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Statement of

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Before the
Senate Special Committee on Aging

Hearing on
Pharmaceutical Marketplace Reform:
Is Competition the Right Prescription?

November 16, 1993

Congress of the United States
Office of Technology Assessment
Washington, DC 20510-8025

Prospects for Competition in the Market for Pharmaceuticals

Thank you, Mr. Chairman. I am here today to provide the Committee with information on the potential for competitive forces in the pharmaceutical market to contain prescription drug and overall health care costs. OTA completed an assessment of the economics of pharmaceutical R&D in February of this year. My comments today draw on what we learned in the course of that study and in the months since its publication.

The pharmaceutical market place is changing rapidly, forcing the makers of branded prescription drugs to adopt new tactics and strategies. The changes in the marketplace bode well for cost containment in the short-run, but questions remain about their effectiveness in the future.

Competition in The Traditional Pharmaceutical Marketplace

Pharmaceutical companies are no strangers to vigorous competition for business, but in the traditional prescription drug market place, product competition, in the form of advertising and promotion, was the main vehicle for generating sales. Price competition played a weak secondary role.

The traditional market place was characterized by strong patent protection of specific compounds and low sensitivity to price on the part of the prescribing physician, who practiced in a fee-for-service environment. Most patients are insured for prescription drugs (approximately 70-75 percent), so they are much less sensitive to drug prices than they would otherwise be. For this and other reasons, when doctors made decisions about what to prescribe for their patients, their opinions about the quality of one drug vs another dominated their decisions. Given this market environment, it is easy to understand why pharmaceutical companies would spend a great deal of money (on the order of 20-25 percent of sales) to advertise and promote their products to doctors.

In the past, strong patent-like protection for innovators' compounds lasted much longer than the patent laws allowed, because FDA regulatory requirements made entry of generic copies of off-patent compounds not only costly but often infeasible. Thus, many compounds' markets were secure against copy; only therapeutic competitors (different compounds acting on the same condition) could threaten a product's market, and the choice among therapeutic alternatives was decided largely on physicians' perceptions of each drug's quality.

The willingness to pay high prices for drugs sent signals to the pharmaceutical industry that new products would be handsomely rewarded, even after the lengthy development process and risks of failure were taken into account. Even when a new compound was a "me-too" drug, offering no real therapeutic advantage over others on the market, it could find its market niche through advertising and promotion. The result was a steady increase in real outlays for pharmaceutical R&D throughout the 1980s and the availability of a wide array of choice among competing compounds within certain therapeutic categories, particularly those with large markets. A recent European study found that more than one-half of the new compounds introduced to the U.S. market between 1975 and 1989 were judged to offer no therapeutic benefit over compounds already on the market (Barral, 1990). Table 1 shows, for example, the compounds currently on the market in the United States in 7 narrow cardiovascular therapeutic categories.

The New Marketplace for Prescription Drugs

Four developments in recent years interacted to enable the emergence of active price competition in certain segments of the pharmaceutical market place.

Table 1--Number of Unique Compounds Available in the United States in Selected Cardiovascular Categories, 1993

	Number of Unique Compounds
Adrenergic Blockers	6
Adrenergic Stimulants	4
Alpha/Beta Adrenergic Blockers	2
ACE Inhibitors	8
Beta Blockers	11
Calcium Channel Blockers	13
Diuretics	17

SOURCE: Physician's Desk Reference, 47th Edition, 1993.

First, and most important, was the passage of the Drug Price Competition and Patent Term Extension Act of 1984, which changed FDA law to permit market entry of generic versions of off-patent pharmaceutical compounds. Because FDA's Abbreviated New Drug Approval (ANDA) warrants the therapeutic equivalence of generic versions of originators' compounds, health insurers could easily encourage or require that prescriptions be filled with low-cost generic alternatives.

Second, the growth of bundled and capitated payment increased providers' incentives to contain expenditures for prescription drugs. Medicare's adoption in 1983 of DRG payment for inpatient hospital services strengthened hospitals' incentives to manage their inpatient drug costs. And, HMOs, which provided services on a capitated basis, grew rapidly throughout the 1980s, today covering over 16 percent of the U.S. population (Interstudy, 1993). When prescription drugs are included in the covered bundle of services provided by HMOs, these organizations have an incentive to take drug costs into account when making choices about particular products.

Third, advances in interactive on-line computer technology have opened up new possibilities for employers' and insurers' management of their prescription drug benefits. Third-party administrators of prescription drug benefits have

established computerized networks in pharmacies that track prescriptions as they are filled. These systems permit new avenues for influencing and controlling prescribing and dispensing.

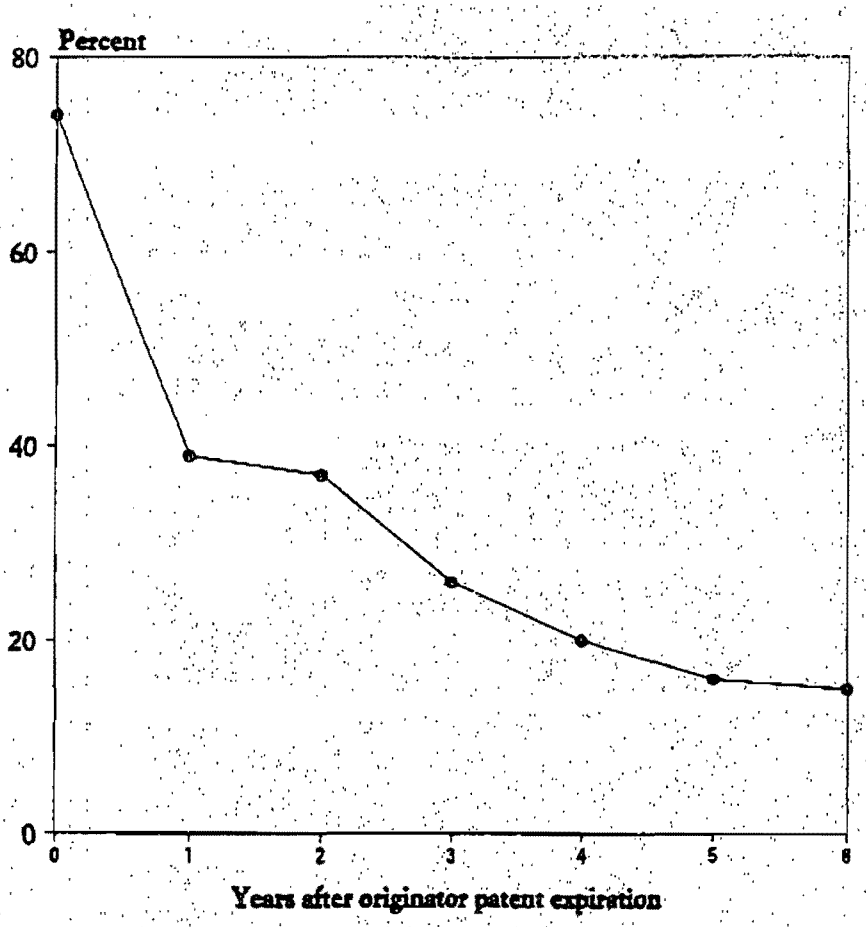
Fourth, employers are under new pressure to contain prescription drug costs as a result of the recent Federal Accounting Standards Board ruling requiring companies to report their obligations for retirees' health care costs as a liability in their financial statements. Although prescription drugs are a small proportion of overall health care costs (7-8 percent), they represent a much larger proportion -- roughly one-third -- of employers' costs of retiree health benefits (Alex Brown & Co., 1993). Every new dollar spent on prescription drugs for their retirees goes to the bottom line of companies' financial statements.

Together, these developments have created a new market place in which employers and insurers have both strong incentives *and* the power to contain the costs of prescription drugs by forcing drug companies to compete more vigorously on the basis of price.

Generic Substitution: Today, many health insurers have programs in place to encourage or require substitution of cheaper generic products for brand-name pharmaceuticals even when the prescription is written for the brand-name product. The most common incentive in private health plans is a lower patient copayment when a prescription for a multi-source drug is filled with a generic version. Mail-order pharmacy programs are another vehicle to maximize generic substitution, because these pharmacies are often located in States with the least restrictive laws on generic substitution. The Federal Medicaid program requires generic substitution unless the physician prohibits substitution in his or her own handwriting on the prescription form.

