need and expect a meaningful benefit that is affordable and available to all beneficiaries. They expect us to be their champion on this issue, and we will be.

We are pleased to be here today to discuss the need for a Medicare prescription drug benefit, some of our recommendations for moving forward, and some initial findings of the public's reaction to prescription drug proposals as well as comment on the President's prescription drug proposal.

**The Need for a Medicare Prescription Drug Benefit**

Increasing need, high drug prices, and inadequate insurance coverage pose serious problems for today's Medicare beneficiaries. A chronic health problem necessitating new and expensive prescription drugs can quickly deplete a retiree's financial resources. Even a beneficiary who has planned well for his or her retirement may not be prepared for drug bills that exceed several hundred dollars a month. Further, it is important to note that support for making a prescription drug benefit part of Medicare is overwhelmingly high for all of our members. Americans of all ages recognize the value of prescription drug coverage. In recent polling conducted for AARP, eight in ten Americans age 45 and over favor making prescription drug coverage part of Medicare. Support was, in fact, greatest among the younger age brackets.

The majority of Medicare beneficiaries—not just those with low incomes—need drug coverage. While AARP strongly supports *additional* financial assistance in Medicare for low-income individuals, low-income assistance is *not* a substitute for a prescription drug benefit in Medicare. It will not solve the problem for millions of people with Medicare who are unable to afford their medications. Further, because AARP opposes means-testing within the Medicare program, we could not support a low-income-only drug benefit unless it were outside of Medicare.

Because of Medicare's current lack of prescription drug coverage, many beneficiaries must pay for all or some of their prescription drugs out-of-pocket. Although about two-thirds of Medicare beneficiaries have some type of coverage for prescription drugs, this figure can be very misleading. The principal sources of coverage that offer a prescription drug benefit—employer-based retiree coverage, private supplemental coverage, or Medicare HMOs—are often inadequate, limited, expensive, and unstable. Moreover, many Medicare beneficiaries do not have continuous prescription drug coverage. A Commonwealth study released earlier this year reported that nearly 42 percent of beneficiaries lacked drug coverage at some point in 1998. More recently, a new study published by *Health Affairs* reports that nearly 40 percent of Medicare beneficiaries had no drug coverage in the fall of 1999. It is also important to understand that those Medicare beneficiaries without coverage pay top dollar for their prescriptions because they do not benefit from discounts negotiated by third party payers. Most of those currently covered by insurance, including most workers, benefit from such discounted prices.

Let me give you some illustrative examples of how middle income people have difficulty in obtaining access to affordable and dependable drug coverage:

- A retired couple has significantly saved for retirement and has an income of $40,000 a year. Both take prescription drugs for heart disease and high cholesterol and the wife also needs medication for breast cancer and osteoporosis. They do not have access to retiree health benefits through a former employer, there are no Medicare+Choice plans available in their area, and a Medigap plan offering some drug coverage would cost them $260 a month each.

• A retired couple has an income of $30,000 a year, significantly above the threshold for Medicaid and most state and private pharmacy assistance programs. They have prescription drug coverage through a Medicare HMO. This year they learn, however, that their HMO plans to terminate its contract with Medicare, effective December 31. There are no other Medicare HMOs in their area, and while they can afford supplemental insurance and are guaranteed access to certain Medigap plans (A, B, C, and F), none of these plans include drug coverage.

• A 75-year old widow is enrolled in a Medicare HMO that offers drug coverage. She currently has prescriptions for a cholesterol-lowering medication at $97.51 a month and an allergy medication at $46.94 a month. While initially her drug coverage was quite generous, this year her drug benefit is capped at $300 a year. As a result, she basically has no drug coverage for three-quarters of the year.

As the Committee moves forward with a prescription drug proposal, it will be critical to judge the proposal on not only whether it could improve the situation for people illustrated in the examples above, but also if it is both affordable and attractive enough to yield a broad risk pool and viable program.

**What Older Americans Need**

Affordable Drug Coverage—Older Americans need *affordable* drug coverage. A *voluntary* drug benefit needs to be affordable to assure enough participation to avoid the dangers of risk selection. The government contribution will need to be sufficient to yield a beneficiary premium that is affordable and a benefit design that is attractive to the majority of beneficiaries. If the benefit is not set at an affordable level, only those beneficiaries who have high risk will want to purchase it. This will lead to a risk pool composed only of those with high drug costs, and program costs will escalate rapidly into what is often referred to as an "insurance death spiral." This is not simply a matter of what beneficiaries would like to pay, it is an issue of how to assure fiscal viability of the risk pool. Medicare Part B is a model in this regard.

The Part B benefit is voluntary on its face, but Medicare's contribution toward the cost of the benefit elicits virtually universal participation. Actuarial work done for AARP last year by the William M. Mercer Company that we shared with the Committee identified the keys to success for a Medicare prescription drug benefit:

• develop a benefit design that will encourage participation by a broad range of beneficiaries in order to spread risk;
• ensure clear and concise communication to improve participation;
• balance the breadth of coverage and beneficiary premium;
• implement cost-containment techniques; and
• limit the enrollment period.

Dependable Drug Coverage—Older Americans also need *dependable* drug coverage. Current prescription drug coverage options are not reliable. For example, beneficiaries who obtain prescription drug coverage from their former employer are finding that coverage to be unstable. Retiree health benefits that include prescription drug coverage are becoming more scarce. While an estimated 40 percent of employers with 500 or more employees offered retiree medical coverage in 1993, only 23 percent did so in 2001. Of those employers who offered retiree medical benefits, 21 percent did not offer drug coverage to Medicare eligible retirees.

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

• Increasing premiums. Over the past few years, more and more Medicare+Choice plans have been charging premiums for their coverage, and those premiums are escalating. For example, between 2001 and 2002, the percentage of Medicare HMO enrollees with zero premiums declined from 47 to 39 percent. This year, nearly one-third of Medicare HMO enrollees (32 percent) will have basic premiums over $50 compared to 14 percent in 2001.

• Higher cost-sharing—Unlike the 1990s, all Medicare HMOs that offer prescription drugs are charging copays for prescription drugs and the average beneficiary copay has increased significantly.

• Decreasing benefit—More plans are lowering the annual cap on the typical Medicare+Choice drug benefit. While in 1999 10.6 percent of Medicare HMOs had an annual cap of $500 or less on their drug benefit, 20.6 percent of plans had a $500 cap in 2000.

• Loss of benefit—Over the last few years, several Medicare+Choice plans have dropped their prescription drug benefit entirely. While 88 percent of Medicare HMOs offered some drug coverage in 1999, that number declined to 63 percent in 2001. Although Medicare+Choice has provided beneficiaries with an opportunity for drug coverage, the volatility of the Medicare+Choice market has made that coverage unpredictable and unstable from year to year.

**AARP Recommendations**

**Adequate Funding**—AARP knows that to craft the kind of prescription drug coverage that beneficiaries will find affordable and reliable—and will thus voluntarily choose to sign up for—will require a sizable commitment of federal dollars. We also recognize that budget constraints are greater than last year. But while the budget situation changes from year to year, the situation facing millions of older and disabled persons who cannot afford the drugs they need continues to worsen, and constitutes a health care and financial emergency that cannot continue to be ignored.

We do not, at this point, have an estimate of what an adequate drug benefit will cost. We know the plans costing $300 billion offered last year did not find public acceptance. However, we believe the new CBO estimates for drug proposals that include beneficiary monthly premiums starting in the $50, $60, and $70 range will not yield an acceptable benefit. We believe Congress and this Committee should focus on the design of a sustainable benefit that will work for beneficiaries and remain flexible as to the projected cost.

That is why in our budget recommendation we asked Congress to renew its commitment from last year, adjust it for inflation and another year of coverage, and earmark $350 billion for prescription drugs and reforms that strengthen the program. However, because we believe that even this level of funding is inadequate to pay for what our members would consider an adequate and affordable benefit, we also recommended that Congress create a reserve fund of about $400 billion, or an amount roughly equal to the amount of the 10-year surplus in the Medicare Hospital Insurance (HI) Trust Fund. A majority of the respondents to our recent poll favored borrowing from the Medicare surplus to pay for a prescription drug benefit. The range created by the $350 billion commitment based on last year, plus the roughly $400 billion reserve fund, will give the Congress the flexibility it needs to craft a prescription drug benefit that beneficiaries will perceive as having real value.

**Priority for drugs**—In addition to our prescription drug recommendation, we also have said that it would be inappropriate to use Medicare or Social Security surplus dollars to increase provider payments without first ensuring that older Americans get the prescription drug coverage they need. Our members would not understand why Congress could find money to help providers but not to meet their increasing prescription drug needs. Further, every dollar for a "givebacks" package means one less available dollar for a Medicare prescription drug benefit. And any giveback package that increases Medicare Part B spending will increase beneficiary premiums because monthly premiums represent 25 percent of Part B costs. We, therefore, would strongly oppose funding for a givebacks package before agreement is reached on a Medicare prescription drug benefit.

**Cost Containment**—We recognize that strong and effective cost containment measures are a necessary part of a Medicare prescription drug benefit. In order for a drug benefit to be sustainable over the long run, mechanisms must be in place to control the rising costs of prescription drugs. AARP actively supports solid cost containment methods as long as patient safety and well-being is not compromised and access to needed prescription drugs is not impeded. Therefore, we support the use of formularies, such as a 3-tiered approach, as long as they are developed in a responsible manner and include an exceptions process.

We also support the responsible promotion of generic drugs as one effective cost containment tool in a Medicare benefit. In fact, because we believe both the government and the consumer have an important role to play in helping to control costs, AARP is rolling out a national public education campaign, beginning this month, to educate our members and the public at large about the wise use of medications—including generic drugs. We will encourage our members to talk with their doctors and pharmacists to reduce unnecessary costs associated with use of medications.

In addition to these cost containment methods, we also would like to work with the Congress in other efforts to control drug costs, including correcting the current AWP pricing structure and stopping abuse of current drug patent laws. AARP has already begun to pursue the need to correct abuse of drug patents through the courts. AARP intends to be involved in litigation against certain brand and generic companies that made agreements that delayed the entry of a generic drug into the market and in litigation against a brand name drug company that unfairly extended its patents to forestall its generic competition.

**Initial Reactions to Drug Proposals**

We have asked our members and the general public what kind of benefit package would generate the kind of high level of participation necessary for a viable benefit, and we have learned the following thus far:

- Beneficiaries will generally perform what we call the "kitchen table test" in determining whether they would purchase a new voluntary drug benefit. That is, they will likely calculate their current prescription drug costs, their Medicare premium ($54 a month in 2002 and rising to $104.90 in 2012), any drug coverage they might have, and their present financial situation, to determine whether a proposed benefit is a real value for them.
- Medicare beneficiaries are willing to pay their fair share for a solid prescription drug benefit, but the premium and coinsurance must be reasonable. We know, for instance, that beneficiaries would not be likely to enroll in a prescription drug plan with a premium of $50 a month.
- While the amount of the beneficiary premium drives the equation, our members also look at the program design features in combination with one another. This means it is difficult to simply assess a single component of a package. For instance, some beneficiaries might look more favorably on a higher level of coinsurance if the premium was lower, or vice versa. In a recent poll conducted for AARP of 885 individuals age 45 and over, only one-third of those 65 and over would be likely to participate in a prescription drug plan that included: a $35 monthly premium, 50% coinsurance, a $200 annual deductible, and a $4,000 stop loss. Clearly, this low level of voluntary participation is not enough to create a broad risk pool and sustainable program.
- Most Medicare beneficiaries are concerned about the unpredictability of health care costs and want to know what they will be expected to pay out-of-pocket. This makes real catastrophic stop-loss protection that limits out-of-pocket costs an important component of any package. We know from past experience that a $6,000 catastrophic stop-loss is viewed by beneficiaries as too high, and even a $4,000 cap is not viewed as providing meaningful benefit protection. For example, if there were a $4,000 cap included in a benefit that also imposed 50 percent beneficiary co-insurance, a beneficiary would have to incur $8,000 (and a couple $16,000) in prescription drug costs before the stop-loss protection would kick in. With the majority of beneficiaries earning less than $25,000 a year, those figures are not seen as providing realistic protection.

We realize that some on the Committee may believe that we are asking for a "Cadillac plan," however, we emphasize we are bringing to you what our members are telling us they need and expect to join a voluntary drug benefit. We will continue to try to educate our members about what is realistic and seek the views of current and future members on specific design packages. We will be happy to work with the Committee as your proposals are developed to test our members' reactions.

As for the President's FY 2003 budget request and proposal to modernize Medicare that was released at the start of the year, AARP is pleased that the President continues to make Medicare prescription drug coverage a priority for his Administration and has indicated his willingness to work with the Congress on this issue, but we believe that the dollar amount proposed is insufficient to provide an affordable and meaningful drug benefit for all Medicare beneficiaries. We also have raised several questions about how the various components of the proposal would help people with Medicare.

In particular, we have raised questions about $77 billion earmarked for low-income drug coverage. The budget proposes an enhanced federal match to enable states to cover drug costs for Medicare beneficiaries between 100 and 150 percent of poverty.

However, the Administration's proposal does not provide details on how the proposed targeted low-income assistance would be used (e.g., in Medicaid expansions or state pharmacy assistance programs), how this effort would improve the current patchwork of drug assistance available, and how many people would actually be helped. Further, the Administration's budget leaves open the question of whether states that could not raise their Medicaid thresholds would be eligible for the new enhanced federal match between 100 to 150 percent of poverty.

The Administration's proposal also does not prevent "dollar trading" by the states that already have higher thresholds. The end result for $77 billion in federal funding could be little or no extension of prescription drug protections for more needy seniors than are being served now.

The President's budget also includes the Administration's proposal to implement a Medicare drug discount card that would give beneficiaries immediate access to drug discounts and other pharmacy services.

AARP is working with the Administration as it continues to refine its drug discount card proposal. There are several issues that we will try to clarify and some consumer protections we will try to add, including: defining what constitutes a "substantial" discount, obtaining firm details on how manufacturer discounts will be disclosed and passed on to consumers, assuring that consumers can compare drug card discount rates to actual retail prices, and making sure drug cards help consumers get generic drugs whenever they are medically appropriate and the least costly option.

However, AARP is encouraged that—unlike current industry card proposals—the President's proposed discount card is designed to establish the drug card program as a building block for a full Medicare drug benefit. We emphasize, however, that neither the Administration's discount card nor the current industry cards are a substitute for a real drug benefit.

We also believe that while the actual discounts would be relatively modest, the President's discount card program would provide at least some help to beneficiaries in buying the drugs they need. It could provide important safeguards to improve the appropriate use of prescription drugs, and this could help avoid unnecessary health care costs due to drug interactions, mis-medications, or poor compliance. It also, importantly, would help the federal government learn valuable lessons about the pharmacy benefit managers (PBMs) that run discount card programs and are included as the delivery system in virtually every drug benefit proposal before Congress. As a result, it will help the Medicare program become more familiar with how PBMs and drug benefit programs work.

