MEDICARE REFORM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

FIRST SESSION

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MEDICARE REFORM

Wednesday, February 28, 2001

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:04 a.m., in room B–318 Rayburn House Office Building, Hon. Nancy L. Johnson, (Chairman of the Subcommittee) presiding.

[The advisory and revised advisory announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
February 21, 2001
No. HL–1

CONTACT: (202) 225–3943

Johnson Announces Hearing Series on Medicare Reform

Congresswoman Nancy L. Johnson (R–CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on Medicare reform. **The hearing will take place on Wednesday, February 28, 2001, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10 a.m.**

Oral testimony at this hearing will be from invited witnesses only. Witnesses will include Senator John Breaux (D–LA) and other leading Medicare reform experts. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

This hearing will be the first in a series to be held this Spring. These hearings will lay the groundwork for reforming and modernizing the Medicare program, including incorporating outpatient prescription drugs into the program.

In announcing the hearing, Chairman Johnson stated: "Strengthening and improving Medicare is one of the most important challenges facing Congress this year—and one of my top priorities as Chairman of the Health Subcommittee. It is time for us to get to work. The American people are waiting for us to act."

FOCUS OF THE HEARING:

This first hearing will provide a general overview of major Medicare reform proposals, including the recommendations of the National Bipartisan Commission on the Future of Medicare and the ideas set forth by the Clinton Administration. In addition, the hearing will feature testimony on new solutions that have emerged to bridge differences between these competing plans and provide concrete guidance on specific reform elements that can be enacted this year.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should *submit six (6) single-spaced copies of their statement, along with an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, with their name, address, and hearing date noted on a label*, by the close of business, Wednesday, March 14, 2001, to Allison Giles, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health

office, room 1136 Longworth House Office Building, by close of business the day before the hearing.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be submitted on an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, typed in single space and may not exceed a total of 10 pages including attachments. **Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.**

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers where the witness or the designated representative may be reached. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press, and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at 'HTTP://WWW.HOUSE.GOV/WAYS__MEANS/'.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
February 21, 2001
No. HL–1–Revised

CONTACT: (202) 225–1721

Change in Location for Subcommittee Hearing on Medicare Reform

Congresswoman Nancy L. Johnson, Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee hearing on Medicare reform, previously scheduled for Wednesday, February 28, 2001, **B–318 Rayburn House Office Building**.

All other details for the hearing remain the same. (See Subcommittee press release No. *HL–1*, dated February 21, 2001.)

Chairman JOHNSON. Since the Senator is here, we are going to start. I understand Mr. Stark is on his way, and when he comes, we will let him contribute his opening thoughts as well. But let me start welcoming you all to this first hearing of the Health Subcommittee of the Ways and Means Committee. We do have a formidable agenda this session, and this first hearing on Medicare reform follows a half-day retreat that we had yesterday to begin to lay a stronger foundation among ourselves of facts and information as we look at the issue of prescription drugs for seniors and the future of Medicare.

Medicare is as important a government program as there is in America at any level of government. And as you all know, local governments and State governments do some things that are pretty important in people's lives. The whole movement to shelter battered women didn't start in Washington, it started in communities. So I say that Medicare is as important a program as any program any level of government has ever developed, with a very deep respect for the programs that other levels of government have developed to address terrible needs in our lives.

Medicare unfortunately is also an antiquated program. It is one of the few health programs that doesn't cover prescription drugs. It is the only program I know of that legally prohibits preventative care. It is really truly quite astounding and a good indicator and reminder of the era in which this program was founded and the degree to which it is desperately behind in the quality of health care it provides to its recipients.

It has become incredibly bureaucratic, incredibly bureaucratic, and any of you who don't believe that, get out of Washington. Go home. Look and see what your nursing homes are hiring their nurses to do. They can't hire them for patient care because they have to hire them for paperwork. Sit down with home health agencies in New England, who looked me straight in the face 10 days ago and said, you let that demand billing memo go through, this is not even a regulation or a guideline, this is even lower than that, and we will have to stop serving dual-eligibles; from agencies who have sacrificed, raised money, struggled to keep in there providing home care services in our urban neighborhoods.

So if you don't think this program is on the verge of denying care in every category to the seniors of America, then you don't—you aren't thinking, and you are too in Washington, and I don't want to know, because I am telling you I consider this program as troubled a program as any program I have ever had contact with, including the programs that we put in place with the States to manage children at risk.

So I face our challenges very seriously. I believe they are formidable. And when the 77 million baby boomers retire, and the number of workers per retiree declines from 4 : 1 today to 2 : 1 in 2030, if we have not prepared for that, we will not be able to meet the needs of our seniors. And I am bound and determined to meet those needs, though I appreciate the enormity of the challenge and the difficulty of the choices we will have to make.

Nearly 2 years ago, by a 10 to 8 majority of the bipartisan Medicare Commission, the premium support program to modernize Medicare was supported. Now, that wasn't the majority required by the law, so the Commission did fall one short, one vote short, of the supermajority statutory requirement to officially report recommendations to Congress. But the Commission's recommendations, because they rested on a vast amount of information, research and discussion among a remarkable group of people, have lived on, have been very useful, and are providing a useful framework for reforming Medicare. President Clinton responded with a Medicare reform proposal of his own, which was then followed by proposals put forth by Members of both parties in the House and the Senate.

Today the Subcommittee begins to examine all of the major reform proposals in an attempt to develop consensus on how we can best modernize this critical program so that it ably serves beneficiaries, taxpayers, and providers in the decades ahead.

We will continue our investigation throughout the spring and build upon the work already performed with fresh and new ideas of our own, but this is going to be real work, and we are going to welcome ideas and those who want to contribute to the thinking about how—where we go and how we get there.

[The opening statement of Chairman Johnson follows:]

Opening Statement of the Honorable Nancy L. Johnson, M.C., Connecticut, Chairman, Subcommittee on Health

Medicare has improved the health and lives of millions of seniors and disabled Americans for more than 35 years. However, Medicare has also become increasingly antiquated, bureaucratic and unwieldy.

The fiscal challenges to the program are formidable. Soon, 77 million baby boomers will begin to retire and the number of workers per retiree will decline from 4:1 today to about 2:1 in 2030. Our seniors will be living longer than ever before and economists predict that health inflation, fueled largely by new technology, will far outpace the growth of the overall economy.

But perhaps more important, Medicare has failed to keep pace with modern health care. Just to cite one example, last year it took an act of Congress to add important new preventive benefits—bi-annual pap smear screenings and pelvic exams and colon cancer screenings for all Medicare beneficiaries—to the program, when private sector plans had done this years ago.

Similarly, no one today would design a seniors' health care program that did not fully incorporate outpatient prescription drugs. Yet because Medicare must wait for Congress to enact a law for it to modernize its benefits or delivery structure, it will, by definition, be behind the curve. Many of our seniors therefore lack prescription drug coverage and the bargaining power to reduce the price of drugs.

In addition, the health care providers that we rely on to serve Medicare beneficiaries are being crushed by more than 130,000 pages of overly burdensome regulations, which hamper their ability to provide quality care to our seniors.

Nearly two years ago, a 10–8 majority of the bipartisan Medicare Commission supported a "premium support" proposal to modernize Medicare. While the Commission fell one vote short of the supermajority, statutory requirement to officially report the recommendation to Congress, the Commission's recommendations are still seen by many as a useful framework for reforming Medicare.

President Clinton responded with a Medicare reform proposal of his own, which was then followed by proposals put forth by Members of both parties in the House and Senate.

Today, the Health Subcommittee begins an examination of all of the major reform proposals in an attempt to develop a consensus on how we can best modernize this critical program so that it ably serves beneficiaries, taxpayers and providers. We will continue our investigation throughout this Spring and build upon the work already performed with fresh new ideas of our own. Let's get to work.

Chairman JOHNSON. Mr. Stark.

Mr. STARK. Thank you, Madam Chairman, and thank you for calling this hearing.

I have submitted to you a written statement describing in detail a bill that I have introduced to "save" Medicare for the long run. It contains a number of reforms, including a generous drug benefit with tough cost containment.

It uses a competitive bidding system, similar in some ways to the Breaux–Frist II legislation, as I refer to it, to obtain some savings in the program, but it does so without hurting beneficiaries who need or choose to stay in traditional Medicare—I want to talk about that in just a moment. It uses new purchasing tools to provide better coordinated care, most of which are designed to improve quality and outcomes, and some of which will also generate savings.

It makes major changes to narrow the differences in medical spending in this Nation, which seem to have no relationship to outcomes, quality or need. There is no reason to be paying two or three times as much for a patient in Miami as we do in Minneapolis, without getting better quality in Miami.

Most of all this bill recognizes that we will need new revenue to keep Medicare sound through the retirement of the baby-boom generation.

We had a wonderful seminar yesterday in which it was explained to us that the number of people on Medicare are going to double. They are going to live longer. They are going to want to access

more new technologies. We can try to preserve Medicare if we just shift the cost to the beneficiaries, cut providers, and claim that there are massive efficiencies that will save us from needing new revenues. But I am afraid we are going to have to look for revenues. Nobody wants to do it. Nobody has done it.

Tobacco related disease for instance, costs Medicare $20 billion a year in treatment costs. Once before this Subcommittee voted narrowly to increase the tax on cigarettes to pay for some of the health care costs.

Senator Breaux, I appreciate your being here and your work on Medicare. But I urge you and my colleagues to start reform discussions based on Breaux–Frist 2000 and not the first bill. Many of us believe the first bill would shift huge costs onto vulnerable seniors and push many of them into HMOs that basically do a poor job.

I believe it would be possible to develop a bipartisan bill by using Breaux–Frist II as a base and by improving it with a provisions from the Moynihan–Clinton bill from last year, while ensuring the plans compete on the basis of core package of Medicare benefits and that payments are risk-adjusted as soon as possible. And if we take this road, I also urge you to look at many of the ideas in our bill that improve quality, save money and would make Medicare a much better program.

However, if we are going to truly look and learn, and I appreciate the Chair's efforts to educate us and learn what is going on, I think we have to recognize that managed care has not been overwhelmingly popular with the beneficiaries and their families. The public wants the patient's bill of rights because they don't like what managed care is doing. Managed care is unpopular with the physician community. Managed care is unpopular with the hospitals. Medicare managed care costs more than fee-for-service. It is supposed to cost less. It is supposed to cost 95 percent of fee-for-service costs; instead, it costs up to 10 percent more. Its quality is of dubious character. And too many of the managed care companies are being sued by various providers and others who have to deal with them.