Despite the fact that generic drugs are cheaper than their brand-name counterparts and become more so over time (Figure 1), the market share of generic drugs is still surprisingly low. Data provided to OTA on prescriptions for

Figure 1--Non-Originator Price as a Percent of Originator Price* ($ 1990)



* Average revenue ($Sales/DDD), of non-originator drugs divided by average revenue of originator drugs.

Source: Office of Technology Assessment, 1993, based on S.W. Schodelmeyer, "Economic Impact of Multiple Source Competition on Originator Products," contract paper prepared for Office of Technology Assessment, December 1991.

multi-source drugs for long-term therapy by Medco Containment Services, a company that administers health plans' drug benefits, illustrates the point. As Table 2 shows, in the first 9 months of 1992, only 56 percent of these prescriptions dispensed through Medco's participating retail pharmacies were filled with a generic version of the compound. (A much higher proportion -- 72 percent -- of such prescriptions filled in Medco's mail-order facilities were filled with generics.) Even today, there is still a great deal of potential for further cost savings through higher rates of generic substitution at the retail level.

Therapeutic Price Competition: Hospitals and HMOs have used the power of restrictive formularies to manage their drug costs. Formularies are lists of drugs that can be prescribed by physicians without special appeals. The availability of numerous similar compounds in some narrow therapeutic categories has made it possible for these organizations to consider price as well as quality in determining whether a drug should be allowed on the formulary. In 1992, about 51 percent of

Table 2--Percent of Prescriptions for Multi-source Maintenance Drugs[a] Dispensed with Brand-name and Generic Products, January-September 1992

Market sector and drug type	Rx volume	Rx dollar value[b]
Mail order		
Brand-name	27.6%	53.6%
Generic	72.4	46.4
Retail[c]		
Brand-name	44.1	67.6
Generic	55.9	32.4

[a]Maintenance drugs are generally used for long-term therapy.
[b]Dollar value is derived from the average wholesale price.
[c]Prescriptions ordered through Medco's retail prescription programs. Some of these programs actively promote incentives to encourage dispensing of generic drugs.

KEY: Rx = prescription drug.

SOURCE: Medco Containment Services, Inc., 1993.

all hospitals had a well controlled formulary system in place (Crawford and Myers, 1993). Over two-thirds of all hospitals had in place for at least one therapeutic category a system of automatic substitution of one compound for another unless the doctor specifically prohibits it on the prescription.

HMOs, particularly those with tight organizational structures, have been able to influence physicians' prescribing practices through formularies. The power to impose limitations on prescribing has given HMOs purchasing clout with manufacturers and over the past few years has led some manufacturers to offer substantial price discounts to some HMOs. When there are enough close substitutes in a therapeutic class, the HMO can use the formulary as a bargaining chip to exact price concessions from producers.

The success of some HMOs and hospitals in getting price concessions from manufacturers of single-source drugs (i.e., those with patent protection) attests to the potential for price competition to lower the cost of drugs to patients or their insurers. For price competition among close therapeutic alternatives to be effective, however, enough similar competing products must exist to allow providers to choose among alternatives on the basis of price as well as quality. Ironically, the proliferation of me-too products, often derided as wasteful, is the key to cost containment through price competition in segments of the market that can take advantage of them.

Managed Care Pharmacy Programs: The potential for price competition is expanding rapidly as all kinds of health plans, both HMOs and indemnity plans, embrace the concept of managed care pharmacy. Under a managed care pharmacy program, the health plan (or its subcontractor) establishes a formulary and attempts to enforce it with the help of on-line computer networks in retail and/or mail-order pharmacies. Enforcement mechanisms range from counseling doctors whose prescribing profiles show a high incidence of prescribing off-

formulary drugs to refusal to pay for drugs not on the formulary except for a formal appeals process. HMO physicians are provided lists (sometimes in computer format) of drugs in the formulary and are expected to prescribe from the formulary except in extraordinary circumstances. In some managed care pharmacy programs network pharmacies are given financial incentives to substitute less expensive generic drugs for brand-name equivalents. For example, Medco recently announced that it will establish a "Coordinated Care Network Program" that will share 20 percent of savings from generic substitutions with the pharmacist (FDC Reports, 1993).

Managed care pharmacy programs have the potential to rapidly increase generic substitution rates, and in crowded therapeutic categories they can also force more price competition among therapeutic alternatives. For example, cardiovascular drugs constituted 22 percent of pharmaceutical sales in the United States in 1991 (Pharmaceutical Manufacturers Association, 1993) As Table 1 showed, most therapeutic categories of cardiovascular agents have a large number of competing compounds, some of which are already off patent.

The potential for cost savings from generic competition and managed care pharmacy will grow dramatically in the next three years as several drugs with high U.S. sales come off patent. Between 1993 and 1996, four compounds whose 1992 U.S. sales placed them among the top 10 drugs in the United States will lose patent protection (Santell, 1993; Top 100 Drugs, 1993). These four drugs alone accounted for $3.6 billion in sales in 1992. Many other drugs with substantial markets will also lose patent protection in the next three years.

Thus, over the next few years, growing price competition can be expected to provide a strong moderating influence on the rise in prescription drug expenditures.

Impact of a Universal Prescription Drug Benefit under Health Reform: Several legislative proposals for health care reform call for a prescription drug benefit for both the Medicare and non-Medicare populations. If the system places many Americans in managed care health plans, the trend toward increasing price competition for prescription drugs will be reinforced. On the other hand, while a prescription drug benefit for Medicare beneficiaries would improve access to health care for the roughly 55 percent of people 65 years of age and older who have no prescription drug coverage today, it would also remove retirees from managed care pharmacy programs and would eliminate employers' current incentives to see that their prescription drug benefits are managed aggressively.

To insure that Medicare pharmaceutical benefits are managed aggressively, the law could stipulate that Medicare beneficiaries purchase the benefit through the regional health alliance, which in turn would develop a Medicare managed care pharmacy program.

Limitations of Managed Care Pharmacy Programs: Managed care pharmacy programs have natural limits to their ability to contain costs. Health plans may be able to require therapeutic interchange within a very narrow therapeutic category (e.g., ACE inhibitors), but unless the plan can persuade physicians to adhere to treatment guidelines, choices across therapeutic categories typically are in the domain of physicians. For example, today several different clinical approaches are available to treat hypertension, including calcium channel blockers, ACE inhibitors, beta blockers and diuretics (Alderman, 1992). Suppose only one compound were available in each of these categories. Active price competition might still emerge across classes if (1) enough health plans were to adopt guidelines based on the cost and effectiveness of the alternative approaches; and (2) health plans had the power to persuade physicians to adhere to their clinical guidelines. At present, relatively few HMOs have the structures in place to develop and enforce clinical guidelines.

Even where such systems are feasible, the managed care pharmacy is unlikely to be the center of this process. First, prescriptions contain no information on diagnosis, so pharmacy data systems are generally not very useful in monitoring adherence to clinical guidelines. Second, formulary committees are not necessarily the most appropriate groups to develop clinical guidelines involving choices among different classes of drugs.[1]

Long-Term Problems for Price Competition

Though the prospects are bright in the next few years for the emerging pharmaceutical marketplace to moderate increases in prescription drug expenditures, the dynamics of technical change in pharmaceuticals may put new pressures on health care costs in the future.

The Thinning of Therapeutic Competition: For price competition to flourish, a sufficient number of generic or close therapeutic alternatives must be on the market. In many important categories today, the conditions are ripe for such price competition. But the new market place will change the dynamics of pharmaceutical R&D in ways that are difficult to predict. Because the cost of developing any new compound is high, pharmaceutical companies will be less likely to add additional new drugs to an already existing therapeutic category. The expected returns from such imitation will certainly be lower than they were in

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1The organization of such efforts within health plans varies, of course. A recent example of a formulary decision in a large group-practice HMO illustrates how formulary decisions can be implicit treatment guidelines. Kaiser Permanente recently announced that tacrine, the first drug approved by the FDA for the treatment of mild and moderate Alzheimer's disease, would not be listed on its formulary (FDC Reports, 1993). Although Kaiser physicians are not barred from prescribing the drug, the message is clear that the plan considers such decisions exceptions from standard practice. Whether this formulary decision to withhold a drug which is the only one so far to show any clinical benefits for Alzheimers' disease will ultimately stand is uncertain, as Kaiser officials have acknowledged.

the traditional market place. Thus, over time, the number of compounds in new therapeutic categories may thin out, offering managed care pharmacies fewer opportunities for cost savings through restrictive formularies.

