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THE NEW MEDICARE DRUG DISCOUNT CARD: AN ADVANCE PROGNOSIS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

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"THE NEW MEDICARE DRUG DISCOUNT CARD: AN ADVANCE PROGNOSIS"

TUESDAY, MARCH 9, 2004

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 10 a.m., in room SD–628, Dirksen Senate Office Building, Hon. Larry Craig (chairman of the committee) presiding.

Present: Senator Craig.

OPENING STATEMENT OF SENATOR LARRY E. CRAIG, CHAIRMAN

The CHAIRMAN. Good morning, everyone. The U.S. Senate Special Committee on Aging will convene.

I want to thank you all. Less than three short months from today, America's seniors will get their first real taste of the new Medicare prescription drug relief enacted by Congress last fall and signed into law by President Bush. I am speaking, of course, of the new Medicare prescription drug discount card and the accompanying $600 transitional assistance for lower-income seniors.

The Congress and the President felt that no senior should have to choose between buying food and buying drugs, and the new card and assistance program is a critical transition to help those seniors in greatest need pay for their drugs during the time it takes to get the rest of the Medicare drug legislation up and running by 2006. This program is just a beginning, but it is a very important one.

Our hearing today will take a close look at how the card and the assistance program are shaping up so far, and more specifically, what seniors can expect as we near the start date in June. So far, progress seems to be quite encouraging. For example, the Centers for Medicare and Medicaid Services have already received more than twice the number of card sponsor application than they originally anticipated, over 100 applications in all. These applications have come not just from traditional discount card leaders like pharmacy benefit managers, but also from many insurers and health plans, and I should add also from organizations representing America's pharmacists. This is a group that I know has had questions about the discount card approach.

Also encouraging is the fact that several of the country's drug manufacturers have stepped forward to say they intend to participate in good faith with the new card program, and in many cases, to continue or even expand their own existing low-income assistance program for seniors.

I also want to offer very special thanks this morning to Dennis Smith, the acting administrator of CMS. This is the man whose shoulders the heavy burden of implementing this program have fallen and who I suspect may be eagerly awaiting the help of Dr. Mark McClellan, the president's new nominee to head up CMS. Administrator Smith will focus on CMS's ambitious plans for beneficiary outreach and education. One such plan is the agency's new Price Compare program. Under this program, seniors and their families will be able to use an Internet-based discount comparison system. Together with real-person assistance from toll-free operators, this system will allow seniors to instantly access and compare prices of drugs offered by card sponsors in their areas.

As we move forward in implementing the card and assistance program, a few key priorities will be especially important. First, assuring that seniors get the information they need to understand and navigate the program. Second, assuring that the discounts are fair and straightforward. Third, seeing that CMS acts aggressively to combat possible fraud and to weed out card sponsors who are not delivering real values. Finally, it is also critical to assure that those seniors eligible for the $600 low-income help get it and get it as quickly as possible.

The new Medicare discount cards have a tremendous potential and the early signals, as I said, are encouraging. However, much work remains to be done. We appreciate our witnesses for their contributions today, and I want to thank them.

Senator Breaux, the ranking member of the committee, I understand will be joining me for some of the hearing, and I do appreciate that.

This committee will monitor progress throughout the phases of implementation of this new legislation, and this is simply the first of a series of efforts that we will undertake to make sure that there is thorough, timely oversight as we move toward full implementation.

As I mentioned, our first witness this morning is Dennis Smith, the acting administrator for the Centers for Medicare and Medicaid Services. Dennis has played an instrumental role in developing the prescription drug card program. I want to thank him for his hard work in a clearly complex and difficult process. However, it appears it is well under way and moving in a timely fashion.

So Dennis, we welcome you to the committee and look forward to your testimony. Please proceed.

STATEMENT OF DENNIS SMITH, ACTING ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, WASHINGTON, DC

Mr. SMITH. Thank you very much, Mr. Chairman. I appreciate the opportunity to come before you and the committee today to update you on our progress for implementing the discount card. The drug discount card itself is good news for the millions of senior citizens who do not have access to purchasing through group plans. Twenty-four percent approximately of Medicare beneficiaries do not have drug coverage, so this will bring access to discounts for millions of our seniors and people with disabilities who are also eligible for Medicare.

While the discount itself is good news, the $600 transitional assistance is even better news. We will put $600 for low-income senior citizens and disabled individuals toward the purchase of their drugs and that is $600 per year. When you consider that the average Medicare beneficiary without insurance coverage is spending approximately $1,400 annually on their drugs, this indeed is a significant benefit to those low-income seniors.

We are being diligent about implementation. I am here to report to you that we are on track for implementation. Our partners in the private sector have, as you mentioned, really given an outstanding response to the challenge of providing discounts to seniors and I am very pleased that we indeed had over 100 applications to offer discounts. We are currently reviewing those applications. By the end of the month we will be announcing who the drug sponsors will be.

You asked me to focus on a number of specific parts of our implementation in terms of savings, the card effectiveness, implementation and outreach, market participation, response by the stakeholders, and I am happy to turn to each of them in turn.

First in terms of anticipated consumer savings, the card sponsors themselves will provide the discounts, as they do in the private sector now, by offering negotiated discounts to individuals through the card sponsorship. We believe that the competition between the card sponsors and we believe that our new tool, the price comparison as you mentioned, will be very powerful incentives to help lower the price of prescription drugs.

For the individual, individual beneficiaries can anticipate savings of 10 to 15 percent off their prescription drug spending with discounts of 25 percent or more on specific drugs as they are getting their prescription filled. Again so the typical senior without drug coverage today is spending about $1,400 annually, so this will be a significant benefit to them.

The card effectiveness itself, we believe that one of our important roles is to do outreach to inform as many Medicare beneficiaries of this bridge to Part D and this is an important education process in anticipation of the full benefit beginning in January 2006. We are very aggressively pursuing an outreach strategy that involves multimedia broadcasts but it also means people on the ground and educating people who senior citizens know well and serve senior citizens on a day-to-day basis. So we are working with state departments of aging, our Senior Health Insurance Programs, known as SHIPs, state minority health offices, state social services offices, as well as our partners in the Social Security Administration. We are also working with the providers themselves—with our pharmacists, with physicians, again to spread the word of the availability of the discount card in anticipation and signing as many seniors up as we possibly can.

We are also working with the states themselves. A number of states have state pharmacy programs. We are working to coordinate the benefits with those state programs and helping the states to have a seamless transition to the drug card. So those interactions with the drug cards are very important, as well.

The advertisements we are pursuing because we believe that it is incumbent on us to spread the good news and reach as many

Medicare beneficiaries as we can. Let me mention our 1–800-Medicare toll-free number that we have been promoting over the last several years, again anticipating the role that it will play to help inform senior citizens.

We anticipate that—to put into context, in fiscal year 2003 we received approximately 5.6 million calls over 1–800-Medicare and we anticipate more than doubling that amount and are anticipating that we will receive about 12.8 million calls this year. To do that we are increasing our capacity to handle those calls and we have already expanded the number of individuals by more than three times in terms of the number of individuals who will be handling those calls and also our contracts are such that we can add additional volume, as well. So I want to assure seniors that when they do call 1–800-Medicare that they will be well served on the other end.

A number of publications are also planned for release this year to explain the drug discount card and the $600 low-income assistance. We are publishing a pamphlet that provides an overview of the discount card and we are also publishing a booklet that will be mailed to all Medicare beneficiaries, that they will have the information that they need.

We are also working with the Social Security Administration that they will specifically do a mailing to low-income Medicare beneficiaries detailing the drug card and the $600.

We are sponsoring conferences across the country and regionally. We are holding a number of teleconferences with our partners in the private sector, the pharmacists and providers, and we will be scheduling a national conference here in Washington, D.C. in April.

Those are some of our outreach activities. We also want to emphasize our outreach to people with disabilities, as well, who are also Medicare beneficiaries, and the importance of this benefit to them.

Let me talk very briefly about, as you mentioned, our price comparison. This is a tool that we will be making available and the price comparison—again, as you know, information and knowledge is power and that is what we are trying to bring to the beneficiaries themselves.

So as they review their choices and their options, they will be able to access through our Medicare website or they can call through 1–800-Medicare or, as I mentioned, the other individuals who are being trained to use our resources will be able to get information by the card sponsor and will be able to make comparisons on the negotiated discounts that will be available to them.

We believe this information will be a very powerful tool to those beneficiaries themselves as they make their choices and to the overall market, as well, as competition in the marketplace will in itself become a benefit to everyone.

Let me assure you, as I said, we are working aggressively on our implementation strategies. We are on target, meeting our time deadlines. We do have some important milestones coming up. At the end of this month we will be announcing the drug card sponsors themselves. In April, as I mentioned, a national conference on training. The mailings will be going out the first of May. The first week of May the drug sponsors themselves will be able to begin

their marketing and outreach and signing up our senior citizens for the benefits to begin the first of June.

So I am very pleased to tell you that we are on target and moving very aggressively. As I said at the outset, the discounts themselves are good news for those without drug coverage. The $600, $1,200 over 2 years, is very good news for our low-income seniors. We believe that this will set the stage for the full Part D drug benefit to begin in 2006, the education of the senior citizens themselves to make them aware of the options and the choices that they will have to be able to lower the cost of prescription drugs that they now face.

Thank you very much, Mr. Chairman. I am pleased to be able to answer any of your questions.

The CHAIRMAN. Well, Dennis, thank you very much. We appreciate again your being here today. For the Congress and the president to hand you late last year a rather daunting task, it appears that you are well on your way toward getting it implemented in a timely fashion.

You testified that CMS has received over 100 applications for potential card sponsors, more than expected. What are the reasons driving such a positive response?

Mr. SMITH. Senator, I believe the positive response was as people positioned themselves for the full drug benefit in 2006, the manufacturers, the Medicare Advantage sponsors, the discount card sponsors are really trying to make their products known to beneficiaries. For their own competition amongst themselves, they are positioning themselves for 2006 and again I think that is good news for everybody.

The CHAIRMAN. It now looks likely that seniors will have quite an array of cards. That is certainly going to be a lot of choices to make in enrollment. To help with these choices, you have talked about the 1–800-Medicare number and the ability to log onto your Price Compare site.

A senior does not have to be, I assume, too Internet-friendly to be able to get there, do they? Talk to us a bit about that because I see that as a very valuable empowering kind of tool for them.

Mr. SMITH. Senator, I believe that it will be, as well. Our website at www.Medicare.gov, we have worked with the senior in mind as we develop that website, making it easy to understand, simple, check boxes to move you through the process.

So the pop-up features——

The CHAIRMAN. You should use me as a guinea pig. I am relatively Internet-and computer-ignorant, so I might be a good test subject.

Mr. SMITH. Well first, let me assure you there is no need to be hesitant. If seniors do not want to use it at all they can call the 1–800-Medicare. But as you said, "Many seniors now are becoming very savvy in the use of the Internet."

But what they will see as they go to that website is a very user-friendly, simple answers, check boxes, that will then move them through the menu. The website is geared to the beneficiary itself and to help them also understand other options that might be available. For example, we want them to know specifically about the $600 but we also want them to know that, in fact, they may

be eligible for Medicaid and that there are other state pharmacy programs available to them, as well.

The CHAIRMAN. That was going to be my next question. How much information does the senior have to bring with them to that point of contact, be it the 1–800 number or the website? Then what kind of options might they be talked through as it relates to choices?

Mr. SMITH. We think it is information that seniors will readily know on their own. As I said, we have tried to make it simple in terms of the questioning itself but because the $600 is geared to an income level, we ask them a question about their income. So we need to know that, that they would be eligible for the $600.

There is also questioning—again they will be able to have a simple check box for the things that they want, that they are answering yes or no to. So they are not filling out a lot of information. The information is basically being presented to them and then they respond in an easy fashion.

The CHAIRMAN. Well, for any of us approaching a new task, a simple, straightforward approach is, of course, the most valuable. For example, will there be a standardized enrollment form? Will that variety of options be accessed through a standardized form?

Mr. SMITH. The enrollment form? Yes, Senator. The enrollment form itself we have been testing with seniors, making it easy to use, easy to understand, and the process for enrollment itself. So we have shared that with the seniors. We have been working with the sponsors, as well, and outside groups, advocacy groups, testing that to make sure they have all the information so that you can complete it, so there is not a lot of back-and-forth, but the standardized form, I think, we have gone through a lot of work and effort to try to refine it down to make it easy to use.

The CHAIRMAN. Now that we have a senior either on the phone or through the Internet, they have filled out a form, obviously they are going to be approached with a variety of options. What kind of action might CMS take against plans that would offer extremely tempting deals in the first instance only to switch later on. I am not going to suggest that anyone would do a bait-and-switch, but actually I am going to suggest that somebody might do a bait-and-switch. That is, after they got the person enrolled, up would go the prices.

How will you monitor that to make sure that that game is not played?

Mr. SMITH. We will be monitoring that, Senator, and we will be monitoring to assure that those discounts that were offered are real.

Also let me assure you again the discount card in many respects is positioning people's plans for the future, so they have every incentive to make sure they are dealing straight with the beneficiary. The worst thing, the last thing they are going to want to do is to upset the beneficiary, to get themselves in hot water with CMS or the inspector general over their marketing strategies or marketing tactics.

The CHAIRMAN. Or some national senior publication highlighting an individual group as a bad performer.

Mr. SMITH. When you are looking to the future and what role you want to play, the last thing you want to do is mess up between now and then.

The CHAIRMAN. You find someone that has messed up, what do you do at CMS?

Mr. SMITH. We have a number—again, each of the plan sponsors sign contracts with us and those contracts deal with enforcement activities. So we have the authority to impose intermediate sanctions in terms of halting enrollment. We can impose civil monetary penalties and pulling the plugs in its entirety, terminating their endorsement of a card sponsor. We have all those tools at our disposal.

I do want to say, since you gave me an opening, for our seniors again to reiterate those basic consumer protections about protecting your individual information—never give out your Medicare number, never give out your bank account number, those are not things legitimate card sponsors are going to be asking for, so never give out that type of information.

The CHAIRMAN. There are some reports out already that there may be some gaming going on. Is it serious? Do we know or have you been able to see anybody out there yet? I notice there are a few reports of I guess I will use the word con artists at hand.

Mr. SMITH. We are pursuing a couple of different leads of behavior that may indeed be fraudulent and again we have really a coordinated activity with the Department of Justice, as well as our own inspector general, to pursue any of those leads and, in fact, we will be doing that. Obviously there are severe penalties associated with that if it turns out to be true.

The CHAIRMAN. Well, we have already mentioned the "do-nots" that certainly a senior ought not get involved in. Are there any other kinds of danger signs that are evident that a senior might see or red flags, if you will? Will you develop in your information a checklist of those kinds of things, a due diligence, due caution kind of checklist, let us say, to the average senior?

Mr. SMITH. Again the legitimate card sponsors who have come to us and entered into contracts, we have specific agreements with them about the timing of their marketing and they cannot jump the gun on everybody else, on specific ways to do their marketing to make sure that they do not cross the line in the way the marketing to seniors is being done.

So those are a part of the criteria and why we invited them to come in for our endorsed cards, to assure seniors that those safeguards have been put into place and people with the endorsed cards are following those specific guidelines and rules.

Again I think our partners in the private sector, in consumer groups, are going to be out there helping us and to spread the word to seniors that if you feel like something is wrong, do not hesitate to call and report any activity that you think is not appropriate.

The CHAIRMAN. Well, thank you. Let me now approach the other part of this that you have spoken to and that Congress is very intent on, and that is the $600 direct assistance. Experience from some public assistance programs has demonstrated that lower-income folks are sometimes a little harder to reach. What effort is CMS planning that would help assist in fully reaching the many

eligible seniors who will qualify for that $600 assistance that we have targeted?

Mr. SMITH. Senator, the Social Security Administration itself will be doing a targeted mailing to low-income seniors to inform them about that $600 and encourage them to participate. Experience does show that the low-income seniors in particular do not always avail themselves of the resources that are available to them.

We are, in addition to working with Social Security, we will be working with the other groups at the state level. A number of states offer their own pharmacy assistance programs and discount cards, so working with the states, they know who a lot of the seniors are and to avail them of that assistance. Again I think that this is an area in particular—in my other job in terms of administering the Medicaid program, we know that seniors need that extra assistance in reaching them, informing them of the options, and helping them to make a choice and make a decision.

So this is an area that we will be very aggressive in. Our partners in the states will be of great benefit to us and again our partners in the private sector, as well, to make sure people know what is available to them.

The CHAIRMAN. A couple of last questions. I think early on many pharmacy groups were opposed to the Medicare-sponsored discount card program for a variety of reasons, and yet the final legislation included several provisions to help assure adequate access to pharmacies. Now we are seeing the major pharmacy groups seeking to sponsor cards on their own.

What do you see as the effect of the card program on America's pharmacies?

Mr. SMITH. Well again, the fact that the pharmacists themselves are coming to you today to talk about their role in the discount card is just a great development and we are delighted to join with them as partners. I think that the protections in terms of access to include the local pharmacist in the delivery of the discount card in itself was an important bridge to cross and Congress did the right thing in making sure that those safeguards were there and our partners have responded in a very positive way and we are very grateful for that.

The CHAIRMAN. Well, getting off on the right foot, I think, is always important for new programs. It certainly appears at this moment that you are making every effort to make that happen, and I hope that the robust interest in the card sponsorship in 2004 bodes well for and is a prelude to a full drug benefit in 2006 and a robust participation there.

How would you react to that? Is that a reasonable conclusion to draw?

Mr. SMITH. I think that it is, Senator. I think that and the folks here in the first row that you see in front of you have worked night and day on building relationships that will make this all work from our information technology and understanding states of their information systems so that the linkages can be made, so everybody can talk together, from a system standpoint to testing out the application form has been a tremendous effort and I do want to thank the professionals at CMS who have, I think, done an outstanding job in these first few months.

I have been on the front lines of bringing new programs up and know what it takes and all the thousands and thousands of decisions that have to be made so it all works smoothly and I come before you today with great confidence that it indeed is going to be a very smooth transition.

The CHAIRMAN. Well, Dennis, thank you very much for your testimony and the enthusiasm you bring to what you are doing, and we hope you have the greatest of success, for America's seniors' sake. But having said that, we will watch you very closely.

Mr. SMITH. Senator, I want to thank you for your leadership and I am delighted to come before you today and look forward to additional visits to assure you we are on the right track.

The CHAIRMAN. When you get your website up and it is fully operative, we might get you back before the committee for a full demonstration, to understand it and to again draw greater attention to it, as hopefully we can, so that it can be effectively used. I would hope that if your better than doubling of calls to the 1–800-Medicare actually develops, that you have a substantial call center to handle those. There is nothing that provokes anybody more than to dial a 1–800 number and wait 45 minutes for a live body to come on line.

Mr. SMITH. Senator, one of the things about Medicare is we have parents and family members who do not hesitate to inform us when maybe we did not perform as well as we expected to. So the feedback is always welcome and I think our seniors are going to be very pleased with the service that they will get.

The CHAIRMAN. Well, Dennis, again thank you. Thank you very much, and let me thank the folks out at CMS for the work that is being done. We appreciate it.

Mr. SMITH. Thank you, Mr. Chairman.

[The prepared statement of Mr. Smith follows:]

TESTIMONY OF

DENNIS SMITH

ACTING ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
ON

DRUG CARD IMPLEMENTATION

BEFORE THE

SENATE SPECIAL COMMITTEE

ON AGING

March 9, 2004

CENTERS for MEDICARE & MEDICAID SERVICES

TESTIMONY OF
DENNIS SMITH
ACTING ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
ON
MEDICARE PRESCRIPTION DRUG DISCOUNT CARD AND TRANISTIONAL ASSISTANCE PROGRAM
BEFORE THE
SENATE SPECIAL COMMITTEE ON AGING

MARCH 9, 2004

Chairman Craig, Senator Breaux, distinguished Committee members, thank you for inviting me to discuss the Medicare Prescription Drug Discount Card and the Transitional Assistance Program, which were enacted into law on December 8, 2003, as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). In the Spring of 2004, as an important first step towards comprehensive Medicare prescription drug coverage, Medicare beneficiaries will be able to enroll in a Medicare-approved drug card program that will offer discounts on their prescription drugs. This voluntary drug card program will give immediate relief to seniors and disabled people covered under Medicare to reduce their costs for prescription drugs. In addition to the expected savings from the drug discount card, certain low-income beneficiaries will qualify for additional assistance in the form of a $600 subsidy on the discount card. CMS is very proud to have a significant role in this important first step towards a comprehensive Medicare prescription drug benefit, which is slated to begin on January 1, 2006. CMS is working diligently to meet the aggressive deadline to implement the drug card and transitional assistance program. We are confident drug card sponsors will begin marketing and enrollment efforts on May 3, 2004, with enrollments taking effect on June 1, as scheduled.

BACKGROUND

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

BENEFICIARY ELIGIBILITY

To qualify for the drug discount card, Medicare beneficiaries must be entitled to or enrolled under Part A and/ or enrolled under Part B, but may not be receiving outpatient drug benefits through Medicaid, including 1115 waivers. In addition to receiving discounts through the drug card, beneficiaries with incomes that do not exceed 135% of the federal poverty level ($12,569 for individuals, $16,862 for couples for 2004) will get a Federal subsidy of up to $600 per year to purchase their prescription drugs. The Federal government will also pay the full annual enrollment fee, which is not to exceed $30, for these cardholders.

To enroll, beneficiaries will submit basic information to the selected approved discount card program of their choosing about their Medicare and Medicaid status. Those beneficiaries requesting the $600 credit also must submit income and other information about retirement and other health benefits, and attest to truthfulness of the information. CMS will verify this information and notify the approved discount card program of the beneficiary's eligibility and enrollment outcome. Beneficiaries who are eligible may then enroll with a sponsor and may start obtaining discounts and, if receiving the $600 credit, using these funds to purchase prescription drugs, upon receiving their cards. Individuals found to be ineligible for either the discount card or the $600 credit may request reconsideration if they still believe they qualify.

