S. HRG. 106–300

DRUGSTORE SURPRISE: THE IMPACT OF DRUG SWITCHING ON OLDER AMERICANS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED SIXTH CONGRESS

FIRST SESSION

WASHINGTON, DC

JULY 20, 1999

Serial No. 106–12

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

60–345 WASHINGTON : 1999

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-060054-5

SPECIAL COMMITTEE ON AGING

CHARLES E. GRASSLEY, Iowa, *Chairman*

JAMES M. JEFFORDS, Vermont
LARRY CRAIG, Idaho
CONRAD BURNS, Montana
RICHARD SHELBY, Alabama
RICK SANTORUM, Pennsylvania
CHUCK HAGEL, Nebraska
SUSAN COLLINS, Maine
MIKE ENZI, Wyoming
TIM HUTCHINSON, Arkansas
JIM BUNNING, Kentucky

JOHN B. BREAUX, Louisiana
HARRY REID, Nevada
HERB KOHL, Wisconsin
RUSSELL D. FEINGOLD, Wisconsin
RON WYDEN, Oregon
JACK REED, Rhode Island
RICHARD H. BRYAN, Nevada
EVAN BAYH, Indiana
BLANCHE L. LINCOLN, Arkansas

THEODORE L. TOTMAN, *Staff Director*
MICHELLE PREJEAN, *Minority Staff Director*

CONTENTS

	Page
Opening statement of Senator Charles E. Grassley	1
Statement of Senator John Breaux	3
Statement of Senator Ron Wyden	4
Statement of Senator Mike Enzi	5
Statement of Senator Tim Hutchinson	5
Statement of Senator Blanche Lincoln	38

PANEL OF WITNESSES

Mary Jane Lathrop, Antelope, CA	6
Elizabeth Helms, Steering Committee Member, Citizens for the Right to Know, Sacramento, CA	11
William J. Scanlon, Director, Health Financing and Public Health Issues, Health, Education, and Human Services Division, United States General Accounting Office, Washington, DC	17
Richard Jones, president, Medicare Programs, UnitedHealthCare, Minneapolis, MN	27

APPENDIX

Letter sent to HCFA about problems resulting from lack of knowledge about drug formulary changes in Medicare+Choice plans	53

DRUGSTORE SURPRISE: THE IMPACT OF DRUG SWITCHING ON OLDER AMERICANS

TUESDAY, JULY 20, 1999

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

The committee convened, pursuant to notice, at 2:41 p.m., in room SD–215, Dirksen Senate Office Building, Hon. Charles Grassley, (Chairman of the Committee) presiding.

Present: Senators Grassley, Enzi, Hutchinson, Breaux, Reid, Wyden, Bryan, and Lincoln.

OPENING STATEMENT OF SENATOR CHARLES GRASSLEY, CHAIRMAN

The CHAIRMAN. I would like to call the hearing to order and thank everybody for being patient since I was late. Senator Breaux, I am referring to me being late, not you.

Senator BREAUX. I am the deputy.

The CHAIRMAN. I am pleased to chair this hearing today, which will examine how Medicare+Choice plans manage their prescription drug benefit. I want to especially thank Senator Wyden, for his role in bringing this issue to the attention of Senator Breaux and myself. During this hearing, we are going to explore key questions for beneficiaries to ask about their drug benefit when choosing a Medicare+Choice plan.

Senator Wyden, Senator Breaux, and I followed up on Senator Wyden's suggestion by asking the General Accounting Office, which I will refer to as the GAO, to prepare a report for the Senate Special Committee on Aging on how Medicare+Choice plans design, manage, and change their prescription drug formularies or approved list of drugs.

Also, we wanted the GAO to identify important questions beneficiaries need to ask in order to understand this complex and diverse benefit. We asked the GAO to give us information on what plans communicate to enrollees about this important benefit. The GAO report, which is being released today for public use, provides useful information to beneficiaries currently in a Medicare+Choice plan.

Millions of Medicare beneficiaries across the country have elected to join these plans. These plans typically offer additional benefits, such as prescription drug coverage, that traditional fee-for-service Medicare does not cover. One of the primary reasons many Medicare beneficiaries choose managed care is to receive this extra benefit.

Due to this fact, and due to the current debate surrounding prescription drug coverage in Medicare, it is vital that seniors receive complete and accurate information about Medicare+Choice drug formulary changes. Full disclosure of health plan information is an issue that Senator Breaux and I have been working on for several years. Today, obviously, we are just interested in disclosure of the prescription drug benefit.

Today's hearing will examine how Medicare+Choice plans manage their drug formularies, and most importantly, what information these plans provide enrollees regarding any changes in the benefit, in other words, basic consumer information. Often, Medicare+Choice plans attempt to control their prescription drug costs by switching beneficiaries from drugs they are accustomed to taking to other drugs which have different side effects or clinical outcomes.

If a Medicare+Choice plan decides that a formulary change is needed, it is very important that Medicare beneficiaries receive proper notice—again, basic consumer information. It is also critical that seniors understand what their options are when changes occur in order to make an informed health plan choice—again, just basic consumer information.

Some of the key questions the committee wants to examine today are: How often do Medicare+Choice plans change their formularies? How do Medicare+Choice plans decide which drug substitutions to make when managing their formularies? And how do plans inform health care providers and beneficiaries about specific substitutions and what are some of the reasons for them? Another question is how do the plans evaluate the implications of substitution on the quality of care beneficiaries receive? And last, should the Health Care Financing Administration, which we refer to inside the Beltway as HCFA, play a role in regulating what plans send to beneficiaries regarding changes to their drug formularies?

We have a wonderful panel of witnesses that I will soon introduce, but I want Senator Breaux to have opening remarks, and I will ask my colleagues, as well, if they have opening remarks.

[The prepared statement of Senator Grassley follows:]

PREPARED STATEMENT OF SENATOR CHARLES GRASSLEY

I am pleased to chair this hearing today which will examine how Medicare+Choice plans manage their prescription drug benefit. I want to especially thank Senator Wyden for his role in bringing attention to this important issue. During the hearing, we will explore key questions for beneficiaries to ask about their drug benefit when choosing a Medicare+Choice plan.

Senator Wyden, Senator Breaux, and I asked the General Accounting Office (which I will refer to as the GAO) to prepare a report for the Senate Special Committee on Aging on how Medicare+Choice plans design, manage, and change their prescription drug formularies, or approved list of drugs. Also, we wanted the GAO to identify important questions beneficiaries need to ask in order to understand this complex and diverse benefit. We asked the GAO to give us information on what plans communicate to enrollees about this important benefit. The GAO report, which is being released today for public use, provides useful information to beneficiaries currently in Medicare+Choice, and it provides Congress with a better understanding of this benefit. This will be very important to us as we examine the issue of adding a prescription drug benefit in the Medicare program.

Million of Medicare beneficiaries across the country have elected to join Medicare+Choice plans. These plans typically offer additional benefits, such as prescription drug coverage, that traditional fee-for-service Medicare does not cover. One of the primary reasons many Medicare beneficiaries choose managed care is to re-

ceive this extra benefit. Due to this fact and due to the current debate surrounding prescription drug coverage in Medicare, it is vital that seniors receive complete and accurate information about Medicare+Choice drug formulary changes.

Today's hearing will examine how Medicare+Choice plans manage their drug formularies, and what information these plans provide enrollees regarding any changes to this benefit. Often, Medicare+Choice plans attempt to control their prescription drug costs by switching beneficiaries from drugs they are accustomed to taking, to other drugs, which may have different side effects or clinical outcomes. If a Medicare+Choice plan decides that a formulary change is needed, it is important that Medicare beneficiaries receive proper notice. It is also critical that seniors understand what their options are when changes occur in order to make an informed health plan choice.

Some of the key questions the Committee will examine at the hearing are:

1) How often do Medicare+Choice plans' change their formularies?

2) How do Medicare+Choice plans decide which drug substitutions to make when managing their formularies?

3) How do plans inform health care providers and beneficiaries about specific substitutions, and what are some of the reasons for them?

4) How do the plans evaluate the implications of substitutions on the quality of care beneficiaries receive?

5) Should the Health Care Financing Administration (HCFA) play a role in regulating what plans send to beneficiaries regarding changes to their drug formularies?

We have a wonderful panel of witnesses who will help to answer these very important questions. I now turn to Senator Breaux for his opening remarks.

STATEMENT OF SENATOR JOHN BREAUX

Senator BREAUX. Thank you very much, Mr. Chairman. I will be very brief. I congratulate you for having this hearing and for Senator Wyden's involvement in it, as well.

I have always said that good information yields good results and bad information yields bad results and no information is just as bad as bad information, because a lot of times, if you do not have any information, you end up making the wrong decisions.

This whole question about pharmaceuticals and prescription drugs under Medicare is, indeed, a real challenging one for all of the nation's seniors and for all of us in the legislative branch. We are moving toward having prescription drugs as a basic ingredient under the Medicare program and we can learn from the mistakes of some of the HMOs and Medicare+Choice that they have made.

I can understand a need to change formularies and to change the type of drugs that are available. As new drugs replace old drugs, you are going to have changes made. But the most important thing is to let the people know about it. That seems to be the real problem. You should not have to wait until you get to the drug store to find out that what you are buying is no longer covered, and you should have the information and your doctor should have the information of exactly what this patient has as a benefit. Without that information, I am afraid that very erroneous decisions will be made.

I know my own State of Louisiana back in 1997 passed a law which requires HMOs to disclose the drugs that are listed on their formularies and outline procedures on how to obtain drugs that are not on the formularies. They have taken the step to move in the right direction. The Federal Government, really, we have not done that yet, and I think that we just have to come up with something that guarantees adequate information to our seniors as they move into the area of prescription drug, which is so very, very important. Hopefully, this hearing will give us some information that we can use in that regard. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Wyden

STATEMENT OF SENATOR RON WYDEN

Senator WYDEN. Thank you, Mr. Chairman. I want to thank you and Senator Breaux in particular for all of your support on this effort.

One of the reasons that I felt so strongly about the committee getting into this is that this issue goes right to the heart of the future of the Medicare program, and particularly how we add a prescription drug benefit to that program. We all understand that the ability to provide prescription drugs is one of the driving forces behind MedicareChoice. If what we have in our country is a situation where seniors sign up believing that they are going to be able to get specific pharmaceuticals and then they show up at the pharmacy and cannot get it, that is going to undermine our efforts to reinvent Medicare.

So it is very important that we dig into this issue. My sense is that, across this country, seniors and their families believe that this is a back-door benefit cut, that, in effect, they are supposed to be getting the benefits and they do not end up getting them.

I, and I think a number of us on this committee—in fact, I think all of the Senators present here want to see a market-oriented approach to Medicare reform. That is certainly the approach that Senator Snowe and I are taking in the SPICE program we have developed, the Senior Prescription Insurance Coverage program. But this new evidence is going to certainly make it tougher for those of us who want to inject these marketplace forces, and that is why I am hoping that we will incorporate some of the ideas that you and Senator Breaux have had with respect to notification.

At a minimum, when new products come on line, these exciting new pharmaceuticals that are, in effect, the bioequivalent of what is already available today but allow for some advances become available, families and seniors ought to be notified before we have those kinds of switches.

So I do not think we need to have some huge set of price controls and some micromanaged, run from Washington and the Beltway, approach, but we cannot allow to go unchecked a situation where seniors and their families believe that they are signing up for products and then, all of a sudden when they go to the pharmacy, their rights seem to evaporate before them.

I am very appreciative that you are holding this hearing. I am in a hometown where we have the highest concentration of seniors in managed care in country, and so we have seen good managed care and how it can work. The kind of evidence that this committee has now uncovered is troubling. It is going to undermine the credibility of those of us who want a market-oriented approach to Medicare reform, and so we have much to do. I thank you, Mr. Chairman, and Senator Breaux, in particular, for your leadership on it.

The CHAIRMAN. Senator Enzi, and then Senator Hutchinson.

STATEMENT OF SENATOR MIKE ENZI

Senator ENZI. In the interest of time, so that we can hear the testimony and ask some questions, and since I want to associate myself with your comments earlier, as mine are very similar and make some of the same points.

The CHAIRMAN. Senator Hutchinson.

STATEMENT OF SENATOR TIM HUTCHINSON

Senator HUTCHINSON. Thank you, Mr. Chairman. I agree with Senator Wyden that managed care can work, but for many senior citizens, managed care is a new thing. The best consumer is an informed consumer, and that ought to be informed up front, not when they get to the pharmacy. It concerns me that Mrs. Lathrop and other beneficiaries have found themselves standing at the pharmacy counter, ready to pick up a prescription, only to find out that they cannot get the drug that they normally take because their plan no longer covers it. It can cause confusion, it can cause concern, and it can potentially cause health problems, as well, without the medication that, while it may be therapeutically equivalent, does not meet their needs.

I also look forward to the testimony today and I thank you, Senator Grassley, for holding this hearing.

The CHAIRMAN. Thank you all very much.

Now we go to our panel. Our first witness is Mary Jane Lathrop. She is a 77-year-old Medicare beneficiary who has come all the way from Antelope, CA, to testify today. She was notified of a change in her prescription for her high blood pressure condition at a pharmacy. She was not notified by the plan that her drug was being switched. She discussed her options with her physician and decided to try the new drug. Problems resulted.

When she called the plan, however, she was not provided information about her option to obtain the original drug when she had an adverse reaction to the drug. She decided to disenroll in the plan, and everybody knows that, soon, beginning in the year 2002, people like Mrs. Lathrop would not have an opportunity to disenroll each month because we are going to start an annual disenrollment policy.

