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PRESCRIPTION DRUGS: WHAT WE KNOW AND DON'T KNOW ABOUT SENIORS' ACCESS TO COVERAGE

HEARINGS

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND ENVIRONMENT

OF THE

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HOUSE OF REPRESENTATIVES

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PRESCRIPTION DRUGS: WHAT WE KNOW AND DON'T KNOW ABOUT SENIORS' ACCESS TO COVERAGE

TUESDAY, SEPTEMBER 28, 1999

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

The subcommittee met, pursuant to notice, at 10 a.m., in room 2322, Rayburn House Office Building, Hon. Michael Bilirakis (chairman), presiding.

Members present: Representatives Bilirakis, Upton, Deal, Burr, Whitfield, Norwood, Coburn, Lazio, Bryant, Brown, Waxman, Pallone, Stupak, Green, Strickland, Barrett, Capps, and Eshoo.

Staff present: Patrick Morrisey, majority counsel; Kristi Gillis, legislative clerk; Carrie Gavora, professional staff member; Amy Droskoski, minority professional staff member; and Karen Folk, minority professional staff member.

Mr. BILIRAKIS. The hearing is called to order. Good morning.

The topic of today's hearing is Prescription Drugs: What We Know and Don't Know About Seniors' Access to Coverage.

I believe the title is appropriate because there is clearly much we do not know about this complicated and politically charged issue. We have all heard the numbers, roughly 65 percent of Medicare beneficiaries have access to some form of prescription drug coverage, but one-third have no drug coverage at all. Today, we will hear more about the coverage options available to Medicare beneficiaries as well as possible methods for expanding coverage to individuals who currently lack it.

Our first panel includes representatives from the Health Care Financing Administration and the General Accounting Office.

The second panel includes experts with a diverse range of experience in addressing these issues, and I look forward to a productive hearing on which we can shed some light on what we do know.

The bipartisan Medicare Commission on which I served spent a significant amount of time wrestling with this problem. The Commission was unable to secure a supermajority vote largely because we could not coalesce on a solution to the prescription drug problem.

As members know, this subcommittee has a strong record of working on a bipartisan basis to tackle difficult legislative issues, and I am hopeful that we can advance a bipartisan plan to improve prescription drug coverage for Medicare beneficiaries. By reaching

agreement on an answer to this difficult question, we can also help advance broader efforts to preserve and strengthen Medicare for the future.

Given the importance of prescription drugs to Medicare beneficiaries, a number of potential solutions have been advanced to help those individuals who currently lack coverage. Since this is not a legislative hearing, we will not focus on specific bills today. I will note for the record, however, my own concern about overly broad proposals that spread limited resources too thin and increase beneficiaries premiums or disrupt their current coverage. A plan which would cause some beneficiaries to lose their coverage, or that would increase their premiums, is worse in my opinion, than no plan at all.

I also believe that it is critical that we act now to help individuals in greatest need, our Nation's poorest and sickest beneficiaries. Our Nation's most vulnerable beneficiaries should not have to wait for broader reform of the Medicare program in order to obtain the help that they so desperately need.

In 1994, I joined then Congressman Roy Rowland, a family practitioner from Georgia and former member of this committee, in proposing a targeted bipartisan solution to reform our Nation's health care system. Our plan included critical provisions to help individuals with preexisting conditions obtain coverage and to allow workers to keep their health insurance when they changed jobs.

Opponents, including the President, took an all or nothing approach to health care reform. Unfortunately, as a result of their stubborn intransigence, individuals in need of care were forced to wait an additional 2 years until these insurance reforms were enacted into law in 1996, with strong bipartisan support, I would add. In my mind, it is unconscionable to ask the neediest beneficiaries to wait for prescription drugs while we continue to debate the broader problems facing the Medicare program.

Therefore, I recently introduced legislation along with Congressman Collin Peterson and Ernie Fletcher of Kentucky to help the poorest and sickest beneficiaries right now. Our bill, H.R. 2925, would provide Federal matching funds to States that establish or expand drug assistance programs serving low-income individuals. It would also protect beneficiaries who obtain up-front coverage from high annual drug costs through a stop loss protection.

I am hopeful that today's hearing will help clarify the need for prescription drug coverage and provide a foundation for further legislative action. I again want to thank our witnesses for the time and effort in joining us today and would thank them, by the way, for having submitted their testimony in enough time, with one exception, for us to have an opportunity to take a look at it.

I would now yield to the gentleman from Ohio, Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

I ask unanimous consent to enter the statement of Mr. Stark from California on this hearing and also any other members that have——

Mr. BILIRAKIS. Without objection, Mr. Stark's statement and the written statement of any members will be included in the record.

Mr. BROWN. Mr. Chairman, I thank you for doing this hearing today.

In response for a moment to your comment about one witness who submitted his testimony only at the last minute, I think that is unacceptable. I think it would help this side of the aisle and those witnesses who are testifying, in terms of being able to get travel arrangements and rearrange their schedules, that we have more than a week's notice in being able to prepare for this hearing. Sometimes witnesses need more time than that.

Today's hearing is about prescription drug coverage for Medicare beneficiaries. That means today's hearing could be one of the most productive hearings that this subcommittee has had the entire year, or we could walk out of here after today and after Monday's hearing having accomplished nothing.

Either way, the parent or grandparent of somebody in this room will be leaving their doctor's office today with a prescription—let's say it is Ticlid, which is prescribed to individuals at high risk of stroke—knowing that she cannot afford to fill that prescription and too mortified to tell her doctor or relatives that.

We can spend the next several hours complaining that there is no current data on the number of seniors without coverage. We can argue endlessly, based on that same data, about the nature and the magnitude of the problem. We could frame the discussion in such a way that continued inaction seems the prudent thing to do.

After all, all of our data goes back to 1995. We do have data indicating that between 30 and 40 percent of seniors, as the chairman said, lacked drug coverage in 1995; and many of those who reported having some coverage in fact had grossly inadequate coverage making that 30 to 40 percent number significantly larger. To me, that is a problem.

We also know the situation is going to get worse. Hundreds of thousands of seniors will lose their prescription drug coverage next year with the continued flight of Medicare+Choice plans. Other plans are dropping or curtailing the prescription drug benefits.

But let's pretend for a moment that the problem is not getting worse. Let's just say that 30 percent, say, of seniors lack prescription drug coverage at any given time. What if 30 percent of seniors lacked coverage for hospitalizations at any given time? Would we simply be dismissive and declare the problem minimal and look for stopgap measures to plug the hole? I think not.

Prescription drugs are as essential to health and well-being to seniors as any health care service or supply covered under Medicare. The purpose of Medicare is to protect seniors and their families from catastrophic health care costs; and, without prescription drug benefits, Medicare is simply not fulfilling that purpose.

In 1965, the U.S. decided it was in the Nation's best interest to create a universal health care coverage system for seniors. That program has lifted millions of seniors out of poverty and has helped them live longer and healthier lives. It is critically important to seniors and to their families; and yes, Flo, it is a government program. It is a government program because the private insurance industry didn't particularly want to cover seniors back in 1965, just like they don't particularly want to cover early retirees or less profitable Medicare managed care enrollees today.

Medicare, to its credit, treats all seniors equally and serves all of us well. We could complete the benefit package.

Obviously, not everyone in this room agrees that Medicare is the right vehicle for prescription drug coverage. We should discuss that.

Among those of us who support Medicare prescription drug coverage, some favor catastrophic, others favor a cap benefit or a hybrid or a doughnut approach. We should discuss that.

Some in this room believe that the government should pay drug companies their monopoly set price for prescription drugs because drug companies have told them if we don't, research and development will dry up. Others believe the threat of reduced research and development is just that, a self-serving and irresponsible threat, and we should discuss that.

Finally, some see the prescription drug debate as an opportunity to promote Medicare privatization. We should definitely trace the logic behind that. It certainly eludes me.

Mr. Chairman, we have a lot of work to do. It is late in the year. We can make up some of the time that we have lost by dispensing with the question of whether or not seniors need prescription drug coverage and instead focusing on how to get it done.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Coburn for an opening statement.

Mr. COBURN. Thank you, Mr. Chairman.

I am pleased that we are having this hearing. The example just used by my friend from Ohio as an example of the problem, he is right, there is a problem. But what he failed to mention in that is the lack of professional activity to solve that problem.

Let's just carry his example, Ticlid, a little further.

A senior comes into a doctor's office. A prescription for that drug is given, and the senior walks out knowing that they are not going to be able to afford it or not knowing and going to the pharmacist and getting a huge bill and saying I can't afford that.

That is a failure not of prescription drugs, that is a failure of the basic standard of professional care by physicians in this country. We should not confuse the two. That physician should ask their patient, here is a drug. Here is what it is probably going to cost. Can you afford that? And if you can't, what can I do as a physician either to make that drug available to you, give a substitute that accomplishes 95 percent of that, which is aspirin, or otherwise solve that patient's problem.

One of the things that has disgusted me in the whole debate is that we are focusing on prescription drug benefit and not the failure of the profession to do its job, what it was trained to do, to inquire, to care for their patients.

The other thing that has extremely concerned me is that we are rushing to provide a benefit on a bankrupt program without the President doing what he can do to make significant increase and improvements of drugs available to the seniors in this country.

Let me give you five instances that the President can do.

The first thing that the President can do is put pressure on the FDA to increase more generics. He has not done that.

No. 2, he can push and the Justice Department can line up on the side of the independent drug pharmacists in this country in their lawsuit against the drug manufacturers because they won't

sell to them as a buying group. They will sell to mail order drug houses, but if the pharmacists want to group buy, they won't do that. They have a suit going. The Justice Department ought to be siding with them. It is a monopolistic practice to not sell to group pharmacists who buy as a buying group that then can pass on savings.

No. 3, he can still work harder on the FDA to lower the cost of drug approval.

No. 4, he can talk to the doctors in this country about their obligation of doing the job that they were trained to do. That is to make sure that you don't just write a prescription, that you know whether or not—you ask your patient, are you taking your drugs? There is good studies, 20 percent of the seniors walk back into their doctor's office, and the doctor never asks the patient, are you taking your medicines?

Finally, he can put forward what is done well by the drug companies in this country because there are over 30 of them that offer drugs free for seniors in this country if they have an income limitation, and I would like to introduce for the record the list of those companies that are providing that service now.

And if physicians get off their can and inquire of their patients whether or not they can afford to buy a drug, whether or not they have an income problem, and utilize the services out there for indigent and low-income seniors by the drug companies to provide a benefit, we could markedly change the access and availability for prescription drugs for seniors in this country.

But what we want to do is fix another government program that is going to disrupt the marketplace. And I happen to agree with Mr. Brown. There are monopolistic practices going on in the pharmaceutical industry, and they ought to be ashamed of some of the prices that they are charging for some of the drugs. But we ought to do the basic smart things first before we obligate our grandchildren and their children for another enlarged program.

The last point I would make is that HCFA has a terrible record of ever estimating any costs right. The closest they have come is missing it by 800 percent. That is the best that they have ever done on anything. So we cannot use data coming from HCFA as to what things are going to cost. And we better well know what we do in terms of prescription drug benefit for seniors because the problems that we have with Medicare now will be minuscule if we don't do this right.

Mr. BILIRAKIS. Without objection, that will be made a part of the record.

Mr. Pallone for an opening statement.

Mr. PALLONE. I want to thank you for holding this hearing.

In my view, the Medicare program cannot be modernized without adding a prescription drug benefit. Some of my colleagues on the other side of the aisle contend that two-thirds of the Nation's seniors have adequate coverage, and we need only devise a plan to cover the other third. This contention, however, is a diversion. The Republican leadership in Congress is intent on downplaying the two most important aspects of the prescription drug debate, those being the exorbitant price discrimination seniors face when pur-

chasing pharmaceuticals and the substandard nature of the coverage held by those lucky enough to have it.

I am pleased that Mr. Coburn mentioned the price discrimination issue today, but the price discrimination seniors face when purchasing pharmaceuticals has been well documented by Democrats on the Government Reform and Oversight Committee. The committee's Democrats found that seniors pay almost twice as much for their prescription drugs than does the pharmaceutical industry's most favored customers.

As a result of this price discrimination, increasing numbers of seniors are being forced to choose between food and medicine. Without a prescription drug benefit and against the recommendations of their doctors, seniors are splitting the pills into pieces and staggering the days on which they take their medications to make their prescriptions last longer.

The record is clear on who is taking the lead in trying to fix this problem. Notwithstanding Chairman Bilirakis' bill, the Republican leadership in Congress has done nothing on this issue. Democrats have been on the House floor day after day all year long pushing for consideration of legislative solutions such as those which have been offered by Congressman Allen of Maine and Henry Waxman and Pete Stark. Both of these plans, as would the President's plan, would increase the negotiating power of those seeking to provide a Medicare drug benefit allowing pharmaceuticals to be purchased at cheaper prices and passing those savings on to seniors.

I know of no Republican proposals that confront the issue of pharmaceutical price discrimination. As I said earlier, many of my Republican colleagues contend that two-thirds of seniors have adequate coverage. Consequently, they say we need a plan only to provide coverage for the one-third of seniors who lack coverage. This contention ignores reality. The quality of the coverage for those who do have it is not that good at all. We need to pass a plan that provides comprehensive coverage as the President has proposed. The case for comprehensive coverage is extremely compelling.

In July, the White House released a report detailing the quality of the prescription drug benefits for those Medicare beneficiaries who do have them. With respect to the availability of prescription drug coverage in the Medicare+Choice program, the President's July report found some disturbing trends. About 17 percent of Medicare+Choice enrollees have prescription drug plans, but again that coverage is not that good and is getting worse.

The President's July report found three-fifths of Medicare+Choice plans were reporting that they are going to cap prescription drug benefits below $1,000 in the year 2000. In addition, it found that the number of Medicare+Choice plans imposing a $500 or lower cap on prescription drugs will increase by over 50 percent between 1998 and 2000. And just last week the White House released another report announcing that, next year, all Medicare HMOs will charge copayments for prescription drugs.

Mr. Chairman, over 50 percent of Medicare beneficiaries without drug coverage are middle-class seniors. As stated another way, over 50 percent of seniors without drug coverage have incomes over 150 percent of poverty level. Passing a plan that provides a benefit to

only one-third of the seniors will not help them nor will it help the millions that have insufficient coverage that is getting worse.

The President has it right. Medicare should be expanded to include a prescription drug benefit for every Medicare beneficiary who wants one. There are a lot of plans that have been introduced by many Democratic members, all of which have considerable merit; and I have a plan which would refurbish Medigap to provide more comprehensive and affordable coverage than currently exists. But I want to stress that I believe, and it is partisan, but I am stating my opinion, that the Republican leadership in Congress has to date failed to show an understanding of the depth of prescription drug problems that seniors are facing, and they need to be disabused of the notion that the problem affects only those with the lowest incomes. The problem affects a vast number of seniors, and the sooner they realize the huge scope of the problem the sooner we can expand Medicare to include a meaningful and comprehensive drug benefit.

Thank you.

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

Mr. Burr for an opening statement.

Mr. BURR. Thank you, Mr. Chairman.

Let me encourage everybody who is in this room, don't listen to a word we say today because, clearly, we are not here with the intention of solving the problem that exists in health care. You can't solve a policy issue with partisan politics. It will not happen. We can blame those individuals who 35 years ago looked at drug coverage as a part of Medicare and we can point a finger at them. They used the facts that were available to them at the time, that drug treatment was not a huge factor in the treatment of sick people—at least seniors.

I am not questioning their judgment at that time, but I wonder if in fact people complained about the Post Office before there was FedEx. I wonder if we really looked at it without a comparison of something that could happen better and cheaper and faster and were critical of it. I doubt we were.

Now health care has changed. As I listen to those who have preceded me on opening statements, I feel shamed that I had a hand in passing the FDA Modernization Act, an act that I think brought new pharmaceuticals and devices to the marketplace faster because, in fact, the success of the FDA and the drug companies, the new applications, the number larger than the year before and the year before that, have contributed to this 7 percent rise in drug costs. That is what it is this year. When we have got twice the number of new pharmaceuticals in the marketplace under their cost recovery period for research and development, the cost of the marketplace is higher. And when we double it this year, it should be significantly higher than it was last year.

Please don't lose focus on what that means. That means that individuals, not just seniors across this country who have terminal and chronic illness, who have for the first time a drug that treats it. We in this committee have lost focus time and time again on who it is that we are here to talk about, and that is patients. It is the human face that each of us are touched by every time we

go home. It is the individual who should be at the forefront of the debate when we talk about seniors.

If there is a commitment that we ought to make, it is that no senior would lose everything that they have accumulated because of an illness. Until we have designed a health care delivery system that I think fits that bill, then we will continue and I will continue to try to refine what we, in fact, should do as this committee.

I will assure you, Mr. Chairman, that I will stay here patiently all day. I won't be critical of the President's plan, as I have been in the past. I won't be critical of any of the other plans which have been introduced. But I would tell you that until we have restructured Medicare to be the best delivery system for health care for seniors, this committee has not completed its work.

Once again, I think we are after a band-aid versus a cure. I am confident before it is over with we will find a cure.

And I yield back the balance of my time.

Mr. BILIRAKIS. Ms. Eshoo for an opening statement.

Ms. ESHOO. Good morning, Mr. Chairman and everyone that is here.

I want to thank you for holding this very important hearing and for the one that will follow on an issue that I think effects all of us. Whether one considers themselves part of the ranks of seniors or in caretaker roles, we are really tied to this issue and need to address it.

We have spent a great deal of our time during this Congress so far talking about the need to shore up the Medicare program. We have also talked about how we can modernize it. We are also painfully aware of the frightening statistics and how those statistics impact the program that is in place now. With Americans living longer, the number of Medicare beneficiaries are growing faster than the workers paying into the system; and without reforming the trust fund, it will be insolvent by the year 2015, which is not too far from now, so we have a lot of work to do.

But securing the system we know, I think that each one of us would acknowledge, it is not enough. We have to modernize it. And the key to ensuring the program covers the best that medical science has to offer is to provide the kind of benefits that are needed in the system today. They weren't when Medicare was founded in 1965, but things have changed.

When Medicare was created in that year, seniors were more likely to undergo surgery than to use prescription drugs. Today, the prescription drugs are often the preferred and sometimes the only method of treatment for many diseases. Seventy-seven percent of all seniors take a prescription drug on a regular basis. Nearly 15 million beneficiaries have no insurance coverage for prescription drugs. Eighteen percent of them spend $100 a month on their prescriptions.

The number of employers who sponsor retiree health insurance coverage has dropped by 20 percent between 1993 and 1997. For some seniors, enrolling in Medicare managed care plans has provided them drug coverage. However, 11 million beneficiaries don't have access—now as a Californian, most of them do, but in other States and across the country, that is a huge number, that 11 million don't even have access to any managed care plans whatsoever.

And many of those plans are dropping or severely limiting coverage. A recent Kaiser study found that current drug coverage in Medicare managed care plans varies greatly, and many of them may be in jeopardy altogether as plans face declining profits.

I applaud the President and my colleagues here who have introduced plans to provide a Medicare drug prescription benefit. I think it is an important one to add, but I think we have to figure out how we are going to do it. That is where the debate is. If I have any regret, it is that we are just starting the hearings on this issue now. I think in many ways it is a march to folly for anyone to make up their mind and say we have the absolute perfect way to address this. We don't know. We haven't examined it thoroughly enough. Today is the beginning of that.

I am hopeful that these fact-finding hearings will be followed by legislative hearings so that we can move to provide coverage for seniors, because I don't think that our Nation's elderly should have to choose between paying for their prescription drugs and their other necessities, food included.

Let me add, when President Johnson signed the law that created Medicare, he said, "The benefits of this law are as varied and broad as the marvels of modern medicine itself." I think we need to bring Medicare up to the current marvels of medicine.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. Mr. Deal for an opening statement.

Mr. DEAL. Thank you, Mr. Chairman.

I want to congratulate my colleague, Mr. Coburn, for his opening statement and some of the most insightful suggestions or practical problem-solving solutions to this issue. I find it regrettable, as this committee now explores the possibility of expanding pharmaceutical benefits for senior citizens, that some on this panel would inject the poison pill of partisan politics. Partisan politics never solved any problem, and if it is the focus of this hearing or any debates relating to this issue, I think we all know that it will not solve anything. It is truly hardened upon the ultimate poison pill that will keep this from going anywhere.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Barrett for an opening statement.

Mr. BARRETT. Thank you, Mr. Chairman.

I want to thank you for holding this hearing. If there is one hearing that is an important hearing, this is it. This is an issue where real people are affected. When I am back in my district and I am at senior citizens meetings or fish fries, this is the issue that when I talk about it, the citizens' heads go up and down because this is a real problem.

We hear the talk here in Washington that it only affects a third of the seniors. Well, that is 13 million people. And there is another third that I think is basically on the tightrope act right now. They are either in Medicare+Choice plans or they are in plans that are covered by employers that could go in the other direction.

And, unfortunately, we have started seeing that with the Medicare+Choice plans both in my area and I think in other areas of the country where those who are enticed into these programs by the offer of prescription drug coverage are now facing the harsh reality that drug coverage is being dropped totally or they are going

to have to pay a significantly higher amount for that drug coverage.

Others have talked that this is a problem that can't be solved by Medicare. Well, if it can't be solved by Medicare, then we have to look for other ways to solve the problem. And I think the bill that has been introduced by Mr. Allen and others is a bill that this committee should take a very, very close look at it, and that is the bill that recognizes that there is a huge market disparity right now in this country. That Joe Jones and Judy Jones, when they go into their drugstore to buy drugs, have no market power, and they are forced to pay 100 to 105 percent higher than an HMO, than the Federal Government, than anybody who is buying at a volume discount.

What I think we have to do and can do is not create a huge government bureaucracy, address this market discrepancy by allowing seniors and pharmaceuticals to form cooperatives. We have to take steps that allow this huge market disparity to be eased in some way, and I think this committee should take a careful look at that. Those who hate government programs and who fear that Medicare cannot solve this problem should take a look at that market-oriented solution, but it is a solution that really does try to deal with the problem. Again, one of the hugest problems we have here is the unequal market forces that are at play.

The second problem, of course, is that there are a number of individuals who through no fault of their own are faced with disastrous bills. The vast majority of seniors don't have to pay $5, $6, $7,000 a year for prescription drug coverage. If we have a greater market force for those paying the lower amounts, we can combine that with more of a disaster type relief policy for those hit hard.

I am tickled pink, Mr. Chairman, that you are holding this hearing. I honestly thought that this was going to be an issue, without sounding partisan, that the majority party would simply ignore. So I want to compliment you for recognizing that this is a real world problem, because I think the first step in solving this problem is sitting down and saying, okay, let's talk about the problem and see what we can do.

I yield back the balance of my time.

Mr. BILIRAKIS. Mr. Whitfield for an opening statement.

Mr. WHITFIELD. Mr. Chairman, thank you very much.

I think, obviously, this is one of the most difficult, complex issues relating to Medicare, not only to keep Medicare from going bankrupt but also to provide adequate coverage for recipients of Medicare. And it is going to take the best minds not only in Congress but of health officials throughout this country to solve the serious problem facing Medicare. And, because of that, I must say that I am disappointed that, once again, the gentleman from New Jersey seems to want to take and blame the Republican party for all of the deficiencies in the Medicare program, and I would just remind him that his party controlled Congress for 40 years and never addressed this problem, as far as I know.

But the important thing is we don't need to sit here pointing fingers at each other, but we need to work together and try to solve the problem. Because senior citizens throughout this country, many

of them cannot afford to pay their medical bills and, therefore, do not take the drugs that they need.

We can solve this problem, but in doing so not only must we look at how it effects senior citizens on the financial side, but we have to look at many young couples today who are paying higher and higher payroll taxes. Many of them do not have any health coverage for their children. So we need to approach this in a balanced way, but I am convinced that we can come up with a meaningful solution to this problem. And there is no question that a lot—many senior citizens need help with prescription drugs, and I think that is what this committee is committed to try to take care of.

I yield back the balanced of my time.

Mr. BILIRAKIS. I thank the gentleman.

Ms. Capps.

Mrs. CAPPS. Thank you, Mr. Chairman.

I, too, want to commend you for holding this extremely important hearing. Ensuring that seniors have access to prescription drugs is as important today as guaranteeing that they had access to hospitals and doctors back in the 1960's when Medicare was started.

Modern pharmaceutical drugs keep seniors healthier and improve the quality of their lives. As a nurse I know that by reducing hospital stays and the need for invasive treatment, prescription drugs save money. In today's health care environment, they are virtually indispensable, and yet Medicare does not cover prescription drugs.

This hearing is to look at the data that we have regarding seniors' access to prescription drugs. While I am glad that we are discussing this problem, I would prefer that we actually begin discussing the merits of particular proposals to address it. Getting more information is good, but easing seniors' suffering today is better.

We already know that one-third of seniors don't have any drug coverage, another quarter have coverage from former employers, but employers who offer retiree benefits are becoming fewer and fewer. Medigap plans are unaffordable or inadequate. Medicare+Choice plans are capping benefits at a thousand dollars or less, and some 40 percent of seniors don't have a plan with a drug benefit available to them.

In my district, this last point is ringing especially true. Last year, three of the five HMOs serving San Luis Obispo County in California pulled out, leaving thousands of seniors scrambling to get into another HMO because that is where they could get the most affordable drug coverage.

This month, Blue Cross, the only HMO that served the entire county, announced that it would pull out as of January 1, 2000. It will leave 1,900 seniors of that county with no HMO coverage, in effect with no affordable drug coverage. 1,300 other seniors in the county currently enrolled in Blue Cross will only have one HMO option, Pacific Care Secure Horizons. Premiums for Secure Horizons are going up some $50 a month, raising costs to those seniors if they choose that HMO as well as to the 6,400 seniors already in Secure Horizons. For me and for thousands of seniors in my district, this experience has only reinforced the necessity of making

prescription drug coverage available to all of our seniors through Medicare.

While I am happy that the subcommittee is holding this hearing, I am dismayed that it has taken so long to look into this issue. It is clear that we have a problem. Our Nation's health plan for seniors is a product that most of us wouldn't chose for ourselves. This is an outrage, and this must motivate us to act and to act now.

A third of seniors don't have coverage and are sometimes choosing between food and rent. I know this personally in my district—or filling that prescription in this, the richest country in the world.

I would hope that this subcommittee begin discussing some of the different proposals to meet this challenge. The President has put his proposal on the table some months ago. Senator Breaux and Representative Thomas have done so as well. Representatives Turner and Allen have a proposal; and your introduction, Mr. Bilirakis, of legislation last week is another productive addition to the debate. I respectfully urge you to expand upon today's hearing and use this subcommittee as a platform for providing prescription drug coverage to all of our seniors. They deserve nothing less, and so I look forward to working with you to achieve this goal.

I yield back the balance of my time.

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

Mr. Bryant for an opening statement.

Mr. BRYANT. I want to thank you for having this hearing; and let me say, first of all, that I don't think that there is anyone in this room or even in Congress that would not want seniors to have access to the prescription drugs that they need. I don't think anyone would argue that point.

But as I sit here and listen to some of the comments that are being made, I really appreciate those well-thought-out, instructive comments that people like Dr. Coburn have made, Tom Barrett has made on the other side about how we can perhaps address this issue short of a national entitlement program.

In listening to Ms. Capps speak about some of the HMOs in her district going out of business, it made me think back to the hearing that we had in here perhaps a month or 2 ago about just that problem, and I know sometimes the way I deal with issues up here is I isolate those issues and forget the big picture sometimes. Listening to her talk about that today, it reminded me that at one point we were looking at nationalized health insurance or health coverage, and that failed, as it should have failed.

But lately we have heard about maybe one big gulp wasn't the way that you do it. Maybe you take it incrementally. As I think back to those HMO hearings we had, the witnesses were all saying we are having to drop out of that business because we can't afford to stay in business where we are not being paid fully or on time. There were all kinds of problems with that. And I had the thought then that, perhaps not a conspiracy, but if one were conspiracy minded, this is the way that it has been handled to force people out of that business because that would direct those people back to Medicare, the traditional form of Medicare and, ultimately, a government-based solution, a government-based entitlement.

And here today I am hearing the same thing in terms of prescription drugs. Many of us would like to see that access to drugs

by seniors to be under the current environment where they have insurance coverage or they are getting it at the lower end through government programs, but these folks that we are dealing with today, that 35 percent who don't have any coverage, that we be creative and use some of these suggestions that have been made today.

But yet what I am hearing again is like the Medicare plus cost, where we are looking for a government-based solution, another entitlement. There again, another step toward government-provided insurance. And again I think sometimes—I know that I have and perhaps it would help if all of us looked at the bigger picture, rather than one isolated part at a time.

Certainly the purpose of today's hearing is to help us as a Congress understand how we can best facilitate access to prescription drugs by seniors, and we are going to hear several opinions, and I would say, as I have said earlier, I have concern about a sweeping prescription drug entitlement coverage for all beneficiaries.

Again, we know that something like 65 percent of the Medicare beneficiaries already have some form of coverage, and that has been discussed. And the degree, the form of coverage might be argued as good or bad, but certainly they have access to some drugs. And before we look at creating another government entitlement in Medicare, I think we ought to look at ways to create a targeted prescription drug benefit for seniors and using creative ways such as what Mr. Barrett and Dr. Coburn suggested.

I think there are other options out there without placing the government in control. I think in a time, too, when Medicare is in trouble financially and we are facing the prospect of my generation, the baby boomer generation, coming ahead, that we must really be careful that we behave responsibly in this area toward working out a solution for this common goal.

Thank you for having this hearing.

I have a more complete statement that I would like to put in the record.

Mr. BILIRAKIS. Without objection.

Mr. Green for an opening statement.

Mr. GREEN. Thank you, Mr. Chairman.

Like my colleagues, I am real glad to be here today and congratulate the Chair on starting a dialog on the committee process on this important legislation.

Frankly, I was surprised about the concern about the poison pill of partisan politics. I am shocked that we have that in this committee room on this floor of this House. After getting here 1 minute ago and hearing how terrible the President was, the poison pill of partisan politics shocks me.

Again, I appreciate the opportunity to be here today. I think this is an important issue facing Congress, how to provide prescription drugs at affordable prices. Several bills have been introduced; and, Mr. Chairman, I know that you have introduced one; and I know that there is both the Allen bill and the Turner bill and the President's plan within the budget.

Critics oftentimes rarely offer their own solution to this growing problem. In fact, our Nation's health care system has dramatically evolved over the last 10, 20 and 30 years to the point where pre-

scription drugs are a major component of the health care system, but they can be critical to an individual's survival.

Everyone agrees that we need to make prescription drugs more affordable to those who least can afford them. Seniors are being forced to choose between buying food or taking their prescriptions. They often delay taking their prescriptions. Instead of one a day, they take one every 2 days. Because Medicare does not cover prescription drugs, so many seniors do not have a prescription drug benefit. I have seen a percentage that 37 percent don't have, but I know that it is much higher in my district. And, again, even those who have something, I think it is such a limited benefit that it is almost nonexistent.

Representatives of the pharmaceutical industry say they have to charge the high cost to cover their research and development. I agree. Part of the success in the last 30 years is that we have medications that keep you from having to go to your physician, and I am certain that the time and money invested by these companies and NIH is exceedingly high.

Last year, Congress passed a 15 percent increase in the National Institutes of Health budget, and hopefully we will be looking at the same thing this year, to continue that trend where we can treat people outside of the hospital or outside of the doctor's office.

These facts do not explain why HMOs and even foreign countries are able to purchase approved drugs at significantly reduced prices. Studies by the minority staff, the Government Reform Committee, show that seniors actually pay as much as double what may be charged to a most favored HMO or someone who can negotiate, such as the Veterans Administration, and so that is the issue of the Turner and the Allen bill. Because seniors do pay substantially more, and I know in my own district they do.

The other problem that we have in districts like I have, we are 6 hours from Mexico, and I understand the same situation in Canada, that shows that consumers in Canada and Mexico can purchase the same drugs for significantly less, and in some cases half of what they are in the United States. So I have constituents who literally drive to Mexico for 6½ hours in order to get their 90 days supply of prescription medication. Often, it is the same pharmaceutical that they can buy at their local drugstore.

I am sensitive to the need for drug manufacturers to make profits for their approved drugs, because the success for the last 30 years is because of that reinvestment. But discounts are already available to HMOs and U.S. Government and hospitals.

Mr. Chairman, I hear the bell. I am glad that we are having the hearing today, and hopefully the pharmaceutical industry will come forward with some type of suggestion on how we can address this issue.

Thank you.

Mr. BILIRAKIS. Thank you, Mr. Green.

Mr. Norwood.

Mr. NORWOOD. I would like to submit my opening statement for the record.

I can associate my remarks with those that have spoken before me. Dr. Coburn made some very good suggestions, Mr. Barrett, and I certainly agree with Mr. Whitfield and Mr. Deal.

If you want to help seniors with their medications, don't turn this into a partisan battle. That is the way that you may get votes, but you won't solve this problem.

Now there is time for partisan politics. I love to participate in it. But I don't like to participate in it when it comes to health care. I probably have a bias in that.

But we can work this out, and it won't be worked out by just simply saying the President has this program that he wants to add and let HCFA run it and add it to the Medicare program. That is not going to be the solution.

We all know that patients that cannot fill their prescriptions are having and receiving very bad health care. It is bad for their health. In addition to that, it is bad for business. It is bad for Medicare and bad for HCFA because, in the end, when you can't take your medications, the cost for treatment down the road is a great deal more expensive than the cost for medications for not having taken those treatments.

I don't think that HCFA can do it. They don't do very much well, and we are most assuredly forgetting what we were just talking about 2 years ago. Two years ago, we were talking about a trust fund going bankrupt. It is still very dangerously low. It is still a large problem. And one of our solutions has been what we have been doing since 1965, when in doubt add more expense to it.

I am reminded of Lyndon Johnson's time when he pushed Medicare through, and he called his lieutenants into the Oval Office and said, this is a great new program for the American citizens, and it was in 1965. You guys go out and give me some idea what this thing is going to cost 25 years from now. And his lieutenants did the work and pushed the pencil and came back and said, Mr. President, by 1990, it is not going to cost much more than $9 million. He said, great. This country can afford that.

But the problem was in 1990 it was $120 billion. Somebody has got to concern themselves with how we do this in terms of what it costs, because there is a limited amount of dollars that young people can put into the program. It doesn't mean, Mr. Chairman, we can't solve this. I believe that we can.

And I would like to ask Mr. Pallone, let's try to do this on the basis of how can we solve this problem for our senior citizens, not how can we get votes next November.

With that, Mr. Chairman, I yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Stupak, opening statement.

Mr. STUPAK. Mr. Chairman, I was at another hearing and missed a lot of the opening statements. I am going to pass right now.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Upton.

Mr. UPTON. Rarely a day goes by that I do not receive a letter or call from seniors very concerned about the increases in the cost of prescriptions which they need and are paying for out of their own pocket. I want to be sure that no senior in America is forced to choose between buying vital prescriptions and other basic necessities.

There is also a fairness issue here. A good number of my beneficiaries are snowbirds. They travel to your district down in Flor-

ida, Mr. Chairman, and they learn from their friends that they meet down there that their friends receive prescription coverage through their own Medicare HMOs, and they wonder why that is because they pay the same premium in Michigan as their Florida friends. It is because Medicare's premium payments are too low in my district to attract any Medicare HMOs. And as we work to change this in the Balanced Budget Act of 1997 over the next several weeks, I hope that every member will give careful consideration to speeding up the current phase-in of more equitable AAPPC rates which will make it fair for all seniors across the country.

I yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Strickland.

Mr. STRICKLAND. Mr. Chairman, for us to sit here and pretend that this is not a political issue is unreal. It is a political issue. If you watch the TV ads and you listen to the comments made by the leadership of both parties, you know this is a political issue.

I think seniors are asking, why do I pay more for my prescriptions than people who have insurance coverage? They are asking me, why do I pay more for my prescriptions than people who live in other countries? They know that there is a problem out there, and it is not a Republican or Democrat problem, but I think it is the kind of problem that is going to require us as Republicans and Democrats to stand and accept responsibility for what we do.

I would like to share some comments from letters that I have received from real people.

One woman from Marietta, Ohio, writes, "My expenses last year were just under $4,500, and this year they will be much higher. Even in the month of May just passed, I had to ask the pharmacist for 15 pills of two different prescriptions because I didn't have the money to pay for the full prescription."

I am sure I am not alone when I say I lack many times for necessary foods to buy enough medicine to get me through until the third when the Social Security check arrives."

A couple from Proctorville, Ohio, wrote to me and included an itemized list of their prescriptions for this past year. Even with insurance, his co-payments totaled $1,046.34 and hers totaled $4,996.83.

Another couple from Portsmouth, Ohio, wrote to share their story for paying for anti-rejection drugs. Their supplemental insurance costs $148 a month and pays $3,000 per year toward their medications. The cost of the drugs they use is approximately $1,100 a month, which leaves them to pay the vast amount of the cost themselves, even though they have limited drug coverage.

I didn't have to dig very deep into the constituent file to come up with this sampling of stories and while they may fall under the category of anecdotes, I have heard enough of them to convince me that we have a serious problem and we have got a responsibility to deal with it. And I believe that data exists to back up these stories.

I want to close with a final thought from an Ohioian: "We have to decide if we get to eat right or buy our medicine. I wonder if anybody in Congress has ever had to make a decision like this. I am sure if you have, the rules would change"

Thank you, Mr. Chairman. I yield back.

Mr. BILIRAKIS. Mr. Lazio.

Mr. LAZIO. Thank you very much, Mr. Chairman. Let me begin by thanking you for your work on this prescription issue which I know has been a multiyear concern of yours, and I am going to forego my complete opening statement and just sort of summarize if I can do that because I think some of the points have already been made. One of the points I think we need to reaffirm is the fact that we have rightfully made extraordinary strides in the increase in public resources dedicated to NIH and the various institutes under the National Institute of Health. It is the right thing to do to press forward at a time when technology and biotechnology is exploding with possibilities, but I think it is fair to ask that as cures and therapies become increasingly real from a research end, what good does that do if people can't access them. We know that there are certain strategies that we can embrace that would allow us to make use of these research breakthroughs for seniors, and I am happy we're looking at ways to provide for more access and affordability today.

New York as you know is a state that addressed this issue almost 15 years ago. The Elderly Pharmaceutical Insurance Coverage Program, which is known as EPIC, is a state sponsored program that helps eligible seniors pay for their prescription drugs. By meeting certain financial requirements, seniors pay an annual fee, an annual deductible to receive benefits. When they go to the pharmacy, they show their EPIC card and pay only a co-payment which ranges from about $5 for $23 based on the cost of the prescription. Currently, this program serves about 107,000 seniors in New York.

Since the program started, over 280,000 have been served. The program has allowed seniors to pay for about 31 million prescriptions and at the same time allowed them to save over $683 million at the pharmacy counter. Generally EPIC seniors in New York on average purchase 36 prescriptions costing about $1,678, but saved $1,207. Without this program many seniors with limited income would be unable to cover the high cost of prescriptions often needed to improve or maintain their health.

Mr. Chairman, I am proud that New York has taken this step. I applaud other states that have taken similar steps. I wish all of them had done this but efforts on the state level does not preclude the Federal Government from being a good partner and from doing our share. I want to endorse your commitment to solving this problem and doing it in a cost effective way that does not undermine the obligation of many private sector employees that already are paying directly or indirectly for prescription privileges. I look forward to this hearing and discussing the different ways that we can combat this complex problem today. I yield back.

Mr. BILIRAKIS. I thank the gentleman for yielding back. Mr. Waxman.

Mr. WAXMAN. Thank you, Mr. Chairman, I am pleased to participate in this hearing on one of our country's most critical problems, the hardship senior citizens face in obtaining prescription drugs. Given the state of modern medicine, every senior citizen should have prescription drug coverage. In my view, the most effective and fairest way to do this is through the Medicare program providing

drug coverage for all beneficiaries. Far too many seniors lack this coverage and are unable to afford the drugs they need.

Now, I don't think that is a partisan statement because I think that Medicare ought to cover prescription drugs and I am astounded to hear the reaction by our Republican colleagues who say you are a partisan if you think Medicare ought to cover prescription drugs. You are partisan if President Clinton just proposed a solution to this problem by saying that in Medicare, not only would doctors and hospitals be covered but so would prescription drugs be covered. Just as anybody would think that when you are buying a health insurance package today, that health insurance package ought to cover needed medical services, including prescription drugs. And when I hear some of our colleagues talk about we don't want our government—big government passes another entitlement. That sounds like all the statements we heard when Republicans argued against ever having Medicare to start with.

Medicare has been a successful program. It has been a Godsend to these seniors in our Nation and while some people still don't like it, the American people sure do appreciate that program.

Many elderly Americans face the cruel choice between buying food for the table or buying the medicines they need. Many take only half the pills their doctors prescribe or skip medications regularly and many don't even fill the prescriptions they need because they can't afford the high cost of drugs. Each of us has met constituents who can tell us heartbreaking stories. Last year I asked my staff on the Government Reform Committee to begin an investigation of prescription drug prices and to look at what was happening to senior citizens who didn't have coverage. I think many people were shocked by what we found. Senior citizens are being victimized by pervasive price discrimination. We found that seniors paying for their own prescription drugs must pay on average over twice as much as what the drug companies charge their favorite customers. This was true not only in my district in Los Angeles but across the country from Portland, Maine, to Gainesville, Florida, and even Milwaukee, Wisconsin, to Houston, Texas.

Today over 80 districts specific drug pricing studies have been completed. These studies show that the very people who are the most vulnerable and frail, our senior citizens, are being forced to pay the most for their prescription drugs. On average our seniors are paying 100 percent more for their prescription drugs than drug companies' preferred customers. In some cases seniors even pay more. This price gouging has devastating effects on older Americans. The result can be a loss of independence, use of expensive institutional services, and in some cases irreversible decline in health.

Representative Tom Allen and 130 of our colleagues have introduced the Prescription Drug Fairness for Seniors Act, H.R. 664, to begin to address these problems. This bill would eliminate price discrimination and help lower drug prices. This bill's premise is that the worst off shouldn't have to pay the most for their drugs, and I support and commend Representative Allen and the co-sponsors for their efforts. But I hope it will do even more. Our senior citizens deserve coverage of prescription drugs under Medicare. It is time for us in Congress to take action and pass meaningful pre-

scription drug coverage, and I think we ought to stop talking about if somebody wants one solution or another they are partisan because they want to deal with the problem. Let's work together on a bipartisan basis to do something about this problem, not simply throw brick bats and say if somebody points out a problem and wants to do something about it they must be acting as partisans in doing it.

I yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman. His time has expired.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. BARBARA CUBIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WYOMING

Thank you Mr. Chairman. I think we can all agree that over the past 35 years since Medicare was created we have seen some phenomenal progress in the discovery and development of new lifesaving drugs. It stands to reason that the cost of these drug innovations will somehow get passed along to the consumer. The challenge we face today is how can seniors get access to these drugs without going bankrupt in the process.

I think the first step in this effort must be a careful study of the statistics. That is, where do we stand today, in 1999, in terms of prescription drug coverage for seniors? Our discussion here today focuses on analyzing data from 1995 and, while this is a good start, I believe that we will need to work with current data in order to move forward on any lasting prescription drug plan.

I'd also be interested in hearing about drug coverage in urban versus rural areas. In Wyoming, where we rely exclusively on fee-for-service, seniors will have less access to drug coverage than would seniors in California, for example, where there are so many Medicare HMOs.

I also think it is important to note that health insurance, be it through Medicare or private plans, is not a guarantee that we won't have out-of-pocket expenses, but rather it acts as a financial safety net in the event of catastrophic illness.

I look forward to hearing from our witnesses today and I thank you again, Mr. Chairman.

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

I am pleased that we are having this hearing to begin to address the issue of prescription drugs in Medicare. But I am perplexed by the title, "Prescription Drugs: What We Know and What We Don't Know About Seniors' Access to Coverage." The situation is quite clear. We know that Medicare does not cover outpatient prescription drugs, but these drugs are increasingly important in treating disease and injury. We also know that while some Medicare beneficiaries do have some coverage for their pharmaceutical expenses, that coverage is unstable, meager, and declining. Most beneficiaries are living off fixed incomes, and as costs continue to increase and drugs become more prevalent as treatment, the cost eats up more and more of their income. It is clear that Congress needs to act.

