

MEDICARE REFORM: PROVIDING PRESCRIPTION DRUG COVERAGE FOR SENIORS

HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED SEVENTH CONGRESS FIRST SESSION

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WEDNESDAY, MAY 16, 2001

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

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

Members present: Representatives Bilirakis, Barton, Upton, Greenwood, Deal, Burr, Whitfield, Ganske, Norwood, Shadegg, Bryant, Ehrlich, Buyer, Pitts, Tauzin (ex officio), Brown, Strickland, Barrett, Capps, Hall, Pallone, Deutsch, Eshoo, Stupak, Engel, Wynn, and Green.

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

Mr. BILIRAKIS. I am being reminded by Mr. Brown that we are 4 minutes late, so we had better get rolling. Good morning. I now call to order this hearing on Medicare Reform.

In our first hearing of the year, this subcommittee examined ways in which Medicare beneficiaries are currently obtaining prescription drugs outside of the Medicare program. Today, we will assess the various needs of Medicare beneficiaries for prescription drug coverage.

The hearing series is built around a critical concept that there is a clear and necessary connection between adding a prescription drug benefit to the Medicare program and broader reforms to protect and strengthen Medicare for the future. I remain determined that this Congress and this Administration can reach agreement on a plan to reform Medicare and establish a voluntary prescription drug benefit for all Medicare beneficiaries.

I would like to welcome all of our witnesses today. Our first witness is Mr. Dan Crippen, with the Congressional Budget Office. Many policy experts believe that any policy we advance will be driven by the numbers. It is true that fiscal responsibility is of the utmost importance in crafting this benefit, however, it is also important that we fulfill the needs of the Medicare beneficiaries to the greatest extent possible, and this committee will rely heavily on the work of the CBO to help us understand the fiscal impacts of the policies we will create and, to that end, I know we all look

forward to hearing about the work that CBO has done so far in this regard.

I would also like to welcome the witnesses from our second panel, the Biotechnology Industry Organization, AARP, and Ms. Jeanne Lambrew. These organizations will be able to best explain the needs of Medicare beneficiaries. Ms. Braun, on behalf of AARP, has come before the committee before to be a voice of seniors who are the biggest and, in my opinion, the most significant stakeholders in this debate.

Before we expand Medicare to provide a costly new benefit, we must ensure that the program is standing on solid fiscal ground. A benefit promised but not delivered is certainly no benefit at all, and I am determined to protect the long-term solvency of this vital program. I would like to think that the entire committee is equally determined.

As members know, this subcommittee has a strong record of working on a bipartisan basis to tackle difficult legislative issues. 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. In closing, I want to again thank our witnesses for their time and effort in joining us today, and now recognize our ranking member, Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. I would like to thank Mr. Crippen for joining us, and also Jeanne Lambrew and our other distinguished witnesses for coming to this hearing and sharing in their wisdom.

Today's hearing is about the structure of prescription drug coverage, the access and cost implications of various coverage options. It is important to be clear about what actually is and isn't optional about prescription drug coverage for Medicare beneficiaries. Affordable, meaningful prescription drug coverage should be available to every Medicare beneficiary. In conjunction with establishing a prescription drug benefit for Medicare beneficiaries, the Federal Government must take action to reduce prescription drug prices. If we truly want to act in the best interest of Medicare and taxpayers, neither principle is optional.

A fundamental principle of Medicare is universality, the goal is and has been since its inception in 1965, to ensure every senior access to appropriate medical care regardless of health, regardless of income. The same principle should apply to prescription drug coverage.

Medicare prescription drug coverage as opposed to State assistance programs or private coverage for prescription drugs means stable benefits over time that leaves no senior behind. If we extend a helping hand to some subset of Medicare beneficiaries based on their being the poorest of the poor or the costliest of the costly, we are leaving seniors behind. If we create a Welfare benefit for prescription drugs, we are leaving seniors behind.

At last count, a third of all seniors lack prescription drug coverage. That was before Medigap premiums spiked upwards 37 percent between 1998 and 2000. That was before 900,000 Medicare beneficiaries lost their coverage, their prescription drug benefits

usually with it and, by the way, these same HMOs are tomorrow holding a rally to ask for a cut and a big share of the \$300 billion included in the budget resolution for prescription drug coverage in unspecified Medicare reform.

HMOs are making this request, having this rally, even though they know they received a third of the Medicare give-back dollars last year even though they only served one-sixth of the Medicare population, even though they know every penny of the \$300 billion is necessary for prescription drugs, even though the managed care companies know how important drug coverage is for seniors, and even though they know they stand to receive additional funding if we establish any kind of Medicare prescription drug coverage. And Medicare HMOs claim to be operating in the best interest of our seniors.

But back to prescription drugs for a moment, if we can help some of those in need of coverage now, when will we get around to helping the growing number left out? Let us talk about dollars for a moment. Mr. Crippen's written testimony discusses the future financial viability of Medicare. Securing the long-term solvency of Medicare as well as that of Social Security is very, very important, as the chairman said. Securing the value of these benefits that the programs deliver is equally important. Prescription drug inflation, to be sure, is eroding the value of Medicare and Social Security. Medicare covers doctors visits, it does not cover outpatient prescription drugs. If a Medicare beneficiary goes to a doctor but can't afford to fill a prescription, how does that affect the value of the doctor's visit?

Prescription drug spending increased 19 percent last year. Seniors' monthly Social Security checks increased 2.4 percent last year. Put yourself in the shoes of a retired individual without prescription drug coverage. You live on an \$844 a month Social Security check. Your doctor prescribes Celebrex or Zocor or Prilosec, maybe all three. Celebrex costs \$80 a prescription, Zocor costs \$105 a prescription, Prilosec costs \$130 per prescription. All together, that is 40 percent of your monthly Social Security income. All these medications are important, no one disputes that.

Take Celebrex. It can help individuals with arthritis live with less pain and disability. Let us give the drug companies the benefit of the doubt and assume it costs, as they tell us, \$500 million to develop Celebrex. That is the per drug R&D estimate the industry has never substantiated, we are supposed to take it on faith. The makers of Celebrex earned \$1.3 billion in 1999, \$2 billion in 2000. Even if their initial investment were \$500 million, they are raking in enormous profits on a drug they know seniors will buy even if it bankrupts them.

Last year, the makers of Celebrex raised the price 11 percent. One more point about Celebrex. Recent studies suggest that it and its rival, Vioxx, are no more effective in reducing the pain and inflammation of arthritis than other anti-inflammatory pain killers.

What is the biggest distinction between Celebrex and Vioxx and their less expensive counterparts? Extraordinarily aggressive direct-to-consumer advertising. What is the message here? The U.S. Government must stop the prescription drug industry from taking advantage of American consumers. We can't afford to permit drug

companies to charge Americans twice, thrice, sometimes four times what consumers in other countries pay for prescription drugs, even though American taxpayers often paid for much of the research costs.

We can't afford to permit drug companies to block access to less expensive but equally effective generic drugs. We can't afford to permit drug companies to exploit direct-to-consumer advertising, seducing us into clamoring for the newest drug regardless of its true effectiveness, regardless of its price.

We need to join every other industrialized nation on this planet and demand reasonable prices from drug companies. We can reduce prices through competition by creating a system of royalties that would permit generic into the market sooner. That is the theory behind my compulsory licensing bill. We could reduce prices by making use of the collective purchasing power of 39 Medicare beneficiaries. That is the theory behind the Allen bill. We could reduce prices by closing loopholes that have enabled brand name drug companies to block access to generic alternatives. That is the theory behind the McCain-Schummer bill and the Emerson-Brown bill which we will introduce later this week, bipartisanly.

We can reduce prices through information by making drug purchasing decisions based on a drug's relative efficacy, not its ad campaign. That is the theory behind New Zealand's pricing reference—reference pricing system. There are many things we can do, the question is, will we, in this institution? Unfortunately, that is a matter of politics.

The Federal Government, Mr. Chairman, must find the political courage to add prescription drug benefits to Medicare without paying excessive prices for prescription drugs. It would be irresponsible of us to pay anymore or to do any less. I thank the chairman for his indulgence.

Mr. BILIRAKIS. There is a vote on the floor. Let us see if we can get in as many opening statements as we can, but limit them to 3 minutes, please. Under the rules, we can do that. Mr. Upton.

Mr. UPTON. Thank you, Mr. Chairman. I have a lengthy statement for the record, and to save on time, I'd like to say three things.

Mr. BILIRAKIS. Without objection, the opening statements of all members of the panel will be made a part of the record.

Mr. UPTON. First of all, welcome to my long-time friend, Dan Crippen. We look forward to your testimony and interaction with us not only today, but in the months ahead.

Second, prescription drugs is a big issue not only in my district, but across the country. A letter I received not too long ago from one of my constituents, and I quote: "I am among those who skip my meds every other day to make it through the month. I am taking nine pills a day plus I am a diabetic. My husband has glaucoma and high blood pressure and eyedrops are very expensive. We have no prescription drug coverage, so it is a very trying ordeal for us."

That is a typical letter, and I myself have seen friends and seniors literally cut their pills or dosages in half to make them go twice as far because of the cost and the other needs in the household.

I was pleased to be part of the House Republican Leader's Task Force last year, I look forward to working with you, Mr. Chairman, on developing a plan and moving it through the Congress this summer, and I yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman. Three minutes, Mr. Pallone.

Mr. PALLONE. Thank you, Mr. Chairman. The lack of an affordable prescription drug benefit is, without question, the biggest problem with the Medicare program today, and the problem can't be corrected piecemeal by simply devising a plan to cover the poor seniors. A comprehensive affordable drug benefit should be available to all seniors regardless of income. Fifty percent of Medicare beneficiaries without drug coverage are middle-class seniors.

Instead of providing a meaningful benefit through Medicare, it seems as though President Bush and the Republican leadership are preparing to either provide drug coverage to only low-income beneficiaries, or to provide drug coverage that relies on private drug only insurance. Neither of these plans will allow beneficiaries to receive a comprehensive affordable guaranteed benefit and, in fact, these plans will nurture the price discrimination beneficiaries face when purchasing pharmaceuticals.

Price discrimination has been well documented by Democrats and a number of consumer groups. Statistics have shown that seniors pay nearly twice as much for their prescription drugs than does the pharmaceutical industry's most favored customers. Robert Pare's article in the New York Times from earlier this month highlights the finding that a large increase in drug spending was disproportionately attributable to only a few top selling drugs marketed to seniors. Aggressive marketing by drug companies has contributed to this growth in addition to rising cost of drugs used most frequently by seniors.

I want to note, Mr. Chairman, however, that price discrimination is only half the battle. The need for passing a comprehensive prescription drug plan is just as important. Twelve million Medicare beneficiaries, approximately a third, lack coverage for prescription drugs. Another one-third have unreliable coverage through Medigap or Medicare+Choice. Medigap coverage is inadequate and too expensive and needs to be reformed. As for Medicare+Choice, an increasing number of enrollees have prescription that is not good and getting worse. Most private health plans that provide services for seniors have unimpressive records of covering prescription drugs, yet the Republicans call for prescription drug plans that force beneficiaries to rely on private health plans to receive crucial coverage.

In closing, I would like to reiterate that Democrats would like to see a voluntary prescription drug benefit through Medicare that is affordable to all beneficiaries regardless of income, accessible to all beneficiaries, and financed without reducing the solvency of Medicare and is a guaranteed benefit that is uniformly available across the country. Thank you again, Mr. Chairman.

Mr. BILIRAKIS. And I thank the gentleman. Three minutes, Mr. Burr, the vice chairman of the full committee.

Mr. BURR. Thank you, Mr. Chairman. Mr. Brown said the question is "will they." I say the question is "did they." When they con-

trolled the White House and the House of Representatives and the U.S. Senate for a 2-year period, did they introduce a plan? Did they even talk about the need for a drug benefit? They didn't. And I think you heard from his opening statement that bipartisanship on a drug bill is going to be hard to find because, to them, this is about everything but a drug benefit. It is about the companies. It is about HMOs. It is about Medicare+Choice. It is not about the constructive advice of how you craft a very delicate plan, a plan that has to incorporate who is currently covered under Medicaid because they are low income; a plan that takes into account that some employers today still provide drug benefits for their retirees, and they are willing to do it in the future if there is a little bit of incentive in what we do.

Twenty-six States currently have expanded drug plans for seniors that rate as high in Pennsylvania as 200 percent or over of the poverty line. And how we write a plan that integrates all these different approaches that they might have into some type of uniform national prescription drug benefit, one that is accessible to all, affordable for all and, most importantly—and not mentioned up to this point—is voluntary, one that seniors can choose whether they participate in.

Mr. Chairman, I am hopeful, I am confident that we can reach a bipartisan bill this year, but we are going to have to drop the political rhetoric of this being an issue about everything but prescription drugs. We have got to work on language. We have got to work on the specifics. We have got to listen to Dan Crippen. We have got to understand that even though Dan mentions in his opening statement, if we extended the drug benefit to everybody under Part B and kept the current subsidy of 75 percent, then I think he would tell us we can't afford it under the current structure. I think we all know that. But the reality, Mr. Chairman, is that this committee has to do it this year, because next year CBO has to begin to score the Baby Boomers that hit the system. In the next 10 years, we will see the size of the senior population outnumber the amount of votes that either candidate got in the Presidential election. They will have a major voice in what the structure of a plan looks like if we wait that long.

We have a unique opportunity on both sides of the aisle this year to craft a plan that can withstand the test of the increase in population and, consequently, the increase of cost of a drug benefit in the future. I hope we won't miss this opportunity. I yield back.

Mr. BILIRAKIS. I thank the gentleman. Mr. Deutsch, for 3 minutes.

Mr. DEUTSCH. Thank you, Mr. Chairman. I have mentioned two statistics. Sometimes statistics can be very telling. I will mention them again. In 1965 when Medicare was created, the average life expectancy of Americans was 65 years old. Thirty-six years later, it has increased almost 15 years. In 1965 before Medicare was created, the average senior in America spent 11 percent of their income on health care costs. Today, with Medicare paying effectively most hospital and doctor costs, seniors in America spend 19 percent of their income on health care costs. Prescription drugs is a great part of that increase. It is sort of high-class problem, I think, accurately described as a high-class problem, that people living are liv-

ing longer. It is a good thing, and prescription drugs in America have fundamentally changed our world. Tens of millions of Americans, let alone people throughout the world, in fact, are alive today because of prescription drugs. But I think it is inconceivable for any of us—and I think it is an important acknowledgement on this subcommittee, on this committee, and in this Congress, and in this country, to say that we can have a health care system like Medicare without prescription drug coverage. It is illogical, it wouldn't make sense. It is clear that if we were creating that system today, we would provide prescription drug coverage, period, without debate.

So, where are we now? We are trying to change the system and make changes. My well-intentioned colleagues on the other side of the aisle, as well as the President, have talked about proposals to limit a prescription drug coverage only to low-income seniors. I think it is unfair considering the majority of seniors currently without coverage are significantly above the poverty level. Let me point out, in Florida, 65 percent of the seniors would not qualify for low-income prescription drug coverage. Many of these seniors make as little as \$15,000 per year, yet they would be ineligible for many of the programs debated last year.

I think what is imperative and I think what is critical, and it is a philosophical divide, that I believe the American people are on our side and not, unfortunately, on the other side on this issue, which is that a prescription drug coverage has to be for all Medicare beneficiaries. It cannot be limited and it cannot be made income-eligible, that is a fundamental mistake, it changes the nature of the Medicare system from an insurance-based program to a need-based program and with all sorts of, I think, tremendously detrimental policy implications. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Thank the gentleman. We are going to break now for this vote, and as soon as I get back and Mr. Brown returns, we are going to start up again. Forgive us, Mr. Crippen.

[Brief recess.]

Mr. BILIRAKIS. Our hearing will be back in order. The Chair recognizes the chairman, Mr. Tauzin, for an opening statement.

Chairman TAUZIN. Thank you, Mr. Chairman. I want to thank you, first of all, for holding this hearing today because it is on a topic of utmost importance to all Americans. It is the second hearing in a series looking at Medicare reform and the lack of a prescription drug benefit today in traditional Medicare program, and the witnesses we will be hearing from today could be some of the most important that we hear from this year.

The Medicare program affects every one of us, whether we are eligible for the program today, or we have family members like my own mother who is eligible. All of us have an interest in ensuring that the program will meet the health care needs of a growing senior population. We are all hopeful that we are part of that population, if we are lucky.

Over the past few years, it has become increasingly clear that the Congress needs to modernize Medicare and to bring the program into the 21st Century. Since the program's inception in 1965, much in health care has changed. Yet many of the program's features, as well as the design of Medicare's basic benefit package, is

still stuck in a 1960's style approach to practicing medicine. Prescription drug coverage is still not included in Medicare's basic benefit package, and there are no caps placed on seniors' out-of-pocket medical expenses. No one in the room today would model a new system after Medicare's current benefit package.

A large part of the debate will no doubt focus on the cost of adding an outpatient prescription drug benefit to Medicare, and I am happy today that CBO is with us. CBO has estimated that the aggregate Medicare spending for the next 10 years will equal \$1.5 trillion. That is a 32 percent increase over last year's estimate alone. Given the new CBO estimates, adding a prescription benefit to Medicare will prove even more challenging, obviously, today than it was last year.

We are fortunate also to hear today from the AARP, and they have a unique insight into the current outpatient drug needs of seniors and the disabled, even though they were, I think, a bit out-of-touch with the broadband argument we had last week.

I am constantly amazed at the almost daily breakthroughs in science and technology. When I hear of treatments to combat diseases such as AIDS and leukemia it all gets put in perspective. If I can be helpful in my role as chairman of the full committee to ensure that patients in need of life-saving treatments have access to them, we will do all we can to make that happen.

We don't have all the answers as to how the public-private partnership should be structured, but our committee is committed to finding that solution, and we intend to pass a prescription drug benefit in this Congress.

I look forward to hearing from BIO, the industry representing the companies who are on the cutting edge of developing life-saving treatments. And I welcome Ms. Lambrew, who will provide us insight into the cost issues we need to be aware of as we structure the new prescription drug benefit to be incorporated in the Medicare program, which has been traditionally slow to adapt to a dynamic health care marketplace.

And as we consider how to modernize the program, I would be remiss if I didn't mention the issue raised by AARP and others in their testimony. Preparing for the retirement of the Baby Boom generation, according to the most recent Medicare Trustee's report, there will be 77 million beneficiaries in the year 2030. That is about double the beneficiaries of today. Conversely, the number of workers paying for the Medicare program will only increase by 15 percent. To the extent that we analyze the Medicare program to modernize the benefits package, we should not squander the opportunity to make the reforms necessary to ensure the long-term sustainability of this increasingly vital program to Americans.

It is a pretty exciting time to be involved in this debate. Our new President has expressed a strong interest in reforming Medicare. Many in the Senate have expressed a desire to move a reform package. My own Senator John Breaux has been instrumental in many of these recommendations, as has Bobby Jindal, who is now the new Assistant Secretary at the Department.

As I stated at our first hearing on the topic, the committee is honored to have two members who participated in the National Bipartisan Commission on Medicare Reform, Chairman Bilirakis and

my ranking counterpart on the committee, Mr. Dingell. With our wealth of talent on health care issues, our committee will be a strong leader in this debate.

Mr. Chairman, I thank you again for this important hearing and, most importantly, for taking on this enormous challenge of both reforming Medicare and making sure we not leave this Congress without providing a prescription drug benefit within that Medicare reform. Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman for his remarks. The gentleman from Texas, Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman. I ask unanimous consent that all members not only have time to provide statements, but also to revise and extend their remarks.

Mr. Chairman, I will be brief and easily within the 3 minutes.

I would like to thank you for holding this second hearing on the prescription drug benefit for our Nation's seniors, and I echo the sentiments of my colleagues who say that such an important and crucial issue for our constituents. Whether they are eligible for Medicare or not, we all have elderly family and friends who rely on prescription drugs to maintain their health.

As our Chairman said, we wouldn't create Medicare today the way it was created in 1965, and I would hope if we created it today, we would provide a prescription drug benefit under Medicare because prescription drugs are just as important as your doctor, just as important as your hospital today as compared to 1965. The rising cost of medications make it more difficult for seniors to manage their prescription costs. In fact, the recent study by the National Institute of Health Care Management reported a dramatic increase in prescription drug cost over the last decade. The report indicates that the cost of prescription drug costs will continue to escalate, and I ask unanimous consent, Mr. Chairman, to place into the record this study by the National Institute of Health Care Management.

Mr. BILIRAKIS. Without objection, that will be the case.

Mr. GREEN. According to the study, from 1999 to 2000, retail outpatient prescription cost rose by 19 percent in 1 year, and I am from Texas and we don't even have that high gas prices. So, 19 percent in 1 year. The increases are highest among our blockbuster drugs that most of our family and friends take—Vioxx, Celebrex for arthritis, Lipitor for high cholesterol, Glucophage for diabetes. Seniors have no choice but to pay these high costs. To make ends meet, most seniors are cutting their pills in half or not taking their dosage.

Mr. Chairman, I will yield back my time and ask my full statement be included, but I appreciate the chance to try and work on a bipartisan effort for prescription drug coverage.

Mr. BILIRAKIS. I thank the gentleman. Without objection, the opening statements, as I have already said, of all members of the panel will be made part of the record. Dr. Norwood, for an opening statement, vice chairman of the committee.

Chairman TAUZIN. Dr. Norwood, would you yield just temporarily, please?

Mr. NORWOOD. Always.

Chairman TAUZIN. I thank my friend. I want to admit an error here. I must have been stuttering a while ago because I didn't say this properly. I also didn't read today's report from the Hill Briefs. AARP has asked to be removed from anti-broadband spots so, obviously, I made a terrible mistake, and I want to congratulate you for that new decision. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Quick work. The gentleman from Georgia.

Mr. NORWOOD. Thank you very much, Mr. Chairman, and I do appreciate your calling this hearing and most certainly applaud your efforts to a further review of Medicare and prescription drug coverage for seniors.

We are here today because of the concern of those seniors that are in need of prescription drugs but due to the escalating cost are forced to choosing between purchasing the prescribed medication and the basic necessities.

Mr. Chairman, I am deeply troubled by the potential cost of adding a comprehensive drug benefit to Medicare. The Congressional Budget Office has now projected that Medicare expenditures will be approximately \$237 billion for this fiscal year. Last year, CBO estimated that adding a drug benefit would cost \$1.1 trillion over 10 years. CBO has now revised that figure to an even more staggering \$1.3 trillion, and if history has shown us anything, Mr. Chairman, CBO estimates are rarely under-estimates.

When considering a prescription drug benefit for seniors, we must also realize that the population of our country is aging rapidly, with the Baby Boomer generation soon becoming eligible for Medicare benefits, prescription drug expenditures for a new Medicare benefit are sure to rise exponentially.

So, today I am particularly interested in the testimony of Dan Crippen. You are a critical player, Mr. Crippen, in this process because CBO scoring, in essence, will guide our process. We are depending on your estimates to be accurate and your assumptions to be logical. It is my hope that you will be able to provide further insights and explanations to raise our comfort level that our confidence in CBO is warranted.

Again, Mr. Chairman, I commend you for calling these hearings and leading the effort to ensure the America's seniors are not left behind and, with that, I yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman. Ms. Capps, for an opening statement.

Ms. CAPPS. Thank you, Chairman Bilirakis, for holding this particular hearing. This subcommittee, of which I am proud to be a member, will deal and has dealt with many important topics in this session of Congress. Perhaps none is more important than this issue before us today—ensuring that seniors have access to quality health care.

Many statements have been made on both sides of the aisle today, which I agree with. If we were designing Medicare today as opposed to 30-plus years ago, we would do so with a prescription drug benefit. And this benefit wouldn't be just for low-income seniors, it would be the kind of health care that each of us desires to have in our health coverage because we know how critically important prescription medications are. Yet look at who takes most of the medications in this country—it is our senior population.

The stories that I hear each time I visit my district echo those of my colleagues here as well. Seniors come to me and say, "I can't afford my medications, I have to take one every other day," or the pharmacists who come out from behind the counter if they see me in the drug store and say, "It is so troubling to have to advise seniors which of their five prescriptions they essentially need to take and which can they do without." This leads me to ask this basic question—what is it costing us as a country not to cover prescription medications?

As exorbitant as the prices are, this is probably the most moderate form of health care that we can give. The cost of not taking prescription medication that doctors prescribe—to save lives, to add to quality of life, to allow for independence of seniors—lands people into hospitals, and into a very expensive form of Medicare coverage. And I would hope that we could get some estimate of the cost that our country is bearing through Medicare by the kind of health care that is being denied our seniors. In other words, when the seniors don't take their medications and their arthritis spirals out of control, or their cholesterol level goes way up and they end up in intensive care, what cost is that not only in their lives and in their health, but to our economy? So, I look forward to this discussion today, and yield back the balance of my time.

Mr. BILIRAKIS. I thank you so much. Dr. Ganske, for an opening statement.

Mr. GANSKE. Thank you, Mr. Chairman. While there are several reasons why even in this time of budget surplus, it is difficult to do a prescription drug benefit that is comprehensive. First, we have made a bipartisan commitment not to use Social Security surplus funds. Second, there are people with no health insurance at all, much less prescription drug coverage. Should we expand coverage for some while the totally unprotected group grows? Third, Medicare is closer to insolvency than it was back in 1988, the last time Congress tried to do something on this. Shouldn't our first priority be to protect the current Medicare program?

I want to address some comments by my friend from Florida, Mr. Deutsch. There are senior citizens who are in Medicare that already get a Medicaid benefit. They are low-income seniors. Their incomes are below the poverty line.

As we look at the budgetary implications of a comprehensive plan, we have to look at what is called the "adverse risk selection process." This is where, in a voluntary program, seniors who do not have much for drug costs won't sign up for the program. We know that this will happen because that is currently the system. In this Medicare voluntary drug program, the only seniors who generally sign up are those who have high drug costs. Consequently, the premiums are high for this program.

We could address this comprehensive plan by making it mandatory. Which was tried back in 1988 and was later repealed in 1989. I think that to say a mandatory program would not have much support here on Capitol Hill would be an understatement.

We could try a risk adjustment program. We have tried that in other cases but they are very difficult to do. A third way of handling this would be to have a mandatory benefits package, that would help a little.

And, finally, we could, as I say, make the program mandatory, spread out the costs in insurance principal. Even so, these 10-year estimates only go up to the year 2011. But, in 2012, the Baby Boomers start to retire and then the cost will skyrocket. We are potentially looking at a benefit that could cost trillions of dollars.

Therefore, at least for the time being, I have introduced a bill, H.R. 1387, which is a modest proposal to help those senior citizens who need a benefit the most. For who aren't below the poverty line now, but are having difficulty surviving only on their Social Security benefit checks. Under my program they could utilize the State Medicaid drug programs, paid for through their Federal side so we don't ask for a match. This plan would help about a third of the senior citizens, but the ones who need it the most, in my estimate. And this plan would probably cost pretty much all the money that we have budgeted for a prescription drug benefit. Later, in the context of a comprehensive Medicare reform bill, we could address the issue of a more comprehensive plan. I think that is the feasible, reasonable way to go about starting on a prescription drug benefit, and I hope that this committee looks at that. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Thank the gentleman. Mr. Hall, for an opening statement.

Mr. HALL. Mr. Chairman, I have not heard the other opening statements. I subscribe to the things that I have heard so far, and endorse them. I can say this, we need to do something now.

Mr. BILIRAKIS. I thank the gentleman. Mr. Whitfield.

Mr. WHITFIELD. Thank you, Mr. Chairman. I think it is quite obvious that Congress could easily pass a universal prescription drug benefit with very low deductible, or zero deductible, and we would be all right for a few years but, in the long-term, I think everyone recognizes that it would be unfair to pay for that program. We need a balanced program that will provide assistance to seniors who, in their twilight years, need help in obtaining access to drugs that they need. At the same time, we need to be aware and concerned about those young couples who are paying their Social Security tax, the payroll taxes, to provide the money for these programs, and many of those families do not have any health coverage at all. Their employer doesn't provide it, they can't afford it, and so they are providing money to give someone else access to health care.

So, I think we need to approach these hearings, and as we design this plan, with a sense of openness because I am genuinely convinced that there is a way to have a meaningful plan that will take care of those people who need it most.

Thirteen percent of our seniors pay over \$5,000 a year in cost for prescription drugs, and 46 percent of them spend less than \$500 a year. So, I think we have a lot of room to work here, and I am optimistic that we can come up with a plan. I yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman. Ms. Eshoo.

Ms. ESHOO. Thank you, Mr. Chairman, and good morning to you, and thank you for holding the first hearing in the 107th Congress on this all-important issue of providing prescription drug coverage for seniors in our country.

I would like to start off by welcoming my constituent, Robert Chess, who is the Chairman of Inhale Therapeutic Systems from San Carlos, California and, of course, it is wonderful to see Dan Crippen here, who I am looking forward to hearing from.

I want to associate myself with many of the comments that have been made this morning. I don't think anyone needs to be convinced that we need to do this, the question is "how," and that is where Congress seems to be on the ropes.

But I think it is worth restating over and over and over again, what some of the startling statistics are on this, and I can't help but think that every single one of us here, at both parts of the bench and across the aisle, we all have coverage for prescriptions in our insurance policies. Those are private sector policies, contracted for through the Federal Government, through our Federal Health Employee plan, and yet the public sector that we oversee is struggling with coming up with the same benefit for older people in our country through the system that was designed in 1965. As Lois Capps said, if it were being designed today, we would never leave out prescription drugs, and we know that in the beginning of this new century, how we have leap-frogged over so much, as is going to be given testimony to by Mr. Chess, in therapeutics, in all of the biotechnology that is really, I think, saving so much money.

So, the question is, how are we going to do it? I think that we need a competitive scheme, multiple PBMs—I had that in my legislation last year. I think there needs to be a balance between how we do it and how we make competition between the drug companies work in all areas of the country. I believe that it shouldn't be administered by HCFA because, in fact, one of our more recent hearings—was it last week—was how to reform HCFA and to do that.

So, I want to be part of putting out some of the best ideas on this, but I also want to say to my colleagues that as we are looking out 5 years, 10 years, 20 years, we kind of shy away from what the implosion of tax cuts are going to be that far out into the future. This is kind of like a pesky fly, and we kind of push that gnat away from us, and yet, oh, when it comes to Medicare and the prescription drug coverage, oh, my goodness, we just get white knuckles and rub our hands over and over again about what the costs are. Yes, the costs are important, but it is up to us to figure that out and to do it.

I think the 107th Congress should be the Congress that accomplishes this, and I look forward to working with my colleagues on it, and I am, of course, interested to hear from those that are going to testify. Thank you, Mr. Chairman.

Mr. BILIRAKIS. And I thank the gentlelady. Mr. Buyer.

Mr. BUYER. Thank you, Mr. Chairman. I feel like I want to grab a machete here and just sort of work my way through the rhetoric of the high weeds. If I carry this unfair or fairness argument to a logical conclusion that I am hearing from the other side, I suppose it would be that the authors of the Medicare program, Democrats 40 years ago, that they were unfair in their discrimination toward seniors in our society. That was awful. The next step is, we apologize. The next step is, we should do reparations to seniors for the

discrimination over the past. I mean, you see how the logic of the rhetoric just leads you to absurdity?

I want to join with Mr. Burr who said it would be wonderful if we could get away from the high weeds of the rhetoric. This is Washington, you will never do that because of politics.

The key is, as the last individual who spoke was, about how we structure this. That is why we welcome you to our panel today, Mr. Crippen, because that is what we are struggling with, is how we actually struggling with this—I am, personally. One of the reasons I came to this committee—several reasons—one was it took me 3 years to restructure the pharmacy benefit for the military health delivery system and, as we extended that benefit for the military retirees, I have a lot of lessons learned. So, how we structure it is extremely important.

And I do not believe we should give in to this “we have got to do it, we have got to do it now.” I am not going to give in to that because if there is one thing I have learned, it is “do not succumb to such temptations and make decisions based on the emotion of the moment,” especially in this town, because how we structure is extremely important because it may not be an issue that we may—we don’t touch it for a very long time.

So, the numbers that you are about to deliver to us, if it mirrors my studies, it will be very sobering. Mr. Chairman, when we had our meeting last week, when we started dealing with the year 2075—I don’t know—has anybody thought where you are going to be in year 2075? Think about that.

Now, the seniors that I represent are going to say, “I don’t care about year 2075, I care about my present problem right now.” Well, we have to be very careful in what we structure because what I have learned in my 9 years here in Washington is, what we do and deliver, there are many unintended consequences. It is like when you take that pebble and you throw it into the pond, you may see the ripples, but what you don’t see is that which goes out infinitum. So, we have to be very careful in how we properly structure this Medicare prescription drug benefit. I look forward to your testimony and the testimony of the witnesses, and I yield back.

Mr. GANSKE [presiding]. Mr. Wynn is recognized for 3 minutes.

Mr. WYNN. Thank you very much, Mr. Chairman. I will be brief, but I do want to thank the chairman for bringing this issue before the committee. It is certainly an issue on the minds of a great many Americans. It was brought home to me just this morning when my mother complained about a small bottle eardrops that cost \$80, and she was appalled. She could not believe it. And that is just one of several medications she takes.

It goes without saying that this is a critical issue. It seems to me this is really a question of priorities and political will. We have the money. We are in a very fortunate situation of having immense surpluses. The problem is, we want to give people a refund of their tax dollars. We want to oppose increased government spending. And in that environment, to say that we are really committed to a serious prescription drug plan is probably not accurate. People characterize it as “tall weeds,” and that is probably true, but the fact of the matter is, this problem requires money. It requires government spending. So, we cannot keep going down the road of “no

more government spending, cut back government spending” and, at the same time, realistically expect to provide this kind of benefit. What we end up doing is cutting back on the spending, shaving the money, and saying, “Well, gee, we can’t really provide the benefit.” We can provide the benefit, it is just a matter of setting the priority and finding the political will. It is certainly a complex issue, it is not given to simplistic solutions, but I think we do have to have a bit more candor about the fact that the money exists and we just need to put it behind this priority. I relinquish the balance of my time.

Mr. GANSKE. Mr. Bryant is recognized for 3 minutes.

Mr. BRYANT. Thank you, Mr. Chairman. In the interest of saving 3 minutes, I am going to yield back my time.

Mr. GANSKE. Mr. Barrett is recognized for 3 minutes.

Mr. BARRETT. Thank you very much, Mr. Chairman. I appreciate the fact that we are holding this hearing. I used to think that Members of Congress, every Member of Congress was an expert on election law because that was the one thing we all had in common. I am finding more and more that this issue of prescription drugs is an issue where we will all be experts as well because it has such a humongous impact in every single district in this country, and it should because it is really, I think, wreaking havoc upon the lives of millions of Americans who are unable to afford to purchase prescription drugs.