The Problem of Breakthrough Drugs: Breakthrough drugs, which offer substantial new medical benefits, will present the greatest challenge to pharmaceutical and health care cost containment in the future. The U.S. government has invested tens of billions of dollars over the past two decades in basic research in the biological and medical sciences, research that is paying off today with a generation of drugs that rely on new knowledge of molecular biology, chemistry, and genetics. For example, the first biotechnology drug was approved for sale in the United States in 1985. As of mid-1992, 36 biotechnology-based drugs were approved for sale in the U.S., Europe or Japan, and 253 products had entered clinical testing in one of those countries by the end of 1990 (Bienz-Tadmor, 1993). Not all of these drugs are breakthroughs, but they vividly illustrate the impact of new scientific understanding of disease on the drug development process.

Breakthrough drugs will be immune from price competition during the period of patent protection unless and until close therapeutic alternatives emerge to compete with them. (And the incentives to imitate will be lower in the future as price competition grows, so fewer such competitors can be expected to emerge.) Under a universal prescription drug benefit, demand for these new products will be insensitive to price. Thus, the power of the formulary to unleash competitive market forces will be restricted for these drugs while they are protected from generic copy. Only the strategic desire of pharmaceutical companies to preserve the goodwill of their customers will limit the entry prices of these drugs.

There is a real need for careful study of approaches to the problem of unconstrained breakthrough drug prices, because the potential losses from the wrong strategy are high. On the one hand, as a society we clearly value and demand medical advances that will lengthen life and improve its quality along the way. On the other hand, our ability to pay for such advances may be limited. Paying higher prices than necessary to induce R&D investors to bring beneficial new drugs to market clearly wastes limited health care dollars. But paying too low a price would stifle R&D and deny us the benefits of breakthrough drugs.

Unfortunately, it is extremely difficult, perhaps impossible, to know what the "right" price for a breakthrough drug is. Every criterion for evaluating the entry price of a new drug is problematic. For example, even at high prices, some breakthrough drugs may save overall health care costs by reducing the need for other expensive care. Some would claim that the reasonableness of a breakthrough drug's price should be judged by its ability to meet this cost-saving criterion, but the cost-saving character of a new therapy is not a reasonable basis for pricing. Even if a drug is cost-saving at one price, it is not cost-effective if the developers would have decided to bring it to market knowing it would fetch a lower price.[2] Second, many breakthrough drugs will offer major improvements in mortality or morbidity but at a net increase in health care costs even when the price is at the minimal level required to assure its availability on the market.

To some, comparing the entry price of a new drug in the United States with its entry price in other industrialized countries would seem to be appropriate. But this criterion is also problematic. When pressed, drug companies have made substantial price concessions in countries representing a small proportion of the

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2Analysis of the costs and effects of new therapies may be useful in deciding under what clinical conditions, if any, they should be used. But these analyses implicitly assume that the cost (or price) of the new drug is not higher than necessary to insure its availability on the market.

world market. Australia, for example, has paid substantially less for drugs than other countries, but it is a very small market. And, the prices that Australia pays may not fully cover the costs of R&D. If everyone were to pay those prices, the worldwide revenues for some products might not be adequate to bring forth the products. In addition, the United States is such a large market (roughly 30 percent of the world market overall) that any tying of prices to those in other countries could drive other prices up rather than U.S. prices down.

Basing price on the R&D costs associated with bringing a breakthrough drug to market is also extremely difficult to do correctly, and the potential for substantial error in measuring such costs could create new uncertainties at the earliest R&D investment decision points, when the risks of going ahead are the greatest.

It is also important to recognize that any new administrative process that raises investors' uncertainty about the allowed price of a drug or whether it will be covered at all once it is approved by FDA could discourage early R&D. R&D managers (and their investors) often take "flyers" on projects by investing relatively small amounts of money to resolve technical or clinical uncertainties about an idea. If these early technical uncertainties are successfully resolved, more money flows into the project. Though uncertainty is never completely removed throughout the discovery/development process, it tends to decline dramatically as a project moves toward market approval. An administrative process for controlling drug prices would add a new source of uncertainty at the end of the process, one that would not be resolvable until all the money has been

spent. Consequently, investors would be more hesitant to commit early R&D money if they knew they could not resolve a major source of uncertainty until the end of a long and expensive project.[3]

There are many aspects of the breakthrough drug problem that will need to be addressed in the coming years, especially if health care reform creates a universal prescription drug benefit. Among the questions for policy makers are the following:

- What role should NIH or other Federal agencies take in controlling the entry price of new drugs whose development is directly dependent on intellectual property rights held by the Government? Should the Federal government put out for bid or negotiate price agreements with private developers up front, at the time a research agreement is made? On what basis should such negotiations be based?
- What role should NIH take in sponsoring or conducting research on important new lines of research? How should it protect the public from paying twice for this research -- once when it funds the studies and again when it pays for the drugs.
- What role could or should FDA play in encouraging the rapid entry of therapeutic competitors to breakthrough drugs? For example, could surrogate endpoints be used for products in the same class as a breakthrough drug already on the market?
- What Federal policies are necessary to assure the rapid emergence of generic competition when breakthrough and other drugs do lose patent protection?
- What impact would recent congressional proposals to strengthen biotechnology patents have on the competitive environment for breakthrough drugs?
- To what extent should awards of orphan drug status for new compounds be conditioned on responsible pricing decisions, and how would such pricing decisions be evaluated?

3Another way of expressing this effect is that the cost of capital for R&D would increase at all stages of the R&D process, but especially dramatically at the earliest stages.

Conclusions

The growing competition in the market for pharmaceuticals spells price and cost relief for many consumers of prescription drugs. In the near term, there are still cost savings to come, particularly in the area of generic price competition for multiple-source drugs, but also as formularies force competition among therapeutic alternatives. The natural growth of managed care pharmacy programs could be retarded by a Medicare prescription drug benefit under health care reform, unless the benefit is structured to make use of these programs.

The long term prospects for prescription drug costs are much more uncertain, as new drug categories emerge with fewer compounds competing. Temporary monopolies through patent protection, combined with insensitivity to price for important new drugs under a generous prescription drug benefit, will permit firms to launch important new drugs at very high prices. Just how big a cost problem breakthrough drugs turn out to be will depend on how many similar competing drugs follow and how soon they do, and how much of a constraint concern over goodwill will be to pharmaceutical companies in the future. Close monitoring of the breakthrough drug problem is imperative, but the search for solutions should proceed cautiously.

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Senate Aging Comm.

x 2599

Call Shirley Sagawa - couple wks ago
forwarded draft letter to HRC to Sec Burg
summary of what is happening on
prescription drugs
Cat not seen, Pryor's not seen
STATUS?

look in computer to update
give to Shirley for HRC's sign of letters for Monday

Per Shirley - much longer & more substantive response than usual HRC letter. She said they did not make changes - did we ever print in final form for HRC signature. May need to be updated at this point.

(N.B. I found the letter in the computer. No changes made except "draft" deleted from 1st para & HRC spelled out)

DRAFT July 26, 1993

As printed from computer. No changes were made except "Draft" deleted & the spelled out

The Honorable David Pryor
Chairman
U.S. Senate Special Committee on Aging
SD-G31
Washington, D.C. 20510-6400

Dear David:

Thank you so much for advising us of your priorities with regard to pharmaceutical coverage and cost containment issues. As you well know, I greatly appreciate your guidance on all matters. However, having the benefit of your years of experience on the many complex issues regarding pharmaceuticals is particularly helpful.

David, because the cost estimates for all the various elements of the health reform package have not yet been finalized, the President has not made final decisions on all the issues related to prescription drugs. Having said this, I would like to take this opportunity to outline for you, on a confidential basis, my sense of where the elements of the proposal related to pharmaceuticals are likely to go.