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

TRANSITIONAL ASSISTANCE PROGRAM

In addition to providing a discount off the price of prescription drugs, MMA creates the Transitional Assistance program, which provides up to $600 in an annual subsidy for Medicare beneficiaries whose incomes do not exceed 135 percent of the federal poverty level ($12,569 for individuals, $16,862 for couples for 2004). When applying the $600 toward prescription drug purchases, beneficiaries at or below 100 percent of poverty will pay 5 percent coinsurance, and beneficiaries between 100 and 135 percent of poverty will pay a 10 percent coinsurance. The subsidy, in conjunction with the discount card, will give these most vulnerable beneficiaries immediate assistance in purchasing prescription drugs they otherwise may not be able to afford. For example, Medicare beneficiaries without prescription drug insurance on average would pay about $1,400 for prescription drugs in 2004. The average discounts of approximately 10 to 15 percent would save between $140 and $210. This savings added to the $600 subsidy will be of substantial help to those who need it most.

COVERAGE

The discount card and $600 in transitional assistance can be used to purchase nearly all prescription drugs available at retail pharmacies. Syringes and medical supplies associated with the injection of insulin, such as needles, alcohol, and gauze, are also included. It is anticipated that many approved programs will use formularies to obtain deeper discounts on prescription drugs. If an approved discount card program uses a formulary, at a minimum, each program must offer a discount on at least one drug in each of the 209 categories of

prescription drugs. However, even if a prescription drug is not on the sponsor's formulary, the $600 must still be applied to all the covered prescription drugs available at the pharmacy if the beneficiary uses the discount card toward the purchase. Drug card sponsors also may choose to offer discounts on over-the-counter (OTC) drugs, but the $600 cannot be used toward the purchase of OTC drugs.

Medicare-approved discount card programs must obtain rebates from drug manufacturers and other discounts to help lower the costs of prescription drugs purchased by their enrollees. Because approved programs will be competing for Medicare beneficiaries, the programs will have an incentive to pass these savings along to the beneficiaries in the form of the lowest possible drug prices. While approved discount card programs may update their prices and lists of offered drugs on a weekly basis, CMS will monitor drug price changes to ensure that prices do not deviate from expected market changes, such as those in average wholesale price.

EDUCATION

To help explain the drug discount card to beneficiaries, CMS has a number of education and outreach efforts underway. Print, radio, and television advertisements will highlight the upcoming changes to the Medicare program, including the addition of the drug discount card. The advertising campaign also includes Internet-banner ads and a 10-minute pre-recorded informational radio interview to educate beneficiaries about the upcoming drug discount cards.

These advertisements will direct beneficiaries to 1-800-Medicare and Medicare's website, www.medicare.gov, for more information. CMS is working to ensure that customer service representatives at 1-800-Medicare have up-to-date information on the drug card, as well as other CMS programs. Based on our analysis, we estimate 1-800-MEDICARE will receive 12.8 million calls in FY2004. This compares to an FY2003 call volume of approximately 5.6 million calls. The 12.8 million calls include an estimated increase of 5.5 million calls as a result of the new Medicare law and 7.3 million calls for routine 1-800-MEDICARE call topics. During FY 2003, we had approximately 386 Call Service Representatives (CSR) available to answer calls during our steady-state period. For the mass media and mass

mailing activities during the fall of 2003, we increased the number of Call Service Representatives to 819. We plan to increase our CSR level at 1-800-MEDICARE and will have approximately 1,330 individuals available in May 2004 to handle the expected increase in call volume. Beneficiaries also can learn more about the new benefits from a fact sheet on the new Medicare law, frequently asked questions and answers, and more specifics about the improvements being made to Medicare, which are all available on the website, www.medicare.gov.

An additional feature of the website is a new price comparison tool, Medicare Price Comparison. Under the drug card program, card sponsors will negotiate drug discounts with both pharmacies and drug manufacturers. The new comparison tool will have the capacity for beneficiaries, or their representatives, to be able to find this sponsor-negotiated price for each drug or all their drugs at the pharmacies in their area. Pricing information will be available for brand name, generic, and mail-order prescriptions offered through each card sponsor's program. Drug card sponsors will be able to update the drug pricing information on a weekly basis. This information will also be available at 1-800-MEDICARE and by contacting the drug card sponsors directly.

CMS also has a number of publications planned for 2004 that will be designed for beneficiaries and will explain changes in the Medicare program. For example, CMS will publish a small pamphlet with an overview of the drug card program and an introduction to the discount cards and the $600 low-income assistance, as well as a larger booklet with more detailed information about eligibility and enrollment. This larger booklet also will include a sample enrollment form and a step-by-step guide to comparing and choosing a discount card. In addition, a brief document that introduces beneficiaries to the discount cards and the Medicare-approved seal will be mailed directly to beneficiary households. This mailing, which will correspond with the television information campaign, is scheduled for late April 2004. Also, as required by MMA, CMS will work with its partners at the Social Security Administration to facilitate a mailing targeted toward low-income Medicare beneficiaries detailing the drug card and transitional assistance program.

To educate providers and pharmacists, as well as the States and other stakeholders, CMS will sponsor conferences and conduct a number of teleconferences to make the information available nationwide. For example, in-person training will take place at the National SHIP Conference, which is scheduled for April 4-7. CMS staff will be available to provide technical assistance and support as the program begins.

SPONSOR SOLICITATION

CMS has already begun the implementation of the drug card program by soliciting bids from private companies to become Medicare-approved card sponsors. Applications were due January 30, 2004. Any non-governmental organization that meets all of the qualifications can receive a Medicare endorsement. Organizations were required to complete a detailed application concerning their qualifications and the design of their proposed drug discount card program to be considered for the program. Card sponsors may be Pharmacy Benefit Managers (PBMs), wholesalers, retail pharmacies, insurers, Medicare Advantage plans, or any other non-governmental legal entity that meets the requirements. States may choose to pay the enrollment fees for beneficiaries not eligible for the $600 credit and coinsurance for low-income who are eligible.

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

Drug card sponsors will be required to provide information to beneficiaries on the program's enrollment fee, which cannot exceed $30 per year, and to publish discount prices for prescription drugs. In addition, Medicare will ensure that beneficiaries have at least two

choices of approved cards in each state, with the state being the smallest service area permitted under this program. If a card sponsor's service area includes additional states, the entire additional state must be included. Medicare will also provide reliable, easy-to-compare information that will show beneficiaries what programs are in their area, and allow beneficiaries to choose the discount card program that best meets their needs.

To facilitate meeting the May 3 target, we have already begun reviewing bids from potential drug card sponsors. CMS received 106 applications, of which one was a duplicate, one was withdrawn, and another chose to join with another sponsor. Of the 103 applications that we ultimately received, about half were for cards that would be available to all Medicare beneficiaries in the specified service areas, while the other applicants were for cards that Medicare managed care plans will make available only to their members. Among the general cards for all beneficiaries, about half of the applications were for national cards that would serve Medicare beneficiaries generally, and the other half is for specified regional service areas. We also received applications for all of the special endorsement categories, i.e., long-term care, the territories and for Indian Health Services, federally recognized Indian Tribes and Tribal Organizations, and Urban Indian Organizations. CMS plans to announce the endorsements at the end of this month, and expects that beneficiaries can begin to enroll in May and begin using their drug cards in June 2004.

CONCLUSION

Thank you again for the opportunity to testify today about this new important transition toward a prescription drug benefit for Medicare beneficiaries. This voluntary drug discount card program will provide immediate assistance in lowering prescription drug costs for Medicare beneficiaries until the new Medicare drug benefit takes effect on January 1, 2006. We recognize the importance of the discount cards and the low-income subsidy to Medicare beneficiaries, who, for too long, have gone without outpatient prescription drug coverage. We at CMS are dedicated to meeting the deadlines set out in the historic Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and are working expeditiously to identify card sponsors by the end of this month in order to satisfy the May 3 and June 1, 2004,

effective dates for enrollment and implementation, respectively. Thank you again for this opportunity, and I look forward to answering any questions you might have.

The CHAIRMAN. We will ask our next panel to come forward and please be seated.

Let me thank our second panel today for being here, and I will proceed in alphabetical order. So we will first hear from Jim Firman, who is president and CEO of the National Council on the Aging. In this capacity, Jim has served as a tireless advocate for seniors, and we appreciate you being here today.

Next will be Craig Fuller, who is the president and CEO of the National Association of Chain Drug Stores, whose organization has announced its desire to enter into a partnership to offer a drug card of its own.

Then next we will hear from Forest Harper, who is the vice president of Pfizer, for Pfizer's Pfizer for Living Share Card program. He will be talking about Pfizer's plans to continue to enhance the Share Card as a supplement to the new program, as well as about Pfizer's unique and very encouraging efforts to go even further and participate directly in the new Medicare-sponsored discount card program. Overall, the assistance programs offered by Pfizer, Merck and certain other drug manufacturers may go a long way toward helping make the new card program a success.

Next we will hear from Karen Ignagni, the distinguished president and CEO of what I understand is now a newly christened organization called America's Health Insurance Plans, or AHIP. AHIP is the product of a recent merger of the American Association of Health Plans and the Health Insurance Association of America, both of which played vital roles in the creation of the new Medicare law.

Finally, with us today is Mark Merritt, CEO of the Pharmaceutical Care Management Association representing America's pharmacy benefit managers, many of whom have been leaders in developing drug discount cards and from whom we can all, I think, learn a great deal.

So I look forward to all of your testimony and again let me now turn to Jim Firman, president and CEO of the National Council on Aging. Jim, welcome.

STATEMENT OF JAMES FIRMAN, PRESIDENT AND CEO, THE NATIONAL COUNCIL ON THE AGING, WASHINGTON, DC

Mr. FIRMAN. Good morning, Senator. Thank you for the opportunity to participate in today's hearing, I am pleased to represent the National Council on Aging, the nation's first organization formed to represent America's seniors and those who serve them.

There are three messages I want to convey today. First of all, the new Medicare law is the single most important opportunity to help low-income Medicare beneficiaries that has emerged in the past 35 years.

Second, the actual savings to many low-income beneficiaries under the new discount card program are going to be far more generous than most people realize.

Third, the confusion about the new law and the benefits created will give us a unique set of challenges that policymakers, government agencies and advocates are all going to have to work together to solve.

The new Medicare law is a unique opportunity to provide prescription drugs and other assistance to an extremely vulnerable population that is struggling daily to get their needs met; namely, low-income seniors and younger people with disabilities, many of whom live alone, suffer from multiple chronic illnesses, and take several medications. Although most beneficiaries will realize savings of 10 to 20 percent under the Medicare-approved discount card, many with incomes below 135 percent of poverty, regardless of assets, will be eligible for $600 transitional assistance this year and next.

However, there is very good news to report about the transitional assistance benefit. Most low-income beneficiaries who enroll will actually save a lot more than $600 because of the commendable action by several pharmaceutical manufacturers to offer savings programs that will wrap around the Medicare-approved card.

There are two charts over here that I would like to draw your attention to. The first is an example of an 82-year-old man from Idaho with an income of $10,000 and assets of cash in the bank of $20,000. Now as you know, Senator, there is no state pharmacy assistance program in Idaho and he would not qualify for Medicaid because of his assets.

In this particular case this individual would be spending $5,500 on three different medications. As a result of the transitional assistance and the wrap-around programs offered by the three companies, this person's actual costs for the year would only be approximately $460. This person will save over $5,000 per year in 2004 and 2005.

The second example, is a 68-year-old woman living in Louisiana with income of $11,000 and assets of $30,000. She currently may be spending $2,500 a year on medications. As a result of the transitional assistance and the wrap-around program she would be spending about $475–480 a year. Her savings will be about $2,100 a year.

Now every case is different. It depends on the individual, the medications they are taking, how much they are paying retail, what the dispensing fees are, but if persons have income less than 135 percent of poverty and qualify for transitional assistance, many of them are going to achieve dramatic savings.

This is very important because as we are out there encouraging low-income people to enroll, the message needs to be that the $600 savings may only be the beginning of what you can actually save in 2004 and 2005.

However, to fully achieve these substantial savings it is imperative that as many low-income beneficiaries as possible actually enroll in the programs. Unfortunately, as you noted, the track record of various past efforts to enroll low-income populations in public and private benefits has been, at best, inconsistent and uneven. For example, the take-up rate for the current Medicare low-income benefits, QMB and SLMB, are estimated to only be 43 percent after all these years. Now, we are talking about a very short timeframe and much more ambitious enrollment goal.

In addition, we face the challenge that beneficiaries are already very confused about the new law and as the Kaiser poll showed, many do not even know the bill passed and was signed into law.

NCOA and others view this as an extraordinary and time-sensitive opportunity to organize and mobilize a broad-based public/private partnership to significantly increase projected participation rates. While proposed CMS and SSA awareness efforts will reach millions of low-income beneficiaries, also the private sector has to do our part, as well. There needs to be complementary, coordinated efforts that go deeper into the community.

In response to these challenges and opportunities, NCOA and other voluntary groups are organizing the Access to Benefits Coalition, a broad-based public/private partnership including CMS, and government agencies, dedicated to ensuring that low-income beneficiaries know about and can make optimal use of the new Medicare prescription drug programs and other resources available to save them money.

The goal of the ABC campaign is to quickly and measurably educate low-income Medicare beneficiaries and their families, provide hands-on, personalized outreach and assistance, and facilitate actual enrollment in the transitional assistance and other benefits. Our plan is to extend and complement Federal efforts, not to duplicate them. This is a huge job and we all have to do our part.

NCOA is now developing an enhanced version of our BenefitsCheckUpRx website to facilitate customized decision-making and enrollment in a full range of savings programs. The new decision support tool will help beneficiaries to determine the individualized combination of programs that will save them the most money, not only the new Medicare benefits but state pharmacy programs, manufacturers' discount cards, 130 private drug company patient assistance programs, because the reality is in 2004 and 2005 people are going to need to piece together a combination of programs in order to be whole.

If their income is over 135 percent of poverty, they will not qualify for the transitional assistance, but they are still going to need help and they are going to need to put together the right package for them.

As part of our effort we will train and support thousands of local coalition members and volunteers to serve as intermediaries with low-income beneficiaries to use our new tool and the CMS Compare tool, which is also a great tool.

With the cooperation of the card sponsors, we also hope to ease the burden of obtaining and completing the enrollment form for transitional assistance by including printable e-forms for the Medicare-endorsed card and other important savings programs right on the website.

Other strategies that can be used to maximize low-income participation in the new Medicare benefit would be to automatically enroll Medicare savings program recipients in the credit program and to create a universal enrollment form for the transitional assistance benefit, which if I understand it, Mr. Smith said CMS is planning to do and I think that would be very helpful to this process.

Let me conclude by saying regardless of whether an individual or organization supported or opposed the Medicare legislation, our responsibility now is to America's seniors and people with disabilities and their families. This transcends politics and is very clear.

We all must come together and combine our energies and resources behind a coordinated, sustained campaign to maximize prescription drug savings for underserved older Americans and persons with disabilities.

By working together in a nonpartisan way on outreach and enrollment initiatives focussed on underserved populations, we can significantly improve the quality of life for millions of Americans who need help this year. Thank you.

[The prepared statement of Mr. Firman follows:]

THE NATIONAL
COUNCIL ON
THE AGING

Statement

of

James Firman
President and CEO
The National Council on the Aging

on

The New Medicare Drug Discount Card: An Advance Prognosis

before the

U.S. Senate Special Committee on Aging

March 9, 2004

300 D Street, SW | Suite 801 | Washington, DC 20024 | PH: 202-479-1200 | F: 202-479-0735 | www.ncoa.org

I am Jim Firman, President and CEO of The National Council on the Aging (NCOA) – the nation's first organization formed to represent America's seniors and those who serve them. Founded in 1950, NCOA is a national network of organizations and individuals dedicated to improving the health and independence of older persons; increasing their continuing contributions to communities, society and future generations; and building caring communities. Our 3,800 members include senior centers, adult day service centers, area agencies on aging, faith congregations, senior housing facilities, employment services, and other consumer organizations. NCOA also includes a network of more than 14,000 organizations and leaders from service organizations, academia, business and labor who support our mission and work.

I appreciate having the opportunity to participate in today's hearing: *The New Medicare Drug Discount Card: An Advance Prognosis.* The availability of new prescription drug and other benefits under Medicare creates an unprecedented opportunity and a unique set of challenges. As a transition to Medicare Part D prescription drug coverage in 2006, the discount card program and accompanying transitional assistance will be available this June. Medicare-approved cards are expected to offer savings of about 10 to 15 percent on total drug costs, with savings of up to 25 percent or more on individual prescriptions. The benefit for many low-income beneficiaries, however, is likely to be much more significant.

Enactment of the new Medicare law is the single-most important opportunity to help low-income Medicare beneficiaries to have emerged in the past 35 years. Medicare approved discount cards will include a $600 transitional assistance (TA) credit for those with annual income below 135 percent of poverty (this year, $12,569 for singles; $16,862 for couples), regardless of assets. The credit is not available to those with drug coverage from Medicaid, TRICARE for Life or an employer group plan.

Savings for Low-Income Beneficiaries: Opportunities and Challenges

To achieve the law's full potential, it is imperative to maximize TA enrollment, and savings from other programs, for low-income beneficiaries. We know from experience and research that this population is more likely to have chronic and/or cognitive illnesses and tends to be very difficult to reach, with enrollment goals hard to achieve.

In recent years, government agencies at all levels, voluntary organizations and foundations have been involved in efforts to identify and enroll low-income beneficiaries who are eligible for but not receiving needed benefits from government and private programs. To date, success on this front has been at best inconsistent and uneven.

For example, take-up rates for the Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) programs – for beneficiaries with incomes below 120 percent of poverty – are estimated at only 43 percent. Participation in the Qualified Individual (QI) program – for beneficiaries with incomes between 120 and 135 percent of poverty – is significantly lower. Take-up rates for Food Stamps and the SSI elderly program are estimated to be as low as 54 and 50 percent, respectively. The bottom line is that millions of vulnerable, low-income seniors and younger persons with disabilities are not receiving the assistance they are eligible for. We must do better.

In just a few months, in order to maximize available savings, most low-income beneficiaries will need to enroll in a Medicare-approved discount card AND enroll in additional public and private benefits programs in order to afford the prescription drugs they need to maintain their health and improve the quality of their lives. Then, beginning in 2006, low-income beneficiaries will have a different and even more confusing set of options regarding enrollment decisions in Part D.

Medicare beneficiaries are already very confused about the new law. Millions of beneficiaries want and expect immediate help with their prescription drug expenses. Some believe that broad Medicare prescription drug coverage will be available this year; they will be disappointed. Virtually all will want to know what kinds of price discounts are available to them and how to apply. Further exacerbating the confusion, states will continue to make significant changes to their prescription drug programs. Last year alone, 49 states had more than 270 bills filed to create, expand or substantially change state pharmaceutical programs and policies.

Last year, a Kaiser Commission report on access to benefits for low-income seniors recommended that policy makers must "improve marketing efforts for Medicaid and state pharmacy assistance programs so that more seniors learn about the programs. A key to these marketing efforts should be to inform seniors that they might, in fact, be eligible." More recently, a Kaiser Family Foundation survey conducted just one month ago found that only 15 percent of senior respondents (7 percent of the public overall) said that they understood the new prescription drug law very well and almost 7 in 10 did not even know that it passed and was signed into law. The findings led Kaiser's President and CEO Drew Altman to conclude: "The complex nature of the law, with all its nooks and crannies and winners and losers, makes the public education challenge much harder. It will take customized one-on-one assistance to really give beneficiaries meaningful help."

There are both short-term and long-term imperatives and opportunities to ensure that as many low-income seniors as possible get the new benefits. In 2004 and 2005, there will be 7.4 million low-income beneficiaries who will be eligible to receive the $600 credit, but CMS estimates that 2.7 million of those eligible will fail to enroll and will forfeit the benefit. An estimated 14.1 million seniors will be eligible for the full low-income benefits which begin in

January 2006. These benefits will pay for between 85 percent and almost 100 percent of prescription drug costs. But the CBO estimates that 8.7 million low-income beneficiaries will receive benefits by 2013. This is only 70 percent of eligible beneficiaries after seven years of program implementation.

We are pleased that the key health leaders in Congress share our concerns about the importance of ensuring that vulnerable low-income beneficiaries receive the new Medicare benefits they are eligible for. Strong, clear report language was included in the Medicare bill on improving outreach to low-income beneficiaries. The language states:

> "[T]he Conferees expect that... HHS will place a priority on, and make a best and concerted effort to, ensuring that the lower income seniors are aware of the additional benefits available to them and how to enroll. Therefore, the public information campaign should include a program of outreach, information, appropriate mailings, and enrollment assistance with and through appropriate state and federal agencies, including State health insurance counseling and assistance programs, in coordination with other federal programs of assistance to low-income individuals, to maximize enrollment of eligible individuals. In addition, special outreach efforts shall be made for disadvantaged and hard-to-reach populations, including targeted efforts in historically underserved populations, and working with low-income assistance sites and a broad array of public, voluntary, and private community organizations serving Medicare beneficiaries. Materials and information shall be made available in languages other than English, where appropriate." [Joint Explanation Statement of the Committee of Conference, page 432]

NCOA and others supported the new Medicare legislation primarily because of the benefits it would provide to Medicare beneficiaries with low-incomes and/or catastrophic drug costs. We are committed to ensuring that as many low-income Medicare beneficiaries as possible know about and take advantage of the "safety net" provisions of the new law. We view this as an extraordinary and time-sensitive opportunity to organize and mobilize a broad public-private partnership to significantly increase projected participation rates by low-income beneficiaries.

The importance of accelerating progress on this front is underscored by the opportunities and challenges inherent in enrolling low-income beneficiaries in the TA benefit. In response, CMS and SSA are organizing an outreach and education campaign primarily targeted to all beneficiaries. Defining features of the emerging CMS awareness campaign include beneficiary publications and mailings; a national advertising campaign; enhanced support through 1-800-MEDICARE and www.medicare.gov; provider education and outreach; training and support of state health insurance programs (SHIPs), State Units and Area Agencies on Aging, and other sources of information and counseling; as well as active partnerships with other public agencies and the voluntary sector.

While these awareness efforts will reach millions of low-income beneficiaries, years of experience tell us that there also needs to be complementary, coordinated initiatives that go much deeper into the community in order to educate consumers, help them make informed choices and facilitate their actual enrollment in the new Medicare benefits. In the past, there have been few opportunities to evaluate or identify and systematically implement effective outreach and enrollment methods to reach this difficult to reach audience.

Access to Benefits Coalition

In response to the significant challenges and opportunities created by the new law, NCOA is forming the Access to Benefits Coalition (ABC) – a public-private partnership dedicated to ensuring that low-income beneficiaries know about and can make optimal use of new Medicare prescription drug benefits and all other available resources for saving money on prescription drugs. ABC members share an interest in helping Medicare beneficiaries (including both those aged 65 and over as well as younger persons with disabilities who qualify) find the

public and private prescription savings programs they need to maintain their health and improve the quality of their lives.