Just a couple of thoughts, and I want to hear from the witnesses as well—and these may be considered somewhat tangential to this hearing, but I think that they are important for the Chair and others to hear. I spoke several weeks ago to the head of a Health Maintenance Organization in the State of Wisconsin, who told me that they had experienced some success in controlling the cost of pharmaceutical drugs in their plan by doing a simple thing, and that simple thing was prohibiting the free dispensation of trips that were being offered by the pharmaceutical companies, the dinners, all those freebies that had been offered to their staff. They made a corporate decision that no one on their staff could accept any of these perks anymore.

What happened as a result of that is that a lot of these prescription drugs that were being magically prescribed all of a sudden after these trips, were not being prescribed as much and they were able to control costs in their plan as a result of that. And I would love to have that gentleman come before this committee to tell his story because I think it will show the impact that the industry’s practice of providing trips and other perks to health care providers has on increasing the demand for drugs.

I also think we have to look at the impact of advertising as well. I was watching one of these fancy commercials several weeks ago with my wife, and I said, “Oh, that is fantastic. That is fantastic. I have got to get that drug.” And she said, “But you don’t even have the disease.” I said, “I know I don’t have the disease, but look at those 80-year-old people, they are having the time of their lives, and they look like they are 35 years old.” And I think what we are seeing is, we are seeing a lot of increased demand as a result of the advertising. I think that that is something that we have to ex-

plore because it obviously has a ramification on what is going on as well.

I also think that we have to look in-depth at the whole debate over changing some of the drugs to over-the-counter drugs, and obviously this has some ramifications. We are reading about the fight right now between the insurance companies who, all of a sudden, have decided that a lot of these drugs should be sold over-the-counter. I think that some of their motives are laudatory, some of them obviously are financial self-interest because if they can switch them to over-the-counter they don't have to cover the cost in their plans. But we are also seeing a dramatic reduction in the cost of some of these in other countries where they are sold over-the-counter.

All of those, I think, are part of this huge jigsaw puzzle, and like some of the previous speakers, I certainly think we have to have this included within Medicare. But if we simply take the existing system and move it into Medicare, we are going to have the same problems, if not worse problems. And so I think we have to look at the big picture.

I also have to say, listening to some of my colleagues talking about the unintended consequences about what will happen years out from now, I wish we were hearing those same speeches about the tax cut that we are going to be voting on, which is backloaded, which people who are pushing that through don't seem to be as concerned about the consequences of that. And with that, I would yield back the balance of my time.

Mr. GANSKE. The gentleman from Pennsylvania, Mr. Greenwood, is recognized for 3 minutes.

Mr. GREENWOOD. Pass, Mr. Chairman.

Mr. GANSKE. The gentleman from Michigan, Mr. Stupak.

Mr. STUPAK. Mr. Chairman, I will pass, thank you.

Mr. GANSKE. And Mr. Deal.

Mr. DEAL. Pass.

[Additional statements submitted for the record follow:]

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

The bottom line on the issue of prescription drugs is seniors need help with their drug costs. I want to help, and I think it's safe to say all my colleagues want to help.

The monumental task we now face is trying to craft a prescription drug benefit under Medicare, and there is no disputing the fact that it is going to require some work. We not only have to reach some sort of agreement on the size and scope of the ultimate benefit, but we have to have a viable plan for getting there.

This hearing will hopefully bring us one step closer to that point.

The Medicare population is going to continue to grow, and we will see new drugs and biologics being developed—likely at greater cost.

Pharmaceuticals are by nature less invasive than most procedures and treatments, which in turn makes them more attractive and more sought after by seniors—by everyone in fact.

All of these different factors continue to fluctuate, making it hard to estimate the cost of any drug benefit. I am hopeful that today's testimony by the Congressional Budget Office will provide us with greater direction in that regard.

The question that continues to plague me is how do we bring together innovation that knows no bounds—like miracle drugs and technologies, and an outdated Medicare program that is totally inflexible?

As I see it, the ultimate success of any prescription drug plan under Medicare will depend on the strength, structure, and sustainability of the Medicare program itself.

We can't build on unstable ground by adding a drug benefit to an already struggling Medicare program.

I hope we keep that firmly in mind today as we discuss the present and future needs of our seniors when it comes to drug therapies.

I look forward to hearing from our witnesses and yield back the balance of my time.

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

Mr. Chairman, I want to thank you for having this hearing today. I also want to thank our panelists for their testimony on this important issue. Providing seniors with affordable access to prescription drugs has been a priority of mine for several years. I have authored legislation to establish a Medicare prescription drug benefit and feel that we cannot wait any longer to provide relief to seniors who today cannot purchase the medicine they need. But today, we may be giving up this opportunity.

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

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

Designing a prescription drug benefit is no small undertaking. There are infinite considerations and many different visions of the size and scope of the benefit. Many feel that providing the poorest elderly with a benefit is as far as we should go or that catastrophic coverage is sufficient. On the contrary, while we must provide for our poorest and most catastrophic cases, average, middle-income seniors are suffering as well and in dire need of assistance.

A question many are asking is whether or not to move forward with a Medicare prescription drug benefit now or wait to completely overhaul the Medicare program. I believe that we must act now to help our seniors. Medicare reform is certainly needed, but it should not become an obstacle to implementing a prescription drug benefit within Medicare. Today, on the floor of the House we will be voting on a tax reconciliation bill. I do support certain tax cuts. In fact, I voted for the marriage penalty—but the package of tax cuts as a whole is too big. Let's be clear on this. By cutting federal revenues so much, we are eliminating our ability to fund a meaningful prescription drug benefit for seniors.

Mr. Chairman, I do appreciate having this hearing today. But I wish it were a mark-up and I wish it were happening before we vote on the tax package.

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

Chairman Bilirakis, I am pleased that the Subcommittee is continuing its series of hearings on the need for a Medicare prescription drug benefit. Although the Congressional Budget Office will provide some new estimates on spending for prescription drugs, much of the testimony will repeat what we already know. The witnesses will state that seniors are spending an ever-increasing share of their incomes on prescription drugs. Seniors with chronic diseases may fill a dozen or more prescriptions a year, and many of these seniors have insurance policies that cover only a fraction of their costs or provide no drug coverage at all. Potential therapies that could yield cures for Alzheimer's disease or slow the progress of arthritis are in the pipeline, but without a Medicare drug benefit, many people will not be able to afford these new treatments.

We may also hear that Medicare is facing a long-term financial crisis and the program is unsustainable in its current form. We may be told that it is too expensive

to enact a prescription drug benefit for all seniors until Congress reforms the Medicare program.

My question is this: if not now, when? **As of this year, the non-Social Security, non-Medicare surplus totals about \$2.7 trillion dollars over the next 10 years. The Medicare Part A Trust Fund is expected to remain solvent until 2029—the longest period of projected solvency in the history of the program.**

The Budget Resolution approved by the House and Senate last week provides for \$300 billion over the next 10 years for a Medicare prescription drug benefit and Medicare reform. That amount is more than twice what the President wanted to allocate to the program, but it is not enough. If Congress were to provide seniors with the same prescription drug benefit that the Department of Defense provides for military retirees, we would need to spend one trillion dollars.

If that amount seems staggering, let me compare it to another large sum that our President is ready to spend. According to the Joint Committee on Taxation, repealing the estate tax would cost \$662 billion over the next 10 years. Only 43,000 Americans, or less than 1% of all taxpayers, would benefit from the estate tax repeal. However, that same \$662 billion could help 43 million seniors with a comprehensive, universal benefit within the Medicare program.

I hope my colleagues in Congress will consider these points as we work to create a Medicare prescription drug benefit.

Mr. GANSKE. I guess we will go ahead and start with Mr. Crippen's testimony.

STATEMENT OF DAN L. CRIPPEN, DIRECTOR, CONGRESSIONAL BUDGET OFFICE

Mr. CRIPPEN. Mr. Chairman and members of the subcommittee, thank you for inviting us to be here today. I have one primary purpose, which is to try to explain to you some of our thinking—share with you how we analyze this particular program or benefit—and in turn elucidate a couple of the policy levers that are obvious but, nonetheless, we can give you some sense of their import and how they affect the estimates.

But before I do that, I would like, Mr. Chairman—as a number of members of your subcommittee have done as well—to kind of set the context for the larger and long-term cost of these benefits.

The annual report released in March by the Medicare Board of Trustees indicates that the Health Insurance Trust Fund expenses will exceed dedicated noninterest revenues beginning in 2016. We actually believe it is going to be sooner than that, as early as 2011. And that, unfortunately, is in some ways the good news.

The retirement of the baby boom, my generation and that of many of you, between 2010 and 2030 will almost double Medicare's enrollment, as I believe Chairman Tauzin said, but the number of workers will increase by only 15 percent. The cost per beneficiary in Medicare will also continue to grow faster than the economy. As a result, Medicare will consume an ever-increasing portion of GDP.

And as this first chart suggests, Medicare is only one of the Federal programs that transfer resources from the working population to those who are retired and disabled. Just these three Federal programs will grow from 7 percent of GDP currently to 15 percent of GDP by 2030, an amount equal to nearly three-quarters of the current Federal budget. Adding a pharmaceutical benefit will obviously exacerbate this outlook.

In recent years, growth in prescription drug spending has far outpaced growth in spending for other types of health care. Even without a Medicare drug benefit, CBO expects prescription drug costs for the elderly to grow at an annual rate of 10.3 percent per

person—nearly twice the pace of growth in the rest of Medicare and much faster than the growth in the economy—ultimately costing \$1.5 trillion over the next 10 years.

In 1997, as many of you have stated today, about one-third of the Medicare population had no prescription drug coverage, but nearly 70 percent did. The next chart indicates the sources of funding for prescription drugs for the elderly in 1997. The single largest component, you will probably not be surprised to know, is out-of-pocket spending, at about 45 percent of total costs. However, that does compare relatively favorably with a 39 percent out-of-pocket share of the cost of providing drugs for all the rest of the population.

The second largest source of funding currently is employer-sponsored retiree health benefits, and the third is Medicaid. I should note that State-based programs, which covered about 5 percent of total spending in 1997, have been growing rapidly in both number and coverage and probably contribute a larger share today.

But, Mr. Chairman, virtually any Medicare drug benefit will move a significant share of this non-Federal, mostly private, funding to the Federal budget, reducing and replacing State funding, employer contributions, and other sources.

Before I turn to some examples, I want to attempt to explain the operation of a low-income subsidy for the payments otherwise made by beneficiaries—the cost sharing and premiums. That assistance, of course, could be an expensive proposition for taxpayers, given that nearly one-half of Medicare beneficiaries have incomes under 200 percent of the Federal poverty level. CBO estimates that those beneficiaries will spend approximately \$650 billion on prescription drugs over the next 10 years.

Several decisions must be made to design a low-income subsidy program for a Medicare drug proposal—who would be eligible, the amount of the subsidy, how it would be applied, who would administer the subsidy, and, if Medicaid did so, how much of the costs of the subsidy would be paid by the Federal Government versus the States. Overall, it may be obvious, but nonetheless true, that a low-income subsidy would add to the cost of any Medicare drug benefit—in some cases, significantly. What is not quite so obvious is that because the low-income subsidy usually covers the cost that the Medicare benefit does not, the subsidy cost will be greater with a less generous Medicare drug benefit.

Now, Mr. Chairman, I would like to introduce a few examples of the comparative magnitudes of some of the parameters in a drug benefit. For that purpose, we have constructed a prototypical benefit—a straw man, if you like—as a basis for comparison. I stress that this is a base case; it is not any of the existing proposals and represents only numbers for 1 year, assuming that the benefit is fully phased in. In designing a drug benefit, policymakers must make four fundamental decisions—who may participate, how the program cost will be financed, how comprehensive coverage will be, and who will administer the benefit under what conditions.

For our prototype—the one up on the board and the one you have in the packet before you as the base case—we assume everyone currently enrolled in Medicare Part B will enroll. We assume 50 percent coinsurance up to the catastrophic cap. We assume beneficiaries will pay 50 percent of the cost of the stop-loss protection.

We assume full Federal coverage of premiums and cost sharing for anyone with income under 135 percent of the Federal poverty level, and some subsidy for premiums for people with income up to 150 percent of poverty. We assume the use of one pharmacy benefit manager, with some restrictions on cost controls.

Members of the subcommittee, this poster, of which you have copies, attempts to depict some of these moving parts in a way we hope is helpful. The first is the base case I just described. As depicted, a beneficiary pays 50 percent of the cost of each prescription filled until his or her cost-sharing expenses reach the stop-loss amount of \$4,000. Note that this cost sharing need not necessarily be paid directly by beneficiaries; it could be paid by third parties.

Above the stop-loss, the costs of the benefit are split between beneficiaries, who pay half the cost through premiums, and Federal taxpayers. In addition, low-income beneficiaries receive subsidies for the cost-sharing and premium expenses. In this case, as the chart and the tables in front of you show, the total cost to Federal taxpayers is approximately \$32 billion—\$26 billion for the Medicare benefit and \$6 billion for low-income subsidies. Beneficiaries would pay, or have paid on their behalf, \$44 billion in cost sharing from those who purchased drugs and \$26 billion in premiums from all enrollees, whether or not they filled any prescriptions.

The first variation on the base case we have made—case A—is the addition of a \$250 deductible, which is common in many of the proposals we have seen. As you would expect, that change lowers the direct taxpayers' cost—in this case, by \$2 billion—and raises beneficiaries' exposure by a similar amount.

Case B takes the base case with no deductible and simply raises the catastrophic ceiling from \$4,000 to \$6,000. The taxpayer costs are reduced by about \$1 billion relative to the base case, and beneficiaries or their third-party payers pay a similar amount more.

Case C again takes the base case and this time adds a benefit cap of \$2,500 in drug spending—well below the catastrophic ceiling of \$4,000—creating a hole in the benefit design similar to many of last year's proposals with the so-called “donut.” Again, the taxpayer share drops while the beneficiary exposure increases.

Our final poster, Case D, depicts all of the previous changes applied to our base case—a \$250 deductible, a benefit maximum of \$2,500, and a \$6,000 catastrophic cap. Not surprisingly, the change produces a more dramatic shift of costs from current taxpayers to beneficiaries. Perhaps more important in this are the shifts within the two categories. The Federal share includes more in low-income subsidies here and much less in direct Medicare benefit costs. Further, the total exposure of beneficiaries is not only increased in this case by \$7.5 billion but the relative contribution is shifted toward cost sharing by those who use drugs and away from premiums paid by all Medicare recipients. In fact, that shift is so strong that this case has the lowest monthly premium of all four cases.

Mr. Chairman, there are obviously many more variations on these themes, and many of them are included in my written submission. These themes cover only the basics. There are a myriad of details that could have a significant impact on our estimates and how the program would work.

Let me circle back, Mr. Chairman, to conclude where I began. CBO estimates that the amount spent on outpatient prescription drugs by the elderly, even without a Medicare drug benefit, over the period from 2002 to 2011, will be about \$1.5 trillion. Thus, a rough cut of a drug benefit that covered 50 percent of current drug spending would suggest a gross cost, before any premiums or beneficiary contributions, of \$728 billion for the next 10 years. If, instead, all costs above \$1,000 a year were covered for everyone, gross costs through the next 10 years would total \$1.1 trillion. If only costs above \$5,000 a year were covered, gross costs—that is, costs without beneficiary contributions—through 2011 would be at least \$365 billion. It should be obvious that it will be costly to provide a generous benefit to all beneficiaries. Either enrollees' costs or taxpayers' costs will be high.

Mr. Chairman, just as we are currently paying for much of the Medicare benefits for our parents and grandparents through payroll and income taxes, our children and grandchildren will pay for us after we retire. Adding a drug benefit would significantly increase Medicare's costs, and, unless the cost of the benefit was largely borne by enrollees, the burden on our children would be even greater. Thank you, Mr. Chairman.

[The prepared statement of Dan L. Crippen follows:]

PREPARED STATEMENT OF DAN L. CRIPPEN, DIRECTOR, CBO

Mr. Chairman and Members of the Committee, I am pleased to be here today to discuss some of the major issues affecting the design of an outpatient prescription drug benefit for Medicare beneficiaries. Those design issues pose some difficult choices among desirable, but potentially conflicting, objectives. Moreover, they need to be considered in the context of the growing financial pressures facing the Medicare program.

I will emphasize several points about the Medicare program and proposals to establish a new prescription drug benefit for Medicare beneficiaries:

- The Medicare program faces increasing costs, particularly after 2010 as the baby boomers become eligible for benefits. Medicare will become more and more dependent on general revenues and, ultimately, will be unsustainable in its current form.
- Medicare does not provide the protection offered by most private insurance, since it lacks coverage for prescription drugs and does not provide insurance protection against the consequences of very costly episodes of illness.
- Most Medicare beneficiaries have supplemental insurance that covers some of their out-of-pocket costs for medical services. However, nearly a third of the Medicare population had no prescription drug coverage in 1997.
- The cost of a Medicare drug benefit would depend primarily on the comprehensiveness of the benefit and the generosity of governmental subsidies. The way in which a drug benefit is administered could also affect its cost.
- Stop-loss coverage would protect beneficiaries from extremely high expenses for prescription drugs, but few people spend more than the typical stop-loss amount. In contrast, most Medicare beneficiaries have some drug spending during the year and would receive some benefit from a program that offered coverage above a nominal deductible amount.
- Subsidies would help make a Medicare drug benefit more affordable for low-income beneficiaries. In general, a more comprehensive benefit would reduce federal costs for a low-income subsidy (including offsetting changes in Medicaid spending) because Medicare would be paying for a larger portion of drug spending. However, a more comprehensive benefit would also raise total federal costs.

PROJECTIONS OF MEDICARE SPENDING UNDER CURRENT LAW

The growth of Medicare spending has been much slower in the past few years than it has been historically. In fiscal years 1998 through 2001, the Congressional Budget Office (CBO) estimates that benefit payments will grow at an average an-

nual rate of 3.1 percent, compared with 10.0 percent per year over the previous decade.¹

CBO further estimates that Medicare will spend \$237 billion on benefits for 40 million elderly and disabled people in fiscal year 2001. Despite the recent slowdown in spending growth, that amount is almost 25 percent more than Medicare spent five years ago. The program now accounts for about 13 percent of estimated total federal spending, or 2.3 percent of gross domestic product (GDP).

Moreover, CBO is projecting faster Medicare growth over the next decade. We estimate that Medicare spending will more than double—reaching \$499 billion—by fiscal year 2011, reflecting an average increase of 7.9 percent per year (see Figure 1). At that rate, Medicare spending in 2011 will constitute 19 percent of the federal budget, assuming that no change occurs in current tax and spending policies. In fact, the program will account for 36 percent of the projected increase in federal spending by the end of the decade.

LONG-TERM PROJECTIONS

Medicare spending occurs under two separate programs, the Hospital Insurance (HI) program, or Part A, and the Supplementary Medical Insurance (SMI) program, or Part B. HI spending will total an estimated \$138 billion in fiscal year 2001, paying for inpatient hospital care, some stays in skilled nursing facilities, some home health care, and hospice services. SMI spending this year is projected to reach almost \$100 billion, paying for services from physicians and outpatient care facilities, as well as medical supplies and home health benefits.

The HI program is primarily financed by the Medicare payroll tax and the portion of income taxes on Social Security benefits that is earmarked for the HI trust fund. The SMI program is financed mainly from general revenues that cover about 75 percent of SMI costs, with the rest covered by monthly premiums paid by enrollees. It should be noted that 87 percent of total Medicare revenues in 2001 come from taxes paid by current workers; current Medicare beneficiaries pay the other 13 percent through SMI premiums and income taxes on Social Security benefits.

The latest report from the Medicare Board of Trustees indicates that estimated total income to the HI trust fund will exceed estimated outlays by \$29.8 billion in fiscal year 2001. But \$12.6 billion of that amount comes from interest on the trust fund's assets and from other miscellaneous sources. If just the tax revenues dedicated to the HI trust fund were counted against the fund's outlays, its estimated surplus this year would be only \$17.2 billion.

The Medicare trustees also report that under their intermediate assumptions, the HI trust fund's expenses will exceed its dedicated revenues beginning in 2016. By 2030, the revenues dedicated to the HI trust fund will equal only 66 percent of costs; by 2075, that ratio will be only 32 percent.

Those data do not take into account Medicare's SMI program, which is growing more rapidly than the HI program. As recently as 1997, HI benefit payments constituted 66 percent of total Medicare benefit payments. As of 2001, that proportion had declined to 58 percent, and CBO projects that it will decline to 53 percent by fiscal year 2011. Some of that change is due to the movement of home health care from HI to SMI according to the provisions of the Balanced Budget Act of 1997; that change increases the estimated balance in the HI trust fund in fiscal year 2011 by about \$240 billion. The shift further blurs an already hazy distinction between the two programs.

The Medicare trustees' report projects that total Medicare spending will increase from 2.3 percent of GDP in 2001 to 4.5 percent in 2030 and 8.5 percent in 2075. Those numbers reflect a change in the trustees' assumptions from last year, following the recommendation of their panel of experts that they raise their projection of long-term growth in Medicare spending per beneficiary.²

The mounting financial pressure on the Medicare program is highlighted by the large and growing difference between projected total Medicare spending and the total amount of federal revenues specifically dedicated to the program, including the Medicare payroll tax on current workers, the portion of the income taxes on Social Security benefits that are paid to the HI trust fund, and premiums paid by enrollees for SMI. To fund total Medicare expenditures, the difference would be made up of other taxes on current workers.

According to the Medicare trustees, the discrepancy between total Medicare expenditures and dedicated revenues will be \$64 billion in 2001, or 0.6 percent of GDP

¹ That statement reflects CBO's May 2001 projections of baseline spending.

² That change is consistent with the one that CBO applied in its most recent report (October 2000) on *The Long-Term Budget Outlook*.

(see Figure 2). By 2011, that gap is projected to rise to \$139 billion, or 0.8 percent of GDP. That amount would represent 30 percent of Medicare's gross outlays, up from 26 percent in 2001. By 2075, that gap is projected to grow to 6.0 percent of GDP.

Beyond the next decade, use of Medicare-covered services is expected to accelerate. Medicare enrollment, which has increased at a rate of about 1 percent a year over the past 10 years and is expected to grow somewhat faster over the next decade, will rise even more rapidly as the baby-boom generation begins to retire in 2011. According to the Medicare trustees, there will be 77 million beneficiaries in 2030—an increase of more than 90 percent over this year's enrollment. In addition, as technology advances, more services will be available for use by more patients, and those services will be more costly.

At the same time, the number of workers whose taxes provide the bulk of Medicare's revenues will not keep pace with the growing number of beneficiaries. While the number of beneficiaries in 2030 will be more than 90 percent greater than it is now, the number of workers paying into Medicare will be only about 15 percent greater. As a result, the ratio of covered workers to Medicare beneficiaries is expected to fall from 4.0 to 2.3. Correspondingly, Medicare HI spending as a percentage of taxable payroll is expected to rise from 2.7 percent in 2000 to 4.9 percent in 2030 and to 10.7 percent by 2075 (see Figure 3).

These financial pressures have focused policymakers' attention on the issue of long-term reform of the Medicare program. Efforts to reform Medicare have focused both on improving the efficiency and financial viability of the program and on modernizing the benefit package, specifically to include prescription drug coverage. Adding a prescription drug benefit could close a significant gap in program coverage but only at a sizable cost to the federal government or to enrollees. Because of the long-term financing pressure facing Medicare, careful consideration needs to be given to the benefit package, cost sharing between the government and enrollees, and the design features of any new benefit.

PROVIDING MEDICARE BENEFICIARIES WITH COVERAGE FOR PRESCRIPTION DRUGS

Prescription drug spending by Medicare enrollees has grown rapidly in recent years and is likely to continue to do so. Although Medicare does not now have a prescription drug benefit, most enrollees have some drug coverage, but that coverage varies widely. The cost of a Medicare drug benefit depends on the decisions made about the structure, financing, and administration of the new benefit.

Baseline Projections of Beneficiaries' Spending on Prescription Drugs

In recent years, growth in prescription drug spending has far outpaced growth in spending for other types of health care. Those rising expenditures have had a significant impact not only on Medicare beneficiaries but on employers who offer retiree health coverage and on state governments as well.

Between 1990 and 2000, annual spending on prescription drugs in the United States grew nearly twice as fast as that for total national health expenditures, and it has maintained a double-digit pace since the mid-1990s. For the U.S. population as a whole, three factors explain most of that growth: the introduction of new and costlier drug treatments, broader use of prescription drugs by a larger number of people, and lower cost-sharing requirements by private health plans. Within some therapeutic classes, new brand-name drugs tend to be much costlier than older drug therapies, which has also contributed to growth in spending. Use of prescription drugs has broadened as well, because many new drugs provide better treatment or have fewer side effects than older alternatives and more people are aware of new drug therapies through the "direct to consumer" advertising campaigns of pharmaceutical manufacturers.

Even without a Medicare drug benefit, CBO expects prescription drug costs for Medicare enrollees to grow at a rapid pace over the next decade (see Table 1). At an average annual rate of 10.3 percent per beneficiary, drug costs are expected to rise at almost twice the pace of combined costs for Medicare's HI and SMI programs, and much faster than growth in the nation's economy. (CBO's estimates of rising drug spending are based on the latest projections for prescription drug costs within the national health accounts.)

CBO's baseline estimate of prescription drug costs for Medicare enrollees is up significantly over last year's because of higher projections of the rate of growth in per capita drug costs. Last year's analysis indicated that spending by Medicare enrollees on outpatient drugs not covered by Medicare would total \$1.1 trillion over the period 2001 through 2010 (see Table 2). This year, our projection for the same period is \$1.3 trillion, or about 18 percent higher.

Our estimate for 2002 through 2011, the current 10-year projection period, is roughly \$1.5 trillion—which is about 32 percent higher than last year's projection for 2001 through 2010. The jump results from assuming a higher growth rate and replacing an early low-cost year (2001) with a late high-cost year (2011).

Those changes to CBO's baseline estimate—higher per capita drug spending and the inclusion of a new high-cost year in the projection window—imply that proposals for a prescription drug benefit will have higher price tags than they did last year. But for any given proposal, the exact magnitude of the difference between CBO's estimate for last year and its estimate for this year will also depend on the bill's specific features.

CBO projects that spending by or for Medicare beneficiaries on prescription drugs will total \$104 billion in calendar year 2004—the first year in which Medicare could probably begin to implement a new benefit (see Table 3). In that year, nearly 60 percent of Medicare beneficiaries will spend \$1,000 or more on prescription drugs. Enrollee spending above \$1,000 is projected to total \$72 billion in 2004, constituting about 70 percent of total drug spending by or for all Medicare enrollees. Only 13 percent of enrollees spend \$5,000 or more on prescription drugs in a year. Spending at or above that threshold would total about \$18 billion in 2004.

Existing Coverage

While third-party coverage for prescription drugs has become more generous over time for the population as a whole, that trend is less clear for Medicare beneficiaries. In 1997, nearly one-third of the Medicare population had no prescription drug coverage. On average, Medicare beneficiaries paid about 45 percent of their drug expenditures out of pocket (see Figure 4). By comparison, all people in the United States paid an average of 39 percent of the cost of their prescriptions. Because Medicare beneficiaries are elderly or disabled, they are more likely to have chronic health conditions and to use more prescription drugs: nearly 89 percent filled at least one prescription in 1997. Medicare beneficiaries made up 14 percent of the population that year, yet they accounted for about 40 percent of the \$75 billion spent on prescription drugs in the United States.

Those factors suggest that growth in drug spending has a larger financial impact on the Medicare population than on other population groups. However, aggregate statistics mask a wide variety of personal circumstances. Nearly 70 percent of beneficiaries obtain drug coverage as part of a plan that supplements Medicare's benefits, but those supplemental plans vary significantly in their generosity.

Traditionally, more seniors have received prescription drug coverage from retiree health plans than from any other source, and the plans' benefits have been relatively generous. In 1997, about one-third of Medicare beneficiaries had supplemental coverage through a current or former employer, and most of those plans provided drug coverage (see Table 4). Although specific benefits vary, it is common to find relatively low deductibles and copayments in employer-sponsored drug plans.

However, because prescription drug spending by elderly retirees has become a significant cost to employers, many have begun to restructure their benefits. For example, a 1997 Hewitt Associates' study for the Kaiser Family Foundation found that among large employers, drug spending for people age 65 or older made up 40 percent to 60 percent of the total cost of their retiree health plans. Average utilization of prescription drugs among elderly retirees was more than double that for active workers. Although relatively few employers in the Hewitt survey have dropped retiree coverage altogether, most have taken steps to control costs, such as tightening eligibility standards, requiring retirees to contribute more toward premiums, placing caps on the amount of benefits that plans will cover, and encouraging elderly beneficiaries to enroll in managed care plans.

Medicare+Choice (M+C) plans are another means by which the elderly and disabled have obtained prescription drug coverage. In 2000, for example, 64 percent of Medicare beneficiaries had access to M+C plans that offered some drug coverage, although a significantly smaller fraction of elderly people signed up for those plans. Many M+C plans have scaled back their drug benefits in response to rising costs and slower growth in Medicare's payment rates. Nearly all such plans have annual caps on drug benefits for enrollees—many at a level of only \$500 per year—and a growing share of plans charge a premium for supplemental benefits.

While 26 percent of the Medicare population relied on individually purchased (often medigap) plans as their sole form of supplemental coverage in 1997, less than half of that group had policies that covered prescription drugs. Medigap plans with drug coverage tend to be much less generous than retiree health plans; medigap plans have a deductible of \$250, 50 percent coinsurance, and annual benefit limits of either \$1,250 or \$3,000. Premiums for plans that include drug coverage also tend

to be much higher than premiums for other medigap plans, due in part to their tendency to attract enrollees who have higher-than-average health expenses.

Certain low-income Medicare beneficiaries may also be eligible for Medicaid coverage, which generally includes a prescription drug benefit. All state Medicaid programs offer prescription drug coverage (usually involving little or no cost sharing) to people whose income and assets fall below certain thresholds. In addition, as of January 2001, 26 states had authorized (but had not necessarily yet implemented) some type of pharmaceutical assistance program, most of which would provide direct aid for purchases to low-income seniors who did not meet the Medicaid requirements. About 64 percent of the Medicare population lives in those states.

Thus, middle- and higher-income seniors can usually obtain coverage through retiree or M+C plans, while seniors with the lowest income generally have access to state-based drug benefit programs. However, beneficiaries with income between one and two times the poverty level are more likely to be caught in the middle, with incomes or assets that are too large to qualify for state programs and less access than higher-income enrollees to drug coverage through former employers. In 1997, more than a quarter of Medicare enrollees had income between one and two times the poverty level, but more than 40 percent of them had no drug coverage (see Table 5). Consequently, half of the drug spending for people in that income group was paid out of pocket.

Design Choices for a Medicare Drug Benefit

A Medicare drug benefit might address a number of objectives. The most fundamental would be to ensure that all beneficiaries had access to reasonable coverage for outpatient prescription drug costs—but this fundamental notion allows for considerable debate about what that would mean. The various objectives that might be thought desirable in the abstract are often mutually incompatible; as a result, difficult choices must be made. For example, it is not possible to provide a generous drug benefit to all Medicare beneficiaries at low cost—either premiums paid by enrollees or subsidies paid by taxpayers would be high. If most of the costs were paid by enrollees' premiums to keep federal costs low, some Medicare beneficiaries would be unwilling or unable to participate in the program. If costs were limited by covering only catastrophic expenses, few enrollees would receive reimbursement for drug costs in any given year, possibly reducing support for the program. (Such coverage, however, would provide insurance protection to those who enrolled.) If, instead, costs were limited by capping the annual benefits paid to each enrollee, the program would fail to protect participants from the impact of catastrophic expenses.

In designing a drug benefit, policymakers must make four fundamental decisions:

- Who may participate?
- How will program costs be financed?
- How comprehensive will coverage be?
- Who will administer the benefit and under what conditions?

Participation. Although most Medicare enrollees use some prescription drugs, the bulk of such spending is concentrated among a much smaller group. In 1997, about 13 percent of enrollees had expenditures of \$2,000 or more, accounting for 45 percent of total drug spending by the Medicare population. Forty-six percent had expenditures of \$500 or less, making up about 8 percent of total spending. Most spending is associated with treatment of chronic conditions—such as hypertension, cardiovascular disease, and diabetes. The skewed distribution of spending and the need for people with chronic conditions to stay on drug therapies over the long term makes stand-alone drug coverage particularly susceptible to adverse selection, in which enrollment is concentrated among those who expect to receive more in benefits than they pay in premiums.

Because of the likelihood of adverse selection, a premium-financed drug benefit offered as a voluntary option for Medicare enrollees must restrict participation in some way. If Medicare beneficiaries were free to enroll in or leave the program at will, only those who expected to gain from the benefit would participate each year. That would drive premiums up, which would further reduce enrollment as enrollees with below-average drug costs dropped out.

Most of the drug benefit proposals developed in 2000 would have provided a voluntary drug option, but they attempted to mitigate the potential for adverse selection by one of two approaches: either they gave enrollees only one opportunity to choose the drug benefit, at the time enrollees first became eligible; or they imposed an actuarially fair surcharge on premiums for those who delayed enrollment. Another approach to avoiding the problem of adverse selection would be to couple the drug benefit with Part B of Medicare so that enrollees could choose either Part B plus a drug benefit or no Part B and no drug benefit. In that case, even if the drug

portion of the benefit was not heavily subsidized, the current 75 percent subsidy of Part B benefits would ensure nearly universal participation in the coupled benefit.

Financing. Program costs could be entirely financed by enrollees' premiums, or some or all of the costs could be paid by federal taxpayers. Given a one-time-only enrollment option, participation rates would be reasonably high, even if the program was largely financed by enrollees. If given only a one-time option to enroll, most beneficiaries would do so because virtually all of them would benefit from drug coverage at some time during their lives. The erosion now occurring in the comprehensive coverage provided by private plans would also spur participation. Further, employer-sponsored health plans would probably require that retirees eligible for a new Medicare benefit participate in it, just as they now effectively require that retirees participate in Part B. And state Medicaid agencies, even if not mandated to do so, would choose to enroll dual eligibles (people eligible for both Medicare and Medicaid) in a new Medicare drug benefit if their costs under the new program were less than the cost of the drug benefits now provided under Medicaid. However, if a generous drug benefit was fully financed by enrollees, premiums would be high, making the benefit difficult to afford for lower-income beneficiaries ineligible for Medicaid. The drug proposals developed last year would all provide full subsidies to low-income people for both cost sharing and premiums, in addition to partially subsidizing premiums for all other enrollees.

Coverage. A Medicare drug benefit could be designed to look like the benefit typically provided by employer-sponsored plans. If so, it would be integrated with the rest of the Medicare benefit. Further, it would have cost-sharing requirements that were low (ranging from 20 percent to 25 percent coinsurance or a copayment per prescription of \$10 to \$25) and stop-loss protection—a dollar limit above which no cost sharing would be required. Such comprehensive coverage would provide good protection for enrollees, but it would be very costly. Not only would it increase utilization among those who now have less-generous coverage, but it would also transfer most of the costs of drugs currently used by enrollees to the Medicare program.

