ALLIANCE FOR HEALTH REFORM

MEDICARE PRESCRIPTION DRUG CARDS: WHAT ARE THEY? WHAT ARE THEY WORTH?

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WASHINGTON, DC

SENATOR BILL FRIST (R-TN): Everybody keep eating, but I'd like to welcome everybody to our Alliance for Health Care Reform topic, which is, "Medicare Prescription Drug Cards: What are they and what are they worth?"

We will spend the next hour and a half, we'll stay pretty much on time, addressing what is a very important issue, and a very current issue for many of us who are involved in health care and health care reform.

The September 11th attacks have shifted the nation's focus, very appropriately, given the task before us, and in some ways has altered, in many ways has altered our legislative priorities over the past 60 days and, indeed, for the remainder for the 107th Congress, that first session at 107th Congress.

But it is critically important, it's imperative that we continue to address the fundamental issues in health care, in modernization of health care and the various areas, whether it is Medicare or Medicaid or addressing the issues of the uninsured or the private insurance market.

Medicare reform, our medical and scientific knowledge has increased exponentially over the last 36 years since Medicare was created. And Medicare has done a tremendous job and I have been one of the real beneficiaries of having the opportunity, before coming to the United States Senate, of participating in a very intimate way, having taken care of thousands and thousands of Medicare patients, written thousands and thousands of prescriptions, and seeing the great benefits of having a program which reaches out and addresses the issues surrounding health care and health care security for individuals with disabilities, as well as our seniors.

There are gaps in coverage and, in truth, we've not done as good a job as we might, as we look inwardly, and I'm talking about the policy makers in the United States Congress, in filling gaps which occur naturally in a field that is changing rapidly, and that is health care delivery, and the policies which set the framework surrounding how that care is actually delivered.

And that is really what we are all about, how to fill those gaps, at the same time we are engaging in larger Medicare modernization. As the Medicare program prepares to enter it's fourth and fifth decade, really, I guess more the fifth decade, those demographic, the financial, the budgetary and health care quality challenges facing the program. We all know, we all recognize, no matter what happens in the world or in this country, those demographics are indelible; they're there, they're changing everyday and

they are predictable.

We have rising health costs, the shifting demographic landscape really do pose unmistakable threats for the long term integrity of the program that we are so, in many ways, blessed to have. We gotta really mustard the political will, and I say that because it is easy to lose focus on what is important as we fill these gaps, these holes in the program's benefit package, as we reduce the paper work and the burden that falls on the shoulders of the women and the men who are on the front line.

We need to improve the quality of care that individuals with disabilities and seniors receive. We need to, I believe, have a more flexible framework that accommodates all the rapid changes that we see in science, in healthcare, delivery and, indeed, we need to address the financial footing in light of these demographic changes, coupled with the cost imposed by expanding expectations, changes in technology, and other issues.

President Bush, I believe, really understands these challenges well and the need to confront them head-on. In July, he outlined a set of principles that in many ways demonstrate the Administration's commitment to strengthening Medicare and improving Medicare.

The issue that we're gonna be talking about today is not a substitute for reform or for a drug benefit, I believe, but the prescription drug card does have the potential to provide some real benefits and relief to seniors, if it is implemented appropriately, and that's the discussion that we will have today.

I believe with that I will stop my comments. I'll turn to Ed Howard just, let me make a couple of comments. First of all, all of you know because many of you have been here many times before. We will have a question and answer period. We will limit each speaker, and I'll be cutting them off, or somebody--I'll have Ed cut them off at eight minutes sharp. But the whole purpose is to help you understand what this issue is. The strengths of it, the weakness of it.

Personally, I'll be listening. And my purpose here is to listen and to share with my colleagues as we go forward. We do have green cards in your sheets. You can write questions on there. We're always overwhelmed with questions, so I would prefer that you go to the microphone and ask your questions. Identify who you are.

You can make a very short statement, to make a point if you would like, keep it very short. Because the real purpose is to take advantage of superb speakers who are with us today and to really discuss with them and hear their thoughts, so that we can all be educated in a way that we might not otherwise be.

The purpose of this hour and a half is that you leave much better educated, and this is the way I look at it, and that I leave much better educated about the topic at hand. And this is a current topic, a topic that we will be addressing in some shape or form, at the policy level and at the factual level, over the next several weeks at the most. Ed?

MR. ED HOWARD: Thank you, Senator. I'm just going to be extremely brief. I would add that, in addition to question cards in your materials, you have evaluation forms, which we would ask that you fill out before you leave. That would be much appreciated and remind you that if you want to check on what you have heard, you can later today look at the video of this event and most of the materials that you will find in your packets on kaisernetwork.org.

My task is to very briefly, and in no way and in as fulsome praise as they deserve, introduce our panelists today. Tom Scully is the Administrator of the Centers for Medicare, Medicaid Services. Tom is appointed my members of voices to head that agency, of course, that over sees Medicare and Medicaid back in April. Before that, he was President of the Federation of American Hospitals and, before that, a Bush Senior White House staffer, and an Associate Director for human resources at OMB.

Let me go ahead make and introduce all the folks so we won't disrupt the continuity.

Craig Fuller, on my immediate left, is President and CEO of the National Association of Chain Drug Stores, which represents the chain pharmacy industry. And, before that, Craig served for eight years in the White house, assistant to President Reagan and Chief of Staff of George H. W. Bush.

Marilyn Moon, is Senior Vice President—I'm sorry, she is not. She is a Senior Fellow at the Urban Institute. I almost moved into the private sector proprietary part. She is also one of the country's best known experts on Medicare issues. She served as a public trustee for the Social Security and Medicare Trust Funds. Holds a Ph.D. from the University of Wisconsin, Madison, was an Associate Professor at the University of Wisconsin, Milwaukee.

It was Jeff Sanders who is a Senior Vice President at Advance PCS, which is a pharmacy benefit management company in Scottsdale, Arizona. Jeff has been Director of the Office of Legislation and Policy as what was then the Healthcare Financing Administration. He worked at the Office of Management of Budget and the Senate Budget Committee, some of you may know.

On Craig's left is Judy Feder, Dean of Policy Studies at Georgetown University. She is an expert on health and long term care financing issues. She has served as HHS Assistant Secretary for planning and evaluation and had a key role in putting together the Clinton Administration's Health Policy.

On Judy's left is Joe Kennedy. In 1998, Joe Kennedy returned after a number of years in Congress to Citizens Energy Corporation, which he had founded back in 1979. Took over as Chairman and President, and took a particular interest in the citizens health initiative. That's designed to address the issue of high prescription drug costs and how to reduce costs for seniors who can't afford to their medications.

The Citizens Health Card Initiative is a membership card that provides discounts on the costs of prescription drugs. And I particularly want to thank Joe Kennedy for getting here, because I know he was just in town last week and had to schedule a bunch of things over again to join us, and I am very

happy to have you here. Let me turn it back to Senator Frist and we'll get on with the program.

SENATOR FRIST: With that, we will start right in. Again, we'll stick with about eight minutes, and we will proceed in the order that people were introduced and, write your questions down or we will go to the microphone after everyone presents. Tom Scully.

MR. THOMAS SCULLY: Thanks. I'll zip through hopefully the slides here in a second. I started working on this issue in 1989, trying to save catastrophic healthcare with what some of these people in this room. It failed miserably, hopefully, this effort will go a little better.

We have been interested, I have been interested in the Medicare prescription drug issue for a long time and I think this is another step. Anyway, if you'll flip up that first slide there. President Bush's quote on the AARPs. I think the point to make here is that we do not see this an answer to Medicare prescription drug. There is a lot more we have to do.

We look at this as a first step, the President looks at it as a first step. The AARP has been very supportive of this initiative and I think it's because they look at as the first step. It's not a substitute, it's a common sense way to get a drug benefit going. You flip to the next one.

Why do we think it will work? The whole goal here is to pool seniors' purchasing power. If you are under 65 years old, and everybody in this room, whether they know it or not, is almost certain to be a member of PBM, and you're buying your pharmaceuticals in—under a significant discount to what seniors pay.

The only people in the world that walk up to a pharmacy counter right now and pay over the counter prices are the uninsured and seniors and we think that's nuts. So we are trying to get that changed. And the issue is to get the ten million people that have no prescription drug coverage at all that are on Medicare, and seven million that have prescription drugs for part of the year, pooled into big purchasing groups.

That doesn't mean--we understand and we'll talk today, I'm sure, about the concerns this causes the pharmacists, but the goal here—and we're very concerned about pharmacists, the goal here is to give these seniors, who are the victims of a huge cost shift--they're paying artificially a lot more than anybody else, to get them the discount that they need to be buying in the market, the way everybody in this room that's under 65 already does.