I, along with a number of my colleagues in the House, have introduced a bill, H.R. 1495, which would provide a meaningful prescription drug benefit in Medicare. I am concerned, however, by recent proposals which would erode the universal nature of Medicare by providing money for states to give assistance only for certain beneficiaries.

These proposals are troubling for three reasons. First, they undermine the universal nature of Medicare. The Medicare program has always been an entitlement for every senior and disabled individual who qualified. Each person is entitled to the same benefits and same protections as the others. However, proposals to turn Medicare over to the states would remove these important protections. Second. these proposals do not guarantee a real benefit. It would be up to the states whether or not to offer coverage. Third, these proposals contain none of the critical elements to protect beneficiaries. So, even for the low-income, access to affordable coverage would not be guaranteed.

Proposals to provide tax credits are equally disturbing, as more than fifty percent of seniors have no tax liability. And, tax credit proposals do nothing to make insur-

ance for prescription drugs more accessible or to reduce the prices of prescription drugs for Medicare beneficiaries.

This is simply unacceptable. I was in Congress when Medicare was signed into law in 1965. Medicare is the most successful social program in the history of this Republic. It has alleviated poverty and improved the health of our elderly and disabled. We need to continue in that tradition and ensure that Medicare provides security for all beneficiaries.

We should not accept any drug benefit that is merely an empty promise made for political gain. Any true drug benefit must provide meaningful assistance to both seniors and disabled. Medicare beneficiaries should not have to wonder whether or not a drug benefit will always be available to help them meet their health care needs.

Mr. BILIRAKIS. The Chair now calls the first panel forward. Mr. Michael Hash, Deputy Administrator, Health Care Financing Administration. Welcome, Michael. Always good to see you. Ms. Laura Dummit, Associate Director, Health Financing and Public Health Issues, Health, Education, and Human Services Division of the General Accounting Office. Welcome, Ms. Dummit. As per usual, your written statement is made a part of the record. We will set the clock to anywhere between 5 and 10 minutes. Obviously I don't want to cut you off if you are on a salient point. We will kick it off with you, Mr. Hash. Please proceed.

STATEMENT OF MICHAEL HASH, DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION; AND LAURA A. DUMMIT, ASSOCIATE DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, GENERAL ACCOUNTING OFFICE

Mr. HASH. Thank you, Mr. Chairman. Chairman Bilirakis, Congressman Brown and other distinguished members of the subcommittee, I want to thank you for inviting us to come today to talk about this critically important issue of prescription drug coverage for Medicare beneficiaries.

Currently about one-third of Medicare beneficiaries have no drug coverage whatsoever. They must pay for essential medicines out of their own pockets. They are forced to pay full retail prices because they do not get the deep discounts that are afforded to insurers and other large purchasers. The situation is worse in rural areas where nearly half of all Medicare beneficiaries have no access to drug coverage. The lack of prescription drug coverage is not just a problem for the poor. More than half of beneficiaries without any drug coverage today have incomes above 150 percent of the poverty level, the Federal poverty level. That is about $12,000 for an individual or $17,000 in income for an elderly couple.

For those who do have drug coverage, it is becoming increasingly expensive and inadequate. Beneficiaries, as we have heard this morning, are paying higher co-payments, higher deductibles and premiums. And for some, coverage is disappearing altogether as former employers drop coverage for retirees and as Medigap, the private supplemental insurance market for beneficiaries, becomes increasingly more expensive and in many cases simply not available to individual beneficiaries who have preexisting health conditions. Yet while coverage is declining, the need is growing. The majority of Medicare beneficiaries use prescription drugs every year and the majority of them use as much as $500 per person or more each year. Thirty-eight percent consume more than $1,000 in drug

expenses on an annual basis. Each year 87 percent of the 39 million Medicare beneficiaries, or about 31 million beneficiaries, fill at least one prescription.

I don't think anyone here disagrees that pharmaceuticals are essential to modern medicine today and just as essential as hospital and physician services were when Medicare was enacted in 1965. Modernizing Medicare by adding an adequate and dependable prescription drug benefit is not an option. It is an obligation. The private sector includes outpatient drug coverage as a standard benefit in almost every employer-based health insurance policy and many individual policies. This is also true of all plans in the Federal Employees Health Benefit Program. No one would design Medicare today without including coverage for prescription drugs.

The President's comprehensive Medicare reform plan provides all beneficiaries with access to a voluntary and affordable outpatient drug benefit. The President's proposal is built upon current practices in the private sector and the benefit design and the way it is administered mirrors the way in which most Americans are covered for prescription drugs. It is kept affordable through private sector competition and expressly, and I emphasize this, it expressly includes no price control authority.

The drug benefit under the President's plan is also completely voluntary. Individuals can keep other prescription drug coverage that they have if they prefer to. It includes incentives, important incentives, to provide such coverage through employment by employers to their retirees by providing an $11 billion subsidy to ensure that employer plans continue to offer drug coverage to their retirees. And importantly under the President's proposal, the drug benefit is available to all beneficiaries regardless of their income.

The hallmark of the Medicare program for the last 35 years has been since its inception its broad social insurance role. Every one regardless of income is entitled to the same basic package of benefits. This has been, I believe, a very significant factor in the outstanding and overwhelming support for the Medicare program from the American public and it should be preserved.

All workers pay taxes to support the Medicare program and therefore all beneficiaries should have access to any new drug benefit. A universal benefit also helps to ensure a representative risk pool and lessens the potential for adverse selection. For those who choose a benefit under the President's plan, the Medicare program will pay half of the premium and 50 percent of the cost of prescription drugs up to a $5,000 a year limit when the benefit is fully phased in and it will include coverage for all therapeutic classes of pharmaceuticals. We expect that most beneficiaries will choose this new drug option because of its attractiveness, its affordability, and its dependability.

Because seniors and people with disabilities rely so importantly on prescription drugs, we believe that about 31 million, as I said a moment ago, 31 million Medicare beneficiaries will actually receive a benefit in the year because they will have at least one prescription drug that needs to be filled.

Chairman Bilirakis, I know you have been and are deeply interested in ensuring beneficiaries, particularly those with low incomes and high drug costs, have access to adequate drug coverage. So are

we. But access to affordable and meaningful prescription drug coverage is a growing problem for Medicare beneficiaries at all income levels. Prescription drugs are a fundamental component of modern medical treatment and all beneficiaries need coverage for this essential benefit. We have an obligation to ensure that comprehensive drug coverage is among Medicare's core benefits. We have an obligation to ensure that this coverage is available to all of them. And we have both an opportunity and the responsibility to make this essential change now as part of a comprehensive and fiscally responsible Medicare reform package as the President has proposed.

Mr. Chairman, I look forward to working with you and other members of this subcommittee toward that end, and I thank you again for holding this hearing and am happy to respond to your questions and those of other members of the subcommittee.

[The prepared statement of Michael Hash follows:]

PREPARED STATEMENT OF MICHAEL HASH, DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Chairman Bilirakis, Congressman Brown, distinguished Subcommittee members, thank you for inviting us to discuss prescription drug coverage for Medicare beneficiaries. In his comprehensive Medicare reform plan, the President has recognized the overwhelming need to ensure that all beneficiaries have access to a voluntary, affordable, and accessible prescription drug benefit. I believe all experts, and the public, agree that pharmaceuticals are as essential to modern medicine today as hospital care was when Medicare was created. Modernizing Medicare by adding a meaningful drug benefit is not an option—it is an obligation.

Currently, about one third of beneficiaries have no drug coverage. They not only must pay for essential medicines out of their own pockets, but they also are forced to pay full retail prices because they do not get deep discounts offered to insurers and other large purchasers. Far too many must choose between buying groceries or filling prescriptions. But the lack of prescription drug coverage is not just a problem for the poor. More than half of beneficiaries without drug coverage have incomes above 150 percent of the federal poverty level (above $17,000 for an elderly couple).

For those who do have drug coverage, it is growing increasingly expensive and inadequate, and eroding with higher copayments, deductibles and premiums, or disappearing completely as former employers drop coverage for retirees and Medigap coverage becomes scarce.

The President's comprehensive Medicare reform plan provides all beneficiaries with access to a voluntary and affordable, meaningful outpatient prescription drug benefit. The President's proposal is built upon current practices in the private sector.

It is kept affordable through private sector competition and expressly does not include government price controls. Making it an optional Medicare benefit for all beneficiaries helps ensure an insurance product with a healthier risk pool and less adverse selection, which also is essential for maintaining affordability.

The drug benefit under the President's plan also is completely voluntary, so individuals can keep other prescription drug coverage if they prefer. And it includes incentives for employers to continue providing such coverage to their retirees.

Importance of Prescription Drugs

Prescription drugs can prevent, treat, and cure more diseases than ever before, both prolonging and improving the quality of life. They can minimize hospital and nursing home stays. And in some cases they can help decrease the total cost of care.

The private sector, recognizing that prescription drugs are essential to modern medicine, now includes outpatient drug coverage as a standard benefit in almost all coverage policies. This is also true of all plans in the Federal Employees Health Benefits Program. No one would design Medicare today without including coverage for prescription drugs.

Prescription drugs are particularly important for seniors and disabled Americans, who often take several drugs to treat multiple conditions. All across the country there are Medicare beneficiaries suffering physical and financial harm because of the lack of coverage.

For example, there is the case of a 70-year-old Durham, North Carolina widow with emphysema, high blood pressure, and arthritis whose monthly bills for Prilosec, Norvase, two inhalers, and nitroglycerin patches forced her daughter to take out a second mortgage on her home.

There is the case of an 80-year-old Sauk Rapids, Minnesota breast cancer survivor who pays $384 every three months for a Medigap policy that does not cover the $89 she must spend each month for tamoxifen, $139 for Prilosec to control acid reflux, $43 for eye drops to treat glaucoma, and $20 for drugs to control high blood pressure.

And there is the case of a New York City man who stopped taking the Lisinopril that controlled his hypertension because he could not afford its $30 monthly cost, and then suffered a stroke that left him without speech or the use of his right arm, and left Medicare with a $10,000 hospital bill.

Current Coverage

Data on prescription drug coverage and spending are gathered each year in the Medicare Current Beneficiary Survey. These data from 1995, analyzed for the Department of Health and Human Services by the Actuarial Research Corporation and projected forward to 2000, show several disturbing trends in Medicare beneficiary drug coverage.

The majority of Medicare beneficiaries (56 percent) use prescription drugs costing $500 or more each year, with 38 percent requiring drugs costing $1000 or more. Each year 87 percent of Medicare beneficiaries need to fill at least one prescription.

One in three Medicare beneficiaries (34 percent) overall has no prescription drug coverage. About half of these beneficiaries have incomes above 150 percent of poverty, showing that this is not just a low-income problem. These beneficiaries are forced to pay excessively high costs because they do not get the deep discounts offered only to insurers and other large purchasers.

The situation is worse in rural areas, where nearly half of all Medicare beneficiaries have no drug coverage. They have less access to employer-based retiree health insurance because of the job structure in rural areas. And three-quarters of rural beneficiaries do not have access to Medicare+Choice plans and the drug coverage they provide.

Only one in four Medicare beneficiaries (24 percent) has private sector coverage provided by former employers to retirees. This coverage, however, is eroding. The number of firms offering retiree health coverage dropped by 25 percent from 1994 to 1998, from 40 percent in 1994 to 30 percent in 1998, according to the employee benefits research firm Foster-Higgins. The true impact of this trend has not yet been felt; as current workers retire, the population of Medicare beneficiaries with retiree coverage will drop even more.

About one in six Medicare beneficiaries (17 percent) has drug coverage from a Medicare+Choice plan, (mostly HMOs). However, nearly one third of beneficiaries live in areas where there are no Medicare+Choice offerings. And where plans do exist, they are raising premiums and copayments, and lowering caps on coverage. In 2000, nearly one third of plans will cap coverage at $500, even though the majority of Medicare beneficiaries use prescription drugs costing $500 or more each year.

About one in eight Medicare beneficiaries (12 percent) has drug coverage through Medicaid. However, eligibility for Medicaid is restricted to the poor, and the majority of beneficiaries eligible for such coverage—60 percent—are not enrolled in the program. This persists despite increasing outreach efforts to enroll those who are eligible, and may be due to the stigma associated with a program historically linked to welfare.

Less than one in ten Medicare beneficiaries (8 percent) has drug coverage from a supplemental Medigap plan. Costs for these policies are rising rapidly, by 35 percent between 1994 and 1998, according to Consumer Reports, in part because of sicker risk pools. The General Accounting Office (GAO) found that almost half of all Medigap insurers implemented substantial increases in 1996 and 1997, with AARP—one of the largest Medigap providers—increasing rates by 8.5 percent in 1997, 10.9 percent in 1998, and 9.4 percent in 1999.

The GAO also found that Medigap premiums vary widely, both within and across States. For example, premiums charged to a 65-year-old beneficiary for the standardized "I" Medigap plan range from $991 to $5,943 around the country. And the average premium for the standardized "H" Medigap plan ranges from $1,174 in Virginia to $2,577 in Georgia. Furthermore, premiums for Medigap coverage can increase with age in most States. In some parts of the country, beneficiaries over age 75 are paying more than $100 per month for drug coverage, over and above the portion of the premiums they are paying for other Medigap benefits.

President's Plan

A voluntary affordable drug benefit available to all beneficiaries is a key feature of the President's comprehensive Medicare reform plan. The President's plan also extends the life of the Medicare Trust Fund by dedicating part of the on-budget surplus to the program, improves preventive benefits, increases competition and use of private sector purchasing tools, helps the growing number of uninsured near retirement age buy into Medicare, and strengthens program management and accountability through increased flexibility and a private advisory committee.

Under the President's proposal, the drug benefit is available to all beneficiaries, regardless of their incomes. The hallmark of the Medicare program since its inception has been its social insurance role—everyone, regardless of income, is entitled to the same basic package of benefits. This is a significant factor in the unwavering support for the program from the American public and should be preserved. All workers pay taxes to support the Medicare program and therefore all beneficiaries should have access to a new drug benefit. A universal benefit also helps ensure an insurance product with an adequate risk pool and less adverse selection.

The benefit also is completely voluntary. If beneficiaries have what they think is better coverage, they can keep it. And the President's plan includes a subsidy for employers offering retiree coverage that is at least as good as the Medicare benefit to encourage them to offer and maintain that coverage. This will help to minimize disruptions in parts of the market that are working effectively, and it is a good deal for employers, beneficiaries, and the Medicare program.

Still, we expect that most beneficiaries will choose this new drug option because of its attractiveness, affordability, and stability. Because Medicare beneficiaries rely so heavily on drugs, we project that about 31 million beneficiaries will benefit from this coverage each year.

For beneficiaries who choose to participate, Medicare will pay half of the monthly premium, which is estimated to be $24 in 2002 and $44 in 2008. Medicare also will pay half the cost of each prescription they fill, with no deductible. The benefit will cover up to $2,000 of prescription drugs when coverage begins in 2002, and increase to $5,000 by 2008, with a 50 percent beneficiary coinsurance. After that, the dollar amount of the benefit cap will increase each year by the increase in the Consumer Price Index.

The prescription drug benefit for beneficiaries in the traditional Medicare program will be administered by benefit managers, such as pharmacy benefit manager firms and other eligible companies.

These entities will bid competitively for regional contracts to provide the service, and we will review those contracts to ensure that there is healthy competition. The drug benefit managers—not the government—will negotiate discounted rates with drug manufacturers, as they do now in the private sector. There will be no Medicare fee schedule or price controls.

And, importantly, the small percentage of beneficiaries whose prescription needs exceed the benefit cap will continue to receive the discounted rates negotiated by their drug benefit manager even after they surpass the cap.

The drug benefit managers will have to meet access and quality standards, such as implementing aggressive drug utilization review programs, as well as conducting beneficiary education. And their contracts with the government will include incentives to keep costs and utilization low.

In general, all therapeutic classes of drugs will be covered. Each drug benefit manager will be allowed to establish a formulary, or list of covered drugs. They will have to cover off-formulary drugs when a physician has reason to request the dispensing of a specific drug that is not on the formulary. Coverage for the handful of drugs that are now covered by Medicare will continue under current rules and will not be included as part of the new drug benefit package.

Beneficiaries enrolled in Medicare+Choice plans will receive this optional coverage through those plans, and the plans will use their existing management to negotiate prices and formularies. In addition to offering the new Medicare drug benefit, Medicare+Choice plans will be allowed to offer additional supplemental drug coverage not subsidized by Medicare, as well.

It is important to stress that Medicare+Choice plans will be explicitly paid for providing a drug benefit under the President's plan, so they would no longer have to depend on what the rate is in a given area to determine whether they can offer to do so. We will no longer see the extreme regional variation in whether Medicare+Choice plans provide drug coverage. Today, only 23 percent of rural beneficiaries with access to Medicare+Choice have access to prescription drugs, compared to 86 percent of urban beneficiaries. Under the President's plan, both rural and urban beneficiaries will have drug coverage available from all Medicare+Choice

plans in their area. And beneficiaries will not lose their drug coverage if a plan withdraws from their area or if they choose to leave a private managed care plan.

Financing will be handled through a combination of beneficiary premiums and general revenue dollars. Premiums will be collected the same way Medicare Part B premiums are collected, as a deduction from Social Security checks for most beneficiaries who choose to participate.

Beneficiaries can sign up for this benefit in the first year the benefit is offered, the first year in which a beneficiary is eligible for Medicare, the first year after retirement if a beneficiary had continued working and kept employer-sponsored coverage after becoming a Medicare beneficiary, in the first year after an employer-sponsored plan drops drug coverage for all retirees, and certain other specific circumstances that would not create potential for adverse selection.

For poor beneficiaries, State Medicaid programs will pay premiums and cost sharing as they do for other Medicare benefits. Beneficiaries with incomes between 100 and 135 percent of poverty would receive full assistance for their drug premiums and cost sharing. Beneficiaries with incomes between 135 and 150 percent of poverty would pay a partial, sliding-scale premium based on their income. The Medicaid costs for both of these groups would be matched by the Federal government at 100 percent.

The drug benefit's cost to Medicare is paid for primarily through program savings resulting from increased competition and efficiency, and other provisions in the President's plan. Additional funding comes from a small portion of the budget surplus devoted to Medicare by the President.

Conclusion

Chairman Bilirakis, I know you are particularly interested in ensuring that beneficiaries with low incomes and high drug costs have drug coverage. So are we. But access to affordable and meaningful prescription drug coverage is a growing problem for Medicare beneficiaries across the income spectrum. Prescription drugs are a fundamental component of modern medical treatment, and all beneficiaries need coverage for this essential benefit.

Medicare's overwhelming success and popularity are premised on the fact that all Americans pay in their fair share and that all Americans have equal access to all the program's benefits. Given the essential nature of prescription drugs in modern medicine, we have an obligation to ensure that comprehensive drug coverage is among the program's benefits. We have an obligation to ensure that this coverage is available to all beneficiaries. And we have both the opportunity and the responsibility to make this essential change as part of a comprehensive and fiscally responsible Medicare reform package, as has been proposed by the President.

I look forward to working with you on this. I thank you for holding this hearing, and I am happy to answer your questions.

Mr. BILIRAKIS. Thank you very much, Mr. Hash. Ms. Dummit, please proceed.

STATEMENT OF LAURA A. DUMMIT

Ms. DUMMIT. Mr. Chairman and members of the subcommittee, I am pleased to be here today as you consider the prescription drug coverage options available to Medicare beneficiaries. In the ongoing discussions by this subcommittee and others on Medicare reform and modernization, one of the most significant issues to emerge has been outpatient prescription drug coverage for Medicare beneficiaries. Outpatient drug expenditures have been outpacing other components of health care spending in recent years due to a variety of factors. These include the introduction of new drug therapies and improved drugs, more individuals with third-party drug coverage, and aggressive marketing of drugs directly to consumers.

A much higher incidence of chronic conditions and the role drugs play in managing conditions among the elderly means they are particularly affected by these rising costs. Almost one-third of Medicare beneficiaries do not have outpatient drug coverage and face the cost of drugs on their own. Evidence indicates that the lack of coverage may raise access barriers. Beneficiaries with no drug cov-

erage who report their health status as poor have drug costs about 35 percent below the average costs of insured beneficiaries in poor health. Medicare beneficiaries lack coverage either because they are not eligible for employer sponsored benefits or Medicaid, they cannot or do not choose to enroll in a Medicare+Choice plan or cannot afford or do not purchase a Medigap policy with this protection.

In 1996 employer sponsored insurance and Medicare+Choice plans provided drug protection to almost 40 percent of beneficiaries and the contribution of Medicare+Choice plans has gone up since then. The trend of rising drug coverage through these sources, however, may not continue. Employer efforts to scale back their retiree health benefits and Medicare+Choice plan withdrawals may result in more beneficiaries without this valuable benefit.

Medigap policies are available to all beneficiaries in most areas during an open enrollment period. The largest barrier to obtaining drug coverage through this option, however, is probably the cost of these policies. Premiums for the three plan types with drug coverage average between $1600 and $2300 a year. Medicaid and state pharmacy assistance programs are available to help beneficiaries with lower incomes. The state assistance programs, however, are only available in 14 states with enrollment concentrated in only three.

Even for beneficiaries with a prescription drug benefit, however, the coverage may be limited and there are indications that benefits may become less generous. Preliminary evidence shows that for next year many Medicare+Choice plans are raising cost sharing, imposing premiums or tightening their formularies. Employee sponsored health plans are doing the same. As pharmaceutical spending continues to outstrip other health spending, payers will continue to try to control the price they pay for each product, to contain utilization or to shift some of the cost to beneficiaries. This changing picture of who has coverage and the breadth of that coverage is critical to the Medicare debate. Assessments of a possible Medicare drug benefit will include many factors, especially who the benefit would cover and how it would be financed. The Congress will also likely examine a number of approaches to control the costs of prescription drug coverage. I would like to briefly discuss two that may be considered.

One approach would be to model a Medicare drug benefit after the Medicaid rebate program. Drug manufacturers would be required to give rebates for outpatient drugs based on the lowest or best prices they charge other purchasers. Such an approach could substantially affect the pharmaceutical market. Given the large share of drug utilization accounted for by Medicare beneficiaries, a rebate could be substantial but it may cause manufacturers' prices to go up. Also, such an approach does not exert any control over utilization, which unchecked can contribute significantly to spending. Another approach would be to adopt formularies and cost sharing like other payers to control and channel drug utilization. These mechanisms also allow payers to concentrate purchases on selected drugs and thereby obtain significant discounts from manufacturers. Such techniques might help Medicare control its costs but they would also raise many concerns. The financial implications to drug manufacturers could be large.

Other plans or insurers make formulary and cost sharing decisions privately but for Medicare they would have to be public decisions based on sufficient, valid, and defensible information. Delegating benefit administration to a pharmacy benefit manager may also prove difficult and raises issues about informing beneficiaries and risk adjusting payments for differences in enrollee health status.

In conclusion, the challenge in addressing outpatient prescription drug coverage for Medicare beneficiaries will be in seeking a balance between its cost to the program and its value to many Medicare beneficiaries.

Mr. Chairman, I would be glad to answer any questions you or other members of the subcommittee have.

[The prepared statement of Laura A. Dummit follows:]

PREPARED STATEMENT OF LAURA A. DUMMITT, ASSOCIATE DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, GAO

Mr. Chairman and Members of the Subcommittee: I am pleased to be here today as you discuss Medicare beneficiaries' access to prescription drug coverage. Over the past several months, the Congress has focused its attention on Medicare reform issues to determine the nature and extent of changes needed to modernize the program and control its effect on the federal budget. This discussion comes at an important juncture in the program's history. The Congress passed landmark legislation in the Balanced Budget Act of 1997 (BBA) that has improved the financial underpinnings of the program, yet more work remains to ensure Medicare's continued financial viability. Budget projections show health care consuming ever larger shares of the federal dollar, threatening to crowd out funding for other valued government programs and activities. At the same time, many believe that Medicare's benefit structure should be updated to include a prescription drug benefit.

Broadening Medicare's coverage to include prescription drugs could ease the significant financial burden some Medicare beneficiaries face because of outpatient drug costs. However, a recent study suggests that such an expansion could add between 7.2 and 10 percent annually to Medicare's costs.[1] At the same time, Medicare's rolls are growing and are projected to increase rapidly with the aging of the baby boom generation. Major technological advances in medicine and biotechnology may continue to boost the importance of prescription drugs. The policy dilemma before you today is that, on the one hand, Medicare's lack of a prescription drug benefit may impede access to certain treatment advances for beneficiaries who have no access to other coverage. On the other hand, the cost implications of including a prescription drug benefit will be substantial. Additional costs could further erode the projected financial condition of the Medicare program, which, according to its trustees, is already unsustainable in its present form.

My remarks today will focus on how growth in prescription drug spending for both the general population and Medicare beneficiaries has made coverage such an important policy issue. I will also address the sources and extent of Medicare beneficiary drug coverage. I will conclude with a discussion of benefit design and implementation issues to be considered in deliberations about adding a new prescription drug benefit. My comments are based on analyses of recent data and our body of completed work on prescription drugs.

In summary, proposals to add prescription drug coverage to Medicare's benefits come during a period of rapid growth in national spending for pharmaceuticals and transformations in the prescription drug market. Coverage of drugs by health plans and insurers, advances in drug treatments, and aggressive marketing have spurred the growth in the use of pharmaceuticals. Insurers have attempted to manage the cost of the benefit through the use of formularies, pharmacy benefit managers, and generic substitutions--cost control approaches that have dramatically changed the nature of the market in which prescription drugs are purchased.

What remains unchanged since the inception of the Medicare program, however, is the absence of coverage for outpatient prescription drugs by traditional Medicare.

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

High drug use among Medicare's beneficiaries translates into a potentially daunting financial burden, particularly for the third who have no drug coverage. For those who obtain coverage through employer-sponsored plans, Medicare+Choice plans, Medigap policies, or Medicaid programs, the rise in spending can have an impact as well. As these payers attempt to control their outlays, coverage may be scaled back, priced out of the reach of the average beneficiary, or dropped altogether. Shifts in the availability of coverage, its costs, and its adequacy are likely to continue.

The implications of adding prescription drug coverage to Medicare's benefit package depend on details such as its scope and financing. Its design and implementation will also shape the effect of this benefit on beneficiaries, Medicare spending, and the pharmaceutical market. Recent experience provides at least two approaches for implementing a drug benefit. One would involve the Medicare program obtaining price discounts from manufacturers. Such an arrangement could be modeled after Medicaid's drug rebate program. While the discounts in aggregate would likely be substantial, this approach lacks the flexibility to achieve the greatest control over spending. It could not effectively influence or steer utilization because it does not include incentives that would encourage beneficiaries to make cost-conscious decisions. The second approach would draw from private sector experience in negotiating price discounts from manufacturers in exchange for shifting market share. Some plans and insurers employ pharmacy benefit managers (PBM) to manage their drug benefits, including claims processing, negotiating with manufacturers, establishing lists of drug products that are preferred because of price or efficacy, and developing beneficiary incentive approaches to control spending and use. Applying these techniques to the entire Medicare program, however, would be difficult because of its size, the need for transparency in its actions, and the imperative for equity for its beneficiaries.

RISING DRUG SPENDING ELEVATES THE IMPORTANCE OF COVERAGE AND EFFORTS TO CONTROL EXPENDITURES

Extensive research and development over the past 10 years have led to new prescription drug therapies and improvements over existing therapies that, in some instances, have replaced other health care interventions. As a result, the importance of prescription drugs as part of health care has grown, as has drug spending as a component of health care costs. To protect against these costs, Medicare beneficiaries can choose to enroll in a Medicare+Choice plan with drug coverage if one is available in their area or purchase a Medigap policy. [2] Many beneficiaries have employer-sponsored health coverage as retirees. Others may receive coverage if they are eligible for Medicaid or other public programs. The availability and breadth of such coverage are changing as the costs of expanded prescription drug use drives payers to adopt new approaches to control these expenditures or cut back on coverage. These approaches, in turn, are reshaping the drug market.

Rise in Prescription Drug Spending

Over the past 5 years, prescription drug expenditures have grown substantially, both in total and as a share of all health expenditures. Prescription drug spending grew an average of 11.1 percent per year from 1992 to 1997, compared with a 5.5 percent average annual growth rate for health expenditures overall. (See table 1.) As a result, prescription drugs account for a larger share of total health care spending—rising from 5.6 percent to 7.2 percent.

Table 1: National Expenditures on Prescription Drugs, 1992-97

Year	Prescription drug expenditures (in millions)	Annual growth in prescription drug expenditures (percent)	Annual growth in all health care expenditures (percent)
1997	$78,888	14.1	4.8
1996	$69,111	13.2	4.9
1995	$61,060	10.6	4.9
1994	$55,189	9.0	5.5
1993	$50,632	8.7	7.4
1992	$46,598	10.6	9.1

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

Table 1: National Expenditures on Prescription Drugs, 1992-97—Continued

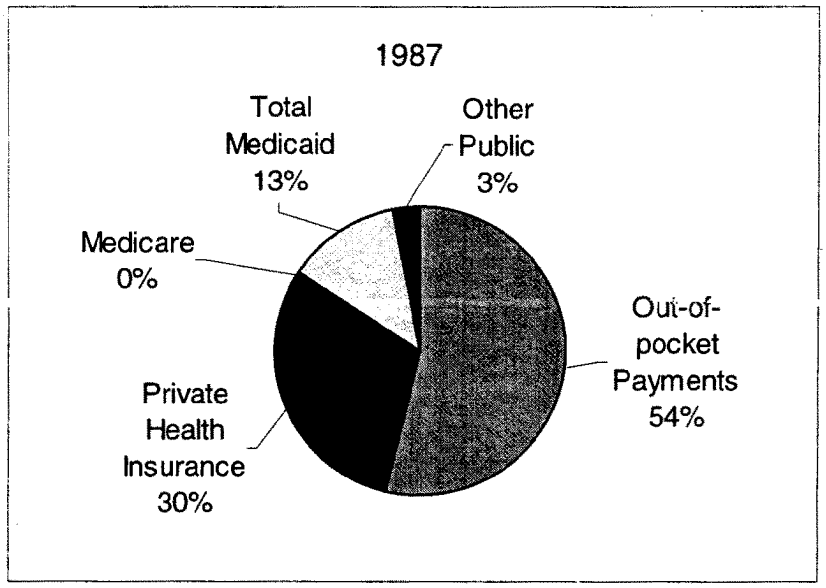
Year	Prescription drug expenditures (in millions)	Annual growth in prescription drug expenditures (percent)	Annual growth in all health care expenditures (percent)
Average annual growth between 1992 and 1997	.....	11.1	5.5

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

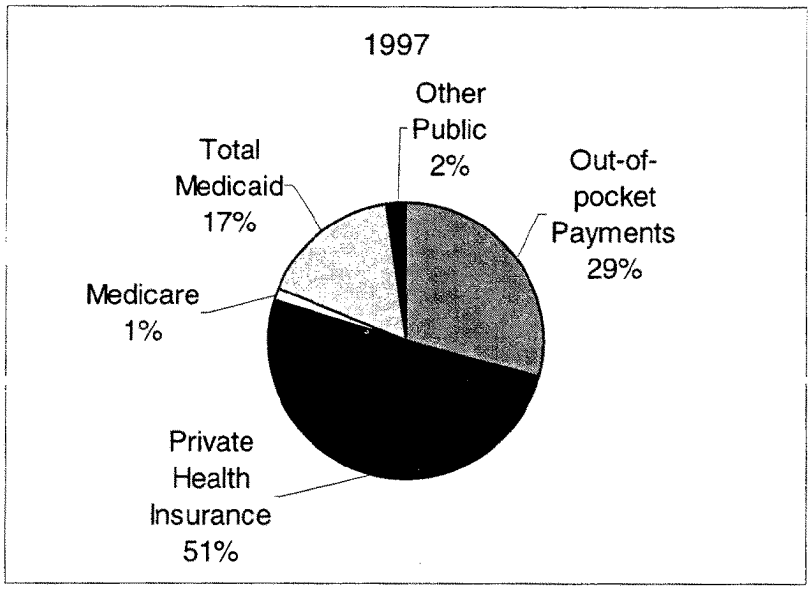
Total drug expenditures have been driven up by both higher utilization of drugs and the substitution of higher-priced new drugs for lower-priced existing drugs. Several factors have contributed to rising expenditures: more third-party payment for drugs, the introduction of new drug therapies, and more aggressive marketing by manufacturers through direct-to-consumer advertising.

Private insurance coverage for prescription drugs is likely to have contributed to the rise in spending because insured consumers are shielded from the direct costs of prescription drugs. In the decade between 1987 and 1997, the share of prescription drug expenditures paid by private health insurers rose from almost a third to more than half. (See fig. 1.) The development of new, more expensive drug therapies—including new drugs that replace old drugs and new drugs that treat disease more effectively—also contributed to the drug spending growth by driving up the volume of drugs used as well as the average price for drugs used. The average number of new drugs entering the market each year rose from 24 at the beginning of the 1990s to 33 now. Similarly, biotechnology advances and a growing knowledge of the human immune system are significantly shaping the discovery, design, and production of drugs. Advertising pitched to consumers has also likely upped their use of prescription drugs. A recent study found that the ten drugs most heavily advertised directly to consumers in 1998 accounted for about 22 percent of the total increase in drug spending between 1993 and 1998.[3] Between March 1998 and March 1999, industry spending on advertising grew 16 percent to $1.5 billion.

Figure 1: Comparison of National Outpatient Drug Expenditures, 1987 and 1997



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



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

Current Medicare Beneficiary Drug Coverage

Prescription drugs are an important component of medical care for the elderly because of the prevalence of chronic and other health conditions associated with aging. In 1995, Medicare beneficiaries had on average more than 18 prescriptions filled.[4] This varies substantially across beneficiaries, however, reflecting the range of their needs and also financial considerations such as third-party prescription drug coverage. In 1995, total average annual drug costs were $600 for elderly persons[5], compared with a little more than $140 for non-elderly persons.[6] For some, prescription drug spending was considerably higher—6 percent of Medicare beneficiaries spent $2,000 or more.[7] A recent report had projected that by 1999 an estimated 20 percent of Medicare beneficiaries would have total drug costs of $1,500 or more—a substantial sum for persons lacking some form of insurance to subsidize their purchases or for those facing coverage limits. [8]

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

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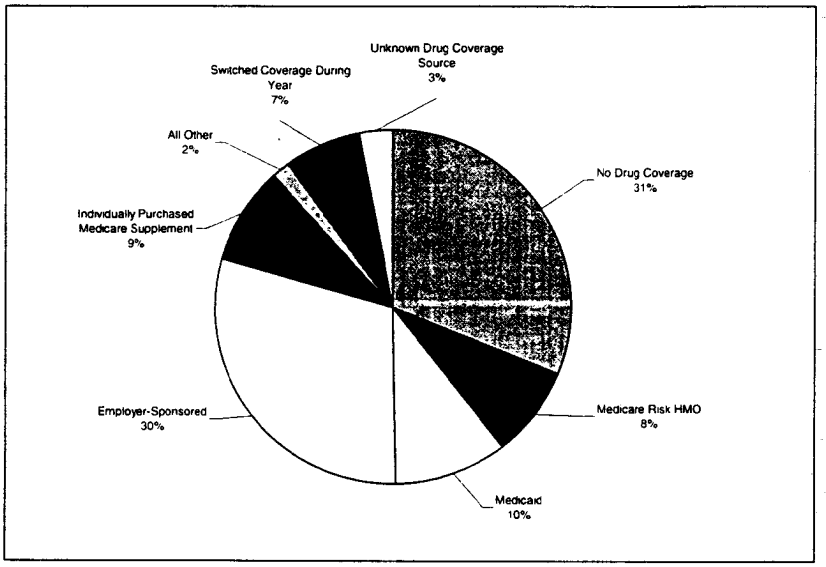
[4] Davis M. and others, "Prescription Drug Coverage, Utilization, And Spending Among Medicare Beneficiaries," *Health Affairs,* Vol. 18, No. 1 (January/February 1999); p. 237.
[5] Davis M., p. 239.
[6] Agency for Health Care Policy and Research Center for Cost and Financing Studies, National Medical Expenditure Survey data, "Trends in Personal Health Care Expenditures, Health Insurance, and Payment Sources, Community-Based Population, 1987-1995," (March 1997); p. 10. http://www.meps.ahcpr.gov/nmes/papers/trends/intnet4d.pdf (6/10/99).
[7] Poisal J.A. and others, "Prescription Drug Coverage and Spending for Medicare Beneficiaries," *Health Care Financing Review,* Vol. 20, No. 3 (Spring 1999); p. 20.
[8] Gluck M.E., p. 2.

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



Note: "All Other" includes non-risk HMOs, state-based plans, the Department of Defense, and the Department of Veteran's Affairs.
Source: HCFA, based on the 1996 Medicare Current Beneficiary Survey

Although employer-sponsored health plans provide drug coverage to the broadest segment of the Medicare population, there are signs that this could be eroding. Fewer employers are offering health benefits to retirees eligible for Medicare and those that continue are asking retirees to pay a larger share of costs. The proportion of employers offering health coverage to retirees eligible for Medicare declined from 40 percent in 1993 to 30 percent in 1998. Of the employers offering health coverage in 1998, 72 percent included prescription drug coverage. However, 90 percent of employers with 10,000 or more employees offered prescription drug coverage to their retirees in 1998.

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

Beneficiaries may purchase Medigap policies that provide drug coverage, although this tends to be expensive, involves significant cost sharing, and includes annual limits. Standard Medigap drug policies include $250 deductibles, 50 percent coinsurance requirements, and $1,250 or $3,000 annual limits. In 1999, the annual premium for one type of Medigap policy with drug coverage ranged from approximately $1,000 to $6,000. Furthermore, premiums have been increasing in recent years.

All beneficiaries who have full Medicaid benefits receive drug coverage that is subject to few limits and low cost-sharing requirements. For beneficiaries whose incomes are slightly higher than Medicaid standards, 14 states currently offer pharmacy assistance programs that provided drug coverage to approximately 750,000 beneficiaries in 1997. The three largest state programs accounted for 77 percent of all state pharmacy assistance program beneficiaries. [9] Most pharmacy assistance programs, like Medicaid, have few coverage limitations.

The burden of prescription drug costs falls most heavily on the Medicare beneficiaries who lack drug coverage or those who have substantial health care needs.

[9] These programs are operated in New Jersey, New York, and Pennsylvania.

Drug coverage is slightly less prevalent among beneficiaries with lower income. An analysis of 1995 data shows that drug coverage is slightly higher among those with poorer self-reported health status. At the same time, however, beneficiaries without drug coverage and in poor health had drug expenditures that were $400 lower than beneficiaries with drug coverage and in poor health. This might indicate access problems for this segment of the population.

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

Cost Control Approaches are Reshaping the Pharmaceutical Market

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

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

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

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

ISSUES TO CONSIDER IN BENEFIT DESIGN AND ADMINISTRATION

Policymakers considering proposals for including a prescription drug benefit in the Medicare program are facing myriad options. Assessing the merits of whether and how to implement a drug benefit will depend, in large measure, on whom the benefit covers and how it is financed. In any such assessment, five criteria should be considered. (1) Affordability: a benefit should be evaluated in terms of its effect on the sustainability of program expenditures for the long term. (2) Equity: a benefit should be fair across groups of beneficiaries and providers. (3) Adequacy: a benefit should foster cost-effective and clinically meaningful innovations, furthering Medicare's tradition of supporting technology development. (4) Feasibility: a benefit should incorporate such administrative essentials as implementation and monitoring techniques. (5) Acceptance: a benefit should account for the need to educate the beneficiary and provider communities about its costs and the realities of trade-offs required by significant policy changes.

Although the Congress will likely examine a number of alternative benefit designs and administrative options, I would like to briefly discuss two approaches that may be considered. One would be similar to how drug benefits are provided in state Medicaid programs, which rely on federal authority to lower drug prices through rebates paid by drug manufacturers to control spending. The other would be modeled after approaches adopted by private sector health plans in which PBMs are used to administer various techniques to control pharmacy benefit costs. Each approach has some advantages and disadvantages.

Medicaid Programs Rely on Discounts and Have Limited Utilization Controls As the largest government payer for prescription drugs, Medicaid drug expenditures ac-

count for about 13 percent of the domestic pharmaceutical market. Before the enactment of the Medicaid drug rebate program under the Omnibus Budget Reconciliation Act of 1990 (OBRA), state Medicaid programs paid close to retail prices for outpatient drugs. Other large purchasers, such as HMOs and hospitals, negotiated discounts with manufacturers and paid considerably less.

The rebate program required drug manufacturers to give state Medicaid programs rebates for outpatient drugs. The rebates were based on the lowest or "best" prices they charged other purchasers. In return for the rebates, state Medicaid programs must reimburse for all drugs manufactured by pharmaceutical companies that entered into rebate agreements with HCFA.[10]

After the rebate program's enactment, a number of market changes affected other purchasers of prescription drugs and the amount of the rebates that Medicaid programs received. For example, the prices many large private purchasers, such as HMOs, paid for outpatient drugs increased substantially. Moreover, the lowest prices in the market increased faster than the drugs" average prices as drug manufacturers significantly reduced the price discounts they offered private purchasers. As a result, within 2 years the rebates paid to state Medicaid programs fell to the minimum percentage required by OBRA.

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

Other Payers Employ Various Techniques to Control Expenditures

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

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

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

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

Negotiated or competitively determined prices would be superior to administered prices only if Medicare could employ some of the utilization controls that come from having a formulary and differential beneficiary cost sharing. In this manner, Medicare would be able to negotiate significantly discounted prices by promising to deliver a larger market share for a manufacturer's product. Manufacturers would have

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

no incentive to offer a deep discount if all drugs in a therapeutic class were covered on the same terms. Without a promised share of the Medicare market, these manufacturers might reap greater returns from higher prices and concentrating marketing efforts on physicians and consumers to influence prescribing patterns.

Implementing a formulary and other utilization controls could prove difficult for Medicare. Developing a formulary involves determining which drugs are therapeutically equivalent so that several from each class can be included. Plans and PBMs currently make those determinations privately—something that would not be possible for Medicare, which must have transparent policies that are determined openly. Given the stakes involved in selecting drugs, one can imagine the intensive efforts to offer input to and scrutinize the selection process.

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

CONCLUDING OBSERVATIONS

As the Congress continues its deliberations on Medicare prescription drug coverage, it will need to consider the needs of beneficiaries and the fiscal health of the program. The lack of prescription drug coverage for some Medicare beneficiaries may cause hardship. Yet, ensuring the sustainability of the Medicare program is paramount. Balancing these competing concerns may require the best from government-run programs and private sector efforts to modernize Medicare for the future.

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

GAO CONTACTS AND ACKNOWLEDGEMENTS

For future contacts regarding this testimony, please call Laura A. Dummit at (202) 512-7119 or John Hansen at (202) 512-7105. Other individuals who made key contributions include Tricia Spellman, Kathryn Linehan, and Lara Carreon.

Mr. BILIRAKIS. Thank you. Thank you very much, Ms. Dummit. CBO reports that competition causes manufacturers to offer discounts while price controls and mandatory rebates will actually halt drug discounting and can cause drug prices to increase for all purchasers. CBO refers to voluntary discounts as—I am quoting them now—an important mechanism for aiding pricing competition in the pharmaceutical market, end quotes. Comments?

Mr. HASH. Mr. Chairman, that is, I think, precisely why the President's proposal is based upon a model that involves competition in providing the beneficiaries access to prices that reflect the benefits of large group purchasing through a pharmacy benefit manager. Our actuaries estimate that the impact on prices that would be paid under the President's proposal would be some 13 percent on average below current retail prices.

Mr. BILIRAKIS. Ms. Dummit?

Ms. DUMMIT. Work we have done in looking at the Medicaid rebate program showed that indeed in response to that program manufacturer prices did go up so that the rebate offered to Medicaid programs ended up being the minimum rebate allowed under the law. That, however, is a broad-based program, the kinds of discounts that smaller programs could achieve through voluntary discounts, we don't know to the extent which they could achieve those kinds of discounts.