Next, we have Liz Helms, who is a Steering Committee member of Citizens for the Right to Know, an advocacy group based in California dedicated to educating consumers about their need to become informed, cost-conscious purchasers of health care. This group promotes full disclosure of health care benefits by health plans. She will testify about how the group began and about the many hours she spends helping beneficiaries become better and more informed health care consumers.

Then we will hear from Dr. William Scanlon, Director of Health Systems Financing at the GAO. He will testify about findings from the newly released GAO report on this subject.

Then we conclude with Richard Jones, who is president of the UnitedHealthcare's Medicare program. Mr. Jones will testify about the plan's outreach efforts to seniors regarding this very complex benefit. UnitedHealthcare does an outstanding job of helping its enrollees understand their drug benefits and informing them of

changes to its formulary. I think that this plan is a model for other plans to follow.

I would ask the witnesses to begin their testimony with Mrs. Lathrop and go across the table from my left to my right. Once everyone is finished, we will have time for questions. Then if we do have votes, what is my hope is that between Senator Enzi and myself, one of us would go vote while the other chairs the hearing and over the course of two votes, keep this meeting going so we do not keep the audience or our witnesses needlessly late.

We will start with you, Mrs. Lathrop.

STATEMENT OF MARY JANE LATHROP, ANTELOPE, CA

Mrs. LATHROP. Good afternoon, everyone. My name is Mary Jane Lathrop. I want to personally thank all of you for inviting me here today to speak on behalf of senior citizens. I am 77 years old, a mother of two, and a grandmother of three.

In 1986, I became eligible for Medicare, in addition to health coverage provided through my husband's insurance. In 1994, I decided to find another health care plan. I knew that Medicare alone was not going to cover my medical needs in terms of prescription drugs and I was going to have to find a managed care plan to supplement my Medicare benefits.

I have high blood pressure, but it is a condition that can be controlled with the proper medication. So when I started searching for a health care plan, I was careful to choose one that would cover my needs. I was previously taking Zestril from my high blood pressure, which was working well for me. I only had to remember to take it once a day. It was convenient and easy. Best of all, it worked well for me.

I started looking into PacifiCare's Secure Horizons. It is a managed care plan that is specifically aimed at seniors who are on Medicare. I attended an enrollment meeting to learn about Secure Horizons and its benefits. My biggest concern was, is Zestril covered? I was assured that my prescription for Zestril was covered. That was all I needed to hear. I signed my name on the dotted line and I became a member. Little did I know that my horizons were anything but secure.

For 3 years, I had no problems with my health plan. All of my prescriptions are filled through a mail service. So when I sent in for my monthly Zestril refill and received a call from the pharmacist, I was shocked. He told me that Secure Horizons was not covering my high blood pressure medication. I could not believe what I was hearing. The drug I had been taking for so long was not covered?

I did not understand. I had been assured when I signed up with my managed care plan that Zestril was covered. I had not been informed otherwise. No one from my health plan called to tell me there was a change. I never received a letter telling me that my high blood pressure medicine was not covered anymore. Did I not have the right to be notified when there was any change? Apparently not, and I did not know what to do. I had never heard of anything like this before and I did not know what I was supposed to do or what my options were. All I knew was that I needed my

medication for my high blood pressure or I would become worse and my health would be in grave danger.

I asked my mail order pharmacist what I could do. He said I could contact my doctor to see if he could prescribe another medication that would be covered by my plan. I was left with no refill. A day later, the pharmacist contacted me and said he had another prescription and I was sent Lotesin. The copayment for Lotesin was $60. I asked my health care plan if I could return it and get Zestril for the $60. They said no. I was wary of trying a new medication, and I had never taken this prescription before. I could not afford to pay the $60 copayment, but I felt I had no choice.

For the next 3 weeks, I was given three different prescriptions for three different drugs to control my high blood pressure. Finally, my doctor prescribed a medication that was covered by my health plan. I was sent Captopril. This medication did not work and my blood pressure went sky high. I thought my managed care plan cared about me and would not want me to become sick. That is what health care is for, is it not, to take care of you? I was never so wrong.

After taking my new prescription, my blood pressure immediately shot up. Not only was I forced to take medication that was not working for me, I had to take it three times a day instead of once a day. Taking medication three times a day required me to carry the prescription at all times. This new drug was a real inconvenience to me, but more importantly, my health was in danger.

What was I to do? I could not very well take Lotesin, costing $60 a prescription, and the other medication did not work as well as Zestril. My only choice was to leave Secure Horizons and find another health plan that would meet my needs.

To this day, Secure Horizons still denies that they ever refused my Zestril refill. They also deny that they sent me Lotesin and forced me to pay for it. They deny any wrongdoing at all.

I am happily a member of a new HMO and I am doing great. I am finally back on Zestril and it is working fantastic. I am not having any of the problems and complications I was having with Captopril. This ordeal taught me a lot. I was forced to learn about formularies and nonformulary drugs. I learned that lack of disclosure of benefits can cause confusion, upset, and most importantly, health problems that are easily avoidable.

Unfortunately, my story is not unique. From what I have learned, drug switching and lack of information or medical disclosure happens every single day to many seniors around the U.S.

I truly hope that there will be a change in the health care field. I ask all of you today to look carefully into the eyes of your mothers, fathers, children, and spouse. Would you want them to go through what I did, or worse, suffer irrevocable damages to their health or die because they were given a cheaper drug or their drug was switched without their knowledge?

Senators, I hope you ensure that seniors are informed of health care benefits, limitations, and exclusions so that we are able to make knowledgeable, well-informed decisions that affect our health. Knowledge is most definitely power, and without it, seniors cannot make the choices necessary to live happy and healthy golden years. Please help us live our lives to the fullest.

Thank you so much for your time and attention. I wish everyone a happy and healthy future.

[The prepared statement of Mary Jane Lathrop follows:]

Mary Jane Lathrop-Testimony
Senate Special Committee on Aging
July, 20 1999
Washington DC

Good Afternoon everyone, my name is Mary Jane Lathrop. I want to personally thank all of you for inviting me here today to speak on behalf of senior citizens. I am 77 years old, a mother of two and a grandmother of three.

In 1986, I became eligible for Medicare, in addition to health coverage provided through my husband's insurance. In 1994, I decided to find another health care plan. I knew that Medicare alone was not going to cover my medical needs in terms of prescription drugs and I was going to have to find a managed care plan to supplement my Medicare benefits.

I have high blood pressure, but it is a condition that can be controlled with the proper medication. So, when I starting searching for a health care plan, I was careful to choose one that would cover my needs. I was previously taking Zestril for my high blood pressure, which was working well for me. I only had to remember to take it once an day. It was convenient and easy. Best of all -- it worked well for me.

I started looking into PacifiCare's Secure Horizons. It's a managed care plan that is specifically aimed at seniors who are on Medicare. I attended an enrollment meeting to learn about Secure Horizons and its benefits. My biggest concern was, "is Zestril covered?" I was assured that my prescription for Zestril was definitely covered. That was all I needed to hear. I signed my name on the dotted line, and I became a member of Secure Horizons. Little did I know that my horizons were anything but secure.

For three years I had no problems with my health plan. All of my prescriptions are filled through a mail service. So when I sent in for my monthly Zestril refill and received a call from the pharmacist, I was shocked. He told me that Secure Horizons wasn't covering my high blood pressure medication. I couldn't believe what I was hearing. The drug I had been taking for so long wasn't covered? I didn't understand, I had been assured when I signed up with my managed care plan that Zestril was covered. I had not been informed otherwise. No one from my health plan called to tell me there was a change. I never received a letter telling me that my high blood pressure medication wasn't covered any more. Didn't I have the right to be notified when there was any type of change? Apparently not, and I didn't know what to do. I had never heard of anything like this before and I didn't know what I was suppose to do or what my options were. All I knew was that I needed my medication or my high blood pressure would become worse and my health would be in grave danger. I asked my mail order pharmacist what I could do. He said he could contact my doctor to see if he could prescribe another medication that would be covered by my plan. I was left with no refill. A day later the pharmacist contacted me and said he had another prescription and I was sent Lotesin. The co-payment for Lotesin was $60 I asked my health care plan if I could return it and get Zestril for the $60. They said no. I was wary of trying

a new medication and I had never taken this prescription before. I couldn't afford to pay the $60 dollar co-payment but I felt I had no choice. For the next three weeks I was given 3 different prescriptions or 3 different drugs to control my high blood pressure. Finally my doctor prescribed a medication that was covered by my health plan. I was sent Captopril. This medication did not work and my blood pressure went sky high! I thought my managed care plan cared about me and wouldn't want me to become sick. That's what having health insurance is for, right? To take care of you. I was never so wrong. After taking my new prescription, my blood pressure immediately shot up. Not only was I forced to take medication that wasn't working for me, I had to take it 3 times a day instead of only once per day. Taking a medication 3 times a day required me to carry the prescription at all times. This new drug was a real inconvenience to me, but more importantly, my health was in danger.

What was I to do? I couldn't very well continue to take Lotensin, costing $60 a prescription and the other medications did not work as well as Zestril. My only choice was to leave Secure Horizons and find another health plan that would meet my needs.

To this day, Secure Horizons still denies that they ever refused my Zestril refill. They also deny they sent me Lotensin and forced me to pay for it. They deny any wrong doing at all.

I'm happily a member of a new HMO and I am doing great. I'm finally back on Zestril and it's working fantastic. I'm not having any of the problems and complications I was having with Captopril. This ordeal taught me a lot. I was forced to learn about formularies and nonformulary drugs. I learned that lack of disclosure of benefits can cause confusion, upset and most importantly, health problems that are easily avoidable.

Unfortunately, my story is not unique. From what I've learned, drug switching and lack of information or medical disclosure happens every single day, to many seniors around the U.S.

I truly hope that there will be a change in the health care field. **I ask all of you today to look carefully into the eyes of your mothers, fathers, children and spouse. Would you want them to go through what I did?** Or worse, suffer irrevocable damages to their health or die because they were given the cheaper drug or their drug was switched without their knowledge?

Senators, I urge you to ensure that seniors are informed of health care benefits, limitations and exclusions, so that we are able to make knowledgeable, well informed decisions that affect our health. Knowledge is most definitely power, and without it, seniors can not make the choices necessary to live happy and healthy golden years. Please, help us live our lives to the fullest. Thank you so much for your time and attention. I wish everyone all a happy and healthy future.

The CHAIRMAN. Thank you, Mrs. Lathrop, for sharing your experience with us. Your testimony sets the stage for this hearing and the issues we need to address.

Ms. Helms.

STATEMENT OF ELIZABETH HELMS, STEERING COMMITTEE MEMBER, CITIZENS FOR THE RIGHT TO KNOW, SACRAMENTO, CA

Ms. HELMS. Thank you. Senator Grassley, Senator Breaux, and members of the Special Committee on Aging, my name is Elizabeth Helms. I am president of the TMJ Society of California, headquartered in Sacramento, and I am also a Steering Committee member for the Citizens for the Right to Know Coalition, a California-based coalition of patients, providers, and voluntary health associations representing more than a million individuals focused on educating consumers about the need to become informed purchasers of health care and to mandate full disclosure of health plans' benefits and limitations in consumer-friendly language prior to enrollment.

I became a patient advocate when I was denied access to care by my health plan in 1993. I did not know the right questions to ask, and not even my member services department could give me the information I needed to jump through the hoops. The lack of disclosure of my plan's benefits was a call to action for me and I have been actively engaged in health care reform since 1993.

I am honored to be a speaker here as well as a national speaker for patients' rights and the need for consumers to be well educated and informed about their health care. On behalf of the Right to Know Coalition, we commend the Special Committee on Aging for holding this hearing to better understand how vital formulary disclosure is for Americans now over the age of 65 enrolled in Medicare+Choice health plans.

At the turn of the century, there were approximately 3.1 million Americans 65 years and older. As we enter the new millennium 100 years later, the number of American seniors has grown to over 34 million, now making up over 12 percent of the U.S. population. The need for education and information has never been greater, and as we embark on the new millennium, we are enjoying a new era of drug discovery leading to innovative drug therapies which will improve the quality of all of our lives. This hearing can set the stage to ensure that our seniors enjoy the benefits of our nation's health care system.

Senators, please for just a moment, if you will, indulge me. I would like to know how many of you read the ingredients on the back label of a product for food that you buy at the grocery store. I would like to know how many of you know what lists of prescription drugs are on your formulary lists. Information about our health should be better and easier to access than what is disclosed on the back of a bag of potato chips, especially for seniors.

When a consumer goes to the grocery store to make a purchase, it is possible to make an informed choice. Take a bag of potato chips, and I happened to bring a bag with me today. If you look on the back panel, it discloses the ingredients, fat, saturated and

unsaturated, sugar, salts, not to mention the artificial colors and flavors.

We need all that just to buy a bag of potato chips. Are we not entitled to at least the same depth of accuracy of information when our lives and health are at issue?

Many seniors sustain life, maintain quality of life, and stay healthy despite chronic conditions through the use of medications. The trick to quality of life and good health in these instances is maintaining your medication regimen, maintaining access. Yet when Right to Know called Medicare+Choice plans in California, we found that there is very little formulary disclosure. Printed material did not contain lists of formularies obtainable prior to enrollment. You had to call the plan and request the information about a particular drug. Only one plan disclosed information about their formulary, and they are sitting at this table right now. In some instances, the HMOs referred us to call a pharmacy directly to seek information about what they covered. They did not give out the information.