One way to constrain costs and utilization is by limiting coverage—covering only catastrophic costs, for example, or imposing a cap on benefits paid per enrollee each year. If Medicare provided coverage only for catastrophic costs, most enrollees would receive no benefit payments in any given year. Nevertheless, it would be inaccurate to say that those enrollees would receive no benefit, since they would be protected against the possibility of catastrophic expenses—the main function of insurance.

Alternatively, policymakers could take the other approach to limiting costs: covering a portion of all drug costs but only up to a benefit cap. However, because that approach would not protect those enrollees who were most in need, most of last year's proposals included stop-loss protection. The end result was a benefit unlike anything available in the private sector—a hybrid that had a capped benefit, then a "hole" with no drug coverage, and finally a stop-loss provision, beyond which the program would pay all drug costs (see Figure 5). The larger the range of spending encompassed by the hole, the less costly the program would be—but also the less coverage the benefit would provide.

An approach to limiting costs within the context of a more traditional benefit would be to have a higher initial deductible amount, relatively high cost-sharing requirements, and a high stop-loss threshold. Or the program could provide a more generous benefit similar to those provided by employer-sponsored plans, with taxpayer costs limited by financing most of the program's costs through enrollees' premiums.

Administration. The way in which a drug benefit is administered can also have a significant effect on how costly it is. All recent proposals have envisioned adopting the now common private-sector approach of using pharmacy benefit managers (PBMs) in each region. Proposals have differed, however, in whether only one or several PBMs would serve a region, in whether the responsible entities would assume any insurance risk, and in the kind of restrictions that would be placed on them.

Private health plans use PBMs to process claims and negotiate price discounts with drug manufacturers and dispensing pharmacies. PBMs also try to steer beneficiaries toward lower-cost drugs, such as generic, preferred formulary, or mail-order drugs. In addition, because of their centralized records for each enrollee's prescriptions, they can help prevent adverse drug interactions. The likelihood that PBMs could effectively constrain costs depends on their having both the authority and the incentive to aggressively use the various cost-control mechanisms at their disposal. In the private sector, PBMs often have considerable leeway in the tools they can use, but they do not assume any insurance risk for the drug benefit. At most, they may be subject to a bonus or a penalty added to their administrative fee, based on how well they meet prespecified goals for their performance.

Some of the proposals developed last year (such as the one developed by the Clinton Administration) adopted the typical private-sector model, with a single PBM selected periodically to serve each region and with all insurance risk borne by Medicare, not the PBM. There are two main concerns about that model: it might prove politically difficult to allow the designated PBMs to use cost-control tools aggressively if enrollees have no choice of provider in each region, and non-risk-bearing PBMs might have too little incentive to use strong tools, even if they were permitted.

Other proposals (such as the Breaux-Frist bills and the drug bill passed by the House) adopted a different model, more akin to the risk-based competitive model characteristic of Medicare+Choice plans. Those proposals envisioned multiple risk-bearing entities (such as PBM/insurer partners) that would compete to serve enrollees in each region. Enrollees would have some choice among providers so that beneficiaries who were willing to accept more-restrictive rules (such as a closed formulary) in return for lower premium costs could do so, while others could select a more expensive provider with fewer restrictions. If the entities bore all of the insurance risk for the drug benefit, they would have strong incentives to use whatever cost-control tools were permitted. However, they would also have strong incentives to try to achieve favorable selection by avoiding enrollees most in need of coverage.

One of the concerns raised about this model was that no entities might be willing to participate if they had to assume the full insurance risk for a stand-alone drug benefit. To mitigate that concern, the proposals included federally provided reinsurance for high-cost enrollees. (Reinsurance means that the federal government, and ultimately taxpayers, share part or all of the costs of high-cost enrollees.) However, reinsurance would tend to weaken the plans' incentives to control costs. Another concern was that differences among plans in benefit structures or strategies for cost control could result in some plans attracting low-cost enrollees and others attracting more costly enrollees. The risk of that kind of selection would lead plans to raise the cost of the benefit. Moreover, to avoid such risks, plans would, over time, come to offer benefits that were very similar in design.

The Cost of Covering Prescription Drugs for Medicare Enrollees

There are numerous design parameters that must be specified in developing a Medicare prescription drug benefit, and decisions concerning those parameters can greatly affect the benefit's cost to the taxpayer and to the beneficiary. CBO has not finished updating its estimates for several of the proposals developed in the last session of the 106th Congress. We can, however, provide some examples that show how costs would be affected by varying certain aspects of the benefit's design.

The estimates that follow are approximate and subject to change; the cost of a detailed proposal would vary depending on its precise specifications. The estimates are for 2004 only.

Base Case. For purposes of this testimony, the base case is a benefit that provides coverage for all of the outpatient drug costs of Medicare enrollees (see Table 6). The enrollee would be responsible for coinsurance equal to 50 percent of the cost of prescription drugs up to \$8,000 of total spending. The new benefit would cover the entire cost of drugs above that amount. Thus, the enrollee would be liable for up to \$4,000 in out-of-pocket spending before reaching the stop-loss amount.

To pay for this program, enrollees would be charged a monthly premium designed to cover 50 percent of the cost of the benefit. The federal government would pay for the other 50 percent. In conjunction with several administrative features, we assume that a subsidy of that size would be sufficient to ensure that all enrollees in Part B of Medicare would participate in the prescription drug program.

Low-income enrollees would receive a subsidy to enable them to participate in the Medicare drug program. Enrollees with income up to 135 percent of the federal poverty level would receive a full subsidy of premiums and cost sharing. Those with income between 135 percent and 150 percent of the poverty level would receive a premium subsidy (on a sliding scale that declined with income) but would be responsible for any cost sharing. States and the federal government would share in those subsidy costs for enrollees with income of less than 100 percent of the poverty level and for those who were dually eligible for Medicare and Medicaid. The federal government would cover 100 percent of the cost for people who qualified for the drug benefit's low-income subsidies but did not meet their state's eligibility criteria for Medicaid benefits.

The base case also assumes that a single PBM would administer the program in each region, with all insurance risk borne by Medicare. The cases presented in this testimony do not consider another major alternative for delivering a Medicare drug benefit: instead of a single PBM, the program could be operated through multiple risk-bearing entities who would compete for enrollees. Competing PBM/insurer part-

ners who bore insurance risk would have a strong incentive to use such tools as restrictive formularies and three-tier copayment structures to aggressively manage costs. However, they would also incur certain “load” costs—such as marketing expenses to attract enrollees and a premium for accepting insurance risk—that a single PBM would not. The net impact on program costs would depend on the specific details of the proposal.

The benefit design assumed for the base case would cost the federal government about \$31.6 billion in 2004. The Medicare benefit portion of that total is \$26.0 billion, and the low-income subsidy (and interactions with the Medicaid program) account for the remaining \$5.5 billion (see Table 7). As we will see in comparisons with other cases, a less generous drug benefit would decrease Medicare costs but increase the cost of the low-income subsidy.

In the aggregate, enrollees would pay a total of \$26.0 billion in premiums, reflecting a monthly premium of \$55.50 that they would pay under the base case plan. That total includes premiums that are paid on behalf of low-income enrollees through the low-income subsidy. In addition, enrollees would face about \$44 billion in cost sharing for the prescription drugs that they used. Again, that amount includes some cost sharing that would be picked up by supplemental payers, including employer-sponsored insurance and medigap plans. As we will demonstrate below, a less generous benefit would lower premiums but raise the amount of cost sharing paid by enrollees.

Federal costs could be reduced by imposing more cost sharing on enrollees or by varying other aspects of the design. The following discussion of alternative cases examines how the costs imposed on taxpayers and beneficiaries would change if one or more features of the program were varied.

Change Beneficiaries’ Cost Sharing. The overall federal cost of a prescription drug proposal would fall if beneficiaries were responsible for a greater share of program costs. Higher cost sharing would, of course, increase the cost of the low-income subsidy.

Case 1-A is identical to the base case except for a \$250 annual deductible. Nearly 89 percent of enrollees have some prescription drug spending during the year and would thus be liable for at least part of the deductible. Including a deductible would lower Medicare costs but raise low-income costs compared with the base case. On balance, the federal cost of the program would fall to \$29.6 billion in 2004, and monthly premiums would decline to \$50.90. Beneficiaries who had more than \$250 in drug spending that year would face higher costs under this option because the added cost of the deductible would be only partly offset by the reduced premium.

An even higher deductible would further reduce program costs. Case 1-B imposes a \$500 deductible on the base case, and the federal cost drops to \$28.0 billion in 2004. Doubling the deductible amount from Case 1-A does not double savings from the base case, however, because some enrollees who would pay the full \$250 deductible would spend less than \$500 on drugs in a year and thus would not pay the full amount of the higher deductible.

Lowering the coinsurance rate could alter program costs dramatically. The base case assumes a 50 percent coinsurance rate, while Case 1-C lowers that rate to 25 percent. That adjustment increases the program’s net federal cost by one-third, to \$42.0 billion in 2004. Medicare’s cost would increase to \$37.8 billion, while the low-income subsidy would fall to \$4.3 billion.

The lower coinsurance would drive premiums upward as program costs rose. Premiums would increase by nearly half, to \$80.70 monthly. In the aggregate, beneficiaries would pay about \$38 billion in premiums. However, aggregate cost sharing would decline precipitously as well, to roughly \$24 billion. While all enrollees would face the higher premiums, the lower coinsurance rate would primarily benefit enrollees with significant drug costs.

Raise the Stop-Loss Amount. The net federal program cost also could be reduced by raising the stop-loss amount, although the additional financial exposure would increase the cost of the low-income subsidy. Under the base case, the stop-loss amount is set at \$4,000 paid out of pocket; a beneficiary who had used \$8,000 in covered prescription drugs and paid 50 percent coinsurance would not be liable for any additional costs incurred during the year. (Enrollees who spend more than \$8,000 account for about 23 percent of total baseline spending in 2004.)

Case 2-A raises the stop-loss amount to \$6,000 in out-of-pocket spending. That higher level is equivalent to total spending by an enrollee of \$12,000, which will account for less than 10 percent of total baseline spending in 2004. Under this option, the federal cost of the program would fall to \$30.7 billion, a reduction of 3 percent from the base case. The low-income subsidy rises to \$5.8 billion compared with the base case. Total premiums fall to about \$25 billion, and aggregate cost sharing increases to over \$46 billion.

Raising the stop-loss amount by an additional \$2,000—to \$8,000—lowers program costs by less than the previous difference found in Case 2-A. The federal cost for Case 2-B is estimated to be \$30.4 billion, or 4 percent lower than the base case.

Cap Benefits. A third approach would place a limit on drug costs covered under the Medicare benefit. Case 3 would impose such a limit when the enrollee reached \$2,500 in total drug spending. That is, the enrollee would receive up to \$1,250 in reimbursement for drug expenses before reaching the benefit cap. Such a cap could be absolute, with no additional reimbursement for spending at any level above the cap. However, Case 3 keeps the same stop-loss provision as in the base case so that the beneficiary faces no cost sharing beyond \$5,250 in total charges. That structure leaves a “hole” in covered spending—a range of prescription drug spending for which most enrollees must pay all of their costs. (Individuals with income below 135 percent of the poverty level, whose cost sharing is fully subsidized, would be unaffected by this provision.)

Relative to the base case, the limit on coverage in Case 3 would lower Medicare costs but increase the low-income subsidy. The net federal cost would total approximately \$28.1 billion in 2004. The option’s benefit cap would also lower premiums to about \$22 billion and raise aggregate cost sharing to over \$51 billion. The lower premiums simply reflect the less generous benefits under Case 3, compared with the base case.

Combine Features. The above options were designed to show how varying one parameter of a prescription drug benefit would affect program costs. This section looks at alternatives that combine several changes at the same time.

Case 4-A combines the base case with many of the features described above: a \$250 deductible, benefits capped at \$1,125 (after the enrollee reaches \$2,500 in total drug spending), and stop-loss protection after the beneficiary spends \$6,000 out of pocket. The costs of enrollees with income below 135 percent of the poverty level would be fully subsidized inside the benefit “hole.”

Such a benefit would be significantly less generous than the base case, but the costs of financing it would be significantly lower as well. In 2004, federal costs would be approximately \$23.4 billion, or about one-quarter less than the base case. Likewise, monthly premiums would fall from \$55.50 under the base case to \$35.20 under Case 4-A. That causes total premiums to drop to \$16.5 billion, with a corresponding increase in aggregate cost sharing to \$61.5 billion.

Case 4-B is identical to Case 4-A except that low-income individuals would not be subsidized inside the benefit “hole.” CBO estimates that in 2004, federal costs would total \$21.4 billion. Nearly all of that savings comes from reductions in the cost of the low-income subsidy. Premiums would drop negligibly compared with Case 4-A.

Case 4-C extends the low-income subsidy to individuals with higher income than those in previous cases. Specifically, it includes all of the features of Case 4-A but provides a full subsidy for premiums and cost sharing to enrollees who have income at or below 150 percent of the federal poverty level. Enrollees with income between 150 percent and 175 percent of the poverty level would receive a premium subsidy on a sliding scale. Medicare costs would remain roughly unchanged compared with Case 4-A, but the low-income subsidy would increase to \$7.9 billion in 2004.

Increasing the federal subsidy for beneficiary premiums would substantially raise program costs. Case 4-D is identical to Case 4-A except that the subsidy is raised to 75 percent of premiums. That change increases Medicare costs by 50 percent compared with Case 4-A but reduces the cost of the low-income subsidy somewhat. The net federal cost would rise to over \$30 billion in 2004. The sharp increase in Medicare costs is mirrored by the sharp drop in premiums, which fall from more than \$16 billion in Case 4-A to about \$8 billion in Case 4-D.

Because we have assumed throughout this discussion that the federal subsidy would be at least 50 percent, the increase in Case 4-D does not yield an increase in participation by Medicare enrollees. However, if the federal subsidy declined below 50 percent, CBO assumes that enrollment would also decline somewhat.

SUBSIDIES FOR LOW-INCOME ENROLLEES

Like the cases discussed above, all of the proposals put forward recently in the Congress would require a substantial contribution by enrollees—through both cost sharing and premiums. To make a new drug benefit more affordable for low-income Medicare beneficiaries, the proposals would at least partially subsidize those costs for eligible enrollees.

Several decisions must be made in designing a low-income subsidy program for a Medicare drug proposal. Rules must be established to determine who would be eligible for a subsidy and the amount. Some low-income Medicare beneficiaries cur-

rently receive assistance for some or all of their medical costs through Medicaid and other state-run programs. Most Medicare drug proposals have included prescription assistance to low-income beneficiaries, keying it to the following categories of Medicaid eligibility:

- So-called dual eligibles meet all state requirements for Medicaid eligibility, either because they are below the limits on income and assets set by the state or because they have “spent down” their resources to those limits as a result of high medical costs (the medically needy). For the first group, their Medicare cost sharing and premiums are paid by Medicaid. They also receive all Medicaid benefits, including coverage for prescription drugs. Most medically needy enrollees receive those same benefits, although a few states do not cover their expenses for drugs.
- Qualified Medicare beneficiaries (QMBs) have income below the federal poverty level. About 75 percent of that group qualify as dual eligibles; the other 25 percent are eligible for benefits only as QMBs. For the latter group, Medicaid pays their cost sharing and premiums under Medicare, but they are not eligible for other Medicaid benefits and they do not have Medicaid drug coverage.
- Specified low-income Medicare beneficiaries (SLMBs) have income between 100 percent and 120 percent of the poverty level. About a third of this group qualify as dual eligibles. The other two-thirds qualify only as SLMBs, and the only Medicaid benefit they get is coverage for Medicare premiums.

In addition to beneficiaries currently qualifying for Medicaid coverage, other low-income Medicare enrollees would also receive assistance under most recent Medicare drug proposals. Such plans would provide subsidies to all enrollees with income below 135 percent of the poverty level (and within certain asset limits) to cover cost sharing and premiums; they would pay some or all of the premiums for beneficiaries with income between 135 percent and 150 percent of the poverty level. A few proposals would extend the subsidy to enrollees with higher income.

A key design choice for low-income subsidies is how much of those costs would be paid by the federal government and how much would be shared by the states. Currently, the federal government pays 57 percent of Medicaid costs on average, with the states paying the rest. Most of the proposals for a Medicare drug benefit would maintain the current federal contribution for dual eligibles and QMBs but allow full federal funding for other low-income beneficiaries with income and assets at or below the eligibility limits set specifically for the Medicare drug subsidy. A proposal that increased the federal government’s share of the cost of low-income subsidies would reduce state costs.

The cost of low-income subsidies would also depend on how many people participated in the program. Not all eligible beneficiaries would choose to avail themselves of the subsidies even if they participated in the drug benefit. Some beneficiaries would not want to be associated with a government “welfare” program; others might not believe that they were eligible or that they needed the subsidy. Participation rates would vary according to the design of the proposal.

A further factor affecting participation is the entity designated to administer the subsidy program. Most recent proposals would rely on state Medicaid programs to determine eligibility and to enroll low-income beneficiaries, but another option would be to have the Social Security Administration (SSA) provide those administrative services. Participation would be higher under the latter arrangement because there is less stigma associated with SSA than with Medicaid.

Another factor is the size of the subsidy: a larger subsidy would probably induce more people to participate in the program. That effect would also depend on how the benefit was designed. High deductibles or premiums might persuade eligible low-income beneficiaries to enroll in the low-income subsidy portion of the program to cover those up-front costs. That incentive to enroll would be stronger if the drug benefit’s coverage of expenses beyond the deductible was more generous.

Perhaps the most significant issue affecting participation by low-income beneficiaries is whether asset standards currently in place for Medicaid would be relaxed for the drug benefit. Less stringent asset standards would expand the number of people eligible for subsidies.

With the introduction of a Medicare prescription drug benefit, there would be offsetting changes in the federal government’s Medicaid spending. On balance, federal costs would increase when the effect of the low-income subsidy was combined with those changes in Medicaid spending. (Depending on how the subsidy was designed, states could also see a net increase in their costs.) A Medicare drug benefit would reduce Medicaid’s costs for current dual eligibles because Medicare would pick up part of their prescription drug costs, in effect refinancing that portion of the current Medicaid drug benefit. However, some people who are now eligible for assistance do not enroll in Medicaid. A Medicare drug benefit would provide a new incentive for

those people to enroll in Medicaid, which under most proposals would cover the drug benefit's cost sharing and premiums.

The magnitude of any increase in federal or state costs depends on the interplay between the generosity of a Medicare drug benefit and its provisions for low-income subsidies. In general, for a given set of subsidy provisions, a less generous Medicare drug benefit would lead to higher federal spending (the result of combining the low-income subsidies and the effect on Medicaid).

CONCLUSION

While policymakers are well aware of Medicare's long-run financial problems, they also know that its benefit package has deficiencies relative to the benefits typically provided by private-sector insurance plans. One such deficiency is that the program provides only very limited coverage for outpatient prescription drugs—an increasingly important component of modern medical care. But adding a drug benefit without other reforms would significantly increase Medicare's costs, and unless it was fully financed by enrollees' premiums, it would greatly increase the already large burden on the next generation of taxpayers.

TABLE 1. CBO'S BASELINE PROJECTIONS OF PRESCRIPTION DRUG SPENDING AND MEDICARE BENEFITS PER ENROLLEE, CALENDAR YEARS 2002-2011

	Spending per Enrollee (Dollars)		Average Annual Percentage Change, 2002-2011
	2002	2011	
Drug Spending ¹	1,989	4,818	10.3
Medicare Benefits ²	6,841	11,268	5.7
Memorandum:			
Gross Domestic Product per Capita	39,275	56,569	4.1

SOURCE: Congressional Budget Office.

¹ Total spending per enrollee on outpatient prescription drugs not currently covered under Medicare, regardless of payer. Based on CBO's January 2001 baseline projections.

² Medicare benefits per enrollee under the Hospital Insurance and Supplementary Medical Insurance programs. Based on CBO's May 2001 baseline projections.

TABLE 2. COMPARING CBO'S JANUARY 2001 AND MARCH 2000 BASELINE PROJECTIONS OF PRESCRIPTION DRUG SPENDING

(By calendar year, in billions of dollars)

Year	January 2001 Estimates	March 2000 Estimates
2001	71	66
2002	81	74
2003	92	82
2004	104	91
2005	117	101
2006	131	112
2007	148	124
2008	165	137
2009	185	152
2010	205	167
2011	228	n.a.
Total		
2001-2010	1,299	1,105
2002-2011	1,456	n.a.
Memorandum:		
Percentage increase in total spending, January 2001 estimates over March 2000 estimates, for 10 years ending in 2010		17.6
Percentage increase in total spending, 10 years ending in 2011 (using January 2001 estimates) over 10 years ending in 2010 (using March 2000 estimates)		31.8

SOURCE: Congressional Budget Office.

NOTES: Numbers may not add up to totals because of rounding.

n.a. = not applicable.

TABLE 3. PROJECTED SPENDING ON PRESCRIPTION DRUGS BY OR FOR MEDICARE ENROLLEES IN CALENDAR YEAR 2004

Spending Level per Enrollee (Dollars)	Spending by All Enrollees At or Above the Level (Billions of dollars)	Share of Enrollees with Spending Above the Level (Percent)	Share of Total Drug Spending (Percent)
0	104.0	87.8	100.0
1,000	72.4	59.3	69.7
2,000	50.6	40.9	48.7
3,000	35.5	28.1	34.2
4,000	25.2	19.1	24.2
5,000	18.1	13.4	17.4
6,000	13.2	9.0	12.7
7,000	9.9	6.5	9.5
8,000	7.4	4.5	7.2
9,000	5.7	3.4	5.5
10,000	4.4	2.4	4.3

SOURCE: Congressional Budget Office.

NOTES: Based on CBO's January 2001 baseline projections.

Total Medicare enrollment for 2004 is projected to be 41.8 million people.

TABLE 4. PRESCRIPTION DRUG COVERAGE AMONG MEDICARE ENROLLEES, BY TYPE OF SUPPLEMENTAL COVERAGE, CALENDAR YEAR 1997

	Number of Medicare Enrollees (Thousands)			Percentage of All Enrollees		
	No Drug Coverage	Drug Coverage	Total	No Drug Coverage	Drug Coverage	Total
No Supplemental Coverage	2,941	0	2,941	7.4	0	7.4
Any Medicaid Coverage ¹	1,448	5,449	6,897	3.6	13.7	17.4
Employer-Sponsored Plans	1,671	11,163	12,834	4.2	28.1	32.3
Individually Purchased Policies	5,753	4,532	10,286	14.5	11.4	25.9
Other Public Coverage ²	0	1,396	1,396	0	3.5	3.5
HMOs Not Elsewhere Classified ³	678	4,696	5,374	1.7	11.8	13.5
Total	12,491	27,236	39,728	31.4	68.6	100.0

SOURCE: Congressional Budget Office based on data from the 1997 Medicare Current Beneficiary Survey.

NOTES: Some beneficiaries hold several types of coverage at once. The categories in this table are mutually exclusive, and CBO assigned people to groups in the order shown above. The numbers in the table may not add up to totals because of rounding.

HMO = health maintenance organization.

¹ Comprises beneficiaries who received any Medicaid benefits during the year, including those eligible for a state's full package of benefits as well as others who received assistance for Medicare premiums or cost sharing through the Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, and Qualifying Individual programs.² Beneficiaries who received aid for their drug spending through state-sponsored pharmacy assistance programs for low-income elderly make up 60 percent of this category. The remainder received prescription drug benefits through the Veterans Administration.³ Primarily HMOs under Medicare+Choice risk contracts.

TABLE 5. MEDICARE ENROLLEES AND THEIR PRESCRIPTION DRUG COVERAGE AND SPENDING, BY POVERTY STATUS IN 1997

Poverty Status ¹	Number of Enrollees (Millions)	Share of All Enrollees (Percent)	Share Within Poverty Group That Does Not Have Drug Coverage (Percent)	Total Drug Spending (Billions of dollars)	Out-of-Pocket Drug Spending (Billions of dollars)
Less Than 100 Percent	6.3	15.9	28.0	5.9	1.7
100-200 Percent	11.2	28.1	40.9	10.0	5.0
200-300 Percent	8.4	21.2	30.7	7.8	3.8
300 Percent or More	13.9	34.9	25.8	12.9	5.8
Total	39.7	100.0	31.4	36.7	16.2

SOURCE: Congressional Budget Office based on data from the 1997 Medicare Current Beneficiary Survey (MCBS).

NOTES: CBO adjusted each enrollee's level of drug spending by 25 percent to reflect underreporting in the survey. Prescription drug spending for MCBS respondents who were in nursing homes was imputed from the expenditures of noninstitutionalized respondents who have difficulties with the same number of activities of daily living.

The numbers in the table may not add up to totals because of rounding.

¹ Income relative to the federal poverty level.

TABLE 6. OPTIONS FOR A PRESCRIPTION DRUG BENEFIT THROUGH MEDICARE IN 2004

Case	Description ¹	Federal Cost (Billions of dollars)	Beneficiaries' Monthly Premium (Dollars)
Base	Federal government pays 50 percent of premiums; no deductible is required; beneficiaries pay 50 percent coinsurance; stop-loss protection is provided after \$4,000 in out-of-pocket spending.	31.6	55.50
Option 1: Change Beneficiaries' Cost Sharing			
1-A	Require a \$250 deductible	29.6	50.90
1-B	Require a \$500 deductible	28.0	47.00
1-C	Reduce beneficiaries' coinsurance to 25 percent	42.0	80.70
Option 2: Increase the Stop-Loss Amount			
2-A	Raise the stop-loss amount to \$6,000	30.7	53.10
2-B	Raise the stop-loss amount to \$8,000	30.4	52.40
Option 3: Cap the Benefit			
3	Cap the benefit after \$2,500 in total drug spending; provide stop-loss protection after \$4,000 in out-of-pocket spending; subsidize low-income beneficiaries' spending in the "hole".	28.1	47.10
Option 4: Combinations			
4-A	Require a \$250 deductible; cap benefits after \$2,500 in total drug spending; provide stop-loss protection after \$6,000 in out-of-pocket spending; subsidize low-income beneficiaries' spending in the "hole".	23.4	35.20
4-B	Require a \$250 deductible; cap benefits after \$2,500 in total drug spending; provide stop-loss protection after \$6,000 in out-of-pocket spending; provide no subsidies for low-income beneficiaries' spending in the "hole".	21.4	35.00
4-C	Require a \$250 deductible; cap benefits after \$2,500 in total drug spending; provide stop-loss protection after \$6,000 in out-of-pocket spending; subsidize some or all cost sharing in the "hole" for beneficiaries with income at or below 175 percent of the poverty level.	24.4	35.20
4-D	Increase the share of premiums paid by the federal government to 75 percent; require a \$250 deductible; cap benefits after \$2,500 in total drug spending; provide stop-loss protection after \$6,000 in out-of-pocket spending; subsidize low-income beneficiaries' spending in the "hole".	30.3	17.60

SOURCE: Congressional Budget Office.

¹The options represent changes relative to the base case. The "hole" is the range of prescription drug spending above the benefit cap and below the stop-loss amount. To "subsidize low-income beneficiaries' spending in the 'hole,'" the federal government and the states would provide aid in the following manner: beneficiaries with income at or below 135 percent of the federal poverty level could receive some or all cost sharing and premium assistance; and beneficiaries with income between 135 percent and 150 percent of the poverty level could receive premium assistance on a sliding scale.

TABLE 7. APPROXIMATE COST OF ILLUSTRATIVE CASES IN CALENDAR YEAR 2004

(In billions of dollars)

Case ¹	Federal Cost to Taxpayers			Payments by or for Participating Beneficiaries		
	Medicare	Low-Income Subsidies/ Medicaid Interaction	Total	Medicare Pre- miums	Medicare Cost Sharing	Total
Base	26.0	5.5	31.6	26.0	44.4	70.4
1-A	23.8	5.8	29.6	23.8	48.1	71.9
1-B	22.0	6.0	28.0	22.0	51.3	73.3
1-C	37.8	4.3	42.0	37.8	24.5	62.3
2-A	24.9	5.8	30.7	24.9	46.5	71.3
2-B	24.5	5.9	30.4	24.5	47.1	71.6
3	22.1	6.1	28.1	22.1	51.5	73.5
4-A	16.5	7.0	23.4	16.5	61.5	77.9
4-B	16.4	5.0	21.4	16.4	61.3	77.7
4-C	16.5	7.9	24.4	16.5	61.6	78.1
4-D	24.7	5.6	30.3	8.2	61.5	69.7

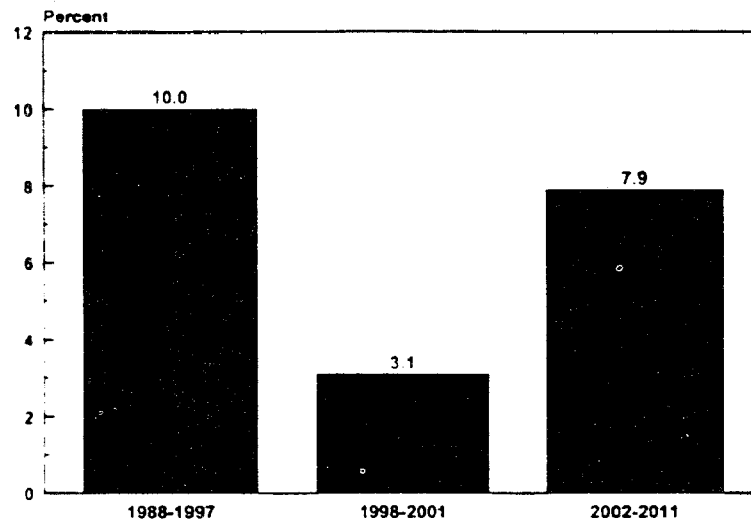
SOURCE: Congressional Budget Office.

NOTES: Based on CBO's January 2001 baseline projections.

Estimates assume that all costs are phased in fully by 2004. The numbers in the table may not add up to totals because of rounding. The table differs from Table 5 in CBO's March 27, 2001, testimony before the House Committee on Ways and Means, Subcommittee on Health, in that it reflects corrections to estimates of cost sharing for participating beneficiaries. Otherwise, it is unchanged. The approximate level of total drug spending by or for beneficiaries who participate in the new Medicare benefit is the sum of Medicare's federal cost to taxpayers plus Medicare premiums plus cost sharing paid by or for the enrollees. Total drug spending by or for all Medicare beneficiaries would also include spending by those who chose not to participate in the new Medicare benefit (in this case, those who enrolled in Part A but not Part B of Medicare).

¹ For descriptions of the illustrative cases, see Table 6.

FIGURE 1 ANNUAL AVERAGE MEDICARE SPENDING GROWTH FOR VARIOUS PERIODS



SOURCE Historical data from the Health Care Financing Administration and projections by the Congressional Budget Office.

FIGURE 2. PROJECTED MEDICARE OUTLAYS AND DEDICATED REVENUES
AS A PERCENTAGE OF GDP, CALENDAR YEARS 2000-2075

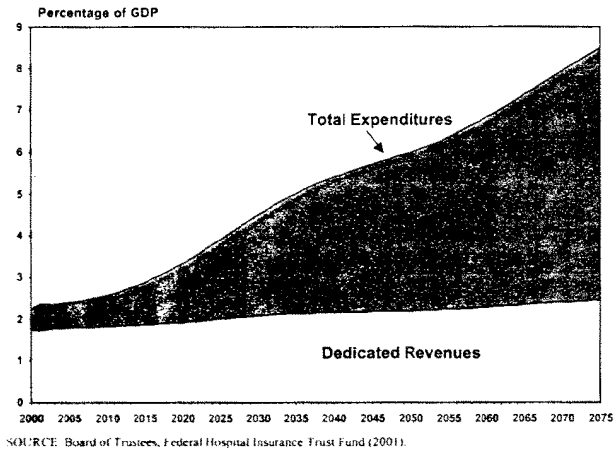
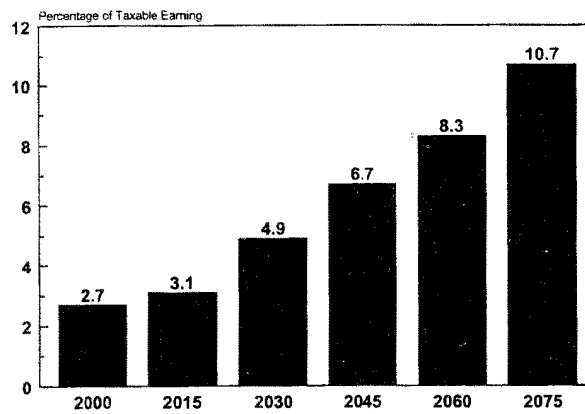
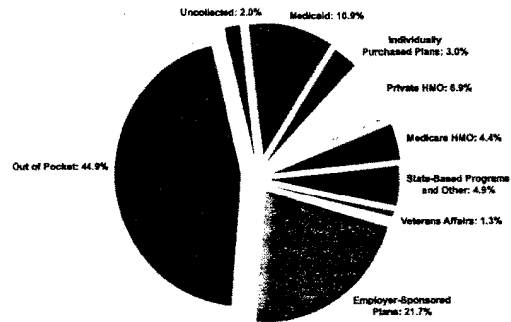


FIGURE 3. MEDICARE HI COSTS AS A PERCENTAGE OF TAXABLE
EARNINGS, 2000-2075



SOURCE:
Board of Trustees, Federal Hospital Insurance Trust Fund (2001).

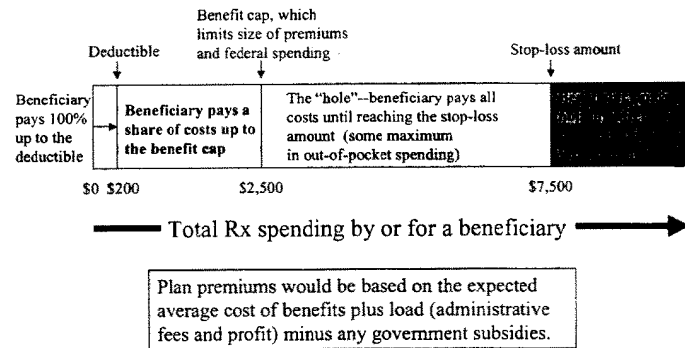
FIGURE 4. DISTRIBUTION OF DRUG SPENDING FOR MEDICARE ENROLLEES, BY PAYER, 1997



SOURCE: Congressional Budget Office tabulations from the 1997 Medicare Current Beneficiary Survey.