Managed care has not helped Medicare. Quite the opposite. It has wasted money. Too often, it has provided less than adequate services. It has aggravated the beneficiaries and the providers. Why we keep looking to managed care as a solution eludes me.

I hope in the hearing today we can see something that says there is some evidence that managed care helps the system; otherwise I think we ought to erase that one and start over, look for something completely new, and I would like to join the Chair in that search. Thank you.

[The opening statement of Mr. Stark follows:]

Opening Statement of the Honorable Pete Stark, M.C., California, Ranking Minority Member, Subcommittee on Health

SAVING MEDICARE

Madame Chair, Colleagues, I've introduced a bill to modernize and extend the life of Medicare that does not raise premiums for seniors who choose to stay in fee-for-service Medicare because their health conditions require a wide array of providers. It is basically the Clinton Administration proposal of June 1999, *greatly* strengthened to achieve major savings and more program improvements. As we consider re-

forms this year, I hope this proposal, or portions of it, can be discussed and included.

Benefit Improvements

The current Medicare benefit is woefully inadequate. Medicare only covers about half of the average beneficiary's total medical expenses, and includes no outpatient prescription drug coverage. The benefit structure needs to be improved. This bill

—provides a generous drug benefit coupled with strong cost containment that encourages research on breakthrough drugs;
—improves Medicare's preventive care package, eliminates co-pays and deductibles on preventive services, and does more to prevent blindness;
—coordinates Medicare with an optional, Medicare-run supplemental policy that reduces beneficiary paperwork and, because there are no sales and overhead costs, provides more affordable medigap coverage than the private sector;
—helps low income seniors use Social Security offices and data matches to enroll in the QMBy and SLMBy programs which help pay premiums and (for QMBy) co-pays for those under 135% of poverty (today only about half the eligible seniors are enrolled in these two programs);
—reduces hospital outpatient department co-pays from 40% in 2006 to 20% by 2010 (a process that will otherwise take several decades);
—permits uninsured individuals age 62–65 to buy into Medicare at full cost, but with the help of a refundable tax credit equal to 50% of the cost of the Medicare premium; provides similar help to those 55–62 who lose their health insurance;
—improves quality of care for beneficiaries by creating an extensive program of case and disease chronic care management (with special emphasis on rural case management), more information on treatment options, more bundled packages of care, and use of a new VA advanced illness coordinated care program, and
—adds adult day care as a service under a home health plan of care.

Saving Medicare for Future Generations

With increasing use of high technology and expensive pharmaceuticals, health expenditures are becoming an increasing part of our economy. As a rich society, there is nothing particularly wrong with that—it is a choice we make. But with so many younger people uninsured and so many other unmet needs, it is imperative that Medicare be run as efficiently as possible, so that Medicare taxes on future generations can be kept as low as possible and so that other societal needs can be met.

The number of people on Medicare will roughly double in the next 30 years. The number of working taxpayers to support the program will decline from today's 3.4 per beneficiary to about 2 per beneficiary in 2030.

There are only 3 ways to save Medicare: shift costs to beneficiaries, cut payments to providers (and that includes so-called program 'efficiencies'), or inject new tax revenues.

I believe it will take all three: beneficiary cuts, provider cuts, and new taxes. Anyone who says differently is not being honest with the American public.

This bill does all three:

Beneficiaries:

—the Part B deductible is indexed for inflation;
—the value of the Part B subsidy (of which 3/4ths is paid by general taxpayers) is added to the income of beneficiaries and if the beneficiary has enough income to be taxed, that subsidy will be subject to tax at the taxpayer's rate of progressive tax (15%, 28%, etc.); lower income seniors will not be hurt.

Providers:

—Medicare will finally start to obtain savings from Medicare+Choice, as plans bid to provide the core Medicare benefit and compete by offering to lower the Part B premium. Plans can offer supplemental packages of benefits separately priced. Any amount a plan bids below 96% of Medicare fee-for-service costs in an area will be shared 3/4ths with the beneficiary, 1/4th with Medicare and the taxpayers. This proposal is somewhat similar to Breaux–Frist 2000, and it protects beneficiaries who choose or need to stay in fee-for-service Medicare;
—extends Medicare's competitive purchasing of durable medical equipment and other services nationwide and gives Medicare more 'inherent reasonableness' authority to cut overpayments;
—saves lives and money by using higher volume hospitals for complicated and expensive surgeries;

—modernizes Medicare's ability to contract with and use intermediaries and carriers;

—gives Medicare numerous "private sector-type" purchasing tools, such as the ability

(1) to act more like a Preferred Provider Organization (and requires the development of PPOs in the highest cost treatment areas of the nation (after adjustment for severity of illness, etc.)),

(2) to impose sustainable growth rates on sectors where there is a questionable explosion of services (e.g., CORFs in doctors' offices),

(3) to receive the most favored price in an area as is appropriate for a volume buyer, and

(4) to pay for quality, safe care at the lowest rate (HOPD, ASC, or doctor's office), regardless of setting;

—allows Medicare to waive the 3-day hospitalization rule for skilled nursing facility care, if less expensive quality care can be provided by going directly into the SNF rather than the hospital (it is increasingly likely that some DRGs can be treated in quality SNFs);

—develops key long range (ten-year or more) cost reforms, such as

(1) a single bundled payment system for an illness or injury; and

(2) a system of profiling patterns of care, educating providers when their pattern of care is abnormal (both for 'excessive' or 'inadequate' care), and eventually reducing payment updates to institutional and individual providers who bill for abnormally expensive care without a quality or severity of illness justification. This proposal is a long-term effort to begin to reduce the huge regional disparities of treatment and health care costs in America which do not appear to provide any particular quality of life difference. As the work of Dr. Wennberg of Dartmouth has repeatedly shown, if we could adopt the style and practice of medicine of certain States where people have high quality health care, the Medicare trust funds would be solvent indefinitely!

—encourages a more rational hospital policy, by using Medicare capital payments and other special payments to discourage over-capacity (the nation's hospitals are roughly half empty, and utilization is expected to continue to decline in the coming decades) and to encourage a trade adjustment assistance-type program to help essential community hospitals "right-size" and achieve long-term financial solvency.

New tax revenue:

With a doubling of the number of seniors and with people living longer, and with new hi-tech devices and medications, we estimate that over the next 30 years we will need about 2.5 times as much money for Medicare as we spend today (in current dollars).

That means new taxes—or at least keeping old taxes.

In addition to upper-income beneficiaries contributing more (as previously noted), the bill proposes

—to forgo some of this year's proposed tax cuts and save the money for Medicare, by transferring 20% of the projected on-budget surplus to Medicare ($542 billion over ten years);

—dedicating any revenues received from the Federal government's legal actions against the tobacco companies to Medicare (treating smoking related diseases is estimated to cost Medicare over $20 billion a year); if that court case is not successful or pursued by the new Administration we should increase the tax on cigarettes an equivalent amount;

—Rather than repealing the estate tax, the bill dedicates the amount raised by the estate and gift tax to Medicare. We are about to give this tax revenue away to 2% of decedents. In the year of its proposed total repeal, the revenue loss will be $50 billion per year—enough to provide a drug benefit to what will then be 47 million beneficiaries: the choice should be made clear to the American people—help improve and extend the life of Medicare, or (per the letter from 300 multi-millionaires opposed to estate and gift repeal) help create a plutocracy; and

—dedicate to Medicare a tax on excess profits of certain pharmaceutical sales, in cases where the company's administrative and sales budgets exceed twice their Research and Development budgets; while this provision is not expected to raise any money, it is designed to encourage the drug companies to spend more on R&D and less on political campaigns to defeat adding a drug benefit to Medicare or ads telling us how much they spend on research!

Colleagues, this is a very ambitious bill that would make enormous long-term savings, while also making the Medicare benefit truly adequate. I certainly do not ex-

pect it all to pass this Congress, but I hope portions could be included in whatever we are able to accomplish.

It is an attempt to honestly point out the need for more revenues, and for increased efficiencies in our fee-for-service payment systems. It does not include everything we need to do, such as provide

—an error reduction and quality improvement program to stop the 50,000 to 100,000 accidental hospital deaths per year;
—true mental health parity in Medicare, and
—a dependable source of funding for HCFA's administrative costs, or
—'reform' the agency, perhaps by making it a free-standing agency like Social Security.

Nevertheless, this bill is a major blueprint for a comprehensive, long-term way to Save Medicare. As this Subcommittee prepares to investigate Medicare reform, it is my hope that this new legislation will be a major part of our discussion.

[The opening statement of Mr. Ramstad follows:]

Opening Statement of the Honorable Jim Ramstad, M.C., Minnesota

Madam Chairwoman, thank you for calling this important hearing today to begin exploring Medicare reform.

I strongly believe that Medicare needs comprehensive reform. We cannot focus on simply tinkering around the edges, and we must not take the easy road of simply adding a prescription drug benefit to an already overburdened program.

As a representative of a state hurt by the unfair and unjust inequity in the Medicare managed care reimbursement formula, I know firsthand the difficulties faced by seniors when irrational decisions at the federal level deny them the choices they deserve.

And as a member who represents literally hundreds of medical technology companies, I know firsthand the damage to small businesses, their employees and seniors when the federal system irrationally delays or denies coverage of their innovative products. I understand the difficulty faced by seniors when they are denied life-saving and life-improving technology. I've even authored legislation to ensure that seniors have access, through Medicare, to new technologies.

That's why I'm so glad that Senator Breaux is here today to discuss his work on the bipartisan Medicare commission. I applaud his work, and I hope that today's hearing sheds more light on other proposals to address this important issue.

Since anything worth doing is worth doing well, we must carefully review all proposals for their strengths and weaknesses, as well as intended and unintended consequences. We must look for methods that will expand access to prescription drugs, rationalize the reimbursement process and provide seniors access to new medical technologies.

I believe that together, in a bipartisan way, we can design an effective and efficient way to comprehensively improve the system and preserve it for the 21st century.

Madam Chairwoman, thanks again for your leadership. I look forward to learning more from today's witnesses on how we can best address this critical issue.

Chairman JOHNSON. Thank you, Mr. Stark. And I do agree that there is a real opportunity for us to work together on this Committee and develop a bipartisan solution. I couldn't disagree more strongly with your closing analysis of managed care, and I think the evidence is the extraordinary outcry of unhappiness when the managed care plans leave the market, and seniors were forced back into regular Medicare. But that is a discussion for another day, and certainly one will have to look more carefully in terms of the data.

But I do consider it a great advantage, Mr. Stark, to have you as Ranking Member with your long experience with Medicare and your very deep interest in health care and commitment to our seniors, and I look forward to working with you and my Democrat col-

leagues—and Mr. Cardin, who has always, from the Ways and Means Committee, taken a special interest in health care issues.