Prescription Drug Costs and Managed Competition

We believe that the negotiating practices utilized most frequently by managed care purchasers have great potential to contain escalating prescription drug prices. In recent years, we have witnessed the new found ability of these purchasers (primarily hospitals and HMOs) to obtain more reasonable prices by negotiating and managing costs with formularies, prior authorization requirements, physician and consumer education programs, drug use review, and other techniques.

While managed care purchasers have been able to generally contain their pharmaceutical cost increases, they have not had success in managing the costs of new drugs that have no therapeutic alternative. Moreover, it is likely to take several years before pharmaceutical purchasing that utilizes managed competition techniques will be developed sufficiently enough to buy and manage the costs of prescription drugs for all Americans.

As a result, it has become clear that we must develop an interim and a long-term pharmaceutical cost containment strategy. Moreover, to ever have a realistic chance to contain these costs, it has become evident that we will have to assure that all Americans have private or public coverage for prescription drugs.

Prescription Drug Coverage

It is our belief that providing prescription drug coverage for all Americans is essential to assuring that everyone has access to affordable and frequently cost-effective medications. It is our hope and expectation that there will be a Medicare prescription drug benefit that parallels the coverage that we will require all Americans under the age of 65 to receive. We share your belief that all Americans, particularly the elderly, are in desperate need of protection from the high costs of pharmaceuticals. While we have not finalized exactly what the cost sharing components will be, we do believe it will be at or close to your suggestion of a $250 deductible and a 20 percent copayment.

Interim Cost Containment Strategy

Under any scenario, consumers will need to be protected from price increases over the inflation rate until there is much greater coverage of prescription drugs and there is a widespread ability -- using managed competition methods -- to negotiate on behalf of consumers. We are, therefore, now considering accepting the offer of many in the pharmaceutical industry to voluntarily constrain their prices to the general inflation rate. Consistent with your recommendations, this policy would assure that retail purchasers would have the same inflation protections as everyone else. The voluntary agreements would be enforced through the use of a fall-back mechanism that would only be initiated if the companies did not sign an agreement in the first place OR signed one but did not comply.

Cost Containment for Under-65 Population

The short-term cost containment provisions that we are contemplating will help assure that the under-65 population will not be subjected to significant price increases for pharmacueticals now on the market. Moreover, the growing movement towards managed competition purchasing principles should achieve substantial savings as well. However, we share your concern about the potential for a continuation -- or even escalation -- of the trend of excessively high prices for new drugs, particularly those that have no therapeutic alternative.

With the above in mind, we believe it is advisable to direct that the National Health Care Board envisioned in our current draft be charged with reviewing the prices of new pharmaceuticals. While the Board would not have the authority to regulate or set prices, it would have the responsibility for evaluating the cost effectiveness and therapeutic value of new medications. In undertaking this responsibility, the Board would then be required to disseminate information to both public and private purchasers of prescription drugs.

Cost Containment for the Medicare Program

No Medicare benefit can be established without a realistic and serious cost containment component. No one knows this better than you. We anticipate that the Medicare cost containment provisions will meet with your approval, since they are very close to your recommendations.

More specifically, since the Medicare program would become the world's largest single purchaser of prescription drugs, we believe the program merits a reasonable price. To achieve this, we believe that Medicare should receive a discount that is at, or close to, the percentage discount that the Medicaid and other public programs are now receiving. Moreover, to assure that excessively priced new drugs do not bankrupt the Treasury, we believe it is advisable to provide the Secretary of Health and Human Services the authority to negotiate Medicare drug prices with manufacturers. Lastly, I believe we should provide incentives for greater use of generic drugs and for more widespread use of patient and physician counseling.

Equitable Treatment of Pharmacists

Finally, it has become clear that community pharmacists are having great difficulty in accessing the degree of discounts that other purchasers have achieved. It remains unclear to us exactly why this is the case. The retail pharmacists argue that it is blatant discrimination by the pharmaceutical manufacturers; the HMOs and hospitals say they earn these discounts because they can push volume in ways the retail pharmacists -- with few exceptions -- have not yet been able to master.

We have been working for months on this complex and controversial issue. It is our hope to find a policy approach that assures that no one receives a particular discount just because they are one particular purchaser or another. We want to make certain that discounts are given to those who earn them. In the upcoming days and weeks, we will be working closely with your and other offices to attempt to find a way to achieve this goal.

David, the contributions of you and your staff to the pharmaceutical coverage and cost containment policy we are developing have been invaluable. It is my hope and expectation that after reviewing this letter you will conclude that we are meeting your policy priorities. However, if you have any questions, concerns or further suggestions, I urge you to give me a call. Once again, thank you for all of your assistance.

Sincerely,

HRC

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

PERSONAL AND ~~CONFIDENTIAL~~

July 12, 1993

Mrs. Hillary Rodham Clinton
Chairperson, President's Task Force
on Health Care Reform
The White House
1600 Pennsylvania Ave
Washington, D.C. 20500

Dear Hillary:

As Chairman of the Senate Special Committee on Aging, you know of my long-standing interest in issues relating to prescription drug access and cost containment. Therefore, the provisions in the Administration's health care reform package relating to these issues are of particular interest to me. The purpose of this letter is to encourage you to consider including the following prescription drug-related provisions in the final health care reform plan that is currently under development:

o Medicare Prescription Drug Benefit: Older Americans are in dire need of better prescription drug coverage. Therefore, I urge that a Medicare outpatient prescription drug benefit be included in the final package. Obviously, it would be optimal if the Medicare drug benefit could cover as many older Americans as possible by having a relatively low deductible and prescription copayment. For example, I would recommend an annual deductible in the range of $250, with 80 percent of the cost of each prescription covered by the program thereafter. However, I recognize that the potential cost of the benefit to the federal government and to the Medicare population may make it difficult to provide this generous a benefit.

Regardless of the deductible, I strongly urge that the Medicare drug benefit contain specific mechanisms to contain the costs of pharmaceuticals for the program. We simply cannot repeat the mistakes made with the Medicare Catastrophic Coverage Act of 1988, which included a Medicare drug benefit without specific pharmaceutical cost containment mechanisms. As a result, the costs of the program skyrocketed very quickly. I recommend that Medicare cost containment strategies include a Medicaid-like drug manufacturer rebate program, negotiations with manufacturers over drug prices, or both.

o **Interim Pharmaceutical Cost Containment Mechanisms:** I know that you and the President are considering mechanisms to contain health care costs during the period of transition to the new health care system. Several drug manufacturers have publicly stated that they will "voluntarily" maintain their "weighted average" annual price increases on their products to the rate of inflation.

If the Administration decides to use this interim approach to contain drug costs, I strongly urge that it be combined with an approach that specifically limits price increase on drug products distributed to the retail class of trade. This can be achieved either by limiting the weighted average price increase of each retail-distributed product's dosage form and strength to the increase in inflation or by limiting the increase in each individual retail product's package size to the increase in inflation.

Without this additional price increase limit, I am concerned that manufacturers' retail prescription drug prices will continue to increase faster than inflation. If this occurs, Americans may see little relief from the excessive price increases of the past twelve years.

o **Mechanisms to Contain New Drug Costs:** The final package should contain some mechanism to contain the cost of new pharmaceuticals that will be marketed. This is especially important in the case where the new pharmaceutical has no therapeutic alternate on the market. I strongly urge the establishment of a National Commission or Board with the primary responsibility of providing information to the health care system about whether the price of a new drug is "reasonable."

Without such a review, manufacturers will likely attempt to offset cost containment pressures on "existing" drugs by increasing prices more rapidly on "new" drugs. As a result of this likely behavior, drug costs will not be contained, they will simply be shifted to new drug prices, which I believe is undesirable.

By establishing a Commission that "reviews" rather than "sets" or "controls" new drug prices, drug manufacturers would still have significant pricing flexibility. However, they would have to become more sensitive to the prices at which they introduce new drugs to the United States. This approach is a middle ground between direct federal regulation of the prices of new pharmaceuticals, and doing nothing at all. This Board could also provide valuable information to all purchasers about the prices of pharmaceuticals in other industrialized nations.