Information was cumbersome and time consuming. Seniors need to know the right questions to ask to get any useful information. When a drug is cut from a list of approved formularies, the patient/consumer finds out at the pharmacy counter. Drugs have been switched to generic and therapeutic substitutions without any prior notice. Delays and trips back to the pharmacy happen often, and it is sometimes difficult for a senior to return to the pharmacy to correct their prescription.

When a drug must go through prior authorization, the senior member is not informed about this process or how it works. For instance, a newer, more expensive drug may only be allowed after several less expensive drugs have been tried. This is called the step system for successful failures. A drug may be cut from the formulary and the patient is switched to another, generally less costly, even if the patient has been doing well on the current medication. This places the senior at great risk.

I have personally witnessed this practice with many people. The senior is totally unaware their medication was changed due to a cost factor. They are not informed. This has happened to patients taking high blood pressure medicine, mental health medications, and lots of other types of drugs. There are innumerable horror stories about patients who suffered severe and serious consequences from switching drugs or suffered serious side effects when switched to drugs that were less effective because they were perceived to be less costly.

Senator I have two more pages. Am I OK?

The CHAIRMAN. Proceed, please.

Ms. HELMS. California law under Knox-Keene Section 1367(g) provides that a plan shall be able to demonstrate to the department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management. This means that any medication, whether it is on the formulary or not, can be obtainable if medically necessary and provided the physician will actively advocate for the patient. I can assure you, seniors and their physicians are not aware of this law unless they have found

out through the media or through other sources. This information is not disclosed.

However, California has taken a bold forward step in the management of formulary disclosure. First, two landmark pieces of legislation were signed into law this year. AB 974, authored by Assembly Member Martin Gallegos, mandates continuity of prescription benefits by requiring plans to continue to provide ongoing doctor-prescribed medications for patients even after the medication has been removed from the formulary. SB 625, by Senator Hershal Rosenthal, requires a plan to provide, upon request, a copy of their formulary and file information about the adoption of the formulary. The Right to Know worked very hard to ensure passage of both of these bills.

Prior to these new laws becoming effective, the Department of Corporations, which oversees HMOs in our State, stepped in. The Department of Corporations, acting on the complaints of many seniors, began an investigation into HMO formulary practices. The HMOs had been accused of drug switching, improper denial of medications, and nondisclosure of formulary changes. This investigation is ongoing.

Misuse of formulary practices have the potential of being severely damaging to the senior population. We applaud the Department of Corporations and our State legislators for taking the initiative to ensure consumers were protected.

To illustrate my point, I asked that each of you take the simple quiz about your own HMO's formulary. Even those of us educated and interested in this subject are uninformed in regards to many coverage issues. Take the quiz to see if you know more than the rest of us. I have enclosed a copy of the questions for you and for your future use.

Senators, you have the opportunity to ensure the Health Care Financing Administration has the ability to protect seniors under their care. I urge you in all opportunities, provide for consumers the right to easy, understandable access to care. Please take the lead in this country and ensure Medicare+Choice plans disclose information fairly, and that those plans make changes to coverage and their formularies without damaging consumer health and happiness.

It has been a great honor for me to be here today and a very long journey in time in coming. Thank you so much.

[The prepared statement of Elizabeth Helms follows:]

TESTIMONY OF ELIZABETH HELMS
UNITED STATES SENATE
SPECIAL COMMITTEE ON AGING
July 20, 1999

Senator Grassley, Senator Breaux, members of the Special Committee on Aging. My name is Elizabeth Helms. I am president of the TMJ Society of California, headquartered in Sacramento. I am also a steering committee member of Citizens for the Right to Know, a California-based coalition of patients, providers and voluntary health associations representing more than a million individuals focused on educating consumers about the need to become informed purchasers of healthcare, and to mandate full disclosure of health plan's benefits and limitations in consumer-friendly language prior to enrollment.

I became a patient advocate when I was denied access to care by my health plan in 1993. I did not know the right questions to ask, and not even my member services department could give me the information I needed to jump through the hoops. The lack of disclosure of my plans benefits was a call to action for me and I have been actively engaged in health care reform since that time. I have been honored to speak nationally regarding patients rights and the need for consumers to be well educated and informed about their health care.

On behalf of the Right to Know coalition we commend the Special Committee on Aging for holding this hearing to better understand how vital formulary disclosure is for Americans now over the age of sixty-five, enrolled in MedicarePlusChoice health plans.

At the turn of the century there were approximately 3.1 million Americans 65 years and older. As we enter the new millennium 100 years later the number of American seniors has grown to over 34 million. Now making up 12.7 percent of our US population. The need for education and information has never been greater, and as we embark on the new millennium we are enjoying a new era of drug discovery, leading to innovative drug therapies which will improve the quality of our lives. This hearing can set the stage to ensure that our seniors enjoy the benefits of our nations health care system.

Disclosure
Senators, please indulge me for a moment. I would like to know how many people in this room read the ingredient labels on the food you buy? I would like to know how many of you know what prescription drugs are covered by your health care plan?

Information about our health should be better and easier to access than what's disclosed on a bag of potato chips–especially for seniors.

When a consumer goes to the grocery store to make a purchase, it is possible to make an informed choice. Take a bag of potato chips for instance. Look on the back panel. It discloses the ingredients, calories, fats (saturated and unsaturated), sugars, salts–not to mention the artificial colors and flavors.

We need all that just to buy a bag of potato chips. Aren't we entitled to at least the same depth and accuracy of information when our lives and health are at issue?

Many seniors sustain life, maintain quality of life and stay healthy despite chronic conditions through the use of medications. The trick to quality of life and good health in these instances is maintaining your medication regime–maintaining access. Yet when Right To Know called MedicarePlusChoice plans in California, we found that there is very little formulary disclosure. Printed material did not contain lists of formularies obtainable prior to enrollment. You had to call the plan and request the information about a particular drug. Only one plan disclosed information about their formulary.

In some instances the HMO's referred us to call a pharmacy directly to seek information about what the plan covered. Information was cumbersome and time consuming. Seniors need to know the right questions to ask to get any useful information. When a drug is cut from a list of approved formularies, the patient/consumer finds out at the pharmacy counter. Drugs have been switched to generic and therapeutic substitutions without any prior notice. Delays and trips back to the pharmacy happen often, and it is sometimes difficult for a senior to return to the pharmacy to obtain their correct prescription.

When a drug must go through prior-authorization, the senior member is not informed about this process, or how it works. For instance, a newer more expensive drug may only be allowed after several less expensive drugs have been tried. This is called the "step-system for successful failures". A drug may be cut from the formulary and the patient is switched to another, generally less costly, even if the patient has been doing well on the current medication. This places the senior patient at great risk, I have personally witnessed this practice. The senior is totally unaware their medication was changed due to a cost factor. They are not informed. This has happened to patients taking high blood pressure and mental health medications, etc. There are innumerable horror stories about patients who suffered severe and serious consequences from the switching of drugs, or suffered serious side effects when switched to drugs which were less effective because they were perceived to be less costly.

California law under Knox-Keene "Section 1367 (g) provides that a plan "shall be able to demonstrate to the department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management." This means that any medication whether it is on the formulary or not can be obtainable if medically necessary and provided the physician will actively advocate for their patient. I can assure you seniors and their physicians are not aware of this law unless they have found out through the media or other sources. This information is not disclosed.

California has taken a bold forward step in the management of formulary disclosure.

First, two landmark pieces of legislation were signed into law this year. AB 974, authored by Assembly Member Martin Gallegos, mandates continuity of prescription benefits by requiring

plans to continue to provide on-going doctor-prescribed medication for patients even after the medication has been removed from the formulary. SB 625, by Senator Hershal Rosenthal, requires a plan to provide, upon request, a copy of the their formulary and file information, about the adoption of a formulary. RTK worked very hard to insure passage of these two bills.

Prior to these new laws becoming effective, The California Department of Corporations (DOC) which oversees HMOs in the State had to step in. DOC, acting on the complaints of many senior consumers, began an investigation into HMO formulary practices. The HMOs had been accused of drug switching, improper denial of medications and non-disclosure of formulary changes. The investigation is ongoing. Misuse of formulary practices have the potential of being severely damaging to the senior population. We applaud the DOC and our state legislators for taking the initiative to insure consumers were protected.

To illustrate my point, I ask that each of you take this simple quiz about your own HMO's formulary. Even those of us educated and interested in this subject are uninformed in regards to many coverage issues. Take the quiz to see if you know more that the rest of us. I have enclosed a list of questions for you to answer and for your future use.

Senators, you have the opportunity to ensure the Health Care Financing Administration (HCFA) has the ability to protect the seniors under their care. I urge you in all opportunities, provide for consumers right to easy, understandable access to care. Please take the lead in this country and ensure MedicarePlusChoice plans disclose information fairly and that those plans make changes to coverage and their formularies without damaging consumer health and happiness.

It has been a great honor for me to be here today and a very long journey through time in coming. Thank you .

The CHAIRMAN. Thank you, Ms. Helms.

Now, we go to Dr. Scanlon, who testifies regularly before this committee. We appreciate his cooperation. Please proceed.

STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, UNITED STATES GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Mr. SCANLON. Thank you very much, Mr. Chairman and members of the committee. It is always a pleasure to return.

I am pleased to be here today to discuss the issues related to prescription drug benefits provided by health maintenance organizations participating in the Medicare+Choice program. The former risk contract and the current Medicare+Choice programs were conceived as alternatives to traditional Medicare that would generate greater efficiency in the provision of care to seniors while offering them greater choice among health plan options. Achieving this promise depends on generating quality-based competition among plans so more beneficiaries are attracted to and remain in the program. As you have indicated, that competition, in turn, depends upon beneficiaries having sufficient, accurate, and comprehensible information to decide whether to join a Medicare+Choice plan and which plan to join.

Over the past 2 years, you have had a series of hearings on the information available to Medicare beneficiaries to enable them to make prudent choices about managed care plans. We have been pleased to participate in those hearings and prepare a number of reports for the committee on these issues. Unfortunately, our work has identified numerous factors that make it difficult for beneficiaries to determine which plans offer the benefits that best meet their needs.

A central aspect of this work was the information plans provided about their prescription drug benefits. Prescription drug coverage has obviously been a primary reason beneficiaries are attracted to Medicare+Choice plans. In fact, 92 percent of Medicare+Choice enrollees are in plans providing such coverage.

Information about this crucial benefit, however, was sorely inadequate. In our previous work, we noted that some plans described their drug benefit using terms like "approved drugs" or "preferred drugs" without defining them and their implications for coverage. In other cases, plans provided little information on annual dollar limits on prescription drug coverage or how they calculated whether a beneficiary had reached their limit.

My testimony today focuses on an important aspect of plans drug benefits, their use of formularies or lists of preferred drugs which they may cover for full or a lower cost sharing on the part of the beneficiary. We are issuing a report today to the committee that examines how Medicare HMOs manage drug formularies to control drug expenditures and the implications of these practices for beneficiaries. For this report, we gathered information from 16 HMOs that account for more than 25 percent of all beneficiaries enrolled in Medicare HMOs.

Drug formularies can be an effective and appropriate tool for managed care organizations. Directing physicians and beneficiaries

to less expensive, therapeutically equivalent, and effective drugs can reduce costs. Aggressive formulary management may control spending, but beneficiaries need to be aware of how it will also affect their drug benefit. Beneficiaries need to know how a plan's formulary is structured, what drugs it contains, how changes are made and what notice of changes are provided, and how an exception to allow use of a nonformulary drug can be obtained.

About two-thirds of the 16 HMOs in our study use closed formularies, meaning the plan will only pay for drugs on the formulary list. Two have open formularies in which beneficiaries pay the same copayment amount for formulary and nonformulary drugs. Three use incentive-based formularies that require high copays for nonformulary drugs than for formulary drugs.

HMOs reserve the option to modify their formulary lists and may do so at any time. Between November 1997 and January 1999, virtually all the HMOs we examined deleted drugs from their formularies in four classes widely used to treat conditions common to the elderly: hypertension, depression, ulcers, and high cholesterol. However, almost all added drugs to their formularies in at least one of these classes. With one exception, the HMOs continued to offer several alternatives for physicians to prescribe in each class of drugs. For a beneficiary, the total number of drugs covered, however, matters less than whether the drug they need is covered.

Nine of the HMOs send letters to beneficiaries notifying them about specific formulary changes that affect them. However, in contrast, four others do not notify beneficiaries of formulary changes. As a result, beneficiaries may not know and may not learn that a prescribed drug has been dropped from a formulary until they are at the pharmacy counter and asked to pay full price for the drug.

When beneficiaries have been taking a drug that is dropped or when a physician believes a nonformulary drug is more appropriate, HMOs may allow exceptions. The effort to obtain an exception can vary considerably. Six of the 14 HMOs that use closed or incentive-based formularies require physicians to submit specific medical documentation to demonstrate why a formulary alternative will not be appropriate for a given beneficiary. One of these six HMOs also requires the physician to document that the beneficiary tried the formulary alternative during a trial period and that the beneficiary experienced either an adverse reaction or the drug failed as a treatment alternative.

In conclusion, Mr. Chairman and members of the committee, drug benefits remain an essential reason why beneficiaries join Medicare+Choice plans. Plans' efforts to control drug spending through the use of formularies are likely to increase as drug costs rise. To help beneficiaries compare Medicare+Choice plans and make informed health care decisions, they need clear and easily understood information that includes the drugs that formularies cover, how formulary changes are handled, and the policies and procedures for requesting coverage for nonformulary drugs.