The goal of ABC is to quickly and measurably educate low-income Medicare beneficiaries, help them make informed choices about prescription savings programs, and facilitate their actual enrollment in new Medicare benefits through:

- Developing and using the best-available knowledge from the public and private sectors about best practices and cost-effective strategies for reaching and enrolling low-income Medicare beneficiaries.
- Activating and supporting nationwide community education and outreach, focused on reducing confusion and providing beneficiary support in decision-making and enrollment.
- Developing and implementing a public information and outreach campaign that complements and extends CMS efforts at the local level.
- Disseminating sophisticated decision-support tools to help consumers make optimal choices; and
- Mobilizing widespread support and participation in national, state and local Access to Benefits Coalitions (four are already in formation).

The ABC is committed to achieving aggressive enrollment goals (numbers are tentative, based on preliminary analysis) including: (1) By the end of 2005, at least 5.5 million low-income beneficiaries will have received $600 in transitional assistance under a Medicare-endorsed discount card, and also will have had an opportunity to enroll in other public and private Rx programs available to help them save money; (2) By the end of 2008, at least 8 million low-income beneficiaries will have enrolled in Medicare low-income savings programs; and (3) By

2012, at least 12 million low-income beneficiaries will have enrolled in Medicare low-income savings programs.

Among the many unique strengths and capabilities that the Access to Benefits Coalition brings to bear on achieving these objectives are:

- Common purpose and commitment;
- Broad representation;
- Exceptional credibility;
- Unprecedented reach;
- National influence;
- Community leadership;
- Depth of knowledge and experience with target audiences;
- Proven decision-support tools and other enrollment-support capabilities; and
- Ability to integrate otherwise disparate and competing efforts.

Key organizing members of the Coalition include: NCOA, AARP, Alzheimer's Association, American Association of People with Disabilities, Catholic Health Association, Center for Medicare Advocacy, Easter Seals, National Alliance for Hispanic Health, National Assembly of Health and Human Service Organizations, National Association for Hispanic Elderly, National Association of Area Agencies on Aging, National Association of Nutrition and Aging Services Programs, National Association of State Units on Aging, and National Medical Association. Other current members of the Coalition include the American Diabetes Association, American Health Care Association, National Adult Day Services Association, National Association of Community Health Centers, and National Rural Health Association. The national Access to Benefits Coalition is expected to include more than 100 core organizations.

The Coalition has formed three Working Groups: Outreach and Mobilization, Research and Policy, and Media and Public Relations. State and local ABCs will mirror the national Coalition, and provide broad and deep grassroots support and mobilization. Every member organization shares a commitment to helping low-income Medicare beneficiaries connect to new Medicare Rx and other Rx benefits, public and private. Coalition partners will include:

- CMS, AoA, SSA and other Federal agencies;
- State health insurance counseling programs, state and area agencies on aging and other aging/disability services;
- State and local governments;
- Health care organizations and systems;
- Physician, pharmacist and other health provider groups;
- Business community, including pharmaceutical and pharmacy companies, PBMs, employers, media; and
- Private foundations.

Decision Support Tools

The use of enhanced decision support tools will also be a key strategy of the Access to Benefits Coalition. Low-income beneficiaries are already confused about new benefits and will face increasingly complex choices. New Medicare transitional benefits are only one of several important components of an Rx safety net - hundreds of other public and private Rx programs are also available. Most low-income beneficiaries will need to take advantage of several of these programs to be able to afford their medicines. People with incomes greater than 135% of poverty will be especially in need of help.

In June 2001, NCOA launched BenefitsCheckUp, a new free, Web-based public service to allow seniors, their families, and the community organizations that serve them to quickly and easily determine what benefits are available and how to apply for them. BenefitsCheckUp offers an alternative to standing in long lines or spending weeks or even months trying to get information about approximately 1,200 federal, state, local and private programs. By taking a few minutes to fill-out a confidential on-line survey, seniors and their families who visit www.BenefitsCheckUp.org can access a detailed report on the benefits that may be available. For some benefits, consumers can download the actual application form to further facilitate enrollment. Over one million seniors and their families have used the service so far.

In January 2003, the Web site was expanded through BenefitsCheckUpRx to include approximately 260 public and private programs to assist seniors in determining what help they can get to pay for prescription drugs. Users can access a questionnaire specifically tailored to promote access to these Rx benefits. The service is also available in Spanish.

NCOA is now developing an enhanced version of BenefitsCheckUpRx to facilitate decision-making and enrollment in a full range of savings programs. The new decision-support tool will help beneficiaries to determine the **individualized combination** of programs that will save the most money – not only new Medicare benefits, but state pharmaceutical assistance programs, discount card programs that are not Medicare endorsed, and over 130 private drug company patient assistance programs. With the cooperation of card sponsors, we also hope to ease the burden of completing enrollment forms by including printable e-forms for Medicare-endorsed cards and the other important savings programs.

We know that many of the seniors who could benefit the most from using BenifitsCheckUpRx do not have access to the Internet. Therefore, thousands of coalition

members (staff and volunteers) will be trained and supported to serve as intermediaries with low-income beneficiaries to use this new tool.

Transitional Assistance Benefit Will Deliver Additional Savings

There is some very good news to report about the Transitional Assistance benefit: most low-income beneficiaries who enroll in the TA program will save a lot more than $600 in 2004 and 2005. This is because of the commendable actions by several pharmaceutical manufacturers to offer savings programs for low-income seniors that "wrap around" the Medicare-approved cards. For example, Merck recently announced that once a Medicare beneficiary uses up their $600 debit on a Medicare-approved card that person can purchase their Merck medications for the rest of the year for only a dispensing fee. Eli Lilly has announced that people who qualify for and enroll in the TA program can purchase any Lilly drug for $12 per month, even when they still have a balance on their card. TogetherRx, which covers more than 170 medications from seven leading manufacturers, will continue to offer savings of 20% to 40% to people who qualify. Pfizer has indicated that it intends to continue to make its ShareCard available to Medicare beneficiaries, enabling them to purchase Pfizer medications for $15 per month.

The bottom line is that low-income beneficiaries who take multiple medications and who have incomes below 135% of poverty could save from 40% to 90% on their medications in 2004 and 2005. Exactly how much an individual will save depends on the specific medications they take, what they are currently paying for them and what the dispensing fees will be at the pharmacy they use. Below are two examples for a Medicare beneficiary who lives in Idaho or Louisiana:

2004-05 savings to low-income beneficiaries may be much greater than $600.

Example #1: An 82-year old Idaho man with income of $10,000 and assets of $20,000

Medication, monthly cost, manufacturer	Current annual cost to consumer	Manufacturer's wrap-around assistance to Medicare TA program	Annual out-of-pocket cost with Medicare TA + manufacturer's wrap around assistance
Pulmicort Turbuhaler – 200 mg $130 per month, made by Astra Zenica	**$1,560**	After TA is used up, consumers can buy medications for $15 per Rx per month + dispensing fee (through the TogetherRx program).	**$165 drug costs $55 dispensing fees**
Zocor – 10 mg $70 per month, made by Merck	**$840**	After TA is used up, consumers can get the medications for only the dispensing fee.	**$0 drug costs $55 dispensing fees**
Zyprexa – 10 mg $260 per month, made by Lilly	**$3,120**	Consumers can purchase medications for $12 per month + dispensing fees.	**$132 drug costs $55 dispensing fees**
Total Cost to Consumer	**$5,520**		**$462**

Estimated Annual Savings = $5,058

Example #2: A 68-year old Louisiana woman with income of $11,000 and assets of $30,000

Medication, monthly cost, manufacturer	Current annual cost to consumer	Manufacturer's wrap-around assistance to Medicare TA program	Annual out-of-pocket cost with Medicare TA + manufacturer's wrap around assistance
Aricept – 10mg $130 per month, made by Pfizer	**$1,560**	Consumers can buy medications for $15 per Rx per month + dispensing fee.	**$90 drug costs**
Serezent – 50 mcg $85 per month, made by GSK	**$1,020**	After TA is used up, consumers can get the medications for an estimated 30% discount + dispensing fee (through the TogetherRx program).	**$357 drug costs $30 dispensing fees**
Total Cost to Consumer	**$2,580**		**$477**

Estimated Annual Savings = $2,103

Policy Issues

There are also a number of ways in which implementation of the discount card program, and enrollment in the TA benefit, can be improved. For example, NCOA is hopeful that current Medicare Savings Program (MSP) recipients (QMBs, SLMBs, and QI-1s) can be automatically enrolled in the $600 TA program. Current MSP beneficiaries could be informed directly of the Medicare-endorsed discount cards serving their area and asked to select one by simply returning a postcard. If a selection is not made within a period of time, they could be automatically assigned a card on a rotating basis, so no card would be favored. By automatically enrolling the MSP population, about 700,000 individuals could be assured enrollment. In addition, a process should be designed for identifying TA enrollees who are not enrolled in an MSP program, so that prompt follow-up can occur to determine if they are eligible for MSP benefits.

We also believe it is important to simplify the discount card application process. CMS should develop or authorize use of a universal application form that would permit applicants to check a box for a chosen card sponsor. It will be difficult for front-line workers and volunteers doing one-on-one application counseling and assistance if they must have and use potentially more than 20 or 30 different forms in some parts of the country. Making available a single form for all card sponsors would greatly simplify enrollment, reduce confusion, and improve participation in the discount card and TA programs.

Conclusion

Enactment of the new Medicare law is the single-most important opportunity to help low-income Medicare beneficiaries to have emerged in the past 35 years. NCOA is firmly committed to working with a broad range of partners to take full advantage of this opportunity to provide much-needed assistance to this vulnerable, hard-to-reach population.

Getting low-income beneficiaries enrolled in the savings programs is essential. Historically, efforts to identify and enroll low-income consumers eligible for needed benefits from government and private programs have been at best inconsistent and uneven. While proposed CMS and SSA awareness efforts will reach millions of low-income beneficiaries, there also needs to be complementary, coordinated initiatives that go much deeper into the community in order to educate consumers, help them make informed choices and facilitate their actual enrollment in the new Medicare benefits.

In response to the significant challenges and opportunities created by the new law, NCOA is forming the Access to Benefits Coalition – a public-private partnership dedicated to ensuring that low-income beneficiaries know about and can make optimal use of new Medicare prescription drug benefits and all other available resources for saving money on prescription drugs. NCOA is also developing an enhanced version of BenefitsCheckUpRx to facilitate decision-making and enrollment in a full range of savings programs. The new decision-support tool will help beneficiaries to determine the individualized combination of programs that will save them the most money.

It is also important to understand that most low-income seniors who enroll in the Transitional Assistance credit program will save a lot more than $600 in 2004 and 2005. This is because of the commendable actions by several pharmaceutical manufacturers to offer savings programs for low-income beneficiaries that "wrap around" the Medicare-approved cards.

NCOA is also interested in opportunities to automatically enroll Medicare Savings Program recipients in the TA benefit, and to create a universal discount card enrollment form.

By working together on these initiatives, we can significantly improve the quality of the lives of millions of vulnerable Medicare beneficiaries in need this year.

The CHAIRMAN. Well, Jim, thank you very much. Information flows are going to be critical. I recently hosted a health care conference in Idaho about the new programs, and it was well attended, upwards of 600 folks. What was fascinating to me throughout that conference, and I have never seen it before, is that there were nearly 600 people there, all of them taking notes with every speaker. There is a great hunger for information. While some have been critical of what Congress did in one way or another, there is still a true recognition that this is a valuable asset for America's seniors.

Now let me turn to Craig Fuller. Craig is president and CEO of the National Association of Chain Stores. We welcome you before the committee, Craig.

STATEMENT OF CRAIG FULLER, PRESIDENT AND CEO, NATIONAL ASSOCIATION OF CHAIN DRUG STORES, WASHINGTON, DC

Mr. FULLER. Mr. Chairman, thank you very much. It is a pleasure for me to be here today. I have submitted a statement for the record and I would like to just spend a few minutes talking to you about some of the experiences we are having and hopefully being responsive to some of the good questions you asked a little bit earlier.

I would also like to reciprocate, frankly, and invite you and members of this committee, indeed your colleagues in the Senate, to visit a pharmacy over the next few months and see first-hand how seniors are coming to learn about the program, enroll in the program, and receive the benefits from this program because that is really where our commitment lies.

As Jim said so eloquently, we debated various aspects of this legislation as it moved through the Congress but today the Medicare Modernization Act is the law. It is a law that reflects some of the concerns we had during the course of last year but it is a law that we fully intend to do everything we can to ensure is made operational and works for America's seniors and provides the kind of benefits not only in 2004 and 2005 but in 2006, as envisioned by the legislation.

We have, of course, members all across the country. Our members are held within 217 different companies, 33,000 different stores. We have 120,000 pharmacists that see hundreds and hundreds of thousands of patients every single day across the country.

I also wear another hat though, as you suggested. NACDS is the co-owner of the Pharmacy Care Alliance. We decided early this year to partner with Express Scripts, one of the nation's largest and leading pharmacy benefit managers, in the Pharmacy Care Alliance for the purpose of offering a senior drug discount card. We felt if we were going to be able to do this effectively, we had to work with an organization that had a lot of experience in this area and we have been very pleased with this partnership. I must say that it is an intense activity. As you were suggesting with the previous witness, Dennis Smith, you kind of get into this on a 24-hour-a-day basis in order to get ready for the enrollment that begins in May and obviously the benefits beginning in June.

We are going to reach out, though, to all of our pharmacists, as well as to independent pharmacists across the country because we think that that's where most of these seniors go. It is always important to remember that of the 40 million plus Americans who are Medicare-eligible, 75 percent have some kind of coverage, not always good coverage, but 25 percent or so have no coverage at all and those patients today, for their medication needs, are speaking with their physicians and with their pharmacists.

The minute this legislation was passed, people were coming into the stores asking about the program, asking about how to enroll, asking about when it would be available. For those 10 or 12 million people who have no coverage during the course of the year, they, and as Jim suggested, their friends or relatives and their caregivers are very much interested in how we are going to deliver on June 1. So we are going to be actively involved through the Pharmacy Care Alliance in enrolling patients and in hopefully meeting their needs.

You asked in organizing this hearing to have a discussion of some of the issues we face, and there are issues. One, I think, lies with expectations. What is that senior going to expect when they come into a pharmacy to enroll and when they come in to receive the benefit from their card? Well, I am pleased to tell you that I actually believe that because the pharmaceutical manufacturers and retail pharmacy are going to be participating and making concessions on the cost of this medication that we should exceed the estimated 10 to 25 percent savings. I think we can beat that. We are working now with the manufacturers on the details of the program and that is good news.

However, of course, some of the expectations are that this is a benefit program with a $10 co-pay and it is not that, and so we are going to have to find ways to help educate seniors. That is why we are very pleased, frankly, with what CMS has done. We commend CMS. They are working tirelessly with us and many others to get this information out to seniors and we have been distributing the information they provide to seniors.

I think there are going to be issues with the sheer magnitude. One of those common phrases heard in this town is "This isn't rocket science." Well, this is about as close to rocket science as a health care program can get when you think of the fact that we may have 10 or 12 million people, plus another 10–12, 20 million people who are concerned about them, coming to stores, coming to organizations like Jim's, coming to the Congress and to Medicare saying, "How do I enroll?" They are all going to do it on May 3 when this program kicks off and they will have 30 days, if they want to be able to participate in June, roughly 30 days to do that. There is a lot of technology behind these programs and we are working closely with CMS to make sure it happens.

The website that you asked about is very important. We also will have a website for our program to help educate seniors. A lot of seniors and their caregivers come to websites for information. A lot of seniors come to our retail pharmacy websites for information and all of these are going to have to be coordinated.

It is an important undertaking and I will close by saying that as you pointed out, we have had concerns but our concerns were ad-

dressed last year. We think one of the reasons we wanted a program that was developed within the community of pharmacy was to demonstrate that a level playing field that does not push people to mail order, a program that has transparency, a program that has open access, can be competitive, can work, and can serve America's seniors, and that is what we are about building as we go forward. Thank you again for allowing us to come and talk to the committee.

[The prepared statement of Mr. Fuller follows:]

Statement on

ISSUES RELATING TO IMPLEMENTATION OF THE MEDICARE-ENDORSED PRESCRIPTION DRUG DISCOUNT CARD PROGRAM

Craig L. Fuller
President and Chief Executive Officer

United States Senate Special Committee on Aging
Washington, D.C.

March 9, 2004

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Mr. Chairman, Senator Breaux, and Members of the Senate Special Committee on Aging. My name is Craig L. Fuller, President and CEO of the National Association of Chain Drug Stores (NACDS). I am pleased to be here today to talk with you about our industry's views about the upcoming Medicare-endorsed prescription drug discount card program. In addition to today's discussion, I would like to invite all members of the Committee, as well as your Senate colleagues, to visit a community pharmacy over the next few months a see first hand how the Medicare prescription drug discount program is being implemented.

You will have no trouble finding one of our members to visit. NACDS represents 217 companies that operate more than 33,000 community retail chain pharmacies. Our members include traditional chain pharmacies, supermarket pharmacies and mass merchandisers that operate pharmacies. We represent large and small chain-operated pharmacies from all over the United States. Our industry employs more than 120,000 pharmacists, and about 3 million total individuals, and provides over 70 percent of all outpatient prescriptions in the United States. We believe that our industry has a critical role in helping to implement the discount card program that will be launched later this year, and the full Part D prescription drug coverage program in 2006. We appreciate the opportunity to express our views today.

With the enactment last year of the Medicare Modernization Act (P.L. 108-173), the Congress committed to the most significant expansion of Medicare benefits in the nearly 40 year history of the program. While NACDS participated in a healthy debate last year, there is only one view among NACDS members today – we must and will do everything possible to make this program work. I know you expect nothing less and America's seniors certainly deserve nothing less.

On behalf of my members and the staff at NACDS, I want to express appreciation for the opportunity we have had to work closely with the Congress and Administration on implementation of various provisions of the MMA. This clearly is an enormous undertaking for the Administration in a rather short time frame.

I want to commend the staff of the Centers for Medicare and Medicaid Services (CMS) with whom we and many others have been working closely on implementation of the discount card program and the Part D prescription drug coverage program which begins in 2006. We believe that Medicare coverage for pharmacy services is a long overdue addition to the Medicare program, and the discount card program in 2004 and 2005 will be an important "first step" in helping seniors understand what to look for in selecting a Medicare pharmacy benefit in 2006.

Retail Pharmacies: Card Implementers and Card Sponsors

As the Committee knows, NACDS began last year with a very clear set of priorities that were addressed during the course of debate on a Medicare prescription drug benefit. Central to all of our beliefs is the notion that our seniors – indeed all of our customers – deserve to make their own choice in where they seek pharmacy related services and pharmaceutical products. Hence, we called for a *level playing field* and *open access* to insure that seniors were not pushed out of their neighborhood pharmacies where they interact today with a trusted pharmacist, and that they could receive medications for 30 or 90 days at competitive prices from their retail pharmacy. We also believe that there should be clear rules of *transparency* associated with a Medicare endorsed prescription drug program.

The leadership of NACDS concluded after passage of MMA that it was important for the industry to offer a national prescription drug discount card program. Thus, we are currently seeking Medicare endorsement for a card program that provides seniors with a meaningful benefit in a manner consistent with the principles we articulated last year.

We approached the implementation of the discount card program with two important perspectives. First, millions of seniors currently come to our pharmacies to obtain their prescription medications, and will continue to do so after the discount card program is launched. Many of them already have some form of coverage for prescription drugs, while some use existing discount cards, and others pay cash for their prescriptions.

Now, with the launch of the card program this spring, many of them will use their new Medicare-endorsed discount card to purchase their prescriptions. How much will these new discount cards reduce the amount that seniors pay for prescriptions? What challenges will these new cards present to beneficiaries and pharmacies?

We can tell you that pharmacists who work in our stores are already getting questions both about the new discount card program and Part D prescription drug coverage program. There appears to be a lot of interest and excitement about these new programs. Therefore, we first want to talk to you today about some of the real world implementation issues that we see for Medicare beneficiaries, pharmacies, and pharmacists in making this new discount card program work efficiently.

Rather than address some of these issues from the sidelines, we elected to develop a senior discount card offering, apply for Medicare endorsement, and make it available to all of community pharmacy. Earlier this year, we restructured an entity we formed two years ago called the Pharmacy Care Alliance. Today, the Pharmacy Care Alliance, known as the PCA, is a joint venture of NACDS and Express Scripts, one of the nation's largest pharmacy benefit managers (PBMs). We are partnering with Express Scripts to offer a discount card program because we found Express Scripts equally dedicated to the proposition that we must make this program work for America's seniors and because they are committed to executing a program that is consistent with the principles that NACDS and all of pharmacy advocated during Medicare reform.

Namely, that patients should have the right to choose the retail pharmacy from which they want to obtain their pharmacy services, and that patients should have the ability to obtain their maintenance medications through their local retail pharmacy or mail order. The card that we will offer will include a mail order component, but will not drive patients away from retail pharmacy by requiring that they use mail or creating financial incentives to use mail order.

We also believe that any price discounts, rebates and concessions that card sponsors are able to negotiate from manufacturers and pharmacies should be passed through to the beneficiary, so that beneficiaries can achieve the maximum savings on their prescription drugs.

As we have heard many times, one of the primary driving forces behind the discount card is to give seniors the same purchasing leverage for prescription drugs that millions of Americans currently have through their prescription drug coverage programs. We will succeed in this mission only if the discounts that card sponsors obtain are in fact passed through to beneficiaries to reduce the prices of their medications At this point in time, I am pleased to report that commitments by most of the pharmaceutical manufacturers as well as the nation's pharmacies suggest that seniors using the Pharmacy Care Alliance card will enjoy levels of savings not previously available in traditional discount card programs. Indeed, we believe we will exceed the generally accepted savings goals for this type of program of between 10 and 25% savings.

Implementation Issues for Beneficiaries and Pharmacies

Managing Beneficiaries' Card Program Expectations: Let me talk more in detail about some of the issues relating to what seniors, pharmacies and the marketplace can expect as the discount card program is implemented. Clearly, pharmacists and pharmacies have been and will continue to be on the front lines in helping seniors obtain their prescription medications. Pharmacies do this by providing assistance to seniors in understanding and navigating their existing drug coverage and drug card programs, offering seniors lower-cost generics, or possibly directing them to manufacturer patient assistance programs that might provide them their drugs free of charge.