Hillary, I know that you and the President are doing your very best to balance the interests of various parties in constructing this health care reform plan. Your leadership on this issue is to be commended. I want to reaffirm to you my commitment to developing a responsible health care reform package, and would appreciate your serious consideration of these ideas on pharmaceuticals. I would very much look forward to discussing these and other ideas with you and the President relating to pharmaceutical access and cost containment. As always, I wish you the best of luck in this very worthy and necessary endeavor.

Sincerely,

David Pryor
Chairman

cc: Ira Magaziner, Senior Domestic Policy Advisor

Senate Aging Com

August 31, 1993

The Honorable David Pryor
Chairman
U.S. Senate Special Committee on Aging
SD-G31
Washington, D.C. 20510-6400

Dear David:

Thank you so much for advising us of your priorities with regard to pharmaceutical coverage and cost containment issues. As you well know, I greatly appreciate your guidance on all matters. However, having the benefit of your years of experience on the many complex issues regarding pharmaceuticals is particularly helpful.

David, because the cost estimates for all the various elements of the health reform package have not yet been finalized, the President has not made final decisions on all the issues related to prescription drugs. Having said this, I would like to take this opportunity to outline for you, on a confidential basis, my sense of where the elements of the proposal related to pharmaceuticals are likely to go.

Prescription Drug Costs and Managed Competition

We believe that the negotiating practices utilized most frequently by managed care purchasers have great potential to contain escalating prescription drug prices. In recent years, we have witnessed the new found ability of these purchasers (primarily hospitals and HMOs) to obtain more reasonable prices by negotiating and managing costs with formularies, prior authorization requirements, physician and consumer education programs, drug use review, and other techniques.

While managed care purchasers have been able to generally contain their pharmaceutical cost increases, they have had little success in managing the costs of new drugs that have no therapeutic alternative. Moreover, it is likely to take several years before pharmaceutical purchasing that utilizes managed competition techniques will be developed sufficiently enough to buy and manage the costs of prescription drugs for all Americans.

As a result, it has become clear that we must develop an interim and a long-term pharmaceutical cost containment strategy. Moreover, to ever have a realistic chance to contain these costs, it has become evident that we will have to assure that all Americans have private or public coverage for prescription drugs.

Prescription Drug Coverage

It is our belief that providing prescription drug coverage for all Americans is essential to assuring that everyone has access to affordable and frequently cost-effective medications. It is our hope and expectation that there will be a Medicare prescription drug benefit that parallels the coverage that we will require all Americans under the age of 65 to receive. We share your belief that all Americans, particularly the elderly, are in desperate need of protection from the high costs of pharmaceuticals. While we have not finalized exactly what the cost sharing components will be, we do believe it will be at or close to your suggestion of a $250 deductible and a 20 percent copayment.

Interim Cost Containment Strategy

Under any scenario, consumers will need to be protected from price increases over the inflation rate until there is much greater coverage of prescription drugs and there is a widespread ability -- using managed competition methods -- to negotiate on behalf of consumers. We are, therefore, now considering accepting the offer of many in the pharmaceutical industry to voluntarily constrain their prices to the general inflation rate. Consistent with your recommendations, this policy would assure that retail purchasers would have the same inflation protections as everyone else.

Cost Containment for Under-65 Population

The short-term cost containment provisions that we are contemplating should help assure that the under-65 population will not be subjected to significant price increases for pharmaceuticals now on the market. Moreover, the growing movement towards managed competition purchasing principles should achieve substantial savings as well. However, we share your concern about the potential for a continuation -- or even escalation -- of the trend of excessively high prices for new drugs, particularly those that have no therapeutic alternative.

With the above in mind, we believe it is advisable to direct that the National Health Care Board envisioned in our current draft be charged with reviewing the prices of new pharmaceuticals. While the Board would not have the authority to regulate or set prices, it would have the responsibility for evaluating the cost effectiveness and therapeutic value of new medications. In undertaking this responsibility, the Board would then be required to disseminate information to both public and private purchasers of prescription drugs.

Cost Containment for the Medicare Program

No Medicare benefit can be established without a realistic and serious cost containment component. No one knows this better than you. We anticipate that the Medicare cost containment provisions will meet with your approval, since they are very close to your recommendations.

More specifically, since the Medicare program would become the world's largest single purchaser of prescription drugs, we believe the program merits a reasonable price. To achieve this, we believe that Medicare should receive a discount that is at, or close to, the percentage discount that the Medicaid and other public programs are now receiving. Moreover, to assure that excessively priced new drugs do not bankrupt the Treasury, we believe it is advisable to provide the Secretary of Health and Human Services the authority to negotiate Medicare drug prices with manufacturers. Lastly, I believe we should provide incentives for greater use of generic drugs and for more widespread use of patient and physician counseling.

Equitable Treatment of Pharmacists

Finally, it has become clear that community pharmacists are having great difficulty in accessing the degree of discounts that other purchasers have achieved. It remains unclear to us exactly why this is the case. The retail pharmacists argue that it is blatant discrimination by the pharmaceutical manufacturers; the HMOs and hospitals say they earn these discounts because they can push volume in ways the retail pharmacists -- with few exceptions -- have not yet been able to master.

We have been working for months on this complex and controversial issue. It is our hope to find a policy approach that assures that no one receives a particular discount just because they are one particular purchaser or another. We want to make certain that discounts are given to those who earn them. In the upcoming days and weeks, we will be working closely with your and other offices to attempt to find a way to achieve this goal.

David, the contributions of you and your staff to the pharmaceutical coverage and cost containment policy we are developing have been invaluable. It is my hope and expectation that after reviewing this letter you will conclude that we are meeting your policy priorities. However, if you have any questions, concerns or further suggestions, I urge you to give me a call. Once again, thank you for all of your assistance.

Sincerely yours,

Hillary Rodham Clinton

PRIVILEGED AND ~~CONFIDENTIAL~~ MEMORANDUM

TO: Hillary Rodham Clinton May 5, 1993
FR: Chris Jennings
RE: Summary of David Pryor's Senate Aging Committee Event

Tomorrow morning, you are scheduled to join Democratic and Republican Members of the Senate Aging Committee for a closed "healthy" breakfast meeting to discuss aging issues and preventive health care. After the breakfast, the Aging Committee will convene a hearing on preventive health for older persons.

While the hearing will explore the senior prevention topic broadly, certain witnesses will stress that tobacco and alcohol are leading causes of disease, premature death, and health costs. Attached to this memo you will find a schedule for the morning and a copy of Senator Pryor's draft opening statement.

Purpose of the Hearing (Which Follows Your Meeting)

The hearing will emphasize that the U.S. health care system is aggressive in its diagnostic and treatment efforts once serious illnesses and injuries have occurred, but that it is negligent and short-sighted in investing in prevention. It will suggest that many of these illnesses and injuries could be avoided not only by investing in preventive services, but by individuals taking a greater degree of self-responsibility for their own health status.

The three leading causes of preventable health problems will be explored in detail: tobacco, alcohol, and poor diet. Specifically, one in four Americans will die as a result of the use of tobacco and alcohol. Tobacco killed an estimated 417,000 in 1990. Alcohol killed 107,000 in 1988.

Costs of tobacco and alcohol to society and the health care system will be quantified. The Aging Committee will release a Congressional Office of Technology Assessment study documenting that in 1990 tobacco cost society $68 billion, including $21 billion to the health care system. The latest study on alcohol concludes that the 1990 costs to society were $98 billion, including $12 billion to the health care system. This information will support any effort to move to increase disincentives (taxes) for unhealthy behaviors, such as smoking.

Background on the Senate Aging Committee

The Senate Aging Committee is a permanent oversight panel established in 1961. Although its House counterpart was recently eliminated, Senator Pryor defeated an effort to kill the Aging Committee on the Senate floor by 56–43. Senator Reid offered the amendment, even though he sits on the Committee (and will attend the breakfast). Senator Pryor made an emotional appeal to save the Committee. The Committee remains at risk because a Joint Committee on the Organization of Congress will put out a report as early as August which is likely to recommend cutting back on the number of Congressional committees.

Anything positive you can say about the Aging Committee would be deeply and personally appreciated by Senator Pryor. Positive comments would be welcome at the breakfast (because some of the Members voted against the continuation of the Committee), but particularly welcome at the 9:30 press availability. You might want to consider acknowledging some of the important work the Aging Committee has produced over the years. In particular, you could highlight its work on controlling drug costs, raising the special concerns of rural communities, highlighting the importance of home- and community-based long term care coverage, and publicizing the importance of cost-effective preventive health care interventions.