Previously, we have recommended that HCFA require standard formats and terminology for important aspects of managed care organizations' marketing materials, including their benefit descriptions, and that that literature distributed by managed care organizations follow these standards. While HCFA has made some

progress in standardizing these important materials, the need to make additional progress remains. The importance of this information is going to increase drastically, as you indicated, as beneficiaries are locked into their plan choices for a full year beginning in the year 2002.

Thank you very much, Mr. Chairman. I would be happy to answer any questions you or members of the committee may have.

The CHAIRMAN. Once again, I thank you.

[The prepared statement of Mr. Scanlon follows:]

GAO

United States General Accounting Office
Testimony

Before the Special Committee on Aging, U.S. Senate

For Release on Delivery
Expected at 2:30 p.m.
Tuesday, July 20, 1999

PRESCRIPTION DRUG BENEFITS

Impact of Medicare HMOs' Use of Formularies on Beneficiaries

Statement of William J. Scanlon, Director
Health Financing and Public Health Issues
Health, Education, and Human Services Division

GAO/T-HEHS-99-171

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the prescription drug benefits provided by health maintenance organizations (HMO) that participate in the Medicare+Choice program. Currently, about 6.1 million of the 39 million Medicare beneficiaries are enrolled in Medicare+Choice plans, in many cases because they offer prescription drug benefits, which are not covered under fee-for-service Medicare. Medicare+Choice was intended to expand beneficiaries' health plan options. Its success depends on generating quality-based competition among plans so more beneficiaries are attracted to and remain in the program.

Over the past 2 years, this Committee has held several hearings on the information available to Medicare beneficiaries to enable them to make prudent choices about whether to enroll in a Medicare+Choice plan. Our previous work has identified a number of factors that make it difficult for beneficiaries to determine which plan offers the benefits that best meet their needs.[1] In some cases, detailed information about plans' benefits and out-of-pocket fees is provided only after a beneficiary enrolls in a plan. In other cases, detailed information may be available before enrollment from plan sales agents and member literature, but beneficiaries may find it difficult to compare available options because plans present the information in different formats and use different terms to describe covered benefits. Further, plan member literature, a key source of information for beneficiaries, has often contained inaccurate or incomplete benefit information. In our previous work we also noted that some plans described their benefits using terms like "approved" drugs or "preferred" drugs without defining them. In other cases, plans provided little information on the annual dollar limits on prescription drug coverage or how they calculated when a beneficiary had reached the limit. The value of a limit can vary significantly depending on which prices a plan uses to calculate the cost of a prescription. For example, if the annual limit is based on the retail cost of a prescription, the benefit would be worth less than if it was based on the wholesale cost. The lack of comparative information is particularly problematic in evaluating plans' drug benefits because so many different aspects determine the true extent of coverage.

Moreover, making informed choices among health plans is becoming more important for Medicare beneficiaries because the Balanced Budget Act of 1997 specifies that beginning in 2002, beneficiaries will no longer be able to change plans on a monthly basis, as they are permitted to now. If beneficiaries experience problems with a plan

---

[1]Medicare+Choice: New Standards Could Improve Accuracy and Usefulness of Plan Literature (GAO/HEHS-99-92, Apr. 12, 1999) and Medicare Managed Care: HCFA Missing Opportunities to Provide Consumer Information (GAO/T-HEHS-97-109, Apr. 10, 1997).

or decide that another plan's pharmacy benefits better meet their needs, they will have a limited time period each year to change plans, after which they will be locked in to their decision for the remainder of the year.[2]

While HMOs use various techniques to help control the cost of providing prescription drug benefits, a common technique is to use a formulary–a list of prescription drugs, grouped by therapeutic drug class, which an HMO prefers its physicians to prescribe. HMOs may cover only formulary drugs or provide financial incentives, such as lower copayments, to use formulary rather than nonformulary drugs. HMOs manage their formularies in several ways, including deciding which formulary drugs to add or delete, notifying beneficiaries and physicians about formulary changes, and considering physician requests to cover deleted or nonformulary drugs for specific beneficiaries. As prescription drug costs rise, formularies may become an even more important tool HMOs use to control drug expenditures. Aggressive formulary management may control spending, but beneficiaries need to be aware of how it may affect the value of their drug benefit.

My comments will focus on a report we are issuing to your Committee today that examines how Medicare HMOs manage drug formularies to control drug expenditures and the implications for beneficiaries. We gathered information from 16 HMOs located in three markets–Los Angeles, Miami, and Philadelphia–which account for a significant share of Medicare enrollment. These 16 HMOs represented more than 25 percent of all beneficiaries enrolled in Medicare HMOs. Our findings are based on our analysis of the policies and procedures the HMOs used to make formulary decisions, notify health care providers and beneficiaries about formulary changes, and consider physician requests for nonformulary drugs. We also analyzed how each HMO's formulary changed from November 1997 to January 1999.

In summary, evaluating the prescription drug benefits Medicare HMOs offer is an important but challenging undertaking for prospective enrollees. To determine which plan best meets their needs, beneficiaries need to assess how HMOs' use of formularies can affect their drug benefit. Comparing plans can be difficult because the types of formularies HMOs use and the way in which they are managed differ considerably. The choices beneficiaries make can have a significant impact on the value of their drug benefit and their out-of-pocket costs. Plans vary widely in the drugs they cover on their formularies, the copayments they require beneficiaries to make, and the annual limits they set on beneficiaries' coverage. Further, beneficiaries

[2]Beneficiaries will have 6 months in 2002 and 3 months in following years to change their enrollment choices.

in some plans may not learn about formulary changes until they are at the pharmacy counter. Some plans also make it difficult for physicians to obtain an exception to allow patients to remain on their existing medication at no additional cost if it is dropped from the formulary.

HMOs USE DIFFERENT APPROACHES TO MANAGE FORMULARIES

HMOs use formularies to control their drug expenditures by limiting the number of drugs a plan will cover and using financial incentives to encourage the use of formulary drugs. Formularies can be open, incentive-based, or closed. Open formularies are often referred to as "voluntary" because beneficiaries are not penalized financially if their physicians prescribe nonformulary drugs. Incentive-based formularies generally offer beneficiaries lower copayments for preferred formulary or generic drugs. A closed formulary limits coverage to formulary drugs only and requires enrollees to pay the full cost of nonformulary drugs prescribed by their physician.

The HMOs we studied rely extensively on the deliberations of pharmacy and therapeutics (P&T) committees to determine which drugs to add to or delete from their formularies. Typically, P&T committees consider several factors when they assess whether a drug should be added to or deleted from a formulary, including the drug's clinical effectiveness, safety, and whether the drug is therapeutically equivalent to drugs already on the formulary. Most of the P&T committees for the HMOs we studied also consider a drug's cost.

HMOs develop and manage formularies in conjunction with decisions they make concerning the design of their drug benefit. Typically, the design includes such features as (1) the extent to which the plan will pay for nonformulary drugs, if at all; (2) the copayments the plan requires from beneficiaries for formulary or nonformulary prescriptions; and (3) limits or caps on the total dollar amount the plan will pay for outpatient drugs.

Ten of the 16 HMOs in our study use closed formularies, and another is "partially closed" in that the HMO limits coverage to drugs in certain classes but will cover all drugs outside of those classes. Two of the HMOs examined have open formularies in which beneficiaries pay the same copayment amount for formulary and nonformulary drugs, and the remaining three HMOs use incentive-based formularies that require a higher copayment for nonformulary drugs than for formulary drugs.

The HMOs we studied also manage their prescription drug expenditures by using formulary controls, such as generic substitution and variable copayments. Generic substitution encourages or requires the use of generic drugs when they are available in

place of a more expensive brand-name drug. Beneficiaries may also be required as part of the overall benefit design to make different copayments for brand-name, generic, and nonformulary drugs. Twelve of the 16 HMOs in our study require the use of generic drugs when they are available, and 7 of the 16 also use variable copayments.

Twelve of the 16 HMOs we examined deleted drugs from their formularies in four therapeutic classes that are widely used to treat health conditions common to the elderly–hypertension, depression, ulcers, and high cholesterol. These deletions required beneficiaries to switch to alternative formulary drugs or increase their out-of-pocket expenses, in some cases requiring them to pay the full price of the drug. However, 15 of the 16 also added drugs to their formularies in at least one of these classes. Considering all the deletions and additions, 12 of the 16 HMOs covered as many or more drugs in each class in January 1999 as they did in November 1997. With one exception, the HMOs continued to offer several alternatives for physicians to prescribe in each class.

DIFFERENCES IN FORMULARY MANAGEMENT HAVE IMPLICATIONS FOR BENEFICIARIES

Beneficiaries interested in determining the value of a plan's prescription drug benefit need to consider a number of factors. Differences in the types of formularies, the drugs they include, and formulary controls used by the HMOs can affect whether a beneficiary's drugs are covered and how much they will cost. Beneficiaries may also be affected by differences in the methods the HMOs use to notify them about formulary changes and how they consider physician requests for exceptions from formulary deletions.

The HMOs vary in the methods they routinely use to notify beneficiaries and physicians about formulary changes. For example, while 9 of the 16 HMOs provide copies of formularies on request, the other 7 routinely mail copies of formularies to beneficiaries with information that explains the formulary's purpose and how the beneficiary can use it to review formulary drugs in different classes. Four of these seven HMOs also send letters to beneficiaries notifying them about specific formulary changes that affect them, as do five of the nine HMOs that send formularies on request. In contrast, four of the nine HMOs do not notify beneficiaries about formulary changes. As a result, beneficiaries may not learn that their drug has been dropped from a formulary and that they will have to pay the full price for the drug until they are standing at the counter of their local drug store.

Beneficiaries are most directly affected by a formulary decision when the drug they have been accustomed to using is deleted from their HMO's formulary and their plan only covers formulary drugs. The change has health care and financial implications

for beneficiaries because it requires that they either switch to a new drug that is on the formulary or continue to use the original drug that has become nonformulary and pay for it themselves.

For a beneficiary whose drug is nonformulary, their physician must decide whether an alternate drug on the formulary is appropriate for the beneficiary's care. However, if the physician believes that it is inappropriate for the beneficiary to switch to a formulary drug, the physician must contact plan representatives to request an exception for the beneficiary so that the HMO will continue to cover the beneficiary's original drug.

The HMOs in our study vary considerably in the processes they use to consider exceptions for nonformulary drugs. Beneficiaries enrolled with 2 of the 16 HMOs are not affected by formulary changes because the HMOs use open formularies. At the other 14 HMOs, requests for nonformulary drugs are handled in different ways. Six of the 14 HMOs that use closed or incentive-based formularies require physicians to submit specific medical documentation to demonstrate why formulary alternatives will not be appropriate for a beneficiary. One of these six HMOs also requires the physician to document that the beneficiary tried the formulary alternative during a trial period and that the beneficiary experienced either an adverse reaction to the drug or the drug failed as a treatment alternative.

Three of the 14 HMOs that use closed or incentive-based formularies will grant exceptions for beneficiaries already enrolled in the HMOs from formulary changes–a policy referred to as "grandfathering." Grandfathering allows a physician to keep a beneficiary on the original drug if the physician believes that is the most appropriate care. The physician's prescribing of a nonformulary drug is not an issue as long as the beneficiary remains enrolled in the plan. Although an HMO's use of grandfathering could enhance the value of a drug benefit to many beneficiaries, this policy was not described in plan materials the HMOs provided beneficiaries.

CONCLUSIONS

The success of Medicare+Choice is predicated on quality-based competition. However, Medicare+Choice cannot realize its potential unless beneficiaries are well-informed about their enrollment options. To fully evaluate the prescription drug benefits offered by different plans, beneficiaries need some knowledge of how HMOs use drug formularies in ways that can affect the value of their benefits. This knowledge helps beneficiaries determine which plan best meets their needs by evaluating a combination of factors, including the type of formulary an HMO uses and whether it covers the drugs they use, whether the HMO requires beneficiaries to share in the cost of prescriptions through copayments, and whether the HMO limits the amount of their drug benefit. This knowledge also helps beneficiaries determine how

well an HMO keeps them informed about formulary changes and how flexible the HMO is in allowing exceptions to formulary drugs when necessary. Naturally, a beneficiary's preferences and circumstances will affect the importance they place on any one of these factors in evaluating drug benefits.

To help beneficiaries compare Medicare+Choice plans and make informed health care decisions, they need clear and easily understood information that includes the drugs the formularies cover, how formulary changes are handled, and policies and procedures for requesting coverage for nonformulary drugs. While particular formulary changes are not predictable, beneficiaries do enroll in Medicare+Choice plans with the knowledge that Medicare contracts do not allow benefits to be reduced during the course of the contract year. Beneficiaries thus also need a clear understanding of which formulary changes would constitute a reduction of drug benefits and therefore would be unallowable during a contract year.

Previously we recommended that HCFA require (1) standard formats and terminology for important aspects of managed care organizations' marketing materials, including benefits descriptions, and (2) that literature distributed by organizations follow these standards. While HCFA has made some progress in standardizing important aspects of plans' materials, it has not yet required Medicare+Choice organizations to provide a single standard and comprehensive document that describes plan benefits and beneficiaries' rights and responsibilities as plan members.

- - - - -

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

GAO CONTACTS AND ACKNOWLEDGMENTS

For future contacts regarding this testimony, please call William J. Scanlon at (202) 512-7114 or John Hansen at (202) 512-7105. Other individuals who made key contributions include Joel Hamilton and David Michaels.