Let's just flip to the next one. The goal here is the major Bills, whether it's Mr. Thomas' Bill in the House, or Senator Graham's Bill in the Senate. Anywhere from 30 to 60 percent, it's about 60 percent of the saving according to our actuaries of Mr. Thomas' Bill, about 30 percent of Senator Graham's. A big chunk of the savings of any of these Bills for seniors come from getting people into group purchasing pools, which are basically exactly what we are talking about here.

So, you know, no matter what you pass, because we haven't been able this year to pass a major

Medicare prescription drug benefit, it would have taken 2-3 years before anything happened. As it is, it is likely to be 3-4 years minimum before you really get to the point where you phase any major prescription drug Bill.

But this is the underlying key and the common denominator of every major Bill out there, that's Republican and Democrat. In our view, is why wait? We have to get started now. We have to get these things in place to start learning how to make it work.

An important point that the AARP always makes is, lets say you could pass a prescription drug benefit this year. Nobody in the government has any experience, and my agency's likely enough to carry it out, in putting together a massive Medicare drug program for seniors. Nobody knows how to do it. So, even if you are starting to phase in a program, it makes a lot of sense to get CMS and seniors experience on how to carry out at the point of sale, at the pharmacy counter.

How do you get a senior to walk into CVS or a Walgreens and get, you know, access to prescription drugs through their Medicare card right now? We have no idea how to do it. Getting the pipeline working, getting the mechanisms working, to figure out how we're gonna get there is important. I don't think that anybody could tell you that you can to it tomorrow. We need to get the whole process moving. That's the point of that.

Switch to the next one if you would. Who benefits the most (inaudible) beneficiary with no drug insurance? The people that do have Medigap insurance, if you are familiar with it, Medigap really does not have any comprehensive drug insurance. Anybody that's in Medigap, it's basically fee-for-service, very flimsy, no network drug insurance. So you are talking about the ten million beneficiaries with no drug insurance.

All the many beneficiaries in Medigap that do have insurance coverage, it's very, very skimpy, unorganized, unstructured coverage, and there is an increasing number, 676,000 in M&C plans, and actually, as of this year, it's probably a larger number of people in Medicare Plus Choice that do not have drug coverage.

Flip to the next one, if you would.

How would it work? The whole issue here is to get comparative pricing in the drug system. The reason this is different than the existing drug card is that there is a lot of misinformation about this, is that essentially there are a ton of voluntary drug cards out there, Walgreens, CVS, pick what you have. A lot of the PBMs have them.

The bottom line is, when you walk into Merck or Pfizer and try to get a discount as a PBM currently, you walk in and they say you can't guarantee us any volume, why should we give you a discount? And you don't get a discount, because seniors have six, seven drug cards in their pockets.

The goal here is to use the power of Medicare, to use our marketing system, to basically give the good

seal of approval through Medicare. And say, look, we had 28 applicants. We expect it to be somewhere between 9 and 15 that actually succeeded. They say look, we are going to use the power of Medicare and the marketing of Medicare to get seniors into a system where they call up and they'd enroll in these plans and we'd get much bigger, exclusive coverage.

The requirements for the program where you sign up with one plan for six months. We knew that we were going to have this fall advertising campaign, which hopefully some of you have seen with Leslie Nelson, advertising 1-800-Medicare. Our goal was to get—we've had on average 34,000 seniors a day calling this 1-800 lines. We peaked at over 65,000. And what we wanted to do was to get those people, at 50-60 thousand a day, calling 1-800-Medicare, asking questions and saying, oh, by the way, I'd like to have the drug discount program.

The goal was to enroll these folks in one of the drug discount cards. Let's say if you called them from Philadelphia and you said I'm interested in the following and I take X-Y-Z drugs, to enroll these people for six months in one drug card. What that gives you that doesn't exist in the current retiree systems now, is volume exclusivity.

Right now, you walk into Merck and want a discount, and you are at the AARP card express scripts, they say forget it. You can't deliver seniors. They've got six cards in their pocket.

What we are trying to do basically is to have the PBMs and the other people, whether it's Walgreens who applied or others, to show up and say we have a million people on our plan, we have two million people on our plan. You know what? We're certain that they're only in our plan so we can deliver volume. That is how we move to get rebates and discounts from the manufacturers. Right now, there is no market share.

Blue Cross in Virginia, the reason they get rebates for all the people in this room under 65 is because they can guarantee membership. They guarantee that they have all those bodies and they're in their system. In the over 65 market, you can't get that and that's why there is no manufacturing rebates. So we are trying to use the good name of Medicare in our–obviously expansive marketing campaign this fall, to get people into prescription drug discount cards. We could walk into the manufacturers, guarantee volume, and get discounts because that's what we think seniors deserve.

Other things in here, which a lot of people—there's been a lot of misinformation about. We don't allow mail order only cards. We require all applicants to have an extensive pharmacy network. I'm probably running close on my eight minutes. Let me flip quickly to the next one, and I'll flip through.

The bottom line is the goal here was to enroll people in large groups and be able to guarantee volume to get discounts to give seniors much more information about prices, something that's not widely reported on was when the plan originally came out, we were gonna require everybody that participated in this plan to publish their prices on the Internet, on a consumers Website this January for a year. And those were AWP-minus prices, which frequently don't tend to mean much but, next January, everybody that participates in this plan would be required to publish all their prices and the drugs they cover on the

consortium Website. That is a big, big change in behavior.

When seniors can figure out where to go to get drugs on a Website and compare prices on compare networks, that's gonna move a lot of behavior and a lot of volume, and start getting seniors the same discounts that all of you that are enrolled in Blue cross or Kaiser, whatever it is under 65 are already getting.

Anyway, I think I've already--I haven't seen anybody shoot up a sign yet on my eight minutes, but--. The goal was to link the–endorse it with high quality. The--pass rebates on through seniors, you're gonna see that, when this regulation comes out, sometime in the next ten days, which is gonna have a lot more meat on the bones than the original proposal did—

SENATOR FRIST: You've still got four minutes.

MR. SCULLY: Oh, I do. Hey, I'll slow down. You're gonna find there will be a lot more information there about how the rebates will be passed on to seniors, about how we're gonna publish comparative information on final prices, about how the discounts will work, and about the customer service that we will provide for the members.

Why don't you flip to the next one, if you would.

Medicare will require each of endorsed card to meet certain marketing materials and guidelines. As I have said, to publicly disclose the prices, to conduct extensive beneficiary education, to have a grievance procedure in place, because obviously we're very aware that, when you start enrolling seniors into voluntary programs, there are going to be people that are gonna be upset. There's gonna be somebody that are enrolls in a plan in January that wants to get into a plan that has good Lipitor discounts and they're gonna find out another plan has a better one, and they're gonna want to switch. So there are going to be problems. We're aware of that.

The system will provide biannual reporting enrollment and disenrollment so that, basically, as I said, you'll be locked into a plan for six months. The benefit of that is t gives us bulk volume discounts to people. And Medicare will conduct an annual qualification process to talk about terminating endorsements for people that are not complying with the program.

Let me flick up the next one.

This is the current drug pricing reality. This is me. I am an old guy, so these are the two drugs that I've take. Lipitor, which is for lowering high cholesterol, and Plaquenil, which is for rheumatoid arthritis. And if you look at what I pay through my PBM, which happens to be PCS and Blue cross in Virginia, vs. what my mom would pay walking in right behind me as a senior, this is the difference in prices today in Alexander Virginia.

Is this gonna be the be all and end all? Is every senior gonna walk in and say, "I'm real excited because

the government came up with a voluntary purchasing program that allows me to pay 69 bucks instead of 102? Or 74 instead of 98? The answer to that is, no. They're still gonna be saying, "I want my $10 co-payment," and we're totally aware of that.

But if you go out and ask seniors today why in the world should they be paying 102 bucks when I pay 69, or why should they pay 98 and I pay 74, the answer is they're a victim of a massive cost shift. They're the only people in society, other than the uninsured, who don't get organized into pools because of they have other [unintelligible] discount. And that's not the pharmacy's problem, it's not anybody's problem. That's an issue of the fact that the system took disadvantages them.

Ten years ago, I was involved in creating Medicaid drug rebates in the 1990 budget deal. And it was basically Chris Jennings and Senator Pryor and some others, but I was the Bush Administration person who put that in there. And the arguments against it were identical to this.

The federal government has 8 percent of the market share for drugs in Medicaid and we said it's ridiculous. Why should Medicaid pay for pure 100 percent over the counter prices, we have 8 percent of the market. And we came up--artificial wasn't particularly pretty, and ugly proxy with best price for how to get rebates for Medicaid. And everybody said, oh, my goodness, this is gonna be terrible. It's gonna squeeze the pharmacists, it's gonna blow up the system.

The bottom line is, Medicaid was the victim of a huge cost shift. In 1990 that was fixed, it shifted the cost a little bit back to the sector. It changed the impact of everybody in the system. But there was no reason why Medicaid should pay over-the-counter prices. There's no reason why Medicare should pay over-the-counter prices.