Members Attending the Breakfast Meeting

The following members have indicated they will attend:

Sen. Pryor, Chairman
Sen. Glenn
Sen. Bradley
Sen. Breaux
Sen. Reid
Sen. Graham
Sen. Feingold
Sen. Krueger
Sen. Shelby

Sen. Cohen, Ranking Minority
Sen. Pressler
Sen. Grassley
Sen. Simpson
Sen. Jeffords
Sen. Durenberger
Sen. Craig
Sen. Burns (arriving late)

Many of these Members are particularly critical to us, especially Bradley, Breaux, Graham, Cohen, Jeffords, Durenberger, and Burns. Attached for your information is a summary of the health backgrounds of each of the Aging Committee Members.

SCHEDULE

May 6, 1993

8:00 - 9:15 a.m. **Breakfast Meeting with Senate Aging Committee**
Russell Senate Office Building, Room 428A
(Small Business Committee Hearing Room)

Meet with members of the Senate Special Committee on Aging. Topics of discussion limited to aging issues and preventive health care. You can make a brief comment on these issues followed by a discussion moderated by Senator Pryor. Closed to press. Quick (two minute) photo opportunity for the media at the beginning of the breakfast meeting. Breakfast will be low-fat, specially overseen by cable TV personality Lynn Fischer, "The Low Cholesterol Gourmet," who will attend.

(Lead staffer: Jonathan Adelstein for Senator Pryor. Other majority and minority committee staff will be in the room for breakfast, but the hearing will be closed to staff of committee members.)

9:30 - 9:45 a.m. **Press Availability**

Lisa has okayed a brief statement to the press on the importance of aging issues, preventive health, and the role of the Senate Aging Committee. You will be joined only by Chairman Pryor and Ranking Republican Member Cohen. After a very brief number of questions, Senator Pryor will cut it off.

You then leave the Senate Office Building.

10:00 - 12:30 p.m. **Hearing of the Senate Aging Committee**

Title: "Preventive Health: An Ounce of Prevention Saves a Pound of Cure."
Witnesses will testify about the cost-effectiveness of preventive measures, even for the elderly. They will discuss the costs to society and the health care system of risky choices such as smoking, drinking alcohol excessively, and eating high-fat foods.

DEMOCRATS ON SENATE AGING COMMITTEE

SEN. DAVID PRYOR (D-AR) – Senator David Pryor is Chairman of the Senate Special Committee on Aging. He is well liked and respected by the powerful aging advocacy community. In addition, he is one of the few Democrats that the small business community genuinely trusts. Further, as a former Governor, his advocacy of state-based approaches to comprehensive reform has gained him a great deal of good will with the Governors. Although an unassuming Member and one who does not get overly involved in detailed policy discussions, he has emerged as one of the most influential and best liked members of the Senate. All of these roles ensure that he will be a key player on the health care front.

In terms of health care priorities, drug cost containment is the first, second, and third highest priority for Senator Pryor. The concept of linking drug cost containment to tax credits (embodied in Pryor's Prescription Drug Cost Containment Act -- S. 2000) was endorsed by President Clinton.

In addition to his drug cost containment interests, he also has a notable legislative achievement record in rural health (relief for hospitals and incentives for primary care doctors in medically underserved areas), state-based reform (his NGA and Clinton candidate-endorsed Leahy/Pryor bill), and long-term care (his proposal for Federal standards for private long-term care insurance policies).

Recent Developments: He backs the use of a dedicated tax for health care, perhaps a VAT. He also supports the inclusion of a significant long-term care benefit. He believes that as long as we will be spending billions of dollars, we should make certain to attract popular support for the plan.

He and Senator Cohen joined in an effort to fight back an unsuccessful attempt to eliminate the Aging Committee. Although the Committee won the vote on the floor of the Senate, the committee remains vulnerable as a result of the deliberations of the Joint Committee on the Organization of Congress.

SEN. JOHN GLENN (D-OH) – Senator Glenn has held hearings on the German and French systems as models for health reform. He supported pay or play but not the Leadership's HealthAmerica bill. His concerns include the impact of reform on small business, retiree health benefits, and potential changes to Medicare and Medicaid.

In a previous meeting with the DPC, Glenn questioned where the savings would come from in the new system. He thinks that doctors have been unfairly vilified in debates over health care costs. He says that their income accounts for less than one-fifth of health care spending. He is more intrigued by the large percentage of lifetime health care costs which occur during the last four months of life as an area for health savings.

As chairman of the Government Affairs Committee, he is likely to be interested in and actively involved with any proposal that would fold the Federal Employees Health Benefit Plan into the new system. Since advocates for federal employees are now asking that they be treated the same as other large employers, they are likely to express serious reservations about the currently envisioned program. It is therefore advisable to meet with Senator Glenn and other chairmen of jurisdiction before any decision is made public.

SEN. BILL BRADLEY (D-NJ) – Senator Bradley is known more for his work on tax policy than for his work on health care financing. He has indicated an interest in introducing health care reform legislation similar to the managed competition model that he believes the President has been advocating. The one exception to his general support of the Clinton health care approach may well be with regard to prescription drugs. As a Senator representing the state which is the capital of the pharmaceutical industry, Bradley is a fierce advocate for the industry and their concerns. With Senator Hatch, he led the fight against Senator Pryor's effort to influence the industry to contain price increases to inflation by linking their pricing behavior to eligibility for tax credits. (The Pryor proposal was endorsed by the President during the campaign).

As a member of the Infant Mortality Commission, Senator Bradley is proud of his work to ensure that the Medicaid program was expanded to eventually cover pregnant women and kids. He also is a strong advocate for preventive care services. He has sponsored several bills on tobacco, including revised warning labels and tobacco as a drug to be included in the Drug Free Schools program. In addition, Senator Bradley introduced legislation this year to rase the cigarette excise tax by $1 a pack. Lastly, although he incurred the wrath of some aging groups with his opposition to prescription drug price constraints, he has been a long-time supporter of home and community-based long term care services, particularly with regard to respite care services.

Recent Developments: At the 4/20 Finance Committee meeting with The First Lady, Senator Bradley asked for an estimate of how much the plan is going to cost and how much revenue is expected to be needed. He is very concerned about taxes and is a great advocate of going slow on this issue. "It is more important to get it right."

SEN. BENNETT JOHNSTON (D-LA) – Senator Johnston has been noncommittal on health reform but wants to be a constructive player. He may defer to his Louisianan colleague Sen. Breaux who has shown increasing interest in health care reform, since they share concerns on its impact on small business and rural areas. His major concern is preventive care and he will be willing to compromise on other issues if this is made a high priority in the package. While he is not opposed to managed competition he sees problems with regional pricing. In discussions with the HCTF in the past, he has asked whether everyone will be in the purchasing cooperative and whether doctors will be able to charge higher fees outside of the package. Senator Johnston is also concerned with the financing of the health care package.

SEN. JOHN BREAUX (D-LA) - Senator Breaux is the second most junior Member of the Finance Committee. He is one of those up and coming "New Democrats" for whom many see a bright future. His politics are moderate to conservative but he is known more as a pragmatist than an idealogue. In the area of health care, Breaux is yet another of the Committee members who care deeply about small businesses and rural health care.

Prior to this year, Senator Breaux was not overly active in health care issues. That changed when he introduced the Conservative Democratic Forum's managed competition bill with Senator Boren in 1992. He is very concerned, however, about the bill's limitations with regard to assuring adequate access to health care in rural areas. He is also concerned about whether this approach will actually achieve broad-based cost savings. Despite this, he remains uncomfortable with the alternatives and he will want to make sure that the Conservative Democratic Forum's model is used as much as possible during the upcoming debate. He opposes price caps and freezes to control costs.

Recent Developments: At the Finance Committee meeting (4/20), Senator Breaux stated that he was very encouraged about what he was hearing. He believes people want health care reform but it will be important to sell the benefits first (and sell people on what they are getting). He wants the plan to be bipartisan and thinks it should contain malpractice reform. the Senator has made very positive public comments about the prospects for health care reform and praised the consultative process with both Democrats and Republicans. In addition, at the invitation of Ira Magaziner, he joined the President at the Democratic Leadership Conference meeting in New Orleans.