In other words, pharmacies are already responsible for doing the actual work of interacting with the patients and filling their prescriptions, collecting copays, coordinating benefits with other third party payors, enforcing plans' formularies, counseling patients on their drugs, resolving problems with their coverage, and telling patients when their drugs are not covered, or that their prescription copays have increased. We expect to continue to do this under both the card and coverage programs.

However, in another very important way – regardless of which card programs our members agree to participate in – pharmacies will also be responsible for managing beneficiaries' expectations regarding the discount card program. This may be just as important in helping them manage their drug benefits or drug therapy. Many seniors, as we know all too well, are desperate for help in paying for their medications. However, pharmacies will have an important role in helping to explain to seniors the nature of the discount card program, that the discount card is not drug coverage, and that they still need to pay for their prescriptions out-of-pocket, minus their discount.

Some Medicare beneficiaries are already asking our pharmacists whether Medicare can pay for some or all of their prescription drug bills. We all know that the earliest that will happen is 2006 for individuals that are not eligible for the transitional assistance that is available to certain low-income seniors under the card program. All of these expectations have to be managed, and pharmacies will be on the front lines of doing this, since we are the ones who primarily interact with patients.

Educational Outreach: To help in the massive educational effort regarding this card program, we have been working with CMS to review and begin distributing materials that they are producing. These include materials that will be provided to pharmacies that work in our stores, so that they understand the discount card program and can answer the many questions that Medicare will have. We will also encourage our member companies to have CMS-prepared materials about the card program available in pharmacies to provide to beneficiaries, and will direct beneficiaries to the 1-800-Medicare number for more information. NACDS is also preparing educational materials for pharmacists, including continuing education programs.

Discount Expectations: Although CMS has said that seniors can expect to see discounts of anywhere between 10 and 25 percent on their prescriptions, remember that many pharmacies already offer discounts to seniors on their prescription medications.

Some studies demonstrate that discounts under existing prescription discount card programs are slightly better – or sometimes less – than the discounts that seniors can obtain by comparing prescription prices among pharmacies, and asking their pharmacy for a senior citizen discount. Remember also that many seniors already have prescription drug discount cards of one form of another, and they may find that their new Medicare-endorsed discount card provides the same, slightly higher, or slightly lower prescription prices than the discounts that they obtained under other card programs. For example, many seniors have enrolled in the recently-launched pharmaceutical manufacturer discount card programs that have been offering either significant discounts on prescription medications, or are only requiring a single, flat copay per prescription, such as $12 or $15 for a 30-day supply of medication.

Therefore, much of the perceived and actual success of the new Medicare-endorsed discount card program will depend on whether card sponsors are able to obtain significant rebates and discounts from manufacturers and pharmacies, the extent to which these are passed along to beneficiaries, and how these discounts compare to existing card programs and the prices that they are already paying with any pharmacy discounts they might already be receiving.

Helping Seniors Decide: We also expect that many seniors will turn to our pharmacists to help them figure out which discount card program to choose, since there are likely to be several national and regional card programs from which to select. If a measure of the Medicare law's success is greater choices for seniors, it looks good so far, at least as it relates to the discount card program. Reports are that CMS has received more than 100 applications from potential card sponsors.

However, the challenge for seniors, and for pharmacies, will be helping them sort through all the details of the various card programs, such as whether the drugs covered under a particular card program match with the drugs that the senior is taking, whether there are significant discounts on the prices of the drugs, and whether the patient's retail pharmacy is part of the card sponsor's network. Invariably, seniors will turn to family members, friends, and their pharmacists to help them decide.

Pricing Website: Pharmacies are also preparing for many questions about drug prices from beneficiaries with endorsed cards. That is because CMS will be creating a new discount card website that will help seniors compare the prices of their medications from the various card sponsors. This pricing website will help seniors choose an initial card program this May, as well as help them decide in the fall of 2004 whether to remain in the same program or pick a new card program for 2005. While we support transparency in medication pricing at all levels, we believe that this website will create some challenges to seniors and pharmacies.

That is because, once the program gets started, prices for prescription drugs under the card programs will be allowed to change weekly on this website, consistent with changes in manufacturers' charges for medications, as well as other changes in the market, such as a change in discounts that are available from manufacturers or pharmacies. We believe that, consistent with free market principles, prescription prices under these card programs must be allowed to change since prices of pharmaceuticals increase, as does the cost of doing business. Anything less would be price controls on pharmacies.

However, in reality, beneficiaries may have chosen a particular card program for 2004 or 2005 based on prices posted on this website. But, by the time the beneficiary arrives at the pharmacy to purchase their prescription, those prices may have changed, and the beneficiary may be disappointed to find that they must pay a higher price than the one that was on the website. The beneficiary may also find that they picked a particular card program because of the drugs that were initially covered under the card sponsor's formulary, only to find that the drugs are no longer covered, or not covered at the same discount level.

CMS must be diligent in all its educational materials – as should all card sponsors – to make clear to beneficiaries that card sponsor prescription drug prices will likely not remain the same during the year, and in fact, that there may be frequent price changes, and that drugs covered on the formulary might change as well.

Transparency in Rebates and Discounts: We think it is key for seniors, Medicare and Members of Congress to know whether card sponsors are obtaining significant price reductions from manufacturers and pharmacies, and whether these are being passed through to beneficiaries in the form of lower prices. The discount card law requires that this type of information be reported to CMS, which cannot make it public. We think it is important, however, to ensure that any PBM or other private health plan involved in the Medicare program be required to disclose any relevant financial data so that federal officials could monitor whether the money was being spent wisely, and savings were being passed on to seniors. In our Pharmacy Card Alliance card program, we will have clear and rigorous rules regarding transparency, verified by an independent auditor who will have the right to review proprietary information to ensure compliance. Congress, CMS, and Medicare beneficiaries should expect the same from every card program receiving CMS endorsement.

Participation by Pharmacies in Card Programs: With regard to participation by chain pharmacy in the various discount card programs, NACDS member pharmacies, as well as all retail-based pharmacies, will have to make their own individual decisions about whether to participate in the various card programs that will be offered. Given that there are likely to be dozens of endorsed programs, each pharmacy operation will have to assess the benefits of participating in each of these programs.

Among our highest implementation priorities for the discount card program and the Part D prescription drug coverage program is assuring that the standards for beneficiary access to pharmacies be implemented consistent with Congressional intent. This refers to the so-called "TRICARE" access standards.

We are concerned however, that CMS's implementation of these standards in the Medicare-endorsed prescription drug discount card and transitional assistance program is inconsistent with Congressional intent. As a result, beneficiaries' access to their local community retail pharmacy will be reduced. As we understand it, CMS is allowing endorsed card sponsors to implement these standards on average across an entire service area or region, rather than in each state in the service area or region.

We are particularly concerned about the impact of this interpretation on beneficiaries in rural areas, who might have to travel much longer distances to a pharmacy if the one closest to their home is not in the pharmacy network. We are hopeful these issues can be corrected before the Part D coverage program is implemented, which is scheduled for 2006.

In our Pharmacy Care Alliance card program, any pharmacy can participate in the program that is willing to meet the terms of participation. There will not be a restrictive pharmacy network. We think that seniors will find our card program to offer a unique combination of highly competitive prices, and freedom to choose the pharmacy from which they can obtain their prescription medications.

Transitional Assistance Issues: Pharmacies will also work with low-income seniors that are eligible for the $600 in annual transitional assistance to help them make the most of this dollar amount. We can do this by offering generic drugs where possible, and working with a beneficiary's physicians to assure they are taking the most cost-effective brand drugs possible. In other words, pharmacies can make the $600 stretch further if we can work with the beneficiary and their physician on assuring appropriate prescription drug use. Because we often know our patients' financial ability (or inability) to obtain their medications, pharmacies are also in an excellent position of identifying low-income seniors that might be eligible for transitional assistance so we can encourage them to enroll in a card program.

Administrative Issues Relating to Card Programs: Pharmacies are highly automated health care providers, processing almost 3.4 billion prescription claims each year in an online, real-time manner. Consistent with this operating model, we want these card programs to be simple to administer for pharmacies that want to provide prescriptions efficiently.

We do envision, however, some potential administrative issues with the card program, especially in cases where state Medicaid or state pharmaceutical assistance programs decide to "wrap around" the benefit, and pay the copays or any additional coverage, for transitional assistance individuals.

This information about "wrap around" benefits must be provided to pharmacies at the point of care in a real-time manner by the card sponsor to coordinate these benefits, without any charge by the card sponsor to the pharmacy for providing this necessary information. This information will help pharmacies determine who is responsible for paying for the prescription, and the pharmacist can bill the appropriate and liable third party.

We also see potential issues where beneficiaries have both a CMS-endorsed prescription drug discount card and multiple non-endorsed prescription drug discount cards, which is a very real possibility. Beneficiaries may ask pharmacies to determine which card provides them a better price for their medication, an endorsed card or a non-endorsed card. To facilitate this process, we believe that all card sponsors should collect information from beneficiaries at the point of enrollment about other potential card programs or sources of coverage that they have. This will facilitate the provision of pharmacy services through the card programs.

Finally, consistent with current industry practices, CMS must also allow card sponsors to adjudicate claims transactions for drugs and supplies covered under the discount card program in an on line, real time manner. CMS cannot require that any part of the transactions for this program be conducted in any form of batch transaction standards.

Conclusion

In conclusion, we believe that there will be many challenges for all stakeholders in implementing this Medicare-endorsed prescription drug discount card program. The next two years will go a long way in helping all of us prepare for the prescription drug coverage program that will begin in 2006 and beyond. Medicare beneficiaries will continue to rely on pharmacists – as they have done in the past – to help them understand how to use the new Medicare-endorsed discount card programs.

We think that, properly structured, these card programs will be a success. Seniors will ultimately judge these programs on the discounts that they offer, whether they offer a wide range of choices for seniors to obtain their medications, and the level of customer service that they provide. We welcome the opportunity to provide you additional information on any of the issues we discussed here. Thank you Mr. Chairman and members of the Committee for asking us to present our views here today.

The CHAIRMAN. Craig, thank you very much for that testimony.

Now let me turn to Forest Harper, who is vice president for Pfizer's Pfizer for Living Share Card program. Forest, we appreciate your participation today, and I will tell you that in the health care conference we had in Idaho, we appreciated Pfizer's involvement there. Obviously your company is taking a very active role in this effort. Please proceed.

STATEMENT OF FOREST HARPER, VICE PRESIDENT, PFIZER FOR LIVING SHARE CARD, PFIZER, INC., WASHINGTON, DC

Mr. HARPER. Thank you, Mr. Chairman and members of the committee and staffers. My name is Forest Harper and I am vice president of Pfizer in charge of the Pfizer for Living Share Card program. I deeply appreciate your invitation and to appear here today to talk about our program. I am happy to discuss Pfizer's continuing commitment to providing patients in need with access to prescription medicines. I ask that my written statement be included in the record.

The CHAIRMAN. It will be.

Mr. HARPER. It was just 2 years ago that we created the Pfizer Share Card program as a bridge to Medicare prescription drug benefits. The Pfizer Share Card has provided immediate assistance to those most in need while Congress took on the challenge of creating a more enduring legislative solution. Over those 2 years Pfizer's Share Card has helped more than a half a million low-income Medicare enrollees fill nearly 4.5 million prescriptions. The Pfizer Share Card allows low-income Medicare beneficiaries who have no prescription drug coverage to purchase most Pfizer medicines for just a flat fee of $15 per month per prescription, as you can see on the chart to my left.

We have learned a number of important lessons that have helped make the Pfizer Share Card a success. We believe these lessons can help ensure the success of the interim discount card and we also learned that to maximize the enrollment of Medicare beneficiaries, the program has to be as user-friendly, simple, predictable, and convenient as possible.

We have also learned that to reach this target population a successor program must go the extra mile, not just advertisement. What really works is partnering with grassroots organizations that Medicare beneficiaries truly trust. We work with a network of over 25,000 local community-based organizations. This is necessary to ensure that nobody is left out and to reach across language and cultural boundaries.

The interim Medicare discount card is an integral and important piece of the new Medicare bill. Like the Pfizer Share Card, it is designed to provide immediate assistance to those most in need. While CMS goes about the challenging task of implementing the new and universal prescription drug benefit in 2006, we will be here.

Let me emphasize that Pfizer is committing to making both programs a success, both the Medicare discount card and the permanent Medicare prescription drug benefit. To that end, we are actively working with leading health care organizations to create a new cooperative program that will offer Medicare beneficiaries im-

mediate assistance through the new Medicare discount card. We believe that this cooperative program currently under discussion could be one of the most comprehensive discount cards currently under consideration by CMS.

The proposed program envisions a broad coalition of health care companies aligned around common goals. Our first goal is to assure continuity of care for our current Pfizer Share Card members. Second, we want to provide patients in need with even broader access to the prescription medicines that can help them better manage their health. We are also committed to preserving the integrity of the physician and pharmacist patient relationship, as Craig mentioned earlier, that is at the heart of the health care delivery system.

Let me also emphasize that Pfizer's commitment to patients in need did not start with and certainly will not stop with the Pfizer Share Card or the coming Medicare discount card. For more than 30 years in which I am proud to say 22 of those years I have personally witnessed, Pfizer has been reaching out to people in need. We donate over $1 million each day in medicines throughout our U.S. outreach programs.

In 2003 alone we donated $500 million in medicines to more than 1.2 million Americans, are our second chart points out, in our three different programs on access. One program is the Sharing Care program. The second program is our Connection to Care program, which is the physicians offices, and then the Pfizer Share Card program.

Before I close I would like to share with you one of the thousands of success stories from a Pfizer Share Card enrollee. You know, I really had the privilege of personally meeting Lorraine, who is a 74-year-old and lives in Sandy, UT. She became a Pfizer Share Card member in September 2002 and at that time Lorraine had no prescription drug coverage and a great difficulty getting the medicines she needed.

She went looking for help and I am pleased to say found the Pfizer Share Card. Lorraine was an accountant before she retired and she did the math. She found the Share Card saved her $100 a month and since then she has become a passionate advocate of the Pfizer Share Card. She has actually taken it up herself to speak at community events, including Aging Committee conferences like yours, Senator Craig, but this time in Utah at an event that Senator Hatch hosts each year in his aging conference.

Lorraine and others like her are the reason we started the Pfizer Share Card and they are the reason we are committed to making the Medicare discount card work. We commend this committee, Congress and the Administration for their commitment to improving Medicare. We are pleased to be a part and do our part of this program.

Pfizer is committed to discovering new medicines that improve health and enhance lives. We are equally committed to doing whatever we can do to ensure people receive the medicines they need and when they need it and how they need it. Thank you for your time and attention and I look forward to answering any questions you may have.

[The prepared statement of Mr. Harper follows:]

STATEMENT

BEFORE THE

UNITED STATES SENATE

SPECIAL COMMITTEE ON AGING

HEARING

ON

"The New Medicare Drug Discount Card: An Advance Prognosis"

MARCH 9, 2004

628 DIRKSEN SENATE OFFICE BUILDING
WASHINGTON, D.C.

FOREST HARPER
VICE PRESIDENT, PFIZER FOR LIVING SHARE CARD PROGRAM
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3/8/2004
5:34 PM

Mr. Chairman and Members of the Committee, my name is Forest Harper and I am a Vice President of Pfizer, in charge of the Pfizer for Living Share Card Program™. I deeply appreciate your invitation to appear today and discuss Pfizer's continuing commitment to providing patients in need with even broader access to the prescription medicines that can help them better manage their health. I ask that this written testimony be submitted for the record.

As you may know, the Pfizer Share Card is the newest component in Pfizer's history of sharing with those in need. The program was launched in January, 2002, and over the last two years the Pfizer Share Card has helped more than 500,000 low-income Medicare enrolled seniors and disabled persons who do not have prescription drug coverage obtain needed medications to improve their health. As of the beginning of March, 2004 more than 4.5 million prescriptions have been filled using the Pfizer Share Card.

Because of Pfizer's commitment, we are actively working with other companies to create a cooperative program which brings together leading healthcare organizations to offer America's 40 million Medicare beneficiaries immediate assistance in getting needed medicines through the Interim Medicare-Approved Drug Discount program.

Pfizer's Commitment to Access for Medicare Beneficiaries

Although this new initiative is still under development, I can tell you that it will integrate administration expertise and retail pharmacy network access with the prescription drug savings of the Pfizer Share Card, as well as discounts available through other participating companies. We believe that the cooperative program under discussion could be one of the most comprehensive discount drug card programs currently under consideration by the Center for Medicare and Medicaid Services (CMS).

The proposed program envisions a broad coalition of healthcare companies aligned around common goals: providing Medicare beneficiaries in need with access to medicines and

preserving the integrity of the physician-patient and pharmacist-patient relationships that are at the heart of our healthcare delivery system.

This new card will help to maximize choice, promote competition, and offer seniors in need real and immediate assistance with the cost of prescription medicines. We expect that Medicare beneficiaries will find this unique program to be of tremendous value to them and their families starting in June.

Pfizer's efforts to date to participate meaningfully in the Interim Medicare Discount Card program underscores our commitment to ensuring continuity of care for our current Pfizer Share Card members, and to providing patients in need with even broader access to the prescription medicines that can help them better manage their health.

We are pleased that other pharmaceutical companies have taken similar steps and are hopeful that more will follow.

More Than Two Years of Experience Reaching Out to Low-Income Medicare Beneficiaries

Pfizer has been operating the Pfizer Share Card program for more than 2 years. The program focuses on Medicare enrolled seniors and disabled beneficiaries who do not have prescription drug coverage but who do need help in obtaining the medications they need. Several studies have shown that these low-income seniors are 15 times more likely to experience health complications due to difficulty in filling their prescriptions and following their doctor's prescribed course of therapy.

As a result, these Americans suffer unduly from untreated disease and spend far too much time in hospitals and emergency rooms. That's a losing situation all the way around - for the patients, for their families and ultimately, for all of us as a society who bear the emotional and financial burden of untreated and under-treated medical conditions. It's a problem we are addressing with a variety of initiatives, including the Pfizer Share Card.

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The Pfizer Share Card is a comprehensive program that provides 3 immediate health benefits to enrollees (see Chart A).

- First, the program provides enrollees with the Pfizer Share Card. This card makes it possible for patients in need to obtain their Pfizer medicines for a flat fee of $15 per monthly prescription. The Pfizer Share Card offers access to a broad array of Pfizer products.

- Second, the program educates patients about their diseases. It provides them with the opportunity to receive easy-to-read, non-branded, health education information on 16 common medical conditions, such as high blood pressure, high cholesterol, diabetes and arthritis.

- Third, the program offers applicants and enrollees access to live customer service representatives who can provide them with assistance filling out the application and with information on specific state and federal programs for which they may be eligible.

Qualifying for the Pfizer Share Card program is simple. Individuals must be enrolled in Medicare, have a gross income of less than $18,000 (less than $24,000 for couples) and have no prescription drug coverage or access to other publicly-funded drug coverage like Medicaid or state-funded prescription assistance programs.

Since we have been operating the Pfizer Share Card, we have learned a number of important lessons that are valuable to help ensure the success of the Interim Medicare Drug Discount Card program. We learned that simplicity works. Seniors are more likely to use a program that is simple to enroll in, predictable in terms of costs, and effective in helping them to get the medicines the need when and where they need them.

Last year, we released a *Report to America* that outlined the lessons we've learned in designing and administering the Pfizer Share Card program, and the impact it's had on the lives of enrollees. Data from a survey conducted by the Marist College Institute for Public Opinion

published in the *Report to America* show that a program like the Pfizer Share Card can dramatically improve treatment adherence among enrollees. Seventeen percent more patients reported taking their doctor's full treatment. They stuck with their treatment and improved their health. That is the ultimate test of success for a meaningful prescription medicine benefit.

The Pfizer Share Card supports the physician-patient relationship first by providing information to patients on sixteen diseases common among seniors. These "plain English" materials help patients better understand their conditions so they can have more productive discussions with their doctors. Secondly, the Pfizer Share Card supports the physician's ability to prescribe the right medicine at the right time for his or her patient without concerns that the patient will be denied access to that medicine. Respecting physicians' clinical decisions when it comes to prescribing medicines is important and part of our plan for the coalition.

We have also learned important lessons about how to reach low-income Medicare beneficiaries and educate them about programs such as the Pfizer Share Card. Specifically, we have learned that to reach this target population, a program must go the extra mile to break down social barriers to enrollment. Pfizer has been very successful in building an extensive network of partnerships with organizations at the local, regional, and national levels to help educate eligible Medicare beneficiaries across language and cultural boundaries about the benefits of the Pfizer Share Card program.

Through an extensive grassroots outreach effort that started at the launch of the Pfizer Share Card, over 25,000 community-based organizations have worked with Pfizer to educate Medicare beneficiaries about the Pfizer Share Card. An effective program must rely on networking with trusted individuals, such as healthcare professionals, caregivers, churches, religious leaders, family and friends, to help raise awareness and facilitate enrollment. As we develop and participate in this new discount card program, we will bring this outreach and communication expertise to bear to help support the successful implementation of the Medicare Interim Drug Discount Card program.

I would like to share with you just one of the thousands of success stories from a Pfizer Share Card enrollee.

Lorraine, who is 74 years old and lives in Sandy, Utah, became a Share Card member in September of 2002. At that time, Lorraine had no prescription drug coverage and great difficulty getting the medicines she needed. She went looking for help, and, I am pleased to say, found the Pfizer Share Card. Lorraine was an accountant before she retired, and she did the math. She found that the Pfizer Share Card saved her about $100 per month. Since then, she has become a passionate advocate of the Pfizer Share Card. She has spoken at community events, including an Aging Conference sponsored by Senator Hatch in May 2003.

Lorraine, and others like her, are the reason we started the Pfizer Share Card and the reason we are committed to making the Medicare Drug Discount Card work

Pfizer's History of Sharing

For over 150 years, Pfizer has been dedicated to improving the health and quality of life of people in communities around the world.

Our experience with the Pfizer Share Card and Pfizer's other patient assistance programs confirms that improving access to the medicines physicians prescribe for their patients increases adherence with recommended treatment. This enhances patient health and quality of life. Our philanthropy programs are designed to put the patient's health first, and support the physician-patient relationship by helping to ensure that patients have access to the medicines that their doctors feel are right for them.