And I would like to welcome our esteemed colleague from the Senate, the Honorable Mr. Breaux of Louisiana, but for the great privilege of introducing him in greater detail, I am going to yield to my esteemed colleague Mr. McCrery, also from Louisiana.

Senator BREAUX. That is enough.

Mr. MCCRERY. Thank you, Madam Chair.

It is my pleasure to introduce my colleague from Louisiana, Senator John Breaux. Senator Breaux and I come from different sides of the political aisle, but having worked with him closely over the years, on behalf of the interests of our home State of Louisiana and on other matters affecting the entire Nation, I can tell you there is nobody on either side of the aisle that is more dedicated to doing things that will make this country a better place in which to live. And he is a recognized expert on Medicare and health care generally, and it is an honor to work with him on these issues, and it is certainly an honor for our Subcommittee today to have him before us to hear his testimony.

Welcome, Senator Breaux.

STATEMENT OF HON. JOHN B. BREAUX, A UNITED STATES SENATOR FROM THE STATE OF LOUISIANA

Senator BREAUX. Thank you, Madam Chair and Congressman Stark and Members of the Committee on both sides of the aisle. Jim, I am sorry I suggested that was enough. I thank you for the fine introduction. I appreciate the comments and thank the Members of the Committee.

Number one, congratulations to the Chair and the Ranking Member and to all of you for beginning this process very early. Too many times we spend too much time delaying and talking about how we are going to go about the process, and we never get involved in the process. So with something as complicated as Medicare, Madam Chair, thank you for starting early. We have not yet reached that point in the Senate, and it is incredibly important we start as early as we possibly can. So congratulations for beginning the process of finding a solution.

The first point I would like to make is one that I think is becoming more and more accepted as a policy matter by more and more Members of Congress and by more and more people in the American public, and that is that while Medicare has been a wonderful program for a very long time, since 1965, that it is no longer a 21st century health care program for modern Americans because it is inadequate in what it does and noted for what it does not do. No one of you behind this desk has a health program that is insufficient as much as Medicare is for the 40 million seniors in this country. Nobody sitting behind us has a health care plan that is as inadequate as Medicare is for the 40 million American seniors.

Almost everybody in America that has health insurance has a better plan than people who are on Medicare have today. Why do I say that? Because of what it doesn't cover. Time after time we have heard evidence that it only covers about 53 percent of the average senior's health costs. That means 47 percent of their costs must come from somewhere else. We don't cover it. They have to

buy an additional Medigap policy. They have to become so poor, they have to get on Medicaid, or their family has to take care of them when they become destitute for the things that Medicare does not cover. It doesn't cover long-term care, it doesn't cover assisted living, it doesn't cover vision and eye care, and, most importantly, it doesn't cover probably the most important medical innovation that we have in the market today, and that is prescription drugs.

None of us have a policy that is that inadequate. So I think that there is a growing admission, if you will, that there is an absolute necessity that we do something about this program. That is almost now a given. We have crossed that hurdle. No longer can someone say with any total degree of honesty that I like Medicare just like it is; don't do anything to change it. That argument doesn't hold water in the 21st century any longer.

So what is the solution? The solution is not to have a totally government-run program with 133,000 pages of regulations that we micromanage to the nth degree in every detail. Nor is it to just abandon what the government does and to say all of a sudden we are going to have the private sector do everything for the health of seniors in this country, and we are not going to have government involvement at all. Neither one of those suggestions, which we have all heard of far too many times, is the correct decision.

I would suggest that the correct decision is combining the best of what government does with the best of what the private sector does, and I would submit that Breaux–Frist I and Breaux–Frist II takes that approach.

Now, what do I mean by that? Number one, the best of what government can do is help pay for it. There is no question that it is going to cost more money, as Congressman Stark talked about. We are not going to save money by reforming Medicare, but in the long term we will make it a better program with more cost efficiency. The best of what government can do is help finance it and help pay for it. The best of what government can do is help make sure that it is being run properly as opposed to micromanage it in detail. And that is what Breaux–Frist I and II does. It combines the best of what government can do with the best of what the private sector can do.

And what do I mean by that? The best of what the private sector can do is to bring about innovation and new technology so that the Congress doesn't have to sit in our back rooms and decide that for the first time Pap smears will be covered under Medicare when private plans have done it for decades. We did that last year. When the private sector can help say that when you have a drug that can be orally administered for the same efficiency as it being intravenously administered, it will be done through the private sector and not take an act of Congress, which we had to do in past years. And the second thing that the private sector can do best is to help bring about competition, which will help lower prices.

So the idea is to combine the best of what government can do with the best of what the private sector can do and create a program that fits the 21st century, and that is why we have tried to model what we have recommended after the same program that every one of you up here, and myself included, and all of our em-

ployees behind us have, and that is a Federal employees health benefit plan.

I mean, every year we get a choice of a large number of plans that we pick from, and some have said, well, Breaux, you are proposing a voucher system, and that is not going to be realistic for seniors. Of course it wouldn't be, but our plan is no more a voucher than what you have and what I have and what all of our employees have. We don't have a voucher. We have an absolute government guarantee that they, in our case, are going to pay about 75 percent of the premiums that are the cost of the plans that we are offered. That is an absolute guarantee. There is an absolute guarantee of what the policy has to cover, although they can cover much more, and most of them do. And there is a Federal involvement through the Office of Management and Budget to guarantee that there is not going to be scamming of the system, there is not going to be programs that have adverse risk selection that are going to be offered.

That is what government can do best. It pays for our premium. It guarantees that the program is run properly, but it also brings about competition because of the various plans that want to compete for the right to serve 10 million Americans.

We have vision. We have prescription drugs. We have competition. We have guaranteed government payment for a large portion of the cost of our policies, and the prescription drug plan works in a way that I think should be available to all seniors as well. So, I mean, that is the concept.

Why did we introduce Breaux–Frist I and Breaux–Frist II? Put the charts up if you can, Sarah. Breaux–Frist I was the result of really what the Commission attempted to report. We got a majority. We got more than a majority, but we didn't get the super, supermajority that was required. The concept in Breaux–Frist I was to really have competition among fee-for-service as well as these private plans that will be offering these benefits. We wanted to do it outside of the current micromanaged system, so we created this Medicare Board. If you wanted to compare it to OPM, that would be a good comparison.

The Medicare Board would ensure the quality standards. We said they would have to have the same benefits that would be available on the current fee-for-service. They could do more, but they couldn't do less. They would negotiate the premiums to make sure that people get the best premiums, that they would have the best possible price. They would have to approve the benefits package, which means they would not let plans be offered that attempt to scam the system by only adversely risk-selecting healthier seniors, which would be a terrible mistake. They would say, you can't do that. You can't play. You can't offer if you are going to do that. And that is the safeguarding against adverse risk selection.

It would also, like we get every year, provide to every Medicare beneficiary a book on what is available to them. And some people say, well, you can't give them choice because they are too old, they are not going to be able to make the right choice. And yet on the fee-for-service they make choices every day. They pick the doctor they want to go to, the hospital they want to go to. If they are not

capable of doing that, their children help them or senior organizations help them and find the right place to go.

You would have the same system under the Breaux–Frist I. And what you would have is have—HCFA would continue to offer their standard plan. They could offer a high option plan which, would provide prescription drugs, and it would be competing again in the same market with other private plans who could come in and offer the plans, and they would hope to get the business as well.

But if you want to stay in fee-for-service, I guarantee you some of our older citizens will stay there. They are not ready to change. But 77 million baby boomers getting ready to hit this market, who are going to be more accustomed to coming into this new system, will be looking for new choices and move into the new plans, but if they don't want to, they could still stay in the fee-for-service system.

Put up the second chart, if you would, which is Breaux–Frist II. You might say, well, why don't you just offer I. We offered II because we want to give you and all of our colleagues an array of options that are out there. Breaux–Frist II is competition, but it is probably less competition than Breaux–Frist I. For those would feel we have to take it more gradually, we offered a Breaux–Frist II option, which again maintains the Health and Human Services and HCFA, which would continue to run the fee-for-service program and the Medicaid program and the SCHIP program for children. But we would have a competitive Medicare agency for the first time outside of HCFA running Medicare+Choice and the prescription drug plan.

The reason I would offer Medicare+Choice has not worked is not because it is inherently not possible to work, but because of the way it has been run. What we set up was that Medicare+Choice was going to be competition for fee-for-service, but guess who was going to run it? Fee-for-service.

HCFA sets the rates on an arcane formula. They put in risk adjusters and all kind of problems to make Medicare+Choice not work. In some areas, as you know, they get paid too much, and some areas they get paid far too little, and they move out and leave the people without any Medicare+Choice managed care options at all.

So you have to—if you are going to have them have a chance to compete, you ought to have it with an agency that is based on competition and that is their purpose, not on trying to fix the prices to make sure one side wins and one side loses. The Medicare Prescription Plus plan is the prescription drug plan that would be provided under the Medicare+Choice. And if you want to stay in the fee-for-service, you would be over there to get in the Medicare Prescription Drug Plus plan.

I think Pete sort of indicated a lot of Democrats are saying, yeah, we believe in prescription drugs if it can be delivered in a competitive mode as opposed to being micromanaged by HCFA. This would do that.

I don't think any of us want to add prescription drugs to a 1965 model and have to sit in our back offices and try and figure out what the proper reimbursement rate is going to be for thousands and thousands of drugs, and which one should be approved and

which one should not be offered. We can't do that. We shouldn't do that. We only have got one doctor and a couple of veterinarians over in the Senate side that you all sent us from over here. Glad to have them, but we ain't got a lot of people with a lot of medical expertise over there trying to decide which prescription drug should be available; should it be orally administered, or can it be intravenously injected; which one do we pay for; which one we don't pay for. We can't micromanage another prescription drug plan. So that is what that would do, and that is the way it would work.

Anything else? OK. That is basically why we have both plans out there. I thank you for your attention. I am more than happy to try and answer any questions. Thank you.