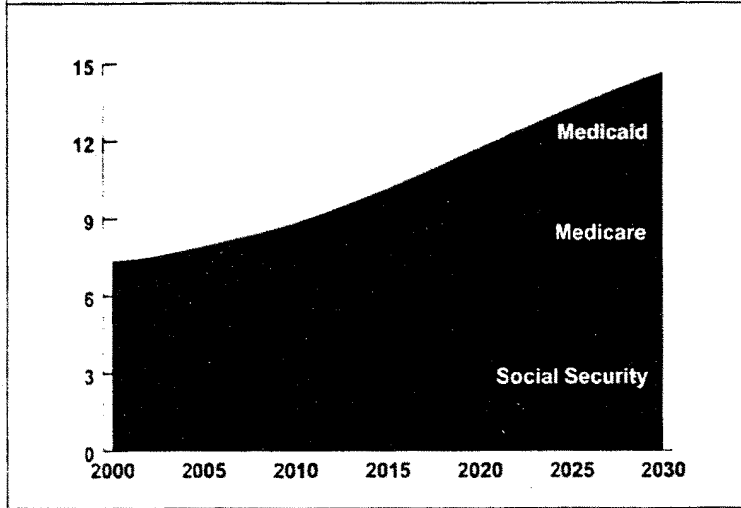
NOTE: Drugs currently covered by Medicare are not included here.

FIGURE 5. POSSIBLE FEATURES OF A PRESCRIPTION DRUG INSURANCE BENEFIT



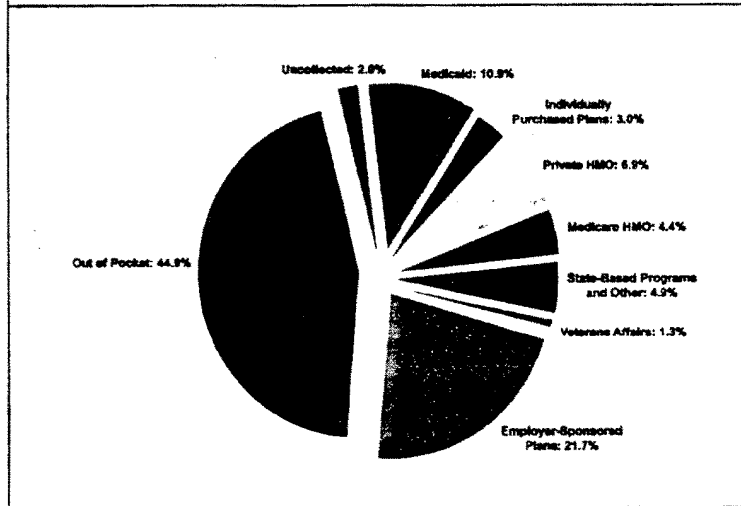
SOURCE: Congressional Budget Office.

Projected Federal Spending for Social Security, Medicare, & Medicaid (As a percentage of GDP; Oct. 2000 estimates)

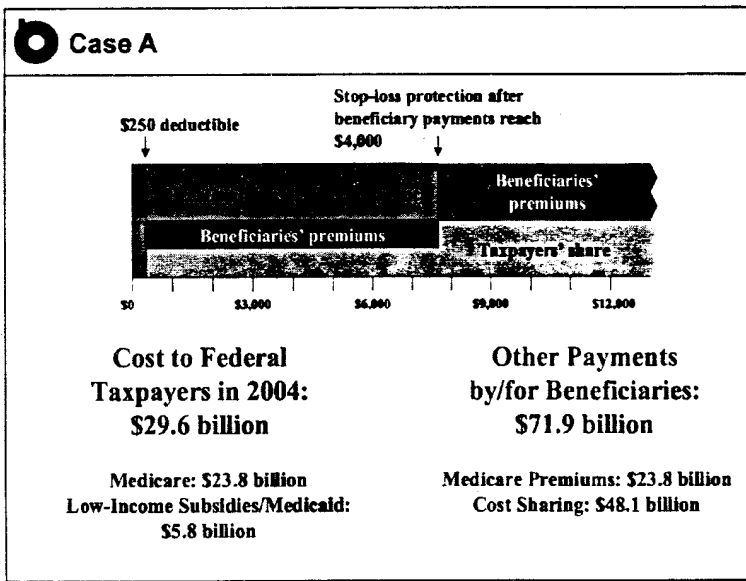
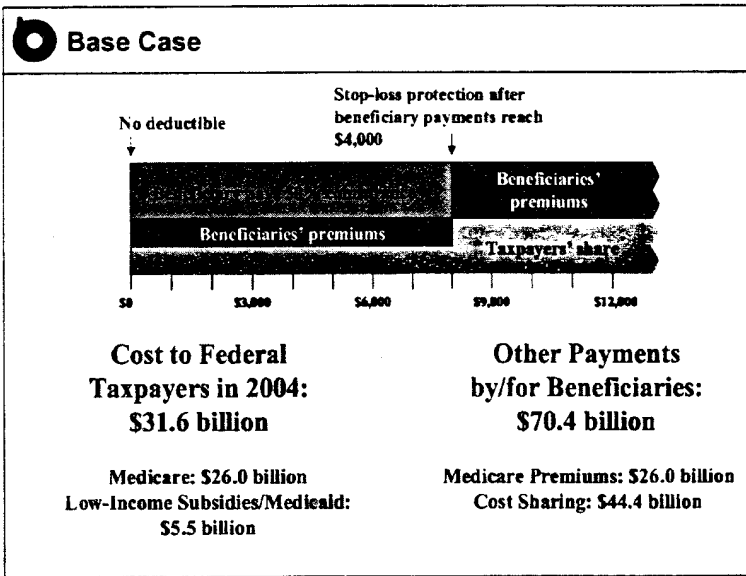


SAC-016

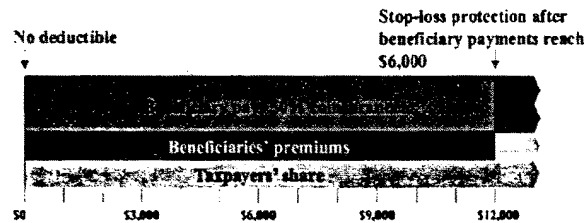
Distribution of Drug Spending for Medicare Enrollees, by Payer, 1997



SAC-016



Case B



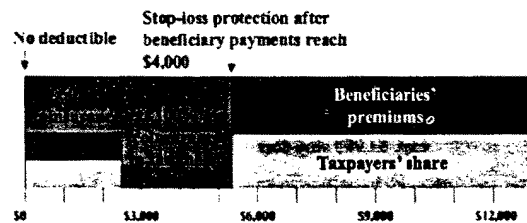
**Cost to Federal
Taxpayers in 2004:**
\$30.7 billion

**Other Payments
by/for Beneficiaries:**
\$71.3 billion

Medicare: \$24.9 billion
Low-Income Subsidies/Medicaid:
\$5.8 billion

Medicare Premiums: \$24.9 billion
Cost Sharing: \$46.5 billion

Case C

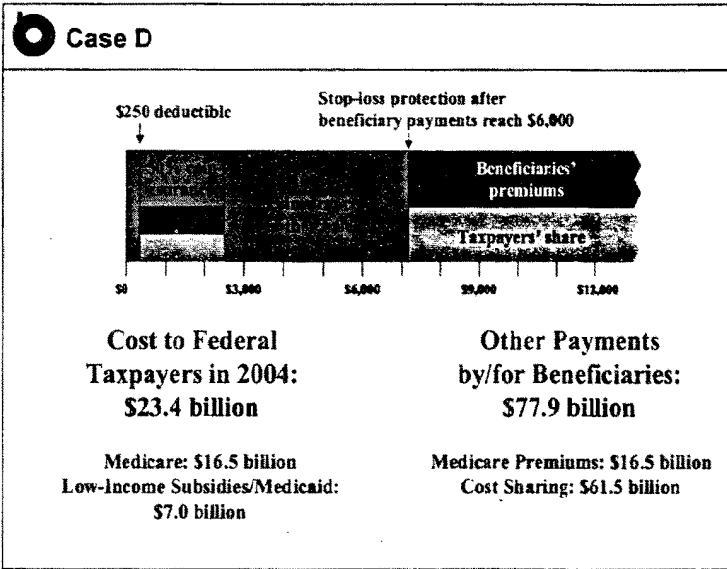


**Cost to Federal
Taxpayers in 2004:**
\$28.1 billion

**Other Payments
by/for Beneficiaries:**
\$73.5 billion

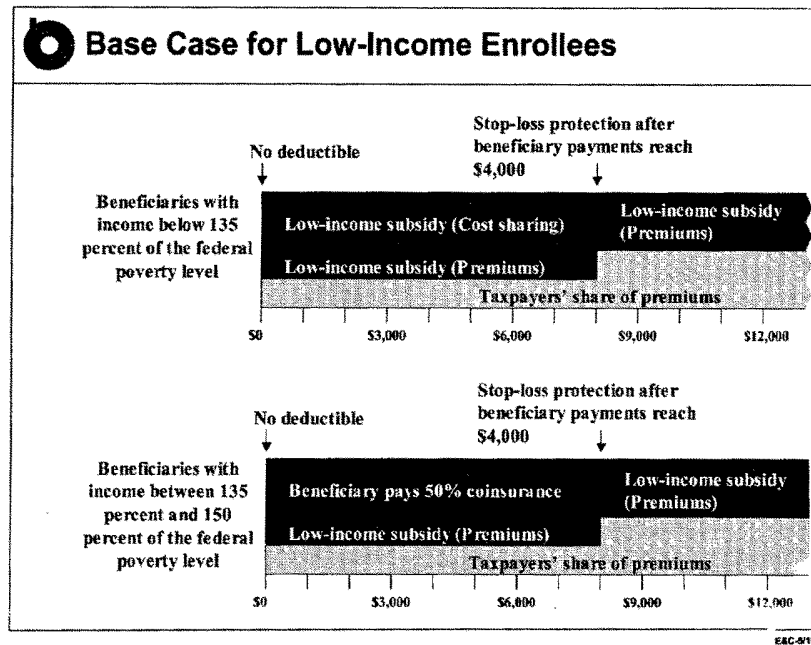
Medicare: \$22.1 billion
Low-Income Subsidies/Medicaid:
\$6.1 billion

Medicare Premiums: \$22.1 billion
Cost Sharing: \$51.5 billion



Summary of Cases

	Description	Federal Cost in 2004 (Billions)	Monthly Premium
Base Case	No deductible, no benefit cap, \$4,000 stop-loss	\$31.6	\$55.50
Case A	\$250 deductible	\$29.6	\$50.90
Case B	\$6,000 stop-loss	\$30.7	\$53.10
Case C	Benefit cap at \$2,500 in total spending	\$28.1	\$47.10
Case D	\$250 deductible, benefit cap at \$2,500 in total spending, \$6,000 stop-loss	\$23.4	\$35.20



Mr. BILIRAKIS. I didn't expect you to finish up in 10 minutes.

Mr. CRIPPEN. As I often say, I would rather hear what is on your mind than what's on mine.

Mr. BILIRAKIS. Well, not only that, but I would imagine by the time we are all finished inquiring here, you would have been able to get your points across.

Let me ask you a general or generic question. Did you consider the use of generic drugs in some capacity or another, in the process of determining your figures?

Mr. CRIPPEN. Yes, Mr. Chairman. In constructing our baseline against which, of course, we measure all of this—the baseline in which we have the \$1.5 trillion over 10 years—we try to account for not only the current use of generics but also the fact that there are a number of fairly expensive drugs used by the elderly that will be coming off-patent in the middle of this 10-year period. So we have looked at what is in the pipeline for new drugs—although that is harder, of course, to estimate, both in terms of price and exact availability—as well as drugs that will be coming off-patent and an assumption about generics therefore kicking in. So, we have included current generic use as well as what we think will be more use, in some cases, for drugs over the 10 years.

Mr. BILIRAKIS. I see. Well, Mr. Crippen, referring now to the \$300 billion that was in the budget vehicle, some, of course, have argued that it is not near enough. Have you considered, in the process of doing this, any reforms to the Medicare program that would generate savings. For example, the thought of combining Parts A and B. Would you just expand upon that?

Mr. CRIPPEN. We have the luxury, Mr. Chairman, of reacting to policy proposals and not creating them. And so, in that sense, we

are in the business of trying to estimate what you all and the President and others propose. So, in that sense, we don't have an independent policy proposal.

Combining Parts A and B, however, has been in a number of proposals made over the last couple of years, and it would clearly depend on what else happened. Just simply combining Parts A and B is, if you will, an accounting change, of how one would count the money going in and out. Without changing the nature of the deductibles and the copayments and other aspects of the program, it wouldn't change the fiscal outlook at all.

Mr. BILIRAKIS. So combining A and B would not change the fiscal outlook at all.

Mr. CRIPPEN. No, not unless you did some other restructuring at the same time.

Mr. BILIRAKIS. Why is it that we seem to feel pretty good about doing something like that?

Mr. CRIPPEN. Well, it may make good, logical sense, as many of you will remember, the history of how we created A and B was one of grand compromise between the House and the Senate, but the shades of the lines between the two have grown hazy over time. You all have moved home health out of Part A to Part B—what used to be a hospital benefit is now an outpatient or physician benefit. So there is a real melding of services anyway. It may make good, logical sense to combine the two. In so doing, there have been proposals to combine the deductibles and do some other things that could have some effects on costs, but simply combining the two programs into one will change the way we account for it but won't change the incentives for the beneficiaries or the providers to change their behavior.

Mr. BILIRAKIS. I notice that in your written statement you refer to that hazy line that is between the two. Well, there is always and we should be concerned about the unintended consequences of our actions. One of the unintended consequences conceivably might be employers dropping their prescription drug coverage in retiree health plans. Any opinion on that?

Mr. CRIPPEN. Well, it is certainly possible. We have assumed, for purposes of this exercise, that employers would continue to provide coverage if they are covering now, but of course, they would take advantage of whatever the Federal benefit would allow. So that not unlike many of the employer retirement schemes now that wrap around Medicare, whatever Medicare doesn't pay, they may cover. And so in this case, if there was a Medicare or pharmaceutical benefit, we would assume the same kind of behavior from employers but not that they would change or drop their benefit altogether. They would wrap it around the Medicare benefit and therefore shift some of their costs to the Federal budget, but not drop coverage or not change coverage.

Mr. BILIRAKIS. I see. So you assume that.

Mr. CRIPPEN. Yes, we do.

Mr. BILIRAKIS. On the other hand, is it reasonable to expect that the dropping would take place?

Mr. CRIPPEN. I don't know that it is reasonable, Mr. Chairman. Certainly, employers have begun to scale back retiree benefits for pharmaceuticals in some ways. I am sure there are instances in

which companies have dropped benefits. And so the provision of a Medicare benefit by the Federal Government may stop that erosion or help keep it from accelerating.

So, it is entirely possible that the employer system the way we now know it, while taking advantage of whatever the Medicare drug benefit would be, would not necessarily change radically one way or the other. You might take that as one way of saying that we don't know.

Mr. BILIRAKIS. My time has expired. Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. Earlier, I found Mr. Burr's comments—I am sorry he is not back here—but his comments about saying that our talking on this side of the aisle—I guess me, in particular—my talking about prescription drug costs as a partisan issue to say that if we don't do something about costs, this Congress and this President, who are not talking about costs, real costs of prescription drugs, that is a partisan statement.

I find it curious especially because, Mr. Crippen, in your statement you said prescription drug costs will rise at an average annual rate of 10.3 percent per beneficiary, twice the combined—the pace of the combined costs for Medicare programs and much faster than the Nation's economy.

My understanding is there is no accounting in the budget blueprint, no accounting by all of you, for prescription drug costs increase in Medicaid, correct?

Mr. CRIPPEN. In our Medicaid baseline, there certainly is. Over the next 10 years, we expect—

Mr. BROWN. In the Medicaid budget, there is no increase, is my understanding correct?

Mr. CRIPPEN. I don't know about—maybe my colleagues do—what is in the President's budget.

Mr. BROWN. My understanding is there was a \$13 billion Medicaid cut.

Mr. CRIPPEN. They remind me that without a change in law, it is an entitlement, and so it doesn't take an annual appropriation. So far, we include, obviously, increases in pharmaceutical prices in the baseline spending.

Mr. BROWN. In the budget that passed the House, there was a \$13 billion cut in Medicaid. Now, we have not Medicaid cut. We have no addressing of the issue of Medicaid increased cost. The \$300 billion for Medicare prescription drugs and Medicare privatization, reform, or whatever term my friends on the other side of the aisle want to use, we do that and then we are considering a \$2 trillion, or \$2.3 trillion, or \$2.- whatever trillion tax cut, most of the money goes to people making over \$2- or \$300,000 a year, people who decidedly do not need, to the same degree as the rest of the population, need that prescription drug benefit.

My question then is, can we do these tax cuts, these tax cuts especially that are loaded in the outyears—5, 6, through 10 years—can we do these tax cuts, cover a prescription drug benefit that is at all adequate, without doing something on either compulsory licensing or the Allen bill where Medicare beneficiaries, as a group, are purchasers, in a sense, or parallel importing things that every other country in the world does, or what Canada does, where they use their 31 million beneficiaries to negotiate prices as a big buying

pool, negotiate prices with the drug companies? Is there any way we can do this huge tax cut, with all its uncertainty, not account for Medicaid increases, do a prescription drug benefit that probably is inadequate anyway with \$300 billion, and not do something strong or direct to control drug prices in some way—not government price controls, but injecting competition in through compulsory licensing—or to find other ways that every other country in the world uses to keep drug prices down? Is that possible to fit together?

Mr. CRIPPEN. I don't know how many questions there are there, but I think—

Mr. BROWN. There is only one question. There is one question. Could we do a tax cut without finding a way to keep drug prices down? When I hear people in this institution say we've got to give this big tax cut, and then say we've got to do a prescription drug benefit, but then shy away, for whatever reason—whether it is soft money that the drug companies spend on campaigns, whether it is direct contributions to those of us in Congress, whether it is phony front groups like Citizens for Better Medicare—to keep this institution immobilized and unwilling to take on the drug companies, is there any way to do this, to do this tax cut, to provide a prescription drug benefit, and not to do something pretty direct about prices?

Mr. CRIPPEN. I answer any of this at my peril, of course. The best example I can give you—and, of course, the answer is going to be yes and no—the best example I can give you is a budget resolution, as it is passed, because it does add up in some sense with a tax cut and with \$300 billion for a prescription drug benefit in Medicare. Obviously, it depends critically upon what kind of drug benefit you do and, ultimately, how the tax cut plays out.

So, over the 10 years, with the way the budget resolution was constructed and the Conference report passed, things do add up. You can do all of the things you laid out without changing the nature of the pharmaceutical market. But that doesn't mean you are wrong; it simply means that there is a way to make it add up, and the budget resolution does add up, but it obviously depends very critically on what else you do and how the drug benefit is structured. There are any number of ways you could think about the benefit that would cost more than \$300 billion or less. There is so much between here and there that—

Mr. BROWN. Too much uncertainty between here and there.

Mr. CRIPPEN. Sure.

Mr. BROWN. That is kind of our point, there is so much uncertainty—

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

Mr. BROWN. Thank you, Mr. Chairman. I have just one comment—there is so much uncertainty about what we do with the tax cut while we promise this prescription drug benefit, while we don't say anything with certainty about dealing with price.

Mr. BILIRAKIS. The gentleman from Michigan, Mr. Upton.

Mr. UPTON. Thank you, Mr. Chairman. Mr. Crippen, again, thank you for your testimony and the documentation that you have provided for us. I look forward to the next number of days of going

through this in real earnest, and perhaps coming back to it with some more questions as well.

Have you all done a re-estimate of what the House passed last year with regard to our drug benefit bill?

Mr. CRIPPEN. We haven't yet. We are in the midst of updating all of the models after our baseline, and so we anticipate reestimating that before long, but we haven't yet. As you know, it hasn't been—what we do is analyze bills as reported from committee first. That is the first priority.

Mr. UPTON. So we have to do our work first.

Mr. CRIPPEN. Yes, kind of.

Mr. UPTON. So maybe come August—

Mr. CRIPPEN. Well, we hope before then.

Mr. UPTON. Do you have a sense of where we are going—the budget resolution that we passed a couple weeks ago ended up with a reserve, I believe, of about \$300 billion for prescription drug benefit. Do you think that if we pass something very similar to what we did last year, that it will fit within that same \$300 billion window, or do you think it will have to be scaled back?

Mr. CRIPPEN. Well, we don't know. I mean, we haven't rescored the bill, as you suggested, and given the new baseline—there are two big changes, of course, in just our baseline. The 32 percent increase that has been alluded to is a combination of two things. One is an increase in drug pricing—or drug costs, more correctly put—of about 15 percent, or about 16 percent. The other half of the increase comes because we have moved in the 10-year timeframe down the road 1 more year, dropping 2001, which was relatively inexpensive, and adding to 2011. So by moving the 10-year timeframe, we have also added about 15 percent or so of costs. So we know that just the base is going to be 30 percent greater; therefore, the cost growth of any benefit would be in about that range, too. But, again, we haven't finalized any of the estimates of last year's proposals.

Mr. UPTON. So if you take those assumptions in line, if you looked even at a further point beyond 10 years, the number will go up quite dramatically on a chart.

Mr. CRIPPEN. Sure.

Mr. UPTON. I notice in your testimony on page 2, you indicated the growth of Medicare spending has been much slower in the past few years than it has been historically. In 1998 through 2001, CBO estimated that the benefit payments will grow at an annual average rate of 3.1 percent compared with 10 percent over the previous decade. How do you see that going in the future, as well?

Mr. CRIPPEN. Well, we think that the total program will grow at about 7.9 percent over the next 10 years. The per capita number is lower because we are also going to increase the number of recipients somewhat in these next 10 years or more anyway, growth is under 6 percent per capita but overall about 8 percent.

In the back of the testimony, there is one page with a bar chart of the three different time periods: prior to 1998; the 3 years of low growth, 1998 to 2001; and then what we foresee for the future. So we certainly don't expect that those low-growth rates over the last few years will give us—will produce the same kinds of results in the future.

Mr. UPTON. Thank you very much. I yield back.

Mr. BILIRAKIS. Mr. Pallone, to inquire.

Mr. PALLONE. Thank you, Mr. Chairman. Mr. Crippen, I was just following up on what Mr. Brown said. You know, I was thinking last night, we were talking about the price of gasoline, and the President basically is saying that you can take your tax refund from the tax bill and pay for higher gas prices. And I guess you could make the same argument here and say that you could take your tax refund and pay for higher prescription drug costs. But the problem is that, you know, the middle-income seniors who pay out-of-pocket aren't going to get enough of the tax refund to do that, in my opinion. And that is my concern.

I notice that in your testimony, you talk about beneficiaries with income between 1 and 2 times the poverty level are most likely to be caught in the middle. These are the people, you know, the sort of middle-income people that aren't eligible for Medicaid but, at the same time, don't have any benefit and are paying out-of-pocket, and that is what concerns me. And I really had two questions.

One is, we have this \$300 billion, I guess, over 10 years in the budget for a prescription drug program, but from what I can see, the budget also proposes twice that, \$600 billion, to pay for repealing the estate tax. So, if you repeal the estate tax, you will benefit only 43,000 Americans, but if you use that money, the \$600, for a prescription drug benefit, you would provide meaningful relief to 43 million Medicare beneficiaries. And I really believe that it is the middle-income person is suffering, we have to have a Medicare prescription drug benefit that is universal and helps everyone because these are the middle-income people that are suffering.

So, I just wanted to ask you, what kind of drug benefit could we provide to all seniors, you know, to all Medicare beneficiaries if we had \$600 billion available, the same amount that is available in the budget for estate tax repeal?

Mr. CRIPPEN. We haven't—and you won't be surprised to know this—reverse-engineered anything from the basis of a level of spending. Most proposals we have seen don't cost that much. As you can see from our examples here, it is more in the range of \$300 billion or so, but you could obviously change the parameters here and make it entirely possible to give a benefit totaling \$600 billion.

I can give you some examples that I brought with me on catastrophic coverage, for example, and how much you could ensure coverage on a catastrophic basis, but that wouldn't be probably the kind of benefit you have in mind.

Mr. PALLONE. I mean, there is no question, with \$600 billion you could provide some sort of universal benefit, you know, that was fairly decent. I mean, you are going to have to have some kind of premium contribution or whatever, but you could provide a pretty decent coverage.

Mr. CRIPPEN. Sure. That would cover, from our estimates, over 40 percent, or two-fifths, I should say, of all elderly drug care spending between now and 2011.

Mr. PALLONE. Okay. Then my second question is, with regard—I think the President is going to come up with a low-income-only benefit, that is what I suspect he is going to do. And the problem that I see with that is, again, in your testimony you talk about how

most States have some kind—well, not most, but a lot of States, I think you said 26 or so—have some kind of benefit for low-income.

My concern is that, again, we are not—a lot of those people are already covered either through Medicaid or through whatever the States are doing, and we are just not going to be helping that many people who really need the coverage.

Also, my fear is that if you only do what the President has proposed, the nature of it seems to be almost like a block grant, and there would be some concern whether or not they would just use it to pay for existing costs that they are already putting out, rather than expand coverage at all.

But a third thing that comes to mind is the fact that in a number of States that have these programs, there are many who are eligible, who are not even enrolled. So, I wanted to ask, does CBO assume that all eligible seniors would participate in a low-income drug benefit that is administered by the States, and what factors make it less likely that seniors would participate in a low-income program? To what extent have you factored in those who are not enrolled? To what extent is there a danger that States would just use this money in some sort of block grant and not really cover anybody in significant numbers?

Mr. CRIPPEN. Let me start with the last first. Obviously, money is fungible, and once the States have it, it could displace spending of other kinds. Congress has fairly frequently included things like maintenance-of-effort requirements so that you couldn't actually just simply displace the money, but as rates of growth change, clearly, money is fungible. And so there is always that possibility that States could—with 26 States now planning or having some benefit in place, there is some possibility that the Federal block grants or grants to those States would have leakage into their existing programs. But, again, there have been a number of things that Congress routinely does to try and minimize that, like maintenance-of-effort requirements.

Regarding who participates or not, in general, we assume for these purposes, for these estimates up here, that even with a low-income subsidy—which are in the base case and these alternatives here—that everyone who is now in Part B will be in this benefit because it is in their interest to be in it, just as the HCFA actuaries assume.

If, however, there was a stand-alone program for low-income beneficiaries only, we don't know for sure if the participation would be quite that high. As we know, with the Medicaid program now—whether it is for children or for people who are off welfare because of the Temporary Assistance for Needy Families program—some people who may be eligible for Medicaid but have not taken advantage of it or signed up for it. Presumably that could happen to this population as well.

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

Mr. PALLONE. Thank you.

Mr. BILIRAKIS. Mr. Deal, to inquire?

Mr. DEAL. Thank you, Mr. Chairman. I, too, thank you for being here today, and thank you for your very well prepared information.

I think that there is a lot that we all need to know about how the current programs work.

Mr. CRIPPEN. You can thank my colleagues for that, they do most of the work.

Mr. DEAL. As you know, the recent Conference agreement on the concurrent resolution on the budget, I believe, provides for about \$300 billion over the next 10-year period. And I understand from your previous answer that you have not actually done a projection of that, but do you have a general sense of how that dollar figure would work to provide a basic program for pharmaceutical benefits?

Mr. CRIPPEN. I could refer you, Mr. Deal, to some of our examples up here. As you see, up and down the board here there are some—and these are, obviously, just very rough approximations—but you can pick one of these cases that was about \$30 billion a year, and over 10 years it would be \$300 billion. Obviously, it depends on how soon you start and how it ramps up, and on lots of other details that would lie behind anything like this. But you could get a sense of what the kind of benefits you could provide for that number would look like.

Mr. DEAL. And, in fact, all of those scenarios fit within that general guideline, do they not?

Mr. CRIPPEN. Again, these are very rough numbers. We are trying to just show what the basic policy levers are. The cost depends a lot on how you structure the benefit, who administers it, and lots of other things, but this gives you a sense at least of the magnitude, and something like this—well, these are very rough. My colleagues are pointing out that the growth rates are quite dramatic, so that if you started at \$30 billion per year, you would end up by the end of the period at probably over \$60 billion. So these benefits are probably a little more generous than you could provide for \$300 billion.

Mr. DEAL. In that regard, though, have you built into any of your calculations the argument that some make that if we provide pharmaceutical benefits, that that will then cut down on the cost of both Medicare Part A and Medicare Part B because the pharmaceuticals obviously would eliminate perhaps some of the hospitalization, some of the doctor visits. Has that been built in?

Mr. CRIPPEN. No, but it is not because we haven't considered it. We have looked at all of the research; of course, you might not be surprised to know that we have been offered much of that research by proponents. And, indeed, we have looked at it quite carefully, and find it so far not convincing. I mean, it is because this is a Medicare population—an elderly, not a general population—and the studies, many of them, haven't been constructed very well. And so we have looked at them and not been convinced that there are general savings from making pharmaceuticals available to people.

In addition, there are going to be some additional costs because of adverse drug events happening for people who don't now get pharmaceuticals, and those are very expensive, emergency room kinds of treatment as well. So there are some costs. There may be some benefit. There is some evidence on that based on particular conditions, some heart conditions, that medication will save money. But, as a general matter, the access to pharmaceuticals and ex-

panding pharmaceutical coverage on the one hand can cost money, and on the other can save money, and at the moment we are agnostic. We don't include anything in the baseline for that.

Mr. DEAL. Once again, a very subjective subject that is very difficult for you, as a number cruncher, I am sure, to calculate is another subject of, do we generally anticipate that our population, even though they are living longer as a general rule, that those entering the Medicare population figures are generally healthier than those who have preceded them? Is that a general fact that is confirmed?

Mr. CRIPPEN. Yes; not only are they younger but also, as longevity increases, 65-year-olds are more robust than maybe our parents were at 65.

Mr. DEAL. I believe that is all, Mr. Chairman, thank you.

Mr. BILIRAKIS. Mr. Crippen, if the gentleman will yield very briefly.

Mr. DEAL. Yes, I will.

Mr. BILIRAKIS. Should you not have considered that the availability of prescription drugs to all of the seniors would probably result in less hospitalization and less current usage?

Mr. CRIPPEN. As I told Mr. Deal, Mr. Chairman, we considered that, but as of now have seen no evidence we find convincing that access to pharmaceuticals among the population of the elderly that don't now get them will save substantial amounts of money.

Mr. BILIRAKIS. There is a reluctance on the part of CBO to give any benefit to preventative care and that sort of thing, I have found over the years.

Mr. CRIPPEN. Sure; until we have fairly convincing evidence, we don't incorporate those kinds of savings into our baseline and, frankly, the studies are either quite weak or off the point that we have seen, and until we see some convincing evidence, we will not change that assumption.

Mr. BILIRAKIS. Ms. Eshoo, to inquire.

Ms. ESHOO. Thank you, Mr. Chairman. It is nice to see you, Dan, and thank you for your testimony. In the last Congress, President Clinton, as you know, introduced a plan to provide Medicare drug benefits. How much did CBO score that plan at? I remember it as \$350 billion over 10 years, is that correct?

Mr. CRIPPEN. It sounds about right.

Ms. ESHOO. Did CBO give any credit—is that your staff—

Mr. CRIPPEN. They are working as well; it is not just you and I.

Ms. ESHOO. Did CBO give any credit for cost-savings in that plan, for the use of PBMs to deliver the benefit?

Mr. CRIPPEN. I think not much, if any—in part, first, because it was only required to be one PBM per region and, second, there were restrictions on what the PBMs could do in terms of management savings—they could not introduce a restrictive formulary, for example. So, I think we did not give much savings to—you are challenging my memory.

Ms. ESHOO. Well, when you say not much, but it scored at \$350 billion, I don't know what "not that much" is. I think that you understand the point I am trying to make.

Mr. CRIPPEN. I do.

Ms. ESHOO. I think it is very important that we have competition in order to drive the price down. This is kind of an All-American agreement in terms of how our system works. And if anyone knows or realizes that we don't have a market, it's Californians and Westerners today, when we are talking about energy. So, we know that there needs to be competition in order to bring the price down, and that is why I am pursuing this thing about multiple PBMs. I think it is a very important approach about how we get it done.

Didn't the actuary say that had President Clinton allowed PBMs to engage in open competition rather than limiting them to one PBM per region, they would have seen greater cost-savings?

Mr. CRIPPEN. Yes, and so would we, because we assume that multiple PBMs in competition—

Mr. CRIPPEN. Why wouldn't CBO do an analysis of that, though? I think that both sides of the aisle talk about the cost-savings that can be realized by seniors being able to have full access to prescription drugs, and that we encourage the new technologies to break through because we know that that drives that point home even more so, but it is only on our lips. We don't have a thorough analysis of it. And I think if CBO is going to really jump in with two feet, to be effective with the Congress, is that you do an analysis in these areas because that thorough analysis on a nonpartisan basis is going to give us that much better ammunition to pursue these various courses.

So, I understand that there are groups and organizations that want you to accept their analysis. You need to do an independent analysis so that the Congress can make use of it. Can you tell us what you are prepared to do in this area?

Mr. CRIPPEN. Sure. We would like to think we have, although we can obviously always do more. Some of the proposals last year—the President's, as you said—have one PBM, and others have more than one; and so we did analyze the competitive effectiveness and discounts that might be available, if you will, or savings, but—

Ms. ESHOO. And what were they relative to the plan?

Mr. CRIPPEN. Well, they range from 0 to 25 percent off retail pricing, but that depends critically on the details. For example, when you introduce—

Ms. ESHOO. Did you develop the details?

Mr. CRIPPEN. We didn't. I mean, it depends on the details of your proposals, of the congressional proposals. There are a number of factors to be considered. Once you have competition, we presume there are some marketing costs because the competing plans are going to have to advertise for enrollees. If you make them take risk, the PBMs—which you probably want to do to give them incentives to save and manage—then there is going to be a risk premium. On the other hand, there are savings available through management of the drug benefit. But most of the proposals last year also included restrictions on the PBMs, as I suggested, like the President's. If they can't have formularies, if they can't do the kinds of things they do now—encourage generics, for example—then they are not going to be able to realize the savings either. So there are some additional costs, there are potential savings—

Ms. ESHOO. Well, we didn't have—we want them to take—to compete, I think it is very important. I think if we had one per re-

gion, then we are just back to square one. I mean, that is an old paradigm, and I don't think that that is going to work, myself. But, again, I think that—and the pharmaceutical companies have to have some risk in this, too. That is part of doing business. But they will have an awful lot of customers in this country.

So, I hope that CBO will weigh in on these things and do some really specific, hard-nosed analysis because if we keep on the way we are going, it is going to be on our lips, there is not going to be the kind of analysis, and we get into political lockjaw. We just don't have the tools in the toolkit that we can take out to the American people and say—I mean, I used CBO as an example in my congressional district all the time.

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

Ms. ESHOO. At any rate, I hope that you will do this because I think that it is really important for you to do in this debate. Thank you.

Mr. BILIRAKIS. Dr. Ganske, to inquire.

Mr. GANSKE. Thank you, Mr. Chairman. Mr. Crippen, I have a bill before Congress, H.R. 1387, which deals with high cost prescription drugs in a couple ways, one of which would be to raise the floor for the AAPCC payments for low-income rural areas primarily. Another would be to close loopholes in the drug reimportation bill that we passed last year, which would help everyone, I think. But the main component of the bill is basically to allow low-income seniors from the poverty line up 135 percent of poverty to have a full Medicaid drug benefit through their State Medicaid drug programs, and then phase out the premiums for those from 135% of poverty to 175%. In your testimony you said you had made some estimates for something like that, phasing it out to 150 percent, I think.