Mr. BILIRAKIS. So you don't necessarily disagree then with the CBO conclusion?

Ms. DUMMIT. That is correct.

Mr. BILIRAKIS. You don't agree either?

Mr. HASH. I believe that competition through a managed benefit would in fact achieve economies in the prices that would be paid for prescription drugs.

Mr. BILIRAKIS. Ms. Dummit, you touched on the state assistance programs. 14 states have those in place. But you indicated only three are really emphasizing it. What were your words in that regard?

Ms. DUMMIT. The majority of the enrollees are concentrated in three state programs. I believe these programs are in Pennsylvania New Jersey, and New York.

Mr. BILIRAKIS. Is that because those states are doing a better job in terms of getting programs to go into effect the way they intended?

Ms. DUMMIT. I don't know the reason for the disparity.

Mr. BILIRAKIS. Do you have an opinion? These are programs that are financed completely with state dollars. Do you have an opinion as to the effect enhanced Federal grants, the enhanced formulas, could have on these programs. I realize that you haven't been asked to study this and come back with an opinion. However, maybe you have formed one in your own mind. How enhanced Federal dollars may impact the existing 14 States programs and also how that could affect others coming aboard?

Ms. DUMMIT. Certainly I wouldn't venture a guess to predict what Federal funding would do to the growth of those types of programs but I would note that since the programs are relatively small in 11 of those 14 states and not existent in others, that there would be a learning curve for other states to gear up to a larger program.

Mr. BILIRAKIS. Mr. Hash, you of course are a proponent of the President's program. I would like to think, knowing you for many, many years even though it is your job, that you are open minded in terms of other ideas. Do you have any opinion regarding this assistance program concept?

Mr. HASH. Mr. Chairman, we have been looking at the proposal that you have put forward and recognize that it is a good faith effort to address this problem. I guess our concern in short would be the lack of certainty and dependability about exactly what the benefit would be. For the existing 13 States, when you look across their programs, they vary quite considerably. Some have initial deductibles in their assistance programs up to approximately $640 per person per year. So I think the lack of specificity about what the benefit would be and in fact whether states would have any obligation to take up this program is another concern that we would have.

Mr. BILIRAKIS. Of course they wouldn't have any obligation to take it up but in terms of the specificity of it all, we tried to cover that to some degree and obviously are open to other ideas.

The Chair yields to Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. Mr. Hash, you are aware I am sure of the Flo advertisements sponsored by.

The—its name is Citizens for a Better Medicare. These ads feature a senior citizen named Flo who expresses vehement opposition to the President's Medicare drug plan, declaring I don't want big government in my medicine cabinet. Flo goes on to cite several things wrong with the President's proposal. I would like to go through each of those claims and ask whether you think the President's plan does in fact do these things. It makes me wonder if Medicare 1965 would ever have become law if Flo had been around in those days.

First, Flo states the President's proposal is not a comprehensive reform that improves Medicare for all seniors. Is that statement true?

Mr. HASH. That is just not true, Mr. Brown. As I know you know, the President's proposal is a comprehensive plan, the prescription drug benefit being one part of it, but other key parts are modernizing the program, continuing to moderate the growth and expenditures and dedicating a significant portion of the surplus to extend the life of the trust fund from 2015 to 2027.

Mr. BROWN. Flo then states that the President's drug plan displaces seniors' existing coverage with a large government run plan. Is that true?

Mr. HASH. That is not true, Mr. Brown. The President's proposal explicitly recognizes the importance of employer based coverage by providing up to $11 billion in subsidy for those programs. Our actuaries and the CBO have both testified to the effect that roughly three-quarters of the employer-based coverage would remain in place and that would be what beneficiaries would elect in lieu of the Medicare program.

Mr. BROWN. Flo also claims in this very, very expensive ad that this group Citizens for a Better Medicare did the President's plan shows promising research with bureaucracy and price controls. Is that true?

Mr. HASH. No, Mr. Brown, I do not believe it is true. I believe the people who designed the ads failed to read the President's plan because it is quite clear that the approach is the approach that is existing in the private sector for the most part and, that is, competitive contracts with pharmacy benefit managers utilizing the techniques that they have used successfully across the country and offering beneficiaries particular protection in the coordination and monitoring of their drug benefits.

Mr. BROWN. Finally, Flo claims that the President's drug plan would let government bureaucrats interfere with doctor-patient relationships and decisions. Is that true?

Mr. HASH. Absolutely not. This plan is clearly one in which while pharmacy benefit managers would be able to use the techniques of formularies, they would be required to offer coverage for every therapeutic class of pharmaceuticals and they would be required to offer coverage for drugs that were found to be reasonable and necessary by their own physician. So there is absolutely no interference with the decisions that a practitioner might make with respect to medically appropriate and reasonable, necessary coverage both inside and outside of a formulary.

Mr. BROWN. Mr. Chairman, I think it is important to point out that—not that we don't really know this, but important to point out

that Flo is an actress paid for by the drug companies, paid by the drug companies. The ads are paid for by the drug companies. It kind of puts a new twist on the term Mediscare.

Thank you.

Mr. BROWN. Mr. Burr.

Mr. BURR. Thank you, Mr. Chairman. Mr. Hash, is it true under the President's plan, and I am trying to understand it better, there will be regional drug purchasing contracts?

Mr. HASH. That is correct.

Mr. BURR. How many contracts in each region?

Mr. HASH. We have not actually specified that yet, but obviously that needs to be incorporated into the legislation. But we would like to work with members and others to ascertain what that would be. Clearly we would want it to be geographical areas that are of a sufficient size that in fact the strength of the purchasing volume discounting activity would be sufficient to ensure beneficiaries got the best price possible.

Mr. BURR. Doesn't the plan call for one contract per geographical region?

Mr. HASH. It calls for competition among PBMs who could serve a particular region.

Mr. BURR. Given that you have one contract that is awarded per region, tell me where we work the word "competition" into that. That they would bid for it and then after that we would allow it to operate as a monopoly?

Mr. HASH. No, sir, the way the President's plan is designed is that there would of course, as you allude to, be competition between pharmacy benefit companies who wanted to achieve the business but in addition, once a winner had been selected, the contracts would be for approximately 2 years. They would be reopened on the basis of offerings and competition that would be specified in the contract offering. So it wouldn't be a franchise, if you will in perpetuity, but be revisited on an every 2-year basis.

Mr. BURR. It would be the first program in the Federal Government that we have ever done that where it didn't become a permanent fixture for one. Let me ask you and I am not suggesting that the President does create price controls, but if any plan created price controls, what would that do for research and development in the pharmaceutical industry?

Mr. HASH. Well, I think the real issue here, Mr. Burr, is of course ensuring that market forces are really at the root of determining the price for pharmaceuticals. That is what has been so beneficial to people with private coverage who are enjoying the benefits of discounts related to the give and take of bargaining in the marketplace. That is clearly the superior way to arrive at appropriate prices for these items.

Mr. BURR. Is that an endorsement of a private sector based plan because it works—is that what we are trying to replicate?

Mr. HASH. We are trying to replicate——

Mr. BURR. Why don't we just let them do it? Why don't we find a way to work it through them versus work it through us?

Mr. HASH. Medicare is a program that is universal in its scope and coverage to age 65. We want to be clear that the core benefit package in Medicare includes coverage for prescription drugs either

through this contract with private pharmacy benefit managers or through purchase or coverage by employer-based retiree coverage.

Mr. BURR. We are all after that objective. The President's plan calls for low income beneficiaries between 100 percent and 135 percent of poverty to be covered under this plan. Tell me what happens to the individuals who are below 100 percent but not covered by state Medicaid.

Mr. HASH. Under this program, under the President's program, all individuals under 135 percent would be covered for the premiums and cost sharing. For those under 100 percent of poverty, they would be covered through the state Medicaid program.

Mr. BURR. But there are only 11 states that currently cover above 75 percent of poverty. How does this plan address them?

Mr. HASH. This plan would in effect be the same model we have in place for the QMB program now where individuals who are up to 100 percent of poverty regardless of whether they are in the basic Medicaid program are covered for cost sharing and premiums under the Medicare program. That is how this coverage would be extended to those low income individuals.

Mr. BURR. So the individuals that are not covered——

Mr. HASH. By Medicaid.

Mr. BURR. [continuing] by Medicaid. So what do you say to the 11 states that cover them today? If I understand you are going to ask them to continue to cover it but you are going to pay for the 25 percent in the other states?

Mr. HASH. Since Medicare would be the primary payer to any Medicaid coverage, the advent of this new coverage would relieve states of that burden to the extent that they were carrying more than the premium and cost sharing associated with the Medicare benefit.

Mr. BURR. Would you consider this to be a Medicaid expansion?

Mr. HASH. I would consider it to be an important protection for low income beneficiaries.

Mr. BURR. One last question if I could, Mr. Chairman, for clarification. Mr. Waxman referred to a report—I haven't had an opportunity to see it but I will try to read it—that suggested that the differential between prices for drugs was as much as 106 percent of the ten drugs that they charted. You said if we accomplish this we would see a 13 percent drop. Where is the difference between your projections on what we can achieve in savings on drug prices and Mr. Waxman's projections that currently seniors pay 106 percent higher than the average?

Mr. HASH. The 13 percent figure I used, Mr. Burr, was from our actuary looking across the entire spectrum of pharmaceuticals and making an estimate based on putting into place the program that I have been describing here and that on average pharmaceutical prices would decline at the point of sale by an average of 13 percent. That average would obviously cover a distribution in local markets that could be much higher or could be lower, as all averages are. I believe Mr. Waxman's figures are the result of local market studies that have been conducted by the Government Reform staff and that they relate to individual market sites, but my figure relates to a national estimated average.

Mr. BURR. So those are not indicative——

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

Mr. BURR. I thank the Chair.

Mr. BILIRAKIS. Ms. Eshoo.

Ms. ESHOO. Thank you, Mr. Chairman. Good morning. Nice to see you here. Mr. Coburn provided the subcommittee with a list of pharmaceutical companies that have patient assistance programs for the poor. Can you characterize for us or elaborate on how much—what this list represents in terms of what they do in picking up the cost of prescriptions for seniors in the country? Can HCFA do that?

Mr. HASH. We would certainly be happy to. I don't have the details. I am aware that a number of pharmaceutical companies offer low income access, low income individuals access to pharmaceuticals. I don't know the details of their policies and what requirements or eligibility criteria they use, but I am aware there is some of this among pharmaceutical companies.

Ms. ESHOO. Is there any way you can do an analysis so you can get that information back to the committee? I say this with all sincerity. I mean, I think that we should know what kind of an impact—it is a long list. I think I handed it to my staff. You will get it, but I think it would be—at least to me, it would be helpful to know what this actually represents.

Mr. HASH. We would certainly be happy to inquire and ask and see what we can get. Perhaps our colleagues at the General Accounting Office also might be able to help us with such an inquiry if that would be appropriate.

Ms. ESHOO. As we look at the senior population in the country, very often it has been divided into thirds. One-third having absolutely no coverage whatsoever for prescription drugs, a third—approximately a third that have coverage as retirees from their employer health plan, and a third that have some kind of coverage through managed care. So if, say, two-thirds already have drug coverage, does it mean that the problem is really a minor one and that we just need to target that third?

Mr. HASH. By no means I think. One needs to look underneath those data to sort of look at the stability and affordability of the coverage in each of those areas. For example, regrettably, employer retiree coverage is declining. It has declined by over 25 percent in the last 4 years, and that is a trend that started well before today's discussions. It is also clear that as you look at Medigap coverage, the private supplemental plans, there are about 8 percent of the beneficiaries who actually purchased one of the supplemental policies that covers prescription drugs. The problem with that is, as was noted in the GAO testimony, the premiums for those policies are very, very high and growing rapidly and, most importantly, those are the very policies that are underwritten and are simply not available to individuals who have preexisting health conditions, the very people who need prescription drug coverage in most cases.

In the case of Medicare+Choice plans, as we noted in a report that was released a couple of weeks ago, nearly three-fifths of the Medicare+Choice plans have in fact imposed $1,000 a year or less cap on their coverage of prescription drug benefits for 2000. As many people know, there is now a cost, co-pay or co-insurance amount, for all drug coverage that is offered by Medicare+Choice

plans, so the adequacy and stability of benefits covered that way is clearly changing very dramatically. What we are looking for is a dependable, affordable, accessible prescription drug benefit that is part of the basic Medicare package.

Ms. ESHOO. How much would the plan as the President has submitted, what would his plan cost once the baby boomers come into the system?

Mr. HASH. What we have, Ms. Eshoo, on the cost is our actuaries have estimated that over the next 10 years between now and 2009, the cost of the President's program would be $118 billion over those 10 years. We don't—I don't have available estimates beyond that period of time, but that is the current available estimate.

Ms. ESHOO. Thank you.

Mr. BILIRAKIS. Mr. Deal to inquire.

Mr. DEAL. I pass right now, Mr. Chairman.

Mr. BILIRAKIS. Mr. Barrett?

Mr. BARRETT. Thank you, Mr. Chairman. I thought that Mr. Brown did a very good job talking about Flo in this commercial. I don't think she is here today. It is unfortunate. I would like to hear her and ask her some questions. I thought maybe—I think she got a new job. She is in another play or performance. I was surprised because I frankly didn't know. Maybe I am showing my naivete as to who paid for those commercials. Do you know who paid for those commercials?

Mr. HASH. It is my understanding its an organization that is financed largely by pharmaceutical companies.

Mr. BARRETT. The pharmaceutical companies themselves have financed this ad campaign?

Mr. HASH. It is my understanding.

Mr. BARRETT. Against a proposal to provide prescription drug coverage for seniors. I think it is important people understand who is paying for that campaign against providing prescription drug coverage for seniors. Why do you think they are doing that?

Mr. HASH. I am—I assume that they believe that the movement of such a plan through the Congress and enactment of such a plan would be deleterious to their interest, their business interest of one kind or another. I think it is unfortunate, of course, that they are allowing a kind of deception campaign to characterize their attack on this proposal instead of dealing with it on the merits. But as to the full scope of what their motivations may be, I am certainly not in a good position to speak on their behalf or to indicate why they may be doing this.

Mr. BARRETT. I assume you have seen the commercials?

Mr. HASH. I have.

Mr. BARRETT. Maybe you can just tell me as you watched them what got your blood pressure up the highest.

Mr. HASH. I think as Mr. Brown indicated, each of the critical message points that are included in these ads are distortions, they are misrepresentations of the facts of the proposal as put forward by the President. It is very disheartening that people, including pharmaceutical interests, do not want to engage this subject on the merits in the spirit of constructive dialog——

Mr. BARRETT. Can you be more specific. As you were watching it there must have been something where you said no way. I am

curious as someone who is obviously involved in the problem, what rankled you the most?

Mr. HASH. The most recent occasion on which my blood pressure went above acceptable norms was the most recent ad which indicates that 9 million Medicare beneficiaries will be losing the employer retiree coverage they have as a result of the President's proposal.

Mr. BARRETT. That is just patently false.

Mr. HASH. It is patently false.

Mr. BARRETT. How do you think they came up with that figure?

Mr. HASH. I cannot speak for how they came up with it, but I do know there is no basis in fact for that allegation.

Mr. BARRETT. I would like to shift gears now just for a minute. There was a discussion a little earlier about how the contracting would occur, that bids would go out. Explain to me a little bit how that segment of the program will work.

Mr. HASH. Let me just say that a lot of the very specific details would be subject to further discussion and development as legislation would be considered. So I want to be straightforward in saying that every detail about how this will work has not yet been put in place. But in general, the approach in the President's plan is to take advantage of the use of pharmacy benefit managing organizations to actually contract with the Medicare program on a competitive bid basis, giving them the responsibility for geographic administration of this benefit and, importantly, bringing to bear the techniques that PBMs are using under private coverage arrangements where they negotiate for economical prices on behalf of the lives that they are covering and, second, the way in which they monitor and track the provision of drugs, the utilization monitoring, the contraindication monitoring, all of which helps to ensure that beneficiaries are properly assisted in using pharmaceuticals appropriately and staying on their compliance regimen.

Mr. BARRETT. Let's bring it down to a lower level here. So I represent Milwaukee, Wisconsin. So you would have a number of companies that would bid?

Mr. HASH. Right.

Mr. BARRETT. What service then specifically for my mother would they provide?

Mr. HASH. They would actually be the organization that receives the claims for pharmaceutical benefits that were covered. They would process those claims and they would pay the vendor of the pharmaceutical item just as a PBM does in a private health insurance plan.

Mr. BILIRAKIS. The gentleman's time has expired. We have got a long hearing here. Forgive me.

Mr. BARRETT. I understand.

Mr. BILIRAKIS. Mr. Whitfield.

Mr. WHITFIELD. Thank you, Mr. Chairman. Mr. Hash, you have been Acting Administrator over at HCFA for how long?

Mr. HASH. Since about the first of August. I am actually still the Deputy Administrator because our Administrator has not really left. She is on maternity leave.

Mr. WHITFIELD. Many of us on this committee do not have detailed knowledge of all the ins and outs of Medicare because it is

a very complex system and you are quite knowledgeable. Looking at the President's proposal if you were going to point out strengths and weaknesses of the proposal, what would you say would be the weakest part of his proposal?

Mr. HASH. It is a good question. I actually think the President's proposal is an excellent approach to a long-standing problem in terms of access to prescription drugs and while obviously one would want to do more in the sense of the scope of its coverage and in the protection that it provides to beneficiaries. What the President I think has done is tried, in a prudent and fiscally responsible manner, to design a program in the context of a comprehensive reform plan that is affordable and prudent given the important limitations on Medicare funding.

Mr. WHITFIELD. Part B, I guess the average Medicare beneficiary pays something like $46 a month.

Mr. HASH. $45.50.

Mr. WHITFIELD. So I was 50 cents off. The President's proposal is going to establish a part C of Medicare for the prescription drug part. Now the premium on that is going to be $24 a month and goes up ultimately to $48 a month. I am assuming that people that would participate in it—I know it is voluntary so you don't have to but those who would participate, would most of them drop their Medigap coverage or at least those that maybe—there has been some testimony about some Medigap policies are particularly expensive because of the drug benefit. So would it be logical that this proposal would save senior citizens that money in that they drop that policy?

Mr. HASH. It would in the sense that the proposal is predicated on the notion that the legislation would have to provide for changes in the Federal standards that now apply to the Medigap market. As you may know, there is Federal law that actually defines each of the 10 products that can be sold to Medicare beneficiaries as supplemental insurance. Three of those include some drug benefit. Those would have to be modified to take into account the presence of this core prescription drug benefit under the President's proposal.

Mr. WHITFIELD. So the standards on Medigap would all have to be changed.

Mr. HASH. In those policies that deal with prescription drug coverage.

Mr. WHITFIELD. Refresh my memory. I haven't read it in a while. Under the President's proposal, the first few years it would pay one-half of up to $2,000 a year?

Mr. HASH. That is correct. That is the beginning. Then there is a transition over a 6-year period, I believe, up to an out of pocket limit of $2,500 or $5,000 in annual drug expenditures.

Mr. WHITFIELD. Now, how many Federal laws are there that require the drug companies provide rebates? It is my understanding they have to provide rebates to the VA, Department of Defense. What other areas are there?

Mr. HASH. I am not sure I know this as well as I should, but the two areas I know about are under what is called the Federal Supply Schedule. The Veterans Administration and certain other Federal health programs do have access to a negotiated price under

that Federal purchasing schedule and then of course there is the statutory provision in Medicaid that provides for rebates to the Medicaid program for covered pharmaceuticals.

Mr. BILIRAKIS. I know that the gentleman is trying to make a point here but we really should continue on. Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman, and following up, I think what we have talked about and I guess the next panel will talk about, we need the private sector to develop a plan and, Mr. Chairman, I don't know why the private sector couldn't develop a plan now that would address the problems. And to follow that up, the GAO in their study said that Medicare beneficiaries have an average of 18 prescriptions filled on an annual basis?

Ms. DUMMIT. Yes, sir.

Mr. GREEN. That is amazing that on a yearly basis a given senior citizen would have 18 prescriptions. No wonder we have a hearing today. I didn't realize it was that high. I was thinking half a dozen maybe.

Ms. DUMMIT. That is not necessarily 18 different drugs. It is 18 prescriptions over an entire year.

Mr. GREEN. They may limit you to 30 pills a month but you could have 12. Okay. You explained that. Mr. Hash, back years ago Congress passed a Medicare Catastrophic Coverage Act. Very few of us on this panel were here then, thank goodness, and for whatever reason, part of that act turned out to be truly catastrophic. I think some of us remember our former chairman of the Ways and Means Committee being attacked in Chicago. The industry opposed it. The prescription drug benefit was repealed and in later testimony today, there will be some comparisons between the President's drug benefit to the Medicare catastrophic benefit plan that was passed in 1988. Is the President's plan going to put us in that same box again?

Mr. HASH. I don't believe so, Mr. Green. This plan is very different from the 1988 proposal in the catastrophic legislation. This plan is voluntary. This plan has subsidized premiums, subsidized 50 percent, which is unlike the prior proposal. I think clearly it also does not have any deductible. That was another issue so that in this—under this proposal, Medicare beneficiaries would receive a benefit from the very first time in a year they needed to have a prescription filled.

Mr. GREEN. In your testimony, you talk about an 80-year-old in Minnesota who is a breast cancer survivor and pays $384 for a 3-month Medigap policy and then you list the prescriptions that this lady spends money on which comes to about $290 a month. And so on a 12-month basis, she is spending $3,482. Could you tell me under the President's plan what would she see to benefit if she decided to join that plan.

Mr. HASH. What she would see is from the very first prescription, that 50 percent of its cost would be covered by this program. No deductible. It would be covered right away and it would be covered in the first year up to a maximum of $2,000 and then under the phase-in in the President's proposal it would cover those expenditures up to $5,000 a year on a 50 percent co-pay basis.

Mr. GREEN. She would be paying $40 a month?

Mr. HASH. In the beginning it would be $24 a month and then over time by the time it was fully phased in, it would rise to $44 per month.

Mr. GREEN. She would be paying $24 per month and now she has no prescription benefit plan. I have had lots of town hall meetings. I guess since 1994, 1995, this issue comes up every time. I have seniors who bring in their prescriptions and list it in every geographic part of my district, very diverse racially and ethnically and even income and it affects particularly lower income seniors who may not be qualified for Medicaid, but I have also found that even for seniors who plan for their retirement, Social Security plus some type of retirement in savings, oftentimes one of the seniors has as much as $400 a month and that's just one of them. The fear they have told me is that if the one passes away and they lose that Social Security benefit and the one who passes away is not the one who has all the prescriptions they just can't make it. That is why it is so important.

Mr. Chairman, again thank you for having this hearing today and addressing this issue.

Mr. BILIRAKIS. Thank you, Mr. Green. Mr. Bryant.

Mr. BRYANT. Thank you, Mr. Chairman. Good morning. I have one question for each one of you, if I might begin with Ms. Dummit. Did I pronounce your name correctly?

Ms. DUMMIT. Yes.

Mr. BRYANT. Thank you. GAO's Comptroller General David Walker testified in a Senate Finance Committee hearing this past summer on this subject and he was quoted as saying a primary means of allocating limited resources is to target them on the greatest needs. With the exception of greater Federal subsidies for certain Medicare beneficiaries, the proposed coverage—that is President Clinton's proposal—is not targeted to the need. And they go on to say or he goes on to say "it would be prudent to target the benefit to those most in need and include additional safety valves to check excessive program costs growth." Can you comment today on why GAO has come to that conclusion and does your presentation here today complement or contradict that conclusion?

Ms. DUMMIT. GAO has come to that conclusion because it believes the sustainability of the Medicare program over the long term should be the paramount concern. Clearly prescription drug spending, as everyone has noted, is very expensive and those costs are expected to rise over time and that is why the Comptroller General urges caution in implementing a broad based new benefit under the Medicare program because of those costs now and into the future. That message is very complimentary to the one I present as well.

Mr. BRYANT. Thank you. Mr. Hash, I have a question for you. You are up here about as often as we are. I congratulate you for the good job that you always do.

Mr. HASH. Thank you, Mr. Bryant.

Mr. BRYANT. In this issue of private coverage, I am concerned about the effect it would have and I am reading here where both GAO and CBO has said the administration's plan has the potential of displacing employee provided retiree benefits, and then I see a Price Waterhouse Cooper study that projects 6 to 9 million Medi-

care beneficiaries with employer sponsored retirement coverage would lose their benefits because employers would have incentives to enroll their retirees in that.

Mr. BRYANT. Now, you have mentioned today that the President's plan has $11 billion. Is that over 10 years to incentivize business not to do that?

Mr. HASH. Yes, sir.

Mr. BRYANT. Again, Price Waterhouse projects that it is going to represent some $3 billion to $5 billion per year in current spending by employers, and that certainly does not sound like enough to disincentivize that. CBO estimates the cost of employer subsidy alone ought to be $19.2 billion rather than the $11 billion. Do you have any comment on that?

Mr. HASH. Well, my understanding is based on conversations with our actuary, that our estimates are that approximately 5 million of the 8 million beneficiaries who now have employment-based retiree coverage, that is about three-quarters of them would elect to stay in that coverage that they are in, and that is also, as I understand it, the position—the estimate that the CBO has made as well.

So I think at least we differ pretty substantially with the conclusion in the Price Waterhouse study which was, as I understand it, done on behalf of the pharmaceutical industry.Our independent and the CBO independent analysis has come to a very different conclusion about that.

Mr. BRYANT. I am not going to question PriceWaterhouse- Coopers' role in this. I know that they are certainly a recognized company that would feel that they are doing the right thing regardless of who sponsored their study. Does GAO have a position on this issue?

Ms. DUMMIT. No, sir, we have not independently looked at those estimates nor have made any estimates on that.

Mr. BRYANT. Again, Mr. Hash, my concern is that when you provide a government entitlement that over—if not immediately over a period of time, why pay if the government will pay it for you? Thank you.

Mr. BILIRAKIS. Mr. Strickland.

Mr. STRICKLAND. Thank you, Mr. Chairman.

Mr. Chairman, I keep going back in my own mind to this question about politics versus policy. And I have appreciated many of the thoughtful questions that panel members have posed today, but I have this gnawing fear in me that, ultimately, this decision regarding what we do with prescription drug coverage will be decided by politics. It bothers me that Flo lies, and I think this is an example of a special interest being willing to invest millions of dollars to get their way so that they can save perhaps billions of dollars. And it is cost-effective on their part, but it is wrong.

Now, I don't want to be trite, but some of us in this Congress have said that we ought to post the Ten Commandments in our schools so that are kids will know it is wrong to kill and steal and bear false witness and perhaps their behavior would be changed as a result. After hearing about Flo's lies, I guess I would encourage more members of pharmaceutical companies to post the Ten Commandments in their board rooms. Because one of those command-

ments is that thou shall not bear false witnesses, and we heard that the pharmaceutical companies are purposely bearing false witness in order to protect themselves, and that is just plain wrong.

Now, I have a question regarding a practical proposal that I think is a part of the Republican tax bill. One approach to helping seniors with prescription drug coverage is to provide tax subsidies for seniors to purchase this coverage; and the Republican bill, as I understand it, includes a provision to allow premiums for Medigap plans that offer drug coverage to count toward the medical deduction under current law.

It seems that one big drawback to this proposal is that a lot of seniors don't pay taxes, so a tax deduction wouldn't help them much. Would you care to comment on that?

Mr. HASH. That is correct. I think if you don't have a tax liability, the opportunity to deduct against that liability is meaningless; and it doesn't do anything to address the affordability of drug coverage before you get to the question of the deductibility.

Mr. STRICKLAND. The follow-up question, if I may, wouldn't such a tax cut proposal perhaps be more trouble than it is worth? How would it be administered? Would seniors be forced to turn their pharmacy receipts into the IRS to get credit? Furthermore, I think Flo may be upset because now we have the IRS in her medicine cabinet.

Mr. HASH. I think you have identified the administrative issues that would surround an expansion of the deductibility of health expenses for tax purposes. It would require that kind of documentation and recordkeeping, at least as I understand how the medical expense deduction works today. So, therefore, it would impose that burden on individuals who in fact—and it would also, as we said, have to have the tax liability against which to apply the deductions.

Mr. STRICKLAND. Thank you.

Mr. WAXMAN. Would the gentleman yield?

Mr. STRICKLAND. Yes.

Mr. WAXMAN. If you are looking at trying to target the health to people who need it the most, it strikes me that tax break would help those who need it the least. They can take a medical deduction off income, and seniors who are making—living on Social Security alone and struggling with these bills will not get any help from this Republican proposal; is that a fair statement?

Mr. HASH. To qualify for the medical expense deduction is very difficult. I think very few Americans have the percentage that allows them to qualify for a medical expense deduction. Seven percent of income has to be identified for that purpose. I think it would be out of the reach except for the most well—highest income beneficiaries.

Mr. WAXMAN. I thank the gentleman from Ohio for raising this point, because we ought to recognize who wins and who loses. The people who need the help the most are not going to win.

Mr. BILIRAKIS. Dr. Norwood.

Mr. NORWOOD. Thank you, Mr. Chairman.

Mr. Hash, did I understand you to say that the President's proposal would cost $118 billion over 10 years?

Mr. HASH. Yes, sir.

Mr. NORWOOD. Would you very carefully explain to me if you have a $100 prescription who pays what for that $100?

Mr. HASH. Under the President's plan, the beneficiary would pay $50 and the individual would pay $50. The program would pay——

Mr. NORWOOD. The taxpayer would pay $50 and the recipient of the medication would pay $50?

Mr. HASH. The 50 percent coinsurance.

Mr. NORWOOD. Is that $118 billion the 50 percent that the taxpayer would pay?

Mr. HASH. Yes, sir.

Mr. NORWOOD. I just want to tell you that my sons don't care to pay half of Ross Perot's prescription. They can't afford to do that. I want you to tell me where that $118 billion comes from. Where do we get it?

Mr. HASH. Dr. Norwood, that is why the President's proposal is put in the context of the comprehensive reform package. It is fully financed by a series of steps to modernize the Medicare program and to extend the reduction in the growth of——

Mr. NORWOOD. What are we cutting in Medicare to afford this?

Mr. HASH. As we leave the BBA period which ends 2002, the President's proposal extends in a more modest way some of the provisions of the BBA which have been important in moderating the growth in Medicare expenditures.

Mr. NORWOOD. So we are guessing that we can pay for it 5 years from now?

Mr. HASH. We are basing it on estimates of what the effect of those policies would be—what the effect of policies would be to give the program more flexibility in managing in a fee-for-service environment, things like PPOs and Centers of Excellence and other approaches to the traditional Medicare program which would also achieve savings and economy for Medicare. The combination of that with the BBA provisions that would extend out after 2002 represent a package of savings that would be financing most of the cost——

Mr. NORWOOD. So you are suggesting that this is not new spending? This doesn't threaten the trust fund? You have clever new ways to pay for this 5 years from now if your actuaries are right?

Mr. HASH. There is some portion of that $118 billion that is a portion of the surplus of the Medicare trust fund that has been identified in the actuary's estimate.

Mr. NORWOOD. Again, we are guessing. Do you believe your actuaries?

Mr. HASH. Yes, sir. I believe the Medicare actuaries time and time again have been the most conservative and accurate in their projections, and I would be happy to provide for the record evidence of what they have been able to achieve. They are an independent office.

Mr. NORWOOD. Is that why the trust fund was going bankrupt in 2000?

Mr. HASH. The trust fund was going bankrupt because the expenditures were exceeding the income from the payroll tax.

Mr. NORWOOD. Oh. So what that means is we were actually spending more than the actuaries planned, because surely they

didn't plan on us going bankrupt because otherwise they would have called you and said we have a problem here?

Mr. HASH. The expenditures have been rising more rapidly than projected.

Mr. NORWOOD. That is because people have been guessing wrong. Dr. Coburn said that the closest you have been was 800 percent off.

Mr. HASH. With all due respect to Dr. Coburn, I think I can show him some examples where we have been much closer to the mark than that.

Mr. NORWOOD. But when you are off, you are off big time, and it affects the other portions of health care. Part of this that I want to be concerned about is the bigger picture and the other values in Medicare that our senior citizens need.

I want you to know, I don't believe your actuaries. I don't think that they are right at all, and they are guessing, and they are guessing on some very dangerous grounds.

I haven't seen this ad that was referred to earlier, and I don't know for sure what all it says, but I am absolutely positive that the employers of this country will drop their prescription coverage for their employees in order to pass it on to the taxpayers. You can absolutely bet on that. That is going to happen.

Does that mean that people are going to have to turn to the taxpayer to pay it rather than in a benefit package that their employers are offering? Yes, that is exactly what it is going to mean, and that is going to grow this number. And I personally don't believe that this number is anywhere near correct. And if you go back and look in 1988 when we were talking about the catastrophic legislation and the mess that got into, the problem was that nobody could predict what the cost was, and people agreed they couldn't predict what the cost was.

This hearing is not about whether seniors should take and receive and be able to get their medication. I don't think anybody here would disagree with that. It is about how to go about doing that without ruining a Medicare system that I want to be on in just a few years.

I yield back the balance of my time.

Mr. BILIRAKIS. Mr. Waxman.

Mr. WAXMAN. Thank you, Mr. Chairman.

The issue that we are discussing is a serious one for millions of Americans who can't afford to pay for their drugs, and we have large numbers of people who don't have any coverage at all for prescription drugs because they can't afford it, because their employers didn't provide it, they are not in an HMO that covers it or their HMO is dropping that coverage.

If we do nothing, if we just paralyze ourselves and do nothing again, what is the trend? Are we going to see more employers dropping coverage because it is just too expensive anyway?

Mr. HASH. The data that I have seen, Mr. Waxman, the trend of employer-based coverage for retirees has been going down. It has declined by 25 percent in the last 4 years.

Mr. WAXMAN. We know that HMOs are starting to drop coverage for prescription drugs as well. Just as we see more and more people completely uninsured in this country because employers are not

choosing to cover it and government is not stepping up to the plate, we are going to find more and more seniors uncovered.

Let's look at the consequences. Seniors who pay for drugs and who pay the most often have the least ability to pay, and I argue that they are being charged the most by the drug companies for prescription drugs.

I mentioned earlier my staff have conducted a study that indicated that uninsured seniors have to pay higher prices for prescription drugs than if they are a favorite customer of the pharmaceutical companies, if they are in an HMO or they have the Federal Government paying for them because they are a poverty case.

I would like to ask you about this problem. In its 1998 study on prescription drug pricing, CBO found different buyers pay different prices for brand name prescription drugs; and in today's market for outpatient prescription drugs, purchasers who have no insurance coverage for drugs pay the highest prices for brand name drugs. Is that—that is the GAO's report, isn't it, Ms. Dummit?

Ms. DUMMIT. There is evidence to indicate that certainly individual buyers going to their retail pharmacies do pay higher prices than, say, managed care organizations or hospitals that can negotiate with——

Mr. WAXMAN. There is more than just evidence. We have done studies that everywhere in this country seniors who don't have any coverage end up paying twice as much, so those with bargaining power get some break on the price. But if you are a frail, elderly, 80-year-old woman and you buy your drugs, you pay twice as much. Is that what our society has come to, that we say that is reasonable, that the free market system is working effectively?

We have also looked at international prices. Americans pay more for drugs than Canadians or Mexicans or Europeans. Isn't that an accurate statement, Ms. Dummit?

Ms. DUMMIT. Yes.

Mr. WAXMAN. So in order for the same pharmaceutical company to sell their brand name drug in Canada or England and then sell it at a lower price for somebody who has prescription drug coverage in the United States, the costs are shifted to make those who can least afford it pay the most. That seems to me unconscionable. As a society, we should be protecting our seniors. Instead, the drug companies are essentially gouging them, forcing them to pay far more for drugs than other purchasers in the United States or abroad.

Maybe that is why the pharmaceutical companies are paying this actress to present herself as Flo to argue against this program to cover seniors so they can continue to gouge the seniors to make them pay the higher prices.

Now let's look at some solutions. This, obviously, makes no sense to have a tax deductibility for these costs of prescription drugs or for the coverage of prescription drugs. I don't want to pay for a tax deduction that some very wealthy people are going to take and the lowest income people are not going to benefit.

Some are suggesting that we have State-based programs. Some States already have some assistance. You have indicated that there is a great deal of disparity between what one State and another has, but hasn't our experience whenever we have a State-based

program meant that people don't want to go to another bureaucracy to get a benefit when they are on Medicare and, therefore, even though we provide help to pay for the Medicare premium through States' efforts that most people don't take advantage of it? But if it is a Federal program like Medicare, 100 percent of the seniors take advantage of it?

Mr. HASH. That is correct, Mr. Waxman. The benefit of the Medicare program is that there is a one-time enrollment. It is good for the lifetime of the individual. They have the entitlement.

The Medicaid and State programs require annual redetermination, and it creates a kind of administrative situation which is not attractive in terms of appealing to people to come in and go through elaborate application and redetermination processes. That is why we would like to build it into the basic core benefit in the Medicare package.

Mr. BILIRAKIS. Mr. Lazio to inquire.

Mr. LAZIO. Thank you, Mr. Chairman.

I read the panelists' testimony, and it is interesting to note that when it came to the CHIP program that extended health care benefits to children, that we did not have a particular problem in a bipartisan way with the concept of allowing the States the creativity to develop those programs which have been largely a success.

And I want to, if I can, just speak to some of the issues that were raised by Dr. Norwood about projections, because it is an extraordinarily important issue in terms of the solvency of the program and giving people the peace of mind so they know that their basic hospital coverage will be there.

Mr. Hash, the administration estimated the drug benefit proposal would cost about $118 billion over 10, and the savings from the fee-for-service program would save about $64 billion?

Mr. HASH. That is correct.

Mr. LAZIO. CBO estimated the cost of the program at $168 billion, about $50 billion more, and the savings from changes to traditional Medicare at about $40 billion, which is $16 billion less than your estimate. I understand that one of the reasons for the difference with CBO, which is an extraordinarily large difference of opinion in terms of overall projection of cost, is that they believe that the administration underestimates the interaction with Medicaid and that there is a resulting increase in Medicaid costs, and I am wondering if you could respond to that and Ms. Dummit could also respond to that.

Mr. HASH. Yes, sir. What I believe is the source of some of the major differences between the two estimates is, in fact, assumptions about participation rates in Medicaid as a result of the improvements in the Medicare program. Obviously, those assumptions are very sensitive in terms of the impact on the budget.

The notion is because, among seniors who are eligible for Medicaid and not enrolled, there is about a 40 percent difference there. That is to say, 40 percent of the individuals who would be eligible for Medicaid as an elderly individual are not currently enrolled in Medicaid. And the issue is, what do you assume about the numbers of them who will come in?

The second issue that I think accounts for the major differences has to do with more recent data on the cost of prescription drugs and projections to the future about the growth in those.

And with respect to the differences in estimating the President's savings package, I think, as the CBO indicated in their testimony recently in the Senate, the major difference was the CBO believed that the Congress would not allow the Medicare program to actually implement the reforms associated with more modern management through PPOs and Centers of Excellence even if they were authorized in the law, and that was the source of the major difference, the effect of those changes on savings to be realized by Medicare.

Ms. DUMMIT. Mr. Lazio, we do not do any work regarding estimates of future programs.

Mr. LAZIO. Thank you.

I want to briefly ask you about utilization, increase of spending by pharmaceuticals, which has to do with the development of more complex, more costly pharmaceuticals which is consistent with the explosion of research which has occurred in the last 10 years. So designing strategies for harnessing the costs of that are going to be extraordinarily difficult, it seems to me.

Now, if you have folks that are not now or that would not otherwise be in this program that are seniors but are private pay, it seems to me that they could very well be a victim of some fairly significant cost shifting, and I am just positing the premise that we have to be very mindful of the fact that, while we are trying to serve a segment of the population, one-third of seniors right now that have no coverage, the last thing that we want to do is exacerbate the cost problem for seniors that are private pay, either through an increase of premiums, HMO or other insurance, or purely fee-for-service private pay.

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

Mr. Deal.

Mr. DEAL. Thank you, Mr. Chairman.

Mr. Hash, in your statistics when you talk about the cost to the average person for pharmaceuticals, for example 56 percent have drug cost of $500 or more every year, that is the total cost of drugs, that is not counting any offset for insurance premiums or anything, is it correct?

Mr. HASH. It is the total cost.

Mr. DEAL. The current Part B, as I understand, since it is voluntary, the participation rate of eligible people is somewhere around 97, 98 percent, is that right?

Mr. HASH. I believe that is right.

Mr. DEAL. What is your participation rate under Part C?

Mr. HASH. Because of the premium amount, the actuaries estimate that the participation rate would be very high, in the 90—well above 95 percent participation.

Mr. DEAL. Let me use some of your figures and see if you can explain to me why someone would want to participate in it. Let's take the $24 per month premium that you are talking about, and my figures show that is $288 a year in premiums. Let's take that cutoff of $1,000 per year of pharmaceutical cost. An individual that

has $1,000 of pharmaceutical cost—and that is less than half of the people in this country? Only 38 percent?

Mr. HASH. Thirty-eight percent have more than $1,000 a year.

Mr. DEAL. And you would agree that less than half have $1,000?

Mr. HASH. Yes, sir.

Mr. DEAL. Let's use that figure, $1,000. I am going to have to pay $500 of that thousand dollars as my part of co-pay, is that correct?

Mr. HASH. Yes, sir.

Mr. DEAL. And the government would pay the other $500. So if I am paying $288 in premium and $500 out of pocket, I have paid $788. The ratio of the Part C premium is based on the same 25/75 ratio; is that correct.

Mr. HASH. No, it is 50/50.

Mr. DEAL. So then the government then is paying——

Mr. HASH. They are paying $24, and the beneficiary is paying $24 a month.

Mr. DEAL. So the government then is paying another $288?

Mr. HASH. That is correct.

Mr. DEAL. On top of the $500. We come out significantly more than $1,000 in total cost. Why if that is the average or more than the average, why would anyone want to participate in a program that is costing more than what they are getting?

Mr. HASH. I think there is for the individual who has no coverage and who would be covered under this program, they would receive a benefit. Because instead of paying $1,000 out of their own income, they would actually pay less than that in order to get this coverage. I think that is the reason why it would be attractive.

Mr. DEAL. But it would seem to me since 44 percent of the people in this country have less than a $500 prescription bill for the whole year, they would be paying about $414 to get $125 worth of benefit? I don't see how your auditors say that people will participate in a program in that regard.

Mr. HASH. The thing to keep in mind is that this is an insurance program, and an insurance program by definition is one in which you create a pool of money where you spread the risk as far as possible in the anticipation of the unexpected event, such as a large medical expense and having the protection there for you. It doesn't mean that each and every dollar one pays in premium one gets returned to them in benefit.

Mr. DEAL. In reality, isn't there another dynamic here and that is increased utilization? Isn't that one of those unexpected but certainly not unanticipated things that will happen? The average cost of pharmaceuticals will no longer be less than half having $1,000 a year, but it will be substantially more than that?

Mr. HASH. Yes, sir. I think it could be.

When we look at surveys that show how much was actually spent by beneficiaries for pharmaceuticals, that is how much they spent. That is not how much they needed.

You have lots of evidence that says that people are foregoing prescriptions that they otherwise would want to fill but don't have the money to fill. So when we say that less than half have $500 or less, that is how much they could afford. If they had coverage and their medical needs were appropriately met, presumably in many cases they would be getting more.

Mr. DEAL. Have your projections of cost been based on the actual amount or that escalated anticipated further use?

Mr. HASH. The $118 billion is based on the actuary's assessment of use and cost over time of prescription drugs.

Mr. BROWN. I enjoyed the exchange. I think each of you neglected to point out that the way that prescription drugs are purchased that there will be additional cost savings for the beneficiaries.

Mr. HASH. That is correct. On average, 13 percent.

Mr. BURR. I would ask unanimous consent for two additional questions for myself.

Mr. BILIRAKIS. We are running into problems here, but I certainly will not object. Brief questions and brief answers.

Mr. BURR. Mr. Hash, you referred to this as an insurance proposal. Tell me, in year 2002 when a beneficiary reaches a cost for pharmaceuticals of $2,000, who pays for the cost of the pharmaceuticals above that $2,000 threshold?