Finally, we are concerned that the limited amount of funding in the Administration budget for both drug coverage and other program changes is insufficient to add a meaningful drug benefit and strengthen the program for current and future beneficiaries.

AARP supports efforts to modernize the Medicare program. Clearly, the creation of a prescription drug benefit that is available in all Medicare options is the most significant improvement, but other changes are also important and would serve beneficiaries and the program well. For instance, most private health insurance plans offer a cap on out-of-pocket expenses, yet there is no such limit in the Medicare program. Creating an out-of-pocket cap for services currently covered by Medicare Parts A and B would not only bring Medicare more in line with what individuals under the age of 65 currently have, but would also make the program more affordable for beneficiaries.

AARP also remains open to the possibility of combining the Part A and B deductible, provided it is structured to be affordable and does not produce beneficiary "sticker shock." Since most beneficiaries meet the annual $100 Part B deductible but significantly less meet the Part A hospital deductible, a combined and increased deductible will affect the majority of beneficiaries. We are opposed, however, to merging the Part A and B Trust Funds. The new solvency measure included in the President's budget, and suggested in the recent Medicare Trustees' Report, appears to indicate that Medicare should be financed *wholly* from its Trust Funds. That is, its financing should come predominantly, if not exclusively, from payroll taxes and beneficiary contributions, with little or no contribution from general revenues. This would represent a radical shift in funding for the Medicare program. The impact of such a shift would be to significantly increase beneficiaries' costs for Medicare, reduce provider payments, or a combination of both.

**Conclusion**

AARP is pleased that the Committee is examining the issue of a Medicare prescription drug benefit and is developing a proposal. The work you are embarking upon is extremely challenging; it is also immensely important to millions of Americans who take prescription medications. It is our hope that today's hearing will help focus attention on the need for an affordable and dependable Medicare prescription drug benefit for all beneficiaries.

Our members believe that Congress should be able to work across party lines to enact and begin to implement an affordable Medicare drug benefit. We pledge to you that we will provide assistance in every way we can to work with members on both sides of the aisle and to promote a meaningful and broadly supported Medicare prescription drug benefit. We also know that our members will not accept failure or delay. The needs of older and disabled Americans who lack adequate drug coverage can no longer go unheeded. We call on Congress to act now. A prescription drug benefit in Medicare is an urgent priority for our members and for the American people.

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## ADDENDUM

### Perceptions of a Medicare Rx Plan Among the Public Aged 45+ Selected Findings

- Eight in ten Americans aged 45 and over favor making prescription drug coverage part of the Medicare system. 67% strongly favor this benefit.
- Almost eight in ten Americans aged 45+ consider providing a Medicare prescription drug benefit to be an extremely or very important priority for the President and Congress.
- A majority of Americans aged 18 to 64, and 48% of Americans aged 65+, favor borrowing from the Medicare Trust Fund surplus to finance a Medicare prescription drug benefit. Lower percentages among all age groups favor borrowing from Social Security Trust Fund surpluses to finance a Medicare prescription drug benefit.
- Respondents aged 65 or older (22%) are less willing than those between the ages of 45 to 64 (29%) to pay a $35 monthly premium for a Medicare prescription drug benefit that has a $200 deductible, pays for 50% of the cost of prescriptions, and has a catastrophic coverage cap of $4,000. Overall, 27% of Americans aged 45+ are willing to pay a $35 monthly premium for this coverage.
- Of the 61% of Americans aged 65+ who identified a premium amount less than $35, one-quarter (or 15% of all respondents aged 65+) said they would pay the $35 premium when asked directly if they would be willing to pay that amount for coverage.
- While 41% of the public aged 45+ would be likely to participate in the above Medicare prescription drug plan, only 33% of those aged 65+ would participate. Almost half (47%) of those aged 45 to 54, and 41% of those 55 to 64, say they would be likely to participate in this plan.
- Americans aged 65+ with prescription drug coverage are less likely to participate in this plan than those without coverage. However, the lack of prescription drug coverage may not be a factor in whether or not a person would participate in this plan since individuals aged 65+ with no coverage are split as to whether they would participate—42% would be likely to participate in this plan while 39% would not be likely to participate.
- The role existing coverage plays in individuals' decision to participate in this plan is complicated by the fact that monthly out of pocket prescription drug expenses are also related to whether or not individuals aged 65+ will accept the plan. Majorities of people aged 65+ (54%) without prescription drug coverage and with current monthly average out of pocket drug expenses of $60 or more are likely to accept the plan.
- Among individuals aged 65+ who have prescription coverage, out of pocket drug expenses are also a factor in whether or not they will accept this plan. Almost four in ten (38%) of those aged 65+ with drug coverage but with current average monthly out of pocket expenses of $60 or more are likely to accept this plan. Only 23% of the 65+ population with drug coverage and monthly out of pocket expenses lower than $60 are likely to accept this plan.

### Methodology

Reed Haldy McIntosh collected the data contained in this survey for AARP through the Market Facts Telenation omnibus survey conducted March 1 through March 3, 2002. All questions in the survey were asked of those aged 45 and over (n=885), with the exception of questions 10 and 11 which were asked of all age groups (18+) in the omnibus (n=2,000). The margin of error for this survey is +/- 3.5 percentage points.

**Before you take your medicine, take this advice.**

IMPORTANT Take exactly as directed, but first call around and compare drug prices.

AVOID paying too much for your prescriptions. Generics may work as well as brand names.

TELL YOUR PHYSICIAN and pharmacist everything you're taking. Some medicines don't interact well.

DO NOT let advertising sell you on drugs you don't need.

**Check up on your prescriptions.**

AARP

*To learn more about the rights of pharmaceutical consumers, call your pharmacist, doctor, or consumer advocate, or write AARP.*

Mrs. JOHNSON OF CONNECTICUT. Thank you, Mr. Novelli.

Mr. Rector?

**STATEMENT OF JOHN M. RECTOR, SENIOR VICE PRESIDENT, GOVERNMENT AFFAIRS, AND GENERAL COUNSEL, NATIONAL COMMUNITY PHARMACISTS ASSOCIATION, ALEXANDRIA, VIRGINIA**

Mr. RECTOR. We certainly appreciate the opportunity to present our views on comprehensive Medicare reform this morning, now this afternoon. We represent 25,000 independent pharmacies, not the publicly-held pharmacies, we provide about half the Nation's prescriptions.

We hope that the benefit will include, in addition to coverage of the product, coverage of pharmacists' professional services. I would like to emphasize that only when the drugs are used properly do they have the value that has already been noted by several witnesses this morning.

I would like to touch on several very specific aspects of the recent legislation you considered 2 years ago. First, we consider our businesses to be highly efficient. They have less than a 30-percent gross margin, less than a pre-tax 2-percent net profit, and we need to remind the Committee and others that we are also private sector.

I know the debate that developed has substituted choice of plan for choice of provider, and, of course, that is the kind of approach that concerns the small businesses that we represent. We think the Committee should allow seniors to select the pharmacy of their choice and not allow the insurance industry or their PBMs to substitute your constituents' choice of pharmacy. I note that 24 Members of the Committee are in States that have laws that guarantee choice of pharmacy to consumers, including seniors, and we certainly urge that you not preempt those State statutes.

Relatedly, so often in the dialog in the last several years we have seen reference to the fact that PBMs, insurance companies, and others negotiate with pharmacies. The literature is replete with this. I know testimony after testimony before the Committee stresses the value of maintaining the PBMs' ability to negotiate with pharmacies. I am here today to stress as emphatically as possible, that we do not have the ability to negotiate with these PBMs. That is a fiction. We are given "take it or leave it" contracts with no choice whatsoever regarding the terms of those contracts.

So, naturally, one of the things we would like the Committee to seriously consider is to include the ability, as several bills that have been introduced, at least in the Senate, have, to allow the pharmacies to actually negotiate their deal on behalf of themselves and their consumers with the PBMs and not just have us accept whatever it is that these intermediaries decide is best for our bottom line. It is usually best for their bottom line and not at all good for our bottom line.

We would like the Committee to seriously consider not penalizing seniors when they want to continue to go to their local pharmacy and decline to utilize the mail order option. We have seen so frequently provisions that incentivize our competitors: the mail order pharmacists and pharmacies. If they have something to offer, fine,

but we do not see a need to tilt the equation in favor of their businesses.

Interestingly enough, those are very highly profitable businesses. Because of rebating and other factors, the PBMs make substantially more profit on the mail order prescriptions that they fill, usually through their own companies, or with other companies under contracts. They make more money on the mail order prescriptions they fill than they do in the insured prescriptions that are filled in a local pharmacy.

We would urge the Committee to carefully assess precisely what it is that the PBMs do to provide the alleged savings that the debate so often has raised. We are fairly skeptical about the savings. We see them taking dollars from our pocket and putting it into theirs and do not necessarily see the employers or government, for that matter, benefiting from their activities.

We think you should investigate the extent to which these entities are regulated under State law. Very likely, they are not. Georgia just this week was the first State to specifically regulate the PBMs.

Lastly, we urge that you review very carefully the growing amount of litigation being brought by employers, by patients, by health plans, and by pharmacists against these PBMs for violations of their fiduciary responsibilities to each of those respective categories.

In closing, I noted in the Secretary Thompson's testimony that he said that they had little experience with PBMs. Frankly, our Members would like to guarantee that continues to be the case. Thank you.

[The prepared statement of Mr. Rector follows:]

**Statement of John M. Rector, Senior Vice President, Government Affairs, and General Counsel, National Community Pharmacists Association, Alexandria, Virginia**

Mr. Chairman, Members of the Committee:

I am John M. Rector, I serve as Senior Vice President Government Affairs and General Counsel for the National Community Pharmacists Association.

The National Community Pharmacists Association (NCPA) represents more than 25,000 independent pharmacies, where over 75,000 pharmacists dispense more than 50% of the nation's prescription drugs and related services. Independent pharmacists serve 18 million persons daily. NCPA has long been acknowledged as the sole advocate for this vital component of the free enterprise system. For decades NCPA has been the only national pharmacy association with universal state association membership, including those of the Committee's members.

The National Association of Retail Druggists (NARD), founded in 1898, has been the association representing the professional and proprietary interests of the nation's community pharmacists. To mark our centennial year, the NARD House of Delegates voted to change the Association's name to the National Community Pharmacists Association (NCPA).

NCPA members are primarily family businesses. We have roots in America's communities. The neighborhood independent pharmacist typifies the reliability, stability, yet adventuresomeness that has made our country great.

As owners, managers and staff pharmacist employees of independent pharmacies, our members are committed to legislative and regulatory initiatives designed to protect the public and to provide pharmacists a level playing field and a fair chance to compete. We appreciate the opportunity to assist the Committee in fashioning a new benefit for Medicare beneficiaries to include drug product coverage and related pharmacist professional services.

Competition in retail pharmacies is alive and well. Competition is an incentive for efficiency and the price competition in retail pharmacy is typically greater than can be found among other providers of health services and products.

The independent community pharmacist of today is simultaneously a health care professional and a small businessperson. NCPA and its members vigorously support the American free enterprise system, which provides the only meaningful climate under which a small business can economically survive, have the opportunity to succeed through personal efforts, and provide an important and essential service to the community.

Community pharmacists are especially trained to assist you and your constituents with the proper use of medications. Medicines, *only when used properly*, can save lives and improve the quality of lives, and only when medicines are used properly can consumers, employers and governments enjoy actual systemic savings.

The pharmacies and the 75,000 pharmacists that NCPA represents are interested in a wide range of health and business issues such as estate tax reform, ergonomics, small business tax relief, confidentiality of pharmacist-physician-patient communications and of pharmacy records, payment for pharmacists professional services and assuring that PBMs process claims but are not allowed to practice medicine or pharmacy, accountability for "managed care," elimination of discrimination in favor of mail order, and internet sales tax collection.

The small business independent health care professionals we represent are the preferred choice of American consumers, including your constituents. Our members function in the market in a variety of forms. They do business as single stores ranging from apothecaries to full line high volume pharmacies; as independent chains (e.g. 100 pharmacies) and as franchises. Whatever the form of business entity, independent pharmacists are the decision makers for the diverse NCPA member companies.

The most in-depth consumer pharmacy preference survey to date, was published by Consumer Reports, in October of 1999. They surveyed 18,000 consumers and found that consumers, especially seniors, preferred independently owned pharmacies for several reasons:

- Independents provided more personal attention
- Independents provided more useful information about both prescription and nonprescription drugs
- Independent druggists were seen as more professional, more sensitive to families' needs, and easier to talk to
- Independents kept consumers waiting less time for drugs, had prescriptions ready for pickup more often, and provided out-of-stock medicine faster

The 1200 plus independently owned pharmacies in the Medicine Shoppes franchise were ranked second; the supermarket drugstores (7,800 stores) were third, the mass merchandisers (5,300 stores) were fourth; and last were the big corporate run chains (19,300 stores). No preference was expressed for mail order.

Numerous studies have documented the cost savings of comprehensive community pharmacy services. When properly utilized, community pharmacists services including compliance and persistence programs, for example, can save the health care system billions of dollars by reducing the need for much more costly medical services, including emergency room visits, hospitalization, and nursing home admissions.

The failure by the insurers/PBMs to provide incentives for full pharmacist services has led to unnecessary and inappropriate prescriptions; to uncounseled prescription drug use; and to reduced patient compliance with appropriate drug regimens. In the long run, this devaluation of professional pharmacists services and the adoption by the insurance industry of a "commodity only" approach has increased total annual health care expenditures by billions. In summary, there is less payment for less care. Consequently, we believe that the Committee should be very skeptical of so called "managed care" which has declined to acknowledge or pay for professional community pharmacist services.

Consumer choice of provider is the life-blood of competition. Limits on consumer choice inhibit competition. In our view Medicare beneficiaries should be entitled to choice of plan, pharmacist provider, and prescription products.

Consumer choice means cost effective prescriptions. The average cash price in a community pharmacy for an Rx drug is $40.47; if insured $44.61; and if mail order $52.42. While NCPA members dispense 55% generic Rxs, the mail order generic rate is 28%.

If pharmaceutical products and pharmacist services are to become a basic core benefit under Medicare, it is essential, as we stressed to the National Bipartisan Commission on Medicare Reform in September 1998, that:

- Medicare beneficiaries have full access to community pharmacy and community pharmacy has full access to the marketplace.

• All pharmacies, irrespective of practice settings, must be able to acquire prescription drugs at the same price, subject only to economies of scale including volume.

• There be established a realistic professional dispensing fee that recognizes the valuable patient care services provided by the nation's community pharmacists.

• Community pharmacists are able to join together to negotiate with Medicare and its intermediaries.

• Medicare beneficiaries are able to receive prescriptions that are compounded by pharmacists to meet their individualized needs.

• Payments be authorized to pharmacists for disease state management on per-encounter basis for such services as smoking cessation, diabetes, arthritis, asthma, lipids, osteoporosis, cardiovascular and coagulation care management when provided by credentialed pharmacists.