What I am interested in is this, can you give me an estimate for what my provision would cost if it is totally funded from the Federal side, taking into account that there are a number of seniors who are currently Medicaid-eligible but not in it, but probably would be if they had prescription drug benefit.

Do you have an estimate for what that would be over 10 years?

Mr. CRIPPEN. I don't know if we have an estimate with us. If we don't, we will certainly get you one because it is something we can do.

Mr. GANSKE. Will you look at the provision in my bill on that particular part, and see if you can give me an estimate.

Mr. CRIPPEN. Sure.

Mr. GANSKE. The way I look at it, it probably is going to be somewhere in the \$300 billion range, \$200 to \$300 billion in additional costs. Some of it is already covered. But I mentioned in my opening statement that there was this adverse risk problem that Congress has been loathe to deal with. And which we currently have in three Medigap policies which do provide a prescription drug benefit, but, because of the adverse risk problem, are expensive since only seniors who have high drug costs tend to sign up for them.

Do you have any suggestions for how Congress should deal with this problem?

Mr. CRIPPEN. Well, let me start out by saying that from what we are seeing on drug launch prices and on developments that your next panel will know much more about than I do, especially the BIO representative, there are going to be very specific drugs for very specific conditions, which, because of the smaller class of people that would need them, will probably be quite expensive. The only way to cover that in the way you are describing is to think of it as an insurance plan in which you have to attract many people who might potentially be eligible some day but who aren't currently—the classic catastrophic insurance benefit.

How one does that on a voluntary basis is tricky. Obviously, there are many ways you could have the appearance of a voluntary program, but not a real one. If you made folks who wanted Part B accept a drug benefit at the same time, make it part of Part B, clearly most people would take it because of the 75 percent subsidy in Part B. But having a true voluntary benefit is always subject to adverse selection.

With the Medigap policies, of course, it is not only true that there are three policies out of the ten prescribed by law that have pharmaceutical benefits. They are also the three at the bottom of the list, if you will, that have increasing coverage for other things. And so they are the most expensive, not only because they have pharmaceutical benefits but because they have kind of the most generous coverage for other things. Not that it is a good buy anyway, but you may want to think about how you structure the Medigap market to make pharmaceuticals closer to the top or a different kind of benefit. Those policies—while I know that many people are loathe to touch them—are prescribed in law, so they are an artifact of what the Federal Government is already doing.

Mr. GANSKE. When you make your estimate for prescription drug costs at over a trillion dollars for the next 10 years, how many multiples of that will it rise after the year 2012 when the Baby Boomers start to retire?

Mr. CRIPPEN. We haven't done that—we have only a 10-year baseline—so we can't tell you, but one has to assume, as you say, that it is multiples, not only because you are doubling the population but because a pharmaceutical benefit would add to the utilization of prescription drugs. So we think it is currently \$1.5 trillion for the next 10 years, without a pharmaceutical benefit. So, first, you have to double that for the doubling of the population over the next 20 years. Also, we believe drug costs are going to grow at about 10 percent per year per Medicare beneficiary, so that goes on top.

So, as you suggest, it would be a multiple, certainly, of the \$1.5 trillion for—

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

Mr. GANSKE. Will we be going back for a second round?

Mr. BILIRAKIS. Well, I would prefer not, but I suppose we could go back for another minute or 2. Without objection, the gentleman's time is extended for an additional minute.

Mr. GANSKE. Thank you, Mr. Chairman. See, Mr. Chairman, you interrupted my line of thought.

Mr. BILIRAKIS. Well, that is my job.

Mr. BARTON. The clock is ticking.

Mr. GANSKE. I know it. I will tell you what, I will finish it up later, Mr. Chairman. Thanks.

Mr. BILIRAKIS. The Chair apologizes.

Mr. GANSKE. I was on a roll.

Mr. BILIRAKIS. Mr. Green, to inquire.

Mr. GREEN. Thank you, Mr. Chairman. Your question a few minutes ago about not the ability of CBO to quantify the preventions that would be used from taking your medication as a cost-savings, I think that would be good for whether it is CBO or someone else to do a real study to see if you can quantify that because we have all sorts of things that talk about immunizations prevention, we can save dollars on that, and it seemed like you could do the same thing, and maybe, Mr. Chairman, our committee ought to work on getting, whether it is CBO or CRS or someone else, to see if we can't quantify that for seniors on the medication cost. I think that is a good idea, which leads me to my question about the cost, Mr. Crippen.

CBO is increasing the amount that we would expect on the baseline estimates for spending on prescription drugs over the next decade by one-third. As a result of your new assumption, CBO ought to be rising its estimates on whatever bills that are introduced this session.

If CBO is increasing its baseline spending for prescription drugs by one-third, what does that mean for the cost of senior citizens without a prescription drug benefit for their cost. We are assuming it will also go up one-third because the report we put in the record, they went up 19 percent for those highest-use drugs just in 1 year. So the out-of-pocket expenditures for seniors will go up one-third, maybe even more. Could you just respond?

Mr. CRIPPEN. That is entirely possible. Certainly, when we increase the baseline without a drug benefit, a Medicare drug benefit, that means that spending for pharmaceuticals for the elderly, absent a change in law, has gone up, we believe, over this 10-year period, by 30 percent. That is half due to the cost increase, and half due to just the 10-year period moving up 1 year. But we don't know how the proportions change.

There is some anecdotal evidence that employers are tightening their retiree benefit package, especially for pharmaceuticals. If that is the case, then one would assume that the elderly are either not going to get as many pharmaceuticals or will pay more out of pocket. So it depends a lot on the reaction of the third-party payers as well. It isn't clear that it would just simply raise out-of-pocket spending by a third; it could be more, it could be less.

Mr. GREEN. When we see what happened in that study that, again, is part of the record, the 19 percent, and when you factor that in with seniors, their retirement income, for example, Social Security payments over the last 2 or 3 years has fluctuated at an increase between 1.5 and 3.5, I guess for the last 6 years.

So, if Social Security payments are only going up less than 3.5 percent yet on an annual basis for those five mostly used drugs, at least a third, but maybe even substantially more for the highest use drugs, I think that probably makes the case on why Congress needs to do something because, whether it be the Federal Government doing it, the taxpayers, the Medicare, or through the seniors

who are going to have to be paying it out-of-pocket, the cost is going to be there, one way or the other.

Mr. CRIPPEN. Of course, while you are right that the growth rates are much different, certainly, than that of the Social Security benefit, other income could be growing faster. But, more important, it really depends on how much of their income is dedicated to pharmaceutical benefits versus anything else. As always, the rates of growth are important, but also the relative size. If it is \$10 out of \$1,000, then the fact that it grows faster than the \$1,000 is less important. But, clearly, pharmaceuticals are a growing proportion of what the elderly are buying.

Mr. GREEN. The Democratic proposal last year on prescription drug benefit offered a 50-percent premium subsidy for seniors who participate in the program. The subsidy was included in order to get enough seniors to enroll, so we would limit the adverse selection problem. And, again, a voluntary program, you want to make it—you want to sweeten it enough to get more people to come into it, other than the people who just have ten medications they have to take.

CBO stated that the premium subsidy necessary in order to maximize participation and decrease that adverse selection. What percentage government subsidy do you assume is necessary and what percentage of government subsidy would result in nearly universal participation, as is true with Medicare Part B, for example.

Mr. CRIPPEN. We have adopted the assumption that the HCFA actuaries have been using, and that is that a 50 percent subsidy will get you near-universal coverage—that is, anyone who is currently in Part B would also enroll in the drug benefit with a 50 percent subsidy.

Mr. GREEN. So, when we are crafting legislation, we probably ought to look at that to make sure we don't create adverse selection?

Mr. CRIPPEN. Certainly, yes.

Mr. GREEN. Thank you, Mr. Chairman. I yield back.

Mr. BILIRAKIS. Thank the gentleman. Mr. Whitfield, to inquire.

Mr. WHITFIELD. Thank you, Mr. Chairman. I think Mr. Ganske has regained his thought process, so I am going to yield him 30 seconds.

Mr. GANSKE. Mr. Crippen, when you made these calculations for this comprehensive bill, did you take into account whether private employers will then drop away from providing coverage?

Mr. CRIPPEN. We assume, Mr. Ganske, that they will take advantage of whatever the Federal benefit is, to the extent they can—that is, like they do now, wrap around the existing Medicare program if it is to their benefit—but we don't assume they will drop coverage. In fact, we assume they will continue coverage but take advantage of whatever the Federal program will pay.

Mr. GANSKE. And, finally, now much of an increase in the baseline did you increase the cost from 6 months ago when you gave us the estimates on the bills that were before Congress?

Mr. CRIPPEN. It is a little over 30 percent.

Mr. GANSKE. So, if we increase the baseline by 30 percent, do we not disproportionately increase the cost of that catastrophic part because it increases the coverage?

Mr. CRIPPEN. We certainly could. It depends on where the increases are—as I said, in which parts of the population, of course—and on what is driving the price increases or the cost increases. Let me back up 1 second. There are two pieces to the baseline increases. One is just moving 1 year down the road from 2001—dropping that year and adding 2011. That added about 15 percent because it is a higher-cost year out in the future. So about half of the increase is due to that. The other is just due to cost increases that we have seen in the recent past. Whether it is prices or utilization, it is a cost increase. So it depends on where those cost increases are taking place, and I am not sure we have good assumptions about which part of the distribution is seeing increases. For example, if the cost increases all took place among people who were normally buying \$500 worth of drugs a year, that wouldn't change the catastrophic threshold—that wouldn't change the catastrophic cost. But what you are saying is not a bad assumption as a rule of thumb.

Mr. GANSKE. I thank the gentleman for yielding me the time, and I just point out that in just 6 months we have had a 30-percent increase in the baseline estimate.

Mr. WHITFIELD. Mr. Chairman, would you tell me how much time Mr. Ganske took?

Mr. BILIRAKIS. Half of your time.

Mr. WHITFIELD. Give him an inch, he will take a mile.

Mr. Crippen, in your base case, you are assuming there would be one PBM per area.

Mr. CRIPPEN. Right.

Mr. WHITFIELD. Did your assumption also include that there would be a reduction, overall reduction, in the cost of the prescription drug because of the PBM's management?

Mr. CRIPPEN. Yes, some.

Mr. WHITFIELD. And what was the percentage?

Mr. CRIPPEN. I don't remember what the—12.5 percent. Think of that as a discount from the retail price.

Mr. WHITFIELD. Okay. Now, under the base case, the total cost to the Federal Government under that case would be the \$31.6 billion plus the \$44 billion cost-sharing on the other side?

Mr. CRIPPEN. No, the cost sharing is what the beneficiaries would pay, those beneficiaries that actually bought drugs. Their half, their copayments, their cost share, would be \$44 billion, so that the—that is part of what the beneficiaries are paying in this base case, plus premiums.

Mr. WHITFIELD. So, in this base case, they would pay half, up to \$8,000, so they would pay \$4,000 for an \$8,000 expenditure, and anything past that the Federal Government would pay all of that?

Mr. CRIPPEN. Well, anything past that all Medicare beneficiaries—not just those who had drug costs—would pay, half of it through premiums. So the difference is that those who used the benefit or bought prescription drugs would pay \$44.4 billion here, in this base case. Every Medicare beneficiary, through premiums, would add up to \$26 billion.

Mr. WHITFIELD. Now, you would expect a Medicare drug benefit would hopefully reduce the cost of hospitalization. Did you all consider that in any way?

Mr. CRIPPEN. No, we haven't. We have considered it, but we haven't included it because, as I told a couple of the other gentlemen, we haven't seen convincing evidence that it systematically saves money. There are certainly some particular diseases in which it could; on the other hand, it will cause some additional adverse drug reactions because more people will be taking drugs. So at this point, we don't think it saves a considerable amount of money in other parts of the benefit.

Now, we remain to be convinced, and can be convinced, but we haven't seen any evidence so far.

Mr. WHITFIELD. Twenty-six States provide a prescription drug benefit through the Medicaid program. Do you have any concern that if we adopt a program at the Federal level, that the States would start dropping their Medicaid prescription drug benefit and those people would move over?

Mr. CRIPPEN. It is certainly possible that States—actually, most States now have a Medicaid drug benefit of some kind, and 26 States are actually adding benefits above that to other beneficiaries. And as we were discussing, they could either fail to put more money in, those 26 States, if we had a Federal benefit, or the States certainly could benefit from a Medicare program in which those dual-eligibles that are now in Medicare and Medicaid—those folks, of course, could save the States money if Medicare were paying the pharmaceutical benefit.

So it is entirely possible that Medicaid expenditures—of both the Federal and State governments—could decrease, depending upon how the benefit is structured.

Mr. WHITFIELD. Do you have any sense on whether—I see my time has expired, Mr. Chairman.

Mr. BILIRAKIS. Very quickly, if you have something.

Mr. WHITFIELD. I would have to see.

Mr. BILIRAKIS. I appreciate that. Mr. Wynn, the gentleman from Maryland, to inquire.

Mr. WYNN. Thank you, Mr. Chairman. Mr. Crippen, I also want to thank you for your presentation, it has been an excellent presentation. I have learned a great deal.

Question. If I understand correctly, the \$300 billion that has been itemized in the budget proposal by the Majority identifies this is for Medicare reform, is that correct, that is specifically for prescription drugs.

Mr. CRIPPEN. My impression was, and this is more—maybe my colleagues know, and I will refer this to them in just a second. My impression was that it was to be used for Medicare and be released by the Budget Committee Chairman, and I think it is both for reform and pharmaceuticals. My colleagues tell me that is about right.

Mr. WYNN. Now, I think what you have said, and correct me if I am wrong, that this figure could fund baseline or within the parameters of your examples, a prescription drug plan, but that would absorb all of the \$300 billion, leaving none for the reforms. So my question is, what are the other reforms that are contemplated, and how much do they cost?

Mr. CRIPPEN. So far, we haven't seen any legislative proposals for reforms, and you are probably not surprised because most of the

reforms that have been discussed have to do with how one would save money, reducing costs in the future. So, the peril, of course, of proposing that very specifically, for us to estimate the savings, is obvious. We haven't seen any reform legislation that would cost more either, so the answer is, I don't know.

Mr. WYNN. So you would say that we could use all \$300—

Mr. CRIPPEN. You could use more or less than that for a drug benefit, as you can see from some of our examples. We aren't trying to propose this as a drug benefit; we are just using this as an example to say, this is how it would change.

Mr. WYNN. I think you also said that at some point along the 10-year spectrum, the \$30 billion would be inadequate and you would begin to move toward something more akin to \$60 billion, is that correct?

Mr. CRIPPEN. Correct.

Mr. WYNN. At what point does that begin to occur?

Mr. CRIPPEN. My colleagues tell me that a \$30 billion first-year benefit would likely double in about 6 years.

Mr. WYNN. So—

Mr. CRIPPEN. So if you started something in 2004, which is probably the first year you could do it, by the end of 2010, or 2011, you would have doubled it to \$60 billion.

Mr. WYNN. Which would mean we really would need about \$600 billion to make it through the entire—

Mr. CRIPPEN. Well, the average would be probably \$45 billion yearly, if it had a—

Mr. WYNN. So we really need about \$450 billion rather than \$300.

Mr. CRIPPEN. Over the 10 years.

Mr. WYNN. Over 10, all right.

Now, you say there is a 50-percent subsidy, is that in premium and co-pay?

Mr. CRIPPEN. Yes.

Mr. WYNN. Your base example had a 250 deductible, is that reduced participation?

Mr. CRIPPEN. We assumed it did not, that anyone who was eligible—or anyone who was currently in Part B of Medicare, because there would be a 50-percent subsidy overall—would enroll in this benefit.

Mr. WYNN. And not be deterred in any way by the deductible.

Mr. CRIPPEN. Exactly.

Mr. WYNN. And so the absence of a deductible is not a problem at all.

Mr. CRIPPEN. We don't assume any change in participation—which is not to say there couldn't be, but, certainly, for purposes of this exercise, we don't assume any change in participation because of the deductible.

Mr. WYNN. If you would indulge me, I know you covered this with my colleague, Ms. Eshoo, but I wasn't exactly clear on it. You are recommending only one PBM, is that fair?

Mr. CRIPPEN. No, we are not recommending it; we use that in this example because many of the proposals last year—like the President's proposal—had one. We would—and I didn't get a chance to go completely through it with her—we would say that

more than one PBM likely would save money over these estimates, if you had two or more in competition. But there are other factors that apply. Competition costs money as well: you have to pay risk premiums and marketing costs. And depending upon what restrictions you put on the PBMs or the managers, you could have two or three, but if you didn't let them do anything to save money, it wouldn't do you any good—for example, disallowing them from having tight formularies or generic promotion or other things. So, it depends—

Mr. WYNN. Let us assume you did those types of things, would you claim a net gain or a net loss?

Mr. CRIPPEN. Net gain. I mean, if you put restrictions on—I'm sorry?

Mr. WYNN. If you put restrictions on—

Mr. CRIPPEN. Probably a wash then, or a slight gain.

Mr. WYNN. Slight gain being an increase in cost?

Mr. CRIPPEN. I'm sorry—slight decrease in cost.

Mr. WYNN. So you have a slight decrease in cost with multiple PBMs even though you impose conditions?

Mr. CRIPPEN. Yes. But, again, it would depend on what the conditions weren't—some of the things they can do save more money than not—and how much risk they were being asked to take.

Mr. WYNN. One final question. There is a lot of talk, I guess these high weeds again, about the outyear impacts of the tax cut, particularly with respect to the rate adjustment and also with respect to the estate tax.

What is the impact of those outyear costs increasing at the same time that the outyear costs for the prescription drug plan also begin to, in your words, double? I mean, do we in fact run into a deficit situation, given the figures that have been laid out for tax cuts and the figures that have been laid out for a prescription drug plan?

Mr. BILIRAKIS. The gentleman's time has long expired. Please answer, but keep it brief.

Mr. CRIPPEN. In these next 10 years—which is all we have from the Joint Committee on Taxation, I believe, but certainly for spending—the things add up, as we suggested earlier. After that, we don't know, and, fortunately, we don't do, in this case, tax estimates. So the Joint Committee would have to provide year 10 through year 30, or year 20, and I am not sure they can do that, either. So over the next 10 years, the answer to your question is, the budget resolution numbers do add up, but how it gets implemented is critical, and we don't know what happens after the 10 years.

Mr. WYNN. Mr. Chairman, could I ask for 5 seconds, and I promise I will stay—

Mr. BILIRAKIS. You have already used the 5 seconds in your request.

Mr. WYNN. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Go ahead, please.

Mr. WYNN. Thank you, Mr. Chairman. Does that include your projection that the cost will double beginning in year 6?

Mr. CRIPPEN. No, because we don't have any—I mean, we don't have a drug benefit in our projection. What we have is a baseline,

and then if you take those numbers minus \$300 billion, the numbers can still add up in some sense, but we don't have a particular drug proposal that we have priced. So if you had a drug proposal that started at \$10 billion and grew to \$20 billion, obviously, it would fit very well. If you had one that started at \$30 billion annually, however, and it grew to \$60 billion, the \$300 billion wouldn't accommodate it. So it depends on where you start.

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

Mr. BILIRAKIS. Mr. Crippen, of course, will respond to written questions.

Mr. CRIPPEN. Absolutely.

Mr. BILIRAKIS. Dr. Norwood, to inquire.

Mr. NORWOOD. Mr. Crippen, I have a number of questions that I would like for you to respond in writing. I can't get to them all right this minute.

Mr. CRIPPEN. Sure.

Mr. NORWOOD. Just a quick little history lesson. When did CBO come into being?

Mr. CRIPPEN. 1975.

Mr. NORWOOD. 1975. Who was around in 1965 that was able to give an estimate to President Johnson for the cost of Medicare?

Mr. CRIPPEN. I assume it was then the Department of Health, Education, and Welfare.

Mr. NORWOOD. Is there any way to find out what that estimate was? Is that—

Mr. CRIPPEN. I think we actually have it. I am sure we don't have it with us, but—

[The following was received for the record:]

CRS Report for Congress

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Health Care Fact Sheet: Original Medicare Cost Estimates

Jennifer O'Sullivan
Specialist in Social Legislation
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Medicare is a nationwide health insurance program for the aged and certain disabled persons. It was enacted as part of the Social Security Amendments of 1965 (P.L. 89-97) and went into effect July 1, 1966. Medicare consists of two separately financed parts, the hospital insurance portion, Part A, and the supplementary medical insurance (SMD) portion, Part B. At the time the program was enacted, actuarial cost estimates were made for both parts, though long-term projections were made only for Part A. These initial Part A estimates fell considerably short of actual experience.

Medicare Part A Projections. Almost all persons over age 65 are automatically entitled to Medicare Part A. (Coverage for the disabled population was not added until 1973.) Original cost projections were based on the estimated costs of providing hospital and related services for the aged.

Part A is financed through payroll taxes levied on current workers and their employers. At the time of enactment, expenditures were projected well into the future so that a payroll tax rate could be established based on potential program costs. Table 1 shows the initial Part A projections for 1966-1990. Table 1 also shows actual expenditures for those years.

The divergence between actual and projected expenditures reflect a number of factors including coverage of the disabled population; expansions in benefits; inflation, particularly medical care inflation; and increased utilization induced by the program's enactment.

Medicare Part B Projections. Part B is financed through a combination of beneficiary premiums and Federal general revenues (i.e., tax dollars). Premium rates and Government contribution rates are set annually to meet current costs. Original Part B expenditure estimates were not made beyond the first 2 years of operation—calendar years 1966 and 1967.

Enrollment in Medicare Part B is voluntary. Therefore projections for Part B had to include estimates of the percentage of the aged population that would elect Part B coverage. Projections for Part B included both high and low-cost estimates at 80 and 95 percent enrollment. Expenditure estimates at 95 percent enrollment, which proved to be correct, are shown in table 2, together with actual expenditures for those years.



TABLE 1. Hospital Insurance Expenditures Part A*
(in millions)

1965 estimates				Actual HI expenditures		
CY	Benefit payments	Admin. costs	Total	Benefit payments	Admin. costs	Total
1966	\$ 987	\$ 50	\$1,037	\$ 891	\$108	\$ 999
1967	2,210	66	2,276	3,353	77	3,430
1968	2,406	72	2,478	4,179	99	4,277
1969	2,623	79	2,702	4,739	118	4,857
1970	2,860	86	2,946	5,124	157	5,281
1971	3,077	92	3,169	5,751	150	5,900
1972	3,303	99	3,402	6,318	185	6,503
1973	3,540	106	3,646	7,057	232	7,289
1974	3,788	114	3,902	9,099	272	9,372
1975	4,047	121	4,168	11,315	266	11,581
1980	5,307	159	5,466	25,064	512	25,577
1985	6,860	206	7,066	47,580	834	48,414
1990	8,797	264	9,061	66,239	758	66,997

*Columns may not total due to rounding.

Source: (1965 estimates) House Ways and Means Comm. Prt. 51-291, *Actuarial Cost Estimates and Summary of Provisions of the Old-Age, Survivors, and Disability Insurance System as Modified by the Social Security Amendments of 1965 and Actuarial Cost Estimates and Summary of Provisions of the Hospital Insurance and Supplementary Medical Insurance Systems as Established by Such Act*, 89th Cong., 1st Sess., p. 33. (Actual expenditures) House Doc. 102-89, *1991 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*, p. 27.

TABLE 2. Supplementary Medical Insurance Expenditures Part B
(in millions)

1965 estimates (95 percent enrollment)				Actual SMI expenditures			
CY	Benefit payments	Admin. costs	Total	CY	Benefit payments	Admin. costs	Total
1966*							
Low-cost	\$260	\$ 80	\$340				
High-cost	410	100	510	1966	\$ 128	\$ 75	\$ 203
1967							
Low-cost	\$1,060	\$ 90	\$1,150				
High-cost	1,260	110	1,370	1967	\$1,197	\$110	\$1,307

*Administrative expenses shown include 1965 and 1966.

Source: (1965 estimates) Same as table 1, at p. 39. (Actual expenditures) *1993 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund*, p. 10.

Mr. NORWOOD. I would love to know.

Mr. CRIPPEN. Again, I have seen it alluded to, but obviously the estimates were ten times too low, or something like that.

Mr. NORWOOD. I have heard some very interesting numbers, and I would like to know exactly what they are. Now, what you have given us today is not a formal CBO estimate, but I think we are calling it a ballpark estimate, and one of the important issues not addressed by the model is how CBO will adjust its estimate to account for an increase in demand, which is going to result from increase in drug coverage. Can you give us some idea of how you are going to account for that? I mean, we know that is going to happen, I think. Perhaps we don't have any evidence, but we certainly can assume that it is going to happen.

Mr. CRIPPEN. There are two aspects that we have included some of, I believe, in the models, and that is, first, there is going to be a price increase because of the demand increase—about 10 percent, as I recall, over the 10 years. And there will be some increase in utilization as well. I don't remember what our assumption is for sure there, but it is one of those areas, as I think you are suggesting, if I understand you, that we don't know very well how much more utilization there will be. We have a fair number of people insured now—70 percent—so that leaves 30 percent of beneficiaries. But it is important for all of us to remember, too, that just because you are insured doesn't mean you have adequate pharmaceutical coverage. Likewise, just because you are uninsured doesn't mean you don't have adequate coverage. The same study that was entered in the record earlier today, I think, is the one that suggests that those folks who are the insured elderly are filling prescriptions at a rate of about 24 or 25 a year, and those who are uninsured are filling about 15 prescriptions a year. So, the elderly are getting—

Mr. NORWOOD. Are you going to be able to give us those, perhaps not formal, but ballpark estimates of that?

Mr. CRIPPEN. On utilization?

Mr. NORWOOD. Yes.

Mr. CRIPPEN. Sure.

Mr. NORWOOD. I was very intrigued by some earlier questions about the comment about employers dropping coverage should we have universal prescription drug benefit, and you said that you have made some assumptions that that probably is going to happen.

Mr. CRIPPEN. What we assume is that whatever the Federal benefit would provide, employers would no longer provide. They would wrap around that benefit, as they do now.

Mr. NORWOOD. That is a logical assumption. I would assume the same thing.

Mr. CRIPPEN. But if they now have benefits that are, say, more generous than whatever the Medicare benefit was, they might continue to add to the Medicare benefit. We don't assume that they will drop coverage altogether.

Mr. NORWOOD. That leads me then to another part of this question. I am a little amazed that you don't seem to find a way to score prevention. And your answer about that was that there is no

evidence. But that is a very good place to make some assumptions that can be fairly intelligent.

If a patient has, for example, a chronic bleeding ulcer, and they need medication for that, Prilosec which is very expensive—let us make a number, \$100 a day—and we also know for sure that hospital cost is going to be \$3,000 a day, and if the patient goes to see the doctor and the doctor prescribes Prilosec and the patient can't afford to fill the prescription, and 3 weeks later ends up in the hospital for 3 weeks, it is not hard to figure out we have spent a lot of money, and we could have preventively saved a lot of that money for the Trust Fund.

I would like for you to go back again and make some assumptions in that area, since you obviously don't have evidence in that area, because it makes it very hard for me to take numbers credible when you assume in one area but won't assume in another area because of evidence. And I would like for you to speak to that because it has got to be a savings if we get people on their medications.

Mr. CRIPPEN. There is certainly—in the kind of case you just outlined, there would obviously be savings. As I said, there is some anecdotal evidence that other conditions—for some heart conditions, medications clearly save money. But, overall, the studies we have looked at—which try to look at all of the drugs for the Medicare population or try and make some inferences about beneficiaries—don't apply, and it isn't systematically evident that all available drugs would—or that making drugs more available would have savings everywhere.

If, for example, the person who got the Prilosec had an adverse drug reaction because they were on another drug, that would cost money as well. I mean, we concede that there may well be savings, but we don't have evidence for how much it would be and where it would occur. We do know there would be some costs as well. So, until we see that kind of systematic evidence, again, we note the anecdotal cases, and, clearly, in some cases drug coverage would save money.

Mr. BILIRAKIS. We really should finish up with Mr. Crippen before we go over to vote because it is not fair otherwise. I brought up that point before and I really feel that CBO has been wrong over the years in not providing more attention to preventative health care.

Mr. NORWOOD. Well, assumptions could be in order, Mr. Chairman, not just necessarily just evidence. I mean, common sense leads us to believe—

Mr. BILIRAKIS. And the entire thing is based on assumption, let us face it. Well, Mr. Engel, if you can do it quickly, I would appreciate it because we have Mr. Greenwood yet, and we have to take those votes.

Mr. ENGEL. Yes, I will be quick, Mr. Chairman. First of all, thank you, and I have a statement which I would like to submit for the record.

Mr. BILIRAKIS. Without objection.

Mr. ENGEL. My beef is that I think there was a lot of talk before the election about prescription drugs for seniors, and I hear less talk about it now that the election is over. And I am very con-

cerned that the \$350 billion is not going to be enough, and that while we are saying that we are going to put money—give money—have money for this program for poor seniors, in reality, a lot of the seniors who really are poor are going to be excluded because they are going to be deemed not poor enough, and that is my big fear.

The one question I would like to ask is that many seniors have large amounts of bills, but they have drug expenditures that probably would not meet a catastrophic limit. So, what I would like to ask you is, the President has proposed creating a drug benefit for low-income seniors and a catastrophic benefit that would help all seniors with very, very high drug costs. And while it is true that a small number of seniors have very, very high drug costs, the vast majority of seniors whose drug costs are high enough, would not be helped by a catastrophic plan. It is probably not uncommon for a senior without drug coverage to spend \$1,500 or \$2,000 a year on prescription drug costs, and it may not sound like a huge amount, but it is a sizable chunk for a senior with an income of 175 percent of the Federal poverty level, which is \$15,000 a year for a single person, and that person would not qualify for the President's low-income assistance plan.

So, my question is, does CBO have an estimate as to what percentage of seniors have drug costs in the \$1,000 to \$3,000 range, and what percentage of total drug spending for Medicare beneficiaries falls within this range?

Mr. CRIPPEN. We do. I don't know that I brought along the number of people, but you wanted \$1,500. Was that—

Mr. ENGEL. Well, \$1,000.

Mr. CRIPPEN. I could give you almost anything and will be happy to, but—

Mr. ENGEL. The \$1,000 to \$3,000 range. What I am trying to figure out is what percentage of seniors would really benefit from this catastrophic plan because it seems to me that a lot of seniors who should benefit, who need the help, wouldn't be covered under this plan.

Mr. CRIPPEN. At a \$1,000 catastrophic limit, you would cover \$1.1 trillion of the \$1.5 trillion in costs over the next 10 years. So you would get a lot—obviously, a lot of spending, but you would cover a lot of people. I don't have the number of folks that this would cover, but it would be a very large percentage.

Mr. ENGEL. Could you get that to my office, I would appreciate it.

Mr. CRIPPEN. Sure. I am happy to give you other—I brought this little table that has all these ranges; some of it is on page 33 of my prepared statement.

Mr. ENGEL. I am just, again, very concerned that, you know, I always get complaints, and rightfully so, from seniors who say, "You know, we really need help, and yet we are just a little bit above so we don't qualify," and I am afraid that the monies that we are putting forth and the President's plan is going to perpetuate that, and there are a heck of a lot of seniors out there that really need our help, and my fear is we are not going to give it to them.

Mr. CRIPPEN. We have included in the submitted testimony—on page 33—Table 3, which has some—it may not have every break-

down you want, but it has spending for all enrollees above a given level and the share of enrollees that would be covered. So the second part of your question, which is not on this table, is included in the written testimony.

Mr. ENGEL. Okay. We will follow up, I would like that. Thank you, and thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman. Mr. Crippen, thank you so very much for being here, you have been an awful lot of help. You are going to continue to be a lot of help, I trust, in this process because in spite of what some of the people have said here this morning, the No. 1 issue insofar as the entire Congress is concerned, particularly the House, is prescription drugs for seniors on a universal type of a basis. Thank you very much. And, of course, you are available for any written questions.

Mr. CRIPPEN. Absolutely, or any other.

Mr. BILIRAKIS. We are going to recess. Hopefully the next panel can then come forward, but we will recess for this vote, and come back and go right into it. I don't think it is right to take a break for lunch because you have been waiting here for so very long. About 15 or 20 minutes, for however long it takes 3 or 4 of us to get back.

[Brief recess.]

Mr. BILIRAKIS. The Chair apologizes to the witnesses. I think at least a couple of you are experienced at this game, and so you know what it is like. Hopefully, we will be able to get finished up, before we get called again.

Panel 2 consists of Dr. Beatrice Braun, a Member of the Board of Directors of AARP. She has appeared here before and does a terrific job. Glad to see you back.

Dr. Jeanne Lambrew, Associate Professor of the Department of Health Services Management and Policy, right here at G.W. University, and Mr. Robert Chess, who is the Chairman of Inhale Therapeutics Systems in San Carlos, California, here on behalf of Biotech Industry Organization.

Welcome. We will set the clock at 5 minutes. Obviously, your written statement is already a part of the record. Hopefully you would complement it or supplement it, and we will start off with Dr. Braun. Please proceed, ma'am.

STATEMENTS OF BEATRICE BRAUN, MEMBER, BOARD OF DIRECTORS, AARP; JEANNE M. LAMBREW, ASSOCIATE PROFESSOR, DEPARTMENT OF HEALTH SERVICES MANAGEMENT AND POLICY, GEORGE WASHINGTON UNIVERSITY; AND ROBERT CHESSE, CHAIRMAN, INHALE THERAPEUTICS SYSTEMS, ON BEHALF OF THE BIOTECHNOLOGY INDUSTRY ORGANIZATION

Ms. BRAUN. Thank you, Mr. Chairman and members of the committee. I am Beatrice Braun, from Springhill, Florida, just about 5 miles from the chairman's district, and a member of the AARP's Board of Directors. Thank you for the opportunity to come before you today.

As a Medicare beneficiary, I would like to reiterate the statement that many members made this morning, that Medicare is the indispensable source of health benefits for older Americans and those

with disabilities, but over the last two decades, a lack of a prescription drug coverage in Medicare has become a critical gap as modern medicine has turned increasingly to drug treatment.

A prescription drug benefit in Medicare would improve quality of care, reduce unnecessary hospitalizations, and also offers a potential to reduce the risk of drug interactions and polypharmacy.

Private health benefit plans generally have kept pace with advances in their benefits for workers, but not so for retirees. In the 1980's, an estimated 60 to 70 percent of large employers offered retiree health benefits. By 1993, that had dropped to 40 percent, and in 2000 it had gone from 70 percent down to 24 percent.

Other sources of drug coverage for Medicare beneficiaries are also inadequate or undependable. Medigap plans provide prescription drug coverage in only three of the standard ten plans, and these plans are expensive and have limits on the benefit.