So, it's as simple as that. It's all about the cost shifting. This isn't gonna solve seniors' problems. No senior is gonna be happy paying 69 bucks for Lipitor. They want to pay 10 bucks, like all of us do, when you go into the pharmacy and pay a co-pay on it. But it's ridiculous for them to pay over-the-counter prices.

Flip to the next one.

Once again, as I said, if this plan had been approved today, and this is part of--a small part, but it's part of our ad campaign this fall. We spent $30 million, we're in the process of spending $30 million on an advertising campaign that, on an average, is generating 45 thousand calls a day to 1-800-Medicare.

And one of the many themes that I campaigned was going to be being enrolling people on a voluntary Medicare discount card. That's not happening. But if you call today from Kansas City, you get somebody on the phone that can tell you about issues in Kansas City, which didn't happen this fall, 24 hours a day, 7 days a week. They can talk to you through nursing homes in Kansas City. They can talk to you through hospitals in Kansas City.
We can talk about whatever information we have about providers in Kansas City. They were gonna tell ya which prescription discount cards are available in Kansas City and sign you up for one.

So, my opinion is that we missed a huge opportunity already by holding this up this fall to enroll millions of seniors on a prescription discount card that's not gonna happen.

You want to flip to the next one?

The status is, my poor staff is sitting in the back, is working away very hard to get this done. We hope that--I'm pretty certain that, in the next ten days, the regulations will be out for comment. As you all probably know, we have been enjoined by the court for reasons we get into the proceeding of this plan. The judge did allow us to go forward with the notice of rule making and it's very clear that we can write comments on that, but we cannot proceed with this until the judge hears the case.

And we're obviously very respectful of this order. We would like to be working with Congress that, if they inserted a few words in our current legislative authority, we could go ahead right now. Because the real issue is, what the found was that we created a new program that went beyond our beneficiary education in Milwaukee.

We have the ability to go out and educate seniors, as we've done in this ad campaign, to run $30 million in ads. We have the ability to run a 1-800 number. The Judge ruled that the Creation Program was a new federal program, not just beneficiary education. Would we love to have Congress clarify that? Sure, absolutely would. Do we want to wait until March or April to go ahead with this if we win in court? We're certainly going to certainly keep plugging away and we want to work with Craig, as my old boss from ten years ago, an Ali fight with these guys.

We would like to work with the pharmacists and everybody else in the system to get this done. But there's is no excuse for seniors being the only people in the world and the uninsured for paying full price for drugs. And we're gonna keep plugging away until we fix it. So, that's basically it.

The last thing I want to add, just for the final thing is, it's frustrating to me, this I just saw in the paper the other day says. It says, "Medicare discount card plan, failed to deliver real savings. That's why we need to crack down on similar schemes.

By the way, we have to crack down and soon. Required to take different medicine no matter what your doctor prescribes, untrue. Eliminate face to face consultation with pharmacists forcing to use mail order, untrue. My point in this is, and I called this 1-800 number this morning and it's probably the most outrageous recording I've ever heard.

I used to run a big trade association until four months ago and I love sitting around debating these issues, rationally and fairly. I'm happy to do it, but I really think that, as we get into this debate, it's important to prop up the facts and the merits and not let this kind of garbage in the newspaper.

Or if you call 1-800-211-0916, I would never even consider. My house probably would have fired me if I had, running a tape as outrageous as when you'll get when you call this number. So my point is I like

to stick to the merits, save seniors money and get discounts started. Thanks.

SENATOR FRIST: Great job. Craig.

MR. CRAIG FULLER: Thank you, Senator, and thank you, Ed. I am very grateful for this opportunity. If you know nothing else at this moment, you know that this is a very complicated and complex program, and this is the second opportunity we have had on Capital Hill to discuss this program and I think this kind of dialog is very, very valuable. So I thank you, I thank the participants here, and I thank the participants through the Kaiser Network, which I am an occasional viewer.

You know I was thinking about this presentation over the weekend and I was with–last weekend I was with Ken Dychtwald who's a noted author and gerontologist. He said something that I think all of us should take heed of. He said, "The unhealthy aging of America will bankrupt our society."

And in many ways, the path that we're on and we're debating here, is as important as that dire prediction suggest, because if you don't take care of the way our seniors age and reduce the cost of that process, there isn't going to be enough money, not next year, not five years from now, not ten years from now.

We now spend in this country some $145 billion a year on prescription medication. It's a very large number. What's even larger however, and shocking to me, is that we spend about $177 billion a year in this country dealing with the consequences of people that fail to use their medication properly. Every company, every government, every dollar you spend, $1.25 is spent on dealing with the admittance to an emergency room. The lost days if of work. The other issues associated with taking that medication.

So when we are passionate about how people receive a pharmacy benefit, it's because that, at MACBS, we look at every proposal we get and ask the question, is this likely to improve patient outcome? Is this proposal going to help the very people it's designed to help. And, for our senior population, it is absolutely the case, as I agree with Tom. There are needy seniors, low income seniors without coverage that absolutely need the medications that will save their life, prevent them from having even more serious health issues, and costing us more serious money.

But they also frankly need the opportunity to engage with a pharmacist. And so when we see proposals that we think threaten that, we definitely do object to them and, what I'd like to do is, with just a few slides, lay out our perspective on this.

You have packets, I believe, of the presentation, which is a longer version. And I'm happy to answer any questions from slides that re not in this version, but in the interest of time, I want them to get through our slides quickly.

This first slide from our perspective what they need is a real benefit, real coverage. Not the promise of discounts. Some people are using the phrase, "Discounts of up to 40 percent." Some say 60 percent. That delivers seniors to our retail stores looking for that discount. On July 13th, 14th and 15th, after the

president's announcement, they wanted to know how to get the big discounts. And there are no discounts of that size.

Seniors want to have the—be able to get the medication that their physician prescribes or that the physician and pharmacist conclude that they need. In fact, 65 percent of seniors, when asked on a scale of one to ten, say ten is very important, it's very important for them to have the opportunity to talk to a pharmacist.

They need, frankly, incentives to use generics. There's huge savings in the generic area and there are incentives at the pharmacy to do that. And they need, frankly, a level playing field, not an incentive to get mail order because they can get a 90-day supply that they can't get in the drug store because of the rules that PBMs set. So a level playing field.

On the next slide, how much do they spend? Some of this is in the packet of materials. I might slip over this fairly quickly. I will say that many pharmacies already provide a 10 percent discount and will match prices when a senior comes in and says they can get a lower price somewhere else. That's happening in the marketplace now.

This next slide on community pharmacy profits vs. other industries, builds to a point. It simply does show that we're about half of what the Fortune 500 average is, in dark blue there, as an industry. The next slide shows what actually happens to the—with the average prescription drug that costs about $47, I think--$45. $45.79. You've got this in your packet.

I think the point is pretty clear by looking at that, at the end of the day, that very small line on top, with a net profit for the retailers about 32 cents on that $45.79 prescription medication. That's less than 1 percent. Less than 1 percent of the cost. So any proposal that suggests the community pharmacy is somehow gonna provide large savings as part of a discount program, it's gotta come out of that number there, or we're simply giving products away. And that's not consistent with what I think government programs should be all about.

The next slide shows—I made this point a little a little bit earlier, shows the dramatic difference in generic and brand prices. I think probably everybody in this room is familiar with that, but it's worth noting because, on the next slide, drawing from data that we don't develop, but we have access to, this makes the point, if you look over on the left side, that individuals who are paying cash, who are by definition, therefore, more price sensitive, they're not paying a co-pay, they're paying cash. Their average prescription price is $37 or so, with a higher percentage of it coming from prescription drugs.

In a real day—real life situation inside a pharmacy, this is the senior who comes in, who has a prescription, for which there is a generic equivalent available, and the pharmacist works with that patient to move them to that drug that they're more likely to afford, from the prior chart you saw the difference, than the brand name drug.

At the opposite end of the chart, the far right side, it shows what happens in mail order and, just before that, what happens in managed care plans. And the difference is dramatic. Again, these are industry statistics, not our statistics.

There's a lot of incentives for pharmacy benefit managers to sell people and to move people from mail order. There's also an incentive, because of the rebates they collect, for them to sell brand name drugs. And that last slide shows you the model that exists today.

Again, before government, as Tom says, give the Medicare name over to pharmacy benefit managers, it's important to at least understand the consequences of what that might do. Under the minimum, insure transparency so that we can monitor what happens in that model if it goes forward.

The next slide really just picks up the same point. The proposal was designed by HHS and presented in July. It does lend, or gives the good name of Medicare to the pharmacy benefit managers and insurance companies. It requires the pharmacies to charge cash customers a specific price. It does not reduce, does not reduce, the pharmacy acquisition cost. By the way, it's retail pharmacy that buys drugs, not PBMs that buy drugs.