• Beneficiaries retain the right to contract with health care providers including pharmacists for products and services not covered by Medicare.

• Additionally, in conjunction with various national pharmacy associations, we have adopted parallel core recommendations for the establishment of an outpatient pharmacy benefit for Medicare beneficiaries.

(See Exhibit 1).

It is important to understand that the pharmacy benefit managers (PBMs) not only dictate unilaterally what pharmacies will be paid, but PBMs directly compete with our small businesses through their mail order pharmacy subsidiaries or through contracts with other mail order companies.

Today the marketplace for insured prescription coverage is dominated by so-called "managed care" companies (a.k.a. PBMs). The dominance of such companies has created additional barriers to competition, it has not enhanced competition. Those attempting to "manage" our market seek to reduce the number of viable competitors and to steer unwilling consumers to a few select competitors often including, as noted, their own mail order companies.

It is important to understand that your independent pharmacists are not engaging in idle speculation when they express concerns that unrestricted PBMs would shift consumers away from their local pharmacy to the PBM's own mail order companies with their characteristic high profits and under utilization of generic drugs. It is estimated by Wall Street PBM analysts that the PBM makes 2 to 4 times as much profit on an insured mail order prescription than on an insured prescription dispensed in a community pharmacy.

For the past several years the major PBMs have aggressively attempted to switch patients to their mail order programs often switching them to a prescription drug not based on the patients health care needs but based on rebates from the highest bidder. Often the patient is switched to more expensive drugs and denied access to appropriate generics.

The impact of their "so-called" care has been equally negative: reduced quality control and reduced quality of providers to which consumers have access, including providers unlicensed in the consumer's state. In fact, the trend for the past decade for insured prescriptions has seen PBMs focus exclusively on the prescription drug product and eliminating payment for traditional professional community pharmacist services. Among the consequences of this "commodity only" approach has been a significant increase in non-compliance with the drug regimen prescribed by physicians and as a consequence diminished quality of life for covered consumers and their families.

NCPA members are forced to accept whatever payment the insurance industry and its PBMs dictate. Simultaneously the insurance industry and its' allies brazenly characterize such payments as discounts "negotiated" by pharmacies.

Experts on the insurance industry and their PBM's practices know that to characterize the payment for pharmacists fixed by the insurance industry and its PBM intermediaries in "take-it-or-leave it" contracts as negotiated by the pharmacists is akin to characterizing the victim of an armed robbery as having donated cash to the assailant's favorite charity.

PBMs refuse to negotiate with independent pharmacies and it is unlawful for several independent pharmacies to collectively negotiate prescription drug contracts with PBMs. In the last Congress the House of Representatives voted 276 to 136 for H.R. 1304, the Quality Health Care Coalition Act, which would have authorized such small business contract negotiations. It is enlightening to recall that the PBMs, represented by Express Scripts, unsuccessfully urged the House Judiciary Committee to deny independent pharmacists and their consumers, including seniors, economies of scale regarding products and services achievable through fair negotiations.

Rather than further erode the small business pharmacy infrastructure through the dictates of our "managed care" competitors, the Committee should guarantee Medicare beneficiaries protections similar to those provided by H.R.1304. Allowing pharmacists to negotiate would help put an end to the present ability of the insurance industry and its PBM intermediaries to unilaterally fix pharmacy payments and to reduce the quality of care. Negotiations would help to put an end to the tying of prescription insurance coverage to the mandatory or coercive use of mail order pharmacy, which denies consumers equal access to neighborhood pharmacies and the services of independent pharmacists. Incidentally, this bipartisan legislation has been reintroduced as H.R.3897, by Representative Bob Barr (R–GA) and John Conyers (D–MI).

We also recommend that the Committee carefully review the growing number of lawsuits against PBMs brought by patients, health plans, employers, and others alleging PBM violations of their fiduciary duties. The PBMs have countered by claiming that they are not obligated to fulfill a fiduciary duty and are only obligated to lookout for their bottom line interests. Would this be the case with Medicare?

Regarding the affordability of prescription drugs for all Americans, including Medicare eligible persons, we recommend two steps: First, the full implementation of the Medicine Equity and Drugs Safety Act (MEDS) P.L.106–387, which would allow the importation by pharmacists of FDA approved drugs from select countries, principally, Canada, United Kingdom, and the European Union. Secondly, the enactment of Representatives Cliff Stearns (R–FL)—H.R.1127, which would restore, for federal tax purposes, the first dollar deductibility of prescription drugs.

On behalf of the members of the National Community Pharmacists Association, we thank the Committee for the opportunity to provide our views on Medicare reform.

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(EXHIBIT 1)

ASSURING A QUALITY, COST-EFFECTIVE PHARMACY BENEFIT FOR AMERICA'S SENIORS
A UNIFIED AGENDA FOR AMERICAN PHARMACY

~~Academy of Managed Care Pharmacy (AMCP)~~ (Withdrew Support)

American College of Clinical Pharmacy (ACCP)

American Pharmaceutical Association (APhA)

American Society of Consultant Pharmacists (ASCP)

American Society of Health—System Pharmacists (ASHP)

National Association of Chain Drug Stores (NACDS)

National Community Pharmacists Association (NCPA)

National Council of State Pharmaceutical Association Executives (NCSPAE)

As policymakers discuss a comprehensive Medicare outpatient pharmacy benefit, we encourage Congress and the Administration to carefully consider the views of the nation's pharmacists—the third largest, most accessible, and consistently most trusted group of health professionals.

**Who We Are**

Our organizations represent the entirety of the practicing pharmacist and corporate business communities that comprise American Pharmacy—independent and chain community pharmacists and pharmacies; hospital and health-system pharmacists; clinical pharmacists in academic health centers, medical group practices, and clinics; pharmacists practicing in managed care organizations; consultant pharmacists in long-term and senior care facilities; home health care pharmacists; and virtually every other type of pharmacist and setting where patient care and medication use occur. Our collective memberships span the breadth and depth of the entire profession of pharmacy. **And we are unified in our core beliefs concerning an outpatient pharmacy benefit for Medicare beneficiaries.**

**What We Believe**

**Medicare Should Provide a "Pharmacy Benefit"—Not a "Drug Benefit"**

Medications are safe and effective *only when they are used appropriately.* Inappropriate medication use leads to hospitalizations and other unnecessary medical costs for which Medicare is already paying a substantial price. Seniors need and want pharmacists to help them understand how to take their medications appropriately so that medication—related adverse events are avoided or minimized. That's because the public recognizes that pharmacists are the most qualified health professional to provide this level of care and service to them. **Consumers should have the choice of and access to the pharmacist and pharmacy that best meet their specific health care needs.**

For that reason, proposals to modernize Medicare need to provide for the addition of a "**pharmacy benefit,**" not simply a "drug benefit." Pharmacists who work together with patients and their physicians are seniors' (and Medicare's) best ally for ensuring that the medications being used are as clinically appropriate, cost—effective, and free from preventable side effects, drug interactions, and other medication—related problems as they possibly can be. Any "benefit" from adding outpatient prescription drugs to Medicare will only be realized if we can assure their proper and effective use. That is the professional expertise, and value, that pharmacists bring to patient care and the health care system.

• **Medicare Must Provide Appropriate Payment to Pharmacists and Pharmacies for their Services**

A Medicare pharmacy benefit must recognize that the nation's pharmacists and pharmacies are the individuals and entities that actually provide the drug products, professional services, and medication therapy management (MTM) programs that are essential to assure that medications are optimally used. Payment to pharmacists and pharmacies for providing these products and services must be reasonable and adequate to cover the professional, administrative, and business costs of providing these services and products—as well as a reasonable return on investment—in every type of pharmacy practice setting in which the care and services are provided.

**Our Key Concern**

None of the legislative proposals introduced to date in the 107th Congress adequately address our two core beliefs: access to and coverage of both medications and pharmacists' medication therapy management services. In reviewing the bills currently being considered, one would conclude that Congress believes that it will have served Medicare beneficiaries well if it can simply find a way to help Medicare buy medications at the reduced prices currently being paid by other federal purchasers and then turn the administration, management, and delivery of services over to 91 private sector" entities sometimes referred to as prescription benefits managers (PBM's).

For example, under several existing proposals, PBM's are charged with "managing care," "developing drug formularies," "increasing generic drug use," "negotiating discounts with pharmaceutical manufacturers," "placing price controls on community pharmacies," and "providing medication therapy management programs to seniors."

While we believe that PBM's can and do have an important role in performing many of the administrative tasks associated with providing the pharmacy benefit to seniors, we have serious reservations about the nature and scope of "patient care and cost management" tasks that many of the current proposals would assign to PBM's. In fact, some evidence suggests that PBM's are not effective in performing these latter activities. Pharmacists and pharmacies are the real "private sector' providers of care and service to patients. Pharmacists and pharmacies provide services and work with patients at their point of care to accomplish appropriate medication use and accurate dispensing. It is pharmacists and pharmacies, our members, upon whom senior citizens and the Medicare program will ultimately rely to achieve the outcomes we all seek for a successful Medicare pharmacy benefit.

**What Should Be Done**

Our organizations are jointly committed, prepared, and able to work with the 107th Congress, the Bush Administration, the pharmaceutical industry, HCFA, physician organizations, senior advocacy groups, and other interested parties to help design a Medicare outpatient pharmacy benefit that improves medication use, helps control overall health care costs, and enhances the quality of seniors' lives. The pharmacy, medical, and health care literature all provide ample evidence that these goals are compatible, not mutually exclusive. But we have to work together to achieve them.

We therefore encourage HHS Secretary Tommy Thompson to establish a national panel of all of these stakeholders to assist the Bush Administration and Congress in designing a Medicare pharmacy benefit framework that achieves these important objectives.

A Medicare outpatient pharmacy benefit will be the single most substantial and important addition to the program since its inception 35 years ago. We must not only do the right thing—but we must do it the right way. Beneficiaries, taxpayers, and the public at large deserve nothing less than our best effort.

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**ADDENDUM**

1. Examples of misrepresentation that our members negotiate with PBMs include:

a) The PCMA testimony to the Committee on June 13, 2002 at page 5, where they stated: "Any legislation that does not empower us as PBMs to negotiate discounts and other pricing concessions from drug manufacturers and pharmacies—as we do today in private plans—will not be able to deliver the anticipated cost savings. Our members are strongly united on this point."

b) The 3/22/00 GAO presentation to the Committee and to the Senate Finance Committee entitled Prescription Drug Benefits: Applying Private Sector Management Methods to Medicare at page 6: "Similar to their negotiations with manufacturers, PBMs negotiate with retail pharmacies to obtain prices that are well below pharmacies' usual price for customers without drug coverage."

c) The PhRMA 6/12/00 ad in National Journal's Congress Daily AM at page 7, which states "For 150,000 Americans with a prescription drug insurance benefit, their private health plans have had considerable success negotiating meaningful price discounts on pharmaceuticals. However, 12 million senior Americans now have no prescription drug insurance coverage. As a result, most of them pay full price for their medicines. That's because they don't have the market clout that comes with a drug insurance benefit. If all seniors had access to private market discounts, the medicines they need, on average, would cost 30% to 39% less."

As noted in 2000, H.R. 1304, which would allow our members to negotiate with health plans and PBMs was approved on 6/29/00 by 276 to 136. Committee members voted 19 to 37 (9 R's and 10 D's) for H.R. 1304.

2. Regarding the PBM corporate strategy to shift patients to their highly profitable mail order businesses the following references are enlightening:

• FAC Equities—Division of the First Albany Corporation—October 4, 2001 Research Report on Express Scripts, Inc. recommending a Buy

Page 3 of the report under **Investment Merits** states that "mail order sales are roughly 2 times to 3 times more profitable on a per adjusted script basis than retail script.

• WR Hambrecht Company Report—March 22, 2001 on CareMark Rx recommending a Buy

Page 2 of the report notes "PBM mail order script margins are 4 times higher than retail scripts.

• CareMark Rx Inc. 10K—December 21, 2000

Page 3 "In 2002 the company, implemented a program designed to encourage its' customers to refill prescription which were originally filled in its' retail network through its automated mail service pharmacy." The company also operates a network of 17 smaller mail service pharmacies.

3. According to IMS Health (See enclosed bar graph), the PBMs under utilize generic drugs. We believe that the Committee should help assure that any new Medicare benefit provide seniors with no fewer than the 50 to 55% level of generic prescriptions made available currently to seniors and others through independents community pharmacies.

A related issue is the pricing of generic drugs. PBMs seem not only to under utilize generics but also reportedly charge significantly higher prices for generics. For example, earlier this year, a Merck-Medco plan for Connecticut state retired teachers entitled "Prescription Drug Server" mandated mail order coverage. One consequence of eliminating local pharmacies as a choice for retired teachers was prices for generic drugs three times greater than the change in independent community pharmacies in Connecticut. (For example, the charge for a community pharmacy of $34.23 and for Merck-Medco mail a order charge of $100.38 for a 90 day supply of 300 tablets of the same generic drugs). Fortunately, on April 1, 2002, this Merck-Medco mandatory mail order program for Connecticut retired teachers dropped its' mandatory mail order requirement in response to protests about the Merck-Medco generic drug overcharges. Unfortunately, the retired teachers plan still discourages

the teachers from using their community pharmacy through discriminatory co-payments that favor Merck-Medco's mail order business.

Initially, the AARP mail order pharmacy business was synonymous with generic drugs. Since IMS Health data does not capture the marketing practices of our non-profit competitors, such as AARP, we can only speculate as to whether AARP may also under utilize generic drugs.

4. Numerous studies, as noted, underscore the systemic value of coverage and payment for pharmacist care services. On such study is entitled "The $76 Billion Dollar Question" funded by our foundation; the National Institute for Pharmacist Care Outcomes; and Merck. Interestingly, the former director of health benefits at GM, Mr. Beach Hall in 1992 observed in this study, "that pharmacist care is the most critical quality and cost controlled vehicle we have in the entire health care system."

As Committee member, Representative Portman observed rather than $76 billion, our health care system is now wasting $150 billion annually due to inappropriate prescription drug use and unnecessary hospitalizations and nursing home placements. In other words, a dollar wasted for every dollar spent annually on prescription drugs. Appropriate payment for pharmacist professional services could significantly reduce these unnecessary expenditures.

It is important, in our view, that the Committee is aware of the joint statement on prescription drug benefit under Medicare announced by our group and Pfizer on 6/11/01. It stresses the value of pharmacist care services, including, persistency, patient compliance, and appropriate counseling.

It is noteworthy that the 1988 Medicare catastrophic law established per prescription payment for a participating pharmacy as AWP + $4.50 indexed. In today's marketplace, fourteen years later, had the bipartisan law signed by President Ronald Reagan not been repealed, the payment would be $10.94.