Medicare+Choice plans are dropping out of Medicare, as I know too well in my county, increasing premiums or reducing benefits. One-third of Medicare beneficiaries do not have any prescription drug coverage, but this figure obscures the shortcomings of current coverage options, and the fact that only 53 percent of beneficiaries have prescription drug coverage all through the year.

AARP is committed to creating a prescription drug benefit in Medicare, and has identified fundamental design features for developing a prescription drug benefit. In the simplest terms, the benefit under Medicare needs to be available and affordable to all beneficiaries. A prescription drug benefit in Medicare should also be voluntary so that beneficiaries who already have coverage can keep it if they want to.

But designing a viable voluntary benefit is challenging. Beneficiaries must want to buy into a voluntary benefit. It must be attractive and affordable enough to draw a broad, stable risk pool. What does this entail?

First, availability must be nationwide. Beneficiaries living in rural, suburban, and urban areas must be assured that the drug benefit is not only going to be part of Medicare+Choice plans, but that it will always be available in their community. In short, it must be available in the traditional Medicare fee-for-service plan.

It must be affordable. This means the premiums and cost-sharing must be reasonable in the eyes of middle-income and healthy enrollees. Thus, the government contribution must be adequate to ensure enrollment of a balanced risk pool. Without a broadbased risk pool, a voluntary benefit will be left with a disproportionate number of beneficiaries with high drug costs, prompting a rapid rise in premiums.

A Medicare prescription drug plan should include a defined benefit. A defined benefit package is easy for consumers to understand, it is dependable, and it will improve the risk pool.

Mechanisms to constrain cost must ensure that beneficiaries and other taxpayers receive value for their premium and tax dollars. And cost restraint cannot simply involve the shifting of cost to beneficiaries.

Affordability also requires additional subsidies for beneficiaries with low incomes. Improvements are needed in the current low-income protection known to this committee as the QMB and SLMB

programs. These programs are funded through Medicaid, but they are paid for by Medicare premiums, deductibles and co-insurance of beneficiaries below certain income thresholds.

It is essential that similar protections complement a prescription drug benefit and continue to be funded through Medicaid to help low-income beneficiaries pay for their prescription drugs and other Medicare services.

Part of the debate over adding a prescription drug benefit in Medicare is whether and to what extent additional changes to Medicare are necessary. Some changes in Medicare are necessary. Incremental, step-by-step improvements can begin to make a difference in the program without being disruptive to current and future beneficiaries.

Without attempting to be all-inclusive about possible reforms, I would highlight the need to expand and adequately fund beneficiary education and outreach, which is vital to Medicare+Choice, and to build a modern, efficient information technology system for the program.

In broader terms, Medicare's administrative structure must guarantee seamless operation of traditional fee-for-service, private plan options, and any prescription drug benefit, and the agency that oversees Medicare must have the resources and the flexibility it needs to continue to improve the program.

AARP is ready to continue to work with the committee, the Congress and the Administration to help shape a benefit in Medicare that will be affordable and meaningful and will make room for the changing role of pharmaceuticals in medicine. Thank you.

[The prepared statement of Beatrice Braun follows:]

PREPARED STATEMENT OF BEATRICE BRAUN, AARP BOARD MEMBER

I am Beatrice Braun from Spring Hill, Florida and a member of AARP's Board of Directors. Thank you for the opportunity to discuss with you today the need for a prescription drug benefit in Medicare.

The Medicare program has been, is, and will likely remain the nation's principal source of health benefits and a key source of financial protection for older Americans and those with disabilities. The program also provides financial protection for the families of Medicare beneficiaries, and it further serves younger Americans with its guarantee of future protection as they plan their retirements. In addition, Medicare is a strong and stable underpinning of the financing of our nation's health care system.

As we examine approaches to updating Medicare, it is essential that we modernize the Medicare benefit package. In particular, it is time to add an outpatient prescription drug benefit in recognition of the changing health care technology that has made prescription drugs an increasingly important—now central—component of modern medical care. A prescription drug benefit in Medicare would improve the quality of health care received by millions of older Americans. It could reduce unnecessary hospitalizations and shorten nursing home stays. A well-managed benefit also offers the potential to reduce the risks of drug interactions and polypharmacy by helping to assure that beneficiaries are taking the right medications in the correct dosages. It makes no more sense to have a Medicare program today without prescription drug coverage than it would to have a program that excludes inpatient hospital or physician coverage.

Background

Medicare today—while the centerpiece of health benefits protection for retirees and those with disabilities—covers only about half of the health spending of older Americans. Further, Medicare beneficiaries spend a significant share of their income on health care. In 2000, out-of-pocket costs for older beneficiaries averaged \$2,580 or 19 percent of their income. While Social Security and Medicare have done a wonderful job in assuring a floor of income support and financial protection for older

Americans, the fact remains that increasing health costs for older individuals coupled with lower incomes in their retirement years often makes the costs of uncovered benefits unaffordable.

As illustrated in Charts 1 and 2, more than half of individuals age 65 and older live in *households* where the total income is less than \$25,000 per year. Looked at another way, more than half of individuals over 65 have per capita income of less than \$15,000 per year. Fewer than 10 percent of individuals and fewer than 20 percent of households had income over \$50,000 in 1999.

The Need for a Prescription Drug Benefit in Medicare

Over the last two decades, the lack of prescription drug coverage has become a critical gap in the Medicare program as modern medicine has turned increasingly to drug treatments. Our nation's long-term investment in biomedical research has yielded enormous scientific progress—and the recent budgetary commitment to doubling the NIH budget highlights our intent to continue that progress. Those investments, coupled with the pharmaceutical industry's spending on research and development, have yielded an array of medications that could not have been even imagined when Medicare was enacted in 1965.

Private health benefit plans throughout the nation generally have kept pace with these advances in their benefits for workers. Employers have recognized the longer-term economic and health care value of providing coverage for prescription drugs. Medicare should do the same. According to a 2000 Mercer/Foster Higgins survey, 99 percent of employer-sponsored health plans offered outpatient prescription drug coverage to current workers. However, employers are finding it increasingly difficult to offer health benefits to *retirees* to supplement their Medicare protection. As a result, health care coverage for retirees is plummeting. An estimated 60 to 70 percent of large employers offered retiree health benefits in the 1980s. But by 1993 only 40 percent of employers with 500 or more employees offered health benefits to future Medicare-eligible retirees, and by 2000 this number had dropped even further to 24 percent [2000 Mercer/Foster Higgins Survey (forthcoming)]. Of employers who do offer retiree benefits, 21 percent do not include prescription drug coverage for Medicare-eligible retirees. Moreover, a recent Hewitt survey of large employers indicates that 36 percent of those employers are considering cutting back on prescription drug coverage for Medicare-eligible retirees over the next three to five years.

Other major sources of prescription drug coverage for Medicare beneficiaries are also proving inadequate or un dependable. Medigap plans provide prescription drug coverage in only three of the standard ten plans, and these plans place limits on the benefit, including a 50 percent coinsurance and caps on the benefit at either \$1,250 or \$3,000 annually. Roughly 600,000 Medicare beneficiaries are enrolled in one of the standardized Medigap plans (H, I, or J) that cover prescription drugs. Another group of beneficiaries are enrolled in pre-standardized Medigap plans that provide some prescription drug coverage, but those plans generally have even more limited prescription drug coverage.

Medicare+Choice plans are another source of prescription drug coverage. In the mid-1990s growing numbers of beneficiaries began moving to Medicare HMOs, often to take advantage of the prescription drug coverage they were offering. But today, many of these plans are dropping out of Medicare, making such coverage very unstable for beneficiaries. In 2001, 30 percent of Medicare+Choice plans *do not* offer a drug benefit at all, meaning that only 3.8 million Medicare+Choice enrollees *have* prescription drug coverage. In addition, many Medicare+Choice plans that have remained in the program have increased their premium charges or reduced benefits; most noticeably for prescription drugs. In 1999, 78 percent of Medicare+Choice enrollees were in basic plans that charged zero premiums and offered some drug coverage; this has dropped to 35 percent in 2001. HCFA has not yet released additional information that describes Medicare+Choice prescription drug benefits in 2001, but we have no reason to believe that there has been any expansion of the benefit.

Without Medicare coverage of prescription drugs, older Americans must depend on supplemental sources of financing for their medications or pay for them directly out-of-pocket. On average, an estimated one-third of Medicare beneficiaries lack prescription drug coverage. However, this figure obscures the variations in drug coverage among certain subgroups of beneficiaries. For example, as shown in Chart 3, a much smaller share of Medicare beneficiaries in rural areas have some form of supplemental drug coverage than do beneficiaries in urban areas.

Moreover, prescription drug coverage data—which focus on coverage at one point in time—obscure the problem of obtaining continuous coverage. While the data indicate roughly two-thirds of beneficiaries have drug coverage at some point during a year, recent research indicates that only 53 percent of beneficiaries have prescription drug coverage for the entire year.

The rising cost of prescription drugs, their large and growing role in good medical care, and the gaps in Medicare beneficiaries' current coverage for medications reinforce the need for a prescription drug benefit that extends to all Medicare beneficiaries. While there has been some discussion of a benefit that would extend only to low-income beneficiaries, this approach has been increasingly recognized as inadequate since a large number of older and disabled Americans with incomes above 175 percent of the federal poverty level lack drug coverage. As Chart 4 illustrates, an estimated 8.2 million beneficiaries above 175 percent of the federal poverty level (\$14,600 for singles, \$19,700 for couples in 2000) lacked any coverage for prescription drugs in 2000.

The following table presents the 2001 poverty guidelines published in the Federal Register, February 16, 2001, pages 10695-10697, for singles and couples. Income measures for the near-poor and moderate income are also included.

2001 Poverty Guidelines

	Single	Couple
48 States and DC	\$8,590	\$11,610
Alaska	\$10,730	\$14,510
Hawaii	\$9,890	\$13,360
48 States and DC		
100 Percent of Poverty	\$8,590	\$11,610
125 Percent of Poverty	\$10,738	\$14,513
135 Percent of Poverty	\$11,597	\$15,674
150 Percent of Poverty	\$12,885	\$17,415
175 Percent of Poverty	\$15,033	\$20,318
200 Percent of Poverty	\$17,180	\$23,220
250 Percent of Poverty	\$21,475	\$29,025

AARP's Policy Approach to a Prescription Drug Benefit

The coverage gap in Medicare is clear. Medicare is the basic health plan for the population that is most in need of these new tools of modern medicine, but it does not cover prescription drugs. For current and future Medicare beneficiaries a prescription drug benefit would improve the quality of their health care and even their quality of life. AARP is committed to creating a prescription drug benefit in Medicare and has identified fundamental design features for developing a prescription drug benefit.

In the simplest terms, a prescription drug benefit under Medicare needs to be available and affordable to all beneficiaries.

To understand what this means, it is first necessary to recognize the general consensus among most players that a prescription drug benefit in Medicare should be a voluntary benefit. This conclusion is based on the fact that some beneficiaries, as noted above, do have alternative sources of coverage. Beneficiaries need to be able to keep the benefits that they currently have if they choose to do so.

Designing a viable voluntary benefit, however, requires careful attention to how to make the benefit widely available and affordable. Availability must be nationwide. Beneficiaries all over the country—living in rural, suburban, and urban areas—must be assured that the drug benefit is not only going to be a part of Medicare+Choice plans wherever feasible, but that it will also always be available in their community to accompany the traditional Medicare fee-for-service plan.

The benefit must also be affordable, which means not only that premiums and cost-sharing must be reasonable, but also that healthy as well as sick beneficiaries see it as a "good buy." Affordability is a critical feature in assuring that this new benefit actually helps beneficiaries gain access to their new coverage and benefit from the prescriptions that their physicians determine are necessary for their health. But the implications of affordability go far beyond that, especially in the design of a viable voluntary program.

In any voluntary insurance arrangement, affordability for the individual is essential to assure that a substantial portion—and broad mix—of eligible individuals actually enroll. Making enrollment attractive and affordable requires a careful balance of covered benefits and government premium subsidies. The government contribution for a drug benefit in Medicare, as in any well-designed employer plan, must be adequate to assure enrollment of a balanced risk pool of enrollees. Part B of Medicare—a voluntary program in which 95 percent of Medicare beneficiaries participate—is a model in this regard. Without a broad-based risk pool, a voluntary benefit will attract a disproportionate number of beneficiaries with high prescription drug costs, prompting a rapid rise in benefit premiums.

Medicare has always benefited from being a defined benefit plan, and we believe that approach should apply to the implementation of a prescription drug plan as well. A defined benefit package is readily understood by beneficiaries and their families, and provides dependability and certainty for beneficiaries planning for the future. In addition, a defined benefit is an important element in lessening selection problems and instability that result from plan design, sometimes known as “cherry picking.”

Affordability also requires that there be adequate mechanisms and incentives to constrain the rate of increase in spending under the program and to ensure that beneficiaries and other taxpayers receive value for their premium and tax dollars. Cost constraint cannot simply involve shifting of costs to beneficiaries, nor can it rely on arbitrary underpayments to providers—in this case pharmacies and drug manufacturers. It should feature drug-purchasing strategies that enable beneficiaries and Medicare to take advantage of the purchasing power of the program. Further, the program must make available reliable, objective, and understandable information that allows providers and beneficiaries to make the best choices among the treatments available to them.

Affordability in any new prescription drug program also requires additional subsidies for beneficiaries with low incomes, for whom the traditional Medicare premium and cost-sharing would be simply unaffordable. Improvements are needed in the current income protections available to low-income beneficiaries. In particular, the income thresholds for eligibility need to be increased and program participation must grow. The current programs, known as the Qualified Medicare Beneficiary (QMB) program and the Specified Low-Income Medicare Beneficiary program (SLMB), are funded through the Medicaid program and pay for the Medicare premiums, deductibles and coinsurance of beneficiaries below certain income thresholds. It is essential that similar protections complement a prescription drug benefit and continue to be funded through Medicaid to help low-income beneficiaries pay for their prescription drug and other Medicare services. While a prescription drug benefit under Medicare must not be limited to individuals with low incomes, nationwide availability for all beneficiaries must be coupled with extra support for those who have low incomes.

Finally, amidst all of the features of program design, we need to keep attention focused on the reason for the prescription drug benefit—access to medically appropriate drug therapies. The new benefit design must include the right to a timely appeal and external review of coverage denials, as well as quality improvement components that reduce medication errors and mismedication—thereby improving quality of care and reducing overall health costs.

Medicare Reform

Part of the debate over adding a prescription drug benefit in Medicare is whether—and to what extent—additional changes to Medicare are necessary. Proponents of completely restructuring Medicare argue that the program is antiquated, unable to respond to the changing health care marketplace, and in need of a major overhaul.

We agree that some changes in Medicare are necessary to modernize the program, secure its long-term financial future, and ready it to handle retirement of the “baby boom” generation. We believe that incremental, step-by-step improvements can begin to make a significant difference in the success of the program and would be far less disruptive to current and future beneficiaries than an abrupt and comprehensive overhaul. Under any scenario, however, Medicare’s defined benefit must be preserved.

To that end, this Committee is to be commended for convening the task force that is assessing the oversight of the Medicare program. Effective administration of Medicare is critical and changes that enable the agency that oversees the program to better serve beneficiaries and providers should be considered. We encourage the Committee to give serious consideration to some of the recommendations made last week by the four previous Administrators of the Health Care Financing Administration (HCFA).

In particular, AARP believes strongly that beneficiary education and outreach efforts must be expanded and adequately funded. Beneficiaries must have good information in order to make the right choices about their health care options. We also believe that a program that serves 40 million Americans, processes roughly 1 billion claims a year, and is responsible for overseeing beneficiaries’ quality of health care needs a modern, efficient information technology system. In this regard, the current constraints on Medicare’s administrative costs should be reevaluated as part of any reform.

In broader terms, the administration of Medicare must be structured in such a way as to prevent fragmentation of the program and to guarantee seamless operation of traditional fee-for-service, private plan options and any prescription drug benefit. The administering agency must remain fully accountable to Members of Congress and to beneficiaries. And, the agency that oversees Medicare must have the tools and the flexibility it needs—such as the ability to modernize fee-for-service so that it remains a viable option for beneficiaries—to continue to improve the program.

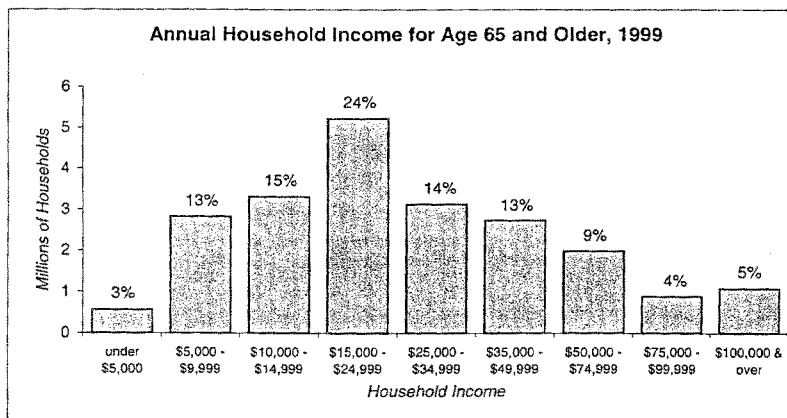
Conclusion

In many respects it seems only a statement of the obvious to say that Medicare beneficiaries need a prescription drug benefit in Medicare. Americans age 65 and older account for over one-third of all drug spending, but represent only about 12 percent of the population. Our nation's health care system relies more and more on prescription drugs to provide high quality care for acute and chronic conditions. Prescription drugs make us well, and they keep us from getting sick. Most private health benefit plans throughout the nation have kept pace with these advances in their benefits for workers, but Medicare has not. That must change.

It will not be an easy change, and it will involve trade-offs on the part of all players. Nevertheless, it must be done so that all older and disabled Americans can be assured that they will have the option of enrolling in an affordable Medicare prescription drug benefit.

AARP believes that there are important principles that must be followed in the development of a drug benefit; we have outlined those in this testimony. We are ready to continue to work with this Committee, the Congress, and the Administration to help shape a benefit in Medicare that will be affordable and viable, and will make room for the changing role of pharmaceuticals in medicine.

Chart 1



Source: AARP PPI analysis of CPS.

Chart 2

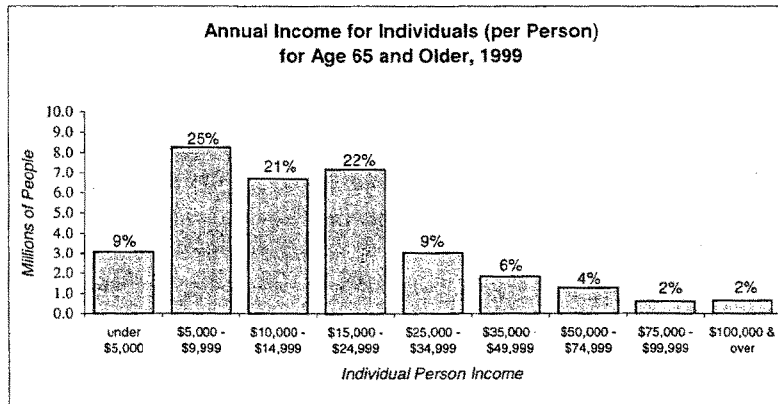


Chart 3

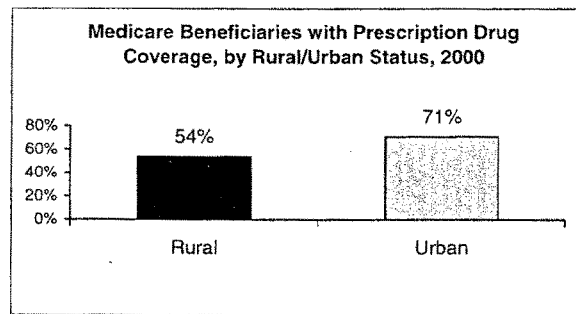
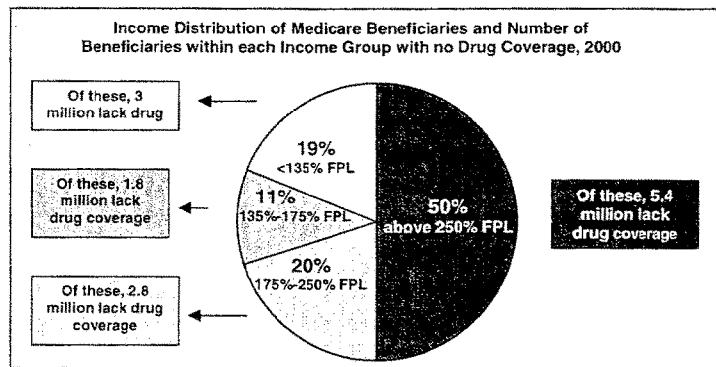


Chart 4



Mr. BILIRAKIS. Were you finished, Dr. Braun, did you complete?

Ms. BRAUN. Yes.

Mr. BILIRAKIS. Thank you very much.

Dr. Lambrew.

STATEMENT OF JEANNE M. LAMBREW

Ms. LAMBREW. Chairman Bilirakis, Congressman Brown, and distinguished subcommittee members, thank you for the opportunity to offer my views on prescription drugs. I am an Associate Professor at George Washington University, and worked for the previous Administration coordinating its estimates on prescription drugs for its Medicare Reform Plan. I will be drawing on this experience for my testimony today.

Although extending Medicare to cover prescription drugs is a major policy challenge, there appears to be the will and the funding to do so. A consensus has emerged that a Medicare drug benefit should be available and affordable to all beneficiaries. There is also widespread support for a drug benefit that has reasonable cost-sharing and protection against catastrophic costs, and we have a budget surplus whose revenues will be necessary to support a Medicare drug benefit, given its costs.

My remarks today focus on the issue of cost. Last week, Congress passed a budget resolution that allocates up to \$300 billion over 10 years for Medicare reform and prescription drugs, and it should be noted that that allocation was to Medicare and not to Medicaid, so it is not clear how low-income protections will be funded.

The committees of authorization will be expected to fit a policy to this cost target. This raises three questions. First, is \$300 billion enough for a prescription drug benefit that is meaningful and helps all uninsured beneficiaries?

Second, if \$300 billion is not enough, is higher spending affordable?

And, third, will decisions about the approach to Medicare payment policy for a drug benefit affect its costs? I discuss this third question in my written testimony, but to keep within 5 minutes I will not discuss it right now.

As Mr. Crippen has testified, CBO has not yet provided any official estimates of prescription drug proposals this year. However, it has provided to congressional staff a useful tool to assess the effects of different premium subsidies and cost-sharing policies. Using this ballpark estimator, it appears that \$300 billion could buy a policy with a \$5 premium, but such a policy would have a \$500 deductible and no catastrophic protection. This benefit is less generous than virtually all previous congressional proposals, and is not significantly better than Medigap.

Alternatively, \$300 billion could provide for a decent benefit with a \$200 deductible and \$4,000 stop-loss, but this benefit would have a monthly premium of \$65-70. This premium is probably too high to encourage all seniors who lack drug coverage to participate, and thus would leave millions uninsured.

This raises a question: How much would an adequate prescription drug benefit cost? As can be seen in the first chart, if Medicare were to spend the same percent on prescription drugs that private health insurance does, then Medicare drug spending would be

about \$750 billion over 10 years. And if Medicare were to extend to all beneficiaries what Congress enacted for military retirees last year, then Medicare would spend \$1 trillion from 2004 to 2011. This helps to explain why organizations such as AARP and other senior groups are concerned about the level of spending that is in the budget resolution.

If, as it is likely to be the case, policy options under consideration are estimated to cost more than \$300 billion, a second question gets raised. How much is too much? To be conservative, this analysis assumed Medicare spending of \$400 billion over 10 years. As can be seen in the second chart, a prescription drug benefit of this size will comprise about 11 percent of total Medicare spending for the next 10 years. It would only constitute about 5 percent of total public spending on health services, and \$400 billion is not much more than what the drug industry is projected to spend solely on promoting their products, as can be seen in the third chart.

Finally, Congress is considering a major tax cut bill. The President's proposed reduction in taxes for the top 1 percent of tax filers reduces revenue by \$237 billion over 10 years. The cost of a full immediate repeal of the estate tax will cost about \$652 billion over 10 years. Mr. Crippen's testimony states that Medicare funding of a prescription drug benefit would "greatly increase the already large burden on the next generation of taxpayers." I would argue the opposite, that reducing the tax burden on this generation of taxpayers without redirecting some of today's surplus toward the obligations of Medicare is what will create problems for the next generation of taxpayers.

In closing, how much a policy costs is clearly a critical piece of information in the policy debate. However, these cost estimates should be put into the proper perspective in the policymaking process. We have the resources necessary to provide for a basic drug benefit. We can assure taxpayers that an investment of even \$400 billion is not overspending relative to private health benefits, relative to Medicare spending, and relative to other priorities like tax cuts.

This gives you the opportunity to focus on what prescription drug policy is best for the program and the beneficiaries it serves. Thank you for the opportunity to share my views.

[The prepared statement of Jeanne M. Lambrew follows:]

PREPARED STATEMENT OF JEANNE M. LAMBREW, ASSOCIATE PROFESSOR, GEORGE WASHINGTON UNIVERSITY¹

Chairman Bilirakis, Congressman Brown, and distinguished Subcommittee Members, thank you for the opportunity to offer my views on prescription drugs. By way of introduction, I worked for the previous Administration as the Principal Associate Director for Health, Personnel and Veterans at the Office of Management and Budget and as the lead health policy analyst at the White House National Economic Council. Part of my job was coordinating the analytic work for President Clinton's Medicare reform plan. Today, I am an Associate Professor at George Washington University.

Covering prescription drugs in Medicare is a top health care priority. As AARP and BIO will testify, prescription drugs are essential to the health of seniors and people with disabilities. Yet, too many beneficiaries face financial barriers to needed medications since Medicare does not cover them.² This problem will only grow worse over time since there inevitably will be a greater reliance on ever-improving pharmaceutical therapies at the same time that there is a deterioration of private insurance coverage for prescription drug coverage for the elderly.³

Although extending Medicare to cover prescription drugs is a major policy challenge, this nation has never been better able to undertake it. We have a budget surplus—in no small part created by recent reductions in Federal health care spending.⁴ Given the cost of a Medicare drug benefit, revenues from this surplus will be essential to funding a prescription drug benefit.

There appears to be bipartisan support for at least two basic principles for a prescription drug benefit. First, most Members of Congress agree with states, advocates of seniors and Americans with disabilities, and policy experts that a prescription drug benefit option should be offered through Medicare to all beneficiaries—not just through states to the low-income. Low-income policies like the President's Immediate Helping Hand not only exclude millions of middle-class beneficiaries with incomes over \$20,000 who lack insurance, but are unlikely to help even those it targets (all states will not expand coverage and, in states that do expand coverage, not all eligible seniors will participate).⁵ Instead, most Members are now concluding that a Medicare drug benefit option should be available and affordable to all beneficiaries. Second, there appears to be widespread support for a drug benefit that is meaningful, defined as having reasonable cost sharing and protection against catastrophic prescription drug costs. Agreement on these principles, coupled with the budget surplus and the urgency of the problem, may mean that this Congress successfully accomplishes what others have failed to do, which is to enact a bipartisan, meaningful Medicare prescription drug benefit.

My remarks today focus on the issue of cost. Cost estimates for prescription drug benefits—and, indeed, most public policies—have taken on unparalleled importance in developing the policies themselves. This is, in part, due to the budget process. The Budget Committees must decide on how much to allocate for prescription drugs and other policies often in the absence of a Congressional Budget Office (CBO) cost estimates of specific policies. Last week, Congress passed a budget resolution that allocates up to \$300 billion from 2002-2011 for Medicare reform and prescription drugs—without knowing what that would buy. The Committees of authorization, thus, will be instructed to retrofit policies, using CBO estimates, to hit these targets. So, rather than beginning with policies, you and other Members of Congress are expected to begin with the cost constraint and work backwards.⁶

Given this expectation, I'd like to discuss three questions related to the cost of a Medicare prescription drug benefit. First, is \$300 billion enough for a drug benefit that is meaningful and helps all uninsured beneficiaries? Second, if \$300 billion is not enough, is higher spending affordable? And, third, will decisions about the approach to Medicare payment policy for prescription drugs affect costs? The answers to these questions will help determine whether bipartisan support can be translated into enactment of a bipartisan, meaningful Medicare prescription drug benefit in this Congress.

Is \$300 Billion Enough?

As Mr. Crippen has testified, CBO has not yet provided any official estimates of prescription drug proposals this year. However, it has, in the interim, provided to Congressional staff a useful tool to assess the effects of different premium subsidies and cost sharing policies on total costs and beneficiary premiums. This "ballpark estimator" tool is used in the analysis that I have prepared for today's testimony.⁷ It is important to note that these are not CBO estimates and that the ultimate CBO scoring may be quite different.

Using this tool, it appears that \$300 billion will probably buy a limited Medicare prescription drug benefit. Two illustrative policies that could be affordable at this level include:

- **No catastrophic protection and \$500 deductible.** One \$300 billion option would maintain a 50 percent premium subsidy (the lowest subsidy that would likely ensure that all currently uninsured Medicare beneficiaries participate⁸) but constrain Federal spending by increasing beneficiary cost sharing. Such an option would have \$45 to \$50 monthly premium, a \$500 deductible, and 50 percent coinsurance for spending above the deductible, with no catastrophic protection. This deductible/copay structure is less generous than virtually all previous Congressional proposals and is not significantly better than Medigap.
- **Catastrophic protection with high premium.** A different approach to spending \$300 billion would be to make the deductible/copay structure more comparable to private plans but reduce the premium subsidy. This option would have a \$200 deductible, 50 percent coinsurance, and \$4,000 stop-loss—but a \$65 to \$70 premium. This premium is about equivalent to the premium that beneficiaries are expected to pay in 2004 for all Part B services (e.g., physician and hospital outpatient department care).⁹ This premium is probably too high to en-

courage all seniors who lack prescription drug coverage to participate in a voluntary benefit and thus would leave millions uninsured.

One could, with \$300 billion, create a hybrid proposal that includes a 50 percent premium subsidy and catastrophic benefit but has a “gap”—meaning that, Medicare pays 50 percent coinsurance up to a fixed dollar limit, then the beneficiary is liable for 100 percent of costs until out-of-pocket spending hit a particular stop-loss threshold. However, such policies have come under criticism from beneficiary groups and experts and, as Mr. Crippen testified in March, it is “unlike anything available in the private sector.”¹⁰

Since the definition of what is “adequate” is relative, it is useful to compare the type of benefit affordable at \$300 billion with other benchmarks that make sense for Medicare. One such benchmark is private health insurance. For 2002-2010, the percent of private insurance spending on prescription drugs is projected to be 19 percent, according to the Administration’s Office of the Actuary.¹¹ If Medicare were to spend the same percent of total spending on prescription drugs as does private insurance, then the cost of a Medicare drug benefit would be about \$750 billion over 10 years (see chart 1).¹² Another benchmark is the prescription drug benefit enacted last year for military retirees. This benefit, which has no beneficiary premium and low copays would, if extended to the entire Medicare population, cost about \$1 trillion from 2004 through 2011¹³—clearly much higher than any proposal under consideration. This helps explain why organizations such as AARP advocate for significantly higher spending on a prescription drug benefit.

In summary, this analysis suggests that \$300 billion is well below the amount needed for a benefit equivalent to a standard private insurance benefit, and is probably insufficient to extend a meaningful prescription drug benefit to all Medicare beneficiaries.

Is \$300 Billion—Or Even \$400 Billion—Too Much?

If, in developing options for a prescription drug benefit, the policies’ cost estimates rise above the budget target, questions will surface about whether this is too much to spend on a Medicare drug benefit. Some still argue that \$300 billion itself is excessive. One way to evaluate this claim is to compare the proposed prescription drug spending to other types of health spending and other budget priorities. For illustration, this analysis assumes that \$400 billion over the 10 years is being proposed for a prescription drug benefit, since this is probably closer to cost estimates for proposals introduced in the 106th Congress using this year’s baseline.

The most immediate way to assess whether \$400 billion is too large is to compare it to projected Medicare and overall Federal health services spending. A prescription drug benefit of this size would comprise about 11 percent of total Medicare spending from 2002-2011. Such an amount would be about equal to projected spending on Medicare’s long-term care benefits (hospice, home health and skilled nursing facility care), even though many more beneficiaries would use a drug benefit.¹⁴ In addition, a new Medicare drug benefit that costs \$400 billion would comprise about 5 percent of the total national public spending on health services (see chart 2).

It is also instructive to compare \$400 billion to projected spending on prescription drugs. CBO projects that prescription drug spending by the Medicare population will total \$1.5 trillion from 2002 through 2011. A bill whose cost estimate is \$400 billion would cover only about one-fourth of this spending (less if some of the \$400 billion replaces existing spending or pays for administrative costs). A different type of comparison looks at private pharmaceutical industry spending. A rough estimate suggests that the pharmaceutical industry’s budget for activities to promote prescription drugs (e.g., marketing, physician “detailing”) will total about \$300 billion from 2002-2011.¹⁵ This is as much or a large fraction of the amount that Congress is contemplating spending on the entire prescription drug benefit for 39 million beneficiaries (see chart 3).

A more conventional way to assess how much is too much is to compare proposed prescription drug spending to other budget priorities. The Joint Committee on Taxation recently estimated that, if the estate tax repeal were fully implemented immediately, it would cost \$662 billion over 10 years.¹⁶ The President’s proposed top tax bracket change alone, which would help only about half a million households, would cost \$237 billion¹⁷—slightly less than the budget resolution’s allocation for Medicare, but helping tens of millions fewer people.

These comparisons are not intended to imply that \$300 billion is an insignificant commitment. Indeed, such a dedication is a major step forward. They are intended to help frame the discussion of the numbers, and to illustrate that spending that is more commensurate with proposals that provide a meaningful prescription drug benefit to all beneficiaries is not necessarily “excessive”.

Will Medicare payment policy for prescription drugs affect costs?

The third and final question is how will the structure of a Medicare prescription drug benefit affect costs? As described previously, most of the cost of a prescription drug benefit will result from its benefit design: the level of premium subsidy, amount of cost sharing, and level of catastrophic protection (if any). Last year, CBO assumed that there was basically no difference in the overall cost of a prescription drug benefit administered through the two major approaches, all else held constant.¹⁸ I'd like to make the case that total costs should differ depending on how the prescription drug benefit is structured, and that paying for drugs on a fully capitated basis will be more costly than assumed—and could have serious side effects.

To review, two major approaches have been proposed for paying for and administering a Medicare prescription drug benefit. The first relies on pharmaceutical benefit managers (PBMs) which would be competitively chosen to negotiate price discounts and deliver prescription drugs in a local area. The second relies on private, risk-based insurers that compete directly for beneficiary enrollment to deliver prescription drugs.¹⁹ These approaches have some common elements. Both give private organizations primary responsibility for the management and delivery of the benefit. Both give these organizations similar tools to reduce prescription drug prices (e.g., authority for prior authorization; incentives for generic substitution). And both contract with private organizations to negotiate prices for covered drugs. The major difference is that, under the PBM approach, the government pays a percent of the negotiated prices to PBMs selected by Medicare because they offer low prices. Under the risk-based plan approach, the government pays a fixed, capitation rate to risk plans selected by beneficiaries.