(101867)

The CHAIRMAN. Now, to Mr. Jones.

STATEMENT OF RICHARD JONES, PRESIDENT, MEDICARE PROGRAMS, UNITEDHEALTHCARE, MINNEAPOLIS, MN

Mr. JONES. Good afternoon, Chairman Grassley, Senator Breaux, and Members of the Committee. My name is Richard Jones. I am president of UnitedHealthcare's Medicare Health Care Operations. UnitedHealthcare provides coverage to more than 400,000 Medicare beneficiaries in 22 markets across the country. I appreciate the opportunity to share UnitedHealthcare's perspectives on the issue of prescription drug formularies in the Medicare+Choice program.

Today, we are dealing with the topic of prescription drug coverage practices in Medicare+Choice arrangements. Let me start by stating that UnitedHealthcare believes that prescription drugs are a vital part of medical care. Our Medicare+Choice offerings are designed to help members gain affordable and flexible access to medications that they need, wherever possible.

Our practices. We do not use formularies. Our prescription drug program is built on the concept of choice. Coverage is provided for all medically indicated drugs based on the terms of the member's benefit contract. Our preferred drug list aids members and physicians in selecting drugs that are clinically effective and provide the best value for their condition. Drugs that are included on our preferred drug list are available to members for a lower copayment than drugs that are not on the list.

We do not substitute drugs. We provide a financial incentive, a lower copayment, to members who utilize the drugs that we believe offer a superior clinical benefit in the most economic manner.

These programs promote quality, protecting our members from unnecessary or unsafe care. Our program is designed to ensure that our members receive the best, most appropriate care for their particular condition. We do not dictate what drugs our members can and cannot receive; rather, we educate and motivate our members to be informed purchasers of drugs.

Our policies stress the importance of the physician-patient relationship. We communicate with physicians and payments and encourage the two to talk about the full range of prescription and nonprescription alternatives available.

The management of our prescription drug program. Coverage for prescription drugs is based on a thorough evidence-based process. Our National Pharmacy and Therapeutics Committee, a select group of expert physicians and pharmacists, internal and external to the company, reviews new and existing FDA-approved pharmaceuticals for their clinical effectiveness and appropriateness based on an evaluation of medical and pharmacological literature and research.

Once a year, they prepare a complete list of preferred drugs. On a monthly basis, new drugs are reviewed by the committee to determine if they should be added to the list. No drugs are removed from the list during the year unless there are special external circumstances, for example, the FDA or manufacturer removes the product from the pharmacy shelves. Some drugs, particularly those that are already on the market in a different form, can be added

immediately. Others may take up to 6 months for a complete and thorough review.

Communication to our members is key to the success of our program. Our program aims to educate members so that they can make an informed decision about their drug choices. We encourage them to raise questions about their medications with their physicians and pharmacist to ensure that they are receiving the most appropriate treatment.

At the beginning of each calendar year, members receive a booklet describing their prescription drug benefits and listing the preferred drugs. At the same time, similar booklets containing references to supporting clinical evidence are sent to participating physicians. The preferred drug list is posted on our website, www.unitedhealthcare.com, about pharmacy, and is updated monthly. Members can also contact their personal service specialist at the health plan for more detailed information about their drug benefit. The personal service specialist is a program we are very pleased with and has been very effective in this program, as well as others.

As I stated earlier, we do not engage in drug substitution. Our members are encouraged to make voluntary choices. We do, however, talk with the physicians in our networks, making them aware of opportunities for drug substitutions when clinical and/or cost advantages are present. We also send notices to members, letting them know that there are therapeutically equivalent, less costly drug options available and that they should talk to their doctor about changing prescriptions. The same notice is sent to their treating physician to encourage the communication. It is between the patient and the physician, however, not at the pharmacy.

For Medicare members, the use of preferred drugs at a lower copayment allows them to extend the amount of dollars they have available before reaching their annual benefit limit.

Our work does not stop with the preferred drug list. We are engaged in a number of efforts to help our Medicare health plan members to get the most from the drug benefit. A good example is our new Rx for Healthy Living program. We target members who are taking multiple medications and invite them to participate in a one-on-one pharmacological review for their medications. We call that a "brown bag" meeting, and that is strictly a voluntary, and just for purposes of understanding that, when a member shows up for that review, many times, there are more drugs than that that are reviewed in the process. These seniors do not often have the benefit of having one clinician evaluating their drug regimen.

Members who have been recently discharged from a hospital with new prescriptions are also contacted by a pharmacist. Our team of pharmacists reviews all the medications the members are taking and send them and their primary care physician a report that may recommend changes in the prescription regimen.

Our experience has shown that members are often taking more medications than necessary and may be confused about the proper use of medications. They may not know why they are on a particular medication or how or when to take it. This can cause duplication of medication and, in some cases, can lead to disastrous consequences. It is estimated that over 100,000 people die from side

effects or incorrect dosing of their medications each year. Members may also be mixing prescription and nonprescription drugs that unknowingly place them at risk for serious complications. We have had many success stories from this program. Our members tell us they feel better, save money, and have a better quality of life.

At UnitedHealthcare, drug changes are our members' choices. Changes may be recommended, but the member has the ultimate decision. That is why we call our program preferred drug list. Our policies promote increased education about drug options so that our members can make informed choices in partnership with their physicians. Prescription drugs are a critical component of care for all seniors, for all Americans. We want to make sure that Medicare health plan members continue to receive an affordable, flexible drug benefit wherever possible.

I would be happy to take any questions from the committee and I look forward to working with you on these issues.

The CHAIRMAN. Thank you, Mr. Jones.

[The prepared statement of Mr. Jones follows:]

Statement by
Richard Jones
President, Medicare Programs
UnitedHealthcare

to the
Senate Special Committee on Aging
hearing on

Medicare+Choice Prescription Drug Benefit Practices
July 20, 1999

Good morning. Chairman Grassley and members of the Committee, my name is Richard Jones. I am the President of UnitedHealthcare's Medicare health plan operations. UnitedHealthcare provides coverage to more than 400,000 Medicare beneficiaries in 22 markets across the country. I appreciate the opportunity to share UnitedHealthcare's perspectives on the issue of prescription drug formularies in the Medicare+Choice program.

Today we are dealing with the topic of prescription drug coverage practices in Medicare+Choice arrangements. Let me start by stating that UnitedHealthcare believes that prescription drugs are a vital part of medical care. Our Medicare+Choice offerings are designed to help members gain affordable and flexible access to the medications that they need.

Our practices: Preferred Drug Lists vs. Formularies

We do not use formularies. Our prescription drug program is built on the concept of choice – coverage is provided for all medically indicated drugs (based on the terms of the member's benefit contract).[1] Our"preferred drug list" aids members and physicians in selecting drugs that are clinically effective and provide the best value[2] for their condition. Drugs that are included on our "preferred drug list" are available to members for a lower copayment than drugs not on the list.

[1] With the exceptions of appetite suppressants; non-FDA approved drugs; drugs for cosmetic purposes or smoking cessation; infertility medications; life-style enhancing drugs; over-the-counter medications, and prescription drugs that are therapeutically equivalent to over-the-counter medications.

[2]When more than one therapeutically equivalent drug is available, we list the one with the lowest cost to our member.

We do not "substitute" drugs. We provide a financial incentive (a lower copayment) to members who utilize the drugs that we believe offer a superior clinical benefit in the most economic manner.

These programs promote quality – protecting our members from unnecessary or unsafe care. Our program is designed to ensure that our members receive the best, most appropriate care for their particular condition. We don't dictate what drugs our member can and can't receive – rather, we educate and motivate our members to be informed purchasers of drugs. Our policies stress the importance of the physician/patient relationship. We communicate with physicians and patients and encourage the two to talk about the full range of prescription (and non-prescription) alternatives available.

Management of our Prescription Drug Program

Coverage for prescription drugs is based on a thorough, evidence-based process. Our National Pharmacy and Therapeutics Committee (a select group of expert physicians and pharmacists, internal and external to the company) reviews new and existing FDA-approved pharmaceuticals for their clinical effectiveness and appropriateness, based on an evaluation of medical and pharmacological literature and research. Once a year, they prepare a complete list of "preferred drugs." On a monthly basis, new drugs are reviewed by the Committee to determine if they should be added to the list. No drugs are removed from the list during the year, unless there are special external circumstances (i.e., the FDA or manufacturer removes the product from pharmacy shelves). Some drugs (particularly those that already are on the market in a different form) can be added immediately; others may take up to six months to complete a thorough review.

Communicating the drug program to our members

Communication with our members is key to the success of our program. Our program aims to educate members so that they can make an informed decision about their drug choices. We encourage them to raise questions about their medications with their physicians and pharmacists to ensure that they are receiving the most appropriate treatment.

At the beginning of each calendar year, members receive a booklet describing their prescription drug benefits and listing the"preferred" drugs. At the same time, similar booklets containing references to the supporting clinical evidence, are sent to participating physicians. The"preferred drug list" is posted on our website: **Error! Bookmark not defined.** and is updated monthly. Members can also contact their personal service specialist at the plan for more detailed information about their own drug benefit.

As I stated earlier, we don't engage in drug substitution. Our members are encouraged to make voluntary choices.

We do, however, talk with the physicians in our networks, making them aware of opportunities for drug substitution, when clinical and/or cost advantages are present. We also send notices to members, letting them know that there are therapeutically equivalent, less costly, drug options available and that they should talk with their doctor about changing their prescription (the same notice is sent to their treating physician to encourage communication). For Medicare members, the use of"preferred drugs" at a lower copayment allows them to extend the amount of dollars they have available before reaching their annual benefit limit.

Value-added services: Providing members with more than just coverage

Our work doesn't stop with the "preferred drug list." We are engaged in a number of efforts to help our Medicare health plans members get the most from their drug benefit. A good example is our new "Rx For Healthy Living" program.

We target members who are taking multiple medications and invite them to participate in a one-on-one pharmacological review of their medications. These seniors often don't have the benefit of having one clinician evaluating their drug regimen. Members who have been recently discharged from a hospital with new prescriptions also are contacted by a pharmacist. Our team of pharmacists reviews all of the medications the members are taking and sends them and their primary care physician a report that may recommend changes in their prescription regimen.

Our experience has shown that elderly members are often taking more medications than necessary and may be confused about the proper use of medications. They may not know why they are on a particular medication, and/or how or when to take it. This can cause duplication of medications, and in some cases, lead to disastrous consequences– it is estimated that over 100,000 people die from side effects or incorrect dosing of their medications each year. Members may also be mixing prescription and non-prescription drugs that unknowingly place them at risk for serious complications.

We have had many success stories from this program– our members tell us that they feel better, save money, and lead a better quality of life.

At UnitedHealthcare, drug changes are our members' choice. Changes may be recommended, but the member has the ultimate decision. That's why we call our program a "preferred drug list." Our policies promote increased education about drug options so that our members can make informed choices in partnership with their physicians.

Prescription drugs are a critical component of care for all seniors, for all Americans. We want to make sure that our Medicare health plan members continue to receive an affordable, flexible drug benefit wherever possible.

I'll be happy to take any questions from the Committee. I look forward to working with you and your staff as you pursue this issue further.

The CHAIRMAN. We will take 5-minute rounds of questions. I have questions of every one of you, but instead of asking my questions all at once and taking more than 5 minutes, I want the rest of my colleagues to ask their questions. Then, I will come back and finish asking my questions when everybody else has had time to ask questions.

I am going to start with Dr. Scanlon. Of the 16 plans that you interviewed for this report, could you identify best practices regarding beneficiary notification, and for those plans that communicated poorly, what could HCFA and/or Congress do to ensure beneficiaries are not kept in the dark?

Mr. SCANLON. Slightly more than half of the plans did a reasonable job in terms of notifying beneficiaries of changes by identifying the beneficiaries that were taking particular drugs and sending them and, very often, their physicians notice that a drug was going to be deleted from the formulary. The other important element is to notify beneficiaries of the exceptions processes that are available to them if they want to continue using a nonformulary drug.

Whether HCFA or the Congress wishes to consider making notices of formulary changes a requirement for all managed care plans is an issue, but at a minimum, managed care plans should be notifying beneficiaries before enrollment as to what their procedures are going to be when they do change formularies, and also how often in the past they have changed formularies.

As Mr. Jones has indicated, United only considers changes once a year, which is something that is very consistent with the lock-in that is coming into place in the year 2002. The idea that you can enroll in a plan and will be enrolled for a full year while the plan can make changes during the year would be troubling to a potential enrollee.

The CHAIRMAN. Where do plans most commonly explain their formulary policies regarding changes to this benefit and what would you recommend to plans and to HCFA as to whether and when this information should be available to seniors?

Mr. SCANLON. As we have indicated before, Chairman Grassley, the availability of information before an individual enrolls in a plan and also after they enroll in a plan varies greatly. Sometimes beneficiaries have to seek information directly from the plan and sometimes they are not successful in getting the kind of information they need. Access varies from plan to plan.

Plan information comes in multiple forms in the marketing materials, the critical information that beneficiaries have before they enroll, there needs to be adequate information to give one a sense of how a plan is going to deal with an important issue like a formulary change. More details should be in the enrollment materials a beneficiary receives after enrollment. There should be no issue that important information is being withheld from beneficiaries.

The CHAIRMAN. What were some of the reasons given by the plans for not disclosing some of their policies, such as grandfathering, which if I understand it correctly, means that the plan would continue to cover a drug when there is a substitution for those patients already on it. It would seem to me that this is an added value the plan is offering and beneficiaries would want to know that they have this option.