[The prepared statement of Hon. John Breaux follows:]

Statement of the Honorable John B. Breaux, U.S.S., Louisiana

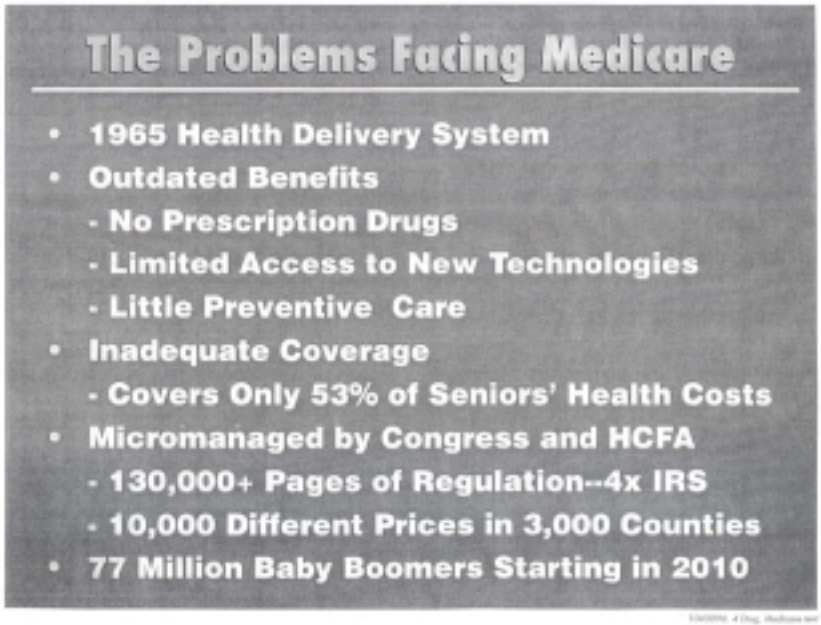
Madam Chairwoman, Representative Stark, and Members of the Committee, thank you for inviting me to testify today on an issue very relevant to the current discussions over the federal budget—how to reform an aging Medicare program while adding a long-overdue prescription drug benefit. I applaud this Committee for beginning the process of addressing what I consider to be one of the most important issues facing this Congress.

As you know, earlier this month Senator Bill Frist and I reintroduced legislation (S. 357 and S. 358) to strengthen and improve Medicare and add an outpatient prescription drug benefit for all seniors. We reintroduced both Breaux–Frist I and II in order to lay out legislative markers for both the Senate Finance Committee and the House Ways and Means Committee to consider as they begin to tackle this very important issue. As I've said with respect to every issue, this cannot be a "my way or no way" approach. We are open to suggestions about ways to improve our bills but we need to start talking about how we're going to get this done sooner rather than later.

The short-term budget picture is indeed rosy but that will change quickly once the baby boom generation starts to retire in 2010. The latest budget projections estimate a $3.1 trillion on-budget surplus over the next ten years. Even Medicare's Part A Trust Fund will post nearly a $400 billion surplus over the next decade. But when making decisions about tax and fiscal policy this year, we should keep in mind the budget picture beyond the 10-year budget window when entitlement spending could turn surpluses into deficits overnight. As GAO Comptroller David Walker testified before the Senate Budget Committee earlier this month: "Our long-term simulations, updated using CBO's new budgetary estimates, show that spending for federal health and retirement programs eventually overwhelms even today's projected surpluses."

We all tout the merits of debt reduction but as much of the debt as we may pay off in the next decade, we will almost certainly have to start borrowing again to pay for the Medicare and Social Security benefits of 77 million baby boomers unless we make much-needed changes to the programs.

We all know that the fear of change and a fear of the unknown make Medicare reform a challenge. If this were easy, it would have been done long ago. But what we do know should give us the incentive to consider some alternatives. As good as the short-term economic outlook is today, the problems facing Medicare haven't changed and they bear repeating:



- **1965 health care delivery system—**Medicare is a program frozen in time. It takes an act of Congress to update the benefit package. For example, pap smears and glaucoma screening were finally covered under Medicare in last year's Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000—several years after the private sector started using these important screening tools.
- **Outdated Benefits—**Medicare's current benefit package is extremely outdated, covering a limited number of outpatient prescription drugs, providing few preventive services, and limiting access to new medical technologies. Medicare is too rigid and slow to change. Seniors deserve access to life-saving drugs and technologies as they become available. The very fact that Congress must pass laws to add new benefits best illustrates the problem with a heavily micromanaged program. The U.S. Congress simply should not be in the business of setting disease-specific or drug-specific health policy. No government program can possibly keep up with the increasingly rapid rate at which new life-saving and life-improving drugs and technologies are brought to the market.
- **Inadequate coverage—**On average, Medicare only covers 53% of beneficiaries health care needs. No other comprehensive health plan—public or private—covers so little.
- **Micromanagement by Congress and HCFA—**The government-administered pricing system Medicare currently operates under is governed by over 130,000 pages of rules and regulations—four times larger than the Internal Revenue Code. I strongly believe that one of the reasons we don't have a prescription drug benefit in Medicare today is because of its rigid pricing system, which is micromanaged by Congress and slow to adapt to changing health care needs and technologies.
- **77 million baby boomers beginning in 2010—**Again, budget projections may change from one year to the next but nothing will change the demographic fact that 77 million baby boomers will begin retiring in 2010 and demanding their Medicare and Social Security benefits.

In addition, CBO estimates that Medicare will continue to grow by an average of 7.5% over the next ten years, doubling spending from $216 billion in 2000 to $456 billion in 2011—and this obviously does not include the cost of adding a new prescription drug benefit to the program.

Elements of Breaux–Frist I and II

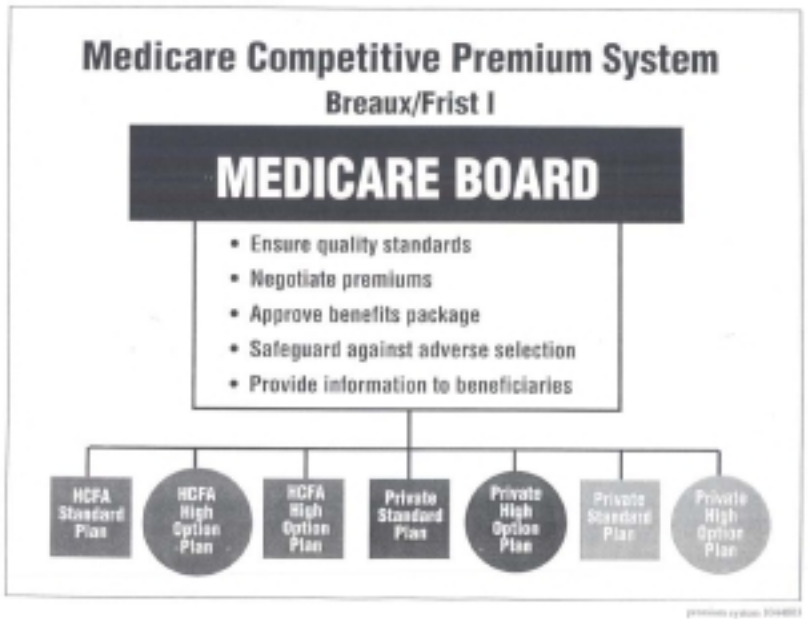
The Breaux–Frist prescription for Medicare reform is to combine the best of what the government can do with the best of what the private sector can do—this is not an either/or decision. The government's role is to provide financing and oversight while using private markets to ensure that Medicare keeps pace with advances in medical technology and injects much-needed competition into the program.

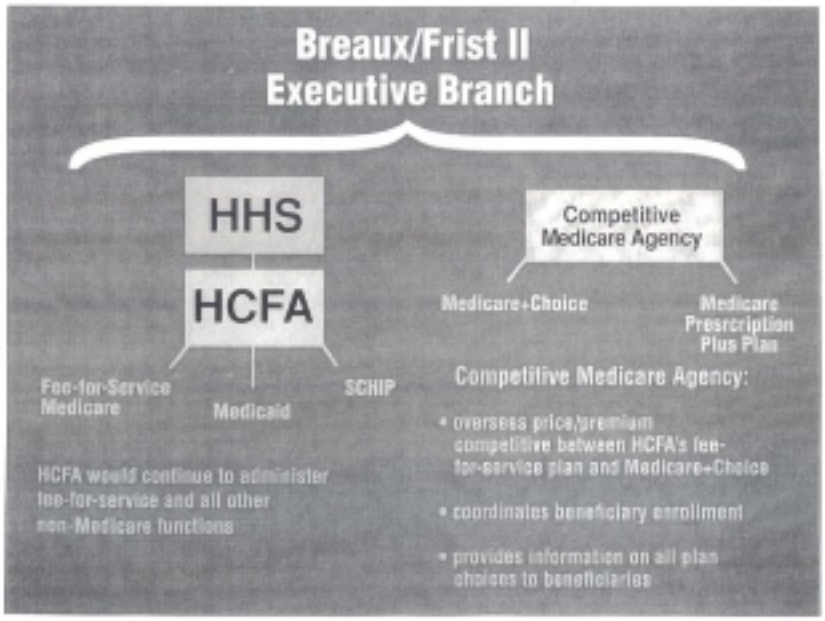
Many critics have mistakenly characterized Breaux–Frist as some sort of voucher proposal where seniors will be given a check and sent into the market to buy insurance. Nothing could be further from the truth. Breaux–Frist is no more a voucher proposal than the Federal Employees Health Benefits Plan (FEHBP). Under Breaux–Frist, the government's contribution is tied directly to the cost of health care and the level of government support is explicitly outlined in statute. The new entity overseeing Medicare (the Medicare Board in Breaux–Frist I; the Competitive Medicare Agency in Breaux–Frist II) will serve a function similar to that of the Office of Personnel Management (OPM) which approves plan premiums and benefits to minimize adverse selection.

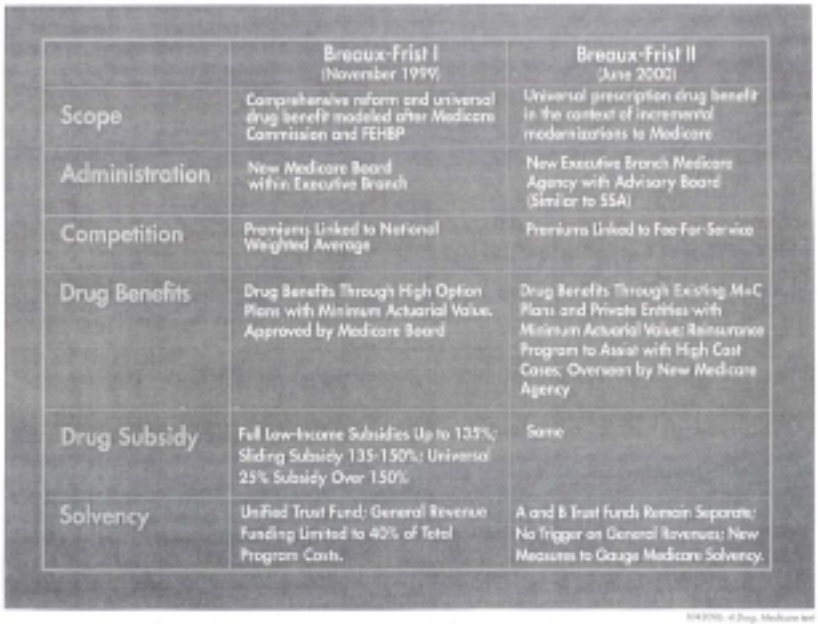
The primary difference between Breaux–Frist I and II is that the premium support model in the original bill would give HCFA the tools to modernize itself and become more efficient but for the first time make it compete with private plans based on premiums, costs and quality of benefits. This represents competition in the purest sense. Much of what we proposed in Breaux–Frist I (S. 358) reflects the policies supported by a bipartisan supermajority of the Medicare Commission which I had the privilege of co-chairing with Ways and Means Committee Chairman Bill Thomas. I have said many times and I continue to believe that we should use the addition of prescription drugs to Medicare as an opportunity to make important structural changes to the program.