Mr. DEAL. The individual is responsible, but, fortunately, they can continue enjoying the discounted prices through their PBM.

Mr. BURR. So a hundred percent is assumed by the beneficiary?

Mr. HASH. That is correct.

Mr. BURR. Clearly this is the first insurance policy where we have seen where a catastrophic situation is borne by the patient.

You also referred to the PriceWaterhouse report. I have had an opportunity while everybody was asking questions to go back to it, and let me suggest that PriceWaterhouse's conclusion is based upon the employers that choose to no longer provide coverage to their retirees. And I want to ask you about one specific area of the President's plan and that is the period that you have to opt in or opt out. Why, in fact, do you have a limited time where, in fact, employees may look at this new Medicare Part D not knowing what their employers will do in the future and opt in because of a fear that their employers might drop it in the future or have to make a decision during that period? What effect do you think that has on it?

Mr. HASH. The reason that we have an initial open enrollment into the Part D that is proposed here is to make sure that we manage the selection issue as effectively as possible because if, as with the usual example of fire insurance, you allow people to sign up for fire insurance as the fire engines are arriving at their property, it becomes an uninsurable risk. If you have people in a large pool where you are spreading that risk as broadly as possible, then it is capable of being an insured risk, and that is what this benefit needs to be.

Mr. BURR. Clearly, the American people are, for the most part, intelligent. And I think Mr. Deal has raised the best question that I hope members on both sides of this committee will look at, and that is, in quite a few of the instances, 40 some percent, 40 plus seniors will in fact pay more to participate in this plan because of the 50 percent coinsurance and the deductible than equates to their annual prescription cost today. Clearly, if they don't participate, your actuaries don't hit their numbers, do they? I think we ought to put that into the methodology that we have gone through.

I thank the gentleman for his generous time.

Mr. BILIRAKIS. We will discharge the panel. As per usual, we will probably have some written questions for you.

Mr. Hash, we look forward to seeing you on Friday.

Thank you very much.

The second panel consists of Dr. Gail Wilensky, Senior Fellow, Project HOPE; Mr. Robert Reischauer, Senior Fellow, Brookings Institution; Mr. Bob Goldberg, Senior Research Fellow; Mr. Bert Seidman on behalf of the National Council of Senior Citizens; and Mr. Bob Michel, Action Team Member, Seniors Coalition.

Welcome. Your written statements are made a part of the record. I will turn the clock on 5 minutes, but, obviously, I will not cut you off if you go over it a little bit.

Dr. Wilensky, please proceed.

STATEMENTS OF GAIL R. WILENSKY, SENIOR FELLOW, PROJECT HOPE; ROBERT D. REISCHAUER, SENIOR FELLOW, THE BROOKINGS INSTITUTION; ROBERT M. GOLDBERG, SENIOR RESEARCH FELLOW, PROGRAM ON MEDICAL SCIENCE AND SOCIETY, ETHICS AND PUBLIC POLICY CENTER; BERT SEIDMAN, ON BEHALF OF THE NATIONAL COUNCIL OF SENIOR CITIZENS; AND BOB MICHEL, ACTION TEAM MEMBER, SENIORS COALITION

Ms. WILENSKY. Thank you, Mr. Chairman and members of the subcommittee. I am pleased to be here.

As you indicated, I am Senior Fellow at Project HOPE. I am also the Chair of the Medicare Payment Advisory Commission. I am here today as an economist and health policy analyst and not in any official capacity.

I would like to make several points to you during my oral presentation.

The first is to remind you, although I know that you have heard this many times before and have spoken about it yourself, there is a continuing need to reform Medicare. A lot of the talk is financial. We have heard about the deficits that we anticipate. We have also heard that with the Balanced Budget Act producing greater savings than anticipated, it may be that we have several more years on the trust fund before it goes into bankruptcy. I would like to remind the members that this is based on razor-thin surpluses in each of the 5 years. Anything that would increase spending or reduce income could take us back to 2010.

But it is not just the financial issues that require us to reform Medicare. The fact is that there are benefit problems, inadequacies, particularly outpatient prescription drugs, catastrophic, as was mentioned during the last panel. There is concern or should be concern about inequities. There are cross-subsidies between people who live in low-cost States with conservative practice styles to people who live in high-cost States with aggressive practice styles. So there is more than ample need to reform Medicare.

The difficulty in taking on prescription drug coverage first before significant other Medicare reform has to do with adding what will clearly be significant new expenditures to a program that is already in a fiscally fragile state.

So the point for me is not whether or not prescription drug coverage and catastrophic coverage should be a part of a reform Medi-

care program. I believe both of these elements should be and will be in whatever Medicare for the 21st century for the baby boomers is produced by the Congress. But the question is, are you ready to do that now?

As I observe the discussions going on in Congress, it appears that you are not ready to take on major Medicare reform right now. There are a lot of issues that have not been resolved, very legitimate issues. What should the structure look like of a major Medicare reform package? What should the design look like? How about the cost-sharing arrangements for government payments? Whether or not income relating is appropriate? What is the appropriate age of eligibility? And, ultimately, how should Medicare for the 21st century be financed?

As you know, our history of estimating costs of new benefits is not very good. We had the experience that many of you were involved with in the catastrophic plan. There was both disputes between the administration and the CBO; and the fact is, by the time the program was repealed in 1989, it was about 2 and a half times greater in its estimated cost than when CBO first estimated the cost projection. And, of course, it was never actually implemented. We don't know what would have happened.

It is also true that exactly how to structure the benefit design is not clear. There has been some discussion about PBMs, the Pharmacy Benefit Management activities that are used in the private sector. I think they offer some promise to try to moderate spending and to have people be able to purchase at lower prices, but there are a lot of difficult questions that have not been resolved in the President's plan or other discussions. Should they be able to take financial risk? Should they be able to have discretion with regard to putting together drug classes and formularies? Will seniors be able to spend more to get outside of the formularies? How do we try to construct competition between the PBMs? Very serious issues that we will need to have thought out before such a program is actually put into place.

So it leads me to say not whether or not prescription drug coverage is an appropriate part of a reform Medicare package, but I think the answer is yes.

What can we do now? I would suggest that you think about the issues raised before. Either a program like the CHIPs program, grants to States where States can either extend their own assistance programs or come up with a new program or make use of Medicaid or to use the existing special categories, the QMBs and SLMBs that are already on the books where we have special benefits for individuals who are above the Medicare line but not well enough off to take care of some of the responsibilities under Medicare and to set up such a special program. To me, I actually think the CHIPs model is better because it might teach us more about how to design such a program.

[The prepared statement of Gail R. Wilensky follows:]

PREPARED STATEMENT OF GAIL R. WILENSKY, SENIOR FELLOW, PROJECT HOPE AND JOHN M. OLIN, SENIOR FELLOW, PROJECT HOPE

Mr. Chairman and members of the subcommittee, thank you for inviting me to appear before you. My name is Gail Wilensky. I am the John M. Olin Senior Fellow at Project HOPE, an international health education foundation and I chair the

Medicare Payment Advisory Commission. I am also a former Administrator of the Health Care Financing Administration. I am here today, however, to discuss my views on Medicare reform and prescription drug coverage based on my experiences as an economist and a health care policy analyst. I am not here in an official capacity, and my remarks should not be interpreted as representing the views of either Project HOPE or MedPAC.

The Need for Medicare Reform

As the Subcommittee has heard in many previous hearings, Medicare is a program in need of reform. Some of the motivation for reform has been financial but issues have also been raised about the benefit structure, the incentives, and the geographic cross subsidies associated with the traditional program. The focus of this hearing, outpatient prescription drug coverage, is a frequently used example of the inadequacies of the current benefit structure.

The Committee is familiar with the financial problems of Medicare. Medicare, as it is currently structured, is partially dependent on a Part A trust fund that is projected to be depleted of funds just as the pressure of the baby boomers' retirement starts to be felt. Although the April 1999 report of the Social Security Trustees moved the date of depletion from 2010 to 2015, the new estimate is extremely fragile. The additional five years of Part A solvency are based on razor-thin surpluses over several years that could easily disappear if Part A expenditures increase slightly faster than anticipated or wage tax revenue grows slightly slower than expected. In addition, the pressure on general revenues from Part B growth will continue although this is less observable since Part B is not funded by a stand-alone trust fund.

Medicare's other problems are also familiar. Traditional Medicare is modeled after the indemnity insurance plans that dominated the way health care was organized and delivered in the 1960's. The benefit package also reflects the 1960's, not covering outpatient prescription drugs or providing protection against very large medical bills.

Because of the limited nature of the benefit package, most seniors have supplemented traditional Medicare, although some have opted-out of traditional Medicare by choosing a Medicare risk plan. The use of this two-tiered insurance strategy has had important consequences for both seniors and for the Medicare program.

For seniors, supplemental coverage has meant substantial additional costs, with annual premiums varying between $1000 and $3000 or more. The supplemental plans have also meant additional costs for Medicare. By filling in the cost-sharing requirements of Medicare, the plans make seniors and the providers that care for them less sensitive to the costs of care, resulting in greater use of Medicare-covered services and thus increased Medicare costs.

There are also serious inequities associated with the current Medicare program. The amount Medicare spends on behalf of seniors varies substantially across the country, far more than can be accounted for by differences in the cost of living or differences in health status among seniors. Seniors and others pay into the program on the basis of income or wages and pay the same premium for Part B services. These large variations in spending means there are substantial cross-subsidies from people living in low medical cost states and states with conservative practice styles to people living in higher medical cost states and states with aggressive practice styles.

A Reformed Medicare Program

A reformed Medicare program should, in my opinion, include coverage for outpatient prescription drugs as well as provide protection against catastrophic expenses. How to structure new benefits so that they do not represent a costly change to the program is among the many issues that will need to be resolved. Should seniors continue to pay the average premium they now pay for Medigap or should there be a higher set of deductibles and coinsurance payments?

The benefit package is not the only issue that needs to be resolved in reforming Medicare. There are also issues of the design and structure of a reformed Medicare program, the structure and cost sharing arrangement of government payments, questions of income-relating government payments, the appropriate age of eligibility and the adequacy of the financing arrangements.

I personally support a program modeled after the Federal Employees Health Benefits Program or what is generically referred to as a premium-support program. I believe this type of structure for Medicare would produce a more financially stable and viable program. Such a program would provide better incentives for seniors to choose efficient plans and/or providers and better incentives for physicians and other health care providers to produce high-quality, low cost care. This type of pro-

gram would allow seniors to choose among competing plans, including a modernized fee-for-service Medicare program, for the plan that best suits their needs.

I also recognize that not all Members of Congress agree that a premium support model would represent an improvement over the current program. Nor does there appear to be strong support for a competing reform model.

Why Not Change the Benefit Structure Now?

Given my agreement that a reformed Medicare package would include outpatient prescription drug coverage, the question is whether that is the place to start the reform process. I think the answer is "no" on several counts, although I do think there are some changes to the benefit structure that could be introduced on an interim basis.

The most obvious reason not to proceed with the benefit changes first is that there are a series of reforms that need to occur to make Medicare viable for the 21st Century and to accommodate the retirement of the baby boomers. These include the issues raised earlier such as the design and structure of Medicare, the design and structure of government payments for services and plans, age and any other eligibility issues and a stable financing structure for Medicare. To introduce a change that would substantially increase the spending needs of a program that is already financially fragile without addressing these other issues of reform is a bad idea.

There are other reasons to proceed with some caution when it comes to introducing a new outpatient prescription drug benefit for Medicare. The difficulty of correctly estimating the cost of such a program is clearly an important other reason. Our past history in this area is not encouraging.

Many of you were involved in the passage and subsequent repeal of the Medicare Catastrophic Coverage Act. From the time the legislation was first introduced until the time it was repealed, the cost estimates of the prescription drug benefit provided by the Congressional Budget Office (CBO) increased by a factor of two and a half. This very substantial change occurred before the program was ever actually implemented.

The experience of the Catastrophic Act also makes it very clear that seniors are not only interested in the benefits they will receive but also in any additional costs that they will be expected to bear. As became apparent, many seniors then felt they would be better off without the new program and were quite vociferous in expressing that belief.

Disagreement over the cost of the new drug benefit plan recently proposed by the President has already occurred. The Administration estimated the proposed drug benefit would cost $118 billion over 10 years and that savings from changes to the fee-for-service program would save $64 billion. CBO estimated the cost of the program at $168 billion ($50 billion more), and the savings from changes to traditional Medicare at $48 billion ($16 billion less).

In addition to cost and estimating concerns, important questions remain about how best to structure the benefit. Most recent proposals have made use of pharmacy benefit managers or PBM's as a way to moderate spending without explicitly using price controls. These strategies, when used by managed care, showed some promise for a few years although more recently they have seemed less effective. But most PBM's have relied heavily on discounted fees and formularies and only recently have begun using more innovative strategies.

If Medicare is going to make use of PBM's, decisions will need to be made about whether and how much financial risk PBM's can take, the financial incentives they can use, how formularies will be defined and how best to structure competition among the PBM's. All of these issues remain outstanding.

Finally, it is important that we understand the reasons we are now experiencing rapid increases in pharmaceutical spending and the challenges these reasons present. Medical inflation or price increases for the same product represents only a small amount of the increase in spending.

Part of the increase in spending has come from increased utilization, but most of the increase has come from the substitution of newer, presumably better, more expensive pharmaceuticals for older, presumably less effective, cheaper ones. Designing strategies that allow for appropriate use of newer therapies as well as appropriate use of existing therapeutics is much more challenging than designing strategies to only moderate medical inflation.

What Can We Do Now?

Although the Congress does not appear ready to take on the broader issues of Medicare reform during this current session, there are changes that could be made on an interim basis. The most important as it relates to pharmaceutical benefit coverage would be to introduce a program that targeted coverage to low income seniors.

One way to do a targeted program would be to introduce a grant program to the states that allowed states to extend existing pharmaceutical assistance programs, expand Medicaid coverage or introduce new programs, following in the model of the Children's Health Insurance Program (CHIP). Another strategy would be to provide pharmaceutical benefit coverage to those populations who already get special treatment under Medicare, that is, the qualified Medicare beneficiaries (QMB's) and the specified low-income beneficiaries (SLMB's). With the latter strategy, all of the decisions about if and how to use PBM's would still have to be resolved.

A targeted program to the low income population in no way lessens the need for more fundamental reform of the Medicare program. It does, however, provide an important interim opportunity.

Mr. BILIRAKIS. Thank you.

Mr. Reischauer.

STATEMENT OF ROBERT D. REISCHAUER

Mr. REISCHAUER. Thank you, Mr. Chairman. And let me start by apologizing for not providing the subcommittee with my testimony in a timely fashion. To be beaten up by Gail Wilensky is probably a record that not many people——

Mr. BILIRAKIS. Yes, you are very busy people and you take the time to come here when we invite you and ask you to come, and yes, ideally if we give you more notice, fine. But, quite often, we can't do that. We do need the time to look at the testimony, but I appreciate your making that comment.

Mr. REISCHAUER. I appreciate that.

My testimony deals with three questions.

First, why have serious legislative proposals to provide Medicare participants with some form of protection against high prescription drug cost surfaced now, a decade after we repealed the Medicare catastrophic act?

Second, which of the various broad approaches to achieving this objective makes the most sense in the current context?

And, third, how should the new prescription drug benefit be structured?

In my judgment, the renewed interest that we are seeing in providing prescription drug coverage is explained by three developments, all of them quite obvious.

First, prescription drugs are becoming an ever more important and increasingly costly component of modern medical care.

Second, the mechanisms that elderly and disabled have been using to obtain such protections are becoming increasingly inadequate, and they are beginning to crumble.

Third, successful restructuring of the Medicare program for the 21st century is going to involve adopting a more adequate benefit package, one that includes coverage of prescription drugs.

Let me just say a word about the second of these developments, namely the erosion of the current system of providing some kind of coverage.

As Mike Hash indicated, there has been a substantial reduction in the fraction of employers that are providing retiree health benefits that cover drugs. This is related to the FASB 106 ruling. It is likely to continue in the future. We haven't seen the full effects of it because, for the most part, they apply to future retirees, not existing retirees; but this is going to be a growing problem.

Because of the Medicare—the Balanced Budget Act changes that you adopted in 1997 and market forces, we have seen a sharp re-

duction in the generosity of drug benefits offered by Medicare+Choice plans. Thirty-two percent of them will have caps of $500 or less in the year 2000. None of you have ever had such a chintzy drug benefit in any plan that you have been covered by. This is not insurance, it is a token form of assistance. Medigap policies which provide prescription drug coverage are very expensive, and their premiums are rising very rapidly, and it is possible that they will price themselves out of the market for many Americans. So we have a real problem here.

A lot of approaches have been put forward as ways to deal with this problem, and they cover such things as tax deductibility for prescription drug expenditures, tax credits, grants to States to support pharmacy benefit programs, stand-alone prescription drug programs offered through FEHB-type structure, mandated manufacturer discounts to retail pharmacies for drugs sold to Medicare participants who lack coverage, mandates on Medigap policies to have all of them cover prescription drugs so you don't have adverse selection problems that you now have, or encompassing prescription drugs in the basic Medicare benefit package.

While all of these approaches would offer some help to some Medicare participants, only the last of those, including prescription drugs and the basic benefit package, would be more than a partial and temporary solution to the underlying problem. And so I would urge you to not deal with stop-gap solutions but to begin in a very gradual and measured way to move down the road that inevitably we will have to follow if this problem is going to be resolved.

When you design Medicare prescription drug coverage policies, you are going to have to deal with a number of very difficult questions, questions for which there really are no right or wrong answers. Policy, budgetary, administrative and philosophical considerations will come into play when you answer them.

Let me touch on a couple of these. Should the benefit be insurance or assistance? Ideally, it should be insurance. It should protect you from large expenditures. Most people can bear some of the expenditures themselves. As we learned in the Medicare catastrophic act and as we have learned from looking at the way employers structure their health benefits, most Americans want some assistance. They want a plan that gives lots of people a little bit.

I don't think you should use that fact as an excuse to not provide real top dollar insurance coverage. Medigap policies don't provide real insurance now. Medicare+Choice policies on the whole don't provide it. The President's plan didn't provide real insurance, and that was brought out by some of the questions. What we really have to do is protect those with high expenditures.

Let me just say a word about the last of these questions, which is should it be a mandatory or voluntary program.

It probably should be mandatory, if we were designing this in the Kennedy School seminar, but the fact of the matter is that it has to be voluntary. And to get people to join a voluntary program to avoid the adverse selection problems, it will require considerable subsidization, as the President has done, and probably inducements for enrollment such as the one-time opt in that the President has provided.

My testimony goes through several other questions that I think are relevant in design, and I will be glad to answer questions on them.

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

PREPARED STATEMENT OF ROBERT D. REISCHAUER [1]

Mr. Chairman and Members of the Subcommittee, I appreciate this opportunity to discuss with you some of the issues raised by proposals to provide Medicare participants with greater protection from large out-of-pocket prescription drug expenditures. My statement addresses three questions:

- Why have serious legislative proposals to provide Medicare participants with some type of prescription drug coverage surfaced now, one decade after Congress voted overwhelmingly to repeal the modest drug protection provided by the Medicare Catastrophic Coverage Act of 1988?
- Which of the various broad approaches to providing the elderly and disabled prescription drug coverage makes the most sense in the current context? and
- How should a new prescription drug benefit be structured?

Why now?

Three considerations have stimulated renewed interest in providing prescription drug coverage to Medicare participants:

- First, with each passing year, prescription drugs are becoming an ever more important and costly component of medical care.
- Second, the mechanisms the elderly and disabled have been using to obtain protection against the high costs of outpatient prescription drugs are becoming increasingly inadequate and threaten to crumble altogether.
- Third, successful restructuring of Medicare for the 21st century will almost certainly require adoption of a more adequate benefit package—one that, at a minimum, provides some out-patient prescription drug coverage, protection against catastrophic costs, and a rational schedule of copayments.

Before World War II, few prescription drugs were available and their therapeutic contribution to health care was limited. The development of new and more powerful antibiotics and antidepressants in the late 1940s and 1950s laid the groundwork for a pharmaceutical revolution. When Medicare was enacted in 1965, this revolution had not yet come to fruition, and the role of pharmaceuticals in health care remained relatively limited. Since 1965, however, there has been an explosion of new drug therapies—more powerful drugs for bacterial infections, immunosuppressant drugs for organ transplants, antidepressants with fewer side effects, vaccines to protect against measles, mumps, rubella, diphtheria, hepatitis B and other diseases, chemotherapies to fight cancer, clot busting and blood thinning drugs, along with pharmaceutical interventions for such chronic conditions as high cholesterol, irregular heartbeats, elevated blood pressure, asthma, and arthritis. The past decades are likely to be just the overture to what lies ahead as new gene therapies and biotechnological applications move from the laboratory to the marketplace.

As the ability of drug therapies to improve health has grown, so too have the total costs of such treatments. When Medicare was enacted, pharmaceutical expenditures constituted 10.6 percent ($3.7 billion) of personal health care expenditures.[2] From the mid 1960s through the early 1980s, the contribution of drugs to the total health care bill fell fairly steadily, reaching a low of 5.3 percent ($15.0 billion) of personal health care expenditures by 1982. This ratio then began to rise. When the Medicare Catastrophic Care Act was repealed, drug expenditures amounted to 6 percent ($32.9 billion) of personal health care expenditures. In 1999, a decade later, the fraction is expected to be 9.3 percent ($100.6 billion) and it is projected to grow to 12.6 percent ($243.4 billion) by 2008. Many believe these projections are conservative.

Employer-sponsored health insurance policies, as well as privately purchased individual policies, have recognized the increasing importance of drug therapies to overall health care and have expanded coverage and reduced coinsurance for out- patient pharmaceuticals over the past several decades. About 95 percent of employer-sponsored plans now provide some drug coverage and many individual policies offer such protection as well. However, Medicare, with a few exceptions, does not cover the costs of out-patient prescription drugs. This constitutes a serious inadequacy in

[1] Senior Fellow, The Brookings Institution [(202)-797-6056, rreischauer@brook.edu]. The views expressed in this statement should not be attributed to the staff, officers, or trustees of the Brookings Institution.

[2] Heath Care Financing Administration, National Health Expenditures.

the program, one that makes no more sense than offering a health insurance policy that does not cover diagnostic imaging such as X-ray, CT, MRI, sonogram, or PET scans.

Most Medicare participants have managed to cope with the program's failure to provide broad coverage by obtaining some form of out-patient prescription drugs coverage through supplemental policies. The 12 percent of participants who are dually eligible for Medicaid have the most extensive protection and face no, or very little, out-of-pocket exposure. Of the one-third of participants who are covered by a supplemental policy provided by their former employer, roughly nine in ten receive more or less adequate drug coverage through these policies—coverage that is similar to that which they enjoyed when they were active workers.[3]

Roughly one in four of those with Medigap policies—those who purchase one of the three standard Medigap policies that offers prescription drug coverage (policy types H, I, and J) or a nonstandard (pre-1992) policy with such coverage—receive drug benefits that are rather limited and which bear a fairly stiff price. The standard H and I Medigap policies pay 50 percent of prescription drug costs above a $250 deductible up to a maximum $1,250; the J policy has a maximum benefit of $3,000. In a 1998 survey of a sample of metropolitan areas, *Consumer Reports* found that the median annual premium faced by a 65 year old for the standard Medigap I plan was $1,201 higher than that for the standard F plan—a pretty steep differential considering that the only additional benefit the I plan offers besides limited drug coverage is payment of the Part B deductible ($100). Such differentials reflect the fact that, in a voluntary system like Medigap, less healthy participants are attracted to plans that offer prescription drug coverage.

The overwhelming majority of Medicare participants who are enrolled in a Medicare+Choice plan (M+C)—some 16 percent of all participants today—are provided with some prescription drug coverage, although this protection is often quite limited. Less than 3 percent of Medicare participants get help with their drug expenses through programs operated by the Departments of Defense and Veterans Affairs or one of the drug assistance programs 14 states have established for their low-income elderly and disabled.

Though this patchwork response to Medicare's inadequate benefit package has functioned tolerably well for many participants in the past, it is inequitable and is starting to erode. There is little or no relationship between access to prescription drug coverage and the need for such insurance or the ability of participants to pay out-of-pocket for their drugs. For those lacking employer-sponsored retiree coverage or Medicaid eligibility, costs and availability can vary significantly. In some areas of the country there are no M+C plans through which a participant can obtain drug coverage. In other regions, participants must pay steep supplemental premiums to obtain M+C drug coverage. In still others, prescription drug coverage is part of the M+C plans' basic or no-cost benefit packages. Similarly, premiums for Medigap policies that provide drug coverage vary more than five fold depending on the purchaser's place of residence.

The consequences of this situation are not just financial. Those lacking coverage or having inadequate coverage are more likely to forgo filling prescriptions written by their physicians or to skimp on recommended dosages. Such behavior not only undermines the effectiveness of the medical care these patients receive but, in some cases, also result in complications that require more costly treatment later on.

While estimates suggest that about 65 percent of participants had some form of drug coverage in 1995, the figure is almost certainly lower today and likely to fall further in the future.[4] The coverage that remains is also likely to be less comprehensive and more expensive for beneficiaries. In response to rising costs and the 1992 Financial Accounting Standards Board statement (No.106) which required that the unfunded liability of retiree health plans be reported on corporate balance sheets, fewer firms will adopt retiree health benefits in the future and more of those that already offer such benefits will drop their coverage, raise the premiums they impose on retirees, or scale back the generosity of their benefits. Between 1994 and 1998, the fraction of employers offering health benefits to their Medicare-eligible retirees

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[3] For breakdown of the distribution of Medicare participants in 1995 by the type of supplemental policy they have and the drug coverage provided by these policies see, Michael E. Gluck, "A Medicare Prescription Drug Benefit," Table 2, National Academy of Social Insurance, Medicare Brief No. 1, April 1999.

[4] Margaret Davis, John Poisal, et al., "Prescription Drug Coverage, Utilization and Spending Among Medicare Beneficiaries," *Health Affairs,* January/February 1999.

fell by one-quarter.[5] The full effect of this retrenchment has yet to be felt because, for the most part, the cutbacks apply to workers who will retire in the future.

The restraints the Balanced Budget Act of 1997 (BBA97) imposed on payments to M+C plans and market pressures are causing these plans to scale back the generosity of their drug benefits. The fraction of M+C plans that provided drug coverage in their basic packages stabilized in 1998 after rising rapidly from 32 percent of all plans in 1993 to 68 percent in 1997.[6] All indications are that the fraction has now begun to fall. In addition, more plans are imposing caps on drug coverage and these caps are becoming more restrictive. In 2000, some 32 percent of plans will impose caps of $500 or less, up from 21 percent in 1999, and 82 percent of plans will set their maximum benefit at $2,000 or less. Copays will also rise—8 percent on average for generic drugs and 21 percent for brand-name pharmaceuticals. In short, while access to some drug coverage through M+C plans does not appear to be changing significantly, the generosity of the drug benefits offered by these plans is shrinking markedly and there is every reason to expect that this trend will continue.

Furthermore, after a period of fairly modest growth, Medigap premiums have begun to grow again at a rate faster than that of the incomes of the retired population. The premiums charged by the three plan types that provide limited drug coverage, which average around $2,000 a year, are already high relative to the incomes of Medicare participants who lack employer-sponsored retiree coverage. A few more years of increases along the lines of those of the past three years—increases in the 7 percent to 12 percent range—will make this source of limited drug coverage unaffordable to many.

The increasing importance of drug therapies to modern medicine and the erosion of access to affordable drug coverage are not the only reasons why there is growing interest in establishing some new mechanism to provide drug coverage for Medicare participants. Such coverage is also an essential component of the leading approach for restructuring Medicare to meet the fiscal challenges that await it in the 21st Century. Premium support—or competitive defined benefit—proposals would encourage competition both among M+C plans and between these plans and traditional fee-for-service Medicare. For such competition to function effectively, the standard benefit package that all M+C plans and the traditional Medicare offered would have to be sufficiently comprehensive so that few participants felt the need for supplemental policies. In other words, the benefit package would have to include some drug coverage. If this were not the case, dual insurance coverage, which is complex, confusing to participants and providers, inequitable, and costly, would persist. Adverse selection would continue to be a problem and the task of adjusting payments to plans for differential risk would be made more difficult.

The approaches

A large number approaches have been suggested to help Medicare participants pay for prescription drugs. These include:

- allowing Medicare participants an above-the-line deduction from taxable income for prescription drug expenditures that exceed some threshold amount,
- providing income tax credits to offset large out-of-pocket drug expenditures of Medicare participants[7]
- giving states matching or block grants so that they can establish or expand targeted drug assistance programs for low-income Medicare participants,[8]
- offering Medicare participants separate prescription drug insurance policies through a FEHBP-like structure of competing plans,

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[5] National Economic Council, Domestic Policy Council, Office of Domestic Policy, "Disturbing Truths and Dangerous Trends: The Facts About Medicare Beneficiaries and Prescription Drug Coverage," July 22, 1999. For similar estimates see, General Accounting Office, "Retiree Health Insurance: Erosion in Retiree Health Benefits Offered By Large Firms," 1998 and KPMG Peat Marwick, "Health Benefits in 1998," 1998.

[6] Health Care Financing Administration, "Medicare+Choice: Changes for the Year 2000," September 1999.

[7] One proposal would provide a $1,000 credit to individuals ($1,500 for couples) with incomes above 200 percent of poverty (250 percent of poverty for couples) for expenditures over $500 a year. See, HIAA, "Proposed HIAA Policy Position on Outpatient Prescription Drugs for Medicare Beneficiaries to be presented at the HIAA Board of Directors on September 15, 1999."

[8] Stephen B. Soumerai and Dennis Ross-Degnan, "Inadequate Prescription-Drug Coverage for Medicare Enrollees—A Call to Action," *The New England Journal of Medicine,* March 4, 1999 Volume 340, No. 9. The HIAA proposal cited in footnote 6 would also provide a block grant with no matching requirements to states to help them pay for assistance to those ineligible for the tax credits.

- establishing a stop-loss arrangement financed by government and the private sector to fully cover the pharmaceutical costs associated with chronic or devastating diseases that exceed a threshold,[9]
- mandating that manufacturers provide drugs at discounted price to retail pharmacies for sale to Medicare participants who lack prescription drug coverage,[10]
- requiring that all Medigap policies provide prescription drug coverage, and
- adding prescription drug coverage to Medicare either as part of the mandatory benefit package or as an optional benefit.[11]

While any of these approaches would reduce the burden that drug expenditures now impose on some Medicare participants and would begin to level the playing field between those who have and those who do not have prescription drug coverage, most would provide only a partial and temporary solution to the underlying problem. Moreover, most of these approaches would make the current system even more complex than it already is.

Prescription drugs are an integral and important component of modern health care and, therefore, should be incorporated into the basic Medicare health insurance package. To adopt some other approach will serve only to delay the inevitable. If stopgap measures that rely on tax expenditures or state grant programs are adopted now because they seem to be more affordable, undesirable inequities will be perpetuated and the eventual integration of drug coverage into Medicare may be made more difficult.

The structure of a prescription drug benefit

Policy makers wishing to design a workable system to assist Medicare participants with their prescription drug expenditures must address a such questions as:

- Should the benefit provide insurance or assistance?
- Should program eligibility be targeted, that is, limited to those with low incomes?
- Should subsidies be provided only to those with low incomes or to all participants?
- Should the benefit be mandatory or optional?

There are no right or wrong answers to these questions. Policy, budgetary, administrative, and philosophical considerations must come into play when answering them.

Insurance or assistance? From both the policy and budgetary perspectives, a prescription drug benefit should be designed to provide insurance protection—security against the possibility that needed pharmaceuticals will impose a financial burden that is large relative to the participant's resources. All but the poorest participants, many of whom are eligible for Medicaid, should have the financial capacity to budget for a moderate level of out-of-pocket prescription drug expenditures each year.

Political considerations, however, seem to rule out designs that benefit only the minority of participants who incur catastrophic drug expenditures. The lack of popular appeal for catastrophic drug insurance was brought home most forcefully by the fate of the Medicare Catastrophic Care Act of 1988 (MCC). That legislation set a relatively high deductible—one that would be exceeded by only 16.8 percent of participants each year.[12] When fully phased in, the benefit would have paid 80 percent of approved drug costs above the deductible. The MCC was ignominiously repealed only 17 months after enactment because both the drug and the other catastrophic protections were concentrated on a small number of beneficiaries while the financing was spread broadly across all participants, many of whom concluded that they would receive no benefits over and above those they were already receiving through their employer's retiree health plan.

Most employer-sponsored plans impose either no deductibles or relatively modest ones for drugs and, therefore, provide some assistance to a majority of participants. It seems likely that any successful drug plan for Medicare will have to follow this practice. This political reality, however, should not be used as a reason for denying true catastrophic protection to the small fraction of participants who face extraordinary drug expenses. In other words, drug benefits should not be capped as they are in most M+C plans, in the H, I, and J Medigap policies, and in the president's drug proposal. Any new drug benefit should pick up all drug expenditures above

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[9] Fred Hassan, "Free-Market Medicare Reform," *The Wall Street Journal,* page A-18, August 11, 1999.

[10] H.R. 696 and S. 731.

[11] Both the proposal of Senator Breaux and Representative Thomas and the President's plan call for Medicare to offer an optional drug benefit. See, National Bipartisan Commission on the Future of Medicare, "Building a Better Medicare for Today and Tomorrow" March 16, 1999 and National Economic Council, Domestic Policy Council, "The President's Plan to Modernize and Strengthen Medicare for the 21st Century: Detailed Description" July 2, 1999.

[12] Had the MCC not been repealed, the drug deductible would have been around $2,000 in 1999.

some high level; ideally, one catastrophic cap should apply to the out-of-pocket expenditures for all covered services. Within any fixed budget, the resources needed to provide true catastrophic protection could be obtained by reducing the level of assistance to those faced with small and modest expenditures.[13] Participants should accept a program whose assistance became more generous as the burden of drug expenditures rose.

Targeted or universal eligibility? Given the reality of limited resources and the fact that most moderate- and upper-income participants have either prescription drug coverage or access to affordable coverage, some have advocated restricting any new drug benefit to those with low incomes. This could be accomplished by providing states with grants to establish or expand state pharmacy assistance programs or by creating a new drug benefit within Medicaid that serves QMB, SLMB, and QI-1 beneficiaries. Such an approach, however, would be inconsistent with the overarching philosophy of social insurance which holds that, while financing can be income related, eligibility for social benefits should not be. There is no more logic to means-testing drug benefits than to means-testing home health, laboratory, or physicians services. Moreover, as pharmaceutical costs rise and private coverage continues to erode, the need for assistance to help pay for large drug expenditures will creep up the income distribution, eventually encompassing many middle-income retirees. For these reasons, any program to provide prescription drug coverage to the aged and disabled should be universal.

Broadly or narrowly based subsidies? Logically, subsidies in any universal prescription drug program should be restricted to those who do not have the resources to pay the full cost of this protection. The high option in the Breaux/Thomas restructuring proposal, which provided drug coverage as well as broader catastrophic protection, followed this precept. Unfortunately, it is not practical to target subsidies only to low-income beneficiaries as long as participation in a new program is voluntary. In such circumstances, those with middle and upper incomes who expect to incur high drug costs will find the program most attractive and the unsubsidized premiums will be driven up by adverse selection. A broad subsidy equal to the cost associated with adverse selection is probably the minimum needed to make a voluntary program workable.

Mandatory or optional participation? If given the choice, any rational Medicare participant should want to have some modest level of prescription drug coverage if it were available at an actuarially fair price. Judging from the similarity in the drug coverage provided by different employer-sponsored plans, it is likely that the vast majority of Medicare participants would be comfortable with the same modest drug plan, especially if those who wanted more extensive coverage were free to purchase supplemental policies. Mandating participation in such a fair plan, therefore, would not constitute a significant infringement on personal freedom. Nevertheless, as the MCC experience proved, requiring participation in a drug plan that is not heavily subsidized is politically infeasible as long as many enjoy heavily subsidized coverage through a former employer's plan and others who are healthy and lack coverage are myopic and fail to perceive their long-run interests. Making participation voluntary, however, introduces the possibility of adverse risk selection. To overcome this hazard, policymakers can either provide broad subsidies that are sufficiently generous to make the coverage attractive even to healthy, non-risk adverse individuals or they can restrict enrollment in ways that encourage participation. For example, beneficiaries could be allowed to enroll only when they become initially eligible for Medicare benefits or when their employer-sponsored supplemental plan is no longer available to them. The president's proposal, quite wisely, relies on both the carrot and the stick to ensure the broad participation that is necessary to ensure stability.

Conclusion

It will be no simple task to design and implement a workable and politically acceptable program to provide Medicare participants with adequate, affordable prescription drug coverage. Nevertheless, the need for such protection is great and will only grow in the future. Furthermore, adoption of a more up-to-date standard benefit package—one that covers prescription drugs, provides an out-of-pocket expenditure cap, and rationalizes copayments—is a necessary first step along the road to making Medicare a more efficient and effective program and allowing it to cope with the demographic and cost pressures that it will face in the 21st Century.

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[13] A system of graduated copayments could preserve the principle that a majority of participants receive some benefit while those with extraordinary expenditures are provided full protection. For example, the benefit could pay 20 percent of the first $1,500 of drug expenditures, 40 percent of the next $1,500, 50 percent of the next $1,000, 75 % of the next $2,000, and 100 percent of expenditures over $6,000.

Mr. BILIRAKIS. Thank you, Mr. Reischauer.
Mr. Goldberg.

STATEMENT OF ROBERT M. GOLDBERG

Mr. GOLDBERG. Thank you, Mr. Chairman and members of the committee.

You have my full written testimony. I am going to be brief.

I believe that Congress has breathing room to work on a full-scale reform of Medicare to incorporate the fact that pharmaceuticals are front-line therapy for most diseases and should begin to restructure and reorganize the program, I think, around the lines of what the Breaux-Thomas Commission was trying to do and in the interim take the step of dealing with the fact that many seniors, including poor seniors, need prescription drug coverage now, and I think there are several proposals in Congress that do that.

I am just going to cite some specific statistics that haven't been discussed today to put—to show you that you do have some breathing room.

There is a report that the Department of Health and Human Services published in 1997, it did a survey of seniors, that said only 2 percent didn't have access to medications when they were needed. The Census Bureau did a consumer expenditure survey that said, on average, that even seniors with the lowest income were more likely to spend more on other items than prescription drugs and Medicare. Its own beneficiaries' survey, which shows that 75 percent of all seniors spent less than $500 out of pocket a year on medications.

The immediate problem of drug costs is concentrated among the poor elderly and those with catastrophic out-of-pocket costs. About 1.2 million elderly poor don't have drug coverage. Of course, those averages often hide real hardship. A small percentage, as other people have said in this hearing, particularly those that are chronically ill, spend thousands a year on medications; and I don't have any magic bullet or formula for what to do. I think there are several proposals that—in Congress that would deal with that specific problem.

I do have one simple suggestion. I did find in my research that 53 percent of seniors with incomes below the Federal poverty level do not receive Medicaid assistance even though they are eligible for it. Ten percent of Medicare recipients also on Medicaid today don't get prescription drug coverage. You can do some tinkering and deal with a big chunk of the problem right there. I think it is a better use of the money than subsidizing corporate drug benefit plans and paying for Ross Perot or George Steinbrenner's prescription drug benefits, as some proposals would suggest.

I also think that dumping a new drug benefit on top of the existing program would make it harder in the long run for seniors to get the benefits in medical progress because I think evidence shows that stand-alone drug benefits that don't integrate the drug benefit as part of the entire health care package lead to restrictions inevitably. Any managed drug benefit with formularies and restrictions have been shown to hurt elderly more than other populations because of their specific medical needs.

And I know that there is an erosion in the private sector because of the fact that drugs are becoming the front-line therapy. I think it shows if we try to keep drug costs down through rationing and price controls and stuff instead of trying to integrate it as part of a new 21st century approach to health care, we are going to be hurting ourselves and seniors.

And while things are getting bad in the private sector they ain't getting much better in Medicare either. I have seen that Medicare is proposing in the year 2000 to pay flat rates for future cancer drugs in the outpatient setting, regardless of their actual cost or effectiveness. For example, they will pay less for Taxol and Herceptin, which is a superior treatment for breast cancer, than for an older form of therapy. And that the hospitals, as a result, will have a financial incentive to shift patients away from superior treatments and will be discouraged from using cutting-edge drugs and that drugs like Herceptin are not available under the VA's formulary and health system formulary. And I don't think that is the kind of drug benefit that I want my mother or father to get.

And that under the proposed Medicare rule that the self-administered drugs will not be eligible for payment. It is sort of like the old joke of the Catskills. The two women are sitting next to each other saying the food is terrible. Yeah, and the portions are so small.

I am afraid if we create a new large drug benefit without fully taking into account what we need to do to reform the entire system, government will go further down the road of rationing, restriction and retrograde medicine. So we need to reform Medicare so that poor elderly and those with catastrophic costs are taken care of now and physicians and patients can choose the best medicines now and in the future.

[The prepared statement of Robert M. Goldberg follows:]

PREPARED STATEMENT OF ROBERT M. GOLDBERG, SENIOR RESEARCH FELLOW, PROGRAM ON MEDICAL SCIENCE AND SOCIETY, ETHICS AND PUBLIC POLICY CENTER

Mr. Chairman, Honorable Members of the Committee, thank-you for the opportunity to testify before you today. I believe that Congress should develop a plan that allows poor seniors to obtain prescription drug coverage in the private sector and focus on reforming Medicare to reflect the fact that pharmaceuticals are the front-line therapy for most diseases. Simply dropping a large new entitlement on top of the existing Medicare program will further undermine its ability to offer seniors advances against stroke, cancer, Alzheimer's, Parkinson's, heart disease now and in the future.

There is no policy or health reason to create a government program to cover prescription drug costs for all senior citizens. Some advocates of a universal entitlement claim that half the prescriptions written go unfilled because many elderly literally choose between drugs and food. There is no scientific data to support this oft-repeated claim. However, there are many surveys that suggest most seniors do not have a problem getting the drugs they need. In a report (Access to Healthcare) published in 1997, the Department of Health and Human Services reported that only 2 percent of people 65 and over did not have access to medications when they were needed. A consumer expenditure survey conducted by the Census Bureau also found that, on average even seniors with the lowest incomes were more likely to spend more on other items than on prescription drugs. Indeed, Medicare's own beneficiary survey shows that nearly 75 percent of all seniors spend less than $500 a year out-of-pocket on medications. That includes many seniors with incomes below $10,000 a year.

There are two reasons that, on average the drug expenditures of seniors are relatively modest. First, we are aging healthier and living longer. A study on aging done by the McArthur Foundation found that we are more independent, have fewer

infirmities and have a better outlook on life than previous generations of seniors. Second, prescription drug coverage, while not first dollar, does defray at least half of the cost of drugs for over 60 percent of seniors. Many seniors, particular those with higher incomes and low drug expenditures find it is cheaper to pay for drugs and go without drug coverage. For example, for seniors with incomes of $50,000 and over, who make up nearly 20 percent of all Medicare beneficiaries, out of pocket drug costs of are only one half of one percent of their income.

The real problem of drug costs is concentrated among the poor elderly. About 1.2 million elderly poor don't have drug coverage. Seniors with incomes below $10000 a year spend, on average about $427 out of pocket a year on drugs. Of course, averages often hide real hardship. A smaller percentage, those that are chronically ill, spend thousands a year on medications.

To be honest, I don't have a specific proposal that targets, defines or cares for the truly needy. Frankly, I am struck by how many proposals there are to cover the cost of prescription drugs for seniors. The last thing you need is another suggestion dumped at your feet.

Rather, I am suggesting that Congress focus on the poor and on easing the risk and burden of catastrophic drug costs instead of subsidizing corporate drug benefit plans and wealthy retirees as some proposals now do. One simple suggestion: 53 percent of seniors with incomes below the federal poverty level do not receive Medicaid assistance. Ten percent of that are on Medicare are not for prescription drug coverage. Enrolling the unenrolled and providing drug coverage to those Medicaid recipients would be a huge step towards meeting their needs.