Representative Nussle raised a question regarding the ability to retain pharmacists in rural areas. Senate legislation, S.10 has an incentive provision for payment for independent pharmacists in rural areas. Importantly, H.R. 3626 by Representatives Emerson and Ross recognizes the value of pharmacist professional services for a new Medicare benefit.

5. Regarding Representative Foley's expressed enthusiasm for the Administration's "so-called" discount card, the Committee should carefully review the 12/01 GAO report stating an average savings of approximately 11%. This percent did not reflect the monthly fees, (for example, $9.95 for an individual and $19.95 for a family) charged for the cards. Savings, if any, were somewhere between 1 and 5 percent.

Regarding Mr. Foley's expressed intent to legislate the Administration' s proposed card, it is important to recall the Federal Judge Paul Friedman on 9/6/01 in *NACDS/NCPA* v. *HHS* enjoined the plan because HHS had no authority to undertake an endorsement plan and had proceeded unlawfully. The bottom line, however, was that the Court found that implementation of the plan would cause irreparable harm, especially to the small business pharmacies that we represent. Enacting legislation would only institutionalize the irreparable harm to small businesses.

6. Mention was made that allowing Medicare to negotiate with drug makers could "distort" the marketplace. The independent pharmacy marketplace where pharmacists are not able to negotiate has been totally distorted by one sided contracts dictated by PBMs. Assuring pharmacists, the ability to negotiate would help ameliorate the distortion.

Please see the enclosed 4/02 article in America's Pharmacist entitled "The Tug of Wars with PBMs", which highlights the various facets of PBM distortion of our marketplace.

Once again, we especially appreciate the opportunity to assist the Committee and staff as you revisit the subject of Medicare pharmacy benefit.

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Mrs. JOHNSON OF CONNECTICUT. Thank you, Mr. Rector.

Dr. Sayare.

**STATEMENT OF MITCHEL SAYARE, PH.D., PRESIDENT, CHIEF EXECUTIVE OFFICER, AND CHAIRMAN, IMMUNOGEN, INC., CAMBRIDGE, MASSACHUSETTS, ON BEHALF OF THE BIOTECHNOLOGY INDUSTRY ORGANIZATION**

Dr. SAYARE. Thank you, Madam Chairman and Members of the Committee. I am here today representing the Biotechnology Industry Organization (BIO). This Committee has been the driving force for Medicare drug coverage for many years. I am particularly honored to be here to describe BIO's views on Medicare drug coverage issues.

ImmunoGen, the company I work for, is a publicly-traded biotech company established in 1981 that has several anti-cancer drugs in various stages of clinical development, for colorectal cancer, small cell lung cancer, and other forms of solid tumors. We do not have any products currently in the market.

The BIO represents over 1,000 biotech companies, academic institutions, State biotech centers, and related organizations in all 50 States. Ninety percent of our companies are involved in health care product development, and 90 percent of those companies do not have a single product on the market. Many of the others have only one product. Clearly, the vast majority of BIO's members do not have an array of health care products to absorb the costs of the research and development tax credit (R&D).

Additionally, many biotech drugs are for small populations. Forty-five percent of FDA-approved biotech products have orphan drug status.

Finally, existing tax incentives for research, the R&D tax credit and the deductibility of net operating loss carry-forwards do not benefit these pre-profitable biotech companies.

For many of BIO's members, the levels of investment in innovation is far from an academic concern, really more of a question of survival. Most BIO members are not Members of the Fortune 500. Rather, they are small companies funded by venture capital, companies that may, in fact, hold the key to potentially important therapies in the future. Anything that could upset this delicate balance that we live in could deprive patients of these breakthroughs in the future, because if investment by venture capitalists is reduced, most of the companies in this area are not going to survive. We urge you to take care when designing a Medicare drug coverage plan not to upset this delicate balance.

The issue of Medicare modernization and the proposal to add prescription drug coverage to the program is of high interest to members of BIO and to the patients that we serve. Many biotech drugs in the pipeline target diseases that predominately affect seniors. We strongly believe that outpatient drug coverage should be established in the context of overall market-based reform of the Medicare program to do the following: Rely on the private market and competition, not price controls that deter innovation; include stop-loss protection and protection of those most in need first; expand beneficiary choices among private plans; improve patient care through innovations in biotechnology; maintain Medicare solvency; and do no harm to current coverage and reimbursement.

Today, most biotech drugs are, in fact, covered by Medicare because they are administered in a hospital setting or in a physician's

office. At the top of our current coverage concerns is the recent imposition of cuts to hospital outpatient pass-through payments. As you recall, the Balanced Budget Refinement Act 1999 created this new transitional payment system to provide an incentive to hospital outpatient departments to use new technologies during the time that a prospective payment system was created. This payment system is truly a mess.

Last year, before Congress finished its work, Chairman Thomas and Mr. Rangel, along with the chairmen and ranking Members of the Senate Finance Committee and House Energy and Commerce Committee, sent a letter to CMS urging a delay in the implementation of the pass-through payments for 2002 as well as recommending that the agency increase to an average of no less than 75 percent of the imputed values used to calculate reimbursement for sole source, multi-source, and generic drugs. Only half of your recommendations were executed by CMS, that is, the delay.

Of course, creating an outpatient drug coverage program in Medicare is of critical importance, but the situation with current coverage will impact beneficiary access to the latest technologies, such as biotech drugs, today. I am requesting that the Committee revisit this issue soon. Specific recommendations relating to BIO's current coverage concerns were outlined in my written proposal.

In closing, Madam Chairman, I would urge this Committee to continue to move expeditiously to pass drug coverage legislation this year. I want to commend you for holding this very important hearing and for your leadership on drug coverage and stop-loss coverage issues. I will be happy to attempt to answer any questions you have. Thanks.

[The prepared statement of Dr. Sayare follows:]

**Statement of Mitchel Sayare, Ph.D., President, Chief Executive Officer, and Chairman, ImmunoGen, Inc., Cambridge, Massachusetts, on behalf of the Biotechnology Industry Organization**

Good morning, Chairman Thomas, Congressman Rangel, members of the Committee. My name is Mitchel Sayare, Ph.D, and I am President, CEO and Chairman of ImmunoGen located in Cambridge, Massachusetts. I am here today representing the Biotechnology Industry Organization (BIO).

This committee has been the driving force for Medicare drug coverage for many years. The Medicare drug coverage legislation this committee reported out in the 106th Congress represented a positive step from BIO's perspective, and the association is pleased that this committee is continuing to work to add drug coverage to Medicare. I am particularly honored to be here to describe BIO's views on Medicare drug coverage issues.

**Background on ImmunoGen**

ImmunoGen, Inc. is a publicly-traded biotechnology company that has anti-cancer drugs in various stages of clinical development for colorectal, pancreatic, small-cell and non-small cell lung cancer. We were founded with venture capital in 1981 and had our initial public offering (IPO) in 1989. Since its inception, ImmunoGen has focused on achieving more effective, better tolerated therapies for the treatment of cancer. The company uses tumor-targeting monoclonal antibodies to deliver highly potent cell-killing (cytotoxic) agents specifically to cancer cells. Two products originated at ImmunoGen are currently in Phase I/II clinical trials under licensing agreements with other companies, but we have no products currently on the market. One product (huC242–DM1/SB–408075) currently being tested is for colorectal, pancreatic and certain non-small-cell lung cancers. The other (huN901–DM1/BB–10901) is for small-cell lung cancer and other cancers of neuroendocrine origin.

ImmunoGen's proprietary tumor-activated prodrug technology (TAP) combines extremely potent small-molecule drugs with monoclonal antibodies that recognize, bind directly to, and kill tumor cells. Our targeted delivery technology increases the

potency and efficacy of these cancer-specific antibodies, which allows our drugs to kill cancer cells with minimal harm to healthy tissue.

From inception through December 31, 2001, ImmunoGen has invested over $160 million in Research and Development (R&D). About 80% of the Company's expenses since it was founded have been R&D expenses.

One example of our research demonstrates some of the risk faced by companies in the biotech industry. ImmunoGen invested over $120 million in the development of a product (Anti-B4-bR) that failed in Phase III clinical trials. We are only back on our feet, developing other products for the treatment of cancer, because the investing public was willing to give us another chance. We need to repay their confidence. I am here to urge this committee to keep the fragile state of companies like ImmunoGen in mind when making changes to Medicare. While we are very excited about some of the potentially lifesaving therapies we might discover, we can only do so if we have the ability to continue significant investments in R&D.

**About BIO**

BIO represents 1,071 biotechnology companies, academic institutions, state biotechnology centers and related organizations in all 50 U.S. states. BIO members are involved in the research and development of health care, agricultural, industrial and environmental biotechnology products. Ninety percent of our companies are involved in health care product development and 90% of those companies do not have a single product on the market. Many more have only one product. Clearly, the vast majority of BIO's members do not have an array of health and/or other consumer products to absorb the cost of R&D; more importantly, many biotech drugs are for small populations. Forty-five percent of FDA-approved biotech products have orphan status.

For many of BIO's members the level of investment in innovation is far from an academic concern and more a question of survival. Most BIO members aren't members of the Fortune 500; rather, they are small companies funded by venture capital, companies that may hold the key to many potentially lifesaving therapies. Anything that could upset the delicate balance these companies live in could deprive patients of these important breakthroughs—because if venture capital investment is reduced, many companies will be unable to survive. The President of NASDAQ recently wrote that a "decrease in investor confidence [in the biotechnology industry] can only result in a decrease in investment dollars, thereby placing critical research at risk." When the Clinton health bill was being considered in the mid-1990s, the growth rate of R&D investment dropped markedly, potentially delaying new products on their way to American consumers. In addition, venture capitalists became less willing to invest in biotech companies, forcing 13 out of 16 companies to withdraw their initial public offerings (IPOs) of stock and their efforts to go public.

During this period, the situation for ImmunoGen was very grave. Investors continually asked me how ImmunoGen could offer a return on R&D investments under a regime of price controls. In order to survive, companies like mine must be able to generate a reasonable return on R&D investments. Imposing price controls could significantly hamper our ability to do so.

Given the unique dependence of drug innovation on capital formation, rather than existing product sales, we, as the biotechnology industry, would be remiss to discuss Medicare prescription drug coverage without briefly addressing some issues related to the formation of that capital.

Biotechnology companies are by definition R&D intensive, and approval processes are often time-consuming. As such, the product development timeframe is longer than in most other industries. In many cases, it takes upwards of 10 years before a product is developed and approved. When, as is usually the case in biotechnology, a company has no product in the market place—and therefore no taxable income—the major R&D tax incentives employed so effectively by other industries simply do not apply. Tax deductions are only theoretical when there is not yet income, and net operating losses cannot be carried forward long enough to apply to profits down the road.

Paradoxically then, the R&D intensive nature of biotechnology makes today's R&D incentives more crucial to apply but less likely to do so. Fixing this "mismatch" would go a long way to improving the investment environment in our industry. Allowing us to continue developing the drugs and therapies that our Seniors rely on to improve and extend the quality of their lives.

Legislation addressing problems in this area has already been drafted, and we look forward to working with this Committee as solutions are further developed.

BIO urges Congress to ensure that any Medicare drug coverage proposal considered or enacted does not upset the delicate balance of the biotechnology industry.

Price controls and other non-market solutions could be highly damaging to the industry, and therefore to the patients waiting for cutting edge new therapies.

Over the past two decades, biotechnology has produced 133 drugs and vaccines, and there are 350 more in late stage development. The biotech products that have been approved by FDA are the work of only 71 of BIO's members, only 37 of which are profitable. The biotechnology industry invested nearly $14 billion in R&D in 2000—reinvesting, on average, more than 50% of its revenues into R&D. This is in an environment when most of BIO's members have no product revenues at all—those companies can be said to be investing more than 100% of revenues in R&D. Across all other industries, the average re-investment in R&D is just 4%. The biotech industry as a whole lost nearly $6 billion in 2000.

In addition to the hope of promising new therapies offered by biotechnology, I also want to point out that BIO's members are an important part of the U.S. economy. According to Ernst & Young Report, the biotechnology industry employs more than 170,000 people—this excludes companies that are mostly pharmaceutical in nature. We have employees in all 50 states and add more than $20 billion to the economy annually.

Many biotechnology products are oriented toward treating, preventing and diagnosing diseases of the aging population and are targeted toward small segments of disease categories and thus small patient populations. Recombinant DNA technology has enabled us to target products at the genetic level. Increasingly, new therapies will be designed specifically for unique and small populations. While we expect this to allow for more effective treatments, many with fewer side effects, it will also mean smaller markets over which we can spread the cost of R&D investment.

One example of this type of product is ImmunoGen's huMy9–6–DM1 for the treatment of Acute Myeloid Leukemia (AML). While only 10,000 new cases of AML are diagnosed each year, an estimated 7,200 patients die from AML each year. Most of these patients are older, as risk of having AML rises after age 40 and increases thereafter with each advancing decade.

ImmunoGen expects to file an IND to begin clinical trials with huMy9–6–DM1 in 2003. Thus, we are still several years from the market. While we are optimistic about this product, there are no guarantees and significant risks remain.

The bottom line is that the biotechnology industry, while being a vital part of the current economy and the source for many potential new cures, is still fragile. We would urge you to take care when designing a Medicare drug coverage plan not to upset the delicate balance of the industry.

**BIO's Medicare Reform Principles**

The issue of Medicare modernization and the proposal to add outpatient prescription drug coverage to Medicare is of high interest to the members of the BIO and the patients we serve. Many of the products in biotech companies' pipelines target diseases that predominantly affect seniors.

Accordingly, BIO believes that the Medicare program should include drug coverage for all Medicare beneficiaries. In recent years drugs and biologics have become an even more integral part of health care, while the drug coverage available to seniors has increasingly included lower coverage limits and higher premiums. BIO strongly believes that prescription drug coverage should be offered to beneficiaries in the context of an overall, market-based reform of the Medicare program, but we believe that seniors need drug coverage now—and comprehensive reform may take years to enact. Thus, we support efforts to enact a Medicare drug benefit in 2002, but we must also continue to work to make Medicare a program that reflects the best of the 21st Century marketplace. BIO stands ready to work with this committee & the Congress to pass Medicare prescription drug coverage legislation this year.

BIO's priority in the debate is to ensure that any steps taken to increase seniors' access to drugs today are consistent with the incentives needed to develop breakthrough medicines to treat the seniors of tomorrow. Consequently, we will staunchly oppose any price controls or non-market solutions.

The following are the full text of BIO's Medicare principles, as approved by our Board of Directors in 1999.

BIO strongly believes that pharmaceutical benefit options should be offered to beneficiaries in the context of an overall, market-based reform of the Medicare program. If interim prescription drug proposals are considered, they should facilitate and not deter the adoption of comprehensive reforms to the Medicare program. As part of any Medicare modernization effort, prescription drug proposals must be designed to:

**1) Rely on the private marketplace and competition, not price controls that harm innovation**—BIO believes that Medicare benefits—including coverage

for prescription drugs and biologics—should be delivered through a decentralized, pluralistic market structure that encourages meaningful competition in order to preserve patient choice, improve quality and encourage innovation. Government regulation should be limited and market-based delivery mechanisms should be utilized. Explicit or indirect price controls that stifle innovation must be avoided.