Breaux–Frist II (S. 357) also adds a universal prescription drug benefit to Medicare but does so in the context of more incremental program reforms. In Breaux–Frist II, plans are allowed to compete, but Part B premiums are used as a reference point so that beneficiaries in fee-for-service won't pay a higher Part B premium than they otherwise would under current law.

When reintroducing our legislation 2 weeks ago, some people suggested that we just reintroduce Breaux–Frist I—others suggested we focus on Breaux–Frist II. The two bills actually share some common elements.







	Breaux-Frist I (November 1999)	Breaux-Frist II (June 2000)
Scope	Comprehensive reform and universal drug benefit modeled after Medicare Commission and FEHBP	Universal prescription drug benefit in the context of incremental modernizations to Medicare
Administration	New Medicare Board within Executive Branch	New Executive Branch Medicare Agency with Advisory Board (Similar to SSA)
Competition	Premiums Linked to National Weighted Average	Premiums Linked to Fee-For-Service
Drug Benefits	Drug Benefits Through High Option Plans with Minimum Actuarial Value. Approved by Medicare Board	Drug Benefits Through Existing M+C Plans and Private Entities with Minimum Actuarial Value; Reinsurance Program to Assist with High Cost Cases; Overseen by New Medicare Agency
Drug Subsidy	Full Low-Income Subsidies Up to 135%; Sliding Subsidy 135-150%; Universal 25% Subsidy Over 150%	Same
Solvency	Unified Trust Fund; General Revenue Funding Limited to 40% of Total Program Costs.	A and B Trust funds Remain Separate; No Trigger on General Revenues; New Measures to Gauge Medicare Solvency.

Both Breaux–Frist I and II guarantee that all seniors are entitled to the same benefits they get today (even though the current guarantee only takes care of 53% of their health care needs). We explicitly say in our legislation that seniors continue to be entitled to the Medicare benefit package outlined in Title 18.

Both bills establish a new competitive system managed outside of HCFA. We must move away from a framework that gives HCFA regulatory and pricing authority over Medicare+Choice and any new competitive systems we design.

Both Breaux–Frist I and II envision a fee-for-service drug benefit not micromanaged by the federal government but run through public-private partnerships overseen by a new Medicare agency. I have serious reservations about giving HCFA any pricing, management or administrative role over a new prescription drug benefit. Moreover, simply using private contractors like PBMs in a given region is no different than how HCFA currently contracts with fiscal intermediaries and carriers today to deliver Part A and B benefits.

FEHBP is a good example of how a public-private partnership could work in Medicare. Private plans participate in FEHBP, a program for nine million federal employees and their families with a 40-year proven track record, without major problems. Clearly the federal government will have to bear some risk in order to encourage the private sector to offer the benefit but the private sector has to bear enough risk so that there is an incentive to get deeper discounts and control utilization. Giving the federal government full risk for a drug benefit will lead to a system where there is no competition, no choice and a heavy reliance on government price controls.

Some have mistakenly characterized these public-private partnerships as not giving seniors a drug benefit "in Medicare." But just as will be the case for all other Medicare benefits, the new drug benefit envisioned in Breaux–Frist I and II is in Medicare—it's just not micromanaged and priced by HCFA.

In both Breaux–Frist I and II a new Medicare agency (which is part of the executive branch) would oversee a new competitive system and would ultimately be responsible for guaranteeing that all seniors—including those in rural areas—have access to a prescription drug benefit. This new agency, using public-private partnerships to administer the drug benefit, and a change in HCFA's role and mission, are the critical down payment Congress must make if it passes prescription drug legislation this year.

Both Breaux–Frist I and II also establish new ways of measuring Medicare's financial health. With general revenues supporting a growing share of overall Medicare spending, we need to look at more accurate methods of gauging Medicare's solvency. In Breaux–Frist II, we require the Medicare Trustees to evaluate general revenue spending in Medicare, provide historical spending trends, provide 10-year and 50-year projections, and provide information regarding the rate of spending under the program compared to the rate of growth in the gross domestic product.

Conclusion

The overwhelming public support for an outpatient prescription drug benefit gives us a real opportunity to make Medicare better with bipartisan legislation. Seniors absolutely need prescription drug benefits, but adding them without addressing the underlying problems facing the program will only exacerbate Medicare's financial deficiencies and administrative inefficiencies.

Medicare must be modernized and put on a sound financial footing to be able to provide seniors with a drug benefit that is an integral part of their health care plan. No system is perfect, and change is always unsettling, but we must move beyond the demagoguery and disinformation campaigns and act responsibly to balance the very real need for outpatient prescription drug coverage with the need for meaningful program reforms. It is time for us to take the necessary steps to reshape Medicare, include a prescription drug benefit, and guarantee health care security for seniors in the decades to come. By doing this, I believe we can truly provide choice and security for our Medicare beneficiaries to ensure their individual health care needs are met, today and well into the future.

The Medicare Prescription Drug and Modernization Act of 2001 (Breaux–Frist II)

IMPROVED MEDICARE MANAGEMENT AND ADMINISTRATION

✔ **Restructures the 1965 Model**

Establishes a new executive branch agency, the Competitive Medicare Agency, outside of the Department of Health and Human Services to oversee Medicare+Choice plans and outpatient prescription drug coverage. Eliminates the inherent conflict of interest of HCFA managing both fee-for-service Medicare and Medicare+Choice plans that compete for the same beneficiaries. Establishes a new mission for Medicare in the 21st century leaving behind the bu-

reaucracy and outdated mindset that continues to plague the program and instead guaranteeing seniors choice, health care security, and improved benefits and delivery of care.

MEDICARE PRESCRIPTION DRUG AND SUPPLEMENTAL BENEFITS PROGRAM

✔ **Establishes Voluntary, Universal Outpatient Prescription Drug Coverage**

Allows all Medicare beneficiaries who are entitled to Part A benefits and enrolled under Part B to elect outpatient prescription drug coverage beginning in 2004. Beneficiaries can receive drug coverage through either a Medicare Prescription Plus Plan, designed for beneficiaries remaining in traditional Medicare, or through a Medicare+Choice Plan.

✔ **Guarantees Medicare Benefits, Standard Coverage for Prescription Drugs, and Protections Against High Out-of-Pocket Drug Costs**

Maintains all current Medicare benefits and offers standard outpatient prescription drug coverage, which includes a $250 deductible, $2,100 in initial coverage and 50% cost-sharing. Provides coverage and security against escalating out-of-pocket drug costs by requiring that all outpatient prescription drug coverage offered to beneficiaries include stop-loss protection of $6,000 so a beneficiary never pays for drugs out of their own pocket beyond this amount. Provides beneficiaries the choice of coverage that best suits their individual needs by allowing the offering of different drug benefit plans, while ensuring the benefit value of standard coverage is maintained along with all stop-loss protections.

✔ **Guarantees Price Discounts off Prescription Drugs**

Requires price discounts negotiated between, pharmaceutical companies and insurers to be passed along to beneficiaries through a prescription drug discount card program offered by the plan, to ensure beneficiaries never pay retail prices for prescription drugs at any time.

✔ **Guarantees Affordable Drug Coverage through Universal Premium Subsidies**

Offers all beneficiaries a 25% subsidy toward the premium costs of prescription drug coverage. In addition, all beneficiaries will enjoy the benefits of additional premium reductions as a result of the federal government sharing in the risk of covering high-cost beneficiaries.

✔ **Protects Low-Income Beneficiaries**

Provides subsidies for beneficiaries with incomes below 135% of poverty by offering 100% full coverage of premiums, deductibles and co-pays associated with prescription drug coverage. Beneficiaries between 135% and 150% receive premium subsidies on a sliding scale from as much as 100% to no less than 25%. Since 39% of beneficiaries with incomes below 150% of poverty have no drug coverage under Medicare, this provision alone will provide comprehensive drug coverage for over 5 million seniors and individuals with disabilities.

MEDICARE+CHOICE PROGRAM IMPROVEMENTS

✔ **Improves Benefits and Health Care Delivery under Medicare**

In 2004 establishes a new competitive system under Medicare+Choice where plans bid for the costs of delivering care and compete based on benefits, price, and quality so that beneficiaries receive the highest-quality, affordable health care. Allows maximum flexibility for plans to reduce current beneficiary Part B premiums and cost-sharing as well as offer new and additional benefits to beneficiaries, including outpatient prescription drug coverage.

BENEFICIARY PROTECTIONS, OUTREACH AND ENROLLMENT

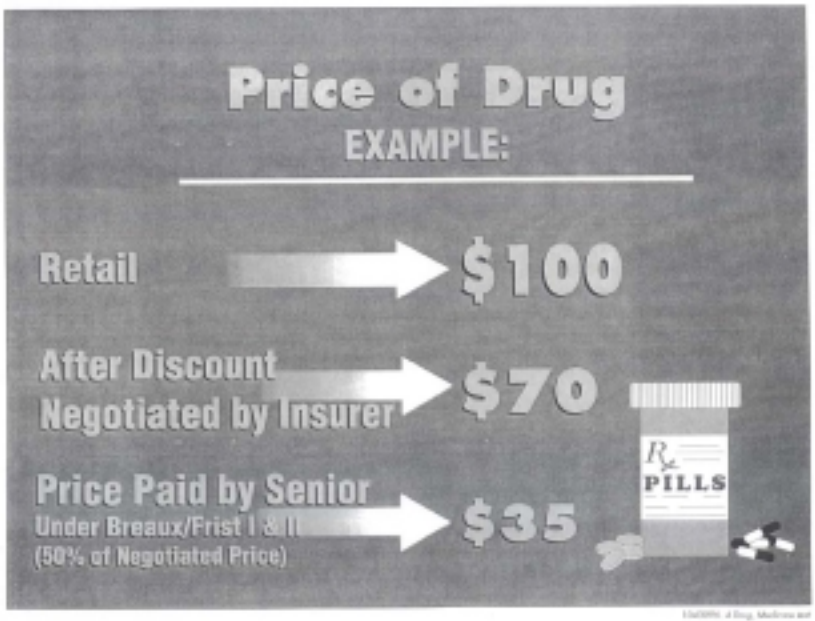
✔ **Encourages Informed Choice and Maintains Beneficiary Protections**

Establishes Medicare Consumer Coalitions, beneficiary supported organizations, designed to provide beneficiaries timely and accurate information at the federal, state, and local levels with respect to Medicare benefits and options. Ensures beneficiaries are protected through appropriate grievance and appeals processes for all Medicare benefits, including outpatient prescription drug coverage.

