Medicare Reform:
An Accomplishment and an Opportunity

Fred Hassan
Chairman and CEO, Schering-Plough Corporation

National Medicare Prescription Drug Congress
Washington, DC
February 26, 2004

Good morning.

It is a pleasure to be here, with all of you.

I am honored to be addressing such a distinguished audience.

I am also excited.

Excited -- to be participating in a forum that brings together so many of the key stakeholders in the healthcare arena.

By coming together this way I believe we can achieve a LOT.

It is an opportunity to find common ground.

And to build on it.

This morning, I would like to give you my perspective on the accomplishment -- AND the opportunity -- that I see in the recently-passed Medicare reform legislation.

Let me start with the accomplishment.

Then I will come back, and talk about the opportunity.

I have been in the pharmaceutical industry for 30 years.

I have been coming to Washington on policy matters for at least that long.

I have observed many unsuccessful efforts to implement health care legislation.

President Nixon's employer insurance mandate.

President Carter's cost containment.

The first President Bush's tax credit.

President Clinton's regional alliances.

In this context, the Medicare legislation just passed is a VERY important achievement.

The bill has many critics.

The bill is not perfect.

But it IS an important step forward.

WHY?

Let me give you FIVE reasons.

First – the bill passed.

That, by itself, is significant.

The Medicare Modernization Act is the first major expansion in health insurance coverage signed into law in nearly 40 years.

After 15 years of debate about a Medicare drug benefit, we finally see legislation that has actually passed.

AT LAST, there will be a drug benefit for seniors.

Second – A THIRD of Medicare beneficiaries will see a cost sharing of just $2 to $5 per prescription.

This law will DOUBLE the number of seniors and disabled people, who will have virtually all of their drugs paid for by the federal government.

That is a VERY important achievement.

Third, even for those who get only the conventional Medicare benefit, this benefit will put a cap on catastrophic expenses.

This benefit will cover virtually all of the most burdensome costs of an expensive drug treatment program.

This will be a godsend for hundreds of thousands of seniors and disabled people…

… For people on complicated multi-drug regimens, or expensive treatments for rare diseases.

This catastrophic coverage will make it possible for these patients to pay for their drug treatment -- without impoverishing themselves or their families.

This dimension of the bill alone, is an historic achievement.

It should give peace of mind and security to seniors -- and to their families.

I wrote about this concept of catastrophic coverage in an Op-Ed in the Wall Street Journal a few years ago.

I am gratified to see that it was adopted.

Fourth, the Medicare drug benefit will help shore up retiree health benefit programs, that former employers now provide to about a third of Medicare seniors.

The number of large employers offering retiree health benefits has been declining steadily…

… They have had to cope with difficult business conditions.

In the past decade alone, the number has fallen from about 80 percent, to less than 67 percent.

The tax-free Medicare subsidy to employer plans will cover 28 percent of drug costs.

This should slow the very worrying decline in retiree health benefits.

It will help millions of retired Americans keep their health benefits.

And here is the fifth major achievement we see in the Medicare reform legislation.

For the next two years, seniors and disabled people will have access to discounted drug prices.

Nearly a third should get $1200 in cash assistance for their drugs.

So: is this Medicare reform legislation perfect?

Far from it.

There is much to improve.

There is much more to do.

In the long run we need more than Medicare reform.

We need to move on to Medicare overhaul.

But this legislation IS a major step forward.

It has moved us from talk to ACTION.

This new Medicare law finally does something SUBSTANTIAL -- to provide adequate insurance coverage for 40 million Americans.

Vulnerable citizens with the greatest medical needs, due to age and disability.

Under this new law Medicare beneficiaries will get more than just financial assistance.

They will have increased access to drug plans with negotiated prices.

Prices that should be lower than those available at retail pharmacies.

They will be able to get these discounts -- even when they are paying out-of-pocket.

I should also state VERY clearly: this legislation is NOT some sort of windfall for the pharmaceutical industry.

In fact, the industry will face a MUCH tougher purchasing environment created by the new drug plans.

An important benefit of this legislation are the expanded opportunity it provides patients to get needed drugs, as part of integrated health plans.

INTEGRATED Health care that includes preventative care, health counseling, and other elements that will improve wellness.

An integrated approach, that will ALSO reduce cost.

I know some critics like to paint ANY shift to private health plans as a great threat to the Medicare program.