In response, supporters of a universal drug benefit argue that private sector coverage is eroding and that in the future the cost of new drugs will make more generous government drug coverage necessary for all regardless of the current need. Build the roof while the sun is shining is how some people put it.

But dumping a new drug benefit on top of the existing Medicare program will make it harder for seniors to get access to benefits of medical progress for two reasons. First, the way most stand-alone drug benefits control their costs usually compromise the health of seniors. A study by Susan Horn shows seniors are much more likely to go to the hospital if they are faced with restrictions on their choice of drugs. In general, all the proposals before Congress would lead prescription drug coverage into a stand-alone "managed" drug benefit that would limit the ability of doctors and patients to choose the right type of medicines. It would give government, HMO and pharmacy benefit management bureaucrats control over what drugs people can and cannot have.

Second, drug coverage is eroding in the public and private sector because both the government and insurance companies have not faced up to the fact that is it medicines, not hospitals or physicians that are the most dynamic and decisive form of health care today. Payment and reimbursement systems have not changed to reflect that new reality. Rather, payors are still trying to keep drug costs down through price controls, rationing, formularies and the like rather than fully capture the value of new medicines by reforming the way medicine is practiced. You can't say your goal is to check to see if all your doctors are giving beta-blockers on the one hand and then complain about rising drug costs on the other. You can't assert that drugs are cost-effective because they keep people out of the hospital and allow people to stay at home and at work and then limit their access to the very medicines that let them do just that. But that is the kind of schizophrenic policy these large entitlements tend to produce.

Indeed, the government's track record on this score is not very encouraging. Supporters of a universal drug benefit point to eroding private sector coverage for retirees and the fact that HMOs are raising drug co-pays and limiting drug choices. But HMO prescription drug cutbacks seem downright altruistic and patient-centered compared to those steps Medicare is taking right now to rein in drug spending.

In 2000, Medicare will pay flat rates for future cancer drugs in hospital outpatient departments regardless of their actual cost or effectiveness. Hospitals will make money on older generic cancer drugs and lose money when they treat with newer "state of the art" cancer therapies. Just as alarming is the fact that even though drugs used to treat the side effects of chemotherapy and radiation therapy are essential to prolonging life, new Medicare rules do not include payment for these supportive therapies.

An old combination of drugs used to treat breast cancer (leucovorin and 5FU) would yield a hefty profit of $3300 per patient. What is considered the superior treatment for breast cancer (Taxol and Herceptin) loses $2500. New compounds such as Rituxan or Gemzar are cancer drugs designed to turn off specific genes or molecules that cause specific cancers. Medicare will only reimburse such drugs at 2-8 percent of their cost according to a study done by the Lewin Group. Hospitals will

have a financial incentive to shift patients away from superior treatments and will be discouraged from using cutting edge drugs. In the British Health Care system, doctors can't prescribe Taxol. In our own Veterans Administration and Indian Health System, Herceptin is not on the drug formulary. Is this the kind of drug benefit we want to offer all our senior citizens?

And ladies and gentlemen, as you heard two weeks ago from Michael Hash, Medicare's administrator, the program will reportedly change current policy and deny Medicare coverage for any drug that can be self-administered—regardless of whether self-administration would be safe for affected patients. Elderly cancer patients will be forced to pay for life-saving medications under that rule. They will be forced to inject themselves at home—even if they are unable to perform this task safely and correctly, even if they are unable to watch for and attend to the adverse reactions that could seriously harm or kill them if not responded to immediately.

If Congress creates a large new drug benefit—one that the data suggests we do not need—it will force the government further down the road of rationing, restriction and retrograde medicine. We must care for the poor elderly with large out of pocket drug costs now. And we need to reform Medicare so that physicians and patients can choose the best medicines available now and in the future.

Thank you for your time and patience.

Mr. BILIRAKIS. Thank you, Mr. Goldberg.

Mr. Seidman.

STATEMENT OF BERT SEIDMAN

Mr. SEIDMAN. Thank you, Mr. Chairman and Representative brown and members of the committee, for the opportunity to speak on this important issue.

Let me just say at the outset that I am a member of the General Policy Board of the National Council of Senior Citizens and speak on its behalf, but I am also a senior.

Mr. BILIRAKIS. You are not alone, sir.

Mr. SEIDMAN. I know I am not. There are many of us, and we are increasing all the time.

I also live in a large apartment complex, a retirement community composed entirely of seniors. And I know because I see them every day how seniors depend on prescription drugs and how important it is to them in order to continue to live in any decent way at all.

The National Council of Senior Citizens is a leading advocate for a stronger Medicare program, and we have been strongly in favor of a pharmaceutical benefit in Medicare ever since its enactment.

Right off the bat, let me say that the NCSC supports the efforts of the President, Senator Kennedy, Representative Stark and others to create a universal Medicare drug benefit and to use some of the on-budget surplus for such a benefit.

At the same time, it is very important that Congress and the administration address the pharmaceutical cost issue in an effective manner because, if costs increase as they are, they could render a Medicare drug benefit absolutely too expensive.

I would like to mention four reasons why a Medicare drug benefit is more important today than ever before.

As you all know, when a patient is in the hospital, he or she is covered for pharmaceuticals. But when they get out of the hospital, they are no longer covered.

You are also familiar with the so-called quicker and sicker phenomenon. That is people are being discharged from the hospital sooner than they were, and now it goes back to 10 years ago that this began, but it is probably truer today than ever before. And that means that, in effect, seniors have lost the drug coverage that

they had, and when they get out of the hospital, if they are getting home health care, instead of being in the hospital, they are not covered for pharmaceuticals.

As has been said, private drug coverage is declining, employer managed care, Medigap, you name it. Beneficiaries are getting older, and the older they get the more dependent they are on prescription drugs, and they are paying for the most expensive prescription drugs because of the conditions that the oldest among us—and I am now among them because I have just turned 80—have.

Finally, drug prices have been increasing far faster than beneficiary income, and particularly those who are dependent on the Social Security COLA.

Mr. Chairman, in simple terms, access is largely determined by income and wealth. But, as others have said, it is not just the poor elderly who are suffering because they don't have adequate prescription drug coverage. Those who are in the middle ranks, many of them are also suffering because of that lack of coverage. And as far as people under Medicaid are concerned, the Kaiser Commission has shown that many of them are not getting the drug coverage that they are entitled to.

Meanwhile, when companies are cutting back on retiree coverage, and the talk has been in this hearing on whether employers will cut back on their retiree coverage if there is a drug plan, well, they are cutting back on their drug coverage. It is a rout. It is not just a gradual cutback. It is a rout. The drug prices are going through the ceiling. There is no end in sight for that. Therefore, it becomes important, as suggested during this hearing, that seniors should not be gouged, that they should be in a position where they are paying no more than the large purchasers of drugs.

So, finally, here are the recommendations of the NCSC to ensure adequate and affordable drug coverage for seniors:

Take steps to stop the drug price spiral. Enact this year a Medicare drug benefit and a comprehensive Medicare drug benefit with a stop loss component of not more than $3,000.

Take steps to, through tax incentives or through strong maintenance of effort provisions, to require or induce retiree health plans covering drugs to continue such benefits.

Beneficiaries should pay a premium for drug coverage, but other sources of revenue should certainly be investigated.

And we simply don't buy the idea, and others have said this, that the pharmaceutical industry needs to gouge seniors in order to carry on research.

So we urge very strongly that this committee recommend a comprehensive drug benefit this year, and we look forward to doing anything that we can to support your efforts.

Thank you, Mr. Chairman.

[The prepared statement of Bert Seidman follows:]

PREPARED STATEMENT OF BERT SEIDMAN, NATIONAL COUNCIL FOR SENIOR CITIZENS

Thank you, Mr. Chairman, and Representative Brown, for this opportunity to speak on this important issue. I am myself a senior, I live in a large apartment complex composed entirely of seniors, and my organization, the National Council of Senior Citizens, is a leading advocate for a stronger Medicare program, the enactment

of a Medicare pharmaceutical benefit and action to moderate the price spiral of pharmaceuticals in this nation.

And, right off the bat, let me say that NCSC supports the efforts of the President, Senator Kennedy, Representative Stark and others to create a universal Medicare drug benefit and to use some of the on-budget surplus for such a benefit. At the same time, this Congress and the Administration must address the pharmaceutical cost issue in an effective manner because costs alone could render a Medicare drug benefit too expensive even with significant surplus financing.

Mr. Chairman, in simple terms, access is largely determined by income and wealth. But, Mr. Chairman, that simple equation of wealth-equals-access begins to break down in the dynamics of the real lives of seniors. According to HHS, more than half of Medicare beneficiaries without drug coverage have incomes greater than 150 percent of poverty. Another 24 percent are at poverty to 150 percent of poverty. The lack of coverage is spread all along the income spectrum although, again, the very wealthy are adequately covered and have full access.

For the very poor, those eligible for Medicaid, the pattern is also uneven. The Kaiser Commission on Medicaid and the Uninsured earlier this year estimated that only 40 percent of Medicare beneficiaries who are also eligible for Medicaid are actually enrolled in Medicaid. This is a scandalous situation that cries out for solution because Medicaid has comprehensive and adequate drug coverage.

For those with Medicare managed care drug coverage, coverage is rapidly deteriorating. In just three years, the number of plans with $500 or lower coverage will increase by almost fifty percent, from 19 percent in 1998 to an estimated 28 percent in the year 2000. Fifty percent of all these plans will have caps of under $1,000 annually for benefits and the costs of these plans, including higher premiums, are increasing at rates exceeding 10 percent and 15 percent annually.

Mr. Chairman, when Medigap insurance was the subject of reform and Federal regulation more than a decade ago, we had hopes of good coverage for prescriptions. But, the history of pricing Medigaps has dashed such hopes. Older persons, my juniors, 75 year olds, are paying over $4,000 in premiums in such places as Miami and Los Angeles for "I" Medigap policies with $1,250 drug coverage with a $250 deductible. Even with Medigap drug coverage, seniors are paying $650 in out-of-pocket annual spending for prescriptions.

Meanwhile, companies are cutting back on retiree coverage, as has already been discussed here. The 30% of firms still offering coverage for retiree drug costs are a declining breed with a 25% drop in company coverage over the past four years.

Mr. Chairman, the back drop to all of these cost and coverage issues is the income picture of seniors. Median household income is below $18,000 per year. More than fifty percent of elderly families have incomes below $24,000. Fewer and fewer active workers are covered by either defined benefit or defined contribution pensions. Fewer retirees are receiving retiree health benefits. Savings for late-middle aged workers are marginal. I would add to this some information on drug prices in the U.S. Although the drug industry has been the most durably profitable U.S. industry over the past 3 decades, it is also one of the least competitive. Our generous patent laws give protections to the companies beyond any other nation. Thousands of seniors visit Canada and Mexico weekly to buy drugs 30 percent to 50 percent cheaper. And U.S. seniors, with only about 12 percent of the population, consume over 36 percent of all prescriptions.

Here are some recommendations of NCSC to the Congress to assure a just level of access for seniors to the prescriptions that they need.

1. Take steps to stop the drug price spiral. We support the proposal of Representative Tom Allen, H.R. 664, to secure for seniors the same level of discounts enjoyed by HMOs, the Veterans Administration, State Medicaid programs and other favored customers. This bill responds to the competitive nature of discounting of drug prices among HMOs, large hospital chains and other large consumers. What we need is to give seniors the same bargaining power.

2. Enact, this year, a Medicare drug benefit. In our view, such a benefit must be of a sufficient scope to provide a universal uniform benefit for all Medicare beneficiaries. It should have a stop-loss component of not more than $3,000. It should not have a deductible of more than $250 and a co-insurance of not more than 30 percent.

3. Take steps either through tax incentives or through strong maintenance-of- effort provisions to require or induce retiree health plans covering drugs to continue such benefits. We should be careful not to weaken the resolve of employer retiree health benefit plans to continue drug coverage. Over time, the public benefit should reach a level of adequacy to make most supplementary plans unnecessary.

4. Beneficaries should pay a premium for drug coverage, but this alone is not enough. In financing such a benefit, the on-budget surplus should be used and the

Medicare payroll tax should be examined for possible increase. In addition, some taxation of unearned income should be examined.

5. The National Institutes of Health finances extensive basic pharmaceutical research. The pharmaceutical industry is granted patents for these publicly developed drugs at bargain-basement prices. The Congress should review the NIH system of granting patents toward more competitive and realistic prices.

Mr. Chairman, the issues that this hearing has raised are some of the most important public policy issues of the coming century. This Congress, the Administration, the scientific community, unions and business, seniors and all citizens should quickly unite on a plan to assure an adequate and just level of access to prescription drugs for not only seniors but for all citizens. The progress of pharmacological treatment, in the long run, may be at the heart of a more effective and more efficient health system for all citizens. But, what you do now, this year, for seniors and for a more responsive Medicare program, can be a jump start for the larger challenge of health reform for all Americans.

Thank you.

Mr. BILIRAKIS. Thank you, Mr. Seidman.

Mr. Michel, who has retained the French pronunciation of his last name.

STATEMENT OF BOB MICHEL

Mr. MICHEL. Thank you, Mr. Chairman. And on behalf of The Seniors Coalition of 3.5 million people, we are very delighted with the wonderful work you and your staff are doing here.

You have my testimony, and so I am going to summarize some of the key points.

I know twice it has been mentioned today the Medicare catastrophic coverage debacle back in 1989. If you recall, Congress passed the Medicare catastrophic act to reform the Medicare program to cover a more comprehensive benefit package, and one of the highlights was a prescription drug program. Initially, about 80 percent of the seniors supported the program benefit but only until the truth of its cost and who was going to pay for it were revealed. The CBO estimate of $5.7 billion, when the bill was passed, turned out to be $11.8 billion a year later, more than twice as much.

For seniors, the premium that they were supposed to pay to get the drug benefit turned out to be a substantial income tax increase for people 65 and over. Seniors realized that the Medicare Catastrophic Coverage Act of 1988 would result in a sharp increase in their tax liability. Seniors knew then, as they know now, that the one-size-fits-all prescription drug benefit is not in their best interest; and with the President's recent outpatient prescription drug proposal, it looks like deja vu all over again.

There are clear signs that the President's plan will open up the same can of worms as the Medicare Catastrophic Coverage Act did. Estimates of the cost of the program run between $20 and $40 billion a year. That number has been kicked around this morning. The Heritage Foundation projects that it will likely cost twice as much as the administration is forecasting.

Using simple economics, it is easy to see why that would be so costly. The National Center for Policy Analysis believes that creating a universal entitlement will foster what is called the problem of increased utilization. In other words, the more people are insulated from the cost of a good or service, the more likely they will use it.

We have seen HCFA use a tactic throughout the Medicare program under the pretense of cost containment. In the case of an ex-

pensive drug plan, price controls will thwart the profit that pharmaceuticals companies use to research and develop new health-enhancing drugs. That means that innovative drugs are less likely to make it to the market and, in turn, to seniors.

I am confused and we all are in the Coalition as to why the President would oppose a costly universal plan when nearly 65 percent of seniors already have prescription drug coverage. The President's claim that seniors don't have enough access to prescription drugs is plain fiction. The facts clearly speak otherwise: 95 percent of Medicare HMOs provide their enrollees with a prescription drug benefit; 84 percent of seniors with employer-sponsored supplemental insurance have drug coverage. Granted some of that is fading away, but there is still plenty of it out there.

There are several Medigap policies that offer prescription drug coverage. Congress should shun the President's one-size-fits-all prescription drug proposal, if it wants to do what is best for seniors, and consider only proposals that would create a targeted program for seniors that actually need the financial assistance. Needy seniors are those with low incomes and/or high out-of-pocket costs.

Congress should strengthen an existing program, such as Medicare+Choice, pay the bills, and Medigap, that already provides millions of seniors with high-quality, inexpensive prescription drug coverage.

My mother-in-law, for example, was paying $400—$400 to $600—I forget what she told me—out of pocket for her prescription drugs. She joined an HMO, and she is now getting it all—all of her prescription drugs free with the HMO. It doesn't cost her anything out of pocket. That was $4,800 a year, almost $5,000 a year. That is a big savings for her.

Will that HMO back away someday? I don't know. If we keep treating them the way we have been, they might. If we do something to clean up our act with the HMOs, maybe they will stick around, and we will see some more out there competing.

Congress should also strengthen—I mentioned that, and I mentioned mom.

Last, Congress should heed the lessons of history. Seniors can smell a rat. The administration as well as Congress will not be able to sneak a costly one-size-fits-all prescription drug program past America's seniors. The truth about the pitfalls of such a program will rear its ugly head, just as it did with Medicare catastrophic coverage.

As a member of The Seniors Coalition, I thank you.

[The prepared statement of Bob Michel follows:]

PREPARED STATEMENT OF BOB MICHEL, ACTION TEAM MEMBER, THE SENIORS COALITION

Good morning. My name is Bob Michel and I am a member and supporter of The Seniors Coalition.

Let me start by saying thank you, Mr. Chairman, for the opportunity to testify today. The three million members and supporters of The Seniors Coalition are grateful to you for your excellent leadership of this subcommittee. We appreciate the diligent and thoughtful work of its members and staff on issues that impact the lives of seniors like myself.

I'm sure many of you remember the Medicare catastrophic coverage debacle of 1989. If you don't, let me remind you. In 1988, Congress passed the Medicare Catastrophic Coverage Act to reform the Medicare program to cover a more comprehen-

sive benefit package. One of the highlights of the new benefits package was coverage for prescription drugs.

Initially, about 80 percent of seniors supported the prescription drug benefit, but only until the truth of its cost and who was going to pay for it were revealed. The CBO's estimate of the annual cost of the prescription drug benefit jumped from $5.7 billion when it was passed to $11.8 billion a year later—more than twice as much. For seniors, the premium that they were supposed to pay to get the drug benefit turned out to be a substantial income tax increase for those 65 and over. Seniors realized that the Medicare Catastrophic Coverage Act would result in a sharp increase in their average extra tax liability.

On August 17, 1989, Congressman Dan Rostenkowski, a strong proponent of the Medicare catastrophic plan, was booed and chased down a Chicago street by a group of senior citizens after he refused to talk with them about the issue. Eventually, Rostenkowski cut through a gas station, broke into a sprint, and escaped into his car. But these seniors were so livid they refused to relent. They surrounded his car and rocked it back and forth. It was a classic case of political protest.

Later that year, in 1989, the firestorm against the Medicare Catastrophic Coverage Act reached a feverish pitch and, fortunately, the law was repealed. Not surprisingly, it was out of this firestorm that The Seniors Coalition was formed.

Seniors knew then, as they know now, that a one-size-fits-all prescription drug benefit is not in their best interests. And with the president's recent outpatient prescription drug proposal, it's deja vu all over again. There are clear signs that the president's plan will open up the same can of worms that the Medicare Catastrophic Coverage Act did.

Just like the drug plan in the Medicare Catastrophic Coverage Act, the president's plan will be a very costly program. Estimates run between $20 and $40 billion a year. The Heritage Foundation has found that it will likely cost twice as much as the Administration is forecasting. Using simple economics, it's easy to see why it will be so costly. The National Center for Policy Analysis believes that creating a universal entitlement will foster what is called the "problem of increased utilization." In other words, the more people are insulated from the cost of a good or service, the more they will use.

We all know that the government despises increased costs, as it should. But the government's favorite weapon against the skyrocketing costs of its programs is price controls. We've seen HCFA use that tactic, under the pretense of "cost containment," throughout the Medicare program. In the case of an expensive prescription drug plan, price controls will thwart the profits that pharmaceutical companies use to research and develop new health-enhancing and life-saving drugs. That means that innovative drugs are less likely to make it to the market, and, in turn, to seniors.

The government is adept at employing even more tactics to "contain costs" when its programs become more costly than anticipated. When the cost of a prescription drug plan explodes, the government, in addition to price controls, will be forced to cut benefits and/or raise premiums. We of course cannot rule out tax increases. Actually, we can probably count on them—the payroll tax for Medicare has been increased 36 times since Medicare's inception in 1965.

I am confused as to why the president would propose a costly universal plan when nearly 65 percent of seniors already have prescription drug coverage. The president's claim that seniors don't have enough access to prescription drugs is plain fiction. The facts clearly speak otherwise. Ninety-five percent of Medicare HMOs provide their enrollees with a prescription drug benefit. Eighty-four percent of seniors with employer-sponsored supplemental insurance have drug coverage. There are several Medigap policies that offer prescription drug coverage. As for me, I have excellent prescription drug coverage through my veteran's health insurance.

Congress should shun the president's one-size-fits-all prescription drug proposal if it wants to do what is best for seniors. Congress should consider only proposals that would create a targeted program for seniors that actually need financial assistance to gain access to prescription drugs. Needy seniors are those with low incomes or high out-of-pocket costs.

Congress should also strengthen existing programs, such as Medicare+Choice and Medigap, that already provide millions of seniors with high quality, inexpensive prescription drug coverage. My mother-in-law, before Congress created the Medicare+Choice program in 1997, was paying more than $600 per month for her prescription drugs. Ever since she enrolled with a Medicare HMO, however, she has been covered by a free prescription drug benefit. Congress needs to restore reimbursement rates to Medicare HMOs. This will encourage Medicare HMOs not to leave the Medicare+Choice program, and it will likely encourage new plans to enter. If this happens, seniors will surely have more access to prescription drugs.

Lastly, Congress should heed the lessons of history. Seniors can smell a rat. The Administration, as well as Congress, will not be able to sneak a costly one-size-fits-all prescription drug program past America's seniors. The truth about the pitfalls of such a program will rear its ugly head just as it did with the Medicare Catastrophic Coverage Act.

As a senior citizen, and a member of The Seniors Coalition, I thank you once again fors inviting me to give my testimony on this very important issue.

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

I just want to make it clear there aren't many of our colleagues here.

Mr. Seidman is here. I want to make it clear to you, sir, and to all the seniors out there and other Members of Congress, I served on the Medicare Commission. In spite of the fact we were pledged, if you will, charged with the responsibility of saving the current program and with the concern that adding anything to it would make our job that much tougher, still every member of that Commission, every Republican appointed and every Democratic appointed felt that prescription drugs should be part of the Medicare program. Anybody who says anything to the contrary is just out and out lying to you.

Today on a 1- or 2-day a week basis, a task force, a bipartisan task force sits together in one of the Ways and Means rooms over in the Capitol and is working on Medicare—some sort of Medicare reform which will include prescription drugs as part of the program.

Now, Ms. Wilensky, Mr. Reischauer, others have talked about how very complex Medicare reform is and the time it is going to take and that sort of thing. I have confidence that in this Congress, if politics next year does not really rear its ugly head as much as we might anticipate it is going to, then we are going to do something with Medicare reform to save it for ever and ever and ever.

Obviously, every current beneficiary and everybody who is about to become a beneficiary is not going to have any Medicare coverage problems. It is just the future—the Mr. Goldbergs, if you will, and others that are younger that we are really concerned with.

So, that having been said, some of us are concerned. I, in my opening remarks refer to the work with former Congressman Roy Rowland. A bipartisan group, sat 3 or 4 nights a week for months and crafted a plan that would go into effect now to do many of the things that we now have accomplished through Kassebaum-Kennedy.

In any case, the feeling was we have got to have comprehensive reform; and, therefore, we can't do it on an incremental basis. Therefore, our plan was not allowed to come on the floor of the House; and we didn't control the floor at that time. Consequently, an awful lot of people could have been helped and started to be helped from that point in time, but a lot of time was wasted, and they weren't helped.

Dr. Wilensky, you have mentioned the S-CHIP program, as we fondly call it, the Children's Health Insurance Program, which is a program that States have. Using that as a model, we created a plan that would help people now outside of the scope of the Medicare program, and it could blend in with a Medicare reform program.

We want it to blend in with a Medicare reform program, Mr. Seidman, but the fact of the matter is, why not help the people now? Why not help our elderly now who are poorest and who are sickest? And so this is exactly what we are trying to do.

Now, that is just one version. This is not to belittle all of the others. Mr. Brown has his and what not; and we are going to hear some of these versions next week. But this is the idea behind it all to help people now, not to keep it from being a part of the Medicare, of an overall comprehensive Medicare program, but to help people now who are sicker and who are poor.

So Dr. Wilensky, I don't know how much time I have left of my 5 minutes, but I guess I am asking why do you believe a State approach mirrored on that Children's Health Insurance Program is a preferred approach to this program.

Ms. WILENSKY. I would like to see something happen now, this session of Congress if possible. I think it is something you can do now. I believe it will be a better program if it is integrated in the long-term pharmaceutical benefits, should be integrated into the rest of Medicare, but I don't believe Congress is ready to make Medicare for the 21st century viable right now. This is something you can do, and you would learn some things.

There are a number of issues about how to actually administer this type of benefit. If you want to use PBMs or States want to explore other options, that could help in designing the structure of this benefit. It is not enough to say you just give it to the private sector. The carriers and fiscal intermediaries technically do that for Medicare now, but they clearly don't run the program.

So I agree that catastrophic and prescription drug coverage should be a part of reform Medicare program. I am eager to do something for seniors now who need the most help, which is low income.

Mr. BILIRAKIS. Mr. Seidman, you used the stop-loss level of $3,000. The piece of legislation I am referring to has a stop loss of $1,500, not $3,000, $1,500 stop loss.

My time is really up. Do you have a brief comment?

Mr. SEIDMAN. I just want to say we have a program which it seems to me is the kind of thing that happens when you target exclusively the poorest people.

Mr. BILIRAKIS. And the sickest because of the stop loss.

Mr. SEIDMAN. Somebody would have to determine who are the sickest, but most people know when they are sick and when they are not.

But the point I was going to make was that we have the spenddown program in Medicaid for people in nursing homes. At least in the National Council of Senior Citizens, we don't want to see another spenddown program. It seems to me that is what we would be risking if we focused exclusively on the poorest. Now, I am not saying that we should not do the maximum that we can for the poorest, and that means making the Medicaid program much more effective than it has been up until now in reaching the poorest elderly and disabled, but that isn't all that should be done.

Mr. BILIRAKIS. And I think I have made it clear that I agree that it is not all that should be done. But we are talking about helping people now, and with enhanced Federal dollars it would certainly

encourage the States to do an awful lot of the good things that are being done in S-CHIP, which does not appear to be working as well as we had intended. We have got to have a hearing to get an overview of what is happening with S-CHIP.

Mr. Brown.

Mr. BROWN. Thank you.

Mr. Michel, I congratulate you on your excellent coverage. You are more fortunate than most. Interesting in your testimony, however, that you deplore government involvement. You deplore anything resembling price controls. Yet, as you know, the VA, through a government agency, last time I checked, gets—always a 25 percent, often as much as a 50 percent discount on all kinds of prescription drugs through the Federal supply schedule that way. What is it? You enjoy this benefit. These cost-containment mechanisms work for you, but you don't want any government involvement in these programs and prescription drugs for the rest of the population?

Mr. MICHEL. Let me clarify that. It was written in my script. It was presented in a little wrong circumstance. I am retired military. As long as I am near a base, I just go into a pharmacy and pick up what my doctor prescribes.

Mr. BROWN. Most people can't do that, right?

Mr. MICHEL. All retired can. That is a few million people. That is not a small group. Of course, a lot of them are now reaching senior age. I also think—answering directly, sir, your question, the Medicare+Choice program, which covers an awful lot of seniors in this country, is good. And I wouldn't want anything to happen to thwart any future expansion of the private enterprise doing the same thing with the government paying private enterprise to do that out of the Medicare fund.

I guess what we are opposed to is a Federal Government run, operated program, because that brings with it a lot of added costs that has been traditional. It is going to jack the cost of it up quite a bit, and someone has to pay for it. The people that don't have anything right now, certainly as this gentleman said, we have got to address that. We have got to do something.

Mr. BROWN. Let me shift to Mr. Goldberg.

Mr. Goldberg, if I can understand your testimony, you generally believe that prescription drug prices are where they ought to be in this society in terms of market forces; is that correct? Prices are set—prices are evolved through market forces, and you don't quarrel with that.

Mr. GOLDBERG. I didn't address prescription drug prices in my testimony, but if you are asking me a question, yes, generally they are where they should be based upon what the market says. Are you asking if I think that when I go to the prescription—to CVS and I pick up a prescription for my daughter and I look at the price and I go, jeez, this is expensive, I have the same reaction as everyone else.

Mr. BROWN. Interestingly, with prescription drugs, because the NIH funds about 50—NIH and other non-industry sources fund close to 50 percent of prescription drug research and development—research and development of new drugs. Additionally, the

government gives major tax breaks for the dollars that they do spend on prescription drugs.

Then because of market forces, because prescription drugs prices are set in a monopolistic sort of way in some sense because there is no government regulation, there is no ability for people to shop somewhere else unless there is a generic when their physician prescribes a drug to them. Yet those same companies turn around and charge Americans who get the honor, as taxpayers paying for NIH and as taxpayers paying for tax breaks for these companies, get the honor of paying two and three and four times more than the Canadians and the Brits and the Germans and the French and the Japanese and others. Isn't that a little bit of an artificial market force setting this? Should we just allow the status quo to continue this way?

Mr. GOLDBERG. I think the larger question, Congressman—over the past decade, for example, prescription drugs as a total of our health care expenditures, it has been about 7 percent. It has been about the same relative to other countries. Now we are entering an era we have all these new discoveries displacing hospitals and physicians and stuff as sort of the front-line therapies. I think what you are pointing out, quite rightly, is that we have come to a point in society where we can no longer sort of deal with this at a retail level kind of business, and we have to start dealing with it in different ways. I guess where you and I would have a difference of opinion is I think we need to reform the way in which we finance health care as opposed to using sort of price control and rationing kinds of mechanisms.

Mr. BROWN. I think we differ probably on a lot of issues.

Mr. GOLDBERG. I am a Yankee fan.

Mr. BROWN. That is another thing. You mentioned Steinbrenner. I don't like Steinbrenner for two reasons. One, he owns the Yankees; the second, he moved to shut down the shipyard in my district. So you missed on that one, too.

Mr. GOLDBERG. I am really in deep doodoo here.

Mr. BROWN. Let me ask one other question. I would really want to pursue this if we had more time. I don't know what—the Ethics and Public Policy Center. Do you get any pharmaceutical drug funding ?

Mr. GOLDBERG. The Ethics and Public Policy Center, we get money from different foundations. And we in the past have gotten some money from pharmaceutical firms, like every other thing tank in Washington, D.C., but I don't get any funding directly from them, no.

Mr. BROWN. Thank you.

Mr. BRYANT [presiding]. Dr. Wilensky, I missed part of your testimony. I had a phone call. I had to step out briefly, but I think those who are here now have been here diligently throughout the hearing. I was just wondering if you had any comments in terms of some of the questions I asked about some of the estimates that Mr. Hash referred to as well as the GAO representative on the first panel and some of the outside groups who have done studies, PriceWaterhouse being one of those. Do you think the universal plan that the administration has proposed is financially not accurate in terms of their estimated cost or is it higher or lower?

Ms. WILENSKY. Well, the history of trying to estimate the cost of a new program without actually looking at anybody's numbers is that we will be low in estimating the cost of a new program. That has traditionally been the case with regard to Medicare and one that has a universal coverage and also one—it is unclear how the program will be administered, and it is unclear exactly what the power of the PBMs—so-called PBMs—will be. But I think it is likely to say—it is a likelier occurrence that the fact is that the spending will be higher than is anticipated, because that has been our experience, particularly because of the broad coverage of individuals who are involved.

I think the real concern is to say if we want to do something to help the people who are most in need of help right now is this a way to go do it, and it seems on two grounds this doesn't really make it. The first is that it doesn't provide any kind of catastrophic back-end coverage. Mr. Burr had mentioned this is a funny kind of insurance program. It is unfortunately true for much of Medicare, but it is a funny kind of insurance program.

So I think the real question is, if you have a limited amount of dollars to start now, how can you best do it? I don't think this is the direction.

I want to be very clear. A reform Medicare program would do better to have prescription drugs as part of the package so you can make use of what therapeutics can do to get you out of the hospital, but I don't see this as the right approach. I think there is a better interim approach. I would be very surprised, if it were to be adopted, that we don't spend substantially more than is estimated.

Mr. BRYANT. Mr. Reischauer, also the question on the cost of the high and low and do you favor and if you do favor a more targeted response to this problem.

Mr. REISCHAUER. With respect to the cost estimates having scar tissue from the Medicare Catastrophic Coverage Act repeal when I was running the Congressional Budget Office, I can try and speak to this in an objective way, but you might question my ability to do that.

Making estimates on new programs like this, as Gail has pointed out, is a very, very difficult job. The data we use is incomplete and usually quite old, and that explains one of the huge differences between the HCFA and the CBO estimate of a likely cost of the drug proposal. The details of the proposal are never really specified as they have to be when the administration puts forward a plan. There is lots of little bits and pieces that will affect cost in important ways.

And, third, you have to use professional judgment on the responses of various actors to the new program. What will consumers do? How much will their demand for prescriptions increase? We can guess, but we really don't know. How will businesses react? Will they drop their retiree coverage big time, as PriceWaterhouse has suggested, or rather modestly, as CBO and the administration have proposed. How will pharmaceutical companies respond to negotiations with the PBMs that will be purchasing these prescriptions for seniors? There is lots of uncertainty.

I think both HCFA and CBO try to do the best job they can. They don't try to spin this in any particular way. As Gail has suggested, almost always the things we can't see and can't predict turn out to be cost increasing; and so if you are going to put your money down on one square, that is the square to put it down on.

With respect to targeting versus universality, I am not a big fan of targeting. This is a program, Medicare, which is social insurance. We can vary the financing by income, by ability to pay, but I think it would be a huge mistake to vary entitlement to specific benefits by ability to pay.

What we have to realize is that pharmaceuticals are an integral part of medical care and should be an integral part of the Medicare package, and to treat it separately I think is going down a very mistaken road and one that will make the eventual solution to this problem much more complex and difficult politically to achieve.

Mr. BRYANT. Thank you.

I think my time is up. I think, Mr. Green, you were next.

Mr. GREEN. Thank you, Mr. Chairman.

Let me first start off with some concerns I guess, and I guess this is the best panel.

One, my concern for a lot of the bills, either the President's plan or the Turner-Allen bill, was that the private sector has not come up with a plan until now similar to the CHIPs program that has both the good and bad side. My statements to pharmaceuticals for a number of months is saying, well, come into us and tell us what you suggest. And the only response I see is the number of TV commercials that cost millions of dollars and actually, as I see them, are distortions. As Teddy Roosevelt said, get into the pit and we will talk about it and see what we can do. And if you don't like, obviously, the Turner-Allen bill or the President's plan, then let's see what we can do.

Mr. Goldberg, let me ask you some questions, because I wasn't familiar with your organization. One of the suggestions today by Dr. Wilensky is that we create something like the CHIP, children's Health Insurance Program. In the past, have you given testimony opposing that program?

Mr. GOLDBERG. I opposed the creation of the specific CHIP program, yes.

Mr. GREEN. So you would not disagree then with what Dr. Wilensky said to create even some type of program patterned after CHIP where the States would buy into it, so to speak?

Mr. GOLDBERG. No. The reason I opposed the CHIP program is because I felt it created a large entitlement again that was not targeted to the specific needs at the time. I think that——

I am trying to think if I even testified. I think I wrote about it, but I didn't testify before the committee.

I felt that the estimate of 10 million children or 24 million children without adequate insurance was overestimated, and I had concerns about the crowd-out effect, about the creation of a new entitlement, about people dropping coverage and going out to Medicaid, which has happened in some States under the CHIP program.

Mr. GREEN. Wait a minute now. People are dropping coverage?

Mr. GOLDBERG. There was a concern that the expansion of the kid care program would lead to people in the private sector dropping private sector coverage and enrolling into a publicly taxpayer subsidized program, which, of course, is the same concern that the President's plan for the drug parity program is trying to address with the $11 billion subsidy.

Mr. GREEN. I only have 5 minutes. I don't like the answers to take longer than my questions.

Mr. GOLDBERG. I am sorry.

Mr. GREEN. I don't share that concern, because I know the Medicaid program—I can't imagine somebody dropping their private sector coverage. Because most of the folks who qualify for CHIP, at least in Texas—and our legislature just bought into the plan this year—those folks typically don't have private sector offered to them at all. So I was just saying, in the past, you have disagreed with the children's health care program—insurance program, so that is the only other suggestion—I know the day is new—other than the President's plan and the Turner-Allen bill.

Mr. GREEN. By the way, I am an Astros fan. I have heard this before. Anybody who plays the Yankees, I am supporting them, even though we are in a different league. You can tell where I come from, also.

Dr. Reischauer, let me ask you a question about the—in Mr. Goldberg's assessment of the effects of the drug benefit, Dr. Goldberg notes in his testimony, if Congress creates a new drug benefit, one of the data suggests we don't need it. It would force the government further down the road of rationing and restriction and retrograde medicine. And, also, the 2 percent in his testimony, that is the only request.

Mr. Reischauer, would you like to comment on that statement in light of the current situation that seniors and the disabled are facing? Aren't they already exposed to rationing and restriction because many can't afford the coverage and many have inadequate coverage?

And, also, I would like to hear your comment on Dr. Goldberg's statement in light of the fact that we are one of the few industrialized nations that do not provide drug coverage for its elderly.

Mr. REISCHAUER. I guess the bell means I should have a very short answer. My short answer would be I disagree with almost every element of his statement.

Mr. GREEN. That is about the best answer I guess I could ask for.

Mr. REISCHAUER. And I am a Red Sox fan.

Mr. GREEN. Mr. Chairman, just one comment, no question.

I appreciate Mr. Michel being here. Houston, Texas, my retired military has to go 200 miles to get prescription medication in San Antonio, Texas. Even for our retired military who are not qualified for VA it is tough to get that. They go to Mexico often.

Mr. MICHEL. There is a mail order—there is a mail thing right now.

Mr. BURR [presiding]. That will teach you to be an Astros fan.

Mr. GREEN. I will know after they beat the Reds two games tonight and tomorrow night.

Mr. BURR. The Chair would ask unanimous consent to enter the written statements into the record of the American Academy of Actuaries and the United Seniors Association. Without objection, so ordered.

[The statements follow:]

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF ACTUARIES

The American Academy of Actuaries appreciates the opportunity to comment on an important issue for seniors in this country—the availability and affordability of coverage for prescription drugs. The American Academy of Actuaries is the public policy organization for actuaries practicing in all specialties within the United States. A major purpose of the Academy is to act as the public information organization for the profession. The Academy is non-partisan and assists the public policy process through the presentation of clear actuarial analysis. The Academy regularly prepares testimony for Congress, provides information to federal elected officials, comments on proposed federal regulations, and works closely with state officials on issues related to insurance. The Academy also develops and upholds actuarial standards of conduct, qualification and practice, and the Code of Professional Conduct for all actuaries practicing in the United States.

The cost of prescription drugs is a major component of the overall health care expenses paid by Americans. According to the Health Care Financing Administration, prescription drug costs accounted for 7.1 percent of the total national health care costs in 1997.[1] Prescription drug prices are rising faster than cost increases for consumer goods or for medical services. The consumer price index (CPI), which measurer the cost of consumer goods and services such as food, housing, clothing and medical services, increased 2.3 percent from August, 1989 to August, 1999 while the CPI for medical services alone rose 3.4 percent.[2] In comparison, the CPI for prescription drugs and medical supplies increased 5.9 percent during the same period.[3] Costs for prescription drugs are also increasing if measured on a per capita basis. Employers questioned in a recent poll by a benefits consulting firm indicated that prescription drug costs for retirees covered under employer health plans were expected to increase by 15.7 percent over the next year.[4] Clearly the cost of prescription drugs can have a significant impact on seniors, many of whom are on fixed incomes.

Congress is considering a wide range of proposals to help seniors with prescription drug costs. In considering how to best address this issue, policymakers should keep the following factors in mind.

How Do Seniors Pay For Medical Care?

Almost 98 percent of the population age 65 years or older in this country are covered by Medicare.[5] For those Medicare beneficiaries, 62.3 percent of their health care costs were paid by traditional Medicare, 15.2 percent came from out-of-pocket spending, 11.5 percent was paid by supplemental insurance, 4.8 percent was paid through managed care, 2.5 percent was paid by Medicaid and 3.7 percent was covered by other sources such as the Veterans Administration.[6]

Proposals to increase the availability and affordability of prescription drugs for seniors must be viewed in terms on their impact on these various sources of funding. For example, any expansion of Medicare coverage will ultimately impact the private health insurance market (Medicare Supplement insurance, long-term care insurance and employer health plans for retirees).

What Health Care Needs Do Seniors Have?

Seniors have their own specific health needs and patterns of utilization of medical services that are different from the general population. While it is helpful to look at data regarding the cost and usage of prescription drugs from other sources, such

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[1] Health Care Financing Administration, Office of the Actuary, National Health Statistics Group.

[2] Bureau of Labor Statistics, Consumer Price Index, All Urban Consumers, U.S. City Average (Not Seasonally Adjusted).

[3] Bureau of Labor Statistics, Consumer Price Index, All Urban Consumers, U.S. City Average (Not Seasonally Adjusted).

[4] Wall Street Journal, July 13, 1999

[5] Medicare Payment Advisory Commission, *Report To The Congress—Selected Medicare Issues,* June 1999.

[6] Medicare Payment Advisory Commission, *Report To The Congress—Selected Medicare Issues,* June 1999.

as information showing the cost of medical services provided in the employer group health insurance market, care should be taken when applying this data to seniors. It is important to consider data showing what types of prescription drugs are used by seniors, the cost of those drugs and the extent to which drug therapies may or may not help control related medical costs.

Who Benefits From Proposals To Extend Prescription Drug Coverage?

It should be expected that most seniors who lack prescription drug coverage through some source, such as a Medicare+Choice plan, Medicare supplement insurance or employer sponsored health plan, would opt for such a benefit if offered through either Medicare or an expansion of Medicaid. For a given population, people who do not have to spend their own money on services will have a tendency to use more of those services. Seniors will choose the drug coverage option that will provide them with the most "bang for the buck."

How Will Plans Currently Offering Drug Coverage For Seniors React?

Undoubtedly some individual and employer sponsored plans will drop prescription drug benefit for those seniors who are able to obtain coverage through a government funded plan such as Medicare or Medicaid. If the drug benefit in those private plans was more generous than that offered by a government plan, the affected individuals will be worse off. This is also true if the level of the benefit subsidy for prescription drug coverage is lower in the government plan than the private coverage. To the extent that private plans drop prescription drug benefits for seniors, this represents cost shifting from premium payers to the general taxpayer.

Who Pays For Prescription Drug Coverage For Seniors?

If a new prescription drug benefit for seniors is offered through Medicare or an expansion of Medicaid, taxpayers will pick up a significant portion of the cost. Unlike funding for Social Security, which relies on employer and employee financing, general revenues provided by taxpayers have always been a significant part of Medicare and Medicaid financing. It should be noted, for example, that when Part B of Medicare was originally enacted, it was intended that participants' premiums would pay 50 percent of the cost, and general revenues 50 percent.

Those ratios are now 25 percent and 75 percent respectively.

What Is The Total Cost Of A Prescription Drug Benefit?

The ultimate cost for a prescription drug benefit is highly speculative in light of the many uncertainties about how individuals and health plans will react to the choices they must make. The resulting uncertainties concerning cost create a risk that should be born in mind. For example, the administration's estimate for the cost of its Medicare prescription drug benefit for the first ten years (2000-2009) is $118 billion. The Congressional Budget Office estimate for the proposal is $168 billion, which is not a small difference. One factor to consider is the extent that a government sponsored program would be able to negotiate price discounts with prescription drug manufacturers.

Conclusion

In summary, public policymakers evaluating proposals to provide prescription drug coverage for seniors, have the difficult task of deciding whether such proposals will result in the improvement of the health care outcomes of older Americans at an acceptable cost borne by the appropriate people. Key issues to consider are:

- Who ultimately benefits from such coverage?
- Is the benefit design optimal?
- Will existing plans drop coverage for the elderly?
- What is the total cost and who pays?