Pfizer is dedicated to discovering and developing new medicines and making them available to people around the world. Pfizer's Research and Development operation is the largest privately-funded biomedical organization in the world. Our scientists have produced innovative breakthroughs in a wide range of research areas, including depression, diabetes, high cholesterol,

AIDS, hypertension, and life-threatening infections. And today we're taking on some of the difficult diseases that affect our lives, including cancer, arthritis, and osteoporosis.

But we believe that our responsibility does not end in the lab. We must ensure that patients across the U.S. and around the world are able to benefit from the fruits of this enormous effort. We firmly believe that access to medicine shouldn't be unfairly limited by a limited income.

In addition to the Pfizer Share Card, Pfizer operates several meaningful patient assistance programs that provide low-income, uninsured patients with simple and convenient access to Pfizer prescription medicines for free (see Chart B).

For more than 30 years, Pfizer has been reaching out to people in need. Every day, we donate well more than $1 million in medicines through our U.S. outreach programs – in fact, in 2003 we donated $500 million in medicines, helping more than 1.2 million patients. These programs are tailored to serve a variety of people with different health care needs and make our medicines available to more than 27 million eligible people – those who have low incomes and lack prescription drug coverage. Our medicines include many essential treatments for the diseases common among Medicare enrollees, including heart disease, diabetes, arthritis, Alzheimer's and mental illness. Our patient assistance programs provide these medicines through physicians, community health centers, and major public hospitals across the country.

- ***Connection to Care*** helps patients through their doctor's office by providing Pfizer medicines free of charge to patients who earn less than $16,000 a year (or $25,000 for families) and who lack prescription drug coverage. Upon acceptance, patients receive a three-month supply of product at their doctor's office. In 2003 alone, Pfizer donated more than $350 million worth of medicines to patients in need through this important program.

- ***Sharing the Care*** donates Pfizer's leading medicines to low-income, uninsured patients through a network of 380 federally-funded community, migrant and homeless health centers across the country. Eligible patients receive their medication at their health center

pharmacy. Developed in partnership with the National Association of Community Health Centers and the National Governors' Association in 1993, Sharing the Care has won several awards and citations as one of the most successful public /private partnerships in the U.S. Pfizer has donated more than 8 million prescriptions to 1.8 million patients at community health centers since the program's inception ten years ago. That's an estimated $460 million in donated medicines since 1993.

Pfizer – Life is Our Life's Work

At Pfizer, our business is about saving and improving lives through the discovery and development of new medical advances. We believe that patients must have affordable access to needed medicines while at the same time incentives must be maintained to search for new and better treatments and cures. While these issues must be addressed by society at large, we recognize that we have a role to play as well.

At the core of Pfizer's vision of a healthcare system based on access and innovation, are what Pfizer Chairman and CEO Hank McKinnell calls the five "I-words."

- First, **Inclusion**: America's healthcare system must give every person the opportunity to get the right diagnoses and treatments.
- The second pillar is **Individualized** care: America's health care should honor the right of an individual to make choices and allow doctors and patients to choose the best courses of care rather than settling for the lowest common denominator of "standard care for the average person."
- Third is **Innovation**: American ingenuity is the world's best hope for a better future in healthcare. In fact, in an age when even high-tech jobs are being exported, we should expand this clear competitive advantage and recognize that in healthcare innovation, America provides the world the opportunity for better health.
- Fourth, **Information**: To help conquer the cost of disease, the healthcare system must give people access to clear and timely information and must help free medical professionals from excessive bureaucracy and help them avoid mistakes in serving patients.

- And the last "I-word" is **Incentives**, for people to pursue better health outcomes. Health care must be re-focused from encouraging reliance on hospitalization and custodial care to encouraging and rewarding patients and health care professional for engaging in holistic health management.

We at Pfizer measure our success not only by our ability to research and develop new medicines, but also by our performance as a corporate citizen—and, in particular, by our ability to provide access to medicines for patients who need them. These efforts reflect our belief that only by providing patients access to the medicines they need will they receive the high quality health care that they deserve.

We believe that a variety of creative public policies and private approaches can improve access without stifling innovation. However, finding these solutions will require new thinking and new approaches.

Concluding Remarks

The enactment of the Medicare Modernization Act is an important step toward increasing the quality of healthcare for Medicare beneficiaries. The law creates a significant benefit for many patients who need help to secure access to life-saving and life-improving medicines. That is particularly true for the most vulnerable of Medicare beneficiaries – those with limited incomes.

The Interim Medicare Drug Discount Card Program is an integral and important piece of the new Medicare bill. Like the Pfizer Share Card, it is designed to provide immediate assistance to those most in need, while CMS goes about the difficult task of implementing the new, universal prescription drug benefit in 2006. Pfizer is committed to helping to make both programs a success.

Two years ago, we created the Pfizer Share Card as a bridge to a Medicare prescription drug benefit. The Pfizer Share Card has provided immediate assistance to those most in need while Congress took on the challenge of creating a more enduring legislative solution. We are pleased to reaffirm and build on this commitment to seniors and disabled Medicare beneficiaries.

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Thank you again for inviting me to be here today. Pfizer looks forward to cooperating with this committee as you work to ensure that as many patients as possible benefit quickly from the launch of the Interim Medicare Drug Discount Card program and the eventual establishment of a lasting Medicare prescription drug benefit.

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The CHAIRMAN. Forest, thank you very much for that testimony and for Pfizer's involvement.

Let me now introduce once again Karen Ignagni, president and CEO of a newly formed organization called America's Health Insurance Plans or AHIP. Welcome before the committee.

STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CEO, AMERICAN ASSOCIATION OF HEALTH PLANS, WASHINGTON, DC

Ms. IGNAGNI. Thank you, Mr. Chairman. Our members would like to commend you for convening this hearing and we are delighted to participate and want to thank you very much for the invitation.

I would like to speak with you about three things this morning. First is to express the strong commitment on the part of our organization, AHIP. We are committed to this legislation and we are committed to the implementation schedule and we believe that we can be strong solution-providers. Second, to that end I want to discuss the value that we can bring and we are bringing to this program, and third, the results that we are achieving.

As this hearing looks ahead and focuses on the June 1 implementation of the drug discount card, I would like to first highlight the progress that already has been made for beneficiaries with the passage of this legislation. CMS has reported that 95 percent of new funding for the Medicare Advantage program is being used in improving benefits, and we see reports of that all over the country. The remaining 5 percent has been saved for benefit enhancements in 2005. 3.7 million beneficiaries are receiving expanded benefits. Premiums have been reduced for 1.9 million enrollees and have declined by an average of 26 percent and co-payments have been reduced for 2 million enrollees.

These improvements are clear evidence that the legislation passed 3 months ago is providing significant value for the nation's seniors and I want to commend the efforts of the members of this committee and you, Mr. Chairman, for making sure that was part of this agenda.

Two-thirds of our enrollees in Medicare Advantage get prescription drugs. This is expanding now with the additional legislation and the discount card will make those dollars go farther for beneficiaries.

As we look forward to the implementation of the discount card, our members are participating in three ways. First, of the 106 entities that have submitted applications, approximately half are for Medicare Advantage and Medicare Cost plans.

Second, a number of our member companies have submitted applications to sponsor nationwide or statewide discount drug cards that will be broadly available.

Third, other health plans and medigap carriers are exploring opportunities to collaborate with general sponsors in offering the cards to enrollees.

In addition to their participation, our members are developing a number of initiatives that go right to the questions that the committee posed in terms of how will we get the message out? First, we are designing innovative training programs for our customer service teams all over the country. We are developing other infor-

mation resources to help beneficiaries, including brochures with frequently asked questions, e-mail access to pharmacists and others who are available to answer questions, web pages, call centers, and other resources to facilitate information-sharing.

Our members are committed to increasing especially the awareness among beneficiaries about the possibility that they may be eligible to receive up to $600 over each of the next 2 years in the transitional assistance. We know further that a significant number of these individuals are already involved in Medicare Advantage plans and we are working especially with CMS to design innovative programs in coordination with CMS to get the word out and get the job done.

The Medicare legislation clearly required the discount card program to be implemented very, very quickly. While entities, Mr. Chairman, in the private sector are often before Congress with concerns they may have with the implementation of specific bills, we believe that it is also important to recognize when performance exceeds expectations.

We want to commend the agency for maintaining, first, open lines of communication and working very hard. This is the work that no one sees but they are on an almost 15-hour day cycle to get this job done, to provide timely responses to our members on the many implementation questions, and I hear from the tenor of the comments from my colleagues on this panel that they are doing the same with the other stakeholders.

Building on our past success—the way we will increase value of this discount card to beneficiaries is that we will use private sector pharmacy benefit management tools and techniques in the discount card program over the next 2 years and in the prescription drug program beginning in 2006. These tools increase access to prescription drugs by reducing out-of-pocket costs, improving quality, an often skipped-over but tremendously important issue for this population, and in reducing medication errors.

They encourage first, the use of generics when doctors say that they are permissible. Second, step therapy programs so we can begin to determine out what works well, what works fast, what works best. Third, negotiating discounts with pharmacies that participate in our networks. Fourth, disease management techniques that includes practice guidelines to encourage the use of safe and effective procedures and the latest in scientific information. Finally, the appropriate use of mail order pharmacies.

To conclude, Mr. Chairman, we are also proud to tell the committee that a number of studies not done by our organization, but by external sources, have demonstrated that the use of these techniques by private sector benefit plans is beneficial not only to enrollees in private plans but to enrollees in public programs. For example, a 2003 study found that the PACE program in Pennsylvania, arguably one of the most effective prescription drug programs throughout the country, could save up to an additional 40 percent by adopting the full range of private sector pharmacy benefit management techniques I talked about.

Second, a Lewin study found that Medicaid managed care plans reduce prescription drug costs for states by 15 percent below the level states would otherwise have experienced under Medicaid fee-

for-service. That is significant in and of itself but when you recognize that this statistic is married with the observation by the consulting firm that did this report, we start at a 10 percent disadvantage, achieving 15 percent reduction is a major accomplishment.

We are pleased, Mr. Chairman, to join with our colleagues in participating in this hearing today. We are pleased to talk about the value we are bringing to beneficiaries and we want to express our strong commitment to being full participants to make this program work effectively. Thank you.

[The prepared statement of Ms. Ignagni follows:]

Statement on

The Medicare-Endorsed Prescription Drug Discount Card Program

by

Karen Ignagni
President and CEO
AAHP-HIAA

Before the
U.S. Senate Special Committee on Aging

March 9, 2004

Good morning, Mr. Chairman and members of the committee. I am Karen Ignagni, President and CEO of AAHP-HIAA. I appreciate having this opportunity to discuss the private sector's role in making prescription drugs more affordable for seniors and persons with disabilities through the Medicare-Endorsed Prescription Drug Discount Card Program. AAHP-HIAA is the national trade association representing nearly 1,300 private sector companies providing health insurance coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and also participate in public programs. Medicare Advantage plans, Medicare cost contractors, and Medigap carriers are included in our broad-based membership.

Introduction

Our member companies enthusiastically support the Medicare Modernization Act of 2003 (MMA). We applaud Congress for enacting this historic legislation to improve choices and benefits for Medicare beneficiaries. We are also very pleased that the MMA establishes tax-free Health Savings Accounts (HSAs) as a new health care option for Americans under age 65.

Although the discount card program is the topic of today's hearing, I want to begin by focusing on the benefit enhancements and cost savings that Medicare beneficiaries are now receiving, effective March 1, as a result of the additional funding the MMA provided for the Medicare Advantage program in 2004.

For the past five years, AAHP-HIAA and our members have urged Congress to address the funding crisis in the private sector Medicare program. During most of these years, funding for the benefits of a significant majority of private health plan enrollees increased by only 2 percent annually, at a time when health care costs were increasing by 8 to 10 percent annually. Congress addressed this problem in a bipartisan fashion by providing funds to stabilize private health plan benefits and choices. This funding increase was included in the MMA largely because a core group of 130 Members of Congress – 81 Democrats and 49 Republicans – worked hard to build support for this priority. Three members of this committee – Senators Santorum, Wyden, and Smith – deserve special credit for working to ensure that these funds were passed into law. Our

members are also grateful to Senators Breaux and Hatch for their work as members of the Medicare conference committee, and we thank many other committee members who voted for final passage of this legislation.

Just as Congress did its part to strengthen Medicare for seniors and individuals with disabilities, I am proud to report that our members have followed through by using the 2004 funding increase to expand benefits and reduce costs for the beneficiaries they serve. The Centers for Medicare and Medicaid Services (CMS) has reported that 95 percent of the additional funding is being used to help beneficiaries this year through reduced premiums and cost-sharing, increased benefits, and enhanced access to providers. The remaining five percent has been put in a reserve fund to stabilize benefits in 2005.

Just last week, 3.7 million Medicare Advantage enrollees began to receive increased benefits as a direct result of the MMA. In addition, premiums were reduced for 1.9 million enrollees and co-payments were reduced for 2 million enrollees in Medicare Advantage plans. Overall, premiums for all Medicare Advantage enrollees nationwide declined by an average of 26 percent. These improvements are clear evidence that the MMA is providing significant value for our nation's seniors.

Beginning June 1, beneficiaries will receive further assistance under another important initiative established by the MMA: the Medicare-Endorsed Prescription Drug Discount Card Program. AAHP-HIAA and our member companies strongly support the steps this program will take to reduce prescription drug costs for beneficiaries – while providing up to $600 annually in added assistance for those with low incomes – in the time that remains before a prescription drug benefit is available to all Medicare beneficiaries beginning in January 2006.

Many of our member companies have submitted applications to participate as sponsors of discount drug cards under this new program. CMS has reported that among the 106 entities that have submitted applications, approximately half are from Medicare Advantage and Medicare cost plans that are planning to offer discount cards exclusively to their own enrollees. In addition, a number of our member companies have submitted applications to sponsor nationwide

or statewide discount drug cards that will be broadly available to both Medicare fee-for-service enrollees and private health plan enrollees. Also, other health plans and Medigap carriers are exploring opportunities to collaborate with general sponsors in offering the cards to their enrollees and policyholders.

Our member companies have demonstrated their commitment to meeting the health care needs of Medicare beneficiaries for more than 20 years. As long-time participants in the private sector Medicare program – now known as "Medicare Advantage" – private sector health plans currently provide comprehensive health coverage to 4.6 million seniors and persons with disabilities.

By covering services that are not included in the Medicare fee-for-service benefit package, Medicare Advantage and Medicare cost plans serve as a crucial health care safety net for many low-income and minority beneficiaries who cannot afford the high out-of-pocket costs they would incur under the Medicare fee-for-service program.

Our Medigap members also play an important role by offering coverage of Medicare fee-for-service costs so that Medicare-covered services are more accessible. For 10 million beneficiaries, Medigap policies provide affordable protection against high out-of-pocket health care costs.

Looking to the future, our members are eager to further expand their role in serving Medicare beneficiaries by participating in the prescription drug discount card program in 2004 and 2005. We view this program as a strong framework for future efforts, beginning in January 2006, to launch private sector participation in the Medicare Part D Prescription Drug Program and to expand participation in the Medicare Advantage program.

Private Sector Participation in the Discount Card Program

Our member companies are planning to participate in the Medicare-Endorsed Prescription Drug Discount Card Program in several ways:

- **General Sponsors:** Companies participating as statewide or nationwide sponsors will make their cards available to all eligible Medicare beneficiaries who live in their service areas. Discount cards offered by these sponsors will be available to beneficiaries in the Medicare fee-for-service system and to enrollees in Medicare Advantage and Medicare cost plans that do not sponsor discount cards, as well as beneficiaries with Medigap coverage.

- **Exclusive Sponsors:** Medicare Advantage and Medicare cost plans will be permitted to participate as exclusive sponsors. This means that they may make discount cards available to beneficiaries they cover through their health plans and, additionally, that Medicare Advantage and Medicare cost enrollees may only choose the discount card offered by their health plan. Low-income Medicare managed care enrollees who are eligible to receive financial assistance may use these funds to help cover the cost of copayments and coinsurance required under their plan's prescription drug benefits. These subsidies may also be used to supplement the prescription drug benefits that low-income enrollees receive through their plans.

- **Collaboration With Sponsors:** Medicare Advantage and Medicare cost plans and Medigap carriers that do not sponsor Medicare-endorsed cards have the option of developing co-marketing agreements with companies that do sponsor them. We anticipate that these agreements will include a role for non-sponsors in conducting beneficiary outreach and education initiatives.

Private Sector Activities to Make the Program Work for Beneficiaries

AAHP-HIAA member companies currently are developing a number of initiatives that will make the Medicare-Endorsed Prescription Drug Discount Card Program work better for enrollees. Even though CMS is not planning to approve the applications of discount card sponsors until later this month, many health plans and insurers are already taking steps to ensure the success of this program.

Our members are already designing training programs to prepare their customer service staffs to answer beneficiary questions about the new program. Health plans and insurers are also developing a wide range of information resources to help beneficiaries become more informed consumers. The private sector is developing these initiatives with the intention that they eventually will be coordinated with CMS' beneficiary education and outreach programs.

Many of these efforts are built on existing initiatives that are being enhanced and coordinated with the new program. These resources include:

- preparing written materials that may include "Frequently Asked Questions" about the new program, as well as detailed information about how to take advantage of the discounts and transitional assistance available through general and exclusive cards and how these cards work in conjunction with Medicare Advantage plan benefits;

- conducting listening sessions with Medicare Advantage enrollees to ensure that their questions and information needs are being addressed;

- e-mail access to pharmacists and others who are available to answer beneficiary questions;

- webpages offering clinical information about prescription drugs, and facts that will empower beneficiaries to become more informed consumers; and

- making call centers and other resources available to facilitate contacts between patients and physicians about clinically sound, cost effective alternatives to prescribed medications.

Our members are also poised to increase awareness among beneficiaries about the possibility that they may be eligible to receive up to $600 annually in transitional assistance, in both 2004 and 2005, under the discount card program. These efforts will expand existing programs that currently focus on educating low-income beneficiaries about other forms of assistance that are available to them (such as QMB and SLMB programs) to include information designed to ensure that they can take advantage of the transitional assistance under Medicare-endorsed cards.

Implementation Through a Strong Public-Private Partnership

The MMA requires the discount card program to be implemented within six months of the law's enactment. While this is a very fast timeline, CMS has dedicated significant resources to working with the private sector to ensure that discounted prices on prescription drugs and low-income assistance will be available to beneficiaries by June 1. Our member companies are also pleased that the agency is demonstrating a commitment to establishing a strong public-private partnership that will provide a foundation for implementation of the Medicare Part D Prescription Drug Program. CMS' efforts have included:

- Just two days after the MMA was signed into law, CMS announced an interim final rule providing for implementation of the discount card program.

- Within two weeks of the law's enactment, the agency held a conference to provide important information to potential card sponsors.

- CMS extended the deadline for submission of drug discount card marketing materials to provide a better opportunity for applicants to complete their development.

- CMS has been very responsive to questions that have been raised about the program. To address unresolved issues and to answer the many questions raised by applicants, CMS has conducted numerous conference calls and posted information on its website.

- The agency has also acted promptly in reviewing draft marketing materials and helping potential card sponsors resolve information technology issues.

AAHP-HIAA and our members commend the agency for maintaining open lines of communication and working hard to provide timely responses to myriad implementation questions.

Even under the best of circumstances, it is inevitable that challenges will arise when a program of this size is implemented in such a short time period. For example, in providing beneficiary information, coordination between CMS and card sponsors in explaining the new program to beneficiaries will be critical. In operationalizing the program, card sponsors face the significant task of fully understanding and complying with program requirements that differ in some respects from private market practices.

Additionally, it is important to ensure prompt and effective communications between the computer systems of CMS and of card sponsors, thus allowing sponsors to determine whether enrollees are eligible for low-income assistance and to receive federal subsidies on behalf of eligible enrollees.

In order to successfully launch the discount card program by the June 1 implementation deadline, AAHP-HIAA and our member companies will continue to work with CMS to meet these and other challenges over the next several months.

Beneficiaries Are Well-Served by Private Sector Participation in Medicare

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

Building upon their past successes, our members will use private sector pharmacy benefit management tools and techniques in the discount card program over the next two years and in the prescription drug program beginning in 2006. These tools increase beneficiary access to prescription drugs by reducing out-of-pocket costs and improve quality by reducing medication errors. They include:

- programs that encourage the use of generic drugs;

- step therapy programs that promote proven drug therapies before moving to newer, different treatments that are not necessarily better;

- negotiated discounts with pharmacies that participate in a plan's network;

- disease management techniques that include practice guidelines to encourage the use of the most appropriate medications; and

- appropriate use of mail-service pharmacies.

Although government programs do not always use all of these techniques, a number of studies have demonstrated that the use of these techniques by private sector health plans is beneficial to enrollees in public programs. For example, a 2003 study, conducted by Associates and Wilson on behalf of AAHP-HIAA, found that the PACE program in Pennsylvania – the largest state pharmacy assistance program in the nation – could save up to 40 percent by adopting the full range of private sector pharmacy benefit management techniques.

Another 2003 study – conducted by the Lewin Group for the Center for Health Care Strategies – found that Medicaid managed care plans reduced prescription drug costs by 15 percent below the level states would otherwise have experienced under Medicaid fee-for-service programs. Health plans achieved these savings by performing drug utilization review, establishing pharmacy networks, and encouraging patients to take the most appropriate medications.

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

These findings demonstrate that the private sector is well-positioned to use its experience and capabilities to make prescription drugs more affordable for a broader range of Medicare beneficiaries. We are excited about the new opportunities our members will have to better serve

Medicare beneficiaries, beginning this year with the discount card program and continuing with the Part D drug program in 2006.

In addition to improving access to safe, affordable prescription drugs, our members have longstanding experience providing comprehensive health coverage to Medicare beneficiaries. Let me briefly review several examples of how beneficiaries are well-served by our members' innovative practices in the Medicare Advantage program.

Private sector plans have applied the concept of disease management programs to their Medicare Advantage plans to improve quality of care for beneficiaries with chronic conditions by focusing on the comprehensive care of patients over time, rather than individual episodes of care. These programs provide specialized care to beneficiaries who have diabetes, congestive heart failure, end-stage renal disease, depression, cancer, and other medical conditions that commonly afflict the elderly. Currently, disease management programs are available to only a small number of Medicare fee-for-service enrollees under demonstration initiatives.