As a threat to Medicare beneficiaries.

I strongly disagree.

My dream is to see the day when 100 percent of our medications are used appropriately.

That means seeing 100% of our medications used in well-managed, integrated health programs.

Well managed programs, that measurably improve health outcomes for patients.

Programs that prevent more serious conditions -- and reduce the need for more expensive treatments.

However, the conventional Medicare program is full of silos.

Silos that don't coordinate their work in improving health outcomes for the patient.

A large percentage of our patients who are in the Medicare program suffer from severe, chronic conditions.

In some cases, multiple conditions.

One senior in five, for example, has diabetes.

Diabetes is a disease that is growing in prevalence -- but it can be managed effectively to minimize complications.

Unfortunately, most of these diabetes patients today are in traditional Medicare.

These patients are navigating the health care system by themselves, and trying to manage their own disease.

Without effective health care education and management of their care, these patients are experiencing higher rates of severe complications.

They are experiencing higher rates of extended hospitalizations.

Today, only a small minority of diabetes patients are in integrated plans.

Integrated plans that would allow them to benefit from effective disease management.

Integrated plans would provide them with better coordination of healthy living, with modern drug therapy and quality medical care.

For the government to simply pick up the tab for all or part of the drug expenses for Medicare patients with these kinds of severe, chronic conditions is not optimal.

What these patients need is INTEGRATED care.

They need effective patient education, support, and care management.

So, I am encouraged by the provisions of the new Medicare law that will encourage enrollment in integrated health plans

I am also encouraged by the many provisions in the new law that will improve patient information, improve quality, and expand disease management.

This new law is a step in the right direction.

We have created a good framework for building better patient care in the future.

And I have a strong warning to those who would strive or tinker with this reform work, in order to make the government a monopoly buyer.

Beware not to harm the very patients you are trying to help.

The patients MUST retain the ability to access the best treatment innovations for their diseases – often, diseases that today remain poorly treated.

Congress created this benefit to give Medicare beneficiaries access to the best possible medicines available to treat their medical conditions.

Patients have a right to choose what's best for them…

Versus government deciding what's best for them via rigid formularies and price controls.

Government price controls will only diminish that access over time.

Command and control economies and tight government price controls have never encouraged drug development.

Quite the reverse.

I am not aware of a single major treatment innovation that ever emerged from the former Soviet Union.

Are you?

And Western Europe, which only decades ago was the heartland of pharmaceutical innovation, has now fallen far behind the United States.

A recent Bain & Company study underscores this point.

The report quantifies the serious blow to Western European drug research that has been struck by years of excessive government price controls.

For example, the report documents the exodus of researchers and research centers out of Europe.

By the way – most of them to places here!

Today, European patients have to wait a third longer to get new treatment than their counterparts do in the U.S.

It is both sad and ironic, that at the very moment when Western Europeans are beginning to question their price control policies, some groups in this country are suggesting that we emulate them!

Likewise, we need to resist the political urge to open our borders to drugs from Canada, China, Bulgaria, India and other countries.

These countries are already illegally shipping drugs not approved for sale in the U.S. -- through internet pharmacies – many of them with Canadian addresses.

It has become fashionable to advocate importation from Canada as some 'silver bullet' to address health care costs.

But Importation from Canada will NOT benefit consumers in the long run.

Just look at Europe's experience with parallel importation.

Almost all the savings that should be going to consumers, is going instead to the parallel importers.

More worrying still, importation will break the integrity of the U.S. supply chain.

The U.S. supply chain, with its intense and highly effective FDA oversight, is the most trusted in the world.

It took decades of effort, and billions of dollars of investment, to put in place.

The FDA is not alone in warning us about the dangers to public health presented by these imports via Canada.

Canadian health authorities themselves say that they cannot guarantee the quality or authenticity of drugs shipped to the U.S. through Canada.

In the end, importation will erode the confidence of U.S. consumers in the safety and authenticity of the drugs they depend on.

Do we really want to undermine all that work, all that investment, based on faulty analysis and a desire for political quick fixes?

I hope not!

Before we start amending the Medicare reform law, we owe it to our patients to make this new legislation work.

Those of us who advocated for a drug benefit must keep the trust of patients, who need this coverage.

We must keep the trust of the many stakeholders, who sacrificed to get this law passed.

So, those are the accomplishments of the new Medicare reform law.