**2) Include stop loss protection and protection of those most in need first**—Federal assistance for Medicare beneficiaries should be targeted to those with the greatest economic and medical need in order to focus limited funds where they can have the most impact. Inclusion of "stop loss" coverage in order to protect the financial security of the sickest and neediest Medicare beneficiaries must be a top priority of any Medicare drug proposal.

**3) Expand beneficiary choices among private plans**—Medicare beneficiaries should have expanded choices of quality health plans and benefit packages that include prescription drug coverage to ensure that all of the elements of modern health care are provided in a system built on the advantages of our market-based economy

**4) Improve Patient care through innovations in biotechnology**—The future of patient care and our ability to prevent, diagnose and treat illness is inextricably tied to innovation in health care. By promoting strong incentives for the discovery and development of innovative new prescription drugs and biologics, America can assure that the new tools of biotechnology are applied as quickly as possible to create medicines for our aging population. BIO believes that such innovation and discovery will generate real savings by reducing the need for hospital, long-term care, and other expensive services and procedures.

**5) Maintain Medicare solvency**—In the context of over-all market-based reform, we must ensure that drug coverage for Medicare beneficiaries does not jeopardize the financial security of the program. Medicare needs to be modernized in such a way as to assure that it is a fiscally responsible program for the coming generations of seniors.

**6) Do no harm to current coverage and reimbursement**—A majority of Medicare beneficiaries have some form of drug coverage today. Additionally, Medicare does cover prescription drugs and biologics in certain circumstances. BIO believes strongly that any Congressional action on Medicare prescription drugs must avoid interfering with existing coverage and payment rules for the types of drugs and biologics currently covered by Medicare.

**BIO's Recommendations**

Based on our principles, BIO has tended to be most supportive of drug coverage plans that focus beneficiaries with very high prescription drug costs, as well as those with low-incomes. We have been the strongest advocate of what many in Congress are calling "stop loss" or catastrophic coverage to cover all or a high percentage of prescription drug costs after a certain level of out of pocket spending. We are encouraged that most of the major drug coverage proposals—from both sides of the aisle—now include some sort of stop loss coverage. We believe that a well-crafted stop loss coverage plan may be an idea whose time has now come, despite the earlier experience of this committee.

**Stop Loss Design Issues**

There have been a variety of different stop loss coverage plans introduced in various bills in the 106th and 107th Congresses. In our opinion, it is the presence of stop loss coverage that is important—coverage that is important for a variety of reasons.

We support stop loss coverage because we are quite concerned that the fruits of the most promising research that some of our members are conducting are likely to be costly—and we want to be sure the results of this research is widely available. Because of some of the dynamics of the biotech industry discussed earlier, the populations they treat are often small, sometimes very small. Moreover, biological products are often more expensive to produce than traditional pharmaceuticals because biotech products are generally made through recombinant techniques. The reagents and tools necessary to make a recombinant protein are generally more costly than traditional pharmaceutical products. As a result, we expect that some new biotechnology products may be too expensive for many seniors that lack outpatient prescription drug coverage.

While most seniors will not make claims under stop loss coverage, the coverage will provide valuable protection and peace of mind for all by ensuring that high cost therapies are available to those who need them. Stop loss coverage is true insurance against the cost of debilitating, and potentially financially devastating disease. While few people ever have their houses burn down, we all believe that fire insur-

ance is valuable. Senior citizens should have the same protection from the potentially devastating costs of disease.

**Other Coverage Design Issues**

BIO also believes that all beneficiaries should have Medicare drug coverage with greater subsidies targeted to those with low incomes. We believe that subsidies should be carefully crafted to emphasize the private market. Some low-income subsidies could have the effect of expanding Medicaid—with the corresponding government rebates and price controls the program entails. BIO believes that the private marketplace offers cost control mechanisms that will not threaten research and development investment. Private sector discount arrangements are made in exchange for movement of market share, while Medicaid rebates are unilateral government price controls.

One issue that we at BIO have spent considerable time wrestling with is the gaps contained in some drug coverage proposals between the initial coverage limit and the attachment of stop loss coverage. Since some of these bills contain no subsidies during these gaps, we are particularly concerned about how the gaps will affect low-income beneficiaries.

**Current Coverage Issues**

In addition to the Medicare drug benefit issues I have just discussed, I would like to spend a moment on some of the current coverage issues facing the biotechnology industry. Many of the treatments available for cancer, hemophilia and other life-threatening diseases are currently covered by the Medicare system because these products are administered in the hospital setting or in physicians' offices.

Medicare Hospital Outpatient Department Reimbursement

A number of changes in reimbursement methodologies have emerged in recent years, and pending additional changes could create more uncertainty in the system. Products administered in the outpatient hospital department prospective payment system (OPPS) have been subject to reduced reimbursement due to the pro rata reduction under the "transitional pass-through" rules. BIO is grateful for the work of the members of this committee in convincing CMS to delay the pro rata reduction until problems with the agency's data could be resolved. Unfortunately, the pro rata reduction implemented earlier this month is still based on inadequate data. This is particularly true for drugs and biologicals because the hospital acquisition costs used to determine the costs subject to reduction are based on faulty estimates. In December, members of this committee on both sides of the aisle urged CMS to resolve this problem in a letter calling for acquisition cost for drugs and biologics to be imputed at no less than 75% (across single source, multi-source and generic products). Unfortunately, CMS never responded to this portion of the committee's letter and implemented a pro rata reduction that we believe has caused inadequate reimbursement for many products.

When addressing Medicare reimbursement concerns, BIO's foremost priority is to ensure that hospitals and providers are reimbursed adequately when using biotechnology products so that they do not have distorted incentives to user lower cost—but potentially less appropriate—means of care. While cost effectiveness must be taken into account, Medicare patients deserve high quality healthcare. BIO attempts to craft its reimbursement policies to ensure that providers receive sufficient payments so that their decisions are based primarily on the most appropriate care for patients and not merely on the cost of the therapies involved. It is with this in mind that we urge you to ask CMS to implement your December request and set imputed hospital acquisition costs at no less than an average of 75% across sole source, single source and multisource drugs covered in the outpatient hospital setting.

BIO is also concerned about some of the decisions CMS must make between now and mid-summer when the methodology for "folding in" current pass-through products into the OPPS is proposed. At a recent town hall meeting, BIO suggested a possible approach to ensure that hospitals are adequately reimbursed for folded in products. We stand ready to work with members of this committee on this important issue. We are particularly concerned that products folded in to the OPPS are assigned to separate payment classification groups and reimbursed based on adequate data. We have called for a system of product-specific ambulatory payment classifications (APCs) with a delay in reimbursement changes until the Secretary can gather adequate data—not only for product acquisition costs, but also for handling and storage costs that are otherwise not reflected in the OPPS.

Physician Reimbursement for Products Medicare Currently Covers

Products that are physician administered also need to have a stable reimbursement path so that companies can be sure that there is a market available for their products among Medicare beneficiaries before investing the hundreds of millions of dollars it takes to bring a new medicine to market. Changes to Average Wholesale Price (AWP) must be carefully crafted to ensure that patients continue to have access to biotech products and providers are adequately reimbursed for handling, storage and aqdministration costs. These administration costs are unique for biotech drugs in that most require refrigeration and other special handling requests.

**Impact of Reimbursement Problems on Research**

I applaud recent increases to government funded biomedical research. It's been said many times before, but this research could help to find cures or treatments for many life-threatening illnesses, continuing a golden age of medicine. Government funding through the National Institutes of Health (NIH) and new biodefense funding will provide investment into the basic research that underpins new treatment, but applied research will be necessary to bring new medicines to market. It is companies like mine, and other BIO members that do the applied research needed to convert basic theories into useful new products. However, we will not have success doing this in an environment where government reimbursement policy removes the incentive for investors to fund new innovation. It would be ironic, to say the least, for government reimbursement decisions to cause the funding for applied research to dry up at the same time that new funding is being infused into basic biomedical research.

I would urge this committee specifically to move carefully when making changes to current Medicare reimbursement formulas discussed above to ensure that payment to hospitals and providers accounts for the unique handling and storage costs that are associated with biotechnology products. In general, members of Congress should take care when trying to extract new budget savings from the biotech and pharmaceutical industries. Companies like mine may not survive if new government rebates and price controls hamper investment in new medicines. Investors must know that there are stable coverage and reimbursement rules at the end of the R&D pipeline in order to keep investing in discovery research.

**Moving Forward on Medicare Drug Coverage This Year**

BIO believes that it is important to move forward this year with a new drug benefit for Medicare beneficiaries. Unfortunately, a BIO member made this same testimony last year, but this year it is even truer! The Medicare benefit package becomes more antiquated with each passing year, and we believe that the time is now to at least begin the process of bringing drug coverage to senior citizens and the disabled.

We believe that the best plans will emphasize stop loss coverage and subsidies targeted to those most in need, as the best interim steps toward more comprehensive coverage for seniors and the disabled. Based on the numbers CBO has provided in the past, we believe that stop loss protection, and some level of subsidies could be affordable. Such a plan would also provide benefits to all Medicare beneficiaries, since all would benefit from the peace of mind that stop loss coverage would offer. Moreover, by taking over some of the risk of rising drug expenditures, government subsidies for stop loss coverage could make primary prescription drug coverage more affordable for seniors.

BIO prefers comprehensive drug coverage in a fully modernized Medicare program. We still think it is important to take the first steps now so that a fully modernized Medicare program can be ready before the new influx of baby boom generation beneficiaries arrives.

**Benefits of New Biotechnology Products**

Sixteen new biotechnology products were approved in 2000. Of the 350 products currently in the pipeline, many are targeted toward Alzheimer's, Parkinson's, cancer, diabetes, osteoporosis and other diseases of aging. The products that make it through clinical trials will be on market before baby boomers retire. BIO's first priority after bringing these new therapies to market is to make sure that patients have access to these new medicines that may save lives and improve overall health and quality of life.

These new products, by reducing hospitalizations and improving overall health could generate savings in the health care system. They will allow people to remain productive longer, with potentially corresponding economic benefits. While we understand that CBO may find these savings difficult to score, we are firmly convinced that they will represent a net benefit to patients in the United States and around the world.

**Conclusion**

In closing, Mr. Chairman and members of the subcommittee, I invite you to think of a future without Alzheimer's Disease. Think of a future without Parkinson's Disease, without leukemia. Think of a future where cures are targeted to patients where treatments can be highly effective with very limited side effects. In the biotechnology industry, we firmly believe that these hopes will be realized. However, in order for these visions to become a reality, we must continue to invest heavily in the research and development of new and potentially lifesaving therapies. Moreover, in order for new treatments to have any benefits, the patients who need them must be able to obtain them. This is why BIO believes that coverage and stop loss protection are so important. Mr. Chairman, I want to commend you for holding this very important hearing, and for your leadership on drug coverage and stop loss coverage issues. I will be happy to attempt to answer any questions you may have.

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Mrs. JOHNSON OF CONNECTICUT. Thank you. Just for your information, Dr. Sayare, we are in constant communication with the Administration on this issue of outpatient reimbursements and the coverage of drugs and hope to improve that situation in the near term.

I am going to just put my concerns in the record. For each of us to have an opportunity means that we will each only have 2 minutes, and that also means that your answers will have to be short. But if we can get through everybody, at least you will have a sense of the concerns of the Members and can get back to us.

My concerns are twofold. I need to know what you think is the best way to manage costs. This morning, someone touted the Maine plan. The Maine plan manages costs by forcing the DoD plan on everyone. That is one alternative in every category, no way around it, and the pharmacist can substitute a generic for the prescription without even talking to the physician. This is not a plan that I would vote for for our seniors and not one I think they would tolerate. So this issue of how far you go down the formulary management tool track is very important.

Second, how do we get the manufacturers' discount down to the pharmacists? That has to be better specified, although in our bill, by requiring bricks-and-mortar convenient access as defined by the government, not the PBM, we think that we will be at least at 95 percent of all pharmacists being in the program. So those are the kinds of concerns I have.

I would say, Mr. Novelli, I am extremely, extremely disappointed in AARP's stand on a couple of things. First of all, if we do nothing about physician reimbursements and we let them fall another 5 percent and another 5 percent the year after that, what makes you think there will be any doctors out there that will take new Medicare patients? We already have overwhelming evidence of difficulty in our seniors finding a doctor. So I have seniors coming to me now and saying, listen, I have got a little drug coverage. I do want the doctor of my choice.

So your adherence to $750 billion as workable after the kind of testimony we have had here today troubles me, and I am glad to hear that you will consider all proposals, and also your opposition to dealing with provider payments before we deal with prescription drugs. Frankly, both are equally important.

I now would like to recognize Mr. McCrery.

Mr. MCCRERY. Thank you, Madam Chair.

Mr. Bradley, I was interested in your testimony for a number of reasons, not the least of which was you went through a number of steps that GM has taken to control costs and you named those. And then later in your testimony, you said any Medicare drug proposal ought to contain, and then you named essentially the same kinds of cost controls. But is it not true that GM's drug costs are rising at double-digit rates every year?

Mr. BRADLEY. The answer is, yes, our costs are going up, but without all the initiatives that we have in place, the benefit design initiatives, the negotiations, to answer Congresswoman Johnson's questions, all those techniques that we are using to educate and so forth, without them, our drug costs would be much higher, seriously, and that is the——

Mr. MCCRERY. I can believe that, but my point is, how can we in good conscience as policy makers create for the Medicare system a drug plan that is going to have 15- to 20-percent increases per year? That is unsustainable. You just cannot do it.

So I guess my question to everybody is, how can we do this? How can we create a drug proposal that is affordable to the taxpayers, at least under the current system? And I do not want you to answer that, I want you to think about it and help us with that.

Another thing that I want to ask about GM is how do you think we can create a program that will not replace the private dollars that you all and your beneficiaries are spending already?

Mr. BRADLEY. I think it is important for Medicare to create the universal program, and then——

Mrs. JOHNSON OF CONNECTICUT. The gentleman is out of time, so if you could delay your answer, weave it into something else, and let me recognize Mr. Cardin.

Mr. CARDIN. I would be glad to give you a moment of my time to respond to Mr. McCrery.

Mr. BRADLEY. The idea would be for Medicare to create the underlying comprehensive universal program and that the private purchaser and the public purchaser that is already offering the additional benefit would offer it as a wrap-around above and beyond that, not unlike what we already have today with the current Medicare Program.

Mr. CARDIN. And also, in response to Mr. McCrery, I think that the cost containment you can put into a plan will give you initial savings, but the annual increases are going to be somewhat comparable to the overall health care increases for prescription drugs. I think it is unrealistic to expect that your plan will beat the market on the percentage increase, but you might be able to lower the base costs.

Mr. BRADLEY. Yes.