MEDICARE SOLVENCY MEASURES

✔ **Establishes Fiscally Responsible Measures of Solvency**

Provides a true and accurate measure of solvency by establishing reporting requirements for the Medicare program as a whole, including both Parts A and B, in determining the financial health of Medicare. Requires reports to Congress by the Medicare Trustees to evaluate general revenue spending in the program, provide historical spending trends, provide 10-year and 50-year projections, and provide information regarding the rate of spending under the program compared to the rate of growth in the gross domestic product.



Chairman JOHNSON. Thank you very much, Senator Breaux, for your presentation and for your many years of thoughtful evaluation of the options that we have in terms of managing the transition of Medicare to a more modern and responsive and affordable plan.

Actually we have so many Members here that I think I am going to forego my right to question so that we get through everybody, because I have had chances to talk with you, and I will.

Mr. Stark.

Mr. STARK. Well, again, I question whether managed care or Medicare+Choice is any good. I happen to disagree, John. I think Medicare is the finest system we have in this country. We have starved it by wasting money on managed care, and we may not be paying as generous benefits as we, in fact, should. I think that last month it was announced came out that the National Academy of Social Insurance is going to issue a report warning that relying on the marketplace to solve Medicare's problems will make matters worse, not better—largely because of the quality of care problems, especially for those who are poor or minorities, that will be generated by a premium support system.

I would like, Madam Chair, to enter the Medicine and Health article in the record that outlines the National Academy of Social Insurance's forthcoming action. I think our colleagues will find it of some interest.

The private market has its problems. Aetna, for example, the largest, most prestigious insurance company in America that runs more managed care than anybody else is now being sued by the Connecticut Medical Society for not paying claims promptly. Too often, there are inappropriate personnel making coverage determinations; there are inappropriate incentives for the reviewers to deny care.

Only approximately 15 percent of the seniors have chosen managed care, many because they have been inundated by advertisements from the managed care companies.

The Chair rightly indicates that many people were concerned about the managed care companies closing up. I submit to you that is only because many beneficiaries in those plans have drug coverage not available in Medicare. If we had a drug benefit in Medicare, we would, in fact, find that few would want to give up the right to the absolute open choice that the fee-for-service system now provides, and we would have happier doctors, hospitals.

Chairman JOHNSON. Mr. Stark, if you could direct your questions more directly to Mr. Breaux, I would appreciate it, because we have so many people who want to ask questions.

Mr. STARK. I understand that. I will get to the question.

Managed care does not help pay for graduate medical education and it does not provide benefits to those in rural areas, which the fee-for-service does now, to the tune of about $10–$12 billion a year. What possible benefit is there to the Medicare beneficiaries to be encouraged to go into managed care? That is my question. What evidence do you have that managed care is any good?

Senator BREAUX. I think there is a good question in there, and I hope I can find a good answer for you.

Mr. STARK. I don't think there is any evidence.

Senator BREAUX. Let me try.

Mr. STARK. All right.

Senator BREAUX. If you only took half of what we are suggesting, and that is to let the private sector take over all of the operations of the Medicare, I think Congressman Stark would be right, because there would be no guarantees of benefits. There would be no guarantees against adverse risk selection, and all of the problems that he talks about would probably be potentially existing. But what we have designed, as I have said, to combine the best of what government can do and what the best of what the private markets can do.

And when you have a Medicare Board or you have a competitive Medicare agency, their role would be the same type of role that we have with OMB that guarantees against adverse risk selection, guarantees it is legitimate and fair competition, and also allows the private sector to bring about innovation and technology advancements. So you have the protection for the beneficiaries that I would argue is not there today, and you have real competition, which is clearly not there today.

But the bottom line is that people who do not want to go into the new system, they have the right to stay in fee-for-service if they think that serves their needs better. They have a choice, and I think that is the right way to go.

Mr. STARK. Well, I would just suggest, Senator, that managed care has an abysmal record and their popularity is plummeting among Medicare and non-Medicare beneficiaries alike—including corporate America, which is getting sick and tired of it. Going to the managed care industry for help with reform is sort of like going to Saddam Hussein to find out how to teach democracy.

Senator BREAUX. The model we are going to is the model that you have as a Member of Congress, I have as a Member of the Senate, is the Federal Employees Health Benefit Plan. I would suggest the reason that Medicare+Choice has not been doing well is because of the way it has been micromanaged by HCFA.

Mr. STARK. Senator, I will bet you a nickel that there aren't two people in this room that belong to a managed care plan.

Chairman JOHNSON. Oh, everyone. There are no Federal employee benefit plans in my district that aren't HMOs.

Mr. STARK. Those are PPOs. I am talking about managed care.

Chairman JOHNSON. They are all managed care.

Mr. STARK. Come on.

Senator BREAUX. He is talking about bad managed care.

Chairman JOHNSON. You are talking about bad managed care.

Mr. STARK. Thank you.

Chairman JOHNSON. Mr. McCrery.

Mr. MCCRERY. Thank you, Madam Chair.

Since my good friend and colleague from California brought up the seminar that we had yesterday, let me refresh the memory of those who were there, and for those who weren't let you know that we are also told yesterday that in the year 2040, based on current projections, if the government is still spending around 18 percent of GDP, Social Security, Medicare and Medicaid will consume 80 percent of the Federal budget. That leaves 20 percent of 18 percent of GDP for national defense, for roads and bridges and highways, for environmental protection, court system, you name it; 20 percent. We all know that is untenable. Can't do that.

We must do something to at least try to curb the rate of growth in Medicare and to curb the rate of expenditures for Social Security. So at least Senator Breaux and his Commission brought forward a plan that gives us some hope of doing that in the Medicare system.

I think Senator Breaux would be the first to tell you, Mr. Stark, that he is not sure this will work. Nobody is. But we are going to do something. And I would certainly urge you and others who don't like the premium support model to come forward with something else that will control costs. So far I haven't heard much. But we are anxious to hear other views, and certainly that is going to be the job of this Subcommittee to look at any alternatives and try to decide what is in the best interest of—the best long-term interest of this program and the country.

Senator Breaux, you have discussed adding a prescription drug benefit, and certainly I don't think there is any argument that Medicare is deficient in that regard. We do need to provide a pre-

scription drug benefit to senior citizens in this country, but I have seen in print you quoted as saying that you don't think a prescription drug benefit should simply be added to the current Medicare program, that it ought to be done in the context of overall Medicare reform. If that is correct, would you expound on that just a minute?

Senator BREAUX. Congressman, that is correct, and I think it is important. I mean, I have used the analogy, I thought it was kind of good when I said it, I think it is still pretty good, that just adding prescription drugs to the existing program is like adding more gas to a 1965 automobile. It is still going to run like a 1965 car. Therefore, just adding more benefits to a 1965 Medicare system is still going to have the same problems. It is going to cost a lot more. It is still going to be micromanaged. There still will be no competition.

So I think that what we have to do in assuring that Medicare does cover prescription drugs, which I feel very strongly it should, that it is part of a reform system that allows the prescription drugs to be delivered in a 21st century model that guarantees the protections, guarantees quality, but also brings about competition which will help on the prices as far as having competition so we don't have to micromanage it or price regulate it, which I think would be a serious mistake.

Mr. MCCRERY. In the work of the Commission, the projections that were developed by the Commission showed that in the first 10 years of Medicare reform under the premium support model, the system would save about $100 billion over current projections for the current program, but then in the outyears, after the first 10 years, it showed considerably more savings for the program. Is that correct? And how did the Commission explain——

Senator BREAUX. Congressman, the Commission, as I know—Jim McDermott was there and others behind me that were on the Commission with me know one of the recommendations that did not get the super, supermajority was an increase in the eligibility age, which would have caused substantial savings. That is not part of our plan. Neither Breaux–Frist I or Breaux–Frist II touches the eligibility age. But I do think going to a more competitive system you will still have the savings. I think we were scored in Breaux–Frist II as $163 billion over 10 years. We have resubmitted that request to be updated, and it is going to be more than that under Breaux–Frist II. And that is going—will be made available as soon as we have it.

You know, I thought in the beginning, quite frankly, you could devise a new system to come up with a lot of savings in a program. I think the best we are going to be able to do is to improve it and to keep the increase in costs down. I don't know—we are going to have to spend more money in this program, and that is it.

Mr. MCCRERY. Sure. I am referring to a savings from the baseline, not a——

Senator BREAUX. OK. Yeah. It would be that. I mean, the projections we have, CBO is now estimating that Medicare will grow by an average of 7.5 percent over the next 10 years, doubling spending from $216 billion to $456 billion by the year 2011, and that does not cover the cost of adding prescription drugs. So when you add

that, then you are looking at some huge amounts, which Jim just pointed out.

Mr. MCCRERY. Thank you very much.

Chairman JOHNSON. I would just mention, to keep things in perspective, that that 7.5 percent growth leading up to very big spending is current law. And just since last year, the House-passed prescription drug bill, which was very modest, I think, by anyone's standards, has increased in its cost 23 percent in 1 year. So we do have to really understand the implications of what we are doing.

Mr. Crane.

Mr. CRANE. Thank you. I don't have a question. I just want to commend you, Senator Breaux, and your colleague Senator Frist for the work you have done, working toward fundamental reform of the problems that we are experiencing with the Medicare program. And I think that approach is infinitely superior to what we have been doing through the years, and that is piecemeal or patchwork. And so keep up the good work, and we are looking forward to continuing to work with you both on the Senate side.

Senator BREAUX. Thanks, Phil.

Chairman JOHNSON. Mr. Kleczka.