SENATOR RICHARD SHELBY (D-AL) - As you know, the media has made much of the rift between Senator Shelby and the White House. He is a conservative Democrat whose vote is considered tough to get. While he has said that he is waiting to see what the President puts forth, he has expressed some clear views regarding health care reform. He opposes "single payer" or any other "top-down" system. He believes there needs to be local control and decision making. He is anti-employer mandates, anti-rate setting, and has significant small business concerns. Some self-insured people have used managed care very well in Alabama.

Recent Development: In March, Senator Shelby sent a "Dear Colleague" asking for cosponsors for his resolution expressing a "sense of the Congress that any National Health Care reform legislation must ensure that every person covered under the plan has access to coverage for medically and psychologically necessary treatments for mental disorders. Such access should be equitable to coverage provided to treatments for physical illnesses."

SEN. HARRY REID (D-NV) – Senator Reid is in his second term in the United States Senate. Traditionally not outspoken on health issues, he spends most of his time with his Appropriations and Environment and Public Works committees. He has yet to take a position on a particular reform model. He is waiting to see what the HCTF and the President have developed. The Senator stresses rural health issues and wants lead screening emphasized. He's concerned about mandated benefit packages because he believes they have not worked at the state level. He is also worried about the impact of reform on physicians' earnings.

SEN. BOB GRAHAM (D-FL) – Senator Graham wants to support the President and, not surprisingly, is most concerned about long term care being included in the final package. With Florida recently enacting health care legislation, he may be sensitive about state flexibility. He is okay on employer mandates and wants to be a player on global budgets. However, he would be concerned if Florida were somehow adversely affected in comparison to other states. His staff is working on the White House Long Term Care Working Group. In previous meetings with the HCTF, he was worried about the role of the Public Health System.

SEN. HERBERT KOHL – Senator Rockefeller believes Senator Kohl will likely support the President. Senator Kohl is one of the wealthiest members of the Senate and spent freely of his own money to win this seat. Using the slogan "Nobody's Senator But Yours," Kohl tried to portray himself in a positive light as a candidate not beholden to special interests. He is up for re-election in 1994. He does not support single payer and has not taken a position yet on managed competition. He is comfortable with employer mandates if coupled with adequate subsidies. Insurance companies are the second largest employer in the state of Wisconsin, which may be a concern for him. He is a member of the Mitchell working group and members of his staff are participating on the HCTF working groups.

SEN. RUSSELL FEINGOLD (D-WI) – Freshman Senator Feingold has also adopted a wait-and-see attitude but is likely to support the President. In meetings with the HCTF he has discussed the need for long term health care, particularly home and community based care for the elderly and the disabled. Senator Feingold is also concerned abut coverage for farmers. At the state level he was a sponsor of single-payer legislation in Wisconsin.

Recent Development: At the 4/30 bipartisan meeting with the Senate, Senator Feingold asked about long-term care and home care. In particular he wanted to know how the states would be affected by the Administration's proposals. This is particularly important to him because Wisconsin is ahead of the game on this issue.

SEN. BOB KRUEGER – Senator Krueger is fighting for his political life trying to hold onto Secretary Bentsen's former Senate seat. He recognizes the importance of the issue, but is preoccupied with returning to the Senate. It is difficult to foresee his positions, or even worry about them at this point.

Recent Developments: Senator Krueger is now engaged in an election run-off with Texas State Treasurer, Kay Bailey Hutchinson. The Republicans are gearing up for a victory as a slap to Clinton.

REPUBLICAN MEMBERS OF THE SENATE AGING COMMITTEE

WILLIAM "BILL" COHEN (R-ME) - Senator Bill Cohen from Maine was elected to the Senate in 1978, winning against Senator Hathaway by a large margin. His platform then focused on military strength, and that won him a seat on the Senate Armed Services Committee. He is currently on the Senate Committee on the Judiciary, the Senate Committee on Governmental Affairs, the Senate Committee on Armed Services, the Senate Special Committee on Aging, and the Joint Committee on the Organization of Congress. He is considered to be an unpredictable and at times a liberal Republican, whose home state priorities often override partisan votes.

Last session, Senator Cohen worked on a health care package which included a refundable tax credit for health insurance premiums and a nationwide low-cost basic benefits package.

On January 27, 1993, Senator Cohen submitted S. 223, the Access to Affordable Health Care Act, a bill to contain health care costs and increase access to affordable health care, and for other purposes. Senator Cohen also co-sponsored Senator Mitchell's Freedom of Choice Act.

Senator Cohen is one of the ten Republican Senators we have a possibility of getting at the present time. He requested that you attend an event in Maine at the same time you went to Nebraska for Senator Kerrey. The First Lady may want to extend regrets. Doing something in Maine and not heavily involving Senator Mitchell is not recommended. An underlying rivalry exists between Senators Mitchell and Cohen. Apparently he may ask you again for another event; we advise not to commit at this time.

Recent Developments: At the bipartisan meeting with the Senate last Friday (4/30), Senator Cohen asked about global budgets and caps. In addition, he wanted to know how price controls (if any) will work. Cohen also asked about the process and gave his advice on consultation. In addition, he expressed interest in long-term care.

Senator Cohen joined Senator Pryor in an effort to fight back an unsuccessful attempt to eliminate the Aging Committee. Although the Committee won the vote on the floor of the Senate, the committee remains vulnerable as a result of the deliberations of the Joint Committee on the Organization of Congress.

SENATOR LARRY PRESSLER (R-SD) - Senator Larry Pressler is a moderate to conservative Republican from the State of South Dakota. Known mostly for wanting Congressional reform, he has fought against pay raises and other issues that are popular back home. Senator Pressler has a tendency to vote the ways the current political winds are blowing. Early in his career, he was known as a liberal Republican, then a conservative and is now known as a moderate Republican. Senator Pressler was narrowly re-elected to the Senate in 1990, and is expected to face a strong challenge from the very popular Congressman-at-large, Tim Johnson, in 1996. Lately, many negative articles have been written about Pressler in South Dakota, which has caused his popularity to slip. However,

much can happen in the next four years.

His health views are not widely known. And it is also unclear whether he will fall to either the Chafee or Gramm side of the current Republican health care debate.

Recent Development: At the 4/30 bipartisan meeting with the Senate, the Senator asked about when the Administration hopes to have floor action on the plan. He also asked about malpractice reform.

SENATOR CHARLES GRASSLEY (R-IA) - Senator Grassley is one of those Senators who can give the impression (since he is not a detail-oriented person) that he is less than sharp and not a significant player. This is not the case. Although he may not be extremely quick, he has a very sensitive and accurate gut for politics and policy and, with a very capable staff, he has managed to become quite an effective member of the Finance Committee.

Grassley's primary health care interest has been rural health care. Again, like most other Finance Committee members, the Senator has been greatly concerned about perceived inequities in reimbursement to rural providers.

Recent Development: Senator Grassley, as he stated at the 4/20 Finance Committee meeting, appreciated The First Lady's trip to Iowa. He was, according to Senator Pryor, impressed with your presentation before the Finance Committee and, again only according to Senator Pryor, said "Hillary is too smart for Republicans." He has also indicated his support for malpractice reform.

SENATOR ALAN SIMPSON (R-WY) - Wyoming's junior Senator, Alan Simpson, handily won re-election in 1990, and currently serves in the Republican leadership as Minority Whip. Simpson serves on the Judiciary Committee, the Environment and Public Works Committee, the Veterans' Affairs Committee, and the Special Committee on Aging. He has taken partisan positions on issues like the Clean Air Act and other environmental issues, but breaks with many Republicans in his pro-choice stance.

Senator Simpson rates the following as his top priorities: state flexibility, rural and frontier delivery problems, managed competition's applicability to rural areas and incentives for medical personnel to serve in underserved areas.

Senator Simpson is currently siding with the Chafee side of the Senate Republican health care debate. Also, in a letter to the First Lady in early March, he was very complimentary about her meeting with the Republican Senators and her mastery of health care reform.