Mr. SCANLON. It certainly is an added value for a beneficiary enrolling in a plan that has grandfathering. The primary reason that the plans gave for being concerned about making that too public was the idea that it would lead to adverse selection, that people that were taking a drug that was not on other plans' formularies would know that they could switch to a given plan and they would be able to continue that drug, undermining the effectiveness of a good formulary.

As we have indicated, good formulary management is something that you would expect to be a part of managed care. But at the same time, you do need policies that allow for exceptions for individuals who cannot use the drugs on the formulary effectively.

The CHAIRMAN. Mrs. Lathrop, were you aware that your plan, Secure Horizons, had a policy known as grandfathering which would have allowed you to stay on your original medication, Zestril? I am curious to know if the plan told you it offers this before you enrolled and did they mention this to you when you called them after your prescription drug coverage was denied.

Mrs. LATHROP. No. I was not informed. When I sent my money in for my prescription refill, that is when they called and told me that Zestril is no longer covered. I did not know that, and they did not give me any options at that time except to call my doctor and get another prescription.

The CHAIRMAN. Based on your experience, what suggestions can you offer regarding information that would have been helpful to you about your drug benefit?

Mrs. LATHROP. I think that they should tell you at the beginning that at some time, the drug may be not on their formulary so that you know and you are not surprised when it is not on the formulary. I was not informed that, at some time, my prescription would not be covered. I just assumed it was going to be covered forever.

The CHAIRMAN. Thank you very much.

Senator Breaux.

Senator BREAUX. I thank the panel for their helpful information. I take it, Dr. Scanlon, most of your comments, the reading that I have made, is basically that it is not that unusual that companies would change the numbers of drugs and replace them with newer drugs or drop others or encourage generic purchases but that they would do it all without letting the people know anything about it. Is it basically lack of information that seems to be the problem here, that people do not really know what they are buying and then they do not know when changes are made and how to accommodate to those changes?

Mr. SCANLON. That is really the essential problem, because as we expect in managed care, we are trying to institute a system in which there is some direction coming from the managed care organization that points us to the best resources that are helpful to us, as opposed to having everything available. But in order to do that well, we have to have good information about how the managed care organization is going to operate. We did not find that.

Senator BREAUX. You did not find that it was a negative to encourage, for instance, generic medication as opposed to the brand

name medication? That in itself is not a problem, it is just that they do not really know that that is being done, I guess.

Mr. SCANLON. In some instances, they do not know it is being done, but the issue is that this type of substitution can be cost-effective and may not be harmful to a patient.

Senator BREAUX. Can we inform the average citizen, and I would consider myself an average citizen? I mean, they gave me a ten-page list of drugs. Not being a pharmacist or a medical professional, I do not know if that would mean a lot. Can this information be put into a form that means something to the average person? It looked like it is all Egyptian hieroglyphics to me.

Mr. SCANLON. I think that as we have talked about this over the last couple of years and argued that we need better and more complete information for beneficiaries, one of the key aspects is that we need understandable information, and turning all of this into understandable information is clearly a challenge.

I believe that the pamphlet that Mr. Jones talked about that United provides is an example of where the information, while still complex, has been boiled down into something that is more user-friendly than some other types of information. We have seen formulary lists, that if you requested a formulary from an HMO, they will send you the same materials that they send to physicians. So you will have the list with prescribing information and all kinds of other details. It is basically a book. It would be something that most beneficiaries would have very great difficulty dealing with.

Senator BREAUX. It seems like the doctors would need the information the most because they do the prescribing and the individual just is filling out the prescription. I noticed United's list. You have nine pages of drugs, and I noticed that it covers from A to Z. It also covers V, which is Viagra. I noticed that. But I was interested that you had Viagra. You had a little QL on the side of it. What does the QL mean?

Mr. JONES. I do not know——

Senator BREAUX. I checked that out, too, what it meant.

Mr. JONES. I can find out exactly what that means, but I think that is limited quantities.

Senator BREAUX. I will tell you what it means. It says that there could be a limited amount that could be dispensed at one time or in any 1 month.

Mr. JONES. That is correct, a limited amount in any given month on that particular drug.

Senator BREAUX. I am finished. Thank you.

The CHAIRMAN. I wanted Senator Reid and Senator Lincoln to know that if you can come back in between votes, we want to keep the meeting going, so you will be able to ask questions then. Are you finished?

Senator BREAUX. Let me just ask one other question of United. You all have pulled out of Louisiana, and that is a whole another subject. I mean, you dropped about 18,000 patients in your HMO managed care in Louisiana, and I do not want to put words in your mouth. I guess you pulled out because of the reimbursement rates that you find are too low?

Mr. JONES. Yes, sir. Yes, sir. Basically, the reimbursement to the health plans in those markets is not enough to keep up with the

medical inflation that we are seeing in those two markets that we were in.

Senator BREAUX. We can spend a lot of time on that subject. I will not do it here. Thank you very much. You have done a good job with this formulary.

Mr. JONES. Thank you.

The CHAIRMAN. Senator Wyden.

Senator WYDEN. Thank you, Mr. Chairman. I think all of you have been very good. I think that not only is this a back-door benefit cut, because I think you do have older people believing that they are going to get a particular product and not getting it. What Dr. Scanlon has essentially said is that in the key parts of the health care system, folks are essentially in the dark. The seniors are not going to know how the system is going to work. I think in most managed care programs, we do not see the kind of effort that United has been talking about. The physicians are in the dark.

I, as somebody who comes from a part of the country where we have a lot of managed care, a lot of good managed care, am convinced we are going to have to overhaul this effort or it is going to chip away at the credibility of the program.

As I understand it, Dr. Scanlon, you believe that the heart of this is good notification, both for seniors in understandable, coherent language, and physicians. Is that essentially the heart of what your——

Mr. SCANLON. We think that is, essentially, the very first step. We need to give good information available a try. The pressure created by individuals having good information and leaving plans that are not providing them what they need may be a powerful force, probably a more powerful than regulation, to promote quality.

Senator WYDEN. So the Federal Government should try to do this in a uniform way because right now, we are also seeing some extra problems given the differences in State law on this matter, according to what you and others have looked at, is that not right?

Mr. SCANLON. That is correct. I would not recommend that you preempt State laws, but the issue is, that the information across plans that beneficiaries have needs to be consistent and uniform so that they can make comparisons among the plans that are available to them. What plans do will vary as they are going to be operating within the laws for their particular State. The issue is beneficiaries are informed of what those operational practices are.

Senator WYDEN. I have to tell you, I specialize in this area. I was director of the Gray Panthers for 7 years, have been on the Aging Committee in the House and the Senate. This stuff barely resembles English, and I am convinced—we had an excellent first witness talking about how you were surprised to learn about the changes in your formulary. I think we know that for a lot of families, the concept of formulary is still a foreign one.

So we have got a big job ahead of us, and for those of us who want to see the Medicare program reinvented so that people can have choices and be able to compare policies and the like, this has really been an eye-opener.

I am going to review your work at United very carefully, as well, because I think you are working hard to try to communicate to both doctors and patients. My guess is that a lot of the seniors may

be more accepting than they would be if they really understood what was out there, and I think we ought to have some further discussions. But I appreciate the fact that you are trying to communicate in a better way.

Mr. JONES. Thank you.

Senator WYDEN. I want this program to work. I think it is an important part of the Medicare future, and I will tell you, it is going to be a lot harder for us to get a prescription drug benefit into Medicare unless we drain this swamp, so we are going to be working with you and I thank you.

Mr. Chairman, as I noted earlier, I initiated this a long time ago, but it happened, essentially, because you and Senator Breaux stepped in. I am very grateful to you because I think it is an important issue. Thank you.

The CHAIRMAN. Thank you. It has been nice to work with you on it.

Senator Lincoln, I think you would have time to ask your questions because you would have until 3:14 that you have to be over there to vote.

Senator Lincoln. I think I can make it.

The CHAIRMAN. I am not sure your microphone is turned on.

STATEMENT OF SENATOR BLANCHE LINCOLN

Senator LINCOLN. I would like to thank the Chairman, of course, and Senator Breaux for their leadership on this and many issues that we deal with in the Aging Committee. They are of the utmost importance to Arkansans and certainly to all Americans and I am appreciative of the panel that is here today.

Obviously, we are here today to listen to all different sides of this and recognize the problem that we may have. I would like to ask for unanimous consent to be able to enter my entire statement for the record.

The CHAIRMAN. Your statement will be accepted.

Senator LINCOLN. Thank you, Mr. Chairman.

[The prepared statement of Senator Lincoln follows:]

PREPARED STATEMENT OF SENATOR BLANCHE LINCOLN

Thank you Mr. Chairman. I am pleased to be here today to take a closer look at how managed care plans routinely change the type and number of drugs they cover for older Americans.

The point of this hearing is to listen to consumers, consumer advocates, the General Accounting Office and a representative from the managed care industry. I am particularly interested in knowing more about the type of information made available to older persons from their health insurance company when the company decides to switch the type of drugs it will cover. Switching drugs is a serious matter because the effectiveness of drugs varies and patients can develop side effects to new drugs. I want to be sure that consumers are alerted in advance if and when their prescription drugs are switched.

I want to thank our witnesses for being here today and I look forward to hearing their testimony.

Senator LINCOLN. Obviously, as a point of discussion and certainly something we need to look at on another day, I would add to Senator Breaux's comments. Mr. Jones, I notice that your group has also pulled out of Pulaski County, which is our central county in Arkansas, the Little Rock area.

I agree with my colleague, Senator Wyden, that in terms of getting any real prescription drug solutions, that this is a problem that we have got to tackle and to ensure that what we are providing is adequate and certainly necessary for our elderly population.

Just a couple of questions. Mrs. Lathrop, I am curious to know what your doctor's reaction was when you told him that the Zestril was no longer covered.

Mrs. LATHROP. He did not really help me. When I would call and tell him that they had called and told me that my prescription was not on the formulary, he would just give me another one. I would send it in. They would call me and tell me that it is not on the formulary. So he never really did help me. I did not know that I had an option and I could ask him to call.

Senator LINCOLN. And actually request the particular medication?

Mrs. LATHROP. Yes. I did not know that. I do now.

Senator LINCOLN. That you could request of him to make that call. So, one of the highlighted issues here, is obviously educating our consumers about what is available to them and what is out there.

So he seemed to think that there was a comparable drug out there, or a compatible drug——

Mrs. LATHROP. Yes, he did.

Senator LINCOLN [continuing]. And so he continued to prescribe those drugs?

Mrs. LATHROP. Each time, evidently, they were not generic. Maybe there is no generic, I do not know, for high blood pressure. But the one that they did send me was going to cost me the same as my original prescription, so that is what I asked them, why would I pay for that if I could not get the original one?

Senator LINCOLN. But apparently, there was no discussion or information provided or at least found out by the physician. I mean, he was as much in the dark, I guess, as you were as to what drugs were available through your formulary, is that correct?

Mrs. LATHROP. Yes, he was.

Senator LINCOLN. Another question, just to know, do you have many friends or peers that you have found have been in that same situation?

Mrs. LATHROP. My sister.

Senator LINCOLN. Is that right?

Mrs. LATHROP. She has rheumatoid arthritis and the medication that she is taking now, they have to call and get approval for every 3 months.

Senator LINCOLN. So you have contemporaries that are running into the same problem. What would you say is the best way that an insurance company could notify you?

Mrs. LATHROP. Well, they could send a letter out saying that these drugs are no longer going to be on their formulary.

Senator LINCOLN. Would it be advantageous, perhaps, just like we have here as Federal employees, we have an open season where you can make changes to your own plans.

Mrs. LATHROP. That would help. That would help.

Senator LINCOLN. So you would like an open season during the year when you could make changes in your formulary?

Mrs. LATHROP. I still have the bottle of pills that they sent me—I never took them—that I paid for because they would not take them back.

Senator LINCOLN. One other point that is interesting, and it has been brought up, and that is that many of our States have laws on the books, about what we are discussing here today. Arkansas is one of those States and I am very proud to report that the Arkansas legislature recognized the importance of passing the Health Care Consumer Act in 1997.

Even though California and Arkansas have strong patient protection laws, Ms. Helms, I was wondering, do you think there are enough consumers that are aware of their rights under these state laws?

Ms. HELMS. No. The doctors are not even aware of the laws, so that is what we are trying to do. I can tell you that, this year, some of our State legislators, went out to their districts to have information days, they discussed women's health. There was standing room only at all of these information days. They were turning people away. Helen Thompson had one in her district and there were 450 people that had signed up and 750 people showed up. The need to be informed is incredible and people want information. We just need to get it out there to them.

Senator LINCOLN. Just to add to that, I would like to compliment you on your list of questions that you submitted in terms of what consumers should ask and I hope that you are working with other advocacy groups to make sure that those lists are available.

Thank you, Mr. Chairman.

Senator ENZI [presiding]. Thank you very much.

I will start with Mrs. Lathrop. Do you know what kind of ability or flexibility your treating physician had in making sure that you received the appropriate medication? I know your testimony said your conversation was with the pharmacist who called you and said, out of luck.

Mrs. LATHROP. When I called the doctor to tell him that my prescriptions were not covered, he just sent me another prescription. I did not know that I could have asked him to call the pharmacy and tell them that this is what I needed. Each time, I just got another prescription until I finally got one that they accepted, which was the Captopril, which for me did not work.