PREPARED STATEMENT OF THE UNITED SENIORS ASSOCIATION

The United Seniors Association (USA), a nationwide seniors advocacy organization of over 685,000 members, appreciates the opportunity to submit this written testimony for consideration by the Subcommittee on Health and the Environment. We respectfully request that it be included as part of the official record.

USA applauds the Subcommittee for focusing on this important issue. Ensuring that America's senior citizens have access to affordable pharmaceutical drugs is a priority of our organization. Seniors should not be forced to choose between purchasing prescription drugs or paying their rent. We are pleased that the topic has received significant attention in recent months. Yet, at the same time, we are concerned that some proposals intended to expand access to drugs for seniors could

have the unintended consequence of disrupting the coverage arrangements already enjoyed by the majority of senior citizens.

We believe that a prescription drug benefit for Medicare beneficiaries should be considered in the context of more encompassing Medicare restructuring. Such restructuring should be modeled after the highly successful Federal Employee Health Benefit Program (FEHBP), which covers over 9 million federal employees including Members of Congress. Under this arrangement, beneficiaries would be given the opportunity to choose from a wide range of health care plans. Choice and competition would ensure quality.

However, if it is the will of this Congress to move a Medicare prescription drug benefit separate from broader reform, then that benefit must be narrow and targeted to those beneficiaries most in need. Exceedingly broad proposals which are not focused on those in need spread limited resources too thin and threaten the fiscal stability of Medicare.

The Administration's Proposal

USA is concerned that the prescription drug proposal outlined by President Clinton on June 26, 1999 could substantially harm Medicare beneficiaries. Under this plan, starting in 2002 seniors would pay an additional premium of $24 per month for the proposed drug coverage. However, the plan would only pay 50 percent of the first $2,000 per year in drug expenses. When the plan is fully phased in by 2008, seniors would pay a premium of $44 per month for the drug coverage and the plan would pay 50 percent of the first $5,000 in drug costs. Nothing above $5,000 per year would be covered, even though some of the latest, most advanced drug therapies could exceed this coverage limit.

According to the National Academy of Social Insurance, currently 72 percent of all seniors spend less than $500 per year on prescription drugs. More than half spend less than $200 per year. Only 14 percent spend more than $1,000 per year, and only 4 percent spend more than $2,000 per year.

Better Alternatives

Fortunately, there are better alternatives to the administration's proposal. The National Bipartisan Commission on the Future of Medicare, chaired by Senator John Breaux, proposed a plan modeled after the Federal Employee Health Benefit Program that addresses the long term Medicare financing crisis and contains superior prescription drug coverage at a reasonable cost for every senior. Such coverage would include a maximum cap on direct, out of pocket costs for seniors with the insurer covering all costs above that limit. The government would pay entirely for seniors with incomes up to 135 percent of the poverty level. USA endorses this model.

While USA remains committed to wholesale restructuring of Medicare along a FEHBP model, we understand that there are a limited number of seniors who need immediate relief from the rising costs of prescription drugs. Therefore, we encourage the committee to consider the bipartisan "Medicare Beneficiary Prescription Drug Assistance and Stop-Loss Protection Act" a bill introduced by Congressman Michael Bilirakis and Congressman Collin Peterson. This legislation targets those most in need by providing federal matching funds to states to create or expand programs to serve Medicare beneficiaries up to a certain percentage of the federal poverty level. Equally important, the proposal contains a stop-loss provision to limit beneficiaries' exposure to high annual drug costs, with no increase in their Medicare premiums.

There are other more limited reforms that would address the problem better than the administration's plan. For example, Congress should change regulations that force Medigap insurers to include many expensive benefits in their prescription drug policies. Then insurers could offer low cost plans providing drug coverage only, enabling many more seniors to buy such coverage.

Conclusion

Reforming and strengthening Medicare is one of the greatest challenges facing America today. As we move into the new century, it will become increasingly clear that the tax burden necessary to sustain the system as currently structured is unreasonable. The Concord Coalition estimates that by 2030 Medicare spending will account for one quarter of all federal revenues. We can not allow this to happen. Accordingly, we urge Congress to consider legislation that restructures Medicare along the model of the FEHBP. Absent such reform, USA believes it is important to target a prescription drug benefit to those most in immediate need of relief without upsetting the plans already enjoyed by many seniors.

United Seniors Association appreciates the opportunity to express our thoughts on improving the accessibility and affordability of prescription drugs for senior citizens. We look forward to working with this committee and with Congress to find a mutu-

ally agreeable solution to both expand drug coverage for seniors and strengthen the system for tomorrow's retirees.

Mr. BURR. Mr. Strickland, are you ready?

The Chair will delay recognizing himself and will recognize the gentleman from Ohio.

Mr. STRICKLAND. Thank you, Mr. Chair.

Mr. Michel, I am going to read a couple of sentences from your testimony. You say, "The President's claim that seniors don't have enough access to prescription drugs is plain fiction. The facts clearly speak otherwise. Ninety-five percent of Medicare HMOs provide their enrollees with a prescription drug benefit." I don't know if you ever met people like my constituents who write me about these problems or not, but I just have problems with your conclusion that seniors aren't having these problems. I just meet too many seniors who have these problems.

Mr. MICHEL. Some seniors are. There is no question about that. But to make it sound like all seniors are in the tough situation of not having any prescription drug service is wrong. That is the way it is presented, a lot of times, to the people.

Mr. STRICKLAND. Then you say, "As for me, I have excellent prescription drug coverage through my veteran's health insurance." and I would say to you, I am glad for you. I think we ought to take care of our veterans, even better than we are, certainly. But there are many older citizens who don't have such coverage, and we ought to be concerned about them.

Mr. MICHEL. We are, sir. I didn't say anything in my testimony that said we weren't. But what I said, we have States doing things now for people. We have HMOs. We have Medicare+Choice. We have things like the VA. We have things like retired military. There are some people that don't fit in that.

Mr. STRICKLAND. You said, "The President's claim that seniors don't have enough access to prescription drugs is plain fiction." that is what I was taking issue with.

Mr. Goldberg, I have been looking forward to meeting you. I never met you, but are you familiar with the Chillicothe Gazette, which is located in Chillicothe, Ohio?

Mr. GOLDBERG. The Chillicothe Gazette, no.

Mr. STRICKLAND. Well, I am surprised, because you wrote them a letter.

Mr. GOLDBERG. I have sent letters out regarding the Prescription Drug Fairness for Seniors Act.

Mr. STRICKLAND. I would like to read you something that you said: The sad truth is that many in Congress are looking for votes, not solutions to the very real problems many seniors face. I would like to ask you, sir, do you think we are looking for votes rather than to try to solve problems of seniors?

Mr. GOLDBERG. I don't know if that applies to you, sir. But I think to the extent that the Prescription Drug Fairness for Seniors Act is being touted as the solution, I don't think it is the real answer.

Mr. STRICKLAND. Do you believe that those of us who support this act are looking for votes rather than trying to help seniors? I am asking for your personal opinion.

Mr. GOLDBERG. My personal opinion is that I think there are better solutions that actually deliver coverage for seniors.

Mr. STRICKLAND. That is not an answer to my question, sir.

Mr. GOLDBERG. Then I will be perfectly frank with you, Congressman. I think that the Prescription Drug Fairness for Seniors Act is based upon a misleading set of statistics and offers a discount that does not and cannot materialize for senior citizens, yes, sir.

Mr. STRICKLAND. I still don't think you answered my question, but we will move on.

Mr. Goldberg, in an article you wrote, the geriatocracy won't swallow Clinton's drug plan.

Mr. GOLDBERG. In the Wall Street Journal, yes, sir.

Mr. STRICKLAND. You say most seniors don't need, want or care about a government-run drug benefit. In fact, most seniors don't have a problem getting the drugs they need, and they don't spend a lot on medications.

Mr. GOLDBERG. Right.

Mr. STRICKLAND. Then you say, seniors know that just the talk of price controls is driving down the price of the pharmaceutical stocks that make up a good chunk of their retirement portfolio.

I don't know who you are talking with, but I would encourage you to come to my district—in fact, I would ask you here today to come to my district and let us talk about this issue publicly so that you can meet some of these individuals face to face.

I talked to a woman in my district a few weeks ago who spent many years of her life as a Christian missionary in Mexico. She reared 36 children. I asked her if she had problems with prescription drugs; and she said, I am supposed to wear a heart patch, Congressman, but I haven't filled that prescription for over a year because I can't afford to do so.

I just take issue with the fact that there is not a crisis and there are not many Americans who need this Congress to take decisive action on this issue.

Mr. GOLDBERG. I agree with you, Congressman. Congress should take decisive action. I think the way to do it is to focus on providing care and direct assistance and coverage now, and I agree with you wholeheartedly in that respect.

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

The Chair would recognize himself for questions.

Let me thank all of you for attending today. As you can tell, this is of high interest to many members; and earlier today we had a packed room ready to listen to members talk about solutions. And I think it is safe to say, in a bipartisan way, every member is interested in solving this problem. They are interested in seeing that prescription drugs are incorporated into the Medicare package that is offered to all Americans, both now and in the future. And, clearly, we have differences as to how to get there. Debate on differences is healthy to reach, in fact, the right end point.

Let me go to you, Mr. Reischauer. I heard you say earlier, and I want to make sure I understood you correctly, that today companies have made decisions and have informed their employees that drug coverage or that health care—retiree health benefits will be phased out. We know that today. Do you believe that that has been

taken into account in the actuary numbers that HCFA has gone through as it relates to the President's plan and the cost of it?

Mr. REISCHAUER. Yes, to some extent. Whether they have, I don't know the specifics. But this is not a new trend, as Mike Hash pointed out. There has been a gradual decline in the prevalence of employee—employer-sponsored retiree policies since the late 1980's.

Mr. BURR. It is accurate to say for every employer that decides not to extend coverage to retirees that we would then absorb that drug coverage that they are not going to have into this new plan that would be created, correct?

Mr. REISCHAUER. That is correct.

Mr. BURR. So if——

Mr. REISCHAUER. But the President's plan, remember, provided assistance to those firms that kept retiree policies that was equal to two-thirds of the cost that would be imposed if the individual shifted into the government system. So it isn't like a nothing-something comparison. It is a two-thirds versus a hundred percent comparison in the cost estimate.

Mr. BURR. But an employee has that opt-in, opt-out decision, look down the road, not know what their employer is going to do as far as the extension of their coverage, and they have got to make a gut decision, right?

Mr. REISCHAUER. Yes.

Mr. BURR. Let me ask you on another front. If any plan moved into price controls, what does that do to—and I know—Mr. Seidman, I understand exactly what you said about future research and development. But if the price controls went into effect, what would that do to research and development? What would it do for the breakthroughs down the road for chronic and terminal illness?

Mr. REISCHAUER. The answer to that question depends on the level at which the price controls are set. And we have had price controls in some government programs that have been, I would argue, above market prices.

Mr. BURR. If they adopted the VA contract, what would it do?

Mr. REISCHAUER. It undoubtedly would slow down to some extent the pace of technological innovation. But do we know that the optimal amount of technical innovation is what we are having right now or is it a little more or is it a little less? And what are the tradeoffs we have to give up to get something that we want?

If you could tell me that we could design a health system in America that would provide coverage to everyone so we didn't have 34 million people uninsured but the price of that would be that we would, in 1999, have to live with 1997 medicine, I would say, fine, as long as the 1997 medicine continued each year. We would be making a tradeoff between one objective which is good, which is universal coverage, and another, which is more rapid increase in new discoveries and health breakthroughs.

That is what we hire you to do. Too much of this discussion makes it sound like any amount of technological advance is good and we should go for it at all costs. And the issue is that you are giving up something when you accelerate technology, and something you give up might be good.

Mr. BURR. We have many panels of patients, children, seniors, that we look at and hope the technology is advanced to the degree

that next year when they come back they are actually on a drug that might have extended their life. Many times we are wrong; and, unfortunately, they don't make that repeat visit.

Yes, sir, Mr. Seidman.

Mr. SEIDMAN. May I just say there are many seniors who, because the drug companies are putting their money into technology, if it is necessary for them to raise their prices because of that, and I don't think it is, but they deprive other seniors of the opportunity to obtain the drugs that are available today, not just the drugs that may be available in the future, and they lose their lives.

Mr. BURR. Clearly, we have conveyed that Congress does have the ability, along with the administration, to extend drug coverage, and that is what we are here to debate. Clearly, we have differences on how that should be structured. Is there a way to keep drug development, device development at the levels that technology allows it to go and extend drug coverage as an option? I think the answer is yes. It is to find an agreement.

Mr. Goldberg?

Mr. GOLDBERG. I just wanted to go back to what Medicare is proposing to do with cancer drugs now, which is to dump all future new cancer drugs into the lowest reimbursement categories as a way of saving money on an outpatient basis. And what that would do to cancer research and quality of cancer care and if that is evidence of how a drug benefit would be administered to all senior citizens on an outpatient level, then I think we should really seriously examine how we should go about restructuring it. Because from the people that I have spoken to running the freestanding cancer centers and cancer patients, it would be devastating. People would be given 30-year-old cancer therapies because HCFA has developed rules that would give it a financial incentive to use 30-year-old cancer therapies instead of cutting-edge cancer therapies in an effort to save money at an outpatient level. That is exactly the same kind of HMO penny wise, pound foolish things that we are decrying in today's hearing.

So before we start running to the government to protect us from the vagaries of the marketplace, I think that your committee ought to take a close look at how HCFA, who would administer a drug benefit, is treating the use of drugs in Medicare today.

Mr. BURR. We try to continually look at the ways that the agencies are interpreting.

Dr. Wilensky?

Ms. WILENSKY. I just want to make sure the members understand that you don't have to rely on price controls as a way to try to moderate spending. In fact, one of the actually more positive issues that has come out of the discussion is that most of the bills do not do that, that HCFA in general has relied on administered pricing, as you well know, but there are better and smarter ways.

I am nervous about VA supply prices because you are not having a major distribution center. And I think the whole economic rationale as to why you have a supply price is not relevant in Medicare, but you could have competitive PBMs that are able to purchase at a cheaper price that allow people, if they don't want to accept the drug in the category at the price, to buy a different drug if their physician is prescribing it but pay the difference. There are smart-

er ways than we have traditionally used in Medicare to try to restrain spending and not get involved in all the problems of price controls. So I would encourage you to remember that.

There is a lot of reasons I think why price controls in the pharmaceutical area would produce some bad outcomes, but we ought to be able to moderate spending in smarter ways, and I think it is encouraging that the President and some of the other bills actually have raised that as an issue.

Mr. BURR. Very good.

The Chair would recognize Mr. Lazio for questions.

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

I apologize for having been out of the room for a good deal of the testimony, but I wanted to focus, if I could, and maybe perhaps target this question particularly to Dr. Wilensky, whose testimony I have read.

Earlier in my introductory comments, I was referencing the New York State program. I don't know if you were in the room. It is the elderly pharmaceutical insurance coverage program. It has got 107,000 seniors that are enrolled. New York is probably one of the most progressive in terms of extending pharmaceutical coverage to folks, to seniors, low-income seniors, and the co-payment ranges from about $5 to $23.

I just want to ask you, what is wrong with building on that kind of success? Is anything fundamentally wrong with taking a State model that has been used successfully, at least in certain States? Fourteen States have some form of prescription drug coverage. Three or four have a very significant presence in terms of the extension of benefits. What is wrong with building on that model and how do you think—and I guess I would open this up to the panel, Dr. Reischauer also—what do you think the reaction would be of the States if they were given flexibility and they were given the resources to administer a program?

I can't help but also reference the CHIP program, health care program for children, that really started almost from ground zero, but many States also had some experimentation with the program. Now it is a very successful program administered at the State level extending health care benefits for low-income children. Why can't we do the same thing for seniors if we can do it for children?

Ms. WILENSKY. I think it is exactly what you should do now.

Ultimately, when Medicare is reformed for the baby boomers, I think it would be better to have a more integrated prescription drug coverage, catastrophic coverage, but there are a lot of decisions that Congress will have to make before they get there. So I think it is precisely what we ought to do now and use the models Pennsylvania and New York have, very long-standing programs. So I would strongly advocate that strategy.

Mr. REISCHAUER. While I applaud the New York program, which is a very good program, I think it would be a mistake to move in that direction for several reasons.

First, while the 14 States that have programs now could expand their programs rather easily with additional Federal grants, the other States would take 2 or 3 years to establish themselves.

And I am more of an optimist about long-term Medicare reform than Gail is. I see that there is a consensus developing around pre-

mium support, and I would hope sometime in the next 3 years or so we really can restructure the benefit and introduce more competition into Medicare and reform it for the next century.

But, more importantly, these are programs that help folks with low incomes, and you have to come in and sign up. They are means tested.

Some people don't like to participate in means-tested programs, even those with low incomes, but it is impossible to do what the chairman suggested is possible, which is protect not only low-income people but people with high expenditures relative to their incomes. And the reason for that is that you have to keep track of how much people have spent out of pocket on drugs. And unless you are in the program, which a $25,000 a year couple wouldn't be in the plan until they had already spent the $3,000 out of pocket associated with some catastrophic event, and so it isn't—administratively and technically it just isn't possible to cover both of the groups of people one would want to help, low income and those who in the course of a year end up having very high expenditures relative to their incomes, because they couldn't retrospectively go back and find out how much they spent.

Mr. LAZIO. Aren't there certainly judgments we need to make in term of resource allocation so that we don't—the public sector is efficiently reaching the most, if not all—the most people that we can that are struggling with the problem. The most efficient way is really by dealing with poverty level and their ability to—it is the same exact model we used with the CHIP program, isn't it, by saying low-income families with children, that these people would have to qualify for the program in order for them to get the benefit and that we gave the States the flexibility to model programs that maybe could be piggybacked with other programs used in a more collaborative way, as opposed to forcing a whole separate program on folks. There is a point in which you could extend it to everybody.

That argument that you make is also an argument for picking up the costs, in part, of current employer-paid health care benefits, aren't they?

Mr. REISCHAUER. Why are we treating prescription drugs differently from physician visits, from hospital care, from home health, from all the other important elements of a complete medical package? The answer is, by historical accident that it was left out and if we had to rethink Medicare again, design it again, we certainly would include it in the package. For us to all say, well, it cost an awful lot to do that, if I said to you——

Mr. LAZIO. The projections would have been significantly higher. We would have been forced to make the reforms that maybe you were calling for many years ago if we would have had that in place; isn't that right?

Mr. REISCHAUER. But I would rather have a Medicare program that was less generous on the things we cover now that covers prescription drugs than a Medicare program that is very generous for home health and very generous for laboratory expenditures and doesn't cover outpatient prescription drugs at all. It makes absolutely no sense.

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

I know all members would like additional time. The Chair would recognize Mr. Strickland for a very quick question, if he has it.

Mr. STRICKLAND. I am going to go back to Mr. Goldberg. Friendly exchange, Mr. Goldberg. I detect that you kind of have a tendency to look at the motives and make determinations about the motives of people who disagree with you.

In the letter to the editor to my district, you said, we are looking for votes, not solutions; and then in a Wall Street Journal article regarding the children's program, you said, there is no children's health care crisis. This crisis has been concocted out of myths and misstatements from interest groups more interested in expanding the welfare state than in the children's well-being.

Those are pretty harsh judgments which you have leveled against some of us, and I am going to try to give you the benefit of the doubt and think that you truly believe those things or you wouldn't be just saying them for purposes of God only knows. The question I have, though——

Mr. GOLDBERG. I think I would have rewritten the lead to my Wall Street Journal's article.

Mr. STRICKLAND. Thank you.

One very quick question, Mr. Reischauer. This multilevel approach for prescription benefits, I think Mr. Lazio and you discussed this, but there are various ways of trying to get prescription coverage to seniors. Some States have programs, HMOs, Medigap policies, and the like. In your judgment, wouldn't it be better to have that effort centralized into the Medicare program?

Mr. REISCHAUER. I think it is essential to do that. To do otherwise, the solution will be temporary, and there will be a stopgap. And I think the chairman and I think Gail and other people have recognized that eventually this should be part of the package. And so what we are really doing is talking about tactics. How long is it going to take Congress to get around fundamental Medicare reform? And if that is a long period of time, shouldn't we have something in the meantime to address this growing problem? It is a judgment.

Mr. BURR. Exercising the authority of the Chair, I am going to suggest to the gentleman that his time is up.

I am going to ask all of our witnesses, following up on the question and the answer that was just given, to supply for the committee answers to this question: If we do something incrementally, in other words, if we give away the carrot, what does that effect have on our ability to reach true Medicare restructuring reform, however you envision Medicare in the 21st century, to look as a cost-effective quality of care delivery system for all seniors?

And again, I don't think that the debate that we are currently having is whether we extend drug coverage to seniors. I think we all agree that we should, that if we had it to do over again, it would be there. The question that we have before us is, how do we do it? And if we do it incrementally, does that affect our responsibility long term transforming this health care system?

Once again, let me thank these witnesses. Let me thank the members. I am sure this won't be the last hearing we have on this subject.

This hearing is adjourned.

[Whereupon, at 1:52 p.m., the subcommittee was adjourned.]
[Additional material submitted for the record follows:]

RESPONSES OF MICHAEL HASH, DEPUTY ADMINISTRATOR, HCFA, TO QUESTIONS OF HON. NATHAN DEAL

Question 1: In your testimony you state that the prescription drug benefit is completely voluntary, and yet you project that 31 million beneficiaries will be covered by the benefit. Is that correct?

Answer 1: Because the program is voluntary, we used a conservative estimate based on data prepared for the White House by the Actuarial Research Corporation. This estimate represents the 87 percent of the 39 million Medicate beneficiaries that fill at least one prescription annually. However, we expect that most, if not all, of the approximately 39 million beneficiaries will choose this new drug option because of its attractiveness, affordability, and stability.

Question 2: If only 31 million of the 39-40 million Medicare beneficiaries will be covered by Part D, will the remainder, the 8-9 million not covered by the benefit have any prescription drug coverage, and if so from what sources?

Answer 2: We expect that most, if not all, of the approximately 39 million beneficiaries will benefit from the President's prescription because all beneficiaries will have access to a prescription drug benefit plan. While some beneficiaries may opt out of the voluntary program, we believe that most will choose to participate.

Question 3: Would you tell the Subcommittee, please, by source of coverage preenactment of the President's plan, what you believe will be the source of coverage post-enactment? In other words, for those preenactment covered by Medicaid, what will be their sources of coverage post enactment? Please provide the committee with a table that presents this information clearly.

Answer 3: The table below shows which payers will cover the prescription drug benefits, premiums, and coinsurance by Medicaid eligibility status.

Medicaid Eligibility	Payer		
	Medicare Rx Benefit	Medicare Rx Premium	Rx Coinsurance
Dual	Medicare	State Medicaid (with Federal Matching)	State Medicaid (with Federal Matching)
Qualified Medicare Beneficiary (QMB)	Medicare	State Medicaid (with Federal Matching)	State Medicaid (with Federal Matching)
Specified Low-Income Beneficiary (SLMB)	Medicare	Federal Government	Federal Government

Question 4: Of the beneficiaries covered by private-sector sources preenactment, what percentage would you project will be covered by the government-sponsored Medicare program post-enactment? What percentage covered by government-sponsored programs preenactment will be covered by private sector program post enactment?

Answer 4:

Current Rx Coverage	Coverage Under Proposal
Medicare secondary payer (Medigap)	Medicare secondary payer
Employer sponsored retiree plan	We project that about ¾ of beneficiaries in employer sponsored retiree plans will continue to be enrolled in employer plans which would be subsidized by Medicare under the employer subsidy provision. The remaining beneficiaries will enroll in Medicare Part D with or without supplementation from the employers.
Privately purchased plans	All beneficiaries with privately purchased plans will enroll in Medicare Part D. Some of these beneficiaries may purchase new supplemental policies.
Medicaid	Medicaid
Veterans Administration	Veterans Administration

NATIONAL COUNCIL OF SENIOR CITIZENS
SILVER SPRING, MD 20910-3314
September 29, 1999

The Honorable MICHAEL BILIRAKIS
Chairman, Subcommittee on Health and Environment
House Commerce Committee
2125 Rayburn House Office Building
Washington, D.C. 20515

DEAR SIR: At the close of the September 28th hearing on prescription drug coverage under Medicare, Representative Richard Burr, then presiding, asked each member of Panel B—of which I was a member—to respond in writing to a question he posed. I understood his question to be something like:

Should prescription drug coverage under Medicare be achieved incrementally?

My answer to the question is "No." I do not believe that the serious problems that beneficiaries of all income groups, except the most wealthy, face can be met soon enough, if ever, by an incremental approach. The National Council of Senior Citizens strongly believes that enactment of comprehensive, affordable Medicare coverage by this session of Congress is imperative and would be widely supported, not just by seniors but Americans of all ages.

The alternative, as I understand it, would be a program "targeted" only to the poorest beneficiaries. Experience has demonstrated over and over again, including the drug coverage under Medicaid, that programs for which only the poor are eligible in the face of a situation in which many non-poor beneficiaries are deprived of desperately needed pharmaceuticals by non-coverage and excessive costs of drugs would be far from the kind of program that would be enacted.

On behalf of the National Council of Senior Citizens and millions of elderly and disabled Americans, I urge your Subcommittee to recommend prompt enactment of comprehensive, affordable prescription drug coverage for all Medicare beneficiaries.

Sincerely yours,

BERT SEIDMAN
Member, NCSC General Policy Board

PRESCRIPTION DRUGS: WHAT WE KNOW AND DON'T KNOW ABOUT SENIORS' ACCESS TO COVERAGE

MONDAY, OCTOBER 4, 1999

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

The subcommittee met, pursuant to notice, at 4:30 p.m., in room 2123, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Stearns, Greenwood, Lazio, Bryant, Brown, Green, Strickland, and Capps.

Staff present: John Manthei, majority counsel; Patrick Morrisey, majority counsel; Carrie Gavora, professional staff; Kristi Gillis, legislative clerk; and John Ford, minority counsel.

Mr. BILIRAKIS. We will call the hearing to order.

I want to first apologize to the members of the subcommittee and to the members testifying for moving this from 3 o'clock to this time. I went to the airport to catch a 10:30 flight, and it was delayed, so I switched over to another airline. That will probably be happening even more in the winter.

But I do want to thank all of the members for taking time to be here.

This is a continuation of the hearing we held last Tuesday on Prescription Drugs: What We Know and Don't Know About Seniors' Access to Coverage. Today we will hear from several of our colleagues on this issue. Although this is not a legislative hearing, the members testifying will share their views on specific measures to improve prescription drug coverage for Medicare beneficiaries.

In considering this complicated issue, I have been guided for a long time by a simple principle, and that is no beneficiary should have to choose between buying groceries and filling a prescription.

Two of our colleagues, Mr. Peterson and Mr. Fletcher, recently joined me in introducing bipartisan legislation that is targeted to help our Nation's neediest beneficiaries, the poorest and sickest, right now. Not later, but now.

Our bill, H.R. 2925, will provide prescription drug assistance outside of the Medicare program to beneficiaries who are low income or have high annual drug costs. Specifically, H.R. 2925 provides Federal matching funds to States that establish or expand drug assistance programs serving low-income individuals. It also estab-

lishes a Federal stop-loss protection to limit the out-of-pocket prescription drug costs of beneficiaries who obtain up-front coverage.

H.R. 2925 would not raise beneficiaries' Medicare premiums, it would not increase Medicare spending or jeopardize the fiscal solvency of this vital program. What it would do is help the neediest beneficiaries today, while we continue working on broader reform to protect and strengthen Medicare for the future. As I have repeatedly emphasized, an overly broad approach will spread limited resources too thin—without helping those most in need of assistance.

By contrast, H.R. 2925 is a responsible plan to help the poorest and sickest beneficiaries obtain prescription drugs. Certainly there are a variety of approaches to this complex problem, and I do not profess to have identified the only solution.

I will welcome the ideas and input of my colleagues on both sides of the aisle. I am committed to working on a bipartisan basis as any legislation moves forward, and I hope that we will use this forum to learn from each other. We have invited you here so we can learn from you and consider all of your ideas in the process of moving forward.

I want to be absolutely clear about one point. I believe it is unconscionable to ignore the plight of our poorest and sickest beneficiaries as some might have us do. An all-or-nothing attitude is a recipe for failure for today, just as it was during the health reform debate of 1994. That approach to health reform forced individuals who lacked coverage due to preexisting conditions to wait 2 years longer for targeted health care reform, which was finally enacted with strong bipartisan support. It would have been enacted 2 years before were we allowed to bring it to the floor.

We should not waste the opportunity to act now on a bipartisan basis to help individuals in need. Our Nation's most vulnerable beneficiaries should not have to wait any longer for drug assistance. I would like to thank the members who have joined us today. I look forward to their testimony and now recognize Mr. Brown for his opening statement.

Mr. BROWN. Thank you, Mr. Chairman. I appreciate your responsiveness to our request on this side of the aisle for a second hearing on Medicare prescription drugs. Should we as a Nation see to it that our seniors have access to prescription drugs? Let's look at the status quo. As much as opponents to any drug plan try to disguise it, gloss over it, ignore it or lie about it, the status quo means health care rationing. Seniors who have money or were fortunate enough to work for an employer that offered generous retirement benefits have access to prescription drugs that can lengthen and enhance the quality of their lives. For the rest, tough luck. That is the status quo.

I have been thinking about Mr. Coburn's comments during last week's hearing. He and I both cited the drug Ticlid as an example of a medicine that serves a critically important purpose, reducing the probability of stroke for high-risk individuals, but it is undoubtedly unaffordable for many seniors. Mr. Coburn admonished physicians for failing to take their patients' financial status into account when prescribing drugs like Ticlid. He said that in the case of

Ticlid, a doctor can instead prescribe aspirin which he said is 95 percent as effective.

Here is my question: Should doctors be in the business of rationing drugs to patients based on the patient's financial status? If my mother is rich and your mother is poor, should my mother receive medicine more likely to prolong her life and your mother get aspirin? Doctors should be in the business of preserving and restoring health, not in the business of rationing prescription drugs.

I have another question about the Ticlid scenario. In my district in Ohio, Ticlid costs $1.91 per pill. Aspirin costs 6 cents per pill when it is not on sale. That means that Ticlid is at least 30 times the price of aspirin and 5 percent more effective. Are we getting our money's worth?

The truth is physicians are not likely to ration drugs. It is not in their job description and it shouldn't be in their job description. In the United States, doctors don't ration drugs, drug companies ration drugs. Drug companies know that they can mark their prices up dramatically and still sell enough to earn enormous profit. It is called price inelasticity. The desire for a product is so great that its purchasers are insensitive to the price. Or at least those purchasers who can afford to be are. When you sell one of a kind or an essential product, you can overprice it dramatically and still sell plenty of it.

Lots of high-end products are priced this way: penthouses, Cadillacs, personal jets. Only the rich can afford them. Prescription drugs are not a luxury. Once they become available, they become a necessity. Rationing luxury items is capitalism. Rationing prescription drugs is inhumane.

That is not to say there are no other examples of rationing health care in the United States. Census Bureau figures released today say that 44.3 million Americans lack health insurance. Uninsured individuals receive far less health care than those with insurance. Our fragmented gap-ridden insurance system for working-age individuals is a crisis that we have yet to face up to. But in 1965 this Nation decided to deliver seniors from the uncertainty and the unfairness of that system.

We created a system designed to treat all seniors equally when it comes to basic health care needs. We made a decision to establish Medicare because seniors generally live on fixed income and cannot absorb catastrophic health care costs, because the private insurance market abandoned at least half of them, because financial crises affecting seniors echo throughout the entire family and, most importantly, because our values as a Nation led us in that direction.

Now that prescription drugs have become as essential as hospital and medical care, we are allowing the drug industry bullying and our own apathy to undercut the commitment that we as a Nation and this Congress made in 1965. We have legitimate concerns about the cost of the prescription drug program. According to the National Institute of Health Care Management, two-thirds of the recent explosion in prescription drug spending is attributable to price inflation.

Drug companies are doing what they need to do to maximize profits. Unlike other industrialized nations the U.S. does not regu-

late drug prices, so drug companies charge us the highest price of any nation, by multiples of 2, 3 and even 4 times what other countries pay. Within the United States, drug companies are charging the highest prices to those with the least bargaining power, seniors and others without health insurance or drug insurance. Drug companies are diverting huge sums of money, money that comes from inflated drug prices, into advertising and marketing. They are in a campaign to convince Americans that life would be meaningless without Viagra, that happiness hinges on Propecia. From a market perspective, though, drug companies are doing everything right. You can't blame drug companies for maximizing profit. That is their job. But you can't blame the Federal Government for taking steps to protect seniors and address policy ramifications to what drug companies do. That is our job.

I have introduced drug legislation, H.R. 2927, that would bring prices down without taking away the industry's incentive to act like an industry. That is, to maximize profits and develop new products. H.R. 2927 does not use price controls or regulation to bring down drug prices. What my bill does is reduce drug industry power and increase consumer power by subjecting the drug industry to the same competitive forces that almost every other industry bears. It is a means of moderating prices that are too high without inadvertently setting prices that are too low.

Drawing from intellectual property laws already in place in the U.S. for other products where access is an issue, pollution control devices are one example, the legislation would establish product licensing for essential prescription drugs. If based on criteria established by the Department of Commerce, a drug price is so outrageously high it bears no resemblance to pricing norms for other industries, the Federal Government could require drug manufacturers to license their patent to generic drug companies. The generic companies could then sell competing products before the brand name patent expired, paying the holder royalties for that right. The patent holder would still be rewarded for being the first on the market, and Americans would benefit from competitively driven prices.

Alternatively, a drug company could limit its prices which would preclude the Federal Government from finding cause for product licensing.

The bill would also require drug companies to provide audited detailed information on drug company expenses. Given that these companies, the drug companies, are asking us to accept a status quo that has bankrupted seniors and ignited health care inflation, they have kept us guessing about their true costs for far too long.

We can continue to protect drug companies from good, old-fashioned American competition. We continue to buy into drug company threats that research and development will dry up unless we continue to shelter them from competition even though that argument falls apart when you look at how research and development is funded today. It is mostly funded by American taxpayers. Drug companies pay only 50 percent of the costs of their prescription drug research and development. Taxpayers pay most of the rest. Taxpayers give generous tax subsidies and tax breaks to those drug companies on the research dollars that they do spend, and then

taxpayers are privileged to pay 2, 3, and 4 times what drug consumers in other countries pay.

We can do nothing, Mr. Chairman, or we can get the guts to challenge the drug industry on behalf of seniors and on behalf of every health care consumer in this country. We can take a serious look at the Allen bill, the Berry-Sanders bill and the Brown bill. If we have questions about drug utilization, we should confront them,not use them as an excuse for inaction. Mr. Chairman, there is no excuse for inaction. Our inaction perpetuates suffering. There is no excuse for that.

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

Mr. Stearns for an opening statement.

Mr. STEARNS. I thank the chairman. Let me compliment him for having this hearing and, of course, the ranking member, Mr. Brown, for his recommendation, and welcome my colleagues for being here to testify.

Many of us have looked at this and agree that it is a problem, and we are also concerned. I want to also give commendation to the chairman for drawing up his bill on this. Mr. Chairman, in an age when the nightly news is full of new and exciting medical discoveries for therapies we could not conceive of in the past, it is an important goal to focus on how the patients who may need these medicines the most will be assured better access. I am also concerned about ensuring that any steps that we take in these areas do not come at the cost of endangering the current benefits that seniors and other patients already enjoy. I say this, Mr. Chairman, because as the chairman of the Veterans Subcommittee on Health, there is concern with limited money in the budget for veterans. The impact this will have and how it will affect veterans.

Our subject today is what we know and don't know about seniors' access to coverage. I think it is timely that we talk about it, and some of the key issues that you are having on this panel is identifying the cost of drug coverage, both premium and out of pocket for seniors today. I think that is important in reviewing the existing options for coverage in the prior Medicare supplemental market, and what level of coverage seniors currently receive through supplemental insurance.

But, of course, the concerns we have today and the testimony we will hear from our colleagues is not new. This is a problem that has existed for at least 10 years and so we are all sensitive at this point because Medicare has so many problems in its funding. Those of us who have looked at this issue recognize that we have to tackle this, but it has been something that has been on the radar screen for some time. We have to look at what we can do in terms of policy and not politics.

I have listened on the House floor to some of my colleagues talk about this issue, and every time they do this I try to put it in perspective and try to understand the impact and what it would cost.

The only bill I am familiar with is H.R. 664 which is Mr. Allen's bill. I know Mr. Allen has been on the floor recently talking about his bill, and I think he mentioned that—and you and Mr. Allen might want to talk about this, that his legislation involves almost virtually no expense to the Federal Government. I could be wrong in my interpretation, but I think that is what you said.

Mr. ALLEN. That is correct.

Mr. STEARNS. I have to view that as Chairman of the Veterans Subcommittee on Health. I had asked Dr. Garthwaite, who is the Department of Veterans Affairs' Acting Under Secretary for Health to review your bill. Perhaps you got a copy of his letter. I thought I would put, Mr. Chairman, with unanimous consent, the letter from Dr. Garthwaite which is dated August 11, 1999, in which he was kind enough to review H.R. 664 relative to the VA.

In his letter he said that H.R. 664 would cost the Department of Veterans Affairs between $500 million and $600 million annually. This Department has had experience with several attempts to take their favorable pricing and extend it to other purchasers and their conclusions have been the same: It costs them hundreds of millions of dollars.

And I think, Mr. Chairman, you realize the effect that would have on veterans. So, I am interested in the hearing and I am concerned about veterans. I think we may need to realize the impact of this legislation, and how it affects veterans. I appreciate Dr. Garthwaite's letter, and I hope that——

Mr. BILIRAKIS. Without objection that letter is made a part of the record.

[The letter follows:]

DEPARTMENT OF VETERANS AFFAIRS
VETERANS HEALTH ADMINISTRATION
August 11, 1999

The Honorable CLIFF STEARNS
Chairman, Subcommittee on Health
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

DEAR MR. CHAIRMAN:

This is in response to your letter on the impact on the Department of Veterans Affairs (VA) of H.R. 664, which would extend favorable government prices for pharmaceuticals to the Medicare population.

We are very concerned that this proposed legislation would have an indirect, negative impact on VA pharmaceutical budgets. Section 3(c) of the bill would force covered outpatient drug manufacturers to sell to Medicare-affiliated pharmacies at the lower of the Medicaid reported best price or the "lowest price paid for [the drug] by any agency or department of the United States". The latter benchmark would include not only low Federal Supply Schedule (FSS) and FSS Blanket Purchase Agreement (BPA) prices negotiated by VA for the Government, but also large volume committed use national contract prices obtained by VA and/or Department of Defense (DOD) in head-to-head competitive procurements. Perhaps most importantly, the "lowest price paid" benchmark would include many Federal ceiling prices (FCPs) already imposed on manufacturers by the Veterans Healthcare Act of 1992, Section 603 (Public Law 102-585; 38 U.S.C. 8126).

By way of further information, through many recent inquiries by drug manufacturers regarding this bill, we have been informally informed that manufacturers may no longer offer lower-than-FCP prices to VA and DOD in BPA and national contract negotiations. They may also invoke 30-day cancellation clauses in FSS contracts and BPAs, to the extent allowed by Public Law 102-585, which would force Government healthcare agencies to buy drugs in the open market at much higher retail prices or AWPs (average wholesale prices).

In summary, we believe enactment of H.R. 664 would increase VA's annual pharmaceutical costs by $500-600 million. We. would be pleased to discuss this matter further with you. If you have additional questions, please contact me or Mr. John Ogden, Chief Consultant for Pharmacy Benefits Management, at 202.273.8429/8426.

Sincerely,

THOMAS L. GARTHWAITE, M.D.
Acting Under Secretary for Health

Mr. BILIRAKIS. Mr. Green for an opening statement.

Mr. GREEN. Thank you, Mr. Chairman. I want to thank the chairman for scheduling this second hearing. It is one that we started last week on prescription drug medication, and today I look forward to hearing our colleagues who have thoughts on how they got to this issue.

Several members that we have here today have done extensive research on providing better and more affordable access to prescription medication. The finding can be translated into legislative language and hopefully our committee can move forward. This will give the members of our subcommittee a second hearing and the opportunity to look at the wide range of options that we can consider.

Whatever model, I hope our primary responsibility is one for now that Congress has recognized the high cost of prescription drugs. The Commerce Subcommittee on Health, this is our second hearing, and although in Washington sometimes you think that it is a win just by having a committee hearing, I would hope that we would carry it much further than that and actually start addressing some of the issues of prescription medication.

In my part of the country from doing town hall meetings, it is very seldom that I have one that prescription medication does not come up, with seniors bringing in receipts to show me that they are spending $200 to $300 a month on medication.

Being 6 hours from Mexico, if a senior is well enough, they will drive or somehow get to Mexico to be able to save half and sometimes more on their cost. The studies in our district show that seniors on the average pay more than double what maybe in Mexico or maybe the most favorable providers, HMO or VA, for a certain number of prescription medications, and I know that happens on the Canadian border, too. Not all of our seniors have that opportunity.

The study that I read and we talked about last week at the hearing shows that 65 percent of seniors have some type of coverage. I don't think that is true in the district that I represent. Maybe there is a lot of them who have partial coverage or some high deductible that they can't get to, but that study seems, at least with the information that I am getting from average constituents, I wish it were 65 percent. We probably wouldn't have as much contact as we do.

I share my colleague's concern. We heard it last week on politics, but our system of government, to get to policy changes, we have to engage in politics. Whether it is me sitting here today or standing on the floor of the House or someone else saying we have identified the problem, the high cost of prescription for seniors. We know that the Veterans Administration and HMOs can negotiate for smaller amounts and lower costs, why shouldn't we try and build on that?

With that, Mr. Chairman, I would hope Mr. Stearns would provide a copy of that letter because I would like to take it further and find out—$500 million is a large cost to be trying to negotiate for prescription medication. That will be part of the committee record, and I hope that it will be shared.

Mr. BILIRAKIS. I thank the gentleman. Yes, that letter is made a part of the record and certainly it is available at any time.

Mr. Lazio.

Mr. LAZIO. Thank you for scheduling this hearing and your personal commitment to the issue of prescription benefits, and I know that we have a fine panel of my colleagues here, including the dean of my home State delegation, Congressman Gilman, who is the people's advocate on so many different fronts.

This is a difficult issue in terms of trying to balance competing interests. On the one hand, we are seeking a program that will be true to cost containment in the Medicare system, ensuring that we don't undermine the solvency of a program that is already under siege.

We are trying to develop a program with a second consideration, which is not to undermine the tremendous innovation that has occurred in the pharmaceutical industry, partly because of the huge investment of the public sector through NIH. And I want to say I am very proud of the current majority for its huge increases in the budget for the National Institutes of Health and the various other institutes which does leverage both basic science and the type of science that evolves to pharmaceutical development, the great breakthroughs that have been occurring. We have to keep that in mind. We cannot undermine creativity for cutting-edge pharmaceuticals.

And third of all, we need to make sure that what we do is accessible, easy for seniors to opt into and does not substitute for current coverage. Right now as the chairman has said, about one-third of our seniors have Medicare+Choice or the equivalent with prescription benefits. About one-third have employer-sponsored health benefits that include prescription coverage, and we are really targeting it to the one-third of seniors that do not have prescription benefits.

I know how important it is to have those kinds of benefits. I have been lucky in my family. My dad was a stroke victim and suffered for many years as a result of a stroke. We were lucky to have coverage that included prescription benefits. I know many other seniors throughout America are not so lucky, and so I know that we need to redouble our efforts to balance these very important competing demands for access, for ensuring cost containment, making sure that we don't cost shift, undermine the ability of pharmaceutical companies to innovate, and bring the very best of pharmaceutical creativity and promise and affordable rates to our seniors.

I want to applaud our colleagues for coming forward here. I don't agree with every approach that has been taken by those that are going to be testifying, but I want to say that I applaud their commitment to try to find a solution to this very difficult problem. Once again I want to applaud you, Mr. Chairman, for your personal commitment to this important issue. I yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman.

Ms. Capps for an opening statement.

Ms. CAPPS. Thank you for continuing the hearing that we began on Thursday. My opening statement was made on Thursday, and I didn't know whether I would be here in time today, but I would like to thank my colleagues who have put in extraordinary amounts of time and energy on this topic. I really appreciate that

this is now an important part of our discussion in the House of Representatives. That is significant.