Recent Development: At the 4/30 bipartisan meeting with HRC and the Senate, Senator Simpson asked about paying for the new health care system. In addition he asked about CHAMPUS and DOD, what would happen to them?

SENATOR JIM JEFFORDS (R-VT) - Senator Jim Jeffords is a progressive Republican who has shown a fair amount of interest in health-related matters. He has sponsored his own bill (The Medicare Health Act), a single-payer approach with 70% federal financing. He believes his is a unique approach and really hopes that the Administration considers his proposal seriously.

According to his staff, the main agenda item for Senator Jeffords this year will be the ERISA preemption. This is an especially important issue for Vermont, which currently has a waiver application in order to pursue comprehensive reform in the state. As a result, he would also like to see state flexibility built into a comprehensive reform initiative.

Senator Jeffords is an advocate of improving access to health in rural areas. As part of health reform, Jeffords believes there needs to be an emphasis on primary care and efforts that encourage providers to enter primary care. He also favors loan deferment programs and expansion of the National Health Service Corps (NHSC) which aim to address the provider shortage issue in rural communities. Jeffords has raised questions regarding how managed competition will affect the need for primary practitioners.

Jeffords has also taken an active stance on lifting the ban on fetal tissue research, increasing AIDS education, and eliminating the special market exclusivity for producers of orphan drugs (drugs for rare diseases). In addition, Jeffords has been taking a lot of credit lately for the fact that the President advises the Administration will be providing lots of state flexibility. This public credit-taking has alienated Senator Leahy in particular because Leahy believes he is the leader in this area.

Recent Development: At the May 4 bipartisan Senate Labor and Human Resources meeting, he stated his view that we should integrate Medicare into the Administration's proposal. He also mentioned that we should emphasize preventive care and childhood nutrition.

SENATOR JOHN MCCAIN (R-AZ) - Senator John McCain of Arizona is conservative with a career-military background. As a former prisoner of war himself, he has focused on the POW/MIA issue in his work on the Armed Services Committee.

In the area of health care, he sponsored the Children's Health Care Improvement Act of 1993 (S. 28) which seeks to improve the health of the nation's children. He has also sponsored the Medicare Provider Payment Equity Act of 1993 (S. 31) which would repeal the reduced Medicare payment provision for new providers. The Senator also co-sponsored Senator Dole's Medicare reform bill.

Senator McCain is siding with Senator Gramm in the health care rift in the Republican party. As you know, there is a growing ideological debate among the Senate Republicans on how to proceed on health care. On the one side is the Gramm-McCain group which espouses the

use of Medical IRAs as a way to make health care available to consumers. On the other side of the debate is the Chafee side, which favors a more government-sponsored approach to curing what ails our health care system. Senator McCain is sympathetic to the pharmaceutical industry.

DAVID DURENBERGER (R-MN) - Senator Dave Durenberger, the ranking Republican on the Finance Committee Subcommittee on Medicare, is one of the Committee's most well versed Members on health care reform. He also is one of the few Members who has served concurrently on the Labor and Human Resources Committee (the other major health care committee) and the Finance Committee. He is a moderate who is viewed by the Republican leadership as somewhat of a loose cannon. Because of this and his long-standing interest in health care reform, Durenberger, too, is a candidate to be a possible and important ally.

In the last Congress, he joined Senator Bentsen as the lead Republican on the Texas Senator's incremental (insurance market reform, etc.) health reform initiative. He has been a key health care player for years, however. He now is the ranking Republican on Jay Rockefeller's Subcommittee on Medicare and Long Term Care, and he has served as either a Chairman or ranking Member of this Committee for years. In addition, he served (as a Vice-Chair) on the Pepper Commission. While he joined all the other Republicans in voting against the access recommendations of this Commission, (he did vote for the long-term care recommendations) it is important to note that it was unclear that Senator Durenberger was going to vote against the Pepper Commission recommendations until very late in the process. An important offshoot of this experience, though, was the close working relationship he forged with Rockefeller.

Most recently, Durenberger has focused on state-based health reform initiatives. He does not believe that a consensus yet exists for national reform and his own state is tired of waiting. Minnesota has a long tradition of moving ahead on health care reforms. It is one of the 5 or 6 states that has gone ahead and passed legislation to implement its own reform proposal.

Minnesota is also THE nation's capital of managed care/HMO delivery systems. As a result, Minnesota has historically been more efficient than other states in terms of the delivery of health care. Senator Durenberger will be very concerned about the allocation of the global budget, particularly that it does not reward the inefficient at the expense of the efficient.

Senator Durenberger called Chris Jennings on April 17 to talk about health policy substance and strategy. He indicated his nervousness with any price controls. He said he thought we could get some savings for speeding up implementation of the new physician payment system. He also urged us to find a way to fold in Medicare into whatever we do. At a meeting with Ira Magaziner on April 21, Durenberger stressed that, unlike some Republicans, he thinks we can and should do health care this year, although he expressed reluctance about universal coverage (and its associated costs) in the near term. Feedback from Governor Carlson's office was very positive, but Durenberger is still telling the press that he's against new taxes and isn't sure the bill can be moved this year.

At the bipartisan meeting with the Senate last Friday (4/30), Senator Durenberger outlined the major problems for Republicans: Employer mandates, global budgets, and stand-by authority for cost controls, how much federal guidelines would be imposed on the states, how much authority would the states have in the Health Alliances, and the $100 billion figure.

Recent Development: At the May 4th bipartisan Senate Labor and Human Resources Committee meeting, Durenberger stressed that market based capitation, rather than enforceable budgets should be the course the President should take. In addition, he stated that Minnesota was good at controlling costs with a market-based system. He also asked about Accredited Health Plans (AHP) and urged reform of the Federal Employees Health Benefit Program (FEHBP). Lastly, Senator Durenberger urged that the President call former HHS Secretary Otis Bowen to get the benefit of his views.

SENATOR LARRY CRAIG (R-ID) - After ten years in the House, Senator Larry Craig won his bid for Senate in 1990, filling the open Senate seat vacated by the retiring Senator McLure in 1990. As Idaho's junior senator, he believes strongly in economic development and is opposed to environmental restrictions and government regulations. He currently sits on the Senate Committee on Energy and Natural Resources, the Senate Committee on Agriculture, Nutrition, and Forestry, the Senate Special Committee on Aging and the Joint Economic Committee.

Senator Craig co-sponsored Senator McCain's Medicare Provider Payment Equity Act of 1993, which is designed to amend the Social Security Act to repeal the reduced Medicare payment provision for new providers. He also co-sponsored Senator Dole's recent bill on Medicare (S. 176).

SENATOR CONRAD BURNS (R-MT) - Senator Burns is Montana's junior Senator. The best description of him appeared in the 1992 edition of The Almanac of American Politics: "Burns...is almost a stereotypical Easterners version of a western politician. He picks his teeth with a pocketknife, chews tobacco, and tells deadpan jokes." Burns came to the Senate in 1988, defeating incumbent John Melcher.

Senator Burns is a quiet Senator with a conservative voting record. Although he is on the Republican Health Care Task Force and on Senator Pryor's Aging Committee, he is not very outspoken on health issues. He is a cosponsor of Senator Kassebaum's BasiCare Health Reform Bill and is interested in meeting with you next week. He is particularly supportive of the bill's rural health provisions.

Recent Development: Senator Burns is scheduled to meet with The First Lady along with Senator Kassebaum and Representatives Glickman and McCurdy on Thursday, May 6th.

SENATOR ARLEN SPECTER (R-PA) – Pennsylvania's Senator Arlen Specter defeated Lynn Yeakel last fall, despite the initial momentum generated by his opponent over the Senator's questioning of Anita Hill. He has long staked a claim to traditionally Democratic issues, like support for labor and women's rights. He currently serves on the Judiciary Committee, the Energy and Natural Resources Committee, the Appropriations Committee, the Veterans' Affairs Committee, and the Special Committee on Aging.

During last fall's campaign, Senator Specter proposed a health care reform package focused on preventive care, while increasing federal funding for health care. He also touted his co-sponsorship of the "Health Care Access and Affordability Act of 1992," a consumer choice based health care reform proposal..

Recent Development: At the 4/30 bipartisan meeting with the Senate, Senator Spector asked about bipartisanship and how much it would cost.