Mr. CARDIN. Mr. Gilmartin, I want to talk a little bit about getting the cost down for seniors. It is very frustrating to hear seniors in my district say, look, we are paying the highest costs of any group prescription drugs because we do not have any insurance to cover them. We have no negotiating power, and we are not getting the discounts that others can because we have to work on our own.

If the government comes in and provides reimbursement, however it is done, through a private company or however it is done, it seems to me that the government then is representing a large

market share of your product, and the way the free market operates, as I understand it, the larger the market share, the better one is going to be able to do as far as price. Is that not basically correct? So if we come in with a comprehensive prescription drug plan within Medicare, will that not give the government the opportunity to bring down the actual cost that seniors are incurring on prescription drugs?

Mr. GILMARTIN. If Medicare is modernized to add a prescription drug benefit in a way that uses private sector health plans, comprehensive health plans as a way to accomplish that, our experience in the private sector is that these health plans are very tough negotiators. They drive a hard bargain on price. They demand value. Those benefits are passed along to companies such as General Motors and prices do come down.

So one of the benefits to seniors of not only having prescription drug coverage through a modernized Medicare plan, particularly through competing health care plans, is that they will not only be able to gain access to the medicines that they are not utilizing sufficiently right now, but they will be at lower prices. So they will benefit from those discounts.

Mr. CARDIN. Thank you.

Mrs. JOHNSON OF CONNECTICUT. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Madam Chair.

To just follow up, Mr. Gilmartin, this morning, I do not know if you were here, but Secretary Thompson was here and we talked about negotiating prices, whether the U.S. government on the behalf of 40 million Medicare patients could negotiate with pharmaceutical companies. He said, well, that would distort the market because we have such a big market share.

And then I was thinking about the fact that in my health care plan, I actually am part of Merck-Medco, and so I know that Merck-Medco, which I think is a part of your operation——

Mr. GILMARTIN. Right.

Mr. MCDERMOTT. Negotiates on behalf of 65 million beneficiaries. Now, does that distort the market? I am not an economist, so I am here to have you explain to me how the government negotiating for 40 million seniors would distort the market if when Merck-Medco negotiates for 65 million you do not do the same thing.

Mr. GILMARTIN. Well, first of all, in terms of the, I think it is important to note that controlling or having cost containment for a particular drug spend goes far beyond getting a lower price. That can help initially. But the key to really controlling drug spend is to have a high quality pharmacy care delivered in a cost effective way, so that the quality features that are built in that were outlined by Mr. Bradley have to do with ensuring that the drug is utilized properly, that the drugs are—basically, there is no overlapping uses of drugs, that there are no dangerous drug interactions, and a whole series of quality measures that are built in to ensure that there is no waste and that there is no serious health consequences.

The cost effective way has to do with the price negotiations, and we compete with Merck-Medco against other plans that are also negotiating with manufacturers and it is very much of a private market mechanism that does not lead to the kind of market distortions

you would have where basically the government would not be negotiating but simply setting a price. So I do not think that they are comparable situations.

Mrs. JOHNSON OF CONNECTICUT. Thank you, Mr. Gilmartin.

Mr. MCDERMOTT. Your feeling is that there would not be negotiations, that just the government would set the price?

Mr. GILMARTIN. That is right. I mean, I think that is the experience. The government, it is not really negotiation. The government sets the price.

Mrs. JOHNSON OF CONNECTICUT. Thank you, Mr. Gilmartin. Mr. Houghton.

Mr. HOUGHTON. Thank you very much.

Mr. Gilmartin, I am going to pick on you again. One of the concerns that comes up in a rural area, and I live in a rural area, is if we create a drug benefit that promotes competition among the companies and employs so-called Pharmacy Benefit Managers to control costs, what is this going to do to access in the rural areas? Is it going to help or hinder some of the smaller communities?

Mr. GILMARTIN. Well, PBMs such as Merck-Medco and the other PBMs in the industry operate really in all areas of the country, so that they are available in rural areas as well as in urban areas. Because they really have pharmacy networks, retail pharmacies, independents as well as chain drug stores, they are able to supply a high quality pharmacy benefit even in remote regions of the country. So we are already there, in effect.

Mr. HOUGHTON. Okay. So you do not worry about it?

Mr. GILMARTIN. No. That is not a constraint.

Mr. HOUGHTON. Thank you.

Mrs. JOHNSON OF CONNECTICUT. Mrs. Thurman.

Mrs. THURMAN. Thank you, Madam Chairman.

Mr. Bradley, you have been kind of sitting over here and you said you put all these things in order. You have done the utilization. You have done all these safeguards that you think. Your prices are still going up, right? They are going up, $509 million is what you are going to pay for how many people?

Mr. BRADLEY. Yes, about 400,000.

Mrs. THURMAN. Mr. Gilmartin, in yours you say that you want to give us tough price negotiation with pharmaceutical companies. Well, if they are doing that and they are going at it and they are negotiating, prices are still going up. Something has got to give here.

The fact of the matter is, we are not fooled anymore. I mean, we are looking at what is happening in Mexico. We look at what is happening in Canada. We look at what is happening in the United Kingdom. We are looking all over the place and everybody is getting their cost of their medicines differently.

We are talking about a benefit through some discount card, and quite frankly, if medicines have gone up 17 to 30, 40, 50 percent, and everybody I am hearing from, that is how much they are going up, I do not know what to do, and it is not because we do not have the negotiation tools. I mean, companies have. We are pushing them out of the ability to give their employees, our Medicare patients, our Medicaid patients the ability to get to those drugs that

you say are so important to us. You have got to give us something better than just, oh, let us go negotiate, because it is not working.

Mr. GILMARTIN. Well, I think that it is fair to say that the utilization of drugs is going up very significantly——

Mrs. THURMAN. And that is because we are seeing advertising on the TV.

Mr. GILMARTIN. And the utilization of drugs is going up because they have become a much more valuable, important component of our health system. Our clients, if you will, plan sponsors for Merck-Medco basically want to make sure that their plan members, their employees have access to these valuable medicines, and so, therefore, their benefit designs are really geared toward getting their money's worth, which means getting the right price to the right patient and used in the right way.

So experiences across health benefit plans vary all the way from single-digit increases to double-digit increases, but it really is an approach to get the value for those pharmaceuticals and make sure they are used properly, not to deny access to them.

Mrs. THURMAN. Madam Chairman, all I can say is I hope we have another hearing with these folks before us and others to talk about this issue because this is the most important issue to health care in this country and rising costs.

Mrs. JOHNSON OF CONNECTICUT. Thank you. Mr. Becerra.

Mr. BECERRA. Thank you, Madam Chairperson, and to all of you gentlemen, thank you very much for your testimony. I would love to ask lots of questions, but no time, so let me just ask two questions of Mr. Novelli.

First, if we had to make a decision on how we were going to spend some of our dollars from the Medicare and Social Security trust funds, would AARP take a position on whether those moneys should be spent on tax cuts or on Medicare and Social Security?

Mr. NOVELLI. We are not taking a position on tax cuts. We are not taking a position on raising revenues. What we are taking a position on is the fact that, as I think you agree, everyone agrees, older people need pharmaceutical drugs in Medicare.

Mr. BECERRA. But if you saw that Congress were going to spend the trust fund monies going in for Medicare and Social Security, including those that are currently in surplus that we are not using to pay out benefits today for Social Security or Medicare, and if you saw that for the next 10 years we are going to spend those surplus dollars that are coming in, would you want them spent on Medicare and Social Security or would you mind if they were spent on tax cuts?

Mr. NOVELLI. We tried to come up with a recommendation so that we could give Congress some flexibility, and I would like to say and to clarify with respect to what Congresswoman Johnson asked, we did not come in here with a $750 billion plan. We came in here and said it is going to be very difficult with the budget resolution that you have to do a drug program that people are going to enroll in. I think the challenge is going to be to try to deal with that and to do it in such a way that you are going to have a viable program.

Mr. BECERRA. One last question, if I may.

Mr. NOVELLI. I am not taking a position on income tax cuts.

Mr. BECERRA. If I could just get to one last question, let me ask you one last question with regard to the survey that you make note of in your testimony where you say that 67 percent of seniors have said that if they were faced with a plan that provided them with a drug benefit that would cost them $35 a month as a premium with a $200 deductible and which paid for 50 percent of the cost of prescriptions and that had an out-of-pocket cost over the year of about $4,000, that they would not voluntarily purchase that.

We have a plan, the only plan we have before us that we can refer to is the Thomas bill that was here before us 2 years ago that would have greater costs involved per senior to participate in that plan. Do you believe that the Thomas plan would be something that seniors, given your survey, would want to adopt?

Mr. NOVELLI. We did not test the elements of the Thomas plan. We tested the plan that you just talked about.

Mr. BECERRA. Right, and the elements of the Thomas plan are even more severe in terms of costs on seniors than what you surveyed.

Mr. NOVELLI. Precisely my point. It is going to be very difficult to come up with a plan that is going to be adequate, that is going to be viable, and as I said before, we are willing to look at anything. We are willing to help. We are willing to test any element, but you have a very tough job on your hands.

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

Chairman THOMAS.[Presiding.] I thank my colleagues. I apologize to the panel. Oftentimes, this place is a three-ring circus, and I was in the second and third rings for a little while.

I do understand the line of questioning. However, I have found that at some point, people have to bump up against reality, and if, in fact, we pass a major prescription drug bill with modernizations in the $350 billion range, I think you will find that there will be a significant difference between what seniors ask as their druthers and what they are willing to do if, in fact, it is in front of them as a real, viable program. My assumption is the real, viable program would be adopted.

However, because of all the other changes that we need to deal with, there are ways in which we can show them in a relative way that the dollar expended by the senior can be better spent tomorrow than it is today, and Mr. Novelli, in that regard, I know that you are involved in terms of the various activities of AARP in providing seniors with Medigap products. Do you have any rough idea of the percentage of your income that comes from the Medigap products?

Mr. NOVELLI. It represents probably about 20 percent of our income.

Chairman THOMAS. So one-fifth of your income comes from Medigap programs, in which only the last dollar on some of the most expensive options go toward prescription drugs. The first dollar of every Medigap plan goes toward immunizing individuals against the cost effectiveness of various copays and other payment structures.

Do you believe that if we could engage in a constructive dialog, we might be able to come up with a higher and better use of those

precious dollars that seniors now spend on what is called Medigap insurance?

Mr. NOVELLI. As you know, Mr. Chairman, we have talked about this before and my answer to that question is, yes, we should have such a dialog. Those Medigap programs are prescribed by law. If they should change, we will be happy to change with them. We also have a pharmaceutical service. What we want to do is do the best job we can for our members. We are perfectly happy to talk about these things and to make changes.

Chairman THOMAS. And oftentimes when we discuss out-of-pocket costs, and it is difficult to do in a questionnaire, we do not remind the seniors how much they are currently paying out of pocket for what is, frankly, in many people's opinion, a kind of a lousy insurance product, and that if those dollars were redirected or combined in a more meaningful way, you could clearly get more bang for your buck.

That is one of the areas that we will be exploring because it is not just additional government dollars that I think we should be dealing with. There are people who are paying out of pocket now and not receiving maximum value if we were to restructure the way in which Medicare and other programs interact.

Second question, and I do appreciate your testimony, Mr. Novelli, because I read it carefully and I noticed differences from the first communication from AARP under the new leadership. One of the points that I really want to stress that I mentioned earlier, and I will repeat myself over and over again, in the Chairman's opinion, what we did when we created Medicare was to create a seniors', basically, acute care health program. We did not say it was just for wealthy seniors or those who joined a particular group or who had a sufficient corporate retirement plan to blend with Medicare. We did it for all seniors.

The failure of previous Congresses to deal reasonably with the low-income issue does not negate that basic fact, in the Chair's opinion, and that our responsibility on Medicare is to all seniors to provide a uniform national program, and that if, in fact, we are going to assist low-income seniors as low-income first and seniors second, we are not really doing what I thought Congress committed itself to do and that is provide a health care program for all seniors.

Unfortunately, that is the way it has evolved, and if you are a senior but find yourself in the unfortunate position of being low-income, you are shuttled to a State structure under a Medicaid arrangement in which two seniors in different States find themselves treated significantly differently and the benefits available to them are significantly different and that is not, I do not think, what was intended when we talked about a seniors' acute health care program.

I know there have been some statements by your organization and others. Just because we focus on low income as a needed assistance in a larger new program does not mean that that low-income senior assistance has to come through what I consider to be the flawed traditional structures, and I hope we can continue a dialog in that area because my goal will be to create a program in which we have a modernized Medicare with prescription drugs

available to all seniors wherever they may choose to live and not have a significant portion of it augmented by the State they happen to live in. I hope you would share that goal.

Mr. NOVELLI. I think we are on the same page. We obviously agree with you that we do not want to means test Medicare. We also agree that there can be ways to work within Medicare on ability to pay and we would be very happy to have that dialog.

Chairman THOMAS. I would only tell you, do not assume I do not want to means test Medicare. I just do not believe that there is a practical way to do it in a real-time way, and I am still working on that, because at the same time we provided affordable health care for all seniors. I do not think it was in anyone's mind that what we wanted to do was to not provide for those in need because it would cost too much on an even-handed way in which we were required to provide resources for those who were not in need, and that needs to be a discussion that we will save for a future day.

Mr. NOVELLI. We appreciate the fact that you see the need for prescription drug coverage that is universal. I think it has been discussed this morning, certainly, but I would like to reiterate that this is a problem for the middle class of elderly people and not just for low-income people.

Chairman THOMAS. There is no question that that is the case and that what we are trying to do is create a structure in which everyone, regardless of their circumstances, has some reason to join because there is an advantage over the current structure. Fortunately, the current structure is so poor that we ought not to have that much difficulty in creating a better arrangement as far as prescription drugs are concerned.

I would just briefly ask if any member of the panel wants to respond. My questions were directly to Mr. Novelli, but obviously in terms of low-income and a broad-based program and the willingness of seniors to adopt them, that is a kind of a broad-based question.

[No response.]

Chairman THOMAS. With that, I want to thank you very much. Your testimony has been made a part of the record, has been read, and will be pondered over as we move forward. This is not the end of the process, it is, in essence, the official kicking off. We will be back working with you and with others as we try to build an affordable prescription drug program into a modernized Medicare structure.

I would like to include in the record the statement submitted by Chellie Pingree.

[The statement of Ms. Pingree follows:]

**Statement of the Hon. Chellie Pingree, Portland, Maine**

Chairman Thomas, members of the House Ways and Means Committee, thank you for the opportunity to testify here today. The high cost of prescription drugs in this country is a travesty and Maine is no different. I am here today to tell you about Maine's innovative approaches to securing affordable prescription drugs. I will focus on the landmark legislation that I sponsored in 2000, An Act to Establish Fairer Pricing for Prescription Drugs, more commonly known as "Maine Rx." I also want to share the story of Maine's ongoing struggle for fair prescription drug prices and what we learned from our experiences.