In 2000, CBO assumed that, relative to PBMs, risk-based plans would achieve lower prescription drug spending per beneficiary, but that this extra savings would be offset by their higher marketing costs and a "risk premium" (a contingency amount built into premiums to offset risk). It is true that full capitation is a powerful incentive for plans to contain costs. Plans paid this way are liable for all excess costs. The key question is how will insurers respond to this incentive. Will they reduce prices through more aggressive negotiation with drug manufacturers, reduce use of and/or access to medications, or "risk select" (seek out enrollees whose average cost falls below the capitation rate).

To my knowledge, no major employer or insurer pays for prescription drugs through full capitation. Thus, experience in the Medicare managed care system may help answer this question. Studies have found that HMOs have reacted to the pressure of capitation through risk selection.²⁰ Avoiding sicker, more expensive beneficiaries while enrolling those with low to no costs may be a more effective strategy to managed fixed payments than reducing prices or utilization of services. Prescription drug coverage is particularly susceptible to risk selection since most seniors and people with disabilities use prescription drugs, and much of the expense is predictable by plans. While risk selection may reduce *plans'* costs, it will not reduce the Federal government's costs since the government will ultimately have to pay for those beneficiaries in some type of plan.

Even assuming no risk selection, risk-based plans may focus less on price and more on utilization to reduce costs. Numerous private insurers that compete for enrollment on an annual basis may have a harder time negotiating price discounts with manufacturers than PBMs (this is the experience in Medigap today). This may lead to aggressive attempts to limit utilization. Recent experience in managed care and in state pharmacy assistance programs suggests that increasingly popular cost containment tools include limiting participating pharmacies and tight appeals processes for medically necessary drugs. Congress can legislatively draw the line between cost containment tools that ensure appropriate utilization and those that limit access. If so, risk-based plans may not be able to constrain costs better than PBMs. If not, then the pressure of capitation may succeed in lowering costs—but at the expense of access to needed prescription drugs. For all these reasons, I would argue that CBO's assumption last year, that risk-based plans result in overall, lower spending per beneficiary (offset by their higher administrative costs), is overly optimistic.²¹

The alternative approach for administering a prescription drug benefit is competitive contracting with PBMs. This approach has a different incentive structure for achieving lower costs. PBMs that have neither lower prices nor strong utilization control systems than their competitors would lose the Medicare contract and thus be denied access to Medicare beneficiaries. Since, once they have been competitively selected, PBMs are paid on a claims rather than a fixed capitation basis, they would not benefit from risk selection or access restrictions. And PBMs may be better positioned to get better price discounts since they are bidding for a local area with a

known set of enrollees. This approach may not have the same incentives to control utilization but offers much lower administrative costs and fewer of the potential problems for beneficiaries that risk-based plans do. This may explain why virtually all private insurers and employers who offer prescription drug benefits today competitively contract with PBMs for prescription drugs.

Thus, I believe that these very different approaches to paying private plans for prescription drug coverage will have different effects on Medicare costs. I hope that CBO considers these issues carefully before finalizing their estimates and would urge Members of Congress to seriously weigh the policy implications of alternative administrative structures.

Importance of Putting Cost Estimates into Perspective

The purpose of my testimony has been to discuss cost issues related to Medicare prescription drug proposals. How much a policy costs is clearly one of the most important pieces of information in a policy debate. It is essential, however, that these cost estimates be put into the proper perspective in the policy making process. As Members of this Committee know, cost estimates are informed guesses, not actual costs. Developing a prescription drug benefit by solving for total costs based on cost estimates may result in flawed policy. This was what happened in the Balanced Budget Act of 1997 when Medicare provider payment policy was changed to meet somewhat arbitrary budget targets using cost estimates that were, in retrospect, too pessimistic. We have been paying for this mistake ever since, and it is important that we not repeat it.

To that end, I would respectfully suggest that this Committee focus on what prescription drug policy is best for the program and the beneficiaries it serves. We now have the resources necessary to provide for a basic benefit that can improve, extend, and literally save lives. We can assure taxpayers that even an investment of \$400 billion is not overspending, relative to private insurance benefits and relative to Medicare and Federal health spending. This creates the opportunity to finally bring Medicare into the 21st century by adding a meaningful prescription drug benefit for all its beneficiaries. Thank you for the opportunity to share my views.

Notes:

¹The views expressed in this paper do not represent those of the University or Department of Health Services Management and Policy.

²Poissal JA; Murray L. (2001). "Growing Differences Between Medicare Beneficiaries With and Without Drug Coverage." *Health Affairs* 20(2): 74-85. Office of the Assistant Secretary for Planning and Evaluation. (April 2000). *Prescription Drug Coverage, Spending, Utilization, and Prices: Report to the President*. Washington, DC: U.S. Department of Health and Human Services.

³For information on declines in retiree health coverage: see Foster-Higgins, Kaiser Family Foundation/HRET Employer Surveys. For information on increasing premiums in Medigap coverage: see Weissratings.com, "Prescription Drug Costs Boost Medigap Premiums Dramatically," and for Medigap coverage declines see Chollet D. (April 24, 2001). "Medigap Coverage for Prescription Drugs", Testimony before the Senate Finance Committee, Washington, DC: Mathematica Policy Research.

⁴OMB analysis, for President Clinton's speech to the National Governors' Association, July 10, 2000.

⁵See Scheppach R. (April 24, 2001). "Finding the Right Fit: Medicare, Prescription Drugs, and Current Coverage Options," Testimony before the Senate Finance Committee, Washington, DC: National Governors' Association. Also, National Economic Council/Domestic Policy Council (September 2000). *Low-Income Prescription Drug Plans: An Unworkable Prescription for America's Seniors*. Washington, DC: The White House.

⁶Note: The budget process for developing the President's budget requires that cost estimates on major policies like a Medicare prescription drug benefit be completed before decisions about budget allocations.

⁷The estimator allows for input of two parameters: premium subsidy and cost sharing. It then produces rough estimates of total Medicare costs for 2004-2001 and monthly beneficiary premiums for 2004. It does not include: discounts, administrative costs, utilization effects, Medicaid costs and is thus incomplete. For this analysis, the Medicare costs were increased by 20 to 25 percent (depending on the proposal's generosity) as a proxy for Medicaid costs, since virtually all proposals provide extra assistance for low-income beneficiaries through Medicaid (based on Medicaid estimates in CBO's March 27, 2001 testimony).

⁸CBO and the Administration's Office of the Actuary have generally assumed that premiums for prescription drug benefits that are voluntary need a 50 percent premium subsidy to encourage all uninsured Medicare beneficiaries to participate.

⁹Health Care Financing Administration Office of the Actuary (March 2001). *2001 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund*. Washington, DC: U.S. Department of Health and Human Services, Table III.C.1.

¹⁰Crippen DL. (March 27, 2001). "Laying the Groundwork for a Medicare Prescription Drug Benefit." Testimony before the Committee on Ways and Means, Subcommittee on Health, U.S. House of Representatives. Washington, DC: Congressional Budget Office.

¹¹ Health Care Financing Administration Office of the Actuary (March 2001). National Health Expenditures Projections; Table 5: Personal Health Care Expenditures; and Table 11: Prescription Drug Expenditures. Private health insurance spending for 2002-10.

¹² Based on CBO projected Medicare net expenditures for 2002-11 (about \$3.2 trillion according to January 2001 baseline).

¹³ Estimated by using the CBO ballpark estimator. See note on Chart 1.

¹⁴ Since CBO has not yet released the service-specific projections for Medicare, this is estimated by taking the 2000 Medicare baseline projected spending for FY 2001-2010 for skilled nursing facilities, home health and hospice; dividing their total spending into net outlays for this period; and applying this percent (14%) to the January 2001 net outlays. This equals about \$450 billion for FY 2002-2011.

¹⁵ According to IMS HEALTH, the pharmaceutical industry spent \$13.9 billion on promoting drugs in 1999 (see April 20, 2000 press release at: www.imshealth.com). If that investment were to grow by the CBO projected average prescription drug baseline growth (10.3 percent) for 2002-2011, then it would equal \$302 billion for this period.

¹⁶ Joint Committee on Taxation. (March 26, 2001). Memorandum to John Buckley; Subject: Estate and Gift Tax Estimates. Washington, DC: U.S. Congress.

¹⁷ Joint Committee on Taxation as reported by Friedman J; Greenstein R. (May 3, 2001). *Reduction of Top Rate Cost \$237 Billion over Ten Years, Even Though Fewer than 1% of Filers Are in the Top Bracket*. Washington, DC: Center on Budget and Policy Priorities.

¹⁸ Note: this is mostly based on informal communication. A summary of the CBO approach to discounts and administrative costs is included in a letter to Senator Daniel Patrick Moynihan from CBO Director Crippen dated September 1, 2000.

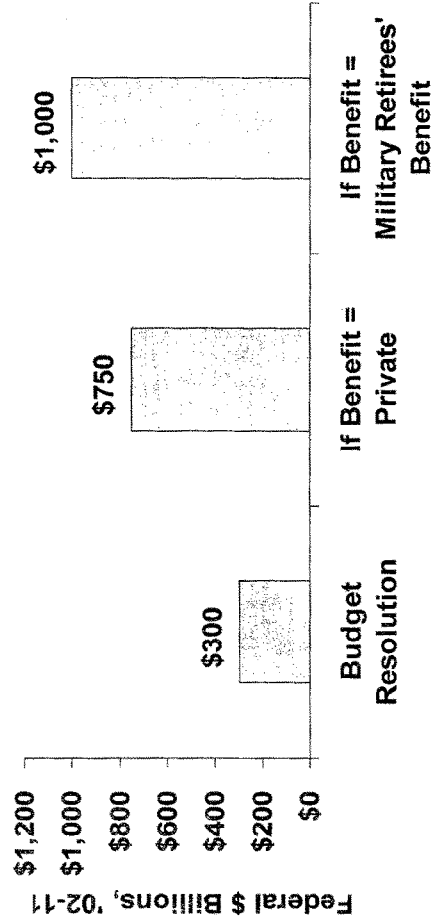
¹⁹ This testimony focuses on proposals like H.R. 4680 (House Republican bill) that pay private plans for prescription drugs through full capitation and S. 2342 (President Clinton proposal) that competitive contract with a single PBM to deliver prescription drug benefit in local areas. A number of hybrid proposals have also emerged (e.g., use of multiple PBMs, partial risk payments, etc).

²⁰ See, for example, General Accounting Office. (August 2000). *Medicare+Choice: payments exceed cost of fee-for-service benefits, adding billions to spending*. HEHS-00-161. Washington, DC: GAO.

²¹ In addition to these doubts about their cost effectiveness, other major policy issues are raised by risk-based prescription drug proposals. Premiums under most of these proposals would vary from place to place, as they do in Medicare managed care, but would do so without having an underlying, nationwide traditional Medicare option. Plans that enroll older or sicker beneficiaries might charge them higher premiums or pull out of the system altogether—a phenomenon in the Medicare+Choice system that has caused serious disruption for seniors. And, although most risk-plan proposals have a PBM-like “fallback” in areas where no plans operate, this, too, presents problems. Beneficiaries’ access to a stable, affordable plan will depend on where they live and what risk-based plans decide to participate there. This raises equity concerns, especially in light of a significant Federal investment in a prescription drug benefit.

Chart 1

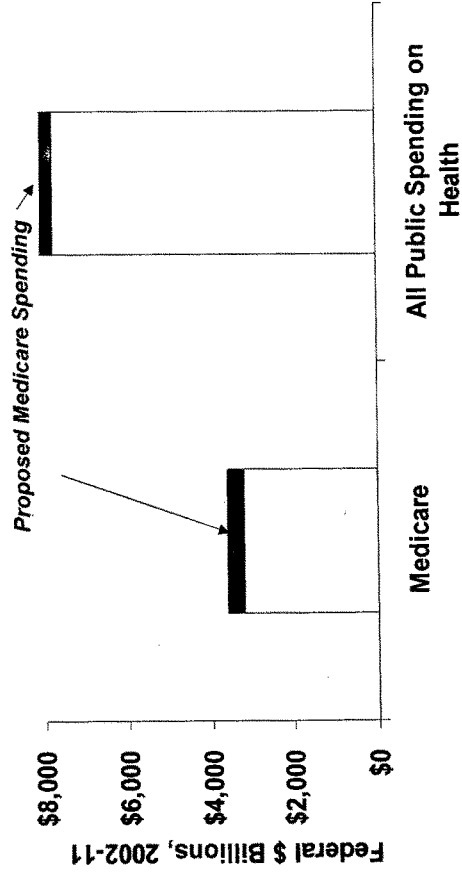
**\$300 Billion for Medicare Prescription Drugs:
Below Equivalent Value of Private Coverage and
Recently Enacted Military Retirees' Drug Benefit**



Source: Based on CBO Ballpark Calculator for Medicare Outpatient Prescription Drugs, 4/13/01. Includes an approximation of Medicaid costs based on CBO's 3/27/01 testimony "Private": The National Health Expenditures projection (HCFR, March 2001) assume that 19 percent of total private insurance personal health spending is comprised of prescription drug spending. It also assumes that 19 percent of Medicare drug spending is comprised of out-of-network pharmaceuticals. It includes \$3.3 billion for brand name, out-of-network pharmaceuticals and 20 percent coinsurance for out-of-network pharmaceuticals. There is no premium for this coverage. Estimate assumes 20 percent coinsurance.

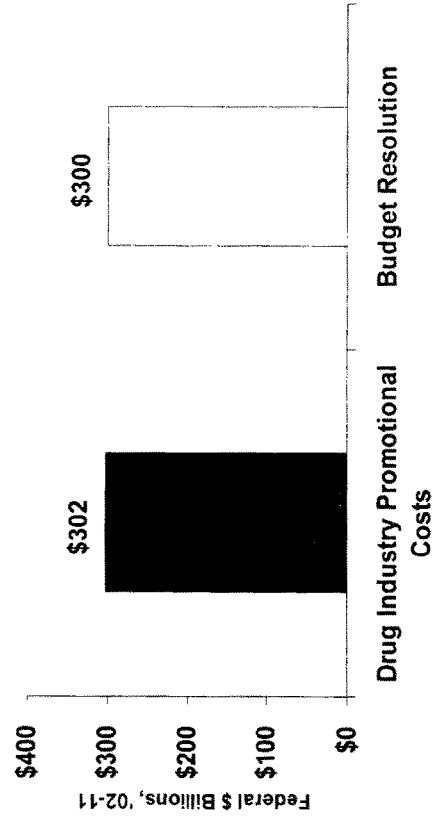
Chart 2

\$400 Billion for Medicare Prescription Drugs:
11% of Projected Medicare Spending
5% of Total Public Spending on Health



Source: Medicare Baseline Projections from CBO's 2001 Baseline
 Public Health Spending Projections from National Health Expenditure Projections, HCFA Office of the Actuary, March 2001. 2011 is extrapolated using 2009-10 growth rate.

Chart 3
Drug Industry Spends More on Marketing Than Budget Resolution's Medicare Prescription Drug Allocation



SOURCE: 1999 IMS HEALTH, 4/20/00 estimated cost of drug promotion provided by CBO 2002-2011 average prescription drug cost growth (10.3%)

Mr. BILIRAKIS. Thank you, Dr. Lambrew. Mr. Chess, please proceed, sir.

STATEMENT OF ROBERT CHESS

Mr. CHESS. Good afternoon, Chairman Bilirakis, Congressman Brown, and members of the subcommittee. My name is Rob Chess, Chairman of Inhale Therapeutic Systems. I am here today representing the Biotechnology Industry Organization, BIO. I am particularly honored to be here to describe BIO's views on Medicare drug coverage issues.

Our company, Inhale Therapeutic Systems, is developing a family of technologies to enable patients to inhale drugs for diabetes, osteoporosis, multiple sclerosis, genetic emphysema, and several other diseases that would otherwise have to be given by injection. In essence, what we are doing is we are taking drugs that have to be given by shot and making them so you can breathe them in through this device right here.

Our most advanced product is inhaled insulin, which has recently completed Phase III trials, and we believe our product would encourage patients to take their insulin more frequently and lead to a major improvement in the health care of diabetic patients. We hope to make similar contributions to the treatment of many other diseases.

Developing and testing this technology has been very time consuming and very expensive. We started our company in 1991 and, since then, we have raised over \$700 million in 13 financings. This year we expect to lose \$75 million, and we still do not have our first product on the market. My company hopes to help many patients, but that will depend on whether or not patients have coverage for our products. That is why I am here today to testify in favor of extending drug coverage to senior citizens and those in need.

A full description of BIO is included in my written statement, but of the 950-plus members, 90 percent do not have a single drug product on the market. Many more have only one product. BIO members are clearly in the research and development phase.

For many of the BIO members, the level of investment in innovation is far from an academic concern, and more a question of survival. Most BIO members aren't members of the Fortune 500, rather, they are small companies funded by venture capital, companies that may hold the key to many potentially life-saving therapies.

When the Clinton Health Care bill was being considered in the mid-1990's, which had the effect of indirect price controls, company financing was hurt. We at Inhale were one of the lucky few at that time still able to raise about 60 percent of what we sought in our IPO. We may have lost a year of progress as a result of that, though.

BIO urges Congress to ensure that any Medicare drug coverage proposal considered or enacted does not upset the delicate balance of the biotechnology industry.

Over the past two decades, biotechnology has produced 110 drugs and vaccines, and there are 350 more in late-stage development. The 110 products that have been approved by FDA are the work of only 71 of BIO's members.

The biotechnology industry invested nearly \$10 billion in R&D in 1999, reinvesting, on average, up to 50 percent of its revenues into R&D. This is an environment when most of BIO's members have no product revenues at all, those companies can be said to be investing more than 100 percent of revenues in R&D. Across all other industries, the average re-investment in R&D is just 4 percent. The biotechnology industry as a whole lost approximately \$5 billion last year.

Many biotechnology products are oriented toward treating, preventing and diagnosing diseases of the aging and are targeted toward small segments of disease categories and thus small patient populations. One example of this sort of treatment is Gleevec, a leukemia drug approved by the FDA just last week. According to Dr. Richard Klausner of the National Cancer Institute, Gleevec represents the first molecularly targeted drug. The drug is specifically targeted to disrupt cancer cells, unlike most cancer therapies that can harm even healthy cells. This type of product is expected to become more and more common in the coming years.

The issue of Medicare modernization and the proposal to add a prescription drug benefit to the program is of high interest to the members of the BIO and the patients we serve. Many of the products in biotech companies' pipelines target diseases that predominantly affect seniors. Accordingly, BIO believes that all Medicare beneficiaries should have drug coverage.

In recent years, drugs and biologics have become an even more integral part of health care, while the drug coverage available to seniors has increasingly included lower coverage limits and higher premiums. BIO strongly believes that pharmaceutical benefit options should be offered to beneficiaries in the context of an overall, market-based reform of the Medicare program, but we believe that seniors need coverage now. Thus, we support efforts to enact a Medicare drug benefit in 2001, but we must also continue to work to make Medicare a program that reflects the best of the 21st Century marketplace. If interim prescription drug proposals must be considered, they should facilitate and not deter the adoption of comprehensive reforms to the Medicare program.

BIO's priority in the debate is to ensure that any steps taken to increase seniors' access to drugs today is consistent with the incentives needed to develop breakthrough medicines to treat the seniors of tomorrow.

To guide our review of various proposals, we have adopted a set of six principles, outlined in my written statement, but let me reinforce three of them. We urge Congress to 1) rely on the private marketplace and competition, not price controls that harm innovation; 2) include stop-loss protection and protection of those most in need first; and 3) do no harm to current coverage and reimbursement.

Based on our principles, BIO has tended to be most supportive of drug coverage plans that focus beneficiaries with very high prescription drug costs, as well as those with low incomes. We have been the strongest advocate of what many in Congress are calling "stop-loss" or "catastrophic coverage" to cover all or a high percentage of prescription drug costs after a certain level of out-of-pocket spending. We are encouraged that most of the major drug coverage

proposals, from both sides of the aisle, now include some sort of catastrophic coverage.

While most seniors will not make claims under stop-loss coverage, the coverage will provide valuable protection and peace of mind for all by ensuring that high-cost therapies are available to those who need them.

These new products, by reducing hospitalizations and improving overall health, could generate savings in the health care system. They will allow people to remain productive longer, with potentially corresponding economic benefits.

Mr. BILIRAKIS. Excuse me, Mr. Chess, would you please summarize?

Mr. CHESSE. I am just about done. Thank you. While we understand that CBO may find these savings difficult to score, we are firmly convinced they will represent a net savings to patients.

That concludes my formal testimony. Be delighted to take any questions.

[The prepared statement of Robert Chess follows:]

PREPARED STATEMENT OF ROBERT CHESSE, CHAIRMAN, INHALE THERAPEUTIC SYSTEMS

Introduction

Good morning, Chairman Bilirakis, Congressman Brown, members of the subcommittee. My name is Robert Chess, Chairman of Inhale Therapeutic Systems. I am here today representing the Biotechnology Industry Organization (BIO). As you know, the Energy and Commerce Committee has jurisdiction over many of the issues that my company, along with BIO, is concerned about: it oversees the basic research done by the National Institutes of Health (NIH), it regulates the applied research and development (R&D) of the biotechnology industry and the drug approvals that result from that R&D and it oversees the Medicare and Medicaid coverage of those products. I am particularly honored to be here to describe BIO's views on Medicare drug coverage issues.

Inhale Therapeutic Systems is developing a family of technologies to enable patients to inhale drugs that would otherwise have to be given by injection. We are developing inhaleable versions of drugs for diabetes, osteoporosis, multiple sclerosis, genetic emphysema, and several other diseases. Our most advanced product is inhaled insulin, which recently completed Phase III trials. This product represents an important advance since it would be far more convenient for diabetics to take than the current injectable insulin. A nine-year, \$150 million, 1,400 patient study funded by NIH found that if patients took their insulin 3-6 times per day the complications from diabetes, such as blindness, amputations, and kidney-failure, could be reduced by 35-60%. Despite this striking result, most diabetics take insulin less than twice a day, primarily because of their dislike of injections. We believe our product would encourage patients to take their insulin more frequently and lead to a major improvement in the health of diabetic patients. We hope to make similar contributions to the treatment of many other diseases.

Developing and testing this technology has been very time consuming and expensive. We started our company in 1991, and since then have raised over \$700 million in 13 financings. This year we expect to lose \$75 million, and we still do not have our first product on the market. I am excited about all the different ways that my company may be able to help patients, but I know that our ability to do so will depend on whether or not patients can gain coverage for our products. That is why I am here today to testify in favor of extending drug coverage to senior citizens and those in need.

About BIO

BIO represents more than 950 biotechnology companies, academic institutions, state biotechnology centers and related organizations in all 50 U.S. states and 33 other nations. BIO members are involved in the research and development of health care, agricultural, industrial and environmental biotechnology products. Ninety percent of our companies are involved in health care product development and 90% of those companies do not have a single product on the market. Many more have only one product. Clearly, the vast majority of BIO's members do not have an array of health and/or other consumer products to absorb the cost of R&D, more importantly,

many biotech drugs are for small populations. Forty-five percent of FDA-approved biotech products have orphan status.

For many of BIO's members the level of investment in innovation is far from an academic concern and more a question of survival. Most BIO members aren't members of the Fortune 500; rather, they are small companies funded by venture capital, companies that may hold the key to many potentially lifesaving therapies. Anything that could upset the delicate balance these companies live in could deprive patients of these important breakthroughs—because if venture capital investment is reduced, many companies will be unable to survive. The President of NASDAQ recently wrote that a “decrease in investor confidence [*in the biotechnology industry*] can only result in a decrease in investment dollars, thereby placing critical research at risk.” When the Clinton Health bill was being considered in the mid-1990s, the growth rate of R&D investment dropped markedly, potentially delaying new products on their way to American consumers. In addition, venture capitalists became less willing to invest in biotech companies, forcing 13 out of 16 companies to withdraw their initial public offerings (IPOs) of stock and their efforts to go public.

While we at Inhale were one of the lucky few to go public during consideration of the Clinton healthcare plan, we were only able to raise about 60% of what we sought. We may have lost a year of progress as a result. Clearly, many biotech companies are fragile and would be devastated by a drop in investor confidence. BIO urges Congress to ensure that any Medicare drug coverage proposal considered or enacted does not upset the delicate balance of the biotechnology industry.

Over the past two decades, biotechnology has produced 110 drugs and vaccines, and there are 350 more in late stage development. The 110 biotech products that have been approved by FDA are the work of only 71 of BIO's members. The biotechnology industry invested nearly \$10 billion in R&D in 1999—reinvesting, on average, up to 50% of its revenues into R&D.¹ This is in an environment when most of BIO's members have no product revenues at all—those companies can be said to be investing more than 100% of revenues in R&D. Across all other industries, the average re-investment in R&D is just 4%. The biotech industry as a whole lost approximately \$5 billion last year.

In addition to the hope of promising new therapies offered by biotechnology, I also want to point out that BIO's members are an important part of the U.S. economy. According to Ernst & Young Report, the biotechnology industry employs more than 150,000 people—this excludes companies that are mostly pharmaceutical in nature.² We have employees in all 50 states and add more than \$20 billion to the economy annually.

Many biotechnology products are oriented toward treating, preventing and diagnosing diseases of the aging and are targeted toward small segments of disease categories and thus small patient populations. Recombinant DNA technology has enabled us to target products at the genetic or cellular level. Increasingly, new therapies will be designed specifically for unique and small populations. While we expect this to allow for more effective treatments, many with fewer side effects, it will also mean smaller markets in which we can spread the cost of R&D investment. One example of this sort of treatment is Gleevec, a leukemia drug approved by

the FDA just last week. According to Dr. Richard Klausner of the National Cancer Institute, Gleevec represents the “first molecularly targeted drug.” The drug is specifically targeted to disrupt cancer cells—unlike most cancer therapies that can harm even healthy cells. While Novartis, the drug's maker, is hopeful that it will be approved for more indications, it has currently been approved only for a relatively rare type of leukemia. This type of product is expected to become more and more common in the coming years.

The bottom line is that the biotechnology industry, while being a vital part of the current economy and the source for many potential new cures, is still fragile. We would urge you to take care when designing a Medicare drug coverage plan not to upset the delicate balance of the industry.

BIO's Medicare Reform Principles

The issue of Medicare modernization and the proposal to add a prescription drug benefit to the program is of high interest to the members of the BIO and the patients we serve. Many of the products in biotech companies' pipelines target diseases that predominantly affect seniors.

Accordingly, BIO believes that the Medicare program should include drug coverage for all Medicare beneficiaries. In recent years drugs and biologics have become

¹ Ernst & Young LLP, *Annual Biotechnology Industry Reports*, 1999.

² 2000 E&Y LLP, *The Economic Contributions of the Biotechnology Industry to the U.S. Economy*.

an even more integral part of health care, while the drug coverage available to seniors has increasingly included lower coverage limits and higher premiums. BIO strongly believes that pharmaceutical benefit options should be offered to beneficiaries in the context of an overall, market-based reform of the Medicare program, but we believe that seniors need drug coverage now—and comprehensive reform may take years to enact. Thus, we support efforts to enact a Medicare drug benefit in 2001, but we must also continue to work to make Medicare a program that reflects the best of the 21st Century marketplace. If interim prescription drug proposals must be considered, they should facilitate and not deter the adoption of comprehensive reforms to the Medicare program.

BIO's priority in the debate is to ensure that any steps taken to increase seniors' access to drugs today is consistent with the incentives needed to develop breakthrough medicines to treat the seniors of tomorrow.

To guide our review of various proposals, we have adopted the following principles:

1) **Rely on the private marketplace and competition, not price controls that harm innovation**—BIO believes that Medicare benefits—including coverage for prescription drugs and biologics—should be delivered through a decentralized, pluralistic market structure that encourages meaningful competition in order to preserve patient choice, improve quality and encourage innovation. Government regulation should be limited and market-based delivery mechanisms should be utilized. Explicit or indirect price controls that stifle innovation must be avoided.

2) **Include stop loss protection and protection of those most in need first**—Federal assistance for Medicare beneficiaries should be targeted to those with the greatest economic and medical need in order to focus limited funds where they can have the most impact. Inclusion of “stop loss” coverage in order to protect the financial security of the sickest and neediest Medicare beneficiaries must be a top priority of any Medicare drug proposal.

3) **Expand beneficiary choices among private plans**—Medicare beneficiaries should have expanded choices of quality health plans and benefit packages that include prescription drug coverage to ensure that all of the elements of modern health care are provided in a system built on the advantages of our market-based economy.

4) **Improve patient care through innovations in biotechnology**—The future of patient care and our ability to prevent, diagnose and treat illness is inextricably tied to innovation in health care. By promoting strong incentives for the discovery and development of innovative new prescription drugs and biologics, America can assure that the new tools of biotechnology are applied as quickly as possible to create medicines for our aging population. BIO believes that such innovation and discovery will generate real savings by reducing the need for hospital, long-term care, and other expensive services and procedures.

5) **Maintain Medicare solvency**—In the context of over-all market-based reform, we must ensure that drug coverage for Medicare beneficiaries does not jeopardize the financial security of the program. Medicare needs to be modernized in such a way as to assure that it is a fiscally responsible program for the coming generations of seniors.

6) **Do no harm to current coverage and reimbursement**—A majority of Medicare beneficiaries have some form of drug coverage today. Additionally, Medicare does cover prescription drugs and biologics in certain circumstances. BIO believes strongly that any Congressional action on Medicare prescription drugs must avoid interfering with existing coverage and payment rules for the types of drugs and biologics currently covered by Medicare.

BIO's Recommendations

Based on our principles, BIO has tended to be most supportive of drug coverage plans that focus beneficiaries with very high prescription drug costs, as well as those with low-incomes. We have been the strongest advocate of what many in Congress are calling “stop loss” or catastrophic coverage to cover all or a high percentage of prescription drug costs after a certain level of out of pocket spending. We are encouraged that most of the major drug coverage proposals—from both sides of the aisle—now include some sort of catastrophic coverage.

Stop Loss Design Issues

There have been a variety of different stop loss coverage plans introduced in various bills in the 106th and 107th Congresses. In our opinion, it is the presence of stop loss coverage that is important—coverage that is important for a variety of reasons.

We support stop loss coverage because we are quite concerned that the fruits of the most promising research that some of our members are conducting are likely

to be quite expensive—and we want to be sure the results of this research is widely available. Because of some of the dynamics of the biotech industry discussed earlier, the populations they treat are often small, sometimes very small. Moreover, biological products are often more expensive to produce than traditional pharmaceuticals because Biotech products are generally made through recombinant techniques. The reagents and tools necessary to make a recombinant protein are generally more costly than traditional pharmaceutical products. As a result, we expect that some new biotechnology products may be too expensive for many seniors that lack prescription drug coverage.

While most seniors will not make claims under stop loss coverage, the coverage will provide valuable protection and peace of mind for all by ensuring that high cost therapies are available to those who need them. Stop loss coverage is true insurance against the cost of debilitating, and potentially financially devastating disease. While few people ever have their houses burn down, we all believe that fire insurance is valuable. Senior citizens should have the same protection from the potentially devastating costs of disease.

Other Coverage Design Issues

BIO also believes that all beneficiaries should have Medicare drug coverage with greater subsidies targeted to those with low incomes. We believe that subsidies should be carefully crafted to emphasize the private market. Some low-income subsidies could have the effect of expanding Medicaid—with the corresponding government rebates and price controls that program entails. BIO believes that the private marketplace offers cost control mechanisms that will not threaten research and development investment. Private sector discount arrangements are made in exchange for movement of market share, while Medicaid rebates are unilateral government price controls.

One issue that we at BIO have spent considerable time wrestling with is the gaps contained in some drug coverage proposals between the initial coverage limit and the attachment of stop loss coverage. Since some of these bills contain no subsidies during these gaps, we are particularly concerned about how the gaps will affect low-income beneficiaries.

Moving Forward This Year

BIO believes that it is important to move forward this year. The Medicare benefit package becomes more antiquated with each passing year, and we believe that the time is now to at least begin the process of bringing drug coverage to senior citizens and the disabled.

We believe that in this environment, the best plans will emphasize stop loss coverage and subsidies targeted to those most in need, as the best interim steps toward more comprehensive coverage for seniors and the disabled. Based on the numbers CBO has provided, we believe that stop loss protection, and some level of subsidies could be affordable. Such a plan would also provide benefits to all Medicare beneficiaries, since all would benefit from the peace of mind that stop loss coverage would offer. Moreover, by taking over some of the risk of rising drug expenditures, government subsidies for stop loss coverage could make primary prescription drug coverage more affordable for seniors.

BIO prefers comprehensive drug coverage in a fully modernized Medicare program. We still think it is important to take the first steps now so that a fully modernized Medicare program can be ready before the new influx of baby boom generation beneficiaries arrives.

Twenty new biotechnology products were approved in 2000. Of the 350 products currently in the pipeline, many are targeted toward Alzheimer's, Parkinson's, cancer, diabetes, osteoporosis and other diseases of aging. The products that make it through clinical trials will be on market before baby boomers retire. BIO's first priority after bringing these new therapies to market is to make sure that patients have access to these new medicines that may save lives and improve overall health and quality of life.

These new products, by reducing hospitalizations and improving overall health could generate savings in the health care system. They will allow people to remain productive longer, with potentially corresponding economic benefits. While we understand that CBO may find these savings difficult to score, we are firmly convinced that they will represent a net benefit to patients in the United States and around the world.

In closing, Mr. Chairman and members of the subcommittee, I invite you to think of a future without Alzheimer's Disease. Think of a future without Parkinson's Disease, without leukemia. Think of a future where cures are targeted to patients where treatments can be highly effective with very limited side effects. In the bio-

technology industry, we firmly believe that these hopes will be realized. However, in order for these visions to become a reality, we must continue to invest heavily in the research and development of new and potentially lifesaving therapies. Moreover, in order for new treatments to have any benefits, the patients who need them must be able to obtain them. This is why BIO believes that coverage and stop loss protection are so important.

Mr. Chairman, I want to commend you for holding this very important hearing, and for your leadership on drug coverage and stop loss coverage issues. I will be happy to attempt to answer any questions you may have.

Mr. BILIRAKIS. Thank you very much, Mr. Chess. The Chair will yield to Mr. Brown now, and advise the members that after his questioning, we will run over, cast our votes, and come right on back and finish up. Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. Mr. Chess, thank you for what you are doing on the Hill, that is a terrific thing, so thank you for that.

Dr. Lambrew, I am intrigued by your chart on Medicare, the marketing versus Medicare prescription drug allocation. Is that a projection of what they are spending on marketing based on last year, or how did you do that?