Senator ENZI. When you had these other drugs, then, did you require some additional medical services?

Mrs. LATHROP. I only got one prescription, other than the Captopril, that they sent me. The others, they just called and said, "This is not on our formulary." When I finally ran out is when they sent me the new prescription that was going to cost me the same as my Zestril was going to cost me.

Senator ENZI. So there was not any cost saving involved in it, either.

Mrs. LATHROP. No. I called and asked them, why would I take that, a new prescription, when it was going to cost me the same as my old one, so this is when I changed. I told them, I said, well, I will just change health plans.

Senator ENZI. As they mentioned, in the year 2002, that will not be an option on a monthly basis, but on an annual basis.

Mrs. LATHROP. But I did not know that.

Senator ENZI. Are you aware of some times when there are additional medical services that are involved because of the change in prescription?

Mrs. LATHROP. No.

Senator ENZI. Ms. Helms, I understand that a number of Medicare beneficiaries are eligible for the California Medicaid program, MediCal, because of their low-income status. I have several questions regarding the experience of these dual-eligible Medicare beneficiaries versus those Medicare beneficiaries who are not eligible for the Medicaid benefits. And I, too, want to thank you for the list. I had a chance to read it on my way over to vote and there are a lot of consumer situations where if we knew the questions to ask, we would come up with better answers.

Ms. HELMS. Thank you.

Senator ENZI. Of course, we try and ask some questions here. Sometimes it is your background that we rely on rather than our questions. Do those dual-eligible beneficiaries receive notification of the type of drugs on the Medicaid formulary?

Ms. HELMS. I do not know that Medicaid informs the beneficiaries any better than any other health plan informs. Under California law, all formularies are to be disclosed upon request, and that law became effective this year, so that should cover that. That information should be available.

Senator ENZI. So the dual-eligible beneficiaries who participate in the California Medicaid program, they will be receiving adequate notice, then?

Ms. HELMS. Well, I do not know if Medicaid is going to be doing anything like what United has done, and I would be happy to find out that information.

Senator ENZI. OK, because I would be interested in knowing if there is a provision now where they will receive adequate notice in advance of the drug if it is deleted from the formulary.

For those same beneficiaries in the California Medicaid program, are there restrictions on any cancer or AIDS drugs?

Ms. HELMS. I believe that cancer and AIDS are on the top of the list of drugs to be able to access. I have to tell you that, at this point, it looks like the Medicare formulary is probably better than what any health plan has in the State, so that is disturbing.

Senator ENZI. In your testimony, you mentioned the Knox-Keene Act. Are you aware of any provision in that act that establishes the criteria for an HMO quality assurance program that includes the drug benefit?

Ms. HELMS. No. Because plans do not have to have a drug benefit, and actually, this year is the first year that the Department of Corporations has really taken a look at formularies because this is the first year we have had so many complaints with switching. It used to be access and now it is access to medications. So this is all being looked at right now and if we have to go back in there and change some of the Knox-Keene Act, then I would say that that is probably going to happen fairly shortly.

Senator ENZI. I was under the impression that California discouraged and in some cases prohibited and limited access to care based on financial considerations.

Ms. HELMS. Right, and they are not supposed to do that. That is 1367(g). The department of corporations has certainly become active. We have put a lot of pressure on them to become active and to regulate what they are supposed to be doing under law.

Senator ENZI. So that adds to your job, then.

Ms. HELMS. Oh, yes.

Senator ENZI. OK. Since the Chairman is not back, I will go ahead and ask a few more questions. I had not gotten a chance to ask either Mr. Scanlon or Mr. Jones some questions.

Mr. Jones, based on your progressiveness in the field, can you comment on how widespread the consideration of clinical and humanistic concerns and health outcomes assessments similar to your National Pharmacy and Therapeutics Committee is by other HMOs across the country?

Mr. JONES. I will say, optimistically, I hope it is all. I would say that I have been associated with several, and the best that I can tell, the economic considerations are the last considerations when a formulary and therapeutics committee works. When all other issues relative to efficacy and so forth have been addressed, only at that point, in my experience, have economics been considered in the decision process. If there is a drug that is clearly better than all others, economics does not, should not, enter into that consideration.

In my association with United, that has certainly been the case. A preferred drug is a preferred drug, and only when the efficacy of similar drugs is seen as being equivalent would the economics and financial status affect that. I hope that is true across the industry.

Senator ENZI. Other than your Rx for Healthy Living program, has UnitedHealthcare established any disease management programs?

Mr. JONES. Yes. We have established a number, and they vary from market to market, but, yes, we have. I am probably not the most qualified person to talk about those, but we consider that categories of care frequently need more intensive consideration, more intensive review by certain specialists and in certain settings than in the normal population. So disease management, focus on categories of care, is a big part of what we do and how we look at providing appropriate care for the members that are included in our HMOs.

Senator ENZI. Do you find that there is much cost correlation between the medication and the disease prevention and disease management costs?

Mr. JONES. I would have to say, for me to make that observation, I might be stepping out a little bit far. But we certainly believe that maintaining a lifestyle where a member is more ambulatory and can pursue their life and their endeavor outside of an acute care setting certainly improves their longevity and their approach to life. So the inclusion of pharmacy and the related benefits of that are known. I think that to make a blanket statement that there is a related cost savings in all applications of that, I think, would be too far for me to go, not being an expert at that.

Senator ENZI. You noted in your testimony that your health plan utilizes copayments in your preferred drug list. Is the impact of the

copays the same as the restrictive formulary except you are shifting the expense to the patient?

Mr. JONES. I am not sure I completely understood the question, but what we are trying to do with the copays, after we have deliberated, we—and I am not one of the deliberators, there are physicians and pharmacists that do that—we are attempting to help the member to make a choice not only by saying there is a preferred drug list but by providing a financial incentive to do that, as well.

Some of the discussions that we have gone through today, the health care system is complex, to say the least. The pharmaceutical options are complex. There are over 100 therapeutic classes. So for us to assume that we could necessarily put a list together that anybody could understand in its totality is just too much. What we have to do is provide a process and adequate communication so that as a senior or anybody else finds themselves in need of a therapeutic class of drugs, it is simple enough, there is enough interaction to find the proper medication.

But the copayment process is an effort to get the member to make a discerning choice. If they choose to use the preferred drug, there is a lower copay. One part of your question was, is it the same as having a restrictive formulary, and I would have to say no to that because there is a method and process for a member of United to get basically any drug that is medically necessary and the copay changes relative to the preferred drug in that class.

I do not know if I have answered your question. I have rambled a lot.

Senator ENZI. You have helped. Could you tell me what your retention rate is among seniors? Is there a correlation between the cost of these expensive programs and the fact that United dropped certain of the markets last year? Was it a cost-related decision?

Mr. JONES. In a normal—normal is not the right word. When there is not a service area reduction, when we have not gone through the process of exiting a market or non-renewing a contract, our retention has been, in my opinion, and I look at this across the nation, has been one of the best in the nation. As we have had the need to exit a particular market, we receive any number of requests not to do so because there is a great attachment.

I had mentioned the program of a personal service specialist, where we provide a service specialist who is aware of how the networks work, how the pharmacy benefits work, how the care is to be accessed, and every senior has one particular specialist they work with. They have their name, their number, they always communicate with the same person. We have had members who have said, I know I have to change but can I keep the same personal service specialist because they have been so helpful in what is, without a doubt, one of the most complex situations to receive care, and these specialists guide them through that.

For that reason, among other reasons, I think the communication is a part of that. I think our retention has been high and our disenrollment has been lower than that we have seen on a national basis. And again, without specifics, and I could get you specifics on that relative to the statistics, it has varied some between markets, but nationally, I believe we are at the lower end of that.

Senator ENZI. Thank you. Mr. Scanlon, I just received the report on the Medicare+Choice this morning and, consequently, have not had a chance to review it in depth. Can I assume that most of the Medicare+Choice plans utilize pharmacy benefit management services?

Mr. SCANLON. Most of them do, either through internal operations or through an explicit contract with an external PBM.

Senator ENZI. How do they achieve the drug budget savings, then? Is there a coordination with the plan's disease or case management program or is it strictly based on drug costs?

Mr. SCANLON. There is both the coordination with disease management activities as well as there is the use of the formularies or preferred drug which enable plans to concentrate their purchasing power into selective drugs and, thereby, get manufacturers and wholesalers to provide better discounts than otherwise.

There are also utilization control techniques that they use in terms of reviewing drugs, encouraging substitution of generics for brand name drugs. These all are parts of generating the savings that are possible through a drug benefit.

Senator ENZI. You are talking about savings and dollars, so are you saying that it is based on drug costs?

Mr. SCANLON. The savings are something that is an additional goal besides the efficacious care, that we want the managed care organization to deliver. It is not to say that the costs should be paramount, but certainly one method of delivering equivalent care is less expensive, that is what we are seeking from a managed care organization and what managed care organizations ask of their PBMs is to point us to the less expensive option.

Senator ENZI. It is my understanding that the National Committee for Quality Assurance has recently incorporated into their accreditation program a number of standards for the management of drug benefits and formularies. Can you tell us if these new standards have or will have any influence on the Medicare+Choice market as plans begin to implement them in the commercial business?

Mr. SCANLON. Certainly, it will bring some more uniformity to the Medicare+Choice market because there is great interest on the part of Medicare+Choice plans in being NCQA-accredited, and to that extent, I believe that this will be a factor in terms of making practices more uniform.

In terms of how efficacious they are, we have not reviewed them from the perspective of will they deal effectively with the problems that we have identified today.

Senator ENZI. Did not the drug formulary policies just go into effect?

Mr. SCANLON. Yes, they did.

Senator ENZI. So it is a little early to get a reading?

Mr. SCANLON. It is too early, correct.

Senator ENZI. Senator Grassley will have just cast his second vote now, so I get some additional time yet.

Mr. Scanlon, do you know of or did you consider during your study how the commercial market is coping with the drug formularies?

Mr. SCANLON. We considered it, but we did not study it in nearly the detail that we looked at the Medicare portion of HMOs' prac-

tices. In some respects, the commercial market or commercial plans do things that are very similar to Medicare+Choice plans. However, the impact of some of these practices is different because they are dealing with a much different population. The utilization of pharmaceuticals among the elderly is orders of magnitude higher than it is among the non-elderly. Therefore, changes, to a formulary or efforts to manage the drug benefit, have a much more profound impact upon elderly beneficiaries than they do upon non-elderly beneficiaries.

Senator ENZI. Earlier, we talked about the PBMs. Do they have the ability to implement a drug formulary that takes into consideration a plan's disease management program?

Mr. SCANLON. Certainly, I think that they have the ability to coordinate between the disease management programs and the drugs that they choose to put on the formulary. In all of these activities, despite the fact that the ideal situation now is to assemble physicians and pharmacists that bring expertise to these decisions, the reality is that there is a lot of work to be done in terms of generating information about how effective different drugs are, to be able to identify an optimal formulary.

We looked at what plans are doing to learn from their experience, not just to rely on the information that experts bring to the table. We found one plan that actually tried to evaluate what a formulary change meant. It was in the area of cholesterol-lowering drugs. They are now engaging in a similar effort with respect to antibiotics.

These are the kinds of things that I think are important. As we talk about managed care, one of the things that we sometimes forget is the fact that the evidence upon which to engage in medical practices is relatively thin and that the more we can do to generate evidence about efficacious practices, the better off we will be in how managed care plans can perform and there may often be spillovers into the fee-for-service sector that will also be beneficial for us. There is an opportunity for the interaction between the PBM and the pharmaceutical and therapeutic committees, but I also think there is a need for generation of more evidence for them to use.

Senator ENZI. Ms. Helms, you were busily jotting some notes there. Did you want to comment on that or something else that we have just spoken of?

Ms. HELMS. I have been taking lots of notes. I would like to comment on one of the questions that you had to Mrs. Lathrop about her doctor helping out. Under the Knox-Keene that I cited, 1367(g), she never should have been put into the position that she was put into had her doctor gotten involved with it, and that was one of the issues I talked about, the successful failures, when they switched you off the formulary, that you have to try some other drugs.

I know patients that were switched five times on their high blood pressure medications with great adverse effects. I almost got involved. I said, if you do not start doing something for yourself here, I am going to get involved with this. She did not want me to get involved. It is pretty widespread, and high blood pressure was one of the very top drugs that were being switched, and especially for seniors who have been on medication for a very long time, that puts them at very great risk, and her doctor should have known

that he could have gotten involved and kept her on the medication without having her change. Hopefully, with our new law that has become effective, that will not happen anymore.

Senator ENZI. Their desire not to be involved, is that because of the faith in the doctor, the faith in the HMO, or the faith in the pharmacist, or just fear?

Ms. HELMS. Doctors, do not have a lot of time to sit on the phone and sometimes have to hire a lot of people in their office extra just to deal with this issue because the issue has become so big. So probably time is one. They just say, OK, we will just try something else until they get angry, and then they get involved and they say, OK, we are not going to put up with this anymore and I am going to have to do something, because they see what position their patients are in.

The pharmacists have another problem because when they go to fill a prescription and all of a sudden it has been taken off the formulary, they have to either put them onto a generic, but the pharmacists are not allowed to do the switches without getting the permission from the doctor, so they have to call the doctor or they have to call the plan. So in every direction that we look, there is confusion and——

Senator ENZI. And more telephone time.

Ms. HELMS. Yes.

Senator ENZI. What motivated the high activity drug formularies in California?