The story of Maine's most recent fight for affordable prescription drugs begins with seniors who were fed up with paying higher and higher prices and who knew

that they could buy their prescriptions at nearly half the cost if they just crossed the border to Canada. In 2000, Maine people, led by seniors, came to me looking for affordable prescription drugs that they could purchase at their local pharmacy. This is not a new problem, and in Maine we've had prescription drug subsidy programs to help low-income seniors and families since 1975. We had already made substantial changes to these programs over the years, but there was great reluctance to further expand them. By the mid 1990s, prescription drug costs were growing so significantly that they put our seniors' health at risk. Hardworking Mainers were forced to choose between food and the drugs they needed to stay alive, and even during a time of economic prosperity in Maine the number of uninsured was growing and an increasing number of seniors were coming forward with very painful stories. By this point, most lawmakers knew another subsidy was not the answer when drug costs were rising faster than a runaway train. Maine could not keep bearing the costs for drug company executives whose profits seemed more important than people. I came to the conclusion that we needed to look at the problem differently. Every industrialized nation in the world negotiated with drug companies for lower costs EXCEPT the United States. I decided that Maine needed to have unified voice with which it could negotiate for lower prices on behalf of its citizens, and so I wrote the Maine Rx bill.

As passed, the Maine Rx Program does the following:

- establishes the Maine Rx program in which the State serves as a pharmaceutical benefits manager (PBM) for the estimated 325,000 Maine residents who have no prescription drug benefit;
- prevents profiteering and hindering the sale of prescription drugs in Maine by drug manufacturers;
- authorizes interstate cooperation for bulk purchasing and cost saving;
- provides for emergency prescription drug prices if the negotiations do not produce prices comparable to the lowest prices paid in Maine; and
- creates a Prescription Drug Advisory Commission charged with reviewing access to prescription drugs in Maine, advising the Commissioner of Human Services and reporting to the Legislature and Governor. The commission is made up of a diverse group of community members representing the medical community, pharmacists and seniors.

The Maine legislation is comprehensive and serves as model for more than twenty other states across the country.

Currently, Maine has three prescription drug programs for its residents, and we are battling lawsuits against two of the programs, Healthy Maine Prescriptions and Maine Rx. In 2000, we were at the forefront with Vermont in securing a Federal Medicaid wavier to extend Medicaid prescription drug benefits to the uninsured, and since 1975, we have steadily increased both the individuals and the prescriptions covered in our subsidy program, the Low Cost Drug Program for the Elderly and Disabled.

Through letters, public testimony and local community forums on prescription drugs, I learned that Maine people want to be able to purchase safe, high-quality prescription drugs at affordable prices at their local pharmacies. They want a system in which consumers, pharmacies, manufacturers and the State get a fair deal. They do not want prescription drugs to consume millions of dollars in State funds, and this is why in Maine we decided to negotiate for lower prices. It is equally important for the Federal Government to negotiate a lower price for Medicare and then offer a comprehensive benefit to seniors. We cannot pay retail for prescription drugs—we should negotiate our price, just like every other industrialized nation in the world, and just like we do with the prescriptions supplied to Veterans through the Veterans' Administration.

In Maine, seniors have been traveling to Canada to buy affordable prescription drugs for years. On the most recent trip in March of this year, sponsored by the Alliance for Retired Americans, 24 people saved $11,000 on their prescription drugs. Many of the folks on this trip had never purchased prescription drugs from Canada before, and several said they had been searching for the bus and ways to buy affordable prescription drugs for some time. Many felt like going to Canada and saving that $500 or $1500 was really changing their lives. These are people with serious health problems, seventy-five year old women traveling alone on a bus to Canada to buy affordable prescriptions and couples traveling nervously, not really believing the position in which they've found themselves. Many of the Maine seniors I know are determined to go to Canada and save as much money as possible. However, most are acutely aware that they are leaving their country to take better care of themselves and as unfortunate as this is, that they are lucky to be able to travel to Canada.

As this debate moves forward, I want to impress upon you the great need for Congressional action. State budgets can be very fragile, and for a state like Maine to spend the millions it does on prescription drugs is very difficult. Our state constitution demands a balanced budget, and the pressures of paying the ever-rising cost of prescription drugs stresses the entire state system. We need federal legislation that will do one of two things: either provide a prescription drug benefit under Medicare, passing on negotiated discounts to seniors, or free up the states to use innovative programs like Maine Rx while the debate in Congress continues.

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Chairman THOMAS. Thank you all for being here. Thank you for your patience.

Mr. MCDERMOTT. Mr. Chairman, could you give us sort of an outline of—you said this was the beginning of the process. I kind of would appreciate it if you would give us some kind of outline of how we are going to get to the period before Memorial Day. What is your outline or your feeling about——

Chairman THOMAS. I am looking for the Chairwoman of the Health Subcommittee. What has been occurring, both at the subcommittee level and on an inter-subcommittee level between Ways and Means and Commerce are ongoing discussions of options, what they might look like. We need to shift into a more rigorous structure in which we begin to build packages and do spend-out arrangements, and again, doing it on both a subcommittee Ways and Means basis and then interacting with the Commerce Committee, since we have to work together. Our goal will be over the next 2 to 3 weeks to move fairly quickly in putting options together and then have the subcommittees begin to vote and move on those options.

Mr. MCDERMOTT. Will there be hearing time for those options when they are put out?

Chairman THOMAS. It is the Chair's intention now to try to put together a package, get responses to the pieces of the package, pull it together, get responses to the package, and move it forward. As to whether that gets done completely at the subcommittee level and then moving up to the full Committee is not yet determined. In part, it will depend upon the ongoing, positive working relationship with Commerce.

If the gentleman will recall, when he was a Member of the Health Subcommittee and I was the Chair of it, it was a slightly different environment than is currently the case. It is this Chair's opinion that the recent changes in chairs create an opportunity between Committees to create a much more cooperative working atmosphere between the Committees and the Chair hopes to capitalize on that.

Mr. MCDERMOTT. When you say you are going to get responses, do you mean put it out to the parties involved or are you going to put it out in front of us and let us discuss and ask questions of witnesses and so forth?

Chairman THOMAS. All of the above, including any other ideas that we can come up with.

Mr. MCDERMOTT. Thank you.

Chairman THOMAS. With that, the hearing stands adjourned. Thank you very much.

[Whereupon, at 3:10 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

**Statement of the American College of Physicians—American Society of Internal Medicine**

The American College of Physicians-American Society of Internal Medicine (ACP–ASIM)—representing 115,000 physicians and medical students—is the largest medical specialty society and the second largest medical organization in the United States. Internists provide care for more Medicare patients than any other medical specialty. We congratulate the Committee on Ways and Means for holding this important hearing to address the need for a Medicare prescription drug benefit. ACP–ASIM thanks Congressman Bill Thomas, chair of the Committee, and other committee members for convening this important hearing.

**Background**

Medicare suffers from an outdated benefits package that denies patients access to life-saving medications. Medicare beneficiaries are denied access to important life-saving medications because the existing plan of benefits, which remains fundamentally the same as that which was established when the program was created in 1965, excludes coverage for most prescription drugs. The Medicare program as a whole faces a difficult financial future, trying to find ways to adequately finance both the HI and SMI programs for beneficiaries. Clearly, comprehensive reform of the Medicare program is required to assure that needed health services are provided to beneficiaries and to maintain the financial solvency of the program. Greater costs could mean higher premiums for beneficiaries, reduced benefits, or a payroll increase for employers and employees. Adding an expensive Medicare prescription drug benefit to the existing program could exacerbate looming financial troubles and prove fatal to the Medicare program. However, by focusing on the neediest beneficiaries first and given an adequate budget outlay by Congress, policy makers could design a well-financed drug benefit that helps our most vulnerable seniors.

Ideally, a prescription drug benefit should cover all Medicare beneficiaries equally. However, if a universal benefit carries too large a price tag, then coverage should be targeted to those most in need—low-income beneficiaries, those with high drug costs, and those with multiple chronic diseases. To ensure a high quality of life and to eliminate costly, unnecessary hospitalizations, our most vulnerable Medicare beneficiaries must have access to needed prescription medications. ACP–ASIM supports a number of mechanisms to control the costs of a prescription drug benefit, but emphasizes that patient safety and quality of care should be the primary focus. Congress should expand Medicare benefits to cover prescription drugs and institute measures to lower the costs of prescription drugs.

Another idea introduced by the Administration, the Medicare-Endorsed Prescription Drug Card Initiative, also offers a short-term solution to seniors' rising drug costs. While a prescription drug card plan would provide some assistance for needy seniors, it is not a substitution for long-term, comprehensive prescription drug coverage for Medicare beneficiaries. As Congress develops proposals to provide drug coverage, the Administration's proposal enables seniors to earn discounts on medications for the immediate future. Even a 10% discount on retail drug prices could help beneficiaries as they await action from Congress. ACP–ASIM supports a drug card plan that ensures minimal costs for seniors, up-front pricing information, and guaranteed savings for Medicare beneficiaries, not at the expense of local pharmacies.

**ACP–ASIM Recommendations**

1. The highest priority should go toward providing voluntary prescription drug benefits for those most in need: low income beneficiaries who do not have access to drug coverage under other plans.
2. If sustainable, predictable financing is available, ACP–ASIM supports providing an optional Medicare prescription drug benefit to all beneficiaries, regardless of income and health status.
3. Drug benefit plans should be voluntary, and seniors should be able to opt out of the program and maintain their existing Medicare coverage.
4. The benefit must be financed in such a way as to bring in sufficient revenue to support the costs of the program, both short and long-term, without further threatening the solvency of the Medicare program or requiring cuts in payments for other services or reduced benefits in other areas. ACP–ASIM recommends that Congress consider: (1) increasing general revenues or payroll taxes to support a Medicare prescription drug benefit, and (2) income-related premium contributions, co-payments, and deductibles to support the program.

5. The maximum allowable Medicare reimbursement for prescription drugs should balance the need to restrain the cost of the benefit with the need to create financial incentives for manufacturers to continue to develop new products. Rigid price controls that will discourage innovation and threaten drug supply should be rejected.

6. ACP–ASIM supports using prudent-purchasing tools in designing a Medicare prescription drug benefit. Like the VA, Medicare should investigate average wholesale drug prices and directly negotiate with manufacturers or wholesalers.

7. Until the safety concerns issued by the FDA and HHS are resolved, ACP–ASIM opposes prescription drug re-importation as a means to reduce retail drug prices.

8. If therapeutic safety and equivalency are established, then generic drugs should be used, as available, for beneficiaries of a Medicare prescription drug benefit. In order to eliminate delays for generic entry into the market and discourage financial arrangements between generic and name brand manufacturers, Congress should close loopholes in patent protection legislation.

9. ACP–ASIM supports research into the use of evidence-based formularies with a tiered co-payment system and a national drug information system,[1] as a means to safely and effectively reduce the cost of a Medicare prescription drug benefit, while assuring access to needed medications. Demonstration projects to test such methods should be established before a national program is introduced.

10. Medicare prescription drug formularies should not operate to the detriment of patients, such as those developed primarily to control costs. Decisions about which drugs are chosen for formulary inclusion should be based on effectiveness, safety, and ease of administration rather than solely based on cost. Formularies should be constructed so that physicians have the option of prescribing drugs that are not on the formulary (based on objective data to support a justifiable, medically-indicated cause) without cumbersome prior authorization requirements.

11. Medicare prescription drug benefit should not limit coverage to certain therapeutic categories of drugs, or drugs for certain diseases.

12. To counterbalance pharmaceutical manufacturers' direct-to-consumer advertising, ACP–ASIM recommends that insurers, patients and physicians have access to unit price and course of treatment costs for medically equivalent prescription drugs.

13. If pharmacy benefit managers (PBMs) are used to administer a Medicare prescription drug benefit, they should be subject to consumer protection standards of accountability, including:

- Disclosure to patients, physicians, and insurers of the financial relationships between PBMs, pharmacists, and pharmaceutical manufacturers;
- Requiring that PBM requests to alter medication regimes occur only when such requests are based on objective data supported by peer reviewed medical literature and after having undergone review and approval by associated MCO/MBHO Pharmacy and Therapeutics Committees,
- Requiring that, with a patient's consent, PBMs be required to provide treating physicians with all available information about the patient's medication history.

14. ACP–ASIM believes that switching prescription medications to over-the-counter status should be based on clear clinical evidence that an OTC switch would not harm patient safety, through inaccurate self-diagnosis and self-medication, or lead to reduced access to "switched" drugs because they would no longer be covered under a prescription drug benefit. Manufacturers and other interested parties should be allowed to request such a reclassification.

15. ACP–ASIM supports the creation of a Medicare prescription drug card program as a first step to providing seniors assistance with prescription drug costs, provided that:

- The program is not a substitute for comprehensive Medicare prescription drug coverage.
- Pharmacy benefit managers (PBMs) are required to pass on rebates from manufacturers to pharmacies, and subsequently, beneficiaries.
- Program costs for beneficiaries are minimal or free.

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[1] A national effort to establish a uniform, evidence-based prescription drug system would provide physicians, insurers, PBMs, and patients with much-needed information about prescription drugs, including which are most beneficial and cost effective. This kind of analysis would require a great deal of expertise, time and money. It must be independent and unbiased, controlled by an independent body of physicians, patients, and pharmacists appointed by HHS to supply important drug information to all involved parties. Any national effort to design an evidence-based system must be non-restrictive for physicians and patients, in order to provide the best quality health care. An evidence-based formulary could be used in an advisory role, rather than as a mandate for prescribing.

• Card sponsors publish complete drug pricing information, so that Medicare recipients can "shop" for the best card.

**Conclusion**

ACP–ASIM is pleased that the Committee is addressing the needs of Medicare beneficiaries to have access to affordable, life-saving medications. The College stands ready to assist the Committee and members of Congress to implement the recommendations identified in our statement. ACP–ASIM supports a number of cost-saving mechanisms described in our statement, but with the condition that patient safety and quality of care should be the primary focus. A benefit that incorporates consumer protections regarding pharmacy benefit managers and formulary use could be both cost-effective and responsive to seniors' prescription needs. In addition, higher-income beneficiaries should pay higher premiums to increase revenue to the program and allow for subsidies to lower-income recipients.

Further research is needed to examine the effects of evidence-based formularies and the long-term effects of more popular methods of reducing costs, including PBMs, tiered formularies, and price controls. No matter what methods are used to administer a cost-effective Medicare prescription drug benefit, reducing costs should not result in diminished care or poor access to necessary medications. ACP–ASIM recognizes the needs of older Americans, and calls on policy makers to respond with a Medicare prescription drug benefit that addresses those needs as soon as possible.

For more on ACP–ASIM's positions on Medicare reform and prescription drug coverage, please visit our web site http://www.acponline.org/advocacy.