Mr. KLECZKA. Thank you, Madam Chair. I might have a question somewhere along the line, but I would like to make a couple of observations.

Senator, thank you for your presentation today. I think the debate that we are having and the discussion we are having is proper, and it is probably healthy, but in the bottom—or at the end of the day, my conclusion will be that it just ain't going to work.

And one can only look back to about 35 years ago at this old Chevy that you are talking about that needs a lot of gas, and the reason that the government bought that automobile was because the private market wasn't providing the seniors in this country with health care. Over 50 percent of the seniors had nothing. So the government stepped in, which is the government's role.

Now, when it comes to making cars, private industry does that, and it does it quite well. When it comes to building our homes, private industry does it, does it quite well. Governments should not get involved in that enterprise. But where there is a gap, where the public is not being served and is in need of a service, that is what we are here for. That is why the Founding Fathers created a Congress to look after the welfare of the citizens of this country.

Well, now we are saying, well, things have changed dramatically in 35 years, and the insurance industry is now clamoring; they are clamoring to insure these seniors.

Well, a couple of responses to that. First of all, we have had a pilot program. We have had a pilot Breaux–Frist program operating the last couple years called Medicare+Choice. What has been the experience? Seniors have gotten more care cheaper, and insurance companies are beating each other to death to insure them. Wrong. What is happening in the city of Milwaukee, which I represent and come from, we had three carriers at one point. Now we are down to one, who is going bankrupt and will probably file with HCFA that they are going to get out of the business, too.

And the problem is you are insuring the sickest of our population, those who are going to be exposed to great medical costs in

a short period of time. Well, you say, let's give them the same plan offerings like the Federal employees. Well, in that market the insurance system works because you are insuring the young, healthy and the 58-year-old somewhat healthy members like myself. When you put them all into a big bin and mix it up, you can make a buck doing that.

OK. So you know it is like rolling averages, but with the senior population, 65 to 100, you don't have that good exposure, all right, because as time goes on, it is going to be more health care, more drugs, more hospitalization, et cetera, so the private insurance market doesn't want them, all right? They ain't going to make any money on them.

Another case in point, let's talk about the great drug bill, Madam Chairman, we passed last year. Well, here is a drug subsidy program to be run by our favorite friends again, the insurance industry. What we are going to do is have them go out and sell drug policies to seniors, and the government, taxpayers, will subsidize their costs or losses or whatever you want to call it. Well, we had a hearing, Pete, didn't we, before the Committee, and half of the insurance industry came before us and said, nice program, girls and boys, but we ain't buying into that, because the people who are going to sign up for that program need drugs.

So here is the Republican response to a decent drug benefit that we produced, and the major actors came forward and said, nice program, but we are not buying into it because we are not going to make any money on it. So there are things, Madam Chair, that the government should rightfully do, and this is one of them, but now if we pass the Breaux plan, and, John, we could be getting to a question pretty soon——

Senator BREAUX. I am taking notes.

Chairman JOHNSON. Remember you only have 5 minutes for question and answer. I would like our witness to have a chance to answer.

Mr. KLECZKA. Now I lost my train of thought. That was probably great. I have to start all over again. I am sorry.

Chairman JOHNSON. Since the yellow light is on, why don't you let the Senator comment on——

Mr. KLECZKA. What has changed now? What do you see in the marketplace that is going to offer all the benefits that are not being offered in Medicare today plus the current base benefits that are going to be more affordable than they are today, and we are going to have more players, more private insurers coming forward to say, gosh, I like your grandma, I would really like to help her out. OK.

Senator BREAUX. Let me take a crack at it and make a couple of points. Number one, we cannot defend the status quo.

Mr. KLECZKA. As I like to say in the South where I come from, it is better than nothing. You know what? It is pretty good.

Senator BREAUX. I will give you an alternative, which I think is better than the status quo, number one.

Number two, let me take the analogy on the cars. You said Detroit makes cars; government doesn't. That is true. The private sector makes the cars, where the government is involved in ensuring safety standards, fuel efficiencies, and so they don't roll over, to make sure that the cars run according to certain national stand-

ards. Private sector makes them, and they bring about efficiency, and there is competition, but the government has a major role in ensuring that they are safe and they meet certain standards and fuel efficiency.

The same type of concept is what we are talking about with health care. Let the government do what the government can do best: help pay for it, help guarantee that it is being run properly and meets certain standards, but allow the private sector to bring about innovation and competition and new technology.

The final point: It is true that agencies that came up and talked about prescription drugs being available would not ensure it only because it is not a good insurance risk. Obviously we all understand that if you are only going to cover prescription drugs, the only people to buy those policies are those who will need prescription drugs. Like in the Medigap insurance, the premiums become so expensive that it is not a good investment.

But this proposal is different, I would suggest, in a major, major way. Number one, the plans would be able to offer more than just drugs only, which is one of their complaints previously. They would be able to offer vision. They would be able to offer dental. They would be able to have coverage for cost-sharing. In addition to that, there would be a one-time enrollment to make sure that more people become involved in the process to give them a larger insurance pool than they had before.

And the final and probably the most important thing is the reason why it would work is there would be substantial risk-sharing by the government agency as well as the insurance companies to help with regard to the risk-sharing in selling this type of policy. So I think that when you look at what we are suggesting, that it——

Mr. KLECZKA. Are you talking subsidy just like the drug program we had?

Senator BREAUX. Yeah. Absolutely.

Chairman JOHNSON. I thank the gentleman.

My friend Mr. Johnson from Texas.

Mr. JOHNSON of Texas. Thank you, Madam Chairman. Let me correct the record, if I might.

Mr. Stark, I have been getting complaints on the Medicare system as it is envisioned. I have been getting complaints about HCFA, and I haven't been getting complaints about HMOs.

Now, I think that what we have to consider is that HCFA, as Senator Breaux has said, is obsolete and inefficient and doesn't work. And can you imagine us adding prescription drugs to this thing, Senator, and every year coming up here and saying, we got to add this one and this one and this one because of new innovations in medicine.

Medicine is moving faster than we can do that. That is what is wrong with HCFA. It hasn't been able to keep up with it. Inadequate benefits, and insufficient choices, and Medicare's administrative inefficiency and structural obsolescence have to be overcome. I like what you are doing.

Would you care to comment on any of that?

Senator BREAUX. You are right on.

Mr. JOHNSON of Texas. God bless you. Thank you.

Mr. MCCRERY. Would the gentleman yield?

Just to correct the record, another time there were, in fact, PBMs that came forward last year and said they would participate in the prescription drug program that we offered. And I think the main industry sector that was saying loudest they wouldn't participate is that sector that already participates in the Medigap policies that are so profitable. So I would urge you to question those sources.

Senator BREAUX. Medco said they would write a drug only plan.

Mr. JOHNSON of Texas. Thank you, Madam Chairman.

Chairman JOHNSON. Thank you.

Mr. Camp.

Mr. CAMP. Senator, thank you for all your good work. I would agree with you that the addition of prescription drugs really is an opportunity to modernize Medicare. And for example, this 1965 model when you get the drugs if you are in the hospital, but you don't if you are out of the hospital, it just cries out for some change.

You said in your written statement and I think in some of your comments that the premium support model in Breaux–Frist I would give HCFA the tools to modernize itself. Could you elaborate on that, please?

Senator BREAUX. OK. What do we have on that Sarah? Basically we are giving them more of an ability to write the regs this away that would encourage more competition within the system, giving them the flexibility to offer some of their benefits through a more competitive system than they do now, and basically giving them greater flexibility in order to be more competitive, because under this they are going to have to compete now with the private plans. So we give them more flexibility on how they would be able to utilize what they do now in a more competitive fashion in order to be able to compete.

Mr. CAMP. OK. Thank you very much.

Thank you, Madam Chair.

Chairman JOHNSON. Thank you.

Mr. McDermott.

Mr. MCDERMOTT. Thank you, Madam Chairman.

Sam, if you can sell the idea that Medicare has been a failure to the people who are on Medicare, you are a real good salesman. I think that anybody who looks at the program can see there is problems, but to say it is a failure or we ought to throw it out and bring in this new, has simply not looked at the problem.

I would comment everybody looking at the GAO report that says, plans withdrawals indicate difficulty providing choice while achieving savings—this is September last year—and there has been a roughly 50 percent decline of members in the Federal Employees Health Benefit Program covered by managed care operations.

Now, if this is such a good option, why are all the Federal employees leaving it? And yet, what we are seeing here is a proposal that is designed to push us—push seniors, I am not quite there—to push seniors into that program. And they are dangling this little benefit of drugs out there, and come on, folks, follow the drug, and we will get you in there.

And the fact is that what has happened to Jerry has happened all over this country, that people have had—every one of us sits in

our office and tries to deal with it, as I did in the State of Washington, almost 500,000 who were dumped by HMOs because they couldn't make money. And we started out with the premise that when we put the HMOs in, they should get 95 percent of what we spent on the average beneficiary in the Medicare program, and they say, we can't make it on 95 percent.

Well, where is the savings? That is what I want to ask you. Because we say we can get competition, and with competition we will get savings. And yet the technology of medicine has gotten more and more complicated, and for us to say that, well, we can do it, I guess we will just let the managed care operations do the rationing.

And the question I have for you, John, is would you rather have the insurance companies do the rationing, or do you want to do it?

Senator BREAUX. Neither one. I think——

Mr. MCDERMOTT. Well, you are going to have to do it one way or the other, or you are going to have to cut back on services. You cannot provide the level of services to an increasingly aging population with the technology that is going on in this country and not cut somewhere.

Senator BREAUX. Let us remember, every one of us, that 47 percent of the average senior who is on Medicare's cost for health care every day is not covered by Medicare today. Forty-seven percent of their illnesses and their ills that need to be treated, they have to go and buy another policy, they have to go on Medicaid, or they have to go to their children. Those facts are factual. It only covers about 53 percent. So you already have a system that is woefully inadequate.

Now, we have to understand—the final thing we have to understand, I think all of us, myself included, that—I remember when Stuart Altman was on the Commission and who is here behind us, I think in the beginning we argued about this as a means of saving a great deal of money. It is not going to save a great deal of money, but it is going to help reduce the increases that are projected. We are still going to be spending more money.

The feature that we have here is that we try to combine the best of what government can do with the best of what the private sector can do. I am not arguing that it is only the private sector making the decisions in terms of risk selection, in terms of making sure the policies offer everything that is needed and necessary to be offered. The government is involved both with that and with paying for it. And the final note is that people have a choice. If they like the old program, they stay there; if they prefer the new one, they have the opportunity to choose it.