Private sector health plans and insurers also play an important role in providing health coverage to beneficiaries who are financially vulnerable. For many beneficiaries who are not eligible for retiree health benefits or Medicaid, the Medicare Advantage program serves as a health care safety net by providing comprehensive, affordable coverage that is not available under the Medicare fee-for-service program. Studies show that low-income and minority beneficiaries are more likely to enroll in Medicare Advantage plans than other beneficiaries.

The private sector also helps to keep out-of-pocket costs low for beneficiaries. A Rand study published in May 2003 found that Medicare health plans, when compared to the Medicare fee-for-service program, reduced out-of-pocket health care costs by $809 annually for the average beneficiary and by $2,160 annually for beneficiaries with the highest health care costs.

Enhanced benefits are another advantage of private sector participation in Medicare. CMS recently reported that 80 percent of all Medicare Advantage enrollees receive some form of

prescription drug coverage in 2004. This is true even though government payments to plans do not yet include funding for prescription drugs.

These facts clearly demonstrate that beneficiaries are well-served by private sector participation in Medicare. With respect to both the quality and affordability of health care, the private sector has a strong track record that bodes well for its involvement in the discount card program as well as longer-term Medicare reforms.

Conclusion

We are confident that a strong public-private partnership will enable the Medicare-Endorsed Prescription Drug Discount Card Program to fulfill its potential to provide beneficiaries with more affordable prescription drugs over the next two years and lay the groundwork for the Medicare prescription drug benefit that will become available in 2006.

The fact that 106 private sector entities have submitted applications for this program is a clear indication that the private sector is committed to its success. Moreover, many of our members have told us that their decisions to sponsor discount cards are also motivated by their interest in expanding their participation in Medicare in 2006 as both prescription drug plans and Medicare Advantage plans.

In conclusion, I want to thank committee members for your role in establishing the discount card program and for closely monitoring implementation of this program at this crucial stage of the process. Please be assured that AAHP-HIAA and our member companies are strongly committed to making the program work for seniors and individuals with disabilities.

The CHAIRMAN. Karen, thank you very much.

Now let me turn to Mark Merritt, CEO of the Pharmaceutical Care Management Association. Mark, thank you very much.

STATEMENT OF MARK MERRITT, PRESIDENT AND CEO, PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION, WASHINGTON, DC

Mr. MERRITT. Well, thank you, Mr. Chairman.

My name is Mark Merritt. I am president of the Pharmaceutical Care Management Association, the trade association for PBMs, and we, too, are enthusiastic about the discount card program and, of course, the funded benefit beyond that.

Our member companies together administer drug benefits for over 200 million Americans. We commend the committee for holding this hearing today to highlight the card program because often it is looked over as we look toward the funded benefit, but seniors are going to save a lot of money on this program and PBMs look forward to helping them do that.

If we could leave you with two key points today it would be this. First, PBMs are new to people and we want to let people know that they work and work well. We do not brand ourselves, but this discount card gives us an opportunity to show in public programs what we can do for seniors.

Second, in line with that first point is that as we go forward with implementation of the discount card and then later the funded benefit, it is really important to preserve the tools that PBMs use that have worked so successfully for seniors and others in the commercial market. The reasons that we saved money in the commercial market are why we are involved in the Medicare plan right now and we need to preserve those tools as we move forward.

Just a quick primer on what PBMs do and how they add value for consumers. Basically what we do is we take regular people and we aggregate their buying power and then we use that to negotiate big discounts with manufacturers and retail pharmacy. Then, of course, we throw in other innovative tools, like mail service and other things that can save people money, add convenience, and so forth.

But we also work on the quality front. We work collaboratively with patients, with physicians, and pharmacists to help promote quality, improve patient outcomes, and so forth. It is not just about money. The drug utilization review that we use is very helpful to people and helps the clinically based formularies, and so forth, helps to be in better compliance with regular people.

I think according to recent projections from CMS, the rate of growth in drug spending, although still too high, is actually decelerating over the last couple of years, which we believe is coincidental with the fact that PBMs' tools have been more and more adopted in the marketplace over the last 5 to 10 years. These tools are multi-tiered formularies, therapeutic interchange, increased competition, and a lot of independent studies and government data confirm that what we are doing are working. From CBO to GAO and others, they have documented that PBMs save significant amounts for people, often 18 percent on drug cards in the ones that have been used prior to this, and can save people hundreds of dol-

lars a year. That is again not even including the examples that Jim showed earlier about people who can save a lot more money.

Turning to Medicare, PBMs are pleased that the new law recognizes the role that PBMs have played to save people money and to provide better access to drugs. The legislation strikes the right balance by promoting more choice and competition while, at the same time, setting forth important beneficiary protections. The interim drug discount card represents beneficiaries' first real encounter with the new law and we are optimistic that seniors and other beneficiaries will like what they see.

PBMs have a great deal of experience in administering discount cards to both seniors and the under–65 population. At last count GAO estimates that at least 17 million Americans are enrolled in a PBM-administered drug card. Preliminary estimates from CMS, as was discussed earlier by Mr. Smith, showed that there is also going to be robust participation from PBMs, health plans, and others.

We expect that seniors will see meaningful savings, on average 10 to 25 percent in this program. For some drugs we anticipate even deeper discounts for beneficiaries.

The transitional assistance program is, of course, going to be crucial. Of course, more than half the people in the discount card program will be in TA and its annual $600 in assistance will provide even greater relief to those who need it most.

At the same time, since PBMs have the vast majority of the nation's retail pharmacies in their networks, seniors and the disabled will have broad access to pharmacies in urban, suburban, and rural settings. Beneficiaries will also have access to mail service pharmacies, which provide even greater savings to those who find that in their interest to use.

The discount card program represents a significant improvement over the status quo for millions of seniors and is an important lifeline while CMS works to implement the permanent benefit in January 2006.

In conclusion, PBMs look forward to the opportunity to serve the Medicare population. We have a unique opportunity to forge a lasting partnership with both America's seniors and the Medicare program. We look forward to working closely with CMS and others to implement a program that puts the needs of seniors and other beneficiaries front and center.

Mr. Chairman, again thank you on behalf of the member companies of PCMA. We thank you for this opportunity to share our views and we look forward to any questions you might have.

[The prepared statement of Mr. Merritt follows:]

Testimony of Mark Merritt

President & Chief Executive Officer

Pharmaceutical Care Management Association

Before the

UNITED STATES SENATE
SPECIAL COMMITTEE ON AGING

The New Medicare Drug Discount Card: An Advance Prognosis

March 9, 2004

I. INTRODUCTION

Good morning, Mr. Chairman and members of the Committee. I am Mark Merritt, President and Chief Executive Officer of the Pharmaceutical Care Management Association (PCMA). PCMA is the national association representing America's pharmaceutical benefit managers (PBMs). PCMA represents both independent, stand-alone PBMs and health plans' PBM subsidiaries. Together, PCMA member companies administer prescription drug plans that provide access to safe, effective, and affordable prescription drugs for more than 200 million Americans in private and public health care programs.

PCMA appreciates the opportunity to come before the Committee today to examine the issues associated with implementing the Medicare prescription drug discount card. The recent enactment of the bipartisan Medicare Modernization Act represents a paradigm shift in the financing and delivering of health care services, including a prescription drug benefit, to Medicare beneficiaries. Because of this law, beneficiaries will be paying less – in some cases, far less – in the coming years for their prescription drugs. By blending the very best that the private and public sectors have to offer beneficiaries, the Medicare Modernization Act has set the stage for moving forward with an historic private-public partnership in Medicare that expands the choices and health care benefits available to seniors and disabled beneficiaries and institutes much-needed reforms that will help ensure the long-term viability of the program.

With today's testimony, we would like to focus on four key areas:

- An overview of PBMs and how they provide value to the system;

  A review of independent, government data assessing PBMs' performance with drug discount cards;

- The value PBMs can bring to the Medicare program; and

- Key issues challenging the implementation of the Medicare prescription drug discount card and the permanent part D benefit.

II. OVERVIEW OF PBMs

PBMs are the one entity in the drug supply chain dedicated to lowering the price of prescription drugs. PCMA believes that "PBM" stands not just for pharmaceutical benefit manager, but for helping "People Buy Medicines." Each and every day across America, PBMs are making a difference and helping to expand consumers' access to safe, effective, and affordable medicines.

Prescription drugs are an essential component of an integrated and modernized health care program. The medical advances and improvements to individuals' quality-of-life that emanate from prescription drugs are now legendary. These advances afford individuals a level of independence and mobility that was simply unthinkable just one generation ago. Indeed, for millions of Americans, prescription drugs have transformed what were once acute medical conditions into manageable chronic illnesses.

The challenge, of course, is that while prescription drugs have brought forth impressive advances in medicine, they command a greater share of every dollar spent on health care. According to researchers at the Centers for Medicare & Medicaid Services (CMS), in 2002, prescription drugs accounted for 11 percent of health care spending, but represented 16 percent of the rate of increase in overall health spending. Overall, health spending rose by 9.3 percent in 2002, on the heels of an increase of 8.5 percent in 2001. [1]

While the drivers of increased health spending are varied, their impact on purchasers and consumers is clear. Private and public purchasers alike are wrestling with how best to maintain access to high-quality coverage and benefits – including prescription drugs – while reining in costs. Many purchasers – including health plans, self-insured employers, union-sponsored plans, federal and state employee benefit programs, and state Medicaid programs – rely upon PBMs to make prescription drugs more affordable and accessible to consumers.

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[1] "Health Spending Rebound Continues in 2002," Katie Levit, Cynthia Smith, Cathy Cowan, Art Sensenig, and Aaron Catlin, *Health Affairs,* Volume 23, Number 1. January/February 2004.

A positive trend emerging is that the rate of increase in prescription drug spending appears to be waning. For 2003, CMS projects that the rate of growth in private-sector prescription drug spending is projected to decelerate to 13.4 percent – the fifth consecutive year of decline in the growth rate. CMS projects the rate of growth in prescription drug spending to decline even further by 2005 to 12.4 percent. Taken together, CMS projects that the rate of growth in prescription drug spending will decline by 37 percent from 1999 to 2005. CMS attributes this decline to a variety of factors, including multi-tier formularies, therapeutic interchange, and increased competition in the marketplace – the very tools PBMs rely upon.

Origins of PBMs

PBMs emerged in the 1970s and 1980s largely to administer prescription drug insurance benefits and to offer mail-order pharmacy services. These early PBMs provided real-time electronic claims adjudication, which significantly reduced claims processing costs. Many also provided and managed networks of pharmacies willing to accept negotiated discounts on drug prices and dispensing fees. PBMs gradually expanded to include clinical services, such as preventing adverse drug interactions through drug utilization review. Mail-service pharmacy also became a prominent part of PBM operations, reducing costs and improving convenience for plan enrollees.

In the early 1990s, PBMs experienced significant growth, as an increasing number of HMOs and other managed care organizations and self-insured employers turned to PBMs to administer their entire prescription drug benefit programs. Combining managed drug benefits with formulary rebates from prescription drug manufacturers helped to improve the attractiveness of PBMs as drug plan managers.

Today's PBM Marketplace: Highly Competitive

The PBM marketplace today is highly competitive, with PBMs existing in a number of forms. PBMs may be independent entities, subsidiaries of health plans, or operated by large retail chain drug stores. Private and public purchasers negotiating drug benefits on behalf of consumers have a wide variety of choices among PBMs. Each PBM offers multiple variations of models,

including tiering, network access, a mail-order pharmacy option, and other similar tools and techniques. For its part, the Federal Trade Commission recently noted that national, independent PBMs see "significant" and "vigorous" competition from both health plans and retail pharmacy chains offering PBM services.[2]

PBMs' Tools & Techniques

PBMs provide purchasers with value through a variety of tools and techniques that promote quality, improve outcomes, and drive down the cost of prescription drugs. PBMs typically offer purchasers a set of core services designed to contain and improve the value of drug expenditures that include claims administration; pharmacy network management; negotiation and administration of product discounts, including manufacturer rebates; and mail-service pharmacy. PBMs also provide purchasers with clinically-based services designed to improve the appropriateness, safety, and quality of pharmacy benefits. These tools may also improve the cost-effectiveness of the drug benefit and include such activities as drug utilization review, clinical prior authorization, consumer and physician education, disease management, and consumer compliance programs.

- **Disease and Therapeutic Drug Management.** PBMs provide disease management functions that target those with the most serious and chronic medical conditions. PBMs work collaboratively with patients and their health care providers to ensure patients receive the necessary preventive medications, are aware of any potential adverse drug events, and help them to avoid hospitalization or further health problems. These strategies have been proven effective – in fact, according to a recent study in the Archives of Internal Medicine, therapeutic drug management served to increase the rate of achieving therapeutic goals for patients from 74 to 89 percent.[3]

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[2] Statement of the Federal Trade Commission, File No. 031 0239. February 11, 2004.

[3] Brian J. Isetts, PhD, BCPS; Lawrence M. Brown, PharmD; Stephen W. Schondelmeyer, PharmD, PhD; Lois A. Lenarz, MD. "Quality Assessment of a Collaborative Approach for Decreasing Drug-Related Morbidity and Achieving Therapeutic Goals." *Arch. Of Intern Med. 2003;163;1813-1820.*

PBMs are often the only source of information for a patient's total set of prescribed medications because all network pharmacy purchases of prescribed drugs for an individual are held – confidentially – in one centralized, electronic file. These data can be especially useful in preventing drug-to-drug interactions and adverse events when enrollees are prescribed medications by more than one physician or when enrollees use more than one retail pharmacy to purchase their prescriptions. PBMs also play an important role in helping to prevent fraud by monitoring for appropriate prescribing, including issues related to age, gender, and frequency of dispensing. Further, PBMs integrate a patient's prescription drug utilization with his or her overall medical history in order to facilitate targeted disease management activities. In a recent study, one large national PBM was able to demonstrate a 24 percent savings in per-member per-month costs for those patients with any number of chronic conditions who were part of a disease management program, compared to those patients with the same conditions who were not.

- **Formulary Development and Management.** Among the most important tools developed by PBMs to manage prescription drug benefits are formularies. Formularies create competition that benefits consumers by driving down the overall cost of prescription drugs. A formulary is a list of prescription drugs approved for reimbursement by the plan sponsor contracting with a PBM. PBMs develop formularies at the direction of the plan sponsor, who may require that it be customized to meet the particular needs of their benefit plans. Some may prefer broad unrestricted access to all medications and therefore are willing to accept higher costs to offset broader access. Other plan sponsors may be very concerned with containing drug costs and will opt for more restrictive formularies based upon their economic needs.

The Role of P&T Committees

In developing a formulary, the primary considerations are safety, efficacy and clinical appropriateness. PBMs use panels of experts, called Pharmacy and Therapeutics (P&T) committees, to develop their formularies and lists of preferred drugs. P&T Committees are comprised of physicians, pharmacists, and individuals with other appropriate clinical expertise. Often, individuals with special expertise are consulted when considering medications within particular therapeutic classes. Development and maintenance of formularies is an ongoing activity, as they must be continually updated to keep pace with new therapies, recent evidence from clinical research, changes in medical practice, and FDA guidance. Through their actions, P&T committees help drive discounts among competing brand-name prescriptions. P&T committee members are typically not employed by the PBM, a pharmaceutical manufacturer, or any other interested parties; do not have any other business or financial relationship with those organizations; and are not directly involved in rebate negotiations with manufacturers.

Once a drug is included on a formulary, it can be classified as preferred, non-preferred or generic. Such classification is known as tiering. Tiered formularies are developed based on the needs of the plan sponsor and what co-pay structure and cost sharing they wish to include in their prescription drug benefit. Often, generic drugs are assigned the lowest co-payment, followed by preferred, and finally non-preferred drugs.

- **Generic Substitution.** An important component of formulary development and management is access to generics. It has been well documented that generic substitution saves money and provides equally beneficial therapeutic value to equivalent brand names. A pharmacist cannot change a prescription but can serve to educate and encourage physicians and patients to consider other products. The ultimate authority for the medication prescribed for a patient rests with the physician or other appropriately licensed prescriber. PBMs help pharmacies recognize opportunities to dispense generic alternatives through real-time electronic messaging.

- **Drug Utilization Review (DUR).** PBMs also offer drug utilization review as part of formulary management activities. DUR is a broad function that encompasses quality, safety, and cost effectiveness. Concurrent DUR detects potential inappropriate utilization for a single prescription drug claim for a specific patient. This process will allow for real-time notification to a pharmacy when a drug is being dispensed that could cause an adverse reaction for that patient. Retrospective DUR is conducted to detect broad patterns of inappropriate prescribing and utilization. For example, a PBM may find as a result of retrospective DUR that a particular physician is prescribing a brand-name drug, while most others in the area are prescribing the more cost-effective generic therapeutic equivalent. Retrospective DUR also can be used to educate physicians about a particular drug when new clinical information becomes available (e.g., that a particular drug has been discovered to present serious risks for some patients with certain underlying conditions). The communications from PBMs to the physicians are typically via mail, fax transmissions, or phone calls.

- **Networks of Pharmacies**. Most PBMs establish a network of retail pharmacies with a broad geographic range. The larger PBMs have networks that include approximately 95 percent of the nation's retail pharmacies. Managing pharmacy networks entails recruiting and credentialing pharmacies, negotiating discounts from pharmacies for drug ingredients and dispensing services, monitoring pharmacies for quality and customer service, auditing pharmacy records, and providing technical support to pharmacies and pharmacists. The Medicare Modernization Act has specific requirements for ensuring beneficiaries have broad access to pharmacies.

- **Mail-Service Pharmacy Option**. Mail-service pharmacy allows for convenient access to prescription drugs at much more cost-effective prices. Mail-service pharmacies fill prescriptions for maintenance medications; i.e., prescriptions that are used on a continuing basis for individuals managing complex or chronic illnesses. Plan designs often allow consumers to obtain a 90-day supply of medication instead of the usual 30- or 60-day scripts that are filled by retail pharmacies. Consumers save money as well by paying only one co-payment for the 90-day supply of medication filled by a mail-service

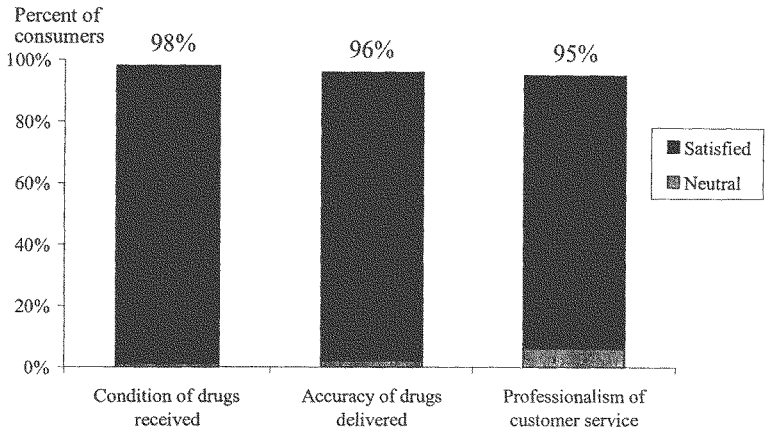
pharmacy, rather than the three separate co-payments required for 30-day supplies filled at a retail pharmacy.

Mail-service pharmacies also provide services comparable to those provided by retail pharmacies. Mail-serve pharmacies retain pharmacists on staff who are available to counsel consumers and consult with physicians on appropriate drug therapies. Counseling is done primarily through toll-free telephone communication. Most mail-service pharmacies have telephone counseling by pharmacists available 24 hours a day/seven days a week. The process offers convenience to consumers, particularly seniors and the disabled, who may have transportation or other constraints that make going to a retail pharmacy difficult. The mail-service pharmacy option is also particularly helpful in serving residents of rural areas who would otherwise have to travel long distances to the nearest retail pharmacy. In addition, some consumers may prefer telephone consultation in order to afford them more privacy than consultations available in public at retail pharmacies would.

Consumers Highly Satisfied with Mail-Service Pharmacy Option

Consumers are highly satisfied with mail-service pharmacies, according to a survey of nearly 14,000 mail-service pharmacy users nationwide (see Figure 1). From the professionalism in customer service to outstanding accuracy in the drugs received by consumers, mail-service pharmacies receive high marks. Older consumers as well as those who have used mail service for longer periods of time are most likely to cite convenience as an important factor as to why they choose mail service.

High Consumer Satisfaction With Mail-Service Pharmacies



Source: PCMA Patient Satisfaction Survey of Prescription Drug Benefit Programs, 2002.

(Figure 1)

Key findings on the satisfaction of mail-service pharmacy users:

- 98 percent were satisfied or neutral with the **condition of the drugs** they received;
- 96 percent were satisfied or neutral with the **accuracy of the drugs** that were delivered;
- 95 percent were satisfied or neutral with the **professionalism of customer service**;

Also, when mail service pharmacy users are asked to identify reasons they choose mail service:

- 95 percent cite cost savings;
- 82 percent cite convenience.

- **Rebates and Discounts**. One of the tools PBMs use to help lower the cost of prescription drugs for consumers is by negotiating rebates and discounts on prescription drugs with drug manufacturers. Independent data confirm that consumers see significant savings on prescription drugs in part because of PBMs' ability to negotiate discounts with drug manufacturers. Maintaining confidentiality is essential to preserving PBMs' ability to negotiate discounts for consumers and purchasers. Public disclosure of contract terms between PBMs, manufacturers, and retailers would dramatically alter the competitive landscape by giving competitors access to proprietary pricing strategies. For its part, the Congressional Budget Office has noted increased disclosure of proprietary pricing information would cost the Medicare program $40 billion over ten years as PBMs would have less ability to maximize savings for beneficiaries.[4]

- **Electronic Claims Processing.** A core activity of PBMs is the processing of pharmacy benefit claims. PBMs have electronic communications systems that link them to their network retail and mail service pharmacies. This allows them to adjudicate claims on a real-time basis quickly and efficiently.

  When a consumer presents a prescription to a pharmacy, the pharmacist is able to communicate immediately with the PBM to verify the individual's eligibility, whether the drug is covered, and determine, based on the benefit plan that is applicable to the individual, the amount the pharmacy will be paid for the drug, and the amount of coinsurance or copayment that is to be collected from the individual. This real-time electronic interchange also allows for the PBM to interact with the pharmacist for cost-management and quality interventions.