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**Statement of the Infectious Diseases Society of America, Alexandria, Virginia**

As the House Ways and Means Committee debates providing prescription drug coverage to one of the nation's most vulnerable populations—the elderly—under the Medicare program and develops legislation to implement this important change, the Infectious Diseases Society of America (IDSA) strongly urges Committee Members to include coverage for home-based outpatient intravenous (IV) antimicrobial therapy and the related physician case management services and supplies in this new benefit. IDSA represents nearly 7,000 physicians and scientists devoted to patient care, education, research, and community health planning in infectious diseases. As the physicians who coordinate care for patients with serious infections, our members are keenly aware of the how Medicare's failure to cover home-based outpatient IV antimicrobial therapy disadvantages both American taxpayers and the Medicare beneficiaries.

Medicare policy prohibiting coverage of outpatient, self-administered drugs has severely limited access of Medicare patients to ambulatory IV therapy, thus forcing them to rely on more costly and less-convenient inpatient hospital care. Covering home-based outpatient IV antimicrobial therapy and its related services and supplies under Medicare would greatly benefit American taxpayers as home-based therapy is a safe and much less-expensive alternative to providing it in the hospital. This is why most private insurers and many Medicare HMOs cover this service. The benefit to elderly patients receiving this therapy in their home is improved quality of life, convenience and time-saved.

IDSA understands that Congressional leaders are considering adding a limited drug benefit that would cover cancer drugs to the Medicare program. We applaud and encourage the addition of this important new benefit, but strongly urge that such a benefit also include coverage of outpatient IV antimicrobial therapy. In addition to IDSA, the American Medical Association also has endorsed this approach. Their written policy states that AMA "endorses the use of home injections and/or infusions . . . (including chemotherapy and/or antibiotic therapy) for appropriate patients under physician supervision, and encourages [CMS] and/or other insurers to provide adequate reimbursement for such treatment" due to "the benefits of such treatments in terms of cost savings, increased quality of life and decreased morbidity." [AMA policy H–55.986]

**The Problem**

Unlike many private insurers and Medicare health maintenance organizations (HMOs), the Medicare fee-for-service program does not cover IV antimicrobial therapy provided in the home whether self-administered or administered by a trained health professional. This means that patients must stay in a hospital, sometimes for several weeks, where they are at risk of exposure to hospital-acquired infections,

or travel to their physician's office, sometimes twice a day to receive this treatment. Not only is home-based drug infusion therapy safe and effective, it also is much less expensive. Whereas hospital-based antimicrobial IV therapy typically costs $1,000 per day, home-based therapy costs less than $200 a day. One study estimates that Medicare can save approximately $5.3 billion in 10 years simply by covering home-based IV antimicrobial therapy.

Medicare patients are often outraged when they discover that Medicare won't cover this essential therapy unless they are hospitalized for long periods of time or visit their doctor's office as often as seven days a week for weeks on end. For rural patients, this can mean traveling 150 miles a day to receive this 15-minute treatment that they could easily receive at home. Their frustration is exacerbated when they discover that patients who are privately insured or covered by Medicare HMOs are released from the hospital to continue drug therapy at home.

Treating Medicare beneficiaries in their homes also would reduce their exposure to hospital-acquired, antimicrobial-resistant infections. Hospital-acquired infections affect over 5 percent of hospitalized patients and result in increased costs to the Medicare program. On average, hospital-acquired infections tend to add four days to a patient's hospital stay and cause more than 20,000 deaths a year.

**When is IV Antimicrobial Therapy Necessary?**

Physicians routinely prescribe antimicrobial IV therapy for serious infections that cannot be treated with oral antimicrobial agents. When prescribed with a physician's oversight, IV antimicrobial therapy is a safe and effective way to treat a number of infections, including certain bone and skin infections, endocarditis (an infection of the heart valves), pneumonia, bronchitis, urinary tract infections and pelvic inflammatory disease. Osteomyelitis, a bone infection, frequently requires long courses of therapy with high concentrations of intravenously administered antimicrobials. Drug treatment for four or more weeks is common. Cellulitis, an infection of the skin and surrounding tissue, is another condition commonly treated in this manner. Serious fungal and viral infections often occur in people who have impaired immune systems, such as those with AIDS, diabetes or who have received an organ transplant. Moreover, antimicrobial infusion therapy can be tremendously beneficial for people predisposed to repeated infections, such as those with cystic fibrosis. Traditionally, these individuals must be admitted to hospitals frequently to treat recurring infections. They also are those at highest risk for catching new infections in a hospital.

Osteomyelitis, cellulitis, endocarditis, and pneumonia account for over 80 percent of all cases requiring IV antimicrobial therapy. Together, these conditions account for nearly six percent of the 12 million annual Medicare hospital discharges, at a cost of over $4 billion annually.

**Services and Supplies Necessary for Outpatient Drug Therapy**

In addition to antimicrobial drugs, other services and supplies are necessary for safe and effective outpatient IV antimicrobial therapy. First, physicians must prescribe and oversee the therapy. Physicians select the appropriate drug, dosage, and length of treatment; monitor the patient's progress; look for side effects of the therapy; and respond to any emergencies. Second, nurses usually educate patients and their caretakers about administering the infusion and caring for the infusion site. They also may monitor the patient's progress, coordinate care, and oversee the actual IV infusion. Third, pharmacists prepare and distribute the prescribed drugs and respond to patients' questions regarding the therapy and its side effects. Sometimes they monitor laboratory results and collaborate with physicians and nurses to adjust drug dosages. Finally, laboratory services are necessary to monitor the patient's status and response to therapy.

Medicare currently does not reimburse physicians for their services unless they see the patient directly or the patient is enrolled in the home health or hospice program. Safe and effective home drug therapy, however, requires continuous, active oversight by a knowledgeable physician. Ongoing physician involvement is as important in the outpatient setting as it is in the hospital. Although physicians probably will need to meet with patients weekly while the outpatient IV antimicrobial therapy is underway, they also will need to spend a significant amount of time coordinating care with the patient and other health professionals, reviewing laboratory test results, and generally monitoring the patient's progress and any complications.

As for equipment, two types are critical. First, there must be an access device to insert the drug into the body. Peripheral (IV) catheters, central catheters and subcutaneous ports are examples. Next, an infusion device controls the rate of drug flow. Infusion devices range from sophisticated pumps that allow for the infusion of multiple drugs at different rates to simple syringes and gravity drip systems. As

opposed to narcotics and other pain medication, IV antimicrobial agents tend to use fairly simple and inexpensive access and control devices. Other equipment that may be needed include IV poles, tubing, and dressing supplies.

Finally, it is not clear that physician dispensing of the drugs and pump used in outpatient antimicrobial therapy to patients in their homes is exempt from the Stark law's prohibition on self-referrals. Thus, we urge Congress to strongly consider a remedy to ensure that physicians be permitted to dispense these drug therapies and the necessary pumps.

The expansion of Medicare coverage to include outpatient IV antimicrobial therapy is a cost-effective reform that will give Medicare beneficiaries access to the same therapies, safety and convenience as their private sector counterparts. Modernizing Medicare benefits to include coverage for this drug therapy makes good common sense and is essential to the good health of our nation's elderly people.

## Statement of the National Association of Chain Drug Stores, Alexandria, Virginia

Mr. Chairman and Members of the Committee, The National Association of Chain Drug Stores (NACDS) is pleased to submit this statement for the record on **"Integrating Prescription Drugs into Medicare."** NACDS represents about 200 chain pharmacy companies that operate about 34,000 retail pharmacies all across the United States.

Chain pharmacy is the single largest segment of pharmacy practice. Our members include the traditional chain pharmacies, the food/pharmacy combinations, and the mass merchandise pharmacy operations. We filled about 70 percent of the 3.1 billion prescriptions provided across the nation last year. We appreciate the opportunity to describe for you our ideas on both providing a comprehensive Medicare prescription drug benefit as well as our suggestions for interim steps that the Congress can take to help seniors obtain necessary medications.

### Comprehensive Approaches to Pharmacy Coverage

NACDS supports enactment of a comprehensive pharmacy benefit for seniors. In particular, we strongly support **H.R. 3626, the Medicare Drug and Service Coverage Act of 2002,** which has been introduced by Representatives Jo Ann Emerson and Mike Ross. This is the only comprehensive bipartisan prescription drug bill that has been introduced in the House, and contains the many elements that we think are important in a meaningful, quality drug benefit for seniors.

This includes ensuring that seniors have access to the pharmacy of their choice, that they are provided with community-based pharmacy services with provisions for adequate payment for these services, and that the use of low-cost generic drugs is encouraged. We are grateful to these two members for their leadership on this issue, and we also appreciate the cosponsorship of the Members of Congress that support this bill. This bill is supported not only by NACDS, but the entire pharmacy community, including the independent pharmacies, hospital pharmacies, and nursing home pharmacies.

In terms of the recent drug benefit proposal that passed the House in June 2000, HR 4680—the Medicare Rx Act—NACDS and all of organized pharmacy is concerned with the approach used in that bill. We believe we would have similar concerns with that type of bill if it were brought to the House floor again this year.

In general, we have concerns with "drugs-only" insurance-based and PBM-based approaches to providing prescription drug benefits. We do not support the approaches used by these entities to contain costs, because they are primarily focused on reducing access to prescription medications, and reducing pharmacy reimbursement. Moreover, we also do not believe that the Medicare program needs to turn to these middlemen to obtain the savings on medications that Medicare should obtain, given its purchasing power in the market.

We believe that the experience of the government's own FEHBP should be instructive to Members of Congress as they consider the true effectiveness of this approach to providing a prescription drug benefit for seniors. Our analysis indicates that escalating prescription drug spending in the FEHBP program—which is administered by the same PBMs that would be used for Medicare—has contributed significantly in recent years to the sharp premium increases seen in the program.

For example, in 2001, 40 percent of the 10.5 percent increase in FEHBP premiums was attributable to drug spending increases. In 2002, 37 percent of the 13.3 percent increase in FEHBP premiums was attributable to drug spending increases.

Keep in mind that the FEHBP population is not typical of the traditional older Medicare population, which uses more drugs and has higher per capita expenditures than the much-younger FEHBP population. If the PBMs have not been able to manage prescription drug spending in the FEHBP program, why should we believe that they would be any more effective in the higher-cost Medicare population?

**Interim Approaches to Pharmacy Coverage**

There are certain interim steps that we encourage Congress to take if a comprehensive drug benefit is not achievable this year. If Congress cannot come to agreement, or insufficient time exists to develop a voluntary benefit for all seniors, then we think we should start with making medications more accessible for the most vulnerable in society, and those with the highest medication bills.

**Consolidated Manufacturer Card Program with "Stop Loss" Coverage:** NACDS supports an interim approach that would have two components. The first component would create the necessary Federal infrastructure for low-income seniors to more easily access the various drug manufacturer medication subsidy and discount programs that are being developed. The second component would provide a full pharmacy benefit for seniors who need "stop loss" coverage because they have high out of pocket drug costs.

At last count, nine manufacturers have developed these programs over the past few months. Some of these programs provide discounts, while others provide subsidies, such as paying the full cost of the prescription other than a $12 or $15 copay.

However, each program has been issuing its own "card" to seniors to access these discounts and subsidies at the pharmacy. Moreover, each program has different eligibility criteria and enrollment forms, and other requirements to access the program. While NACDS views these programs as very worthy, we are concerned that seniors will be confused by the multiple programs, and that they will create operational difficulties for pharmacies having to deal with multiple cards for seniors.

As a result, NACDS announced last month that it was launching the ***Pharmacy Care Alliance,*** which represents a strong first step by retail pharmacy leaders to help seniors obtain needed prescription drugs. Among other activities, the Alliance will help educate seniors about these programs so that they can be used to the maximum extent possible.

We have also created the **PharmacyCare***OneCard*—a new concept that would allow low-income seniors to carry a single card for participating in a broad number of these manufacturers' discount and subsidy programs. We hope all pharmaceutical manufacturers that sponsor special programs for seniors—whether they maintain their own card program or not—will become partners in the Alliance and offer their programs to a national network of retail pharmacies through the **PharmacyCare***OneCard*. We hope to build an open, flexible program that allows individual manufacturers and retailers to choose whether and how to participate.

We already have seen results from our efforts to push for a consolidated approach. Over the last few days, several manufacturers have responded to our call for a "one card", and have joined forces to create the "Together Rx" program, which would allow seniors to access these manufacturers' discount programs through the use of one card. We are hopeful that this card program might eventually be joined with our program—as well as other manufacturer card programs that exist in the market—to offer these programs to seniors through the use of a true, single standard card.

While the "Together Rx" card clearly moves in the right direction, we believe that legislation is needed to facilitate the evolution of the goal of creating one card, and making the program more permanent for seniors. We believe that Federal legislation should be enacted to create a single administrative structure that can be used by any manufacturer that wants to offer a discount or subsidy program. Seniors would be able to use one card at the pharmacy—rather than multiple cards—to obtain lower medication prices.

Quality of care would also be enhanced, since a single electronic prescription processing system would allow the pharmacist to check for any potential adverse reactions in filling prescriptions for seniors. This could not be achievable without a Federal solution. Our hope is that all manufacturers with these programs would use this approach to offering their discounts and subsidies.

Second, as part of our interim proposal, we would support full pharmacy "stop loss" coverage for seniors who incur more than a certain amount in unreimbursed drug expenses each year, such as $6,000. The same infrastructure that is used to administer the manufacturer subsidy and discount programs can be used to implement this "stop loss" coverage program.

Offering this coverage will start us down the road to providing more comprehensive coverage for prescription drugs, beginning with the population that needs help the most. Over time, Congress can take steps to lower the "stop loss" amount so that more seniors become eligible for coverage. But, at least we've been able to take the first step this year.

**Medicare-Endorsed Discount Card:** Before turning to comprehensive approaches to pharmacy coverage, we should share with you that we continue to oppose the Administration's efforts to establish a Medicare-endorsed prescription drug discount program.

The Bush Administration does, however, deserve credit for starting last year a serious examination of innovative private approaches that can provide meaningful pharmacy benefits to low-income seniors. However, their program will not result in meaningful reductions in the price of prescription medicines for seniors. Moreover, any reductions will likely just come from reduced pharmacy prices, and not a reduction in the price of the medication from the drug manufacturer. This debate was moved forward in very productive ways with the result that many manufacturers are now offering meaningful price reductions on the cost of their medications.

In addition, we don't think that HHS should be picking winners and losers in this market through their endorsement program, or that its appropriate to lend Medicare's time-trusted name to private-sector entities without strict standards. Finally, we do not believe that the Department has the legislative authority to develop this program, nor do we support Congress giving it to them as an interim measure.

Mr. Chairman, NACDS wants to be constructive players in the debate on both comprehensive and interim solutions to pharmacy coverage for seniors. Our industry is an important player in this debate, because we are the primary method by which pharmacy services are actually delivered to the patient. We operate an efficient, low-margin, but highly effective primary health care delivery system that is accessible in many places 24-hours a day, 7-days a week. We look forward to working with you and members of the Committee in making this happen now and in the future. Thank you again for the opportunity to submit a statement for the record.

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