It does not pass along manufacturer's rebates. You will hear that there's an intention to do that. We have heard that HHS will encourage pharmacy benefit managers to do that. Pharmacy benefit managers are very solid, important organizations that are doing very well today, and I know we're gonna hear more about that in a minute. But the fact is they make a lot of their money by both collecting rebates and holding onto them. They don't share them. Maybe that's possible in the future, but it's not—it doesn't guarantee it and it's hard for us to see how it would work. So a lot of cost is absorbed by the pharmacy.

Next slide. The proposal promises something for everyone. Discounts for customers, pharmacies they said would get more customers and that people over the age of 65, unless they're confined to a health facility or their home, come to our pharmacies. Manufacturers will increase market share if PBMs will get rebates on enrollment fees and, for politicians, it's a step in the right direction. It's political cover, or it provides some support at seemingly no cost. But if it seems too good to be true, it probably is, and that's the next slide.

Seniors under the plan, as we saw it, seniors' drugs were not covered. There was one drug per class. Seniors' pharmacies may not participate, so the pharmacy they're used to going to, large, small, chain or independent, might not participate in the [unintelligible] so they wouldn't have any benefit at all.

As I said before, I just don't think the discounts are there. We've looked at comparisons and we just don't see discounts in it. If the prescription drug cost is $2-3,000 a year, and somebody's saving a couple of hundred that can't afford $2,000, $1,800 isn't going to make a large difference.

And we are concerned that the program would push the seniors to mail order. Pharmacy benefit managers have, as a corporate objective, Advanced PCS, in a recent analyst survey, hoped they would get a 35 percent increase in direct mail, and that's a concern to seniors.

My—let me just skip over the next slide. There are new state experiences. We might come back to that. There's been a lot of experimentation with discount cards in states, and a lot of folks who have announced them with great fanfare have backed away from them.

Pharmacies' concerns I've talked about. I'll just conclude with the next slide that says 2002. My hope is that we can take the kind of discussions I hope we have here today, and certainly discussions we've had with HHS and the White House about the plan, and come back next year and look at a meaningful benefit for seniors. We're committed to that. We think that's what's necessary.

We were afraid that the approach that was taken, without consultation by a number of parties, was a serious distraction from this effort, but we, too, look forward to working with Tom and his colleagues going forward.

Thank you.

SENATOR FRIST: Good, Craig. Thank you very much. We got some good point-counter point going on. So let's hear, Marilyn, your perspective on it.

MS. MARILYN MOON: Thank you, Senator. I'm going to try to—as long as my voice holds out today, try to essentially agree with both the previous speakers to some extent, and disagree to some extent.

SENATOR FRIST: You can't agree with both of them. I've got—if I had to draw a line on both axis, no way to agree with both of them!

MS. MOON: No, I think that there are some possible lines of agreement here. First of all, I do think that it's important to put price into perspective. As Craig has said, that a lot of the price issues are not so much as important as the use of drugs, and are not the drivers of high health care costs in prescription drugs right now. They're accounting for less than 20 percent of the increase in what people are paying for drugs each year.

And one of the important things to remember is that all of us, especially those of us who are older Baby Boomers, as well as seniors, are going down that road of becoming large healthcare users in the area of prescription drugs. And that's going to swamp, in all likelihood, a lot of the things that people think about in terms of the costs. So that's one thing to keep very much up front.

I appreciate the fact that the Administration says that it recognizes that this is not a prescription drug benefit, and I think they've tried to be honest about that. But I think they've also jumped on the bandwagon of suggesting 30 or 40 percent discounts, and I don't think that the data support that.

I think the data support that Tom's mom is gonna spend $102 for Lipitor but, under a discount card, she's probably going to get it at $85 to $88 to $90, and not at the $69 that he gets because he's in a situation in which the PBM is doing more than just offering a discount. He's in the situation in which there are strong formularies and other things going on that affect prices.

But I think it's also important to stress that, while people need access to drugs, and they need to have them less expensive prices, absolutely, it's a good idea. They also need better information and I think, as we think about setting up a structure for a prescription drug benefit, I'm concerned about setting up a structure in which we not only talk about the issue of offering discounts, but also providing information and education to people about the appropriateness and necessity of drugs.

One of the important things that a lot of people who oppose a prescription drug benefit are afraid of is that people will go in demanding Celebrex and Vioxx. They'll demand the Prevacid and Prilosec instead of the Zantac, which is less expensive. And I don't see anything in the prescription drug benefit to prevent that. In fact, there may be some things that actually encourage it.

From the standpoint that, if you have a captive audience and you know what those folks are taking and they're all taking Zantac, then if I were the maker of Prilosec or Prevacid, which is a step up in terms of anti-ulcerant drugs, I would want to send a little mailer out in the package that these folks get and say, why don't you talk to your doctor, and Prevacid and Prilosec are much more exciting drugs. They help keep you out of that precipice, if you see the—those are wonderful advertisements.

I think that we run the risk here of potentially stimulating demand for prescription drugs, and I would like to see a structure, when you talk about a structure in which price comparisons are made, that there's also a lot of good information about generics, good information about the fact that Celebrex and Vioxx do good things. But they mostly do good things for people who have problems taking other drugs, not because they're so much better inherently than a lot of the other drugs that people can take.

Those things aren't going to come from PBMs or manufacturers; not because they're horrible people, but because they're in the business of selling goods and services. That's what they want to do, and that's the information that they're going to provide.

So I think that price has to be put in perspective, both in terms of understanding what it means, and understanding that one of the real challenges of dealing with the use of prescription drugs.

Secondly, I think that we need price information right away. I don't want to buy a discount card that says, "Good news! Here's a discount card. Trust us, you're gonna get 25-40 percent off on prescription drugs. Oh, by the way, we'll tell you what they are later on."

I want to know right away. I want to see that. It seems to me that that's an obvious and easy thing to set up first, rather than waiting until the very end. I don't want to wait until the PBM signs everybody up and then sees what it can get. That doesn't seem to me to be the right way.

I am—the last time I spoke about this, talked about the reason that I would buy a prescription drug discount card in this situation, and that's for the anti-chump benefit. I buy a Safeway—I have a Safeway discount card. I don't have to buy it, thank goodness. I don't think I save any money. But if I went in and didn't use my Safeway discount card, I would be a chump because I would be paying too much.

I think if I didn't use my Safeway discount card, that I went to some other place that didn't have discount cards, I would probably pay about the same amount as I get with my discount card. So it's a defensive reason. And I would sign up, in all probability. I'd probably take, if I had no information, the zero cost card, or perhaps the one from the biggest industry. I'd have to figure out how to do it. But I want to know whether I'm really getting something from my dollars and whether—something for the effort.

So I think that what we really do need is good information, and I think that has real benefits. I think Tom is absolutely right when he says price comparisons are important, and that would help this market. I believe that and I agree with him on that. But I think that should be started initially. And we should, if necessary, pony up a few government dollars to make sure that that happens quickly, rather than later.

Also, I believe that one has to worry that, when you sign up for a discount card, you are going to get the biggest discounts when they're steering you to particular—in particular directions. So if I use Prevacid and not Prilosec, then I'm going to buy the card that has Prevacid. But then if I need Celebrex and not Vioxx, then it may not be covered or it may not be good deal under that. Again, I want to be able to comparison shop and I may not be able to do it.

I also worry that, if I don't get a discount on everything, for the ones I'm not getting a discount on, will the prices go up when manufacturers recognize that retail prices don't mean quite what they did before? And one way to—if you've got a lot of market power, as a lot of pharmacies—as drug companies do, you may just raise the retail prices.

Finally, I want to know exactly how these programs work. I want to know what the negotiations are with pharmacies. I don't want Craig's people to be put in the middle and expected to provide something with no benefit. I want to know what happens to the rebates, which usually come after the fact and will be difficult and expensive to share with beneficiaries potentially, unless you find a good way to do that.

And I want to know what kind of marketing and information gathering is allowed. How much benefit are the PBMs getting out of this in terms of collecting data on my use of prescription drugs, on what drugs I use and whether or not I am a desirable customer if they shift to taking risks. Am I one of those people that uses all those really high cost drugs and demand the high cost drugs all the time? Then I may not be the person that they want to market for and maybe someone else that they want to market for, and they'll have a lot of information about me.

And finally, I would just suggest that this is not just a no-brainer in terms of let's just do it and see what happens. I think we should be very careful with the use of branding from the Medicare standpoint. I think we want to make sure that Medicare, which has an extremely good reputation from its beneficiaries, and does branding in very, very few cases, needs to turn around and make sure that it's doing a very good job here. That there are standards and there are protections and controls.

I was glad to hear Tom say that he wanted to do that. I think that's very important. I don't want quality control run by a consortium of the industry. It is a case of the hen house being guarded by the fox in that case. Not, again, that these are terrible people, but they're in a business to make money and they are not going to look out for my best interest as an individual, nor should they necessarily be required to. That seems to me to be the role of government.