  About 98 percent of pharmacy benefit claims are processed electronically, thus eliminating most of the need for paper claims and retrospective adjudication. Enrollees may be required to file paper claims in certain circumstances, such as when a prescription

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[4] Congressional Budget Office, "Cost Estimate of HR 1, Medicare Prescription Drug and Modernization Act, and S 1, Prescription Drug and Medicare Improvement Act of 2003," July 22, 2003

is dispensed by a pharmacy that is not within the PBM's network, or when the enrollee's eligibility cannot be verified at the time of purchase.

- **Consumer Information.** PBMs often provide general educational materials for consumers on appropriate prescription drug use as well as other health and wellness issues. PBMs will sometimes send educational information directly to plan enrollees about their specific disease or condition. Such information ranges from pamphlets to web-based interactive programs linked to the PBM's website. Enrollees with chronic conditions that benefit from self-management, such as asthma, congestive heart failure, and diabetes, are often targeted for such consumer education programs. Education regarding the importance of patient compliance is part of many PBMs' consumer education programs. Medication non-compliance can result in increased costs, particularly if the non-compliance leads to a relapse of the condition being treated and a hospitalization or other medical intervention results.

- **Consumer Compliance Programs.** Patients who unwillingly or unknowingly fail to comply with doctors' orders regarding prescribed medications can up end with poor medical outcomes and ineffective use of resources. For this reason, PBMs, with purchasers' and patients' consent, will often follow-up with patients to remind them to take medications and to get prescriptions refilled.

III. INDEPENDENT, GOVERNMENT DATA DOCUMENT SAVINGS, ACCESS PBM-ADMINISTERED DRUG DISCOUNT CARDS PROVIDE CONSUMERS

Numerous independent and government data have documented the quality, savings, and access that PBMs bring to the health care system, both for seniors with no prescription drug coverage and the under-65 population. With respect to drug discount cards, both the US General Accounting Office (GAO) and private researchers have assessed PBMs' record in the private sector – and with it, have provided a preview of what seniors and disabled beneficiaries should expect with Medicare-endorsed drug discount cards.

GAO Examines Savings, Access Provided by PBM-Administered Drug Discount Cards[5]

In September 2003, the GAO issued a report examining prescription drug discount cards available in the private market and sponsored by a number of entities, including PBMs and drug manufacturers. GAO examined the median retail drug-discount card price charged to consumers on nine prescriptions versus the median retail price charged to consumers with no drug card at pharmacies in the Washington, DC area, California, and North Dakota. Among the report's key findings:

- PBM-administered drug-discount cards can save consumers hundreds of dollars per year. According to the GAO, consumers using PBM-administered drug discount cards save as much as much as 44 percent off the median pharmacy price charged to consumers with no drug discount card. In Washington, DC, GAO found these savings for consumers average 18 percent for the nine drugs surveyed, translating to hundreds of dollars per year, even after deducting consumers' annual enrollment fee.

- Mail-order pharmacy provides consumers with significant savings over retail pharmacy prices paid without a drug discount card. For consumers who prefer the convenience and pricing advantages of the mail-service pharmacy option, drug discount cards also provide significant savings to consumers compared to what they would otherwise pay at the retail pharmacy counter without a drug discount card. GAO's comparative analysis of mail-service pharmacy prices and retail pharmacy pricing without a drug discount card found that consumers can save hundreds of dollars per year. In California, the savings provided to consumers from mail-service pharmacy options can potentially run into the thousands of dollars.

- PBM-administered drug discount cards provide much broader access to medications to working families and seniors than competing drug-manufacturer discount cards. GAO found that PBM-administered drug discount cards are available to all adults and can be

[5] "Prescription Drug Discount Cards: Savings Depend Upon Pharmacy & Type of Card Used," US General Accounting Office (GAO), September 2003

used to purchase most out-patient drugs. PBM-administered drug discount cards enroll more than 17 million Americans.

- Consumer savings with drug discount cards often depend upon the extent of the retail pharmacy mark-up. It is documented that prescription drug prices charged to consumers by retail pharmacies can vary widely, even among drug stores in the same chain in the same market. GAO found that "choice of pharmacy rather than choice of card had more effect on how much a person saved with a discount card." In short, GAO's analysis appears to suggest that consumers should shop around for lower drug prices, even when using a drug discount card.

PBM-Administered Drug Discount Cards Provide Savings for Uninsured Seniors[6]

In a survey published in March 2003, researchers at Brandeis University's Schneider Institute for Health Policy analyzed more than 3 million pharmacy claims from eight national drug discount card programs for individuals aged 65 and older. The data analyzed in this research represent savings provided by PBM-administered drug cards for 124 prescription drugs. Among the key findings:

- For seniors with no supplemental drug coverage, the total average savings for all prescriptions with a PBM-administered drug discount card was 15.3 percent.

- For seniors with no supplemental drug coverage, PBM-administered drug discount cards provide average savings for generic prescriptions of 26 percent ($7 per prescription) and average savings for brand-name prescriptions of 14 percent ($11 per prescription). These savings are over and above any discounts otherwise provided to individuals with no drug coverage at retail pharmacies.

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[6] "PBM-Administered Prescription Drug Discount Cards: Savings for Uninsured Seniors," Brandeis University Schneider Institute for Health Policy," March 11, 2003

- For patients taking multiple prescription drugs concurrently, as many seniors do, savings for a month of medications were substantial, ranging between 12 percent and 21 percent overall. These savings could translate into hundreds of dollars per year. Savings depended on the mix of medications, location, and pharmacy.

- Card savings were similar for pharmacies located in rural states and those in urban states.

GAO Examines Savings Provided to Federal Employees' Health Benefits Program[7]

In January 2003, the General Accounting Office examined the cost savings provided to federal employees by PBMs participating in the Federal Employees' Health Benefits Program (FEHBP).

- For prescription drugs dispensed through mail-order pharmacies, the average mail-order price was about 27 percent below the average cash price paid by consumers for a brand-name drug at a retail pharmacy and 53 percent below the average cash price paid for generic drugs.

- For drugs dispensed at the retail pharmacy counter, PBMs negotiated discounts of 18 percent below what consumers would pay in cash at the retail pharmacy counter for 14 brand name drugs and 47 percent below what consumers would pay for 4 select generic drugs.

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[7] "Federal Employees Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, & Pharmacies," GAO, January 2003

IV. MEDICARE SHOULD PRESERVE PBMs' PROVEN TOOLS & TECHNIQUES FOR BENEFICIARIES

The bipartisan Medicare Modernization Act represents an historic step forward for the nation's seniors and disabled beneficiaries. By preserving those very tools and techniques that PBMs have used to drive down the cost of prescription drugs in other parts of the system, Medicare stands poised to avail itself of this approach and reap the rewards for beneficiaries. Indeed, policymakers on both sides of the aisle have long recognized the value that PBMs can bring to the Medicare population. As some have noted, if PBMs did not exist, policymakers would have had to invent them.

The good news for millions of seniors and disabled beneficiaries is that the Medicare program has been modernized and that beneficiaries will have access to a wide range of medicines at a lower price. According to an estimate from the Congressional Budget Office, in 1999, 10 million Medicare beneficiaries had no prescription drug coverage. These beneficiaries have had no protection in the marketplace and typically paid the highest prices on prescription drugs at retail pharmacies. Moreover, these beneficiaries have tended to utilize fewer prescription drugs and pay higher out-of-pocket costs for their medicines.[8]

Beneficiary Savings

PCMA fully expects the interim Medicare drug discount card will provide important and meaningful savings to millions of beneficiaries when the program becomes operational in June 2004. While others groups in the past – most notably the retail pharmacy lobby – have sued the Administration (twice) to block a drug discount card program from taking effect, PCMA member companies have long thought that Medicare beneficiaries should benefit from the savings offered by Medicare-endorsed drug discount cards. While CMS estimates that seniors can expect savings on average of 10 to 25 percent, the experience of drug discount cards in the private sector indicates that in some instances seniors may well benefit from even steeper discounts – in some cases as much as 50 percent less than what they otherwise would have paid. While we

[8] "Medicare and Prescription Drug Spending," Kaiser Family Foundation, June 2003.

expect the savings provided to beneficiaries will be meaningful in all settings, in particular, we expect that mail-service pharmacies will offer beneficiaries the steepest discounts of all.

Pharmacy Access

Seniors can also expect to have access to a wide network of retail pharmacies through the interim Medicare drug discount card. Card sponsors seeking to offer a Medicare-endorsed discount card will have to meet pharmacy standards set forth in the TRICARE program (the Department of Defense's worldwide health care program). These standards are:

- For beneficiaries in urban areas, at least 90 percent of beneficiaries live within 2 miles of a participating pharmacy;
- For beneficiaries in suburban areas, at least 90 percent of beneficiaries live within 5 miles of a participating pharmacy; and
- For beneficiaries in rural areas, at least 70 percent of beneficiaries live within 15 miles of a participating pharmacy.

V. KEY CHALLENGES GOING FORWARD

PCMA believes strongly that the Medicare prescription drug discount card program will provide meaningful savings to beneficiaries. A key challenge before policymakers in implementing both the drug discount program and the full Part D benefit lies in preserving the ability of PBMs and other entities to negotiate maximum savings for beneficiaries.

Ensuring a Competitive Marketplace in Medicare

A competitive marketplace is key to making prescription drugs more affordable for consumers. PBMs represent the best alternative to direct government price controls on prescription drugs in Medicare. The Congressional Budget Office recently refuted the notion that price controls – or

"direct negotiation" by the federal government and manufacturers – would provide greater savings than would a competitive marketplace:

> "We estimate that striking that [non-interference] provision would have a negligible effect on federal spending because CBO estimates that substantial savings will be obtained by the private plans and that the Secretary would not be able to negotiate prices that further reduce federal spending to a significant degree. Because they will be at substantial risk, private plans will have strong incentives to negotiate price discounts, both to control their own costs in providing the drug benefit and to attract enrollees with low premiums and cost-sharing requirements."[9]

Maintaining Flexibility in Formulary Design

A key challenge before policymakers in implementing the Medicare Modernization Act lies in preserving the integrity and flexibility of formulary design. Clinically-based formularies are crucial to ensuring that beneficiaries have access to safe, effective, and proven prescription drugs. PBMs are well versed in devising formularies that achieve these goals and control costs. The goal of the card program is to create a competitive marketplace where Medicare beneficiaries will be able to select a card that best suits their needs in the selection and the cost of the covered drugs. We recognize that because of the limited time available to launch the new benefit and the need to ensure that plans provide coverage in key categories that the 209 class structure was used by CMS. We are concerned, however, that extending this level of mandate into the 2006 benefit may diminish the ability participating plans would have in negotiating discounts with manufacturers, which are vital for driving down drug prices for seniors. The outcome of the U.S. Pharmacopoeia (USP) process as described in the Part D portion of the statute for defining therapeutic categories will be critical to the success of the program. The legislation calls for substantial input into that process.[10] PCMA believes strongly that the category structure used in the discount card program should not be used as the starting point for the USP process.

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[9] January 23, 2004 Letter from Douglas Holtz-Eakin, Director, Congressional Budget Office to Honorable William H. Frist, Majority Leader, United States Senate.

[10] Social Security Act Section 1860D-4(b)(3)(C)(2), (Pub.L.No. 108-173, Sec. 101)

Card-sponsor requirements for pharmacy accountability and guarantees

The interim drug discount card regulation appears to require card sponsors to "guarantee" that network pharmacies notify enrollees of the cost differential between the price of a prescribed drug and the lowest-priced equivalent generic available at the pharmacy. In addition, sponsors are to guarantee that pharmacies charge the lower of the contract price or their usual and customary price (U+C), which is typically the amount a cash-paying customer with no drug coverage would pay at the retail pharmacy counter.[11] PCMA believes that the term "guarantee" could be misinterpreted as imposing liability on a sponsor if a pharmacy failed to comply with these requirements. PCMA believes that the regulation's intent would be satisfied by contractually requiring pharmacies to notify beneficiaries of lower-cost generic availability and the approximate cost differential. Such contracting requirements and routine network pharmacy auditing would also ensure compliance with the intent of the U&C pricing language. PCMA has requested that CMS clarify their intent with these provisions.

Standardized Industry Formats for Data Reporting

The interim regulation requires that sponsors submit certain data elements as part of claim and enrollment forms that are not a part of the current industry standard transaction set [National Council for Prescription Drug Programs (NCPDP)]. For example, CMS requests submission of the U+C price-without dispensing fee. The U+C price-without dispensing fee simply does not exist within current industry standards. The U+C price is the price pharmacies charge for cash paying customers in its totality and does not include a breakdown of the dispensing fee.

Another example is requesting the Drug Enforcement Agency (DEA) number for each prescriber. Not every prescriber has a DEA number, physicians may have more than one number, and in some cases institutions may have a DEA number under which house staff may prescribe (e.g., an emergency room or clinic). Therefore, the DEA is a less-than-ideal proxy for a unique physician identifier and would not provide the individual prescriber identification that CMS is seeking.

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[11] 68 FR 69918

PCMA recommends following the industry standard for all data submissions, not only for the drug card program, but also in looking ahead to the Part D benefit. It is important that the agency model this program as much as possible on the existing private industry framework to ensure that the expected efficiencies will also mirror those obtained in the private sector.

State Payment of Transitional Assistance Coinsurance

The interim final rule allows for States to provide financial assistance to Transitional Assistance enrollees for paying the required 5 or 10 percent coinsurance (depending on income status) at the point of sale. Within the preamble and regulation it is not clear whether the State would make arrangements for payment of any coinsurance assistance to the card sponsor or the pharmacy. [12] Given the budgetary pressures under which states currently operate, PCMA believes CMS should defer to States the decision on how best to pass coinsurance payments made on behalf of a State's beneficiaries. CMS should ensure that its regulations provide as few obstacles as possible to encourage States to participate. If States use the plan sponsor to manage the coinsurance payment, they should only be required to demonstrate that pharmacies have actually received the amount covered. Since the card sponsor is responsible for managing all Transitional Assistance funding, this clarification would ease the tracking of such funds and assure the applicable coinsurance requirements have been met.

VI. CONCLUSION

The Medicare Modernization Act represents an historic opportunity to expand the benefits and choices available to seniors and disabled beneficiaries and to institute much-needed reforms that will put the Medicare program on a path to long-term viability. As a first step, the interim Medicare drug discount card will provide meaningful savings to beneficiaries. For low-income seniors and those without any drug coverage now, the savings provided by the drug card – as much as 50 percent in some cases off the retail price – represent a lifeline.

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[12] 68 FR 69863 and 69883

PCMA and its member companies stand ready and willing to help implement the interim drug card and the permanent part D benefit. We are excited by the opportunity to bring the proven tools and techniques that have worked well in other parts of the system to the Medicare population and to helping expand beneficiaries' access to safe, effective, and affordable medicines. PBMs have worked well for 200 million Americans and we believe PBMs' participation in Medicare in the years ahead will only serve to strengthen the program.

Mr. Chairman and members of the Committee, thank you for the opportunity to testify today and we look forward to answering any questions you might have.

The CHAIRMAN. Mark, thank you very much.

Some of the questions I will be asking may be directed at specific individuals here on the panel, but others who might wish to add to or make comment off of those questions, please do so.

Jim, you testified that low-income seniors, those below 135 percent of poverty, could actually see savings well above the $600, indeed, as much as 40 to 90 percent savings on prescription drugs during the 2004–2005 period, and that much of this has to do with interaction of the new law itself, with supplemental assistance programs being volunteered by drug manufacturers like Pfizer, Merck, Lily and others. This is obviously very encouraging news for low-income seniors.

Jim and Forest, could you comment in a little more detail just how this will work and what benefit seniors might be able to expect?

Mr. FIRMAN. I think all of the details on how this will work remains to be seen as the companies work out some of their relationships with the card sponsors. For example, Merck has indicated that once a person qualifies for transitional assistance and uses the $600 benefit, they will be able to get Merck drugs for free for the rest of that year. Now, part of what Merck needs to do is work out an arrangement with every single one of the card sponsors to make sure that this is a seamless process.

TogetherRx has taken a different strategy. TogetherRx represents seven companies and about 170 medications and offers discounts of anywhere from 20 to 40 to 70 percent, depending on the medication and they are saying that you use your CMS-approved card and then you use the TogetherRx card and you come together to the pharmacy and you show them.

I will let Forest speak to the Pfizer experience. Lily has indicated that people who qualify for transitional assistance will be able to buy medication for $12 per medication per month and you can use the $600 transitional assistance to pay the $12.

So the bottom line is it is going to be complicated and people are going to need help sorting through it but those savings are there if they are able to navigate them and figure out the right combinations.

The CHAIRMAN. Forest?

Mr. HARPER. Yes, Senator Craig. In taking off from Jim's comment, what we learned in our Pfizer Share Card experience over the last 2 years is that when you make it a meaningful benefit—that is, a $15 flat fee—the seniors can predict it. It is pretty simple. The average price—I think the GAO put out for average cost of prescription drugs of about $70.70 for a 1-month supply and if you pay $15, that is about a $55 out-of-pocket that goes back into the pocket of those seniors.

We plan to continue that same type of meaningful benefit or something similar in taking forward and supporting the interim discount card. So our focus is to continue that same pattern of types of benefits that are meaningful to disabled and the Medicare beneficiary.

The CHAIRMAN. Craig.

Mr. FULLER. Mr. Chairman, if I may on this question, it is an important one. There are about 1.2 million seniors using the

TogetherRx card. There are over 500,000 on the Pfizer Share Card. I think it approaches that on the Lily Answers card.

Obviously our pharmacies work with those patients now and they rightfully know that they are signed up and enrolled and qualified for those plans. We are working hard with the Pharmacy Care Alliance with each of these organizations to try to find ways to, through automation and other ways, make sure that the patient gets the best benefit they are entitled to. This is not only important for the patient; I would flag it as an issue to look at. It is very important as these programs are run in the individual pharmacies.

I do not need to tell you pharmacists are very busy people. There is still a shortage of pharmacists in this country of several thousand. If every patient that comes up with multiple cards and says, "I have multiple prescriptions and multiple cards; please help me sort it out," that kind of interaction, one, does not really help the patient who needs counseling perhaps on medication, not on which of the cards to use.

So we are looking for ways and we have worked very closely with Forest and the folks at Pfizer, as well as the other two organizations, to try to make sure that this process can be as seamless as it possibly can be for the senior. It is a very important question.

The CHAIRMAN. Let us pursue that line a bit further. First of all, there are real benefits to be gained out there if you can understand the system and you are properly educated and effectively access it. Obviously, Craig, probably the greatest point of contact for anyone is the pharmacy and the informational flow that would be available there.

So let me ask these questions of you all and any of you can certainly respond. Is CMS on the right track in doing what needs to be done to give seniors the information they need, based on what you now know?

Mr. FULLER. I will just quickly say that we have applauded what CMS has done. They are a very good partner in the early stages here of implementing this program and I certainly think they will continue to be.

The fact sheet that they produced, they gave it to us and we sent it electronically within 24 hours to all of our pharmacies and tens of thousands of pharmacists because it was the single best official document that explained exactly what the program was about. That sort of collaboration, not just with us but really with others on the panel, as well, is, I think, the spirit in which CMS has been operating and that is very encouraging to us.

There is going to be an enormous need to continue, as you have suggested by your questions, in helping seniors and their caregivers understand the program and its benefits over the next couple of years.

Mr. HARPER. I would like to reiterate that we have seen them out in the community and I think that is one of the most effective parts we have seen with our program. CMS has dispatched folks like Leslie Norwalk out. I have seen her at conferences presenting for the seniors and getting the information and getting the word out on a one-on-one basis with senior groups. The advertisements. We learned through our commercials that you have to repeat it over

and over and over as seniors and their caregivers see the message, as well.

So we think CMS is off to a good start in getting the word out.

The CHAIRMAN. Karen.

Ms. IGNAGNI. Mr. Chairman, I wanted to echo a point that Mr. Harper just made. There are two parts to your question. One is getting to the people, and we have been engaged in very active discussions and I know my colleagues have, as well, with CMS about their operational systems, making sure that they are doing what needs to be done to actually find and locate beneficiaries. The second part of this challenge is giving people understandable information. We think we have an important role to play in that and I discussed about the ways that we are going about designing outreach and giving people understandable information. But the agency really needs to be commended for prioritizing these issues and being very aggressive about a full-court press designed to deal with these issues.

Will there be bumps in the road? Probably, but I think that this agency is doing more than has ever been done to find, to locate, as well as give people information, and we intend to be full partners with them.

The CHAIRMAN. Jim?

Mr. FIRMAN. Senator, I think that CMS is certainly to be commended for what they have been able to do under a tremendously short timeframe, but there are limitations that we should all recognize.

First of all, as we know, there are an estimated 7.4 million low-income seniors estimated to be eligible for this transitional assistance and CMS's earlier estimate is that 2.7 million of them, would not get them. So the best case is that we are going to get to about 60–65 percent of the people who are eligible.

We also have to recognize that to achieve that 65 percent enrollment penetration in 18 months is unprecedented. It has never been done before in the history of any low-income benefit in this country. There is no program that has been able to achieve that kind of success.

So that means that we just cannot look to CMS to achieve this. We all have to do our part—the voluntary sector, the faith-based groups, and everybody else.

The second thing is that CMS is doing an excellent job on what it was charged to do, which is to help people make choices and comparisons among the Medicare-approved cards. But there are larger decisions that people are going to have to make. In 30 states, they are going to have to decide should I take this card or should I take my state program? How should I sign up for the Pfizer card? What about Merck and Lily?

So, there is a more complex set of decisions that need to be made beyond which card do I choose, and that is where I think we and other groups can help with complementary decision support tools because it is not one decision; it is multiple decisions that have to be made very quickly.

I might make one last point as I have thought about this whole thing. This is a whole track meet. It is both a 50-yard dash to get things ready by June; it is a quarter mile for the next period of

time, 2004 and 2005; and then it is a marathon, looking at what we are going to do in 2006, 2007, and 2008. Even if you look at the CBO estimates for the longer-term benefit where we think there will be 14 million people eligible, CBO is only estimating—7 years into it—that we will only get a 70 percent enrollment rate.

So we are both doing it for the short term and the long-term. But these people we are finding now are by and large going to be people who will also be eligible for the Part D. So we have to approach this short term and long term and recognize that everything we learn now will contribute to the long-term success.

The CHAIRMAN. Anyone else wish to comment on that?

Mr. HARPER. I would just like to make one further comment. We published a report by Marist National Poll and we actually talked to the seniors and I think that that is the part that we all must remember. We have to talk to the seniors and the Medicare beneficiaries that are disabled.