Now let me address the opportunity that it presents.

This law demonstrates that we CAN pass health care legislation that expands coverage.

It shows that we CAN make a major investment in improving the value – the results – that patients get from our health care system.

We have done something significant for 40 million seniors and disabled people.

Now: we need to work hard to bring coverage to the 43 million people who still don't have health insurance.

Those of you who have experienced the health insurance battles of the last few decades understand that achieving these goals will be no simple matter.

But there is good news:

We now have momentum coming out of the Medicare success.

And so today I would like to make three concrete proposals.

Three proposals, that will help us seize on that momentum.

Three proposals, that will help us to take important steps toward those goals.

Proposal Number ONE:

The first proposal I want to outline today is an approach to providing more effective access to drugs for the one sixth of the population who are still uninsured.

The ultimate goal must be good legislation to extend health insurance coverage to the uninsured.

But in the meantime we need to test what I call a "bridge to coverage."

Schering-Plough -- and the other research-based pharmaceutical companies -- already provides free or low-cost drugs to low-income individuals without insurance.

In 2003, our industry provided free drugs to more than six million patients.

Last year alone, my own company alone provided over $200 million worth of our drugs.

To more than 75,000 patients suffering from diseases such as cancer, and hepatitis C.

Schering-Plough provides our most expensive drug regimens free for uninsured patients – patients with incomes less than 325 percent of the federal poverty level – nearly $60,000 for a family of four.

This income level covers approximately fifty percent of the population!

This is a VERY substantial commitment that, unfortunately, gets relatively little attention.

Pharmaceutical manufacturers would like to do an even better job of serving America's uninsured population.

But anti-trust law currently prevents us from doing it as an industry.

Currently, each company must run its own separate program.

Each with its own access, application procedures, renewal requirements and restrictions.

Now that Medicare is expanding drug coverage for its low-income beneficiaries, our industry can focus its attention on further improving access for the uninsured population.

So my first proposal today is this:

I propose that we establish a National Charitable Medicines Foundation.

This foundation would provide a single point of entry and eligibility clearinghouse for all pharmaceutical industry patient assistance programs.

It would do so, without raising anti-trust concerns.

This foundation would be an independently-chartered entity.

The foundation would have the ability to work with participating manufacturers to create a common structure.

This foundation would greatly simplify the process of applying and qualifying for free drugs, no matter what the source.

This foundation would also encourage the generic drug manufacturing industry to begin providing free drugs, greatly expanding choices for low-income patients.

Finally, this foundation would improve the outreach to physicians and patients to ensure they know how to access this resource.

If we establish this simple mechanism, I believe access to free drugs for the uninsured will increase very significantly over the next few years.

Through this foundation our industry can build a bridge to effective health care coverage for all.

But this approach cannot stand by itself.

Because alone, this foundation approach would not create the necessary framework of integrated care.

To reach the other side of the bridge, we still need to provide better access to affordable health insurance.

This leads to the SECOND proposal I would like to make this morning.

In this country we have an employer-based system of health coverage that works remarkably well for employees, their families, and retirees of large and medium sized companies.

This system covers 175 million Americans with very high levels of satisfaction.

For example, we know that the health benefit at Schering-Plough for our employees is one of the more appreciated and successful parts of our employee compensation package.

My proposal this morning is to take this proven model -- and apply it to the challenge of bringing effective coverage to the uninsured.

There are two, critical, elements to this model.

First: ACCESS without regard to health risks.

And second: AFFORDABILITY based on employer contributions and tax benefits.

Let's look at both pieces.

What is it about access that works with large employers?

Quite simply, it is risk pooling.

People with all kinds of health risks go to work for the company – not because of their health needs but because of their job skills and interests.

These people and their families do not seek out a particular health risk pool.

They end up there for reasons that have nothing to do with health care needs.

They are randomly – and involuntarily -- assigned to large pools.

Because of the large numbers the health risk of their large pool comes out looking a lot like the health risk of every other large pool.

They have predictable manageable health care costs.

Now contrast this with individual or small-group insurance.

Individuals, or small groups of individuals, decide which health risk pools they will join on the basis of their health care needs.

A lot of low-risk people joining the same pool creates the danger of "adverse selection" of the high-risk people to another pool.

To make sure that premiums are commensurate with risk, insurers medically underwrite and charge higher premiums for higher individual risk.

Premiums rise.