So I want to know more about the structure, the advertising, the marketing, the quality control, and the prices before I buy a pig in a poke.

Thanks.

SENATOR FRIST: Good. Marilyn, thank you very much. Jeff Sanders.

MR. JEFF SANDERS: Thank you.

SENATOR FRIST: Can everybody hear in the back? I know this room's a little bit tough to hear. Can you hear all right? Reasonably? Thanks.

MR. SANDERS: First thing I'd like to touch on briefly is, there is an existing market for these discount cards. Perhaps wasn't widely known in policy circles. Seniors represent the largest block when measured by drug use of those who are now purchasing or getting access to these cards.

There is also a large block of people between 55 and 65 who use these. I would also mention there's a lot of younger people who could benefit from these. They are much lower utilizers and tend to use drugs much less than the senior population.

Those are just the numbers in terms of drug utilization by age. Couple points here that haven't been raised before. There is a value to these discount cards simply beyond the simple cost savings that has not been part of the debate at all. And that is, we include some of the things that funded beneficiaries get, such as concurrent drug utilization review, an education to beneficiaries about diseases and their choices. Those things have proven measurable results in improving costs—safe and cost effective use of drugs.

Some of these cards—we're focused on Medicare and the drug portion, but many of these cards provide discounts on vision and dental services, over the counter products, and some—obviously these are not targeted to the Medicare beneficiary, provide discounts on physician and hospital services for the fully uninsured.

From our perspective, how do discount cards get distributed out in the marketplace prior to the policy debate? There are many companies who focused on this that aren't PBMs. They compete with PBMs and we compete with our competitors to provide services to them. In some cases, the PBM is the actual aggregator. In many cases, these are given away or marketed as an add-on to some other service that someone is provided.

Many insurers offer discount cards to their medical groups that have narrower insurance, that might just have more of a catastrophic or medical benefit in the small market. They will give people a discount card for drugs because they're not covering the drugs, and that is something that's increasing. We've seen a slight uptick in that in the last year or two as some small groups are no longer offering drug coverage.

Next card. Wanted to stress here that there really are two values to the users of these drug cards. One is the discount and second is the overall clinical value that they get. Drug uninsured customers can save drugs by being cost effective purchasers of the actual drug they get, knowing what the therapeutic alternatives are, and talking to their doctor about it.

What Craig showed, the numbers that Craig showed demonstrate that doctors will prescribe differently if they know someone does not have insurance than someone who does have insurance coverage. So it's important for a—with or without a discount card, that a consumer let their doctor know that they're in that circumstance and make sure they're getting the most cost effective alternative that's out there.

And then, once they've got the drug that they need, they shop for the best price. There are alternative means to shop for the best price besides discount cards. That's been part of the debate that is out there.

If a consumer wants to check the reputable, I highlight reputable, Internet pharmacies, all of the chains, all of the independent stores in their community, often they can get a discount. Craig mentioned matching best prices and the like. That is possible for an older consumer to do.

An alternative, and one that has proven itself pretty well in the market, is obtain a discount card that kind of guarantees you, in most cases, savings; not in all cases.

Advanced PCS manages discount cards for 7-8 million Americans. Five million of these are through aggregators or health plans. In other words, we're a service provider to someone else. Two million are through direct programs, including our recently launched Advanced PCS Prescription Discount Card, and other brands such as Mature Rx, Femscript, and Avita Rx. Forty thousand pharmacies participate in our programs.

The discounts that I'm gonna cite, I'm gonna provide some numbers, what we consider the real numbers. There's been a lot of debate about what those are. They vary by program. The breadth of

the network, the retail network, by the sponsor. The savings level vary by comparison to where the member purchased their medication, and they vary by the specific drug in question.

Clinical value. I stress some of the programs that Advance PCS runs. These are not universal in the industry, so the clinical value varies by program.

The numbers I'm gonna cite are measured against the pharmacies' usual and customary price. Pharmacies usual and customary price is the price they would otherwise charge cash paying customers, including applicable discounts that might exist within the store level.

Next slide. On average, for our programs, I'll use specifically the Advanced PCS prescription discount card, the savings average over $9 per prescription, or 21 percent. For generic drugs, the average savings is over $8, and about 30 percent. The percentage is higher, the number's lower. That's because generic drugs, as mentioned many times, are less costly.

For branded medications, the average savings is over $10 and over 15 percent. There is variation by brand and by generic. For drugs purchased through mail order, savings against average retail usual and customary price is over $30. Keep in mind that's three times as much supply as the $8—as the $9 mentioned above. That represents more than a 25 percent savings.

Compared to this usual and customary price, we have many members in our programs who have saved over $1,000 a year. The average for utilizers is closer to $150-$200.

The—now probably to the more interesting part, which are just some comments. I think that, historically, there have been very low rebates available to cash paying customers from manufacturers. There has been an active effort, even prior to the Administration's proposal to rectify that. Three of Advance PCSs four programs have, for three years, provided rebates at the point of sale to the member. We'll be converting the fourth one to that mechanism early next year.

Marilyn said it's very difficult. There are two ways to do it in the marketplace today. One is through a cash back rebate after the fact. The other is to adjudicate the rebate at the point of sale in the pharmacy, extremely simple for the member, and pay the pharmacy back after the fact. That is—that later mechanism is how three of the Advance PCS programs work, and we'll be converting our other program to that same mechanism.

So, if you start to think about this, there is a—you know, to me, if I were a retail pharmacy concerned about this, I would think about signing up only for programs that manufacturer rebates do go back to the consumer. I think that, once the comparisons are out there, consumers are only going to enroll in programs that provide those discounts back to them.

So a lot of this is information and education. I think that information and education was happening naturally in the marketplace. The announcement by CMS and the Bush Administration has certainly

sped that up. It sped it up whether or not they end up being successful. It'll speed it up more if they're successful probably.

I think probably the last important point I'd like to make is, understand completely that the brand vs. generic argument. People need to understand, pharmacy benefit managers make much more money on generic drugs in mail order than they do branded products. We would be completely supportive of the educational campaign that Tom is talking about, Marilyn talked about, including the full range of therapeutic alternatives to patients so it's not just comparing drug to drug to drug. It puts the generic, it puts the low cost alternatives right up there next to it. We think that's the right thing to do.

Thank you.

SENATOR FRIST: Good, Jeff. Thank you. You can just--real quickly, 7-8 million Americans, after you, who has the next largest number of people?

MR. SANDERS: I think our two—there are probably three other major providers. I'm not sure any of them have cited exact numbers. It would be Merck, Medco, Express and a small company that's really focused on this market segment in Tucson called ScriptSave.

SENATOR FRIST: Okay.

MR. SANDERS: And I would say each of those are probably in the 3-4 million. Keep in mind, though, these include all Americans, not just seniors.

SENATOR FRIST: Right. Understand. Good. Thank you. I just wanted some perspective for our audience.

Judy.

MS. JUDY FEDER: Thank you, Senator. I am just gonna give you—I'm not gonna give you new information. What I'm gonna share with you is what I think are some broad questions to ask as—and you can hear the issues as people discuss them, broad questions to ask about this discount drug card policy in its ability to address what brings everyone to the table, and that is a concern about I think both the level and the affordability of drug prices.

So I want to reflect back on some of what we've heard and on, from Congressman Kennedy in advance, by raising for you four questions. The first one that I would ask is would a proposed initiative in this area have a real impact on the prices people pay?

As we listened to the speakers, it's really hard to tell. We can't tell, at this point, whether—what a discount is against. I'm a really good shopper and I come home lots of times where I tell my husband what a great discount I've gotten. And a few questions asked, and I'm not so sure. That sounded sexist, but what can I say. It does happen.

So essentially, against what? We have lots of questions about average weighted price and I think those questions have been raised and really knowing whether a discount is meaningful is a very good important thing to ask.

Second, we've heard a lot of discussion, very important discussion, about comparing it not just to a price that the druggist would have otherwise charged for a particular drug, but the discussion of relative to other drugs that a consumer could have taken. And so, again, what really matters is whether consumers are getting a best price.

The third issue that we've heard a lot about is that there already are in existence a lot of ways for consumers to shop for better prices. And it's not clear, as I listened to the discussion, that this strategy necessarily adds a new and effective way.

We also heard that the likely discounts may vary, whatever they are, may vary considerably across drugs. People take a different mix of drugs. What they're actually gonna get on the drugs they want to use. Very unclear.

Finally, and related to lots of what I already said, that I think from—when we look these various issues, it becomes very uncertain whether, given the fact that the incentives in the industry to earn revenues remain—will always remain the same, as to whether what we have in this area is really more of a shell game than an actual impact on price in the industry.

So that's the first question: Is it real? Is the impact real?

Second question is, if it's real, is the impact fair? And that I guess is, once again I would say, if it's hard for a consumer to use, and if what one gets is hard to understand in advance and varies very much on the particular circumstances of an individual, and the information is very unclear, and let's all be clear about this, we don't have a great track record here on providing consumer information, although we are improving. If it's hard for the consumer to use, then there's a real question of whether this is fair across consumers.