We did talk to them in our polling and they told us where to go and how to reach the hard-to-reach groups of beneficiaries and that also includes keeping it at the local level, working with churches. We just finished a project with the General Baptist Convention in Virginia. We trained 1,000 ministers on how to help fill out the applications. I think it is going to take that kind of grassroots efforts, day to day, door to door, and the Visiting Nurses Association, which we work with.

So it is those kinds of organizations who live in the community on a day-to-day basis, Senator, that we will continue to work with and I know that CMS has been all ears in listening to those kinds of approaches.

The CHAIRMAN. It is interesting you would say that. Here is a wire story out of the Tennessean newspaper this morning: "Methodists Offer Drug Discount Card." There is also an interesting line at the end. They also, through the Methodists, might offer it to Baptists and Catholics, so at least they are being nondiscriminatory. It is fascinating to me that so many different organizations are getting in the act and in a very important way.

Is there any one thing that you can think of now as you interface with CMS that they are not doing that might be recommended in this 50-yard dash that remains? Because Jim, I think you have assessed it well. We are not going to get to everybody now. It is a beginning, and what is most important is as big a beginning as is possible and then the continuation of working and improving as we do that.

As I mentioned in passing, one of the frustrating disappointments I had, while in Idaho hosting that health care conference, CMS informed me that one of the networks had refused their advertising. Now I guess maybe that has been solved by now, but the refusal came because they thought it was too political. I thought, shame on that network. You know, it is a very political year, but this is a program that has already passed and that and is now well on its way toward being implemented, and I hope that bias has gotten washed out of it at this moment. To me, the network's decision was a demonstration of a bias, or at least I read it that way.

These CMS efforts are clearly an outreach effort, and a very open way to reach as many people as are eligible and truly in need of it.

Yes, Craig.

Mr. FULLER. If I could turn your question just slightly, I would say that one thing I hope CMS does not have to do is go back and make modifications to the program as a result of legislative activity, which I do not mean to be audacious in saying that. There is plenty of work to do probably in refining the 2006——

The CHAIRMAN. Are you telling us to leave it alone for a while?

Mr. FULLER. Well, I think all of us who are trying to get this work done want a degree of certainty about what the next 18 months will look like.

The CHAIRMAN. That is a fair——

Mr. FULLER. I know there is concern.

The CHAIRMAN. Sure.

Mr. FULLER. I hope Forest Harper will agree to do this—I would say that report ought to be submitted into your record—I was pleased to participate in the press conference a few months ago in which it was released—because it identifies how real people actually benefit by these programs.

I am certain we are going to deliver real benefits as a result of implementing these programs. The toughest thing to do would be to deal with sort of shifting sands as we are in the middle of doing it.

Mr. MERRITT. Mr. Chairman.

The CHAIRMAN. Yes, Mark.

Mr. MERRITT. One other mission that the rest of us have here as we educate consumers is not just on what the program entails but I think truly everybody here at this table is making a good faith effort, along with CMS and the Federal Government, to do the very best they can to get a very big and complicated project out the door as quickly and well as we can.

Ms. IGNAGNI. Mr. Chairman.

The CHAIRMAN. Yes, Karen.

Ms. IGNAGNI. In the spirit of Mr. Merritt's comment, we are establishing a baseline for 2006. So I think Mr. Fuller has made a very important observation about the need for predictability and the need to plan now with consistent rules and regulations as we look forward to 2006. Our members want very much to participate in that program and intend to do so but if there are major changes, it becomes very difficult because you do not know what to look forward to; you do not know what world you are living in, et cetera.

So I just want to join the points that have been made, very effectively by my colleagues. This is a very serious—we are accomplishing a lot in a short period of time. I think people can already see tangible benefits, which we are very proud of, in our health insurance plans in terms of what we have already contributed in 3 months. We will be also major contributors in the discount program and beyond to 2006. But consistency and predictability is a very important part of this.

The CHAIRMAN. Well, I hear you. I serve on the board of "Medicare, Inc"., as do a good number of others, about 535 of us, I be-

lieve, and the message you are delivering is a very important message for the interim period as we go into implementation.

Let me ask this question. Some of you have alluded to it; see if there is something you might add to it. Seniors will be choosing between cards offered by a wide variety of organizations, including health plans, PMBs, pharmacy organizations, consumer groups, and others. From the standpoint of the average senior, how will the products offered by these varying kinds of sponsors differ from one another? I.e., will a senior see a difference between a card offered by a pharmacy group and one offered by a health plan or a PBM?

Mr. MERRITT. I would say first of all, assuming we can get them access to the right information through the web and so forth, they will have more information on drug pricing than they have ever had. So they will be able to look at the negotiated price of each drug before they sign up for a card and they will see which cards offer which drugs at which prices. Of course, health plans, some of them have a different, special thing that Karen can talk about.

But overall, there is going to be a multitude of blessings of information. The question is just making sure that people get access to it. So the information is there; it is just a matter of people seeing it.

Ms. IGNAGNI. I think, Mr. Chairman, the difference between our sector and some of the others, an individual who is a member or enrollee in a health plan would have the discount card as part of an integrated benefit program and we would use all the tools and techniques I described from a quality perspective, disease management perspective, a pricing perspective to try to leverage those dollars and make them go farther and make it part of the integrated benefit plan.

Mr. HARPER. Mr. Chairman, I would just like to say I certainly agree with Mark. The pharmaceutical industry has already experienced that in the last 2 years. If you can imagine, companies that typically compete against each other on the front came together with one unified stance—whatever is best for that beneficiary. We all put our cards out on the table. Some were discounts, some were flat fees, some were discounts with less, but at the end of the day we spoke on panels together, presented to each other. I mentioned my competitors' programs just as much as they mentioned mine.

I think you are going to see that same spirit and atmosphere going on because of coalitions that were gathering today because it is all about the beneficiary and not about any of the companies at this point.

The CHAIRMAN. Karen, many of your members are obviously looking ahead to 2006 when America's health plans will be entering the new Medicare drug market and the expanded Medicare Advantage market. What effects do you think the background experience of 2004–2005's transitional drug card program will have on the 2006 enrollment of the full Medicare drug benefit?

Ms. IGNAGNI. I think two things, Senator. One is clarity and second is confidence. Clarity in terms of understanding the rules and having had now a great deal of discussion with CMS about their views about setting up the regulations, the architecture, we are very clear about that and now we can lay the groundwork for 2006. This has been tremendously helpful.

Individuals, I might say, consumers and advocates and observers, will be able to see results. So we are proud of that.

Second in terms of where we go next, we are looking in an excited fashion at the clarity that has been established in the legislation with respect to providing true choices for seniors. Some of our members are going to be out in the market with HMOs, PPOs, medigap plans. Some will participate in the regional PPO structure. Others will be participating in a smaller region but more locally based.

We will have a multiple set of plans, in addition to some consumer-directed plans that are being developed for this population, as well, and that is, exactly what Congress envisioned—to give people choices. Our responsibility will be to work with CMS to give them information and we are proud of that and will be giving people the information they need to make the choices that are appropriate for them.

The one lesson we have learned in health care is that one size does not fit all, so beneficiaries appreciate the opportunity to have these choices and we are committed to putting a range of products out there so people can evaluate them. We will be working with partners. We work with PBMs, we are working with a variety of individuals represented on the pane. WE will be working with consumer advocates and senior advocates to make sure that we are partnering appropriately in local communities, getting the word and message out.

The CHAIRMAN. Anyone else? Yes, Jim?

Mr. FIRMAN. Senator, the Access to Benefits Coalition, which I chair, a public/private partnership, that is focussed on making sure that low-income seniors get the assistance both short-term and long-term.

So the CBO estimates that by 2013, 7 years into the program, approximately 8.8 million of the 14 million people who are eligible will receive this benefit. Our coalition is taking a much more aggressive goal. We want to beat those numbers. We will let you guys worry about the budgetary impact. Our goal is to make sure that at least 8 million people are there by 2008, and 12 million by 2012.

So we view this process of the short-term period of most of the people who sign up for the transitional assistance, we know they will qualify on the basis of income for the Part D benefit. So we view by capturing 5.5 or 6 million people, at least 80 percent of those we will have the names for, we will know who those people are and we can help beat those enrollment goals.

In addition, there are people between 135 and 150 percent of poverty who are going to be looking for this assistance in 2004. But they are going to be told that they are not eligible, so we are also going to tell them they will be eligible for the Part D low-income assistance in 2006.

So if we do our job well now in 2004 and 2005, we will beat the enrollment numbers. The reason the NCOA supported this legislation was primarily because of the benefits to low-income seniors and we and all of us collectively are going to do what we can to make sure that those enrollment numbers are met. So, this really is critical both for the short-term and for the long-term success.

The CHAIRMAN. Yes, Craig?

Mr. FULLER. I would quickly add that in addition to the comments Karen made, we too are looking at this program as a way to give ourselves valuable experience leading toward 2006 and one of the important elements that you will hear a lot of us talk about in the next 18 months or so has to do with risk.

We need to understand how to help this population that has not had a traditional drug benefit manage their medication needs and reduce their costs. If we are going to be called upon to accept risk going forward in 2006, we need this kind of experience and I think this program will help give us that.

The CHAIRMAN. I am very pleased to hear you say that. We continually hear about it. We have done some oversight on it, overmedication, and the problem of patients having a prescription filled out when they no longer need it, and that kind of thing, and the kind of counseling and observation that needs to go on. If there is greater access, and that is what we hope there will be, clearly what you have just said, Craig, is every bit the more important today than it was.

Mr. FULLER. It will be very valuable, sir, to have a patient who may have been going from store to store purchasing medication for cash suddenly in a system where their drug utilization can be reviewed, where conflicting medications can be sorted out, where their physician can be contacted and medications changed and where, frankly, they can be helped through various means to find the medication most appropriate for them and which perhaps costs a little less than what they have been taking.

Ms. IGNAGNI. Mr. Chairman, physicians in our networks often report compelling testimony about individuals presenting themselves in their office with a shopping bag full of prescriptions and one of the hallmarks of what we have been able to do in our networks is to coordinate the care, to assess what has been prescribed, and our physicians have contributed quite substantially to the learning of what it takes to actually accomplish that objective.

So we would be delighted to share some of those experiences with the committee should that be desirable to you.

The CHAIRMAN. I appreciate that.

Mark, another question of you. It has been argued that the new Medicare drug card program could well be much more effective at securing discounts than current card programs because the additional $600 low-income assistance payments will give card sponsors added new leverage at the bargaining table. Do you agree? Why is this the case, if it is, and how significant might that effect be?

Mr. MERRITT. Well, we are not sure how significant it will be. First of all, it kind of is the case, kind of is not. It depends what company you talk to. The philosophy behind it is that transition assistance is actually kind of a funded benefit, so you have cash-paying customers, uninsured, who typically when they do buy drugs pay more than AWP, more than the average wholesale price.

So the problem is they underutilize drugs. They do not use the drugs that they need. So often the problems being monitored are people using too many drugs, using the wrong drugs. The problem with people who are poor is, of course, they do not buy them as much.

This program, by taking $600 of the $1,400 that a typical senior spends, a beneficiary spends on drugs, should give pharmaceutical companies an incentive to offer bigger rebates because there will be more utilization of their drugs but in early discussions with some of our companies, although that is proprietary information, it is not clear how great that value is, although it certainly makes sense in theory.

The CHAIRMAN. Before I close, one of the things that I find fascinating here today, and I sense you are all agreeing, is that I do not think Congress, when we looked at an immediate discount card, we probably did not fully understand the value of that transitional time that you are now reflecting on as it relates to getting it right, getting people identified toward a full-blown system coming on line in 2006.

Obviously we knew giving attention to those who are truly needy now was critical. At the same time, we also knew giving time to get it right so that we could gain all of the advantages of what we wanted, plus cost containment and meeting budget goals and all of that, gaining access to the eligible, was all very, very necessary.

Am I hearing from you that the discount card, beyond just improving access in its own right, is also a valuable transitional learning experience for all the parties involved?

Mr. HARPER. I would certainly agree with that, Senator. What we learned, it is not just the discounts; it is also health information. Our model is built on the fact that we give the beneficiaries health education on diabetes, high blood pressure, and other illnesses, along with the information on how they can get the best discount and/or a flat fee.

So in the last 2 years we have learned a lot but we are also going to learn even more in this interim period as we go to reach a broader group of patients out there. Our focus is to work with volunteers—Jim said it a lot but we also want to train volunteers on how to respond to those who are most in need.

Ms. IGNAGNI. Mr. Chairman, this is a private/public partnership, so I think that two things have been accomplished. One is that Congress has clearly established for the private sector and all the stakeholders is a line of sight, which is very important and was a major issue in the discussion of how this legislation should be crafted. I think we are only all beginning to understand the power of that as we go through this process.

Second, the allegation has been made that beneficiaries will not be able to sort through complicated information in 2006. We do not agree with that. We work with beneficiaries every day that are looking and evaluating our members and the products that they offer. But nonetheless, CMS now has time to do a dry run in terms of developing information, developing information to help people sort through multiple products. That will be tremendously valuable in the market that has been designed for 2006 and beyond where there will be a range of options for this population.

So frankly, in our community we gave all of you a great deal of credit in being smart in establishing the line of sight, thinking about moving and phasing the benefits so that we could get the implementation worked out before the program would be fully live in

2006 with a full implementation of prescription drugs. So it was a smart thing to do.

Mr. FULLER. Mr. Chairman, NACDS developed a reputation back in 2001 for feeling fairly strongly that there should be legal authority for enacting a prescription drug card. The initial efforts of the administration actually deserve credit because out of that came the cards from the manufacturers—the Pfizer Share Card, TogetherRx and the Lily Answers Card—and those gave us good experience and we supported those programs.

But I actually will tell you that we strongly believe that the legislative effort last year produced a card program that is much stronger than what was originally envisioned, that definitely leads us down a path that gets us to a meaningful prescription drug benefit in 2006 and, as you have heard today, gives us the experience we need in order to be able to understand how to best implement that.

So it serves a number of purposes. It was, I know, not an easy issue to deal with but I think the process itself helped all of us and I do believe we are going to learn more as we go through this.

Mr. MERRITT. Furthermore if I may add, Mr. Chairman, just very quickly, PBMs have kind of been at the center of these discussions on discount cards and drug benefits for almost a decade, so this is our first opportunity to really get our feet wet and really begin understanding this program, but also getting beyond all the politics of it, showing that we really can help a lot of people when things are done right and where PBMs' tools are really used.

Mr. FIRMAN. Mr. Chairman, I agree with what has been said. I do think this is an important dry run but I think I disagree a little bit with Karen Ignagni. I think the choices that people—the stakes are going to be a lot higher in 2006. The choices that people are going to make will have larger consequences. Whether you choose one discount card over another discount card probably will not make a huge difference in the quality of your life and may make a difference of 10 percent or 15 percent on the drugs you save. Choosing among the Part D plans or opting into Medicare Advantage programs and the new plans is going to be a much more significant choice with much more complexity in choosing among the cards.

So it is good that we are at least going to get some of the kinks out, but we should not underestimate the challenge ahead.

Ms. IGNAGNI. Mr. Chairman, clearly we understand the complexity of the choices before seniors in 2006. The point, though, that needs to be acknowledged is that CMS has learned a great deal and is learning a great deal in how to educate this population and we intend, along with our colleagues, to be full participants in that and I think that has been valuable not to have to approach that de novo in 2006. That was the point that I was making.

The CHAIRMAN. Well, there is no question it is a great challenge for all of us.

Let me use this as a concluding comment that you may wish to respond to. If I liken this to a space odyssey, this may be your last chance before May to talk to the mother ship and I am not it. CMS is.

In your conclusion, and I will offer you that opportunity, are there any one or two additional recommendations based on your current experience that you might want to extend to CMS at this moment as we work toward the enrollment period and the introduction of the program in June? Jim?

Mr. FIRMAN. I know CMS is trying to do this but in order to get to these ambitious enrollment goals, we cannot just do things the way we have always done them. Insanity is doing the same thing over and over again expecting a different result. So, it is predictable that if we use the old strategies, we will not succeed.

I think that we need to the extent possible to look at wholesale strategies, meaning I know states have come in and said we want to enroll in the program; help us do that quickly. They recognize that the people eligible for transitional assistance may already be in some other database receiving home energy benefits or SSI or other kinds of programs. To the extent that CMS is able, and they are limited in the short term, to enable government, states or local, to use innovative strategies to bring people in wholesale, it will really help achieve the goal.

The CHAIRMAN. Anyone else?

Mr. FULLER. A similar thought. Maybe just that with the "marketing programs" kicking off on May 3, we really have a very short period of time to help enroll seniors. CMS has been good in looking at some ideas that we and others have put forward about educating seniors.

When these announcements come out in March, that flag goes up and seniors are going to be in our stores, 55,000 stores, talking to 130,000–140,000 pharmacists about why they cannot enroll now. We can explain that but we really need to be able to provide as much information as we can on demand, if you will. Telling them that "sorry, the government says we cannot share with you information until May" is not going to work.

We are sharing the CMS information and it is good information but I think all of us who have card programs or who are contemplating them would like to get about the business of educating seniors directly just as quickly as we can.

Mr. HARPER. Mr. Chairman, I would just like to say at the start of my presentation and my testimony I talked about the intent of the model of this program. I would like to just ensure that CMS works with those who have had the experience in the last 2 or 3 years of reaching out to low-income seniors and Medicare beneficiaries, take the reports we will offer again from our Marist polling and our National Polling system to see how we reach those low-income and tough to reach and at the end of the day the intent is to assure the American people, particularly those who are Medicare beneficiaries, this program will lower the cost of drugs and make accessible to those innovative things that they need to take care of their health.

The CHAIRMAN. Mark.

Mr. MERRITT. I would ask on, I guess, a nontechnical level something that CMS is probably already doing but it would be very helpful if they could get together with top executives of each of the major television networks, radio networks, and so forth, and explain not only the ins and outs of what is going on in the program,

but also that now is not the time to pile onto the program. Now is not the time to say oh, there are going to be so many choices; what are seniors going to do? I mean people need to have the information that they should have about the program but it would be helpful if, almost as a public service, the networks could get involved in helping try to educate people, not just whether or not they air our ads or not, but some of the news articles I have seen have been almost kind of neurotic in their fear of overinformation, and so forth.

I think, as Karen mentioned earlier, there are going to be some bumps in the road because we have such a short time line but the benefits we are offering are going to be numerous, they are going to be great for seniors, and if we can just give it a little time to play out, it is going to be a tremendous opportunity for them.

The CHAIRMAN. Karen.

Ms. IGNAGNI. Mr. Chairman, to conclude, it really involves an assessment of what happened in the past and not to repeat it. Post–1997, post-Balanced Budget Act, we faced a regulatory framework that strangled the private sector. It, in addition to the funding situation, forced our members to reluctantly withdraw from this program. We did not want to do that.

This has been such a breath of fresh air. This is a new day where CMS is actually going out and listening to the private sector about how to implement this program, how to work in a partnership and develop a workable structure.

So my message would be to keep up the good work. We will continue to work with them on all issues and there are challenges, but I think with that spirit of cooperation, a great deal can be accomplished, and I think that is good for beneficiaries.

The CHAIRMAN. Well, thank you all very, very much. Obviously, this is an extremely important issue for America's seniors. I have always been frustrated by those who assume that a senior could not navigate his or her way through. Given access and information, they can and they will. It really is an information game. It is of the highest importance to make sure that we reach out as extensively as we can. I think the Congress has also spoken very clearly.

This is a partnership between the private and the public sector. The public sector cannot afford to go this alone. But obviously, the need for access to these critical care components today is necessary for all of our citizens.

So we thank you very much. We will stay in close contact. We will continue to monitor and do necessary oversight where we think it important to give greater exposure, and please feel free to contact us as we work our way through this, and with CMS to make sure that, at the end of the day, as Jim said, we have broken out of the old models and we have reached out and contacted and brought people in.

Thank you all very much. The committee will stand adjourned.

[Whereupon, at 11:53 a.m., the committee was adjourned.]

APPENDIX

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

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

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

Education and Enrollment Challenges

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

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

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

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

Transitional Assistance is Special Challenge

Perhaps the greatest opportunity – and challenge – is reaching those eligible for the $600 annual transitional assistance credit. People eligible for this program have limited incomes – below 135 percent of the federal poverty limit – and in most cases no other drug coverage. These are the people who most need help with prescription drug costs.

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

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

ABC-Rx Coalition

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

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

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

Removing Regulatory Barriers

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

- A universal enrollment form should be authorized. Currently each card sponsor will have two different application forms, one for those who do not qualify for transitional assistance and another for those who do. This means local community outreach workers providing one-on-one help in evaluating cards and completing the application forms will need to carry around dozens of different forms. That will be unmanageable, with great potential for confusion and error. A universal application form that could be used to apply for different drug cards by checking off a box for the chosen card sponsor would greatly increase their ability to be effective.

- Automatic enrollment for people in Medicare Savings Programs should be conducted. People eligible for transitional assistance are by definition eligible for these programs. They are very difficult to reach through traditional outreach efforts, as experience has proven with less than two thirds of all eligibles enrolled. Automatically enrolling people in Medicare Savings Programs into the discount card transitional assistance program if eligible beneficiaries do not choose a card after a specified time period, while still

giving them an option to decline or change enrollment if they wish, would ensure that millions of difficult-to-reach people will receive this benefit.

- State pharmacy assistance programs should be allowed to directly enroll their members when they already have the information necessary to determine eligibility. Many of these state programs already have income data telling them which of their enrollees qualify for transitional assistance. These state programs also are eager to maximize enrollment in transitional assistance – again while giving individuals the option to decline or change enrollment – because it will help stretch their own resources in these continuing times of state budget shortfalls.

- Family size definitions should include entire household size. The legislation authorizes transitional assistance for beneficiaries below 135 percent of the federal poverty level. However, CMS regulations exclude many people who are below 135 percent of poverty by stipulating that income eligibility be based only by whether a beneficiary is married or single. They do not take into consideration any dependent children or grandchildren that may also be a part of a beneficiary's household, even though these dependents can be a significant drain on a low-income family's resources, and as part of the household increase the amount of income that falls below 135 percent of poverty. For example, a married couple raising two grandchildren under the new 2004 poverty guidelines can have an income of up to $25,448 and be

under 135 percent of poverty, which is substantially greater than the $16,862 allowed for this same household to qualify for transitional assistance under the CMS regulation.

Conclusion

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

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

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