People with serious health problems cannot find coverage.

Younger, low-risk people drop out.

Add to the premiums a substantial markup associated with managing this risk problem --and you can understand why so many people in this country end up without health insurance coverage.

SO: How do we ensure access to individual and small-group insurance?

Not through government regulation.

That has failed miserably in the past.

Instead, we need to let the individual and small group market, work like the large-group market.

We need to build a secondary market that would function like a collection of large employer plans.

This is an approach that has been used in the past successfully to pool other kinds of insurance risk.

For example, it has had a positive effect on the home mortgage market.

This secondary market would be created and managed by a privately-owned intermediary.

It would function in a somewhat similar way to the way Fannie Mae operates in the home mortgage market.

-- With provisions for VERY rigorous regulatory oversight.

This kind of secondary market -- with the support and involvement of participating health insurers -- would combine small groups of their "insured lives" into large groups.

This approach would make sure that each of the pools was geographically and demographically diverse – just like large employer pools.

Individuals could still do business with their favorite insurance companies.

They could change insurance companies at any time, without regard to the "pool" they were assigned to.

The pool would be invisible to them – in much the same way that the different companies that hold pieces of one's mortgage, are relatively invisible.

This approach would assemble and manage risk pools -- to ensure access, maintain stability, lower costs, and greatly reduce the risk premium deviations in the market.

People would enjoy greater access to insurance… -- without regard to health conditions.

So, that is the first piece of this insurance-based approach.

The second piece of this approach is affordability.

A secondary market could help make individual and small group premiums look more like large group premiums.

But health insurance even on this basis may still be seen as too expensive for most moderate-to-low-income Americans.

We need to make sure these people get tax credits that replicate the tax benefits of employer plans.

These tax credits would reduce individual premiums to more affordable levels.

So that is my second proposal to get us closer to the right kind of health coverage for the 21st century.

And finally, proposal number three.

We MUST Foster behavior among our citizens that builds individual health savings, and individual health responsibility.

The Medicare drug benefit and expanded health insurance coverage are necessary.

Any of us could get sick at some time, some of us very sick.

Very few of us would ever be able to finance the cost of that kind of health care by ourselves.

We need insurance to pool those risks and spread those unanticipated costs.

But we cannot rely on insurance alone to manage the cost of health care.

The costs of health care if we have an UNHEALTHY aging, population will be more than we can collectively bear.

We MUST address preventable health problems, such as the growing rate of obesity.

But we CANNOT do that -- unless and until Americans take MORE responsibility for their own health, and for the consequences of bad health habits.

So my third proposal is this: We must find ways to tap the entrepreneurial spirit of Americans to address this critical need.

Programs are important.

But BEHAVIOR is just as important.

We must all begin to focus intently on how we can change the health behavior of American citizens.

Particularly the behavior of the baby boomer population and our children -- who will be the drivers of health care costs in coming decades.

One step in this direction is the expanded access to Health Saving Accounts that is part of the new Medicare legislation.

I applaud this feature of the law.

It is money well spent if Americans, particularly younger Americans, will start to save more, and be more aware of the health and cost consequences of their own actions.

Stop eating Super Size meals.

Start putting more money in your savings account!

The HSA concept enables individuals to choose catastrophic insurance and savings -- and at the same time, play a greater role in managing their own health care.

Let me conclude by saying this: I do not have any illusion that the proposals I am making today are a total solution to the complex health care issues we face.

But my proposals for a National Charitable Medicines Foundation, for a secondary insurance market, and for behavioral change would be important steps toward our larger goals.

I am prepared -- along with others in my industry -- to take the lead, and help find common ground with other stakeholders.

To do the right thing for health care in this country.

These are solutions that can serve patients..

…and preserve private risk-taking, private markets and the incentive to invest in high risk research.

One test of the strength of any society, is how well it cares for its more vulnerable citizens.

We can do better by them.

And we must.

So I ask all of you to join with me today in a pledge to seize this opportunity.

Rather than debate and argue, let us move to productive ACTION.

Join me, in testing these proposals in the real world.

Join me, in keeping an open mind to other propositions that have merit – and testing them also, in the real world.

Together, I know that we can do the right thing.

We owe it to our fellow citizens.

We owe it to the patients, who deserve good care.

And we owe it to the future generations -- future generations, whose health will depend on the wisdom and compassion of the policies we set today.

Thank you very much.