And the issue of out of whose hide is this—if it's real, is this discount coming. I think questions have been raised about whether it is actually a reduction in what the manufacturer is earning, whether something really less is going in, or whether it's being, as I said, shifted around to other drugs, or burden-shifted to the pharmacist or other parties in the system.

So, that's the question about is it fair.

Third question, is it enough, is the impact enough to make prescription drugs affordable, which I think is the bottom line for this population. And Tom has been quite clear from the outset. The first comment he made, this is not the same as insurance and, indeed, it's not. But it's worth reiterating that it's not.

I was thinking, Tom, in your example on the different price you pay vs. your mother, I thought about it in a couple of respects. First of all, well, what I think you're showing is the difference your insurer pays vs. your mother. I suspect, unless you need to switch plans, that you're only paying $10 or $20 for that prescription.

And I thought about it in terms of the prescription drug that I take. I, too, am willing to reveal my medical history! I liked Marilyn's term today. I'm an aging Baby Boomer, otherwise, in other conversations referred to as "near elderly!" And, as a near elderly woman, I am taking a very valuable medication in protecting against osteoporosis. That prescription costs $70 a month. I pay $20 a month for it as a beneficiary of a Federal Employees Health Benefit Plan.

So, it's—that, without confusing the issue, that is one hell of a discount. Alternatively stated, it is a benefit. It is a benefit that that's a co-pay. It's about a—on that particular drug, it's about a 30 percent co-pay. But I have a real benefit there and I think it behooves us to remember that real benefits cost real dollars. Somebody pays for that benefit. And it's a real distinction between discounts and insurance coverage that we ought to remember.

Finally, one I think we ought to ask as we undertake, or consider undertaking a new federal initiative in this area, a new Medicare initiative, is it an appropriate use of Medicare and government time, energy, blessing, all of the above. And again, I think that is quite clear here—excuse me, quite unclear. The—demonstrated my own problem.

The value--Medicare is at its best. Medicare is at its best. Well then it is quite clear to consumers when it offers benefits that they understand, they know what to expect. It gives them both protections and predictability. Not at all certain that they would derive that value from this proposed initiative.

People need to, and want from Medicare to know, to put it simply, what they're entitled to. And the way this is put forward, that seems unlikely to fit the bill. And if we think about our experience in the last few years with Medicare Plus Choice, where there is tremendous uncertainty for consumers, and tremendous confusion about what they're gonna get and what they can expect and at what price, etc., and whether they can count on it, it's not been our happiest of experiences.

So it gives me pause as to whether this initiative is really a long lines of the stronger, clearer Medicare that I believe we all want to have.

The second piece, going beyond Medicare, is to think about it as an initiative for the federal government. There is lots of activity going on here, as other speakers have indicated, where lots of discount cards—or discount arrangements and other mechanisms to get lower prices available. This is not something that can only be done through a federal initiative. By contrast, there are other things that the feds can do that nobody else can do. We can look at some real direct negotiating as ala Cipro on prices of drugs. We can essentially focus on, as Tom was talking about doing, enhancing transparency in overall drug pricing. We can look at the arrangements and policies affecting patents and the use of

brand names vs. generics. And we can concentrate our energies on developing and acting and in implementing real insurance.

So, overall, I would say there are several reasons to question the value of this initiative. If it's not real, and it's not fair, and it's not adequate, it makes me wonder whether it is worth of our effort.

SENATOR FRIST: Judy, thank you very much. Joe?

MR. JOE KENNEDY: Thank you, Senator Frist. First of all, let me thank you and Mr. Howard for hosting us this afternoon. I also want to just thank the members of the staff and others who are interested in the whole issue of prescription drugs.

The fact is, everybody in this room, I'm sure, understands, both personally as well as through members of your own family and people that you see come into these building all the time. Prescription drugs, and the cost of prescription drugs, can be both, on the one hand a tremendous opportunity for this country, but it is also devastating for millions of Americans who simply can't afford it.

When I left the Congress, I went back to a non-profit organization whose sole mission and purpose is to try to bring down the cost of basic necessities to the poor and senior citizens. If you look at the conditions that they live in today, the cost of prescription drugs for these families is something that many of them just simply can't afford.

You look at the cost of food and housing and shelter, and then you throw on top of that the cost healthcare. It's no wonder that literally half the senior citizens in this country today have no prescription drug insurance. Most senior citizens, people over the age of 65, live on Social Security. And most people who get Social Security earn around $8,000 a year. Those are the families, those are the individuals that we're trying to talk about providing some benefit to.

It is so clear that whatever the prescription drug initiative that we're all discussing here today is completely, totally and utterly inadequate when it comes to the needs of these individuals and families. Citizens [unintelligible] has a whole business that is dedicated to just this opportunity. But I am here to tell you this cannot, cannot, in any way, shape or form, be viewed as a substitute for a real prescription drug benefit.

I think it might be worth just going through a little bit of the history of how we got to where we are. About 20 years ago or more ago, this country paid prescription drugs. The insurance industry would simply get the bill from a pharmacy or an individual, and pay back the individual for the cost of drugs. The average markups at that point were probably about 20 percent. And it was a fee-for-service business, the same as much of the healthcare industry in this country operated.

I had started a non-profit oil company, a gas company, an electric company, a conservation company, and thought that maybe we could start a non-profit drug company. Well, it took about five minutes to figure out how the patent laws worked and the fact that that was gonna be kind of a hard nut to crack.

And so what we did find, much to Craig's dismay, is that a very significant chunk of the cost of every pill that anybody in this room has ever bought, goes to the distribution system. So I though, well, maybe we can start a different distribution system and we initially started allowing people to buy drugs through the mail.

The mail today is still by far the cheapest way to get drugs. And it's about—you can buy drugs for about 50 percent off of the average retail price, if you buy it through the mail. That business grew so fast that companies started wanting it so much that I began to think that there may be a way to join together with a company that could fill the scripts, a way to negotiate with big drug manufacturers, to get them to start bidding against one another to get you a better price.

And then we would go to drug stores and we would do the same thing with them. If you're in Boston, Massachusetts and you get the Blue Cross/Blue Shield contract, you've got 1.5 million people out of the state of Massachusetts which, back at that point, had about 5-5.5 million people in it. If you can go to every drug in the state of Massachusetts and say to them, look, if you give us a fee—if you agree, instead of marking up every pill by 20 percent, we're gonna pay you a $2.50 or $3.00 fill fee. And, on top of that, we'll give you a little percentage over and above that that you're gonna be able to keep.

The drug stores don't like it. But the fact of the matter is, a lot of drug stores don't make all their profits from selling drugs. They make it from selling toothpaste and stockings and everything else. So we were able to get the drug stores to go along, and were able to then begin negotiating in earnest with drug manufacturers to get them to give us significant price breaks.

Today's industry operates in a circumstance where about half the savings comes from the manufacturers. And I couldn't agree with Craig Fuller more, they can certainly afford to pay for it. And about half the savings comes from the distribution channels, in other words, the drug stores.

And those average—now, I'll tell ya. There is no average in the drug industry. Because what you have is a circumstance where everybody uses different drugs, and every drug store charges different prices. And even within chains, they charge dramatically different prices. So it's—you're gonna hear pricing all over the line.

The fact remains, however, that if you—over the 20 years since that company was first formed, and in the years that I was in Congress, literally 100 percent of the health insured market in this country went out and hired a prescription benefit manager to assist them in achieving the savings, that is roughly 40 percent; 20 percent from the drug stores, 20 percent from the manufacturers, that you can achieve in today's market. That's what's out there.

What that has meant is that we have evolved into a two-tiered pricing system in this system. We have one tier of pricing, much cheaper, for those with health insurance, whether you calculate it as Judy did by saying that Tom's actually only paying $5, $10 or $15 as his co-pay, the fact of the matter, whether

it's the government or a private employer, he or she is picking up the rest of the cost of the rolled in price.

So, if you want to have—get price comparison, you can do it. And the point is, that what we have today is a system where the only people paying full price walking into a pharmacy are senior citizens, half of which have no prescription drug benefit, and the uninsured.

Now, there are a bunch of card companies that have gone out there because one of the things they don't tell you, when everybody uses that 40 million people are uninsured in American, what they don't tell ya is actually that there's a bunch of them out there that choose to be uninsured, who are kind of wealthy. And that there are a bunch of card companies that have been formed to sell into that market. And they're doing okay but, to tell you the truth, it has nothing to do with what Citizens Health is all about.

Citizens Health is a unique sort of effort that joins together every community health center, every mental health center. It joins together all the community action agencies, the WIC programs, the Head Start programs, hospital emergency rooms, every—the doctors' organizations, the medical associations, the medical school, and the government, into a single organization that can go out and assist people in getting the savings that are out there in the market today.