Ms. LAMBREW. Yes. IMS, which is a private consulting firm, estimated that in 1999 the drug industry spent \$13.9 billion on prescription drug promotion. That includes marketing, advertising, physician detailing—which means going and talking to physicians, giving free samples.

If you take what Mr. Crippen said is a 10.3 percent growth for prescription drugs, and you trend that \$13.9 billion, that is what sums up to \$302 billion over 10 years.

Mr. BROWN. And I have got to think that if you base it on the 2000 figures, it would be significantly higher because I have got to think that the 1999 to 2000 was much bigger increase than that percent Mr. Crippen talked about for the whole.

Mr. Crippen had said—and it was a difficult question to answer, I understand—my question about if we do the tax cut, considering the increase Medicaid costs that are not reflected in the budget resolution, can we provide—with the \$300 million available, can we provide this prescription drug benefit without major cost containment on prescription drug prices?

Ms. LAMBREW. I think it is a good question, and I agree with Mr. Crippen, that it is a hard question to answer. I will say that, you know, irrespective of exactly the dollar amount that a prescription drug benefit will cost, it is a significant investment. Nothing that I have said is meant to say it is not a significant investment. And to the extent that we can figure out not just ways to insure beneficiaries, what this is about and what these numbers are about is insuring them, but it is also about how we contain the costs which are so rampant.

I think there are a lot of ideas on the table about how you do that. There was some discussion about PBMs and multiple PBMs, et cetera. There are also clearly proposals out there that would help do this, but I do think that in light of competing priorities for the Federal budget surplus, most obviously, the tax cut and a prescription drug benefit, there will be increasing attention drawn to this issue of how do we keep the prices low so we can afford a better benefit.

Mr. BROWN. Thank you. One of the sort of presumptions on which this hearing is based is that Medicare fiscally is in big trouble, that we have got to—this hearing isn't just on prescription drugs, it is also on Medicare reform. The President talks about them together. The Republican Majority typically talks about them together.

Share with us your thoughts on the fiscal outlook for the Medicare program—in particular, is it a problem that Medicare needs general revenues to finance benefits?

Ms. LAMBREW. I think it is an interesting point. This Congress, or the past several Congresses I should say, have really done a good job at looking at Medicare and trying to restrain its cost growth when, in 1993, Medicare was projected to be insolvent in 1999. Today, it has the longest prognosis than it has had in its history. It is projected to be solvent through 2028. Now, that doesn't mean that we don't have a doubling of the Medicare population. Truly, there will be a cost pressure as the retirement of the Baby Boom generation takes place. But what are the responses to that?

One is cut provider payment rates, two is to cut benefits, and three is to increase revenue dedicated to Medicare. Dr. Crippen talked about a Medicare per capita cost growth rate of 5.3 percent projected. That is below what the private sector health spending projections are going to be. So, I am not sure how much room there is to address this doubling of the Medicare population through provider payment cuts.

In terms of cutting back on benefits, well, we already know Medicare only covers 55 percent of the seniors' health care costs. And if you look at some work done by Marilyn Moon, out-of-pocket spending for beneficiaries will grow from 22 percent today to 30 percent by 2025. So, I am not sure how much room there is to cut benefits. That does leave a third question about revenues.

As Mr. Crippen said, merging the Trust Funds does nothing for the fiscal outlook of the program. The only way to really add new revenues is to explicitly do that, either through some sort of dedicated tax or through budget proposals like have been proposed in the past, to dedicate part of the on-budget surplus toward Medicare. But I think that the solutions for reform are challenging, and I hope that people recognize that the challenge of prescription drugs is immediate. I hope that we don't hold our prescription drug benefit debate hostage to trying to address these harder, long-term issues.

Mr. BROWN. Thank you.

Mr. BILIRAKIS. Well, I think we are going to run out of time as far as casting the vote is concerned, so with your indulgence, we are going to have to break for another few minutes and run right on back. If I am the only one here, we are still going to go forward. Thank you.

[Brief recess.]

Mr. BILIRAKIS. The committee is back in session. I do want to apologize to the witnesses not only for having to run back and forth, but for the lack of people up here. It is quite an existence up here. We all have so many commitments, and it is very difficult.

Dr. Braun, we just got word—and I haven't gotten the details yet—that BlueCross-BlueShield just pulled out of all three of my counties as far as Medicare.

Ms. BRAUN. Oh, my goodness.

Mr. BILIRAKIS. Yes.

Ms. BRAUN. That is too bad.

Mr. BILIRAKIS. Well, I don't have any of the details yet.

Ms. BRAUN. Your county will suffer like ours, or your counties.

Mr. BILIRAKIS. Isn't it interesting, Dr. Braun, that CBO will not score the savings that you mentioned—for instance, the fact that probably having more drugs available would be beneficial insofar as less hospitalization and less current usage. Do you have an opinion about that? You were in the audience, I know, you were sitting over there. Do you have any opinion about why they just won't take into consideration those savings?

Ms. BRAUN. They are talking about there not being really any evidence for it. I just happened to notice a National Academy of Science report on the decrease in chronic disability over the past few years, and that certainly is due to—I wouldn't be sitting in front of you today if it weren't for—the present-day medicine. I would have had another heart attack, or I would have had a stroke—

Mr. BILIRAKIS. I read that article.

Ms. BRAUN. [continuing] and be chronically disabled.

Mr. BILIRAKIS. And that is evidence, it seems to me.

Ms. BRAUN. I think that is evidence of savings, but I think it probably would be pretty difficult to score, and they like—

Mr. BILIRAKIS. They make it awfully difficult. A few years ago, in a very bipartisan piece of legislation—we added the preventative health benefits to Medicare—but we really had a tough time. We thought that we probably wouldn't be able to even get that through, because CBO would not be very helpful as far as scoring was concerned.

Ms. BRAUN. I was thinking of the immunizations, too, and how many fewer pneumonia cases we have among seniors now, with the pneumonia vaccine and the flu vaccine.

Mr. BILIRAKIS. Mr. Chess, is there data to suggest that paying for high-cost drugs, saves money through a reduction in more expensive treatment?

Mr. CHES. The one area that I am pretty familiar with there is in the diabetes field. There was a study done a few years ago in a Minneapolis HMO with about 3,100 patients that showed that if you were able to control diabetes better—for each point of control that is better, sort of going from 10 to 7, you were able to reduce health care costs, not just the health care costs of diabetes, but the overall health care costs of the patient around anywhere from 30 to 40 percent. And so at least in the diabetes field, there is a very direct correlation between better control of the disease, which really is taking the medicines and having access to them, and lower health care costs, in addition to the most important health care benefit, that the people live longer and better lives.

Mr. BILIRAKIS. Yes. What is the source of that information?

Mr. CHES. We can probably get you a copy of it.

Mr. BILIRAKIS. Would you get that to us as soon as you can?

Mr. CHES. Yes.

Mr. BILIRAKIS. Appreciate that. Dr. Lambrew, any comment on that particular point?

Ms. LAMBREW. I actually would like to make just one comment, which is one demonstration that the last Administration approved was a Medicare demonstration to ask this very question—will covering prescription drugs have any sort of effect on Part A and Part B service use? We just approved that demonstration in January. It is going to be conducted on United Mineworkers enrollees in West Virginia, and we are hoping that we can use that demonstration in Medicare to kind of collect this evidence that would, I think, prove this is common sense.

Mr. BILIRAKIS. It is not going to help us for right now.

Ms. LAMBREW. I am afraid not. I am afraid not.

Mr. BILIRAKIS. Yes, that is going to be taking place. Thank you for your position on the idea of combining Parts A and B. Again, I am not attacking CBO. If there is a representative here, I don't want them to think that, we need them. We have got to be friendly toward them.

But the gentleman, Mr. Crippen, indicated that he didn't think there would be any savings in combining the two, so I won't go into whether you all think there would be savings. But let me ask Dr. Braun, what is the AARP position on that? Any position on combining A and B?

Ms. BRAUN. I think we would have to look at just how you were doing it. As you say, Mr. Crippen seemed to be thinking it would be set up the same way that it is now and just combined. I think there are many other possibilities that people are looking at as to having one deductible and so forth. And there certainly may be some value to doing that, but we would need to know the particulars before we would know.

Mr. BILIRAKIS. That is a good, safe response. Any other comments on that? Dr. Lambrew?

Ms. LAMBREW. I would say very briefly, there basically are sources and uses of spending for Medicare. The sources is really what the Trust Funds are about. What you do is you pool different sources of revenue to offset the Medicare costs.

I think that Mr. Crippen is right, that if you do nothing else but just merge those two Trust Funds, it is the same amount of money and it has no effect on spending.

Mr. BILIRAKIS. Depending on what the deductible is.

Ms. LAMBREW. Well, that is actually a policy change. You have to merge the Trust Funds to change the deductible. I mean, I think they are two separable policies. I will say one thing that does happen, or has to happen if you are merging the Trust Funds is, you have to rethink how much general revenue will be going toward Medicare.

Currently, what we do is we spend 75 percent of Part B costs, those come from the general revenue funds. If you merge the two Trust Funds, you have to answer the question, what now? There is no longer a Part B spending, so what is the general revenue contribution to Medicare? That will create, I think, a big debate. How much is too much? How much should we put in from general revenues to Medicare? And I think in the past, the Medicare Commis-

sion had raised this very issue, and there were concerns because capping it at, say, 40 percent of Medicare spending will actually make Medicare insolvent earlier. It doesn't mean you have done anything to change Medicare spending, it just means you have limited the source of funding. So, I think it raises a lot of questions that will encounter if you go down this path.

Mr. BILIRAKIS. Well, I think Dr. Braun basically said the same thing, that it depends on the details. And you all agree that a stop-loss provision of some sort should be a part of whatever we do.

Okay. Very quickly, I just want to say that everything we get from the White House, and from the majority leadership is that we should have universal coverage of prescription drugs as a part of Medicare, and that it should be voluntary. I am not sure really what the White House parameter is, but I believe that is one of their principles.

I think we would kind of all agree. The only point that the White House is making, is that this idea of the helping hand—which is similar, Dr. Braun, to the legislation that we talked about when you previously spoke here, but that was outside of the scope of Medicare, was only going to be a temporary plan to help needy people right now until we are able to get the whole thing done. And I know that an awful lot of people on the other side of the aisle were concerned that if we do something like that, it takes the pressure off, and then we probably will never do the universal coverage. I would like to think that would not be the case, and I also like to think we won't have to resort to the State-based plans or to the helping-hand type of proposal, but that we will do what we say we are very hopeful of doing.

We have been given a timeline from the leadership. It is a tough timeline to meet, because of all the complexities involved. The seriousness is really there to get the job done.

Having said that, the Chair now yields to Mr. Deutsch.

Mr. DEUTSCH. Thank you, Mr. Chairman. Actually, I appreciate those comments as sort of a segue into the questions I want to focus on. In my introduction when we were doing opening statements, I talked about exactly what you are talking about, that from a policy perspective, I think all of us would want there to be universal Medicare drug coverage, and what we have heard from members—in fact, Dr. Ganske specifically talked to it—and my opening statement and his opening statement about the cost issue. And the President specifically has proposed drug costs for seniors with incomes under 135 percent of the Federal poverty limit, and just to mention those numbers, that is an income of \$11,600 a year for a single person, \$15,700 for a couple. The President's plan would offer partial assistance for seniors who earn up to 175 percent of poverty, \$15,000 a year for a single, \$20,300 for a couple.

Dr. Braun, specifically to you, I know the AARP has done research that seems to point out that a low-income benefit would miss a great many people. Specifically, who would be left out if a target such as the President proposed would occur?

Ms. BRAUN. Certainly, the next group above those who would be helped, would be left out, and that is a big concern because when you are talking about couples income, if both of those couples are on medication, they could be spending a very large proportion of

their income, even if the income is \$20,000 or \$25,000, and then you are talking about a big half of your Medicare beneficiaries. So, it would miss a great many people who very much need help.

Mr. DEUTSCH. I think that is the thing to point out, that the vast majority of seniors are not at, they are getting by, and what could be \$1,000 a month prescription drug bill could obviously make a dramatic difference in their lives.

Could you specifically comment in terms of AARP's position regarding the type of proposal that the President has suggested, which is targeting a drug benefit just for low-income seniors, or does AARP support drug benefit only for low-income seniors? What is your sort of official position?

Ms. BRAUN. I think, in fact, I know AARP wants a universal benefit in Medicare, defined benefit, and the low-income benefit would not do that. I do think, though, that the President is now speaking of universal coverage, as the chairman just said, of universal coverage for all Medicare beneficiaries, and he has also talked about that before. So, one would hope that we would be able to do that this year, and not just do low-income.

Mr. DEUTSCH. Well, you must know something we don't know because, again, based on the comments of this committee, I think they want in a very theoretical sense, but no one is willing to talk about it in a practical sense. And, you know, giving lip service to the theory when the legislation doesn't do that, I really see that as a fundamental divide. Hopefully they have come onboard because I think you are reflective of what most seniors in America and what most Americans want.

Ms. BRAUN. Well, we hope to be able to help you out a little bit, help the committee out a little bit next month, because we have actuaries working on plan designs and what would be acceptable for beneficiaries and so forth, which is a question that committee members have asked frequently. So, I hope we will be able to give you some help in another month or so on that.

Mr. BILIRAKIS. Would the gentleman yield? You say next month you are expecting that information?

Ms. BRAUN. I understand that we could have something.

Mr. BILIRAKIS. Could you get that to us? As I say, we are on a fast-track. And we are always concerned about unintended consequences and about haste making waste. The more help you can be, the better. Thank you.

Mr. DEUTSCH. Again, in terms of any specifics that we have seen, I have seen no proposals, and I would love that there existed—and I know the chairman is well-intentioned in terms of where he wants to see the policy ending up—but in terms of specific proposals from any Republican for universal coverage, as you defined, as an additional benefit for Medicare, I have not seen that. And if there is a specific thing that exists, I am happy and hope we can do it on a bipartisan basis, but I think that really is a policy divide that exists at this point.

What the President has proposed is a catastrophic protection coverage for all seniors with very high drug costs, and although this level is not defined, it would mean a lot more seniors would benefit, or would most seniors be left out of that type of situation, if it is just a catastrophic coverage in terms of drug costs.

Ms. BRAUN. Well, I think we have the same problem if it is just catastrophic and low-income. I think we really need a universal benefit in Medicare so that we pick up all of the people.

Mr. DEUTSCH. Let me just give Dr. Lambrew or Mr. Chess, do you want to respond, just in terms of the policies?

Mr. CHESSE. Well, I think the only thing I want to mention there is in terms of BIO and our members—our focus, given the resources available, has really been around low-income coverage and stop-loss, and with stop-loss obviously—you know, there are various proposals out there in Congress regarding what appropriate levels are. We really don't speak for that. But we view it very much as actually a benefit for all seniors because, while every senior may not necessarily draw on drugs up to the level of the stop-loss, all of them would benefit from the peace of mind that it would give. It is very much like I buy fire insurance at my house, and while I assume my house isn't going to burn down next week, it does give a lot of peace of mind and a lot of comfort knowing that we have that covered and we have that situation that we don't need to worry about. So, in some ways, we view it as a benefit for everyone, though not necessarily every person, may necessarily be drawing on it each year.

Ms. LAMBREW. I would like to make two quick comments. One is that I think that Mr. Crippen said that about \$1 trillion of the \$1.5 trillion that is projected to be spent on Medicare beneficiaries for prescription drugs is below some pretty low threshold. I thought he said \$1,000, but I would have to go back and look. So, even though I agree that insurance is important, we can't forget that the dollars are often for people who don't have spending that high.

And, second, on the low-income benefits, as Dr. Braun said, we do miss many, if not half, of the uninsured beneficiaries who lack prescription drug coverage, but it is also important to note that the policy itself will miss low-income beneficiaries. First of all, we know that States are not that interested in doing the type of policy. The National Governors' Association testified to the Senate Finance Committee saying this should be a Federal responsibility. It is not like the Children's Health Insurance Program where all States were supportive. So, it is not clear that all beneficiaries in all States will have access to this.

And, second, within those States even that do expand, it is not clear that all beneficiaries will participate. Mr. Crippen said that he does think a stand-alone, State-only drug proposal has lower participation than providing a Medicare benefit and having States wraparound. Truly, the best way to help low-income beneficiaries is to provide a Medicare benefit and have States provide that extra assistance for low-income folks.

Mr. BILIRAKIS. The gentleman's time has expired. And the Chair appreciates the gentleman from Tennessee and Mr. Deutsch for having returned to the hearing.

Mr. BRYANT. Thank you, Mr. Chairman. I have about 5 minutes, and an office full of songwriters waiting on me, so I am going to be brief here.

Dr. Braun, I wanted to ask you, in your statement—and this has to do with making sure that any plan we have does not affect an existing plan in a way that would be detrimental or even deter per-

haps other people from providing this benefit—you say making enrollment attractive and affordable requires a careful balance of covered benefits and government premium subsidies.

I am wondering, too, what AARP's position is on a mandatory date, if we have a program of requiring an opt-in/opt-out, a date to enter or not enter, one-time position. To me, that would be encouraging, too, if you had to make a choice. Does AARP have a position on that?

Ms. BRAUN. I don't think we have a specific position, but we certainly realize that that is probably going to be the route that we are going to have to go because, otherwise, people will wait and you won't get the healthy people into the pool because they are going to wait until their drug costs are going up, and then you don't have an insurance program. What you have then is just paying, like you do with Medicaid now, just for drug costs. So, I think you are going to have to have that sort of arrangement.

Mr. BRYANT. I agree with you. I come from the insurance business of defending companies, you know, we couldn't have people having a car wreck and then coming in trying to get the insurance after-the-fact. The pool doesn't work so well that way.

Dr. Lambrew, on this chart, I am interested in that in terms of spending of the drug industry roughly equivalent to what our budget resolution would have in it. I have heard that before in terms of criticism of the drug industry, and given all the reasons they would advertise, like anybody else—I mean, I suppose they have a right like anybody else in the First Amendment and so forth—and, as well, they have a relatively short period of time—I say relative—to recapture their profits and their expenses on not only that drug, but others that don't make any money for them under our patent laws. Is there really any relevance to this? I mean, how and why would we want to stop them from advertising?

Ms. LAMBREW. I probably should make it clear, what this chart is intended to do is not necessarily say this is wrong, or this shouldn't be happening, or we should use some of the savings for a Medicare drug benefit. Instead, the goal of this chart is to say \$300 billion is not that much. I think that we have a situation where policymakers are focused on dollars, and we have a process that forces you to be focused on these dollars because the Budget Committee and the budget resolution say this is how much you all should be spending in the committees to do things like drug benefits.

So, this is just basically to say, look, put aside how much is being spent on actual prescription drugs. If you just look at drug promotional costs alone, it is about the same that we're considering spending on all 39 million Medicare beneficiaries. It is not intended to say, this is inaccurate or wrong or something we should be looking into.

Mr. BRYANT. I have been in and out, I didn't hear all of the testimony. I do know there is that criticism from some in Congress, and somehow trying to tie the two together, and I don't know realistically how or why we would want to do that.

Mr. Chess, I don't know if you have any comments on that issue, but recalling your testimony, I had a couple of questions I wanted to ask you. I am trying to remember what my question was. It is

on your comment about do no harm to current coverage and reimbursement. I think it is a similar one I asked Dr. Braun. Any ideas there in terms of a mandatory day, or any other ideas of how we could not—would not do any harm. And also, I guess, any comment you might make on the related question I asked Dr. Lambrew, coming from the industry and talking about the numbers in the first part of your statement about how expensive all this is, and how—I am shocked that there are that many companies that far in debt. You have got some great venture capitalists that will underwrite this, but it is—and I don't think people on the outside understand, appreciate it, because the drug companies are the whipping dog right now, but how much is involved in researching and developing and marketing a drug before you ever make the first penny on it, and if we don't do that, and if we had price caps, for instance, that is not going to happen, and we are not going to have these new technologies and new drugs. Did I lead you enough on that one?

Mr. CHES. I can certainly tell you enough in our situation. I mean, I think I mentioned that we got started in 1991, and what we had to do was develop a whole family of technologies—make this powder, also how to process the powders, how to get them to be stable for years, how to make this device. It took us several years to figure out that. Then you need to go through several years of clinical testing, and then on an individual drug, you know, things that enter clinical testing—you probably know the statistics—about 1 in 8, 1 in 10, make it to the other side. And we have had, in the history of our company, to go out—it is funny—13 times in 1 year. We do more than one financing a year, just to kind of keep this alive. And the basis of it all is really around, you know, when the product gets out there, we think it is going to deliver a huge amount of value and be able to price it from a value side.

One anecdote, if you don't mind me sharing, is when we first went out on inhaled insulin, which is the product that we are most known for, we talked to U.S. and European companies to partner with them. And we found we couldn't get any interest out of the European companies because they were unsure how their pricing authorities would deal with the product. And if we were a European-based company and only had companies that were basically government entities or other types of entities that were dealing with it, and you couldn't value price our product—we never would have raised the money and we never would have gotten our product as far as we have. And I don't think that is uncommon in our industry.

In terms of your question, sort of on advertising, most of us are in the same boat in our business. We haven't gotten to the point where we have to worry about that yet, but I can certainly say for a product like ours, making consumers aware of it, I think, is actually a valuable service for them. Where you are giving a more convenient therapy you want people to know that they have choices out there. So I actually think there is a component of it that is actually education in addition to a component that may actually be product advertising.

Mr. BILIRAKIS. The gentleman's time has expired. I wish the ranking member, Mr. Brown, were here to hear the anecdote that you shared with us.

We are finishing up. First of all, I hope that you accept the fact that we are serious about doing something. We have got to work together. Mr. Deutsch spoke about bipartisanship and that sort of thing. Well, we ought to concentrate on what is at hand, and what is at hand is trying to do something regarding prescription drugs. If we get off onto too many issues which are behind us, it doesn't do any good. Right now we are trying to do something with prescription drugs, and if we are all serious about doing it, we are going to get it done.

Mr. Chess, I understand you have had to pass up meetings with the Speaker and with other leaders in order to be here all day long, and we very much appreciate it, and appreciate, of course, Dr. Braun and Dr. Lambrew being here.

Again, use us. We will have written questions, as we always do. We expect that you would be willing to respond to those but, at the same time, please take the initiative. Any ideas you have, suggestions—Dr. Lambrew, you mentioned a number of things—please share them with us because it is a tough job and we have a short period of time to do it in, and you can only be helpful. Thank you. Thank you so very much. The subcommittee is adjourned.

[Whereupon, at 2:02 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

PREPARED STATEMENT OF PHARMACEUTICAL RESEARCH AND MANUFACTURERS
ASSOCIATION OF AMERICA

America's innovative pharmaceutical industry welcomes the opportunity to share its views at today's hearing about an issue that is vitally important to all of us—prescription drug coverage for seniors and disabled citizens. Across America, 40,000 scientists in our research labs work day and night in hopes of finding the next cure or the next treatment to allow individuals to live long, healthy, and productive lives (see attachment). On average, it takes 12 to 15 years and \$500 million to develop a new drug and bring it to market.

Today, industry has more than 1,000 new medicines in development to treat hundreds of serious illnesses including Alzheimer's and Parkinson's diseases, cancer, stroke, arthritis, and depression. We are confident that, in time, we will find the cures for these and other conditions that are so prevalent among our aging population.

The 21st century brings even greater promise. As the human genome is mapped, many new targets for pharmaceutical innovation will be identified. Today's 500 or so targets for drug interventions are expected to increase to 3,000 to 10,000 targets in the near future. When these treatments and hopefully cures are brought to market, we want to ensure that seniors have access to them—without discouraging the discovery and development of new medicines.

We believe there is bipartisan consensus on four key points :

First, expanded drug coverage for seniors will happen. The question is not whether it will happen, but when, how, and with what effects on the quality of health care for seniors and disabled Americans and on drug discovery and development. If we work together, it could happen in this Congress. Most Medicare beneficiaries have prescription drug coverage through their (or their spouse's) current or former employer, a Medicare supplemental insurance (or Medigap) policy or a Medicare+Choice plan, or by qualifying for Medicaid or other governmental programs. But many of those who do not have the coverage they need require additional assistance. The pharmaceutical industry wants to be part of a sound, market-based solution that will help all patients today and into the future.

Second, expanded drug coverage for seniors will be a positive development. Prescription drugs are increasingly the most effective and cost-effective therapy with which to treat diseases or conditions. Some Medicare beneficiaries are in

need of prescription drug coverage and our medicines provide extraordinary value to them.

Third, as we expand drug coverage for seniors, we must sustain the American pharmaceutical industry's worldwide leadership. The industry has developed new medicines that benefit all patients—young and old—and their families. We do not want to harm the environment in the U.S. that has allowed our industry to thrive. In the 1990s alone, 370 prescription drugs, biologics, and vaccines developed by industry were approved for patients' use with a physician's prescription. Almost half of the globally important new medicines in the world are discovered by the U.S. industry. We are the world's leader in pharmaceutical research and development.

As we work together to expand access to prescription drug coverage, we must remember that Medicare beneficiaries want access to new medicines *because they were invented*.

Finally, we need to always remember to put the interests of patients first. In an environment where we discuss 10-year forecasts, adverse selection, risk pools, and premium calculations, we must not forget that the real focus is on patients. Our goal should be to expand Medicare drug coverage in the way best for patients, their children, and their grandchildren—who need access today to medicines already developed, and who also depend on the pharmaceutical industry to continue to lead the way in developing new medicines and hopefully cures that exist today only in our dreams.

THE PHARMACEUTICAL INDUSTRY SUPPORTS EXPANDED PRESCRIPTION DRUG COVERAGE FOR ELDERLY AND DISABLED AMERICANS

Since February 1999, the pharmaceutical industry has strongly supported strengthening and modernizing Medicare, including expanding Medicare coverage of prescription medicines. We believe that the best way to expand prescription drug coverage for Medicare beneficiaries is through comprehensive Medicare reform. The current program is based on a 1960s-style, one-size-fits-all model that relies on centralized price controls and complex regulations. The result is a program that is confusing for patients and providers, difficult to administer, and inadequate to meet the health care needs of the 21st century.

If the Congress decides to pursue instead interim expansion of drug coverage through private-sector insurance (using choice and competition to ensure quality and contain costs), PhRMA can be supportive so long as the interim measures would improve, rather than impede, opportunities for future comprehensive reform.

With respect to the delivery system for any proposal, law and policy makers need to ask:

- Should the drug benefit be delivered by the government or the private sector?
- Should the benefit be a single, one-size-fits-all program, or should seniors and disabled beneficiaries have a range of choices?

We believe several principles are key components of any interim proposal. As Congress continues to grapple with this complex issue, we will support proposals consistent with these key principles:

- All beneficiaries would have the ability to enroll in a private insurance coverage plan of their choosing, ranging from private fee-for-service to HMOs and various private-sector options in between.
- Federal subsidies would help low-income beneficiaries afford coverage.
- Plans would provide coverage for beneficiaries with high pharmaceutical expenditures.
- Beneficiaries would have access to all medicines.
- Plans should be overseen by a new government entity.
- The new program would be consistent with, and a step toward, needed comprehensive modernization of the Medicare program.
- Coverage would be offered through competing, private insurance or health plans that rely on marketplace competition to control costs and improve quality.

Government price controls are unacceptable because they would inevitably harm the industry's ability to develop new medicines for patients. We urge you to say "no" to price controls in any form, not direct price controls, not indirect price controls, not by design, not by accident, not by stealth, not by baby steps.

A PRIVATE INSURANCE INCREMENTAL APPROACH WILL BEST SERVE PATIENTS TODAY AND TOMORROW

The pharmaceutical industry believes that if Congress decides to provide an incremental prescription drug benefit, the best approach would be to provide seniors access to private insurance products. This approach would fit easily into the current

marketplace, since well over 150 million people get their drug coverage through private entities. In delivering drug coverage, these private entities would do more than simply pay the claims. They could provide disease management programs, drug utilization review, patient education, and help to reduce medical errors. We in the research-based pharmaceutical industry believe that seniors and disabled beneficiaries would benefit greatly by having access to these private insurance products, with the government providing subsidies for those in need.

Skeptics point to complex issues, such as “adverse selection,” and claim that a private insurance program will not work. Adverse selection can occur because individuals purchase insurance only when it is in their best interest. If an individual could purchase insurance at any time, it would be perfectly rational for them to wait until they were sick. Consequently, insurers often place limits on when individuals can purchase insurance and under what conditions.

Recognizing that adverse selection is an important issue, we asked the experts for assistance. We turned to leading actuarial and economic firms, including Milliman and Robertson, Abt Associates, and Towers-Perrin. These actuaries and economists note that a private prescription drug insurance program can work if designed properly. They also note that adverse selection is “one of the most difficult issues in designing *any* insurance program involving individual choice.” Actuaries and economists have several tools to minimize the impact on adverse selection. These include:

- Limiting election opportunities for enrollment;
- Providing low-income subsidies for premiums and deductibles;
- Establishing a high-risk pool for enrollees with very high expenditures;
- Requiring up-front cost sharing, such as an annual deductible; and
- Allowing insurers to negotiate with manufacturers and distribution networks to reduce costs.

We believe that a properly designed prescription drug insurance benefit would attract many Medicare purchasers and many private market sellers. Why are we so confident? In the market today, there are private *health* insurance policies for cancer, sports accidents, emergency room visits, pregnancy complications, and campers. There are private insurance products for goats, carriage rides, and the weather on the day of your daughter’s wedding. We believe that there are similar opportunities for private-market solutions to increase access to prescription drug coverage for the elderly and disabled Americans.

CONCLUSION

The pharmaceutical industry supports expanded drug coverage for seniors and disabled Americans—done the *correct* way.

Some say that this issue is life or death for the pharmaceutical industry, America’s premier high-technology industry. After the debate is over and the dust settles, we will still have a pharmaceutical industry—but depending on what you do, the industry could be profoundly different, and the results for patients could be demonstrably less. As the debate unfolds, we hope you’ll remember the millions of Americans and their families waiting impatiently for new treatments and hopefully cures. We can provide quality health care for seniors and the disabled, including better prescription drug coverage, but we need to do it the *correct* way. If we do it the wrong way, the industry and the patients we serve will undoubtedly suffer the consequences.

ATTACHMENT

THE RESEARCH-BASED PHARMACEUTICAL INDUSTRY: FACTS AT A GLANCE

A Strong Commitment to Research and Development

- This year, research-based pharmaceutical companies will invest \$30.5 billion in research and development (R&D) on innovative new medicines. This represents an increase of 12.5 percent over research spending in 2000. Since 1980, research-based companies have multiplied their R&D investment 13-fold.
- Domestic R&D is expected to increase by nearly 18.2 percent in 2001.
- R&D conducted abroad by U.S. based companies will grow only 1.02 percent—a clear sign that the American system nurtures innovation and discovery.
- Over the past two decades, the percentage of sales allocated to pharmaceutical R&D has increased from 11.9 percent in 1980 to approximately 20.3 percent in 2000, higher than virtually any other industry. The average for all U.S. industries is less than four percent.
- Approximately 36 percent of pharmaceutical R&D conducted by companies worldwide is performed in the United States, followed by Japan with 19 percent.

- This U.S. industry investment is very efficient. Of 152 major global drugs developed between 1975 and 1994, 45 percent are of U.S. origin.

Drug Discovery and Development Are High-Risk

- During the 1990s, the average time it took to discover, test and develop a single new drug increased to nearly 15 years. This was almost twice the development time in the 1960s.
- Of every 5,000-10,000 compounds tested, only five enter human clinical trials, and only one is approved by the FDA for sale in the U.S. Of every 10 medicines in the market, on average, only three generate revenues that meet or exceed average R&D costs.
- The Boston Consulting Group estimates that the pre-tax cost of developing a drug introduced in 1990 was \$500 million, including the cost of research failures, the opportunity cost of capital over the period of investment, and the increasing cost of clinical trials.

Medicines in Development

- The research-based pharmaceutical industry currently has more than 1,000 new medicines in development to treat hundreds of serious diseases.
 - There are nearly 1000 biotech medicines in the pipeline to combat scores of diseases. Almost half the medicines—402—are for cancer, the second leading killer of Americans. Biotechnology and new technological tools have revolutionized cancer research.
 - Among these drugs and biologics in development are promising new treatments for cancer, heart disease, Alzheimer's, AIDS, diabetes, multiple sclerosis, Parkinson's, stroke, rheumatoid arthritis, and depression. The

Value of Medicines

- The estimated life expectancy of an American born in 1920 was 54 years. By 1965, life expectancy had increased to 70 years. The average American born today can expect to live more than 76 years, and life expectancy has risen dramatically for all age groups. Every five years since 1965, roughly one additional year has been added to life expectancy at birth. These improvements in life expectancy are due to advances in medicine and our improved ability to prevent and treat disease:
 - Antibiotics and vaccines have virtually wiped out such diseases as diphtheria, syphilis, whooping cough, measles and polio in the U.S.
 - The influenza epidemic of 1918 killed more people than all the battles fought during the First World War. Since that time, medicines have helped reduce the combined U.S. death rate from influenza and pneumonia by 85 percent.
 - Over the past 30 years, innovative medicines have helped reduce deaths from heart disease and stroke by half, enabling 4 million Americans to live longer, better lives.
 - Since 1965, drugs have helped cut emphysema deaths by 57 percent and ulcer deaths by 72 percent.
- In a year-long disease-management program for about 1,100 patients with congestive heart failure run by Humana Hospitals, pharmacy costs increased by 60 percent, while hospital costs (the largest component of U.S. health care spending) declined 78 percent. The net savings were \$9.3 million.
- A National Institutes of Health (NIH) study showed that while it initially costs more to treat stroke patients with a clot-busting drug, the expense is more than offset by reduced hospital rehabilitation and nursing home costs. Treatment with the clot-buster costs an additional \$1,700 per patient, but reduced hospital rehabilitation and nursing home costs result in net savings of more than \$4000 per patient.
- According to a study published in the *New England Journal of Medicine*, the use of ACE inhibitor drugs for patients with congestive heart failure reduced mortality by 16 percent, avoiding \$9,000 in hospital costs per patient over a three-year period. Considering the numbers of people at risk for congestive heart failure, additional use of ACE inhibitors could potentially save \$2 billion annually.
- According to a study conducted at the University of Maryland Medical Center, patients treated with beta-blockers following a heart attack were up to 40 percent less likely to die in the two-year period following the heart attack than the patients that did not receive the drugs. According to another study, use of beta-blockers resulted in an annual cost savings of up to \$3 billion in preventing second heart attacks and up to \$237 million in treating angina.
 - Unfortunately, a study published in the *Journal of the American Medical Association* found that only half the people who could be helped by these medicines are getting them.

- Estrogen-replacement therapy can help aging women avoid osteoporosis and crippling hip fractures, a major cause of nursing home admissions. Estrogen-replacement therapy costs approximately \$3,000 for 15 years of treatment, while a hip fracture costs an estimated \$41,000.