I represent a district where Medicare HMOs have been pulling out, and Saturday morning the front page news in our paper was that our largest hospital is probably going to eliminate HMO service and this will affect our Medicare population. Seniors tell me every day I am in my district how difficult it is for them to have no options for their prescription drug coverage.

So, clearly it is something that we need to address, and I know that although we may have differing ideas about how we should go about doing that, all of us understand that this is a need or an issue that is important in our country today. Thank you for holding the hearing, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentlewoman for her comments. Any written statements that the subcommittee members wish to make a part of the record, without objection, that will be the case.

[Additional statement submitted for the record follows:]

PREPARED STATEMENT OF HON. RALPH M. HALL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. Chairman, I am pleased that the Subcommittee has decided that its time would be well spent in thoughtful consideration of an issue that is of paramount importance to so many of our constituents—how to provide prescription drug insurance coverage for Medicare beneficiaries. It is not going to be simple to accomplish this goal, and time spent understanding discussing all the components of the issue is time well spent.

One of the things that I believe to be most critical to a good outcome for this debate is that we clearly define the issue—what it is, and what it is not. The reason that many Medicare beneficiaries do not have adequate access to prescription drugs is that they do not have prescription drug coverage under their health insurance. The problem we need to discuss, therefore, is drug coverage. How can drug coverage be expanded so that it is accessible to all Medicare beneficiaries?

Our task as the Subcommittee looks into Medicare drug coverage is not, nor should it be, to engage a battle about the price of prescription drugs. That fight is unproductive and off point. Furthermore, it is a valid concern that meddling in the marketplace, including establishing price controls, can and will have a detrimental effect. We are witnessing this now, as a result of certain Medicare payment controls imposed under the Balanced Budget Act. The BBA made well-intentioned changes, based on the best information available at the time. But some of those changes, especially where they resulted in substantial reductions in payments for Medicare services—in essence, controlling the prices of these services—have not turned out as we expected and planned. In fact, some of the changes may have compromised the services Medicare beneficiaries are receiving.

We cannot afford to make a critical error that will result in the enactment of a Medicare prescription drug program that won't work over the long term, or that will cause perturbations in the market that inevitably will result in reduced availability of new drugs resulting from reduced investment in pharmaceutical research. With the aging of the population will come an increase in chronic diseases for which we do not have good treatments; we will hurt our Medicare beneficiaries if we slow or jeopardize the possibility of their getting new and better treatments for the diseases that primarily affect the aging—such as arthritis, Parkinson's disease, and Alzheimer disease.

So let us maintain our focus, Mr. Chairman, as we move forward on this issue. Our focus should be on drug coverage. If we stay focused, and determine to solve problems carefully as this Committee and Subcommittee historically have done, our chance of success is much improved.

Mr. BILIRAKIS. Gentlemen, thank you for taking time away from your busy schedules and all of the time that you have put into this subject.

We will kick off with Mr. Peterson. Collin, you have 5 minutes. Your written statement is made a part of the record. Please proceed.

STATEMENT OF HON. COLLIN C. PETERSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. PETERSON. Thank you, Mr. Chairman and members of the committee. I appreciate being able to be with you today. My interest is in trying to get something done with this prescription drug issue. Medicare has been a good program. It has delivered health care for over 30 years, but I think everyone agrees that we are going to have to make some changes and finally within the context of that we will get some kind of prescription benefit.

But having sat through a lot of meetings this year, I think this issue has become highly politicized to the point that I am not sure that we are going to get something accomplished in the short term.

I am interested in getting some help for people that need it. I was glad to work with the chairman and introduce legislation, along with Dr. Fletcher, to provide targeted prescription drug assistance to the neediest Medicare beneficiaries, individuals who have low incomes or who have high drug costs. This bill would help Medicare beneficiaries now. They would not have to worry about getting through the whole process. It is a positive first step while Congress works on the other broader Medicare reforms.

Approximately two-thirds of Medicare beneficiaries have some form of prescription drug coverage now. The one-third that do not have are largely women and individuals on fixed income. The high cost of prescription drugs coupled with individual's low incomes forces beneficiaries to make decisions that no American should have to make. I am speaking of Medicare beneficiaries who have to choose between paying bills and buying groceries or purchasing prescription drugs that they need. Some have to cut costs by rationing their medicine in efforts to prolong their prescription.

With the best health care system in the world, these are decisions that should never have to be made. There are many policy issues to be addressed while Congress considers Medicare reform. But as I have stated, the one issue that should and can be addressed immediately is prescription drug coverage for the most vulnerable beneficiaries in our society. As Mr. Bilirakis stated, our bill would provide drug coverage outside of the Medicare program and it would not raise beneficiaries' Medicare premiums, increase Medicare spending, or jeopardize the program's solvency.

This bipartisan legislation is consistent with my philosophy of a middle-of-the-road solution to important policy questions. I believe it is truly a common sense approach. It is not an overly broad proposal resulting in benefits being spread too thin and not providing substantive help. Instead it is targeted and really helps those beneficiaries in the greatest need. Additionally, it avoids excessive regulation and sometimes ineffective government price controls and unnecessary bureaucracy.

As a member of the Veterans' Affairs Committee along with Mr. Stearns, and I have a copy of this letter from the VA, and I sat through the situation where we were told in the independent budget we needed $3 billion and we only ended up with $1.7 billion in

the House, and in the Senate $1.1 billion, I would be concerned if we put another $6 billion cost on top of that. I think there would be negative ramifications for the VA. I would hope that this committee would look into that.

Providing prescription drugs for Medicare's most vulnerable beneficiaries is simply good medicine. As I mentioned, the lack of drug coverage leads to inappropriate use of medications which can result in increased costs and unnecessary hospitalization.

My home State of Minnesota is one of 15 States that has created a drug assistance program for low-income seniors. The program offers relief to seniors who have too much income and assets to qualify for Medicaid but can't afford private insurance. During community forums around the State last year, State officials frequently heard seniors say they often can't afford their prescribed medication or ration their dosages to make ends meet. Minnesota being a progressive State, in spite of some of our politicians making interviews, is often ahead of the curve on important policy decisions. Their targeted assistance program offers real help to people who need it the most. Congress should look at the success that States like Minnesota are experiencing when considering this issue.

Currently I am working with a bipartisan group of my colleagues on a broader Medicare reform. I hope Congress will send the President a Medicare reform measure that preserves, strengthens, and modernizes the program for current and future generations. However, until we reach that point, we should act now to help the neediest Medicare beneficiaries. We should not make them wait longer for assistance. I hope that Congress will take this opportunity to help seniors and individuals with disabilities before it slips by. Thank you very much.

[The prepared statement of Hon. Collin C. Peterson follows:]

PREPARED STATEMENT OF HON. COLLIN C. PETERSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Good afternoon. I am Collin Peterson and I represent the 7th district of Minnesota. I'd like to thank Chairman Bilirakis and the committee for inviting me to testify today.

Medicare has delivered quality health care for over 30 years, but everyone can agree that it needs reformed for the future. As Congress considers Medicare reform measures, the debate has evolved into a highly politicized issue. I'm concerned that it has become so politicized that Congress will fail to produce a proposal that has a real chance to become law. Unfortunately, the real losers in this political battle are the people that need help the most.

To address this concern, I introduced legislation with Chairman Bilirakis and Congressman Ernie Fletcher to provide targeted prescription drug assistance to the neediest Medicare beneficiaries—individuals who are low-income or have high drug costs.

This bill would help Medicare beneficiaries **now**. It is a positive first step while Congress works on broader Medicare reform.

Approximately two-thirds of Medicare beneficiaries have some form of prescription drug coverage. The one-third that do not are largely women and individuals on fixed-incomes. The high cost of prescription drugs coupled with individual's low-incomes forces beneficiaries to make decisions that no American should have to make. I'm speaking of Medicare beneficiaries who have to choose between paying bills and buying groceries, or purchasing prescription drugs. Some have to cut costs by rationing their medicine in efforts to prolong their prescription.

With the best health care system in the world, these are decisions that should never have to be made.

There are many policy issues to be addressed while Congress considers Medicare reform. But as I have stated, the one issue that should, and can, be addressed immediately is prescription drug coverage for the most vulnerable beneficiaries.

As Mr. Bilirakis stated, our bill would provide drug coverage outside of the Medicare program, and it would *not* raise beneficiaries' Medicare premiums, increase Medicare spending, or jeopardize the program's solvency.

This bipartisan legislation is consistent with my philosophy of middle of the road solutions to important policy questions. I believe it is truly a common sense approach. It is not an overly broad proposal, resulting in benefits being spread too thin, and not providing substantive help. Instead, it is targeted, and really helps those beneficiaries in the greatest need.

Additionally, it avoids excessive regulation, ineffective government price controls and unnecessary bureaucracy. As a member of the Veteran Affairs Committee, I am particularly concerned about proposals that could inadvertently impact the Department of Veterans' Affairs pharmaceutical budget, and put veteran's access to health care at risk.

Providing prescription drugs to Medicare's most vulnerable beneficiaries is simply good medicine. As I have mentioned, the lack of drug coverage leads to inappropriate use of medications, which can result in increased costs and unnecessary hospitalization.

My home state of Minnesota is one of 15 states that has created a drug assistance program for low-income seniors.

The program offers relief to seniors who have too much income and assets to qualify for Medicaid, but can't afford private insurance. During community forums around the state last year, state officials frequently heard seniors say they often can't afford their prescribed medication, or ration their dosages to make ends meet.

Minnesota is a very progressive state and is often ahead of the curve on important policy decisions. Their targeted assistance program offers real help to people that need it most. Congress should look at the success states like Minnesota are experiencing when considering this issue.

Currently, I'm working with a bipartisan group of my colleagues on broader Medicare reform. And I hope Congress will send the president a Medicare reform measure that preserves, strengthens, and modernizes the program for current and future generations.

However, until that point, we should act **now** to help the neediest Medicare beneficiaries. We should not make them wait any longer for assistance.

Congress should not let this opportunity to help seniors and individuals with disabilities slip by.

Thank you very much.

Mr. BILIRAKIS. Thank you. I would remind the gentleman that I am not only a member of the Veterans' Committee, but also that particular subcommittee that you referred to.

Mr. Fortney Stark, fondly referred to as Pete Stark, as we all know, has been very involved in health care issues for many, many years. Please proceed.

STATEMENT OF HON. PETE STARK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. STARK. Mr. Chairman, thank you for having these hearings. They are timely and important. I quite frankly would be happy to see any of the bills before you passed. As you are aware and many of you here are aware, I am on a bill with Congressman Dingell and Senators Kennedy and Rockefeller, and we are trying to expand the Medicare drug benefit which we did a decade ago, only to have the pharmaceutical industry rally around and defeat it the following year.

I would like to make some observations and you or my colleagues at the table may challenge this, but first of all, I think that it is unrealistic to think for a moment that we are going to enact in any forum a pharmaceutical benefit which we would spend any Federal money on and not eventually have to control the price of pharmaceutical drugs. That is what sends the pharmaceutical industry into orbit and which has got them committed to spend a couple of

hundred million dollars to defeat any pharmaceutical benefit. We do it with hospitals, we do it with doctors.

We formed the Medicare program in 1965 because there wasn't medical care for people over 65. Nobody was writing the insurance, and most people over 65 couldn't afford the insurance. So unless we are willing to face up to the fact that we have a responsibility to get a good deal for the taxpayers, to get a good deal for whatever kind of program that we are going to enact, unless we think for some reason that the pharmaceutical fairy is going to come along and put these prescriptions under people's pillows at night, which I don't think, I have always had the Stark triology, and it is as close to religion as I get, Mr. Chairman; that is, that as a matter of right, and it applied to Medicare, and now it applies to pharmaceuticals because without pharmaceuticals you are not getting medical care today, every citizen as a matter of right ought to have pharmaceutical drugs mailed. One small group of citizens constitutionally has a right to that. A nickel to anybody who can tell me who it is. Come on.

Prisoners, gentlemen. Cruel and inhumane punishments. I have always said that what is good enough for Haldeman, Ehrlichman, and Rostenkowski is good enough for me. If you have a constituent who doesn't have medical care and can't get his prescription drugs, have him hit a cop, particularly in Los Angeles; he will get more medical care free at the cost to the Los Angeles County Government than he ever thought possible. Seriously, we ought to as a matter of right provide this.

Second, every provider as a matter of right should have reasonable, not necessarily desired, but reasonable compensation for their services. We have learned to negotiate that for better or worse over the years, and I suspect that we would have to do that spending taxpayer's money.

The third part of this is we all to have pay for this right according to our ability to pay. For Medicare we do. If you make $1 million a year, you are going to pay $10,000 out of your pocket in premium. If you make $20,000 a year, you are going to pay about $200 in premium. That sounds to me about right.

I do not know why if everybody is going to pay for this drug benefit, we want to take it out of their hides when they are old and sick. That is the worse time to pay your copayer premiums, when you are sick, can't work even if you wanted to. Why not do it when you are young and healthy like my kids and grandkids? Let's start, as we do with Medicare and Social Security, and pay a little in when you are young, more if we need it. I don't see how we can end up with any program that doesn't touch on all of these items. I would say one thing, and this is a matter of choice, but I heard—I think Mr. Lazio said he didn't like the idea.

We can do one of two things.If we want to save some money, give everybody a bottle of aspirin and include everybody and gradually ratchet up the number of drugs that we don't cover. Or you can pay for all drugs for 1,000 people and then just add the number of people as we go or some combination.

But all of our bills, mine and everybody at this table, have got the darndest convoluted system for figuring who is in and who is out. That is not how you get sick and that is not how you need

drugs. As we have done in Medicare, I believe the best thing would be to include everybody so we don't get into the fights of income levels, what we do with the disabled, include everybody, phase it in as we can, pay for it as much as politically we can increase the payroll taxes, sales tax if you choose to do it that way, a consumption tax, I would support that.

And third, be prepared to have to do battle with the pharmaceutical industry who will oppose any prescription drug because they know—and I don't say this as a moral issue, I just see it as a practical matter—they know that they won't get all of these fat profits if we have to control the prices.

I think that is what is before us and I hope that in this Congress we can take one small step. Let's design a camel's head and get it in the tent. I want to thank you, Mr. Chairman, for taking the first step. Let's talk about it. Thank you for letting me participate.

[The prepared statement of Hon. Pete Stark follows:]

PREPARED STATEMENT OF HON. PETE STARK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman and Members of the Subcommittee: I am pleased to be here today with Reps. Tom Allen (D-Maine), Marion Berry (D-Arkansas), Ernie Fletcher (R-Ky), Benjamin Gilman (R-N.Y.) and Collin Peterson (D-Minn.). I testify in strong support of providing America's seniors with a Medicare prescription drug benefit.

When it comes to pharmaceutical coverage, seniors in America are getting a bad deal. Unlike the majority of Americans under the age of 65 who have health insurance, Medicare beneficiaries have to buy their drug coverage separately. Many can't afford to—an estimated 15.5 million, and rising.

This means seniors can't count on being able to afford the prescriptions their doctors order. Yet it's a well-known fact that older Americans need prescription drugs far more than younger people do, both to stay healthy and to stabilize chronic health conditions.

I take a cholesterol-lowering medication every day. For me, it's the difference between being at high risk for a heart attack and costly hospitalization . . . and being here this afternoon to talk about Medicare's future.

We tried a decade ago to enact catastrophic drug coverage, only to see it turned back by an intensive campaign funded by pharmaceutical companies. Much has changed in the private health care marketplace since then, and almost all of it is for the worse. Retiree health coverage has become skimpier, and for millions it has evaporated—despite our economic prosperity. Supplemental drug-Medigap policies have become nearly worthless—with payouts that are lower than the premiums paid.

So now that we know the private sector won't do it, we're back to discussing how Medicare can be improved to give ALL seniors access to affordable pharmaceutical coverage that they can count on. And from the various proposals that have been introduced so far, it's clear there's a lot of interest.

It's my hope that this interest can be translated into legislative action.

I hope we will resist proposals calling for incremental coverage, which, by their very nature, would help some seniors, while hurting others. Medicare is *not* a program that provides benefits to only some beneficiaries but denies others. Rather, it is an entitlement to a uniform set of benefits for all those 65 and older, and the disabled. Congress shouldn't unravel Medicare by enacting legislation that would begin to carve up the program into haves and have-nots.

In April, I introduced the "Access to Affordable Prescription Medications in Medicare Act of 1999" with Reps. Brown, Waxman, Dingell, and Senators Kennedy and Rockefeller. It proposes to add an outpatient drug benefit to Medicare Part B, covering 80% of costs up to $1,700 per year after a $200 annual deductible. The bill also has a stop-loss benefit under which Medicare would pay all prescription drug expenses after a senior incurs $3,000 in out-of-pocket expenses. Administration of the benefit is by private-sector entities under contract with HHS, which would competitively bid for Medicare's business and meet a range of federal quality standards—including those governing formularies—to ensure that the benefit is equitable for seniors across the country.

More recently, President Clinton has proposed a similar Medicare drug plan that is sound and well thought-out. That makes it a target for the pharmaceutical industry, which has mounted an all-out campaign to kill drug coverage for seniors.

But PhRMA's "Flo" cannot defeat the needs of millions of seniors. Like HMO reform, we'll be talking about a Medicare drug benefit until the day we enact it. The reason for this is simple. Public pressure for affordable drug coverage is being fueled by the aging of our population and its growing health needs—even as genetic engineering is beginning to provide remedies and cures for diseases that we thought were unbeatable.

It's my hope that this hearing, along with subsequent discussions and good-faith negotiations, will provide the momentum to do what we all know is the right thing to do. Let's prove the pundits wrong, and enact a Medicare drug benefit this Congress.

Thank you.

Mr. BILIRAKIS. Thank you.

Dr. Ernie Fletcher.

STATEMENT OF HON. ERNIE FLETCHER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KENTUCKY

Mr. FLETCHER. Thank you, Mr. Chairman and distinguished members of the committee, it is certainly a privilege to testify before you.

As we look at this issue, I think everybody recognizes that it is important to focus on the change that has occurred in medicine over the last 30 years. Length of stays as far as inpatients have decreased. Much of the treatment is done as outpatient. We have had a tremendous number of new medications with market effectiveness in preventing disease, decreasing morbidity and mortality. Obviously, we have had an accompanying increase in cost with those medications and with our outpatient prescription drug costs that we have seen.

We also have seen insurance companies offering more prescription drug benefits. As we look at the demographics, we need to recognize about 64 percent of our Medicare patients do have some sort of prescription drug coverage. It has been addressed, alluded to, that that may be eroding as the cost increases, but over the last year, the estimates have increased that have some prescriptive coverage.

The average out-of-pocket cost for beneficiaries of Medicare is about $200 to $400 per year per person. About 14 percent incur no prescriptive drug cost; 4 percent or over, $2,000 a year; and if you round off the total cost, that is probably about 10 percent, may spend about $3,000 a year on prescription drugs. Thirty-six percent of our Medicare beneficiaries have no prescription drug cost, and it is estimated that 40 to 44 percent are below the poverty level.

So I think when we look at the demographics there, it is important as we address the issue that we focus on the folks that are the neediest and the sickest.

I am reminded of a story of practicing medicine not too long ago. The most affected individuals, of not being able to afford the prescription drugs, are single women, often widows that are living on Social Security alone; $600 to $700 a month. They are trying to live on and buy prescription drugs. I had a patient come in and I wrote a prescription because of her high blood pressure. Continued to follow up, and her blood pressure was out of control. Finally, this very

proud lady who worked very hard all of her life said, I could not afford the medication.

So I think it is very important that we do address the needs of these low-income seniors who have worked hard, that we provide them the kind of medication that will actually improve their life and prolong their life.

I have some concerns about the President's plan. I certainly appreciate the focus that he has brought in the arena and really beginning the dialog. The estimates of cost, are $168 billion over 10 years. I am very concerned about how that will threaten Medicare, which is already having financial problems. Also, we see it may displace 50 to 75 percent of the employer-sponsored plans. That means $3 to $5 billion paid by employers, that cost will now go to the taxpayer; so that is $3 to $5 billion more that taxpayers will have to pay. I am also concerned what it will do with price control, what it will do at the cost of VA or veterans, other Federal and Medicaid drug plans, and how it is going to affect those.

Additionally, let me share a little story. My son had a chronic illness, a disease very severe, and we found a medication that might work. It was being tested and researched at the University of Kentucky for anti-tissue necrosis factor. There was a study, and so we got him into the study and he responded tremendously, and the study was over. I even requested with Dr. Kessler to get some compassionate use and that was not available at the time. But I am very concerned when we see the new things that are available and the tremendous response that we make against diseases that have tremendous effect on morbidity and patient's livelihood, that we affect that by price controls.

Folks talk about maybe some compulsory licensing, that has been a Third World practice. I think we are above the Third World. I think we can come up with more innovative ways to control costs and provide prescription drugs for our patients.

As we look at the plan that the chairman and Mr. Peterson and I have offered, it does have bipartisan support. It helps the poorest and neediest, those that are below the poverty level and those that incur those extraordinary outpatient costs that keep them from having to go into the hospital or keep them from other costs. It really does not discourage investment from the private industry.

Let me say as we look at this plan, it is certainly not perfect and I think there are many plans, and I am glad the dialog has begun. I hope that we do something. That is the right thing to do. Certainly as we conclude this I will be glad to answer any questions and thank you very much, Mr. Chairman.

[The prepared statement of Hon. Ernie Fletcher follows:]

PREPARED STATEMENT OF HON. ERNIE FLETCHER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KENTUCKY

Mr. Chairman and members of the subcommittee, thank you for inviting me to testify before you this afternoon. I appreciate the opportunity to be a part of this very important and timely discussion on Medicare prescription drug benefits.

We are blessed in America with advances in medicine that make dramatic differences in our lives, particularly benefiting the elderly who consume a large portion of prescription drugs. Innovations in pharmaceutical and biotechnology research are transforming health care from traditional and costly inpatient hospital treatment to outpatient treatment based largely on prescription drugs. Prescription drugs allow our seniors to stay out of the hospital, avoid surgery, improve their health, and even

prolong life. Unfortunately, as the importance of these new technologies increase, so does the cost of these medications.

Overall, spending on prescription drugs has been rising faster than any other component of health care. From 1990 to 1997, prescription drug expenditures almost doubled from $37.7 billion to $78.9 billion. In just one year, from 1996 to 1997, spending on prescription drugs increased 14.1%, while overall spending on health care increased only 4.8%. In 1995, the average Medicare beneficiary used 18 prescription drugs, and 86% of Medicare beneficiaries used at least 1 prescription drug. On average, beneficiaries spend $600 per year on prescription drugs with roughly half paid by insurers and half paid out-of-pocket. The distribution of these costs, however, is very unequal. The vast majority of Medicare beneficiaries spend a relatively modest amount on prescription drugs, and 14% have no drug expenditures at all. Only 4% of Medicare beneficiaries have expenditures that exceed $2,000 every year.

I think we can all agree that the time has come for Medicare to include a pharmaceutical drug benefit. Too many seniors must choose between taking the medications that will improve their lives or buying everyday necessities. As a family physician, I have encountered many seniors who cannot afford their prescriptions, either not filling them at all or taking only half of the prescribed amount. I am reminded of one of my elderly patients who came in for elevated blood pressure. I prescribed the medicine she needed to correct her problem, however, on the follow up visit her pressure was not better. After several changes in her prescription, she finally overcame her pride to confide to me that she couldn't afford to buy the medication. Experiences such as this have made a lasting impression, and guide me as I work with my colleagues to modernize Medicare.

Over the past several months Congress and the nation have focused their attention on Medicare reform issues. How do we as a nation update the program while controlling costs in the federal budget? We all know the problems facing Medicare. We also know that the Medicare Part A trust fund is projected to be depleted in 2015, just as the pressure of the baby boomers' retirement begins to be felt. As the debate continues on how to best restructure Medicare for the 21st century, I think it is imperative that Congress makes changes on an interim basis to guarantee that seniors have access to lifesaving prescriptions.

Recently, President Clinton introduced a plan that would provide universal prescription drug coverage for Medicare beneficiaries at a cost of $168 billion over ten years, according to the Congressional Budget Office. This proposal would bankrupt Medicare instead of targeting assistance to those who need it most—the poor, and the small fraction of beneficiaries who have extremely high drug costs. The President's one-size fits all plan will result in many beneficiaries paying more for fewer benefits. CBO estimated that the average enrollee would pay about 75 percent of the cost of covered drugs up to the cap.

To justify his tremendous expansion of the Medicare program, the President claims that seniors do not have enough access to prescription drugs. This simply is not the case. About 64 percent of our nation's seniors have prescription drug coverage through employer sponsored plans, Medicare+Choice, Medigap, and Medicaid. Eighty-six percent of Medicare beneficiaries who receive supplemental benefits through employer sponsored insurance have prescription drug coverage. Ninety-five percent of Medicare+Choice beneficiaries have prescription drug coverage and 90 percent of those who are enrolled in Medicaid have coverage. In addition, the Medigap H, I, and J plans cover prescription drugs.

What's more, the President's plan could displace the existing sources of coverage that Medicare beneficiaries already have. According to research by PriceWaterhouseCoopers employers would have an economic incentive to encourage Part D enrollment. This would displace employer-sponsored retiree drug coverage from 50 percent to 75 percent, affecting between 6 million and 9 million beneficiaries. This represents $3 billion to $5 billion annually in employer spending being transferred to American taxpayers.

I believe that we should work to help those who do not have any coverage without displacing sources of private coverage. There are three core principles to follow in providing our seniors a prescription drug benefit. First, a proposal must be targeted to help those beneficiaries in need. Second, the benefit must be enacted IMMEDIATELY. Third, any proposal must be fiscally sound so that it does not jeopardize the Medicare program. I have recently joined Chairman Bilirakis, and Representative Collin Peterson in introducing a prescription drug benefit that meets these guidelines.

The first part of our proposal would be targeted towards the 36% of beneficiaries who do not have coverage. The proposal would help states in developing or expanding a State Drug Assistance Program to aid low-income Medicare beneficiaries in

obtaining prescription drugs. It gives each state the flexibility to design a program that will fit the unique needs of their residents. Federal matching funds will help states serve Medicare beneficiaries up to a certain percent of poverty. States would receive enhanced FMAP funds for coverage up to 150 percent of poverty, and regular matching funds for coverage up to 200 percent of poverty.

States must follow certain guidelines when establishing their programs. First, states can not use federal funds to provide low-income drug assistance through their Medicaid program. Second, states must offer drug coverage that meets the coverage provided under the states' Medicaid programs, the Federal Employees Health Benefit Plan, coverage available to state employees, or coverage available to consumers of the state's largest HMO. Third, states would subsidize the portion of the premium that is attributable to drug coverage and for individuals who choose to receive drug coverage through Medicare+Choice or employer-sponsored health plans. Fourth, participants must meet income eligibility levels and meet state residency requirements to participate in the program. The neediest individuals would not be required to pay coinsurance; however, the states could impose up to a $5 or 20% coinsurance for individuals above 120% of poverty.

The second part of the proposal would limit a beneficiary's out-of-pocket expense through a federal stop loss protection. The federal government would protect beneficiaries who obtain qualifying up-front coverage from paying more than a set amount annually in out-of-pocket costs for prescription drugs. The out-of-pocket expenses would initially be set at $1500 per year. This protection would be available to beneficiaries whose up-front coverage meets minimum financial requirements—no more than a $500 deductible and no more than 50% cost-sharing. In addition plans would not be allowed to cap their expenditures below the level at which the stop-loss protection takes effect.

This plan will help those who need help the most—low-income beneficiaries and beneficiaries who have high annual prescription drug costs. Congress must concentrate on the 36 percent of beneficiaries that do not have any drug coverage. If fully implemented, this plan can cover 44 percent of beneficiaries who currently lack coverage. This amounts to over 6 million beneficiaries who will be eligible to receive assistance through State Drug Assistance Programs. Congress must also concentrate its resources on beneficiaries who have high annual drug expenditures. This proposal will provide stop-loss-coverage to 31 million Medicare beneficiaries. Our seniors should feel assured that they will never have to sell their possessions to afford their prescription drugs. This proposal provides true insurance for Medicare beneficiaries.

I believe this proposal is a good start. Is it perfect? No. I will work with my colleagues to expand upon certain aspects of the proposal to ensure a smooth running program. I am also open to suggestions. For instance, I believe that we should set up a board or corporation outside of the Health Care Financing Administration to operate the stop-loss program. The Board would be able to establish eligibility criteria within a specified framework that each private plan must meet. I also believe it is important that plans focus coverage on those drugs that have been proven to decrease morbidity and mortality.

The need for a targeted prescription drug benefit is great, and will only continue to grow. Congress cannot wait to provide assistance to those in need while we debate fundamental reforms to the Medicare program. We must take this opportunity and provide relief to those beneficiaries struggling to pay for prescriptions—low-income beneficiaries or beneficiaries with catastrophic yearly expenditures—that will prevent or treat illnesses. A fiscally responsible approach to drug coverage is the only lasting prescription for real reform.

Mr. BILIRAKIS. Thank you.

Mr. Allen, please proceed.

STATEMENT OF HON. TOM ALLEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MAINE

Mr. ALLEN. Thank you, Mr. Chairman, Congressman Brown, distinguished members of the committee, I am pleased to be here today to testify about one of the most pressing issues for America's seniors, the availability of prescription drugs. Prescription drugs can improve and extend the lives of seniors and others, and they are doing that. But the explosion in prices for prescription drugs, together with the widespread and growing lack of prescription drug

insurance coverage, has left millions of Americans unable to afford the drugs that their doctors tell them they have to take.

Seniors today are 12 percent of the population, but they use 33 percent of all prescription drugs. Over one-third of all Medicare beneficiaries have no drug coverage at all and must pay for their drugs out of pocket. About 8 percent of seniors have Medigap drug coverage, but those plans are too expensive and inadequate for most beneficiaries. About 17 percent of Medicare beneficiaries have coverage through Medicare managed care. These plans are very unstable. Some right now are increasing premiums and reducing benefits. Some are dropping prescription drug coverage. Some are dropping out of Medicare entirely. About 21 percent of those plans last year limited drug coverage to $500 or less, and 1 year later the percentage is 32 percent that have that limit.

Look at the retiree plans. About one-quarter of Medicare beneficiaries have meaningful coverage provided by a retirement plan, but there again look what is happening. The proportion of firms offering retiree health coverage has declined by 25 percent in just the last 4 years and a principal reason is the high cost of prescription drugs. The result is that seniors are making choices that no one should have to make. I have had women write me and say, I don't want my husband to know but I am not taking my prescription medication because he is sicker than I am and we can't both afford to both take our medications.

Under the leadership of Henry Waxman, a member of this committee, there have been studies done by the Democratic staff of this committee in over 80 districts around the country, and they show a shocking pattern of price discrimination. The studies have found, on average, older Americans pay almost twice as much as the drug companies's favored customers such as large insurance companies and HMOs for the medications with the highest dollar sales to seniors.

In my district of Maine the price differential was 96 percent. In other districts the differential is significantly higher. Not only are seniors paying the highest prices in the country, but in this country we are paying the highest prices in the world. Another study showed that in my district American seniors are paying 72 percent more than consumers in Canada and 102 percent more than consumers in Mexico. Older Americans pay the highest prices in the world for their prescription drugs. Contrast the plight of these seniors with the profits of the industry. The pharmaceutical industry earns more in profits, $26.2 billion in 1998, than it spends on research, $24 billion.

This is the Nation's most profitable industry, No. 1 in return on revenues, return on assets and return on equity. In short, the most profitable industry in the country is charging the highest prices in the world to those who can least afford it: senior citizens without prescription drug coverage. The Prescription Drug Fairness for Seniors Act which I introduced, H.R. 664, has over 130 cosponsors. It has been introduced in the Senate. It is a simple bill. It costs no significant amount to the Federal Government. It creates no new bureaucracy. It simply allows pharmacies to buy drugs for Medicare beneficiaries at the best price given to the Federal Government, which today is the Medicaid price or the VA price.

I designed this bill to attract bipartisan support. As I say, no significant increase in Federal spending, no new bureaucracy, but it would reduce prices for seniors by up to 40 percent. It doesn't impose price controls. It simply ends price discrimination. It won't restrict research and development. The industry is competitive. The pharmaceutical industry must invest in research and development heavily or they won't stay ahead of the generic industry. Their profits come from their patents. Their patents run out. They have to do the research, and they will do it whether or not this legislation or others pass as well.

Medicare beneficiaries need more than the kind of discount that is set out in my bill. They need a Medicare prescription drug benefit as well. The President has proposed the benefit and Representatives Stark, Dingell and Waxman have proposed the benefit. I support these initiatives. They are moving in the right direction.

Mr. Chairman, I thank you again for convening this hearing and I hope that we can work together to find a good answer for America's seniors for this particular problem.

[The prepared statement of Hon. Tom Allen follows:]

PREPARED STATEMENT OF HON. THOMAS H. ALLEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MAINE

Chairman Bilirakis, Congressman Brown, distinguished Subcommittee members, thank you for this opportunity to join you today to discuss one of the most pressing health care needs of seniors today, the availability of prescription drugs.

Prescription drugs can improve, and often extend the lives of people with serious illnesses and chronic disabilities. Recent pharmaceutical breakthroughs offer hope and relief to patients suffering from Alzheimer's, AIDS and other deadly disorders. But the explosion in prices for prescription drugs, coupled with widespread and growing lack of prescription drug insurance coverage, has left millions of Americans unable to afford the drugs their doctors tell them they have to take.

The Need for Affordable Prescription Drugs for Seniors

Prescription drugs, no matter how innovative and effective, provide no benefit to people who cannot afford to take them. Who are the people left behind? Disproportionately, they are many of our nation's seniors.

Congress did not include an outpatient drug benefit when Medicare was created 35 years ago because pharmaceuticals played a much smaller role in health care and were not a significant cost to consumers. But today, seniors, who comprise 12 percent of the population, use one-third of all prescription drugs.

It is estimated that at least one-third of Medicare beneficiaries have no drug coverage at all and must incur these expenditures out-of-pocket. Medicaid is available only to the poor, often driven into poverty by rising medical bills. About 8 percent have Medigap drug coverage. But these plans are too expensive and inadequate for most beneficiaries.

About 17 percent of Medicare beneficiaries have coverage through Medicare managed care. These plans are very unstable. Some are dropping prescription drug coverage. Some are dropping out of Medicare entirely. In 1999 almost 400,000 people have been dropped form Medicare managed care plans. According to a recent report all Medicare HMOs will begin charging copayments for drugs next year. Already 21 percent of Medicare plans limit drug coverage to $500 or less. By next year 32 percent of Medicare managed care plans are expected to have such limits. Seniors deserve more predictability, continuity, stability, and equity than is offered by medicare managed care.

The National Economic Council and Domestic Policy Council report only about one quarter of Medicare beneficiaries have meaningful coverage provided by a retirement plan. Even these plans are even threatened by the high prices of prescription drugs. The proportion of firms offering retiree health coverage has declined by 25 percent in the last four years. Among the largest employers, over one-third have dropped coverage. A principal reason for dropping coverage is that employers cannot afford to pay for prescription drugs.

What does this lack of adequate coverage mean? The General Accounting Office has estimated that the misuse of prescription drugs costs Medicare an estimated

$20 billion per year in hospital and physician expenses. The National Economic Council reports that inappropriate use and underutilization of prescription drugs has been found to double the likelihood of low-income beneficiaries entering nursing homes. They report that drug-related hospitalizations accounted for 6.4 percent of all admissions of the over 65 population and that over three-fourths of these admissions could have been avoided with proper use of medications.

Perhaps most importantly, this lack of adequate coverage means that seniors are left to make choices that no one should have to make. Do they pay the rent or take their high blood pressure medication? Do they buy groceries this week or fill their prescription for an osteoporosis drug? We can do better by our nation's seniors.

Seniors are Paying the Highest Prices

As prescription drugs have become an increasingly important component of health care, the pricing practices of drug manufacturers have become increasingly discriminatory toward those least able to afford their products, especially seniors without prescription drug coverage.

Under the leadership of Representative Henry Waxman, who sits on this Subcommittee, the House Government Reform Committee minority staff have spent much of the past year and a half examining the drug prices charged to senior citizens and others who pay for their own drugs. They have conducted studies in over 80 Congressional Districts across the nation. The resulting studies confirmed a shocking pattern of price discrimination.

These studies examined the five to ten drugs that are most commonly prescribed to seniors. The studies found that older Americans pay, on average, almost *twice as much* as the drug companies' favored customers, such as large insurance companies and HMOs, for the medications with the highest dollar sales to seniors. For the top five drugs (Zocor, Prilosec, Norvasc, Procardia XL and Zoloft) the price differential in my district was 96 percent. This is a price differential four times greater than the average price differential for other consumer goods. In other districts the differential is significantly higher.

For some specific drugs the findings are even more dramatic. Synthroid', a commonly prescribed hormone treatment manufactured by Knoll Pharmaceuticals, costs favored customers $1.75 per dose. The study in my congressional district found that an uninsured Maine senior pays $29.80 for the same dose—a price differential of 1,600 percent.

The National Economic Council reports that by the year 2000, the average total drug costs for Medicare beneficiaries will be more than $1,100 per year. But averages are misleading. Many seniors already pay thousands of dollars every year. A Harvard Medical School study of patients with five patterns of disease common among the elderly found that the cost of prescription drugs ranges from $2,400 to $26,500 per year.

Not only are seniors in this country paying high prices for their drugs, they are paying more than consumers in other countries. The Government Reform Committee conducted a cost survey of medications commonly used by seniors in the U.S., Canada and Mexico for the same drugs in the same amounts from the same manufacturer. In my district American seniors pay 72 percent more than consumers in Canada, and 102 percent more than consumers in Mexico. Older Americans pay the highest prices in the world for their prescription drugs.

The Industry

The pharmaceutical industry earns more in profits ($26.2 billion in 1998) than it spends on research ($24 billion). Fortune magazine rates pharmaceuticals as the nation's most profitable industry: No. 1 in return on revenues (18.5 percent), assets (16.6 percent) and equity (39.4 percent). The profits of other industries that rely heavily on research pale in comparison: telecommunications, 11.5 percent; computer and data services, 5 percent; and electronics, 3.6 percent.

In short, the most profitable industry in the nation is charging the highest prices in the world to those who can least afford it, senior citizens without prescription drug coverage.

The Prescription Drug Fairness for Seniors Act

To protect America's seniors from this drug price discrimination, over 130 other members of Congress have joined me to support H.R. 664, The Prescription Drug Fairness for Seniors Act. Senators Edward Kennedy and Tim Johnson introduced a companion bill, S. 731. Our legislation gives Medicare beneficiaries the same advantages that large HMOs and other bulk purchasers like the federal government receive. Currently, virtually all federal health care programs, including the Veterans Health Administration, the Public Health Service and the Indian Health Service, ob-

tain prescription drugs for their beneficiaries at low prices. Our legislation takes the same common sense approach, which is to buy in bulk and save money.

H.R. 664 would allow pharmacies to buy prescription drugs for Medicare beneficiaries at the "best price" given by the manufacturers to the federal government. The best price to the government typically the Medicaid or Veteran's Administration price and, according to GAO, is close to the best price given by the manufacturers to private sector customers. In practice, the federal government would negotiate lower prices for beneficiaries who are already on a federal health care plan called Medicare.

I designed this bill to attract bipartisan support. This bill would not significantly increase federal spending. It creates no new federal bureaucracy. Yet it provides a price discount to seniors of up to 40 percent. While other plans for a prescription drug benefit under Medicare involve substantial expense, my plan involves no significant cost to the federal government or the taxpayers. I believe that H.R. 664 is a fiscally responsible approach relying on free market negotiation to ensure that Medicare beneficiaries get the prescription drugs they need.

The Prescription Drug Fairness for Seniors Act does not impose price controls on the pharmaceutical industry, it ends price discrimination. The bill enables senior citizens to purchase prescription drugs at the same prices the drug manufacturers offer to their favored customers. Rather than imposing a top-down, arbitrary price, the bill leverages the market power of the federal government. Companies can set their best price at whatever level they want and the market will bear. Given our government's social contract with seniors, it is fair and appropriate to use this buying power for the benefit of Medicare recipients, just as we do for other government-sponsored health care beneficiaries.

I understand the need for ongoing research and development in the drug industry. That is why I have supported efforts to extend the research and development tax credit as well as to increase funding for the National Institutes of Health. I am confident that if enacted, H.R. 664 will not force the pharmaceutical industry to reduce research expenditures. Competition within the pharmaceutical industry would assure continued investment.

The historical evidence assures us of continued research and development in this industry. The 1984 Waxman-Hatch Act increased the availability of generic drugs and provided more competition for brand name drugs. Despite the dire predictions of the pharmaceutical industry, the legislation did not stifle or even reduce innovation in the pharmaceutical industry. In fact, pharmaceutical companies more than doubled their investment in research and development, from $4.1 billion to $8.4 billion over the five years following enactment of Waxman-Hatch. Similarly, 1990 legislation that created a drug rebate, requiring drug companies to reduce their prices for drugs sold to the Medicaid program, did not reduce innovation in the pharmaceutical industry. Since 1990, pharmaceutical companies have almost tripled their spending on research and development, from $8.4 billion in 1990 to $24 billion in 1998.

While H.R. 664 is designed to assist all Medicare beneficiaries, it will not solve the problem. Medicare beneficiaries don't just need lower prices for their medications, they need coverage. The President has proposed a benefit, and Representatives Stark, Dingell and Waxman have proposed a benefit. I strongly support these initiatives and believe that it is time to update the Medicare program for the 21st Century and include a prescription drug benefit.

That said, I believe that the Prescription Drug Fairness for Seniors Act complements a prescription drug benefit. We must work to ensure that drug prices are lowered, even in the context of a benefit. With questions about the future viability of our nation's health care program for seniors, this approach will assist seniors without increased burdens on taxpayers.

Conclusion

Chairman Bilirakis, I again want to thank you for holding this hearing today. I realize that you, several of my colleagues on this panel, as well as many members of this subcommittee have proposals aimed at providing seniors with assistance in affording their prescription drugs. I look forward to working together toward a solution that makes prescription drugs affordable for all citizens in this country.

Mr. BILIRAKIS. Thank you, Mr. Allen. I feel sure that if we don't evidence a prior ownership, if you will, there is always hope that we will find a solution to this problem.

Mr. Berry.

STATEMENT OF HON. MARION BERRY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Mr. BERRY. Thank you, Mr. Chairman. I want to thank Ranking Member Brown also for holding this hearing today and I think you have it absolutely right, Mr. Chairman, when you said that no senior citizen in this country, the greatest Nation in the history of the world, should have to make a choice between food and medicine.

I believe providing seniors affordable access to prescription drugs is one of the most important health care issues pending in the Congress. I think it should be said that the pharmaceutical manufacturing companies are the only health care providers that have not contributed to holding down health care costs.

Every senior and Medicare beneficiary needs to have some kind of prescription drug coverage. The prices that seniors and others must pay for prescription drugs has risen much faster than the ability of senior citizens to pay for them. Congressman Stark and Allen have done a good job of explaining why Medicare recipients need prescription drug coverage, and the need to address the pricing situation cash-paying seniors are paying.

What I would like to talk about today is the need to level the playing field in the United States who are paying sometimes twice, and sometimes more than that, as much as seniors in other countries. As you may know, there are tens of thousands of American consumers who cross our borders just so they can get prescription drugs that they need at a cheaper price.

This is because they cannot afford to pay the outrageous high prices charged by the drug companies.

Seniors and other Americans go to Canada and Mexico because prescription drugs in those countries cost much less than in the U.S. recent studies that have been prepared for several Members of Congress have shown this.

In the district that I represent in Arkansas, seniors pay 72 percent more for the 10 prescription drugs they most commonly use than their elderly counterparts in Canada. Americans pay even more when compared to prices in Mexico. Seniors pay 103 percent more in Arkansas than they do in Mexico.

Why are seniors leaving this country to get cheaper drugs? The General Accounting Office reported in 1991 that out of 121 prescription drugs surveyed, 99 had higher prices in the United States than in Canada. In 21 of those cases, the price differential exceeded 100 percent.