About a year ago, I had an opportunity--I was actually trying to find a fella named Frist who was running a healthcare organization down in Tennessee at the largest hospital chain. So I tried to find him and I went to a certain Senator from Massachusetts. I said, who do I know—how can I get to a Frist. And he said, well, forget the Senator. You gotta go to Scully who lobbies for them a little bit. And so I had an opportunity to meet with Tom Scully. Well, we told him about this opportunity, that you could actually create these savings.

I was a little surprised when I read about it six months later in the newspaper but, nevertheless, you know--! The fact of the matter is, gang, that there's a great opportunity right now to get a very significant drug savings to people. It is not a—it is not what health insurance or drug insurance needs to do.

You know, Citizens Energy might be able to get prices down by 30-40 percent to the poor. But you know what? Poor people and senior citizens still can't afford $67 for Celebrex, or $41 for Cosar [sp], or $96 for Lipitor, or $69 for Paxil, or $64 for Zoloft. They can't afford it! So we got to get them that prescription drug benefit.

But in the—my time is up already. Okay, well. Can I--.

SENATOR FRIST: Add 30 seconds.

MR. JOE KENNEDY: Absolutely. Thank you. What I would—the one thing that I would suggest that all of you consider is, you know, it's all fine and good to talk about how we can get everybody to

compete against one another. It is—if you are a senior citizen and you are trying to sort through all of these different cards, it becomes next to impossible, and most of them end up going out and buying five or ten of them.

Why can't we set up a circumstance where all of these companies have to bid on the Medicare contract. And then the Medicare contract can in fact just provide the card, whether you want to do it on a state by state basis, on a regional basis. Make all these companies bid against each other.

And in terms of how you deal with the drug stores, my suggestion is that you very strongly consider using the drug stores for what they are good at. They are good at helping the patient determine which drugs the patient should use, and they have the information. The doctor has no information about what formulary you as an individual are on.

So the doctor writes you a script. He doesn't know whether or not your Blue Cross/Blue Shield hired Advance PCS or hired some other PBM that came in and got a great deal on something like Celebrex vs. Vioxx. So some of you might have gone into a drug store and the druggist will say to you, you know, your getting—your doctor wrote you a Celebrex script, but you'd be much better off with Vioxx.

Now, because you're paying $5, $10 or $15, you don't really care. But behind that, there is a significant cost differential that costs the system a lot of money. And rather than allowing that inefficiency to continue, why don't we simply provide the drug store with a return for the service when they have the information, because of that little number on the back of the card, pay these guys. Pay them money for directing traffic into the drugs that are best used for the patient.

If we do that, I think we can find a way to get the drug stores, who are in a much more difficult circumstance in many cases than pharmaceutical manufacturers. I think you can create a system where you can get the drug stores on board. You can drop the stupid lawsuit. And, as I understand it, the thing's gonna have a very hard time getting passed anyway. So if—that always happens around here, until the industry itself gets its act together and gets everybody to agree.

And what I'm suggesting to you, Senator, is that I think that the elements are there right now to get the drug stores, to get the PBMs and to get the manufacturers pulled together in a way that will not allow them to be disruptive, even though they don't like each other a whole hell of a lot, but nevertheless, they can in fact find a way to all make money and to provide significant savings to the people who need it most.

Thank you, Mr. Chairman.

SENATOR FRIST: Thank you. You know, one of the very frustrating things about today. We have as an objective, and really fulfill a—Jay Rockefeller and I, who moderate these sessions, is to finish on time and we're gonna go straight up until 2:00, but we will stop because—out of respect for everybody's time. But this session really does set a tremendous foundation, I think, for issues that are on the forefront as we go forward.

We're gonna go straight to the microphones because the cards, we're not gonna have time to—if you want to pass your cards up, I'd like to have those. But go to a microphone if you'd like to be able to speak so we want to finish on time.

Just—let's go straight—let me just ask one question.

Jeff, just to get things started because this is one of the main counterpoints. You basically, in your slides, said PBM or other negotiates discounts from pharmacies and/or manufacturers on behalf of participants. The—Craig and his chart had the manufacturers and the PBM and then the pharmacies and then the patient.

We heard Tom say we want to get the manufacturers' rebates to the consumers, and then we heard Craig say that this proposal does not pass along the manufacturers' rebate and the cost is absorbed by the pharmacy. Just two totally different things. And then we had, Jeff, you commented—or you—I'll ask you. Joe, you said it's about 50/50 based on your experience. I think that's correct.

Jeff, on your experience, what has it been, in terms of where this money that we're passing on to the senior or individual with disability?

MR. SANDERS: Well, in the unfunded business, it has been predominantly from the retail pharmacy historically. I think that's an issue. I mean it's—that's a fair issue. It's been much more balanced in funded business. In Medicaid, it's probably more balanced towards the manufacturer. So it varies a little bit by market segment.

In the unfunded business, the history has been the overwhelming proportion of this has come from the retail pharmacy. And there's active efforts in the industry and tangible signs that that's shifting. That we're going—we're effective at putting programs in place that get manufacturers to come to the table.

SENATOR FRIST: Okay, good. And Joe, that's your point I think. If we're gonna bring everybody to the table to make this thing work, at the end of the day, we're gonna have to make sure it's shared.

Let me go to the microphones just to get a little interaction going and then we'll answer quickly and then, Tom, I know you wanted to respond. Yes?

UNIDENTIFIED MAN: Senator Bill Frist, I'd like to thank you for having this opportunity and the panel was very enlightening for me. My daughter's a pharmacist. I'm a steelworker from Ohio and I traveled here to find out more information. This is the first hearing that I heard of, someone mentioned there was one other one. I didn't know about it. But she's a pharmacist in Ohio, my boy's in med school and I'm struggling to get him through school. I think both of them have an issue that I'm involved with, that's why I came here to find out--.

SENATOR FRIST: Are you still paying the bills? Is that what you're saying?

UNIDENTIFIED MAN: Yes, sir! I am! He's in his last year, so he's gonna get his coat in June. That'll be another thing. This is very important to me because it affects their future. I've got 37 years in a steel mill so I'm trying to limit--.

SENATOR FRIST: All right, what question you got?

UNIDENTIFIED MAN: My question is, why isn't there any Congressional hearings on this, being the fact that, you know, you have a legislative branch and you have your executive branch and this is a great forum and this is the first one I've heard about. I think--.

SENATOR FRIST: This is where the action's at. The question is, why don't we have Congressional hearings? Congressional hearings are not this effective in terms of exchange of information. I sit through them all day long and this is where you get things done.

UNIDENTIFIED MAN: The Senator's good! But I used to be able to tap on the floor of the union hall, too, so I'm gonna get--.

SENATOR FRIST: --All right. Another question real quick--.

UNIDENTIFIED MAN: --With all due respect. But I'm saying this is the first meeting that I heard about and such a magnitude as this program, I think there should be other hearings or at least other programs.

SENATOR FRIST: Good idea, but this is a foundation. Again, the advantage of this particular group, we move quickly to the audience of the really the decision makers here in Washington D.C., and that's the purpose of this. But this will be the first of many.

Let's go over here for a question. Thank you very much. I got eight minutes left. Question.

MR. LAVARNE BURTON: Thank you, Senator. I'm LaVarne Burton. I'm President of the Pharmaceutical Care and Management Association. We're the trade association representing Advance PCS and other PBMs. I don't have a question, but I have three very brief points.

The first is our association supports Medicare prescription drug coverage. The discount card, for any number of reasons that have been stated today, is not a substitute for that. But the point of comparison we believe for the discount card is, does the person walking into a drug store, who does not have prescription drug coverage, what does that person pay without a discount card and what would you pay with a discount card?

We've done some analysis of that which indicates that that particular person would save up to 10-25 percent on brand name drugs, and probably up to about 30-40 percent on generic drugs.

There were a couple points made today that I want to try and put in perspective because this is a very complex issue. With regard to generic drugs, when you look at generic drugs, you have to look at are you looking at a brand where there is a generic substitute available. Because, if there isn't, then there's no point in making that comparison.

When there is a generic substitute available and you compare the use of that generic substitute vs. the brand, between retail and mail order, the mail order use of that drug is actually about 2 percent greater than the retail. And I think to address the question of whether there is shifting, there is no reason for anyone to want to push a brand drug over a available generic because the generic is the pretty price and the better for the consumer, where it is available.

The other point that I want to make is that--.

SENATOR FRIST: Please be real brief, just because—I got two more minutes, two more minutes.

MS. BURTON: Okay. We work very closely with retail pharmacy, although there obviously are differences. About 95 percent of the retail pharmacists in this country participate in PBM networks. We're gonna have some further discussion on many of these issues at a conference that we're sponsoring at Loews L'Enfant Hotel on December 4th through 5th. If Hill staff are interested, you can go onto our Website and register for it at pcmanet.org and thank you.