Ms. HELMS. Back in the summer of 1998, the Right to Know and the International Patient Advocacy Association had an increase in calls where the shift was in access to problems that patients were having with their formulary, and as we got more involved in answering phone calls from the people that were calling in—this was hundreds and hundreds of calls—what we figured out is that possibly because we had a new law that was becoming effective after the first of the year, that the HMOs were purposely cutting drugs from their list so they could go to the less expensive drugs before this law became effective. So that is what prompted the investigation with the Department of Corporations.

Senator ENZI. So it can be pinpointed, then. Thank you.

I will return the gavel to the Chairman.

The CHAIRMAN [presiding]. I thank Senator Enzi for his cooperation. I told them you would be over there to vote right away, so thank you very much.

Now, I call on Senator Reid.

Senator Reid. Thank you very much, Mr. Chairman. Dr. Scanlon, there is, I think, a sense out there sometimes that a lot of insurance companies might be attracting Medicare recipients by some variation of the bait-and-switch, promising them a lot in terms of pharmaceutical coverage beforehand, signing them up, and then presenting all of this information, all of the lists of formularies, which at that point to most people is just not terribly useful. In your survey and review, do you find any credence to those types of anecdotal impressions which are out there?

Mr. SCANLON. I think that we find it both in the work that we did here and the work that we have done previously for the committee. In looking at participation in Medicare+Choice plans across

different markets, we found incredible variation in terms of beneficiaries joining and then leaving plans, and especially leaving plans quickly.

Earlier, about a year and a half ago, we reported to the committee that the range in some of the bigger markets was from 5 percent of beneficiaries leaving a plan to 40 percent of beneficiaries leaving a plan. The plans that had very large disenrollments were not plans that were shrinking. They were going out and still signing up more people, and the sense was that part of the problem was how they were educating beneficiaries about what the plan was going to offer, drug benefits being one thing, access to physicians being another.

These findings were the basis for the concern that we really do need clear, standardized information that beneficiaries have access to before they enroll in a plan. It is a problem today when we have monthly disenrollment available to beneficiaries. It is going to be a huge problem when we have an annual lock-in and people are going to be stuck in a plan for a full year when they discover that it does not have the benefits that they really thought they were signing up for.

Senator Reid. So the issue, it is not just the type of disclosure, it is also the timing, that plans could sort of oversell up front and then provide a ream of information, but that is not particularly helpful because once people figure out what is going on, they just disenroll.

Mr. SCANLON. That is correct. We found that, in many cases, you did not get essential information until after you enrolled, and sometimes even not then.

Senator Reid. I think Ms. Helms wants to comment. Do you have a comment?

Ms. HELMS. Yes. On one of the questions that I was just asked, I also want to say that one of the reasons that doctors do not get involved is they feel the pressure from the plans, the financial pressure. There has been a lot of shift, cost shifting to the medical groups. Medical groups are having a real hard time. Seventy percent of them, I believe, in California are looking into bankruptcy and a lot of the drug expense has been put onto the doctors. So it is hard for them. It is like a conflict of interest. Should they go and try to help the patient get the right drug for that patient or should they risk losing the financial risk of staying in beneficiaries.

Senator Reid. Thank you. That brings me to another question I want to raise with Mr. Jones. Mr. Jones, you pointed out that United essentially incentivizes the custom to the patient. If you go off the formulary list, you pay more. Are there any financial incentives or disincentives to physicians about prescribing off the formulary list?

Mr. JONES. Not that I am aware of.

Senator Reid. So at the end of the year, it is all on the patient's side. It is all that patient. If they choose to get the "X" version versus the "Y", they pay more, is that correct?

Mr. JONES. In the example that was just described, in a number of markets, there is a type of reimbursement called capitation, and in those situations, the physician groups through a negotiation or through a discussion in some cases take risk for the pharma-

ceuticals in the amount of money that they receive. So I would say that using that as an indicator, that could have an impact on their total.

Senator Reid. And you operate in certain markets with capitation so that there is at least a second degree incentive for the physician to stay on the formulary list because you pay for the whole thing, then, I presume.

Mr. JONES. When they are on the formulary?

Senator Reid. Yes.

Mr. JONES. If the capitation—and there are a number of ways that are done. It varies with as many markets as there are. But it could include all of the pharmacy costs in their pool. It could say that the health plan pays a targeted amount and amounts over and below are shared in some fashion. But, generally, there are as many different types of reimbursement to the physicians as they would like to entertain and they are capable of, we hope capable financially as well as in the process of understanding the information to administer.

Senator Reid. So within just your plan, for example, within your company, there are variations in which there are certain incentives for doctors to prescribe from the formulary list, maybe not every doctor you contract with, but some doctors?

Mr. JONES. I would say that there are a variety of ways that they are reimbursed. I would say that every one of them has a different implication on how the pharmacy piece is treated.

Senator Reid. One of the things that was done in my home State of Rhode Island, I was talking to the Chairman on the way over and he points out that many States have adopted legislation. Ms. Helms, you have also indicated that California recently adopted legislation. We have recently enacted legislation which would require or at least allow the physician to prescribe off the formulary list if it is "medically necessary," which gets us back into the whole justification system. But at least it gives someone who wants to get their old prescription the right to at least have their doctor argue for that.

I wonder, Dr. Scanlon, is that something that you have looked at in terms of your review? Is it effective?

Mr. SCANLON. As Mrs. Lathrop indicated, while that can be a provision, it may not be effective because it is not well known. Beneficiaries' rights are only going to be useful when the beneficiaries know to exercise them or when the physician knows how to exercise them on their behalf.

Senator Reid. Mrs. Lathrop, just a final question. In your experience which you related, was your physician someone who was battling to make sure you got, in your view, the proper medicine?

Mrs. LATHROP. Actually, when I would call in, I did not talk to the doctor. I would talk to his secretary and tell her that my prescription was not accepted. So I assume that she would tell the doctor. He is the one that wrote the prescription and would send it to me and I would send it in. I do not feel that he helped me with a lot, no.

Senator Reid. Do you feel that was just a lack of knowledge or just simply that——

Mrs. LATHROP. I think he was busy, very, very busy.

Senator Reid. Again, even in the concept of medical necessity, and we heard so often last week during our debate and before our debate, just the volumes of paperwork which physicians have to do simply to do things which years ago were almost taken for granted. They would scribble out—I do not know where they learned to scribble, but they had a special class in medical school—they scribbled out these prescriptions and automatically gave them out and that was the least of their worries. That was done. Now, obviously, seniors are coming back to them and saying, you have to help me get my prescription.

Mrs. LATHROP. Well, if I had known, I would have called and asked to speak to him personally to tell him that I could not get my prescription and I would appreciate a call, for him to call me or call Secure Horizons and tell them.

Senator Reid. Thank you very much. Again, Mr. Chairman, thank you for this hearing. It has been very, very helpful and useful. Thank you.

The CHAIRMAN. Yes, and I appreciate your being so dutiful to your attention to the work of the committee.

I only have maybe two or three questions that I want to ask and then I will conclude with something I had a chance to discuss with Senator Breaux, as the ranking Democrat on the committee, as a follow-up.

I think I will start, first of all, with Ms. Helms. From your experience working with seniors on the Medicare+Choice plans, do you find that they decide to disenroll from plans when they are not properly informed about their drug benefits and policies regarding the benefits?

Ms. HELMS. Oh, absolutely. If they cannot get the medication and they do not understand how to work the system and they have no information to know that their doctor can advocate on their behalf or that there is a provision in Knox-Keene or whatever is out there that could make a difference, even just going to an appeal, they do not understand the appeal, it is easier for them to find another plan that might just say, OK, we will supply you with that. That is on our formulary. What they do not understand is that if they switch to another plan, that that plan could do the same thing that their other plan just did and all of a sudden they are back in the same position that they were.

One of the things that we have seen as a remedy that the plans are beginning to go to is a three-tiered system, where you can get nonformulary, formulary name brand, preferred, and generic, and there are different copays in each of those categories. So you can get any drug.

The CHAIRMAN. I thank you for that because I think you have strong feelings about the reaction of seniors and lay it out very clearly that this is a main point of contention with a particular plan.

Ms. HELMS. Absolutely.

The CHAIRMAN. First of all, before I ask you a question, Mr. Jones, obviously, the committee recognizes that your organization has gone out of its way to inform seniors about their drug benefit. What was the impetus for providing all the materials that you give to seniors regarding a drug benefit and what are the results, and

I would assume they would be things like greater consumer satisfaction and lower disenrollment, of your efforts when you fully disclose these policies?

Mr. JONES. The result is a much higher understanding and compliance. With more information, we find that members, as would anybody, they make more informed choices. The emphasis around United overall is to emphasize the patient-physician interaction and to facilitate that on the best terms possible to prevent our members from receiving inappropriate or injurious care, but to protect that relationship, provide as much choice as possible, and I will say, with the capitation payments that were paid, to be as good as possible to provide more benefits.

The pharmacy benefit is not one that is included in the capitation payment as a specific item. We believe that through being as efficient and appropriate with care as possible, that we are able to provide that within the capitation payment received. More communication and more connectivity in a complex environment provides for a more appropriate use of the health care system. It is a discontinuous type of spectrum of care. So the emphasis is on choice, it is on emphasizing the patient-physician relationship and being an efficient manager of the health care process.

The CHAIRMAN. Do you have a policy regarding exceptions to your formulary when changes occur, and if so, how do you communicate these to enrollees? Let me ask it another way because I realize your formulary is open. Are there any exceptions if a drug is no longer reimbursed at the same level or deleted from your formulary altogether?

Mr. JONES. Yes. The first level of that request would go to the PBM, and based on their findings one way or another, if it was appealed from there, it would go into the normal, and I should say the normal appeal process within each health plan. Effective July 1 of this year, we have a third party, actually can appeal outside the health plans for any issues to a third party for any issues you feel like medication is needed for. So there is an appeal process. It is explained to the individual members in the material. It is also explained by their personal service specialist, and I hope that it moves fast enough to accommodate all issues, because medicine is usually urgent. It is not a casual thing.

The CHAIRMAN. Let me thank you all again particularly those of you who came a long way. Each one of you, including Dr. Scanlon, have studied this deeply, three of you from personal experiences, and we appreciate very much your firsthand information. Dr. Scanlon, you bring it all together in your report.

As I indicated earlier, Senator Breaux and I have had a chance to visit about this and we think appropriate follow-up would be to have the Health Care Financing Administration look into this to a greater extent. We are going to request in writing that the agency develop a plan of action to address some of the disclosure problems highlighted at today's hearing. I happen to believe that HCFA should survey the participating plans, first to gather records on their policies regarding their drug benefit.

Once they collect the data, HCFA can then determine where these policies should be communicated to the beneficiary in writing. I would like to see enrollees understand and have access to this

type of information before they enroll in a plan. If drug coverage is a part of their benefit package, they have a right to know the plan's policies prior to enrolling in the plan.

So I look forward to working with my colleague, Senator Breaux, the Ranking Member on this committee, in our continued effort to improve information available to Medicare beneficiaries about their options and benefits under the program.

This is a continuation of hearings we have held on this topic when we became Chairman and Ranking Member of this committee. We see today's hearing and those earlier hearings as all part of our efforts to ensure Medicare beneficiaries understand the program and have information available to them to compare plans. Seniors have a right to know what benefits and rights Medicare+Choice plans offer, and this information should be provided in an understandable and user-friendly language.

We are going to follow up with HCFA as a result of today's testimony. Thank you all very much.

Mrs. LATHROP. Thank you.

Mr. SCANLON. Thank you.

Mr. JONES. Thank you.

Ms. HELMS. Thank you.

The CHAIRMAN. The committee is adjourned.

[Whereupon, at 4:23 p.m., the committee was adjourned.]

APPENDIX

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

July 26, 1999

The Honorable Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration
U. S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Ms. DeParle:

As you know, the Senate Special Committee on Aging recently held a hearing entitled, "Drugstore Surprise: the Impact of Drug Switching on Older Americans." At the hearing, several witnesses testified, including one Medicare beneficiary, about problems resulting from lack of knowledge about drug formulary changes in Medicare+Choice plans.

We realize that the drug benefit is an important selling point for M+C plans, and that plans change the drugs on their formularies in order to keep costs down and provide the most clinically appropriate drugs. However, we are concerned that many times these plans make formulary changes without alerting beneficiaries or their health providers. What is even more disconcerting is that the GAO found that many plans also do not inform their members of grand-fathering or exceptions policies that would allow beneficiaries to remain on their medication after it has been removed from the formulary.

As longtime advocates for quality, user-friendly information and full disclosure of health plan coverage policies and procedures, we believe it is important for beneficiaries to know what their benefits, rights and responsibilities are when choosing a M+C plan. Currently there is little information available on the plans' drug benefits, and there is no concerted effort to educate beneficiaries about this complex benefit. We therefore ask that the Health Care Financing Administration conduct a survey of all M+C plans to find out how much they are currently doing to educate their members about formulary changes and exceptions policies when drugs are eliminated. We also request that HCFA report back to us with a plan for incorporating this information into participating plans' enrollment forms, and marketing materials, and to ensure proper notification is given to enrollees when formulary changes occur. We ask that this information be provided to us no later than six months from the date of this letter.

Thank you for your continued cooperation with the Aging Committee. If you have any questions please call Rebecca Jones (majority) at 202-224-5364 or Kristy Tillman (minority) at 202-224-1467of the Aging Committee staff.

Sincerely,

John Breaux
Ranking Member

Charles E. Grassley
Chairman

ISBN 0-16-060054-5