In a similar study conducted in 1994 looking at price differentials in prescription drugs between the U.S. and the United Kingdom, the GAO determined that 66 of the 77 drugs surveyed were priced higher in the United States. In fact, four of the five most commonly dispensed drugs in the United States cost anywhere from 58 to 278 percent more in the U.S. than in the UK. And 47 of the drugs evaluated had a markup of over 100 percent.

This is because drug companies are the only ones allowed to reimport drugs made in the United States back into this country under current Federal law. The drugs are made in our country, shipped to Canada, England or other countries, and sold by their pharmacists and distributors in those countries, but if an American pharmacist or distributor wants to purchase these American-made

products at a much lower price in another country and pass the savings along to their customers, they are prohibited by law from doing so. Because the international marketplace is structured in this manner, manufacturers are able to charge a much higher price in the domestic marketplace.

Acting in a safe manner to close this loophole will give Americans billions of dollars on their prescription drug bills. Drug companies are the only ones allowed to reimport drugs made in the United States back into this country under Federal law, as I have already said. I have introduced legislation with Congresswoman Emerson and Congressman Bernie Sanders, H.R. 1885, the International Prescription Drugs Parity Act, that amends the Food, Drug and Cosmetic Act to allow American pharmacists to reimport prescription drugs into the United States as long as the drugs meet strict safety standards. This includes ensuring drugs are FDA-approved and made in FDA-approved facilities and have been stored and handled in compliance with FDA guidelines.

Our bill will remove nontariff barriers to trade that cause American citizens to pay significantly more for FDA-approved drugs than citizens of any other country in the world. Thus, American pharmacies and distributors benefit by purchasing their drugs at lower prices, which they can pass along to American consumers.

When Americans are allowed to benefit from this competition in the international marketplace, the free market will eliminate the ability of manufacturers to overcharge Americans more for the exact same products, and the market forces will cause manufacturers to charge fairer prices for their products within our country.

Our bill will give American citizens the same purchasing opportunities as citizens of other countries. This legislation is a fair, common-sense, free-market approach to lowering drug prices for our constituents while benefits small business. We need to put the American consumer on a level playing field with consumers in Canada, Mexico and other countries.

Thank you, Mr. Chairman, for your time.

[The prepared statement of Hon. Marion Berry follows:]

PREPARED STATEMENT OF HON. MARION BERRY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Thank you Chairman Bilirakis and Ranking Member Brown for holding this hearing today.

I believe providing seniors affordable access to prescription drugs is one of the most important health care issues pending in Congress. Every senior and Medicare beneficiary needs to have some kind of prescription drug coverage. The prices seniors and others must pay for prescription drugs has risen much faster than the ability of senior citizens to pay for them.

Congressmen Pete Stark and Tom Allen have done an excellent job of bringing attention to why Medicare recipients need prescription drug coverage and also the need to address the pricing situation cash-paying seniors are facing.

What I would like to talk about today is the need to level the playing field for seniors in the U.S., who are paying sometimes twice as much as seniors in other countries. As you may know, there are tens of thousands of American consumers who cross our borders just so they can get the prescription drugs they need at a cheaper price. This is because they cannot afford to pay the outrageously high prices charged by the drug companies.

Seniors and other Americans go to Canada and Mexico because prescription drugs in these countries cost much less than in the U.S. Recent studies that have been prepared for several members of Congress have shown this. According to a Government Reform minority study prepared for my district, seniors pay 72% more than

Canadians for the 10 brand name prescription drugs with the highest dollar sales to the elderly in the United States. Americans pay even more when compared to prices Mexican seniors pay—103% more for Arkansans.

GAO reported in 1991 that out of 121 prescription drugs surveyed, 99 had higher prices in the United States than in Canada (in 21 cases, the price differentials exceeded 100%). In a similar study conducted in 1994 looking at the price differentials in prescription drugs between the United States and the United Kingdom, GAO determined that 66 of the 77 drugs surveyed were priced higher in the United States. In fact, four of the five most commonly dispensed drugs in the United States cost anywhere from 58-278% more in the United States than in the United Kingdom, and 47 of the drugs evaluated had a mark-up of over 100%.

This is because the United States does not benefit from global price competition since drug companies are the only ones allowed to reimport drugs made in the United States back into this country under current federal law. The drugs are often made in our country, shipped to Canada, England or other countries, and sold by pharmacists and distributors in those countries. But if an American pharmacist or distributor wants to purchase these American-made drugs at the much-lower price and pass the savings along to their customers, they are prohibited by law from doing so. Because the international marketplace is structured in this manner, manufacturers are able to charge a much higher price in the domestic marketplace.

Acting in a safe manner to close this loophole will save Americans billions of dollars on their prescription drug bills. I have introduced the International Prescription Drug Parity Act, H.R. 1885, with Rep. Emerson and Rep. Bernie Sanders, which amends the Food, Drug, and Cosmetic Act to allow American distributors and pharmacists to reimport prescription drugs into the U.S. as long as the drugs meet strict safety standards, this includes ensuring the drugs are FDA approved, made in FDA approved facilities, and have been stored and handled in compliance with FDA guidelines.

The *International Prescription Drug Parity Act* will remove this non-tariff barrier to trade which causes American citizens to pay significantly more for FDA approved drugs than citizens of any other country.

American pharmacies and distributors could benefit by purchasing their drugs at lower prices, which they can then pass along to American consumers, and allowing this to happen would result in fairer pricing at the manufacturing level in the United States. When Americans are allowed to benefit from price competition in the international marketplace, the free market will eliminate these discriminatory pricing practices that harm Americans.

H.R. 1885 will give Americans the same purchasing opportunities as citizens of other countries. This legislation is a fair, common-sense, free-market approach to lowering drug prices for our constituents while benefitting small businesses. We need to put the American consumer on level playing field with consumers in Canada and other developed countries.

Thank you for allowing me to testify today.

Mr. BILIRAKIS. Thank you, Mr. Berry.

Mr. Gilman, the chairman of the International Relations Committee, a very busy man. We are pleased to have you.

STATEMENT OF HON. BENJAMIN A. GILMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. GILMAN. Thank you, Mr. Chairman, and I thank you and Mr. Brown and our colleagues on the committee for providing this opportunity for me and my colleagues to testify at this hearing examining the various alternatives to address this serious challenge posed by the high cost of prescription drugs for today's low- and middle-income seniors.

Along with many of our colleagues, I have heard from so many of our seniors voicing their concerns about the ever-increasing costs associated with their monthly prescription drug requirements. In response, I have introduced H.R. 2375, entitled the Senior Prescription Drug Assistance Expansion Demonstration Act of 1999. In doing so, I am offering legislation which can, Mr. Chairman, serve

as a viable first step toward addressing the serious issue of the rising prescription drug costs.

The purpose of my legislation is to provide assistance to those States which have already undertaken an important step in offering supplemental assistance for low-income seniors to help defray the rising costs of their prescription medications. This legislation will provide a demonstration project that will provide block grant funding to permit three States with an existing prescription assistance program for low-income seniors to raise their income eligibility by $5,000 for both single individuals and for married couples. Should this program prove to be successful, it can later be expanded to many other States that have created such prescription assistance programs.

It would encourage States to undertake these programs. My bill, H.R. 2375 recognizes the States with existing prescription plans have widely varying requirements with regards to the administration of those plans. Consequently, this bill does not alter those requirements in any way except to qualify for Federal funding, each State must raise its income eligibility for both single and married couples.

Mr. Chairman, the last 5 years have seen a rapid increase in the amount of revolutionary medications available on the market. At the same time, these new drugs come with an ever-increasing price tag. The availability of these new drugs has been a wonderful result of annual advances in medical technology and knowledge. Regrettably, though, the price that accompanies these new medications has become increasingly burdensome for so many of our seniors.

A number of our colleagues in the House as well as in the other body have offered a number of bills, as demonstrated today, designed to address the rising costs of prescription medications for seniors. And we commend you, Mr. Chairman, and the members of your committee for your bipartisan approach. These bills have tended to utilize either price controls or the extension of free or heavily subsidized prescriptions as a new Federal entitlement as a solution to this problem.

Our Nation's experience, though, with price controls during prior administrations in the 1970's has demonstrated that price controls are not a viable tool. Moreover, while the new entitlement proposed by the current administration sounds appealing, the President has downplayed both the 50 percent copayment requirement in his plan as well as concerns that a universal prescription entitlement will displace existing company-based plans for retired employees.

Furthermore, price controls for prescription drugs run the very real risk of stifling future development in medical advances, and while none of the major drug companies has any reason to plead poverty, there is concern that the implementation of a Federal system of mandatory price controls would serve as a major disincentive for future research and development of new prescription medications.

In that sense, medical success does come with a price. On the other hand, prescription prices should not be so high that the target audience for which the drugs were developed cannot afford to purchase those drugs.

Regrettably this has been increasingly the case over the past several years for our seniors who live on fixed incomes. The Federal Government has a vital role to play in fostering innovation in medicine so that today's seniors can receive the benefits of tomorrow's new medical technology. The last few years have seen wonderful advances in drugs to treat such problems as osteoporosis, arthritis, and Alzheimer's.

At the same time, a new federally run bureaucracy is certainly not the answer to address the needs of our seniors being able to afford new medications as they become available. Such a bureaucracy would take medical decisions with regard to which drugs to prescribe away from the physicians, dampen the overall level of medical research on new drugs, and force our seniors to accept a one-size-fits-all Federal program.

My legislation sets out to avoid those problems. It expands on the ideas that the States have shown do work in practice. The EPIC program in New York State has been a highly successful program. Both parties in Albany have consistently voted to expand that program each and every year. However, the State officials also recognize that New York State cannot afford on its own to cover every senior that it should. New York's EPIC program provides assistance to State residents aged 65 and over. Its budget, $68 million in this past year, comes out of the State's general fund. The eligible income levels top out at $18,000 for an individual and $23,700 for a married couple. Annual deductibility ranges from $468 to $638. The New York EPIC plan covers the bulk of prescription costs. Plan members are responsible, though, for a copayment of $3 to $23, based in large part upon the actual cost of the prescription.

By partnering with New York State——

Mr. BILIRAKIS. If you would summarize, Ben, I would appreciate it.

Mr. GILMAN. I am concluding, Mr. Chairman. I recognize that I have taken a great deal of time.

By partnering with New York State and other States with prescription assistance programs, the Federal Government is going to be able to both provide aid to thousands of seniors on fixed incomes with their monthly prescription drug bills while leaving prescribing authority where it belongs, with the physicians. In essence, everyone would win.

Mr. Chairman, I thank you for your patience and for permitting us this opportunity to testify.

[The prepared statement of Hon. Benjamin A. Gilman follows:]

PREPARED STATEMENT OF HON. BENJAMIN A. GILMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Chairman, I want to thank you for permitting me to testify this afternoon, at your hearing examining the various alternatives to address the challenge posed by the high cost of prescription drugs for today's low and middle income seniors.

Along with many of my colleagues, I have heard from many constituents voicing their concerns about the ever increasing cost associated with their monthly prescription drug requirements. In response, I introduced H.R. 2375, the Senior Prescription Drug Assistance Expansion Demonstration Act of 1999. In doing so, I am offering legislation which can serve as a viable first step towards addressing the serious issue of rising prescription drug costs.

The purpose of my legislation is to provide assistance to those states which have taken an important step to offer supplemental assistance for low income seniors to help defray the rising cost of prescription medication.

This legislation will create a demonstration project that will provide block grant funding to permit three states with an existing prescription assistance program for low income seniors to raise their income eligibility by $5,000 for both single individuals and married couples. Should the program prove to be successful, it can later be expanded to other states that have created such prescription assistance programs.

H.R. 2375 recognizes that the states with existing prescription plans have widely varying requirements with regards to the administration of these plans. Consequently, it does not alter these requirements in any way, except that, to qualify for the federal funds, each state must raise its income eligibility for both single and married categories.

Mr. Chairman, the last five years have seen a rapid increase in the amount of revolutionary medications available on the market. At the same time, these new drugs come with an ever increasing price tag. The availability of these new drugs has been a wonderful result of annual advances in medical technology and knowledge. Regrettably, the price that accompanies these new medications is increasingly burdensome for many senior citizens.

A number of our colleagues in this House, as well as in the other body, have offered various bills designed to address the rising cost of prescription medications for seniors. These bills have tended to utilize either price controls, or the extension of free or heavily subsidized prescriptions as a new federal entitlement, as a solution to this problem.

The Nation's experience with price controls during the Nixon Administration in the 1970s has demonstrated that they are not a viable tool. Moreover, while the new entitlement proposed by the current administration sounds appealing, the President, has downplayed both the 50% copayment requirement in his plan, as well as concerns that a universal prescription entitlement will displace existing company based plans for retired employees.

Furthermore, price controls for prescription drugs run the very real risk of stifling future development in medical advances. While none of the major drug companies has any reason to plead poverty, there is a concern that the implementation of a federal system of mandatory price controls would serve as a major disincentive on the future research and development of new prescription medications. In this sense, medical success does come with a price.

On the other hand, prices should not be so high that the target audience for which the drugs were developed cannot afford to purchase those drugs. Regrettably, this has been increasingly the case over the past several years for seniors living on fixed incomes.

The Federal Government has a vital role to play in fostering innovation in medicine, so that today's seniors can receive the benefits of tomorrow's new medical technology. The last few years have seen wonderful advances in drugs to treat osteoporosis, arthritis, and alzheimer's disease.

At the same time, a new federally run bureaucracy is not the answer to address the needs of our seniors being able to afford these new drugs as they become available. Such a bureaucracy would take medical decisions with regard to which drugs to prescribe away from doctors, dampen the overall level of medical research on new drugs, and force seniors to accept a one-size-fits-all federal program.

Mr. BILIRAKIS. Thank you very much, Ben. And thank you so much for your hard work.

Before the Chair goes into his 5 minutes, without objection, I would like to ask unanimous consent that a letter from David Kessler to the Honorable John Dingell dated June 29, 1999, be made a part of the record.

[The letter follows:]

The Honorable JOHN D. DINGELL
2328 Rayburn House Office Building
United States House of Representatives
Washington, DC 20515

DEAR REPRESENTATIVE DINGELL: You may recall that there has been a continuing controversy about the re-importation into the United States of prescription drugs manufactured here and exported abroad (so-called "American Goods Returned"). As you know the Prescription Drug Marketing Act of 1987 (the PDMA), P.L. 100-293

(Apr. 22, 1988), of which you were the principal sponsor in the House prohibits such reimportation. As the former FDA Commissioner who oversaw the implementation of many of the provisions of the PDMA, I wanted you to know of my concerns about this issue.

I believe the prohibition on re-importing exported drugs serves two critical public health purposes: (1) preventing the introduction into U.S. commerce of prescription drugs that may have been improperly stored, handled, and shipped overseas, and (2) reducing the opportunities for importation of counterfeit and unapproved prescription drugs. I know you will recall that the Energy and Commerce Committee described these purposes in its report accompanying the bill that became the PDMA.

Specifically, the existence and method of operation of a wholesale submarket, herein referred to as the "diversion market," prevents effective control over or even routine knowledge of the true sources of merchandise in a significant number of cases. As a result, pharmaceuticals which have been mislabeled, misbranded, improperly stored or shipped, have exceeded their expiration dates, or are bald counterfeits, are injected into the national distribution system for ultimate sale to consumers.

A significant volume of pharmaceuticals is being reimported to the United States as American Goods Returned. These goods present a health and safety risk to American consumers because they may have become subpotent or adulterated during foreign handling and shipping. The ready market for reimports has also been a catalyst for the perpetration of a continuing series of frauds against American manufacturers, and has provided the cover for the importation of counterfeit pharmaceuticals in several cases. Moreover, the hazards associated with reimports have forced the Food and Drug Administration and U.S. Customs Service to spend inspectional and other resources that are sorely needed in other areas.

H.R. Rep. No. 76, 100 Cong., 1st Sess. 6-7 (1987).

In 1986, the Oversight and Investigations Subcommittee of the Energy and Commerce Committee, which you chaired, described the public health and safety concerns of allowing "American Goods Returned" as follows:

[T]he clear and present danger to the public health from reimported pharmaceuticals is the threat that subpotent, superpotent, impotant or even toxic substances labeled as U.S.-produced legend drugs will enter the distribution system. The foremost danger comes from so-called "generic" drugs produced in developing countries that do not provide product patent protection for pharmaceuticals.

Uncertain Returns: The Multimillion Dollar Market in Reimported Pharmaceuticals, 99th Cong., 2nd Sess, 23 (Comm. Print 99-GG 1986). One well-publicized example involved importation of more than one million counterfeit birth control pills, complete with counterfeit packaging and labeling. Id. Dangerous Medicine: The Risk to American Consumers From Prescription Drug Diversion and Counterfeiting, 99th Cong., 2nd Sess, 22 (Comm. Print 99-Z 1986).

In my view, the dangers of allowing re-importation of prescription drugs may be even greater today than they were in 1986. For example, with the rise of Internet pharmacies, the opportunities for illicit distribution of adulterated and counterfeit products have grown well beyond those available in prior years. Repealing the prohibition on re-importation of drugs would remove one of the principal statutory tools for dealing with this growing issue.

I know one argument now being made for allowing re-importation is that this would make lower priced prescription drugs available to U.S. consumers. But, your Committee effectively rebutted that argument in 1986, in terms that seem to me to be equally applicable today.

Pharmaceuticals re-imported by diverters displace full price sales in the wholesale market. Moreover, prices to ultimate consumers are generally not lowered as a result of diversion. Rather, the profits go to the various middlemen, here and abroad, while consumers bear the risk.

Uncertain Returns, supra, at 32 (emphasis added). See also Dangerous Medicine, supra, at 25-26 ("there is little or no significant benefit to consumers from pharmaceutical reimportation, and there are obvious costs in terms of health and safety risks and utilization of scarce FDA resources").

I know of no changed circumstances that require either a shift in FDA policy or the passage of legislation to repeal PDMA's prohibition on re-importing drugs. Furthermore, I believe that such a repeal or change in policy would re-create the substantial public health risks PDMA was designed to eliminate. I would welcome your analysis and comments on this matter.

Sincerely,

DAVID A. KESSLER, M.D.

Mr. BILIRAKIS. And additionally at the request of Chairman Bliley, there are a number of letters here from patient advocacy groups regarding their concerns about bills that would impose price controls on the pharmaceutical industry: A letter from WomenHeart, the national coalition for women with heart disease, dated October 4, 1999; a letter from the International Patient Advocacy Association, dated October 4, 1999. I ask unanimous consent that all of those letters be made a part of the record.

[The letters follows:]

THE NATIONAL COALITION FOR WOMEN WITH HEART DISEASE
October 4, 1999

The Honorable TOM BLILEY
Chairman
Committee on Commerce
U.S. House of Representatives
Washington, DC 20515

DEAR MR. CHAIRMAN: The National Coalition for Women with Heart Disease was founded by young women heart attack survivors to respond to and advocate for the concerns of the 8,000,000 American women living with heart disease. One of our primary concerns is increasing the access of women to advanced medicines. We also want to encourage the development of new and better medicines for heart disease.

The Coalition appreciates the concern expressed by this Committee and others in Congress about access to medicines, particularly among the Medicare population. We favor enhanced access to medicines, but we have concerns about some of the bills introduced that would use price control mechanisms to achieve this end.

We believe that the real issue is pharmaceutical coverage, and we respectfully suggest that Congress concentrate its energies in expanding coverage under Medicare a comprehensive reform that will allow beneficiary choice and will encourage research and development.

Sincerely,

NANCY LOVING
President

cc: Members of the Subcommittee on Health and Environment

INTERNATIONAL PATIENT ADVOCACY ASSOCIATION
October 4, 1999

The Honorable TOM BLILEY
Chairman
Committee on Commerce
U.S. House of Representatives
Washington, DC 20515

DEAR MR. CHAIRMAN: As a patient who was saved from death or crippling disability by an innovative medicine, I want everyone to have the benefits of modern medicines. Unfortunately, I do not believe that many of the bills recently introduced with the stated goal of increasing access to medicines would accomplish this goal. Specifically, I ask that you reject the legislation introduced by Representatives Allen, Sanders and Brown. All of these bills include price controls, in one form or another, and price controls would deprive patients of future cures.

In 1986, at the age of 27, I learned that I had Gaucher disease—a rare disorder for which there was then no known treatment. After several years of suffering and narrow escapes from death, my life changed dramatically, because of a new drug called Ceredase, which supplies the enzyme people with Gaucher disease lack. Because of this drug, I am alive and well today. To help others with rare diseases, I founded the International Patient Advocacy Association. Like me, our members know the value of pharmaceutical research and the need to encourage it. For this reason, the International Patient Advocacy Association asks Congress to reject the aforementioned price control bills.

Sincerely,

LENNY VAN PELT
Executive Director

cc: Members of the Subcommittee on Health and Environment

NATIONAL KIDNEY CANCER ASSOCIATION
October 4, 1999

The Honorable TOM BLILEY
Chairman
Committee on Commerce
U.S. House of Representatives
Washington, DC 20515

DEAR MR. CHAIRMAN: The Kidney Cancer Association acts as an advocate for patients with kidney cancer and their families. More than 25,000 new cases of kidney cancer are diagnosed annually, and the disease takes the lives of more than 11,000 Americans each year. One of our primary goals is to encourage both public-sector and private-sector research on kidney cancer.

Earlier this year, we went on record in opposition to The Prescription Drug Fairness for Seniors Act of 1999, because it would chill the incentives for research on cures for diseases, including kidney cancer. Price controls and innovation don't mix. Our members don't need price controls—they need their government to provide incentives for companies to develop new drugs.

More recently, other bills that would have a similar chilling effect on research have been introduced, namely The International Prescription Drug Parity Act introduced by Rep. Sanders and the Compulsory Licensing bill introduced by Rep. Brown. Both of these bills would reduce the incentives to develop new medicines that patients with kidney cancer need.

We believe that Congress should reject such approaches—which won't help and which will do a lot of harm—and, instead, craft a comprehensive Medicare reform that would enhance the access of beneficiaries to state-of-the-art medicines.

Sincerely,

CARL DIXON
President

cc: Members of the Subcommittee on Health and Environment.

Mr. BILIRAKIS. I think it is important that we not tear each other's ideas apart. It is critical because we all have good ideas. I am going to concentrate on Mr. Berry's comments. You make good points, and how could anyone quarrel with the fact that these things you mentioned do take place.

Back in 1987, the Prescription Drug Marketing Act was approved by this committee, and that bill was intended to prohibit reimportation of prescription drugs. I am not sure whether you are aware of that, Mr. Berry. Then-Chairman John Dingell reasoned that reimported pharmaceuticals posed a serious health and safety threat to consumers. The letter that I have referred to from former FDA Commissioner David Kessler expressed his concerns—and I am just going to quote from that letter: "In my view the dangers of allowing reimportation of prescription drugs may be even greater today then they were in 1986. I know of no change of circumstances that require either a shift in FDA policy or the passage of legislation to repeal PDMA's prohibition on reimporting drugs. Furthermore, I believe that such a repeal or change in policy would recreate the substantial public health risks PDMA was designed to eliminate."

And I go into those, Mr. Berry, because it is an obstacle that you have to surmount, obviously, so I would ask you what is your assessment of these comments?

Mr. BERRY. Mr. Chairman, we already import $18 billion worth of pharmaceuticals into this country every year. We allow private citizens to go across the border any time and buy up to a 3-months' supply of these products and bring them back into this country, and we have not had any problem from that, and I think it is bogus. I think I would have to see some evidence here that—we are in the international marketplace.

A member of my staff just a few weeks ago got on the Internet and ordered prescription medicine from New Zealand, got it within 3 or 4 days, and it came in anyway. And it was made in this country. It is a good product. There is nothing wrong with it. It costs one-third what it would have cost to go down to CVS to buy it.

I just think that we have to recognize we are in a world marketplace. We import into this country every day food that sometimes we have a problem with. But what I am talking about is products that are made in FDA-approved facilities, and they are FDA-approved products. We are already doing this. All we are doing is protecting the manufacturers' market and protecting—giving them a monopoly situation as far as their ability to price their product. And if it is so necessary to have these protections, why do the other countries not have to have to do this?

Mr. BILIRAKIS. Well, I guess——

Mr. BERRY. And why do we charge 2, 3, 4 times as much for the products in this country as they do in other countries?

Mr. BILIRAKIS. I guess we could always ask why does it take FDA to be so concerned about the safety and quality of drugs as against the time of approvals in many other countries.

Mr. Allen, your bill would require manufacturers to sell their products to pharmacies at a government-set price. I say that only from the standpoint that it would be basically the best available price or the lowest price paid by any government agency. That is what I mean. My question is, what guarantee is there that the pharmacies then will pass these savings on to the beneficiaries?

Mr. ALLEN. If I could respond first, it is not a government-set price, in my opinion, at all. All we are saying is if the pharmaceutical industry, a pharmaceutical manufacturer, gives a discount to the Federal Government or to HMOs or to hospitals, but particularly to the Federal Government, then those who are on Medicare, beneficiaries under a Federal health care plan ought to get the same discount. It is very simple. The idea is simple. It is just buy in bulk and save money. And there is no reason why that, by itself, is a government-set price. I don't believe it is.

Mr. BILIRAKIS. And I appreciate your explaining that it is either the lowest price paid by any government agency or the best price for the drug as the term is defined under Medicaid. Whether we say government-set price or not, I think it probably ultimately amounts to that. But how, again, can we be sure that the pharmacies will pass those discounts or discount prices or savings on to the beneficiaries?

Mr. ALLEN. You can be sure because the retail pharmacy market is a competitive market. All of our studies, 80 studies around the country, have shown that the markup charged by retail pharmacies is by and large a single-digit markup, and with few occasions it may be a low double-digit markup, but 75 to 80 percent of the price differentials or price discrimination that we found is as a result of pricing at the wholesale level. Wherever you go, if you talk to seniors, you find this as well. They are checking around among pharmacies in the area to find the lowest price. The pharmacies are trying to, you know, get something of a markup, but they are limited in how much they can mark up their prescription drugs by the competitive marketplace.

If we had—if we had tried to set controls at the retail level, that would be price controls, and those people who are opposed to this bill because they claim it is price controls now would be even more upset by it. But the truth is that we felt as a competitive market, at the retail level we should leave it alone, and because there is a competitive market, a discount at the wholesale level will be passed on over time.

Mr. BILIRAKIS. I thank you. My time has expired.

Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

One panelist mentioned product licensing is a Third World pricing mechanism. Actually, product licensing, far from being a Third World phenomenon, is used and has been used and is being used in England and France and Germany and Israel and Japan and a host of smaller countries, too. And according to a fact book put out by—and I use that term lightly—PhRMA, the trade association for the drug companies, half of all new medications are developed in the United States. And by quick reasoning, I figured out that, therefore, half of all new medications are not developed in the United States, and that means a significant number of those prescription drugs are developed in countries that use price controls. Some use product licensing. Some use parallel imports. All of those countries where half the new drugs are developed are in countries where they charge significantly lower prices than they do in this country for drugs.

So the companies, I guess—inferring then, the companies don't seem to have any trouble, drug companies, developing new—with the research and development, developing new prescription drugs in those countries. So I guess for Mr. Allen and Mr. Berry, comment, if you will, based on that and based on other thoughts that you have had about this whole process. Comment, if you will, Mr. Berry, first, and then perhaps Mr. Allen, on this threat by PhRMA and by the drug industry and their using front groups like some of those letters that we see all the times, letters to the editors and letters circulating from groups we have never heard of. It is not the Kidney Foundation, the major group; it is some offshoot group that the drug companies are generally funding. Comment, if you would, on their threats that they will have—their research and development will dry up. Mr. Berry?

Mr. BERRY. The drug companies, when the bill was passed—and I don't remember what year it was, but when we actually made generic drugs a viable thing in this country, the drug companies said the same thing. If we allow generic drugs, all the research will stop. The fact is that they have dramatically increased their research. The research and the new products that the drug companies produce are their life blood for profits, and they are not going to stop doing that. That is the way they make their money. And that is a good thing. We want them to make money.

But the fact is they are not going to stop doing that, and that is just another bogus argument. It is interesting that the drug companies are willing to even ask for patent extensions on drugs at a time when they are already charging us three and four times for that product as they do people in Canada or Mexico or Europe or

wherever you want to go. It is just a smoke screen to try to continue this overpricing system that they have for Americans.

Mr. BROWN. Mr. Allen?

Mr. ALLEN. I actually have some numbers in front of me, and Congressman Berry is right. Just look at history. I mean, this is an industry which always comes in and says, if you try to contain our prices, we will cut back on research and development, but then they don't do it. In 1984, the Waxman-Hatch Act was passed that increased the availability of generic drugs and provided more competition for brand-name drugs, and the industry had said, well, this will force us to cut back on research and development, but in the 5 years following enactment of that legislation, they increased their R&D from $4.1 billion to $8.4 billion.

Then in 1990, legislation was passed that created the drug rebate requiring companies to reduce what they were charging for Medicaid, Medicaid program, and since 1990 pharmaceuticals have almost tripled their spending in R&D from $8.4 billion in 1990 to $24 billion in 1998. The same thing will happen.

The basic point is this: Their profits come from their patents. Their patents run out. The only way they can be successful is to develop new drugs. So they will always do research and development. For this particular industry, research and development is critical, and there is no way the Federal Government can stop them from doing that, and no way we want to stop them from doing that.

Mr. BROWN. Thank you.

Mr. Stark, having known you for 7 years, and knowing that you probably don't watch a lot of television, but also knowing that you have an opinion on virtually everything, and particularly a good staff that you are known for sitting behind you, we hear this about bipartisanship. Let's do this together. Are those Flo ads adding anything to public understanding?

Mr. STARK. No. They are good, though. The ranking member of the health committee when I chaired in the Ways and Means later sponsored the Larry and Louise ads and knocked our socks off when we tried to bring a health reform bill. And as a politician I have a deep respect for negative advertising when it is done well, I just don't like it when it is directed against me. So it is going to cause us some problems politically. You can scare people. That is how you sell Noxzema, because you are afraid you are going to get zits, and you scare people that nobody will like you with zits.

Mr. BROWN. Actually, that was for Clearasil, Mr. Stark, but you are obviously from a generation that doesn't remember that.

Mr. BILIRAKIS. I guess we can bring up a lot of instances from both sides of the aisle regarding scaring people and ads and misleading ads.

Mr. STARK. It is a political tactic, Mr. Chairman.

Mr. BILIRAKIS. Well, it is a terrible political tactic.

Mr. STARK. But it works.

Mr. BILIRAKIS. Mr. Bryant.

Mr. BRYANT. Thank you, Mr. Chairman, and let me join in the chorus of this panel in thanking you and Mr. Brown for this series of hearings on a very important issue. I doubt there is a Member in Congress who holds town meetings that doesn't deal with this

issue of increasing drug cost and what do we do in terms of senior citizens, people on Medicare.

And I just flew in from my district and missed, unfortunately, some of the statements, including Mr. Fletcher, and I wanted to ask, Ernie, if you would grab a microphone so I could ask you a couple of questions about what you are talking about in your statement. I hurriedly went through this, and I know that you referenced there—first of all, let me commend each one of the panelists, too, for stepping forward and offering proposed solutions to this problem. I think it is going to take maybe some combination of what some of you are saying to help me work through this process.

But, Mr. Fletcher, in terms of your statement, you included reference to the President's bill. And in the first hearing last week, I had concerns about that because while you can quarrel with the quality and the nuances of the various bills, the various policies out there, I think the Medicare survey in 1995 showed that some 65 percent of the Medicare recipients did have some sort of drug benefit, whether it was at the low end through Medicaid and those kinds of low-income supplements that helped poor people get prescription drugs, or perhaps at the other end for people who could afford to buy Medigap policies or who were on Medicare+Choice and where a drug prescription was a benefit of that policy.

And so really what we are talking about are those people, if you subtract 65 percent from 100 percent, really it seems to me our first obligation, our first order of priority ought to be to reach that other 35 percent that do not have that benefit. And it may be later we can come back and look at the quality of some of that 65 percent's drugs coverage, but our first priority ought to be to reach out to the 35, 36 percent of people that don't have that drug benefit. And I think you suggest a couple of things in what you are doing that would set that same priority. Can you comment further on that?

Mr. FLETCHER. Yes, Mr. Bryant, I appreciate that. It is important as I think we look—there is really two different subjects here. One is, are pharmaceuticals overpricing? But right now when we are facing the immediate problems out there, we are facing a number of about 6 million people, a little more than that, that are in that income bracket where they fall through the cracks. They cannot afford the Medigap plans, and they do not qualify for Medicaid or some of the other programs that help low income.

There are 13 States that have already started programs and they are very similar to the CHIPs program for our children where they provide low-income assistance on their Medicare prescription drugs. This will address the real need for the individuals there that are not able to afford their medications.

I think if we begin to address where the real problems are, as you have identified, then I think we have start to address this problem in a way that not only can increase the competition among pharmaceuticals, but we can begin to have more competition, and I think we can address some of the other concerns with a great deal of dialog. But I think you have very aptly pointed out that we are talking about 44 percent of that 35 percent, which amounts to

about 6 million people that would benefit substantially from what we are trying to do.

Mr. BRYANT. The first part covers the States working basically, as you say, similar to a CHIPs program. Is there another component to this also?

Mr. FLETCHER. There is. There is one where we have enhanced Medicaid payments for those folks 150 percent below the poverty level, and then the standard Medicare reimbursment for States at 200 percent, but we also have some stop loss. It depends on what you look at. You have anywhere from 5 to 15 percent that end up having increased cost of medication, so they may not fall within that 200 percent below poverty level, but they are incurring a tremendously high cost of prescriptions.

We just got a call from a retired State employee receiving health benefits through Kentucky retirement for persons 65 years of age, and he has now become eligible for Medicare, but because the plan that he had was much better than Medicare, and by being forced into Medicare, he is going to lose prescription coverage, and he is at that income where he can't afford that and probably will not qualify for Medicaid. We have a plan that will help those people with high prescription drug cost be able to get into the plans that will be able to get the negotiated costs from the larger negotiated prices that are reduced so they will be able to afford those and get into it and would help those individuals in particular.

Mr. BRYANT. Mr. Chairman, I yield back the balance of my—I have no time.

Mr. BILIRAKIS. You yield back the balance of time that you don't have; right?

Mrs. Capps?

Mrs. CAPPS. Thank you. And again, Mr. Chairman, it is clear to me that our distinguished panel of witnesses, a bipartisan panel, gives us the framework for what I believe should be a bipartisan discussion on the floor on this very topic because of its timeliness and because of its urgency all across the country.

I will just comment on something that Congressman Berry said. I come from a border State, and you talked about people going across the border to buy their prescription drugs. I was just joined by two of my constituents from Santa Maria, California. We are 300 miles from the border, and so many people in my central coast area drive regularly to Tijuana, across the border, to buy their prescription drugs and have been doing so and will continue to do so. It is not that they want to drive down there; that is the only way they can afford their prescriptions.

So you clearly—whether the studies indicate it, whether your bill passes or not, patients are doing it. And I believe that is a symptom of something that is not working right in our country.

Congressman Allen, you know, I am a cosponsor of your bill and glad to be that because the study in my district indicated that the markup for seniors for the top 10 most commonly used medications is 113 percent. And yet the answer always comes back from the drug companies, that your bill is price controls. But I think about the fact that we have the veterans as a group who are negotiating a lower price and the HMOs as well. Explain for me again—you

know, you deal with this every day—it is like the one argument that comes back to us about the reason we shouldn't be doing this.

Mr. ALLEN. The argument about price controls?

Mrs. CAPPS. Yes.

Mr. ALLEN. Well, the fact is that when you think about this issue, the legislation I have introduced simply says pharmacies should be able to buy drugs for Medicare beneficiaries at the best price given to the Federal Government. The best price given to the Federal Government is going to be a matter of negotiation. It largely is now, either through the VA or through Medicaid. And one of the reasons, in one of those programs there is a statutory discount, but it is a statutory discount from what is called the average manufacturer's price. That is a market price.

Basically, the pharmaceutical industry has chosen this price structure. The pharmaceutical industry has decided to charge seniors who don't have any coverage twice as much as HMOs, twice as much as big hospitals, twice as much as the Federal Government, and far more than citizens pay in Canada, Mexico and around the world.

All we are saying is that the Federal Government should act as the negotiating agency on behalf of the 39 million Americans who are on Medicare. It is a Federal health care plan. The Federal Government sets reimbursement rates for doctors, nurses, home health care agencies and hospitals. All we are saying is that they should make sure that seniors get a break; get not a huge break, just the break that HMOs and hospitals and the Federal Government itself gets. And what would happen is the industry would be faced—and this is why they don't like it—with a very big buyer. It is not that the government is going to tell them they have to sell a drug at a particular price. It is that for once there would be real negotiating power on the other side of the table. That is what the industry doesn't like, but that is what our seniors need.

Mrs. CAPPS. I appreciate that reinforcement of what you said before. I guess my final—I know we have things to do—final appeal to you, Mr. Chairman, is something that Congressman Stark said. Any of these bills would be better than what we have today. And I would just urge—this is such an important topic, and I appreciate your urging us to keep the spirit of bipartisanship, which I believe here today we have evidenced, and I think we could do this on the floor as well. I think we should.

Mr. BILIRAKIS. Thank you. And I appreciate Mr. Stark's comments. It is just important that we do something that will be better than what we have now. It may not be perfect, it may not be all that some people think it should be, but it will be better than we now have.

Mr. Greenwood?

And I would like very much if we can all cooperate here. I don't mean to shut anyone off, but it would be great if we could finish up so that these gentlemen don't have to come back.

Mr. GREENWOOD. Thank you, Mr. Chairman. And I thank the members of the panel for your testimony.

When I think of providing prescription drug benefits for seniors, I have about five bottom lines. The first is that in this day and age, and certainly in the future, if you don't have a prescription drug

benefit, you simply don't have adequate health care. It is as simple as that, and that is particularly true of seniors, and it is going to be more and more true as we move forward in time.

The second bottom line is that two-thirds of seniors have a drug benefit, and so as we go about the business of trying to figure out how to provide a benefit for the third that do not have it, we don't want to do anything to charge seniors for something that they already have. That is important. We have been down that road before in 1988.

Third, bottom line is we don't want to do anything to reduce the incentives for the private sector employers who are already now providing much of this coverage for their retired employees. So we don't want to make that mistake and have the employers dump this responsibility on to the Federal Government.

Fourth, one size does not fit all. Seniors have different health care needs, different pharmaceutical needs at different times in their lives, and that changes over their lives, and they need choices that they can adapt as their health care changes.

And fifth, and this is equally important, we don't want to do anything to kill the biotech and the pharmaceutical industry that produces the research and development for these miracle cures and the new drugs that eventually cure cancer and AIDS and Alzheimer's, et cetera.

Those are my bottom lines. A question to see if any of these plans are consistent with those important bottom lines. And let me turn to Mr. Stark for a starter.

Sir, your proposal which would create a new Medicare benefit, I think we ought to do that; I think we ought to do it differently than you do. I think we ought to do it creating private sector options, and Mr. Thomas and a group of us are working in that direction. How can you—how would you respond to the concern that all of these employers who provide health care benefits for their retirees, and in many cases very good prescription drug benefits, would not simply look at the fact that Uncle Sam is doing it and say, gee, we can avoid that expense, let's not cover prescription drug benefits postretirement?

Mr. STARK. If we had a reasonable prescription drug benefit for Medicare, I am sure they would. They are dropping away from providing Medigap. The plans are dropping not only retirees, but they are dropping people who retire early. So that is why the President has wanted to allow people to buy in.

I don't think that we can depend on the responsibility of employers. Traditional employment in the workplace is changing. We are getting more leased employees, telecommuting employees. The traditional idea of going to work for a company and working for them for 45 years until you retire and then being taken care of, I think, is disappearing, so the benefits are already disappearing. Medigap is cutting, managed care plans are cutting back, and employers are cutting back whether or not we provide this benefit. And I don't think—I think that we would be replacing it to some extent, which means money they will save and hopefully could be used to contribute to pay for the overall plan.

Mr. GREENWOOD. I think the gentleman's answer is straightforward and honest. It would shift most of this responsibility, prob-

ably eventually all of this responsibility, from the private sector to the public sector. I think there are ways to meet the needs of the one-third by subsidizing their opportunities on a means-tested ability to do that in a way that minimizes the cost shift from the private sector to the Federal sector, and I would like to work with you.

For Mr. Allen—I am trying to go quickly because the chairman has requested it—you identified in your plan the Federal Government being the big buyer. But, in fact, when big purchasers get discounts, it is generally because they can create efficiencies. You can ship your product to a big central warehouse. You can avoid middlemen. There are all kinds of ways that you can justify selling the product for the reduced price because of the bulk consumption.

The problem that we have in the pharmaceutical case, it seems to me, is that you don't get that when you simply say to the pharmaceutical companies, sell your product to these pharmacies so individuals can, one at a time, on a retail basis, buy it. I don't see any efficiency in there. So you have the current system where the pharmaceuticals sell at a price that they can to the pharmacies, and then your system overlies that, but there is no cost savings in the process. You don't do anything to reduce anybody's cost, you simply, in my view, artificially reduce the price.

Mr. BILIRAKIS. A very brief comment. I apologize, but what you are going to do?

Mr. ALLEN. Briefly this has nothing to do with costs. The pricing structure has nothing to do with costs. The pharmaceutical industry charges what the market will bear. That is why you have these huge disparities. So what is really important is the market power on the other side, not the cost of delivering pills. Both the cost of——

Mr. GREENWOOD. That is not market power, it is coerced power.

Mr. ALLEN. It is market power. The Federal Government buys toilet paper and tanks and fleets of automobiles, and it always tries to get a reduced price for the benefit of the taxpayer. We should do the same thing when it comes to providing health care for seniors. It is a market power even though because what the Federal Government is doing is simply acting as a bulk buyer.

Mr. BILIRAKIS. Let's not get into a debate, though. We don't have time for it, although I think it would be interesting.

Mr. Strickland.

Mr. STRICKLAND. Mr. Chairman, I will be very brief. This is what I have heard today: That Americans are paying much more for prescription drugs than are people who live in other countries; that individual senior citizens are paying much more for prescription drugs than are large HMOs or the Federal Government. I have heard numerous witnesses say that America's senior citizens in many cases are having to choose between buying prescription drugs and buying food.

We have got to do something about this, and in my judgment, we cannot do it in a piecemeal, mediocre way. This calls for bold action, and I believe—I will say this to all of the witnesses—I believe this: If we do not do this, and we don't act boldly and courageously and provide justice and fairness to American senior citizens, that

every one of us will pay a heavy price when the American people make a decision about us in the future. It is as simple as that.

No issue in this country, in my judgment, is as powerful as is this issue because it affects every family in this country. And I thank you for your good work and for your information, and, Mr. Chairman, I thank you.

Mr. BILIRAKIS. I thank the gentleman very much. Without objection, there is a CRS issue brief updated April 7, 1999, entitled Prescription Drugs Pricing Differences between Insured and Uninsured Consumers. Without objection, I would ask that be made a part of the record.

And it has been commented a couple of times as to the percent of prescription drug research and development which is paid for by the Federal Government. That is a very significant point——

Mr. BROWN. Mr. Chairman, I have never done this, but I reserve the right to object to the CRS report because my understanding is that it has actually officially been withdrawn. I have not heard that that has happened before, but if it has, I would like to——

Mr. BILIRAKIS. Why don't we withdraw my request until maybe that is clarified?

Mr. BROWN. Fine, fair enough.

Mr. BILIRAKIS. If it has not been withdrawn, you have no objection?

Mr. BROWN. Exactly.

Mr. BILIRAKIS. And the point that I was making is that we felt that it was a very significant point, and we contacted both CRS and NIH, and both organizations said it is not possible to determine how much of the funds dedicated to drug research and development were government dollars.

And also Mr. Nader made a comment before Congress back in 1993, regarding a certain percentage of Federal funding that is supporting drug research, but that was research and development on all health care, not just drugs. It wasn't broken out.

Thank you very much. The hearing is adjourned.

[Whereupon, at 6:15 p.m., the subcommittee was adjourned.]