SENATOR FRIST: Good. Thank you very much.

Tom, you want to comment? I know that we've got a lot of issues, but why don't you comment on several of the issues.

MR. SCULLY: I'll just be quick. I think what Jeff talked about, the much lower discounts from the retailers and the non-funded business not attributable is exactly the point we're trying to do. As Judy said, there are a lot of cards out there and the fact is, they don't work very well because the discounts for the existing seniors cards are all voluntary, they all come out of the—probably out of the retailer, because they can't guarantee volumes moving around. And they're exactly right and that's the point that Jeff made and that Judy made.

What we're trying to do here is through Medicare and the reason we think it's worth using Medicare's name is basically, by using Medicare, and by using our 1-800 number call in center, and by using—locking people in for six months, we can guarantee volume, as much as you can possibly do to make the under-65 Blue Cross market as we can. Are we gonna get as much out of it as an insured product? No, but we do think we can get a lot more out of it.

The other part I'd just make quickly, in case some of you are worried about Joe Kennedy being a wallflower, is that—which I know is a great concern of many of you. He did call me the day that that came out and said, "Scully, what the hell are you doing here. Your card came out today. This is my

idea!" But anyway, we were doing the best we could and he is right. He is the first person that gave me the idea and, hopefully, we'll make it work remotely close to where the original idea was.

MR. FULLER: I think I called right after Joe with pretty much the same question.

MR. KENNEDY: You should have called me, Craig.

SENATOR FRIST: And he's still looking for me. Craig wants to comment.

MR. FULLER: Well, just a quick comment. You know, again, I thank you for doing this. I think the presentations today were fair and I think they demonstrated and put a lot of issues out on the table. This is a very, very, you know, complicated industry—I think that virtually at this—on this platform is dedicated to trying to get seniors the drugs the need.

I think that, you know, the pharmacy benefit managers, and Jeff's presentation I appreciate, and I appreciate his response to the questions because they play a very strong role on making sure transactions are managed billions of times a year. They are successful companies and they're striving to take on new and added responsibilities. And, in this marketplace, you know, that should be applauded.

In some areas, I'd say we're very dependent on them for the processing of these transactions. In other areas, we compete very much directly with them. They look at retail as a competitor to their mail order business. They've been able to perform a valued service for drug manufacturers and, thereby, secure rebates from drug manufacturers. Rebates that, as I say, now amount to, in some cases, close to 50 percent of their earnings. That's very significant. There's must be great value there.

I think it's important, though, to examine this, as somebody suggested, to examine each of the players in this process to that, ultimately, the senior is well served and is not moved out of their pharmacy they choose to go to or into mail order. We have mail order pharmacies within retail. There is a mail order service, so we're not opposed to that. We very much want a level playing field. We very much want to see seniors get a real benefit, and we very much want the government to understand, through a process of hearings and discussions like this, the consequences of taking certain actions.

That easy first step may not necessarily be the right step going forward.

SENATOR FRIST: Good. Thank you, Craig. Let me go to one question here, then to Judy. Yes?

UNIDENTIFIED MAN: Wow! I'd like to switch gears if I might. The U.S. Undersecretary for Arms Control has said that Iraq—Iran—possibly Iran and North Korea have violated the 1972 bioweapons convention, but he has specifically refused to state whether or not those countries may have provided Osama Bin Laden with biological weapons. Can you comment on that refusal at all?

SENATOR FRIST: You know, I'm not gonna comment just because we have two more minutes, but it is important. If you come up afterwards, I'll be happy to talk to you. As you know, with Senator Kennedy, we're working very aggressively on this, but just in the interest of time—Judy.

MS. FEDER: Thanks. Back to the drug card. Tom, in terms of I appreciate and applaud the efforts of CMS to—and Medicare, to use its market power. I think that's a great idea and lots of respect. What I'm a little concerned about is whether—and tried to indicate, is whether you're using it as effectively as you might.

Not clear that, just because there are these Medicare cards that people will not have lots of cards. We're not going to be control Marilyn. She's gonna be all over the place avoiding the chump factor and so there really—I don't know that there is a lock-in that you're talking about to gain that volume. And I also, then, think that lots of the questions about what a plan has to deliver, it's transparency, all of those things are places that you ought to be using your market power that I'm not sure you've demonstrated you're doing.

SENATOR FRIST: Let me have Tom to respond to that. Blue sheets in your folder, critical for us to keep these sessions going that you fill these out. Give us some feedback as to how it's going. I'm going to ask Tom to respond, come to the last question, then we'll close.

MR. SCULLY: Well, obviously, we tried to get this thing out as quickly as we could this summer and we didn't want it to be a government program. We did enjoin from putting it out the way it was. We now have a Notice of Proposed Rule Making Processing. We're looking for input. We'd like to make it work as well as we can. And we're gonna make it better. I think there'll be a lot more meat on the bones when it comes out in 10 days. We're gonna look for comments and try to improve the program, but the bottom line, which I think is the point here today, is that seniors are the victims of a massive cost shift and, within our ability to do so, we want to at least get them the market power to buy drugs at reasonable prices. And I think that's a very worthy goal.

SENATOR FRIST: To the mic.

MR. DAVID LAWMICH [SP]: Yes, first of all, let me say God Bless America. My name is David Lawmich. I'm Sixth Ward Councilman from Steubenville, Ohio, and a retired steelworker of 35 years. Mr. Scully, I have a two part question. One for you, and I'm gonna ask Dr. Frist for the second one.

First of all, have you taken into consideration the job loss in communities with pharmacists when buildings closes and the tax erosion that we will be facing with this job loss? There are good paying jobs. We have a wage tax.

Second of all, Dr., you are a caregiver and you know first hand what elderly people go through every day. I would like everybody in this room who wears glasses, but a little Vaseline on your glasses and wear a pair of gloves, then try to do business. Go to a bank and get your cards out. Go get on the Internet and try to order your prescription drugs. These people have difficulty maneuvering every day.

Their fingers aren't as nimble. Their glasses, maybe they're not even getting the prescription drugs that they should or have the money to upgrade their glasses. It's very difficult for seniors to do business with blurred eye vision and not nimble fingers. So I think getting on line with this business about ordering our drugs and I think it's gonna hurt them in the long run. And I believe, throughout the valley and throughout the nation, I believe there is a lot of unions against this proposal here and I think we should discuss it a little bit more in the long run and see what the heck's going on. Thank you.

MR. SCULLY: Well, I've been doing healthcare policy for Washington for about 20 years and my number one frustration is nothing ever changes. So I don't think this drug card's perfect. I think it's got a lot of problems. I think we need a prescription drug benefit for seniors in the Medicare program. I hope we're gonna get there in my lifetime. I've been at it for 12 years, we haven't made much progress there. But I don't believe in letting the perfect be the enemy of the good. This drug card will save seniors money. It'll help. There's no reason to pay the prices they're paying. And I think it's a good first step towards where we're going. So my greatest frustration in healthcare is you look back as long as I've been here, since 1979, nothing ever changes, and virtually nothing ever changes in Medicare. This is a positive incremental step and I don't—and I think we need to press forward. And I can tell you the Administration, with all due respect, we're very concerned about all the economic issues, is going to push forward very hard to get this thing done as soon as we can.

SENATOR FRIST: In terms of the second question, and I think Joe Kennedy really put it in perspective. This is a step, probably a pretty small step. It gives us experience. It's something that we can do now. We need to do it very carefully, with everybody at the table and, therefore, your caution, and probably the earlier one about getting more information out so we can have the discussions in hearings, in discussions, bringing people around the table. None of us are gonna have the answer to the larger issue, and I think the issues you brought up about the ability of our seniors to be able to access, whether it's information or discount cards or healthcare, these are real issues. And it's gonna take a lot more debate, a lot more discussion. I'm glad to see the Administration pushing along. I mean, I think it does give experience in many ways. We have to continue the dialogues.

The purpose of this Alliance, as most of you know, two weeks ago, we didn't have even the date set for now, is that we can move quickly. And Jay Rockefeller and I are committed and we come from the Democrat, Republican, the spectrum itself. I think all of us want to make sure whatever we do is done right, that it is not done in a way that, a year or five years or ten years later, we say, gosh! Why weren't we smarter. Why didn't we give it more discussion.

On the other hand—and you're right. I spent the 15 years before coming here taking care of seniors every day and listening to them, and watching the medicines and manipulating the medicines, and looking at the challenges they had in terms of purchasing those medicines. And therefore, I do want to move and I want to move fairly aggressively in a way that can be assimilated as we engage in that larger reform.

With that, on Wednesday, December 5th, the Alliance will hold a briefing on financing care at the end of life. You can register on the Website over the next several days. We'll have it up in the next several days.

With that, I want to bring this meeting to a close. I want to thank everybody for participating and we will likely be doing more sessions on these issues and these types of issues as we go forward.

Thank you, and thank the panel for being here.

END

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