Mr. MCDERMOTT. I think that that is admirable, and I like that part of what you are doing. What I don't like is the slanting of the incentives to say, if you stay over on this old fee-for-service 1965 Chevy, you are not going to get that nice, big Cadillac that we got for you.

Senator BREAUX. You do if you pick this Breaux–Frist I.

Mr. MCDERMOTT. It has got a drug in the front seat.

Senator BREAUX. That is the argument for Breaux–Frist I. Because with Breaux–Frist I, HCFA would offer their high-option plan and prescription drug plan as well, so you could stay in fee-

for-service and get drugs under Breaux–Frist I; and under Breaux–Frist II, you would go to the competitive Medicare.

Mr. MCDERMOTT. Why do you even bring Breaux–Frist I here when it is so patently designed to drive seniors into HMOs?

Senator BREAUX. I don't think it does that. You can still stay——

Mr. MCDERMOTT. You mean if I offer my mother, who is 91 years old, a drug benefit if she goes into an HMO if she doesn't have it now?

Senator BREAUX. For Breaux–Frist I, under HCFA's high-option plan, they offer not only all of the current benefits but also prescription drugs; and the prescription drug plan would be available under fee-for-service and HCFA. If my father wanted to stay in HCFA and get prescription drugs under the high-option plan, they would have prescription drugs under the high-option plan.

Mr. STARK. A $50 benefit for 1,200 bucks? That is a heck of a benefit.

Senator BREAUX. We can design it. We can pick the number. That is an actuarial value. That is not $800 worth of drugs. It is an actuarial value.

The average senior in this country spends approximately——

Mr. MCDERMOTT. Would you say, in closing——

Senator BREAUX. —between $600 and $700 a year on drugs. That is the average cost. An actuarial value policy of $800 is a pretty good deal.

Mr. MCDERMOTT. Let me just say, in closing, that what you have to keep in mind here is that you are designing a program that presently has something like 9 million widows in it living on $8,000 a year. Now, if that is the program we are trying to design—we are not worried about Bill Gates when he goes into Medicare. He is going to be able to afford a few extras. But it is the people at the bottom who you give this miserable benefit to at a time in their life when $800 may turn out to be a pittance of what they spend. When the average out-of-pocket cost is $3,500, according to our seminar yesterday, an $800 benefit doesn't cover it.

Senator BREAUX. Let me suggest that an $8,000 income is probably covered by Medicaid which covers 100 percent of their drugs and 100 percent of their health costs.

Mr. MCDERMOTT. Do you make an automatic entry into Medicare—Medicaid? Because nobody on this Committee will automatically default people into Medicaid. They make them go down to the welfare office and beg to get in. And that is why this is deceptive.

Chairman JOHNSON. I would like to exercise the prerogative of the Chair to make two comments.

First of all, Medicare is currently a fee-for-service plan and a plan that offers managed care choices. It has offered them for many years. It has offered the HMO risk plans. Now it offers some other variants. In 40 years, Medicare is going to be there, and it is going to be offering fee-for-service coverage and other choices.

So no one here is for a moment suggesting that we do away with Medicare, and it concerns me when we allow an opportunity to educate ourselves to become in a sense a political debate. You know, neither party, the administration, nor anyone else——

Mr. STARK. No, no politics here.

Chairman JOHNSON. I find that disrespectful, Mr. Stark.

Mr. KLECZKA. Madam Chair, I——

Mr. STARK. I am just bringing some humor into the subject.

Chairman JOHNSON. I understand what you are saying, but hear me out.

No political party and no administration has come up with a plan that meets your criteria, nor that we have costed out, nor that we have figured out how we are going to fund.

Now, this Committee is going to try to do that, going to try to get into more depth on why is it that the choice plans haven't met the needs of either the recipients or the taxpayers or the plans. But I think it is very important to remember that nobody is talking about doing harm to Medicare.

What people are talking about is Medicare's inability to offer state-of-the-art benefits to the recipients, and how are we going to do that in the context of extraordinary expenditure estimates, and how are we going to do it in a way that we don't force people into choices to get benefits but do honestly give them a choice. And how are we going to deal with some of the problems of the low-income seniors who are just above the Medicaid level, and can we really afford to continue a program that doesn't take into account the very minimal needs of someone—just minimal abilities of someone just above the Medicare level or just above 150 percent of poverty to pay even premiums whether they are in—whatever bill they are in.

So I think we have very big challenges before us, and I don't think that we have understood clearly on the congressional side—and I think you would agree with me on this, Senator Breaux—that we really haven't understood clearly why is it Medicare didn't work as well and what is the complexity of the system that it found itself facing. What are some of the things that it did that were good, and what are some of the things that it did that were bad? Because, clearly, if we are going to do this, we are not going to try to re-create the experiences of the last few years. We are going to try to strengthen Medicare fee-for-service with prescription drugs; and we are going to try to provide stable, predictable, funded alternatives; and it is going to cost money.

So if we can focus on our questions about Mr. Breaux's answer as precisely as we possibly can, I think we arm ourselves to go forward and work through some of the problems that have been brought up that are real.

Mr. Ramstad.

Mr. RAMSTAD. Thank you, Madam Chair.

Senator Breaux, let me just first say that this is one Member who appreciates the fact that you have approached Medicare reform in a bipartisan, pragmatic, common-sense way; and it is just a crying shame that the final vote necessary to constitute a supermajority wasn't there on the Commission. Because to the degree possible—and I realize it is not fully possible to depoliticize this debate and the subject we are working here on, but to the degree possible that, more than anything, would have depoliticized and that Commission report would have sailed through in a bipartisan way certainly the Congress, both bodies, I believe.

But let me focus in on this. In his opening remarks, Mr. Stark acknowledged the incredible inequities of the Medicare+Choice pro-

gram and the reimbursement formula. In fact, I think he mentioned the difference between Minneapolis and Miami, and everyone knows that a Medicare beneficiary can receive 2–1/2 Medicare surgeries at the Mayo Clinic in Minnesota for every one in Miami, Florida. That is absolutely unconscionable and unfair. We did take a baby step forward in increasing the minimum payments or the floor last year to $525 in urban counties and $475 in rural counties, but we still have incredible disparities, and seniors and providers are being cheated in States like Minnesota who are penalized for their history of prudent health care spending. Minnesota, for example, over the last decade has kept its costs 3 percent under the national average. As a result, our reimbursement formula is less.

How, in your judgment, should Congress address the unfair equities in the Medicare+Choice reimbursement system?

Senator BREAUX. Well, I mean, you have to I think get rid of the arcane methodology in which Medicare+Choice plans are being paid for. It is a political formula. It is a somewhat cost-oriented formula, but that is not the premise of it. They ought to be paid based on competition. They ought to be asked to compete in the marketplace, and they would be paid accordingly, and we would be looking at who can do it for the best price, providing the best services.

Right now, as you point out, some areas are getting paid more than they need; other areas are getting paid far less than they need. I mean, they get hit with risk adjusters and user fees and payment recalculations. It is no wonder Medicare+Choice has not been able to be working out there as it was intended to work, because it is managed by the organization that is in competition with it. It was not in their interests to help make it work.

Therefore, we get out of the concept of having it paid based on an arcane national formula, rather than being paid based on the competition that they would have to compete with; and the ones who would do it for the best price with the best services would get the business and others would not.

Mr. RAMSTAD. Well, I thank you for that response; and on behalf of all Minnesota seniors, Medicare seniors, I truly hope we can get that done this year, because it is simply not fair. I have every—every town meeting I attend, every senior center I visit I am barraged with complaints and questions about the inequities, so I appreciate your approach to that problem.

The second question I have, I represent 300 of the best medical technology, medical device companies in the world, comprising Minnesota's Medical Alley, and they are developing new technologies all the time—Medtronic, for example, the first pacemaker—technologies that save lives and improve the quality of life for people all over the world. These technologies, as we all know, are available in the private sector years before they are approved by HCFA for Medicare beneficiaries.

I saw in your other chart the fourth item listed was—maybe it was yet another chart. Anyway, it was medical——

Senator BREAUX. It is in one of our charts.

Mr. RAMSTAD. Exactly, one of the charts. But, anyway, we have to get more access to seniors to medical technology, and how in

your judgment should we address this in a comprehensive Medicare reform bill?

Senator BREAUX. Well, first, Congressman, the Commission had the privilege of going to your home area for one of our Commission hearings.

Mr. RAMSTAD. I know. In fact, I was there; and I appreciate that.

Senator BREAUX. It was fascinating what we were able to learn.

The whole question of innovative technology is part of what the private sector can do best, as opposed to what government can do. We now make technological decisions that we have not the competence to make in the Senate Finance Committee, and I would say also in your Ways and Means Committee as well, about what we are going to pay for and what we are not going to pay for. Is this the best procedure to pay for, or are we not going to pay for this, but we will pay for this procedure over there.

We all have, probably, examples of industries that have come to us and said, we want you to introduce a bill to get Medicare to cover this, and the other side who is selling the other product will say, no, we don't want you to do that because they are paying for our product.

That is not the best way to bring about innovative health care technology. The best way is to allow the marketplace as it is developed to be able to offer it, and then through choice we pick the thing that best fits our particular needs, as competition among the technologies, both on price and on efficiency and quality. The government in this role guarantees that no one is scamming it, that no one is offering quack type of proposals. That would be what government can do best, to see that it is not being run incorrectly but not micromanaging it.

Mr. RAMSTAD. Thank you very much, Senator.

Thank you, Madam Chairman.

Chairman JOHNSON. Thank you.

Congresswoman Thurman.

Mrs. THURMAN. Senator, I am sorry I missed your opening remarks. We have been in hearings for the last couple of days and my constituents were beginning to wonder if I was missing in action some place when they came by to see me, so I apologize for that.

Senator, I guess the thing that I am most concerned about and am trying to understand, try to explain to me what is really the difference between what is going on today—I mean, we have a fee-for-service, we have Medicare+Choice programs. For those, in those regions that they can have them, I mean, most of them are pulling out, some of them are losing their prescription drugs. And I am kind of having a hard time understanding what exactly, if I were to go home and try to explain this to a constituent, why they would buy into this after what they have seen over the last couple of years.

To just tell you what has happened in one of my counties, yes, I am from Florida, but I am not from Miami, so we don't get the big numbers, I kind of have some rural areas. But what do I say to them when they say, well, you know, our Medicare programs pulled out last year, our choice programs. I mean, only by the fact that we were able to put an incentive back in did they come back

in, and we are only hoping they stay there for as long as we can keep them.

Are we still going to have, or do you still see the volatility within these markets? I mean, are they still going to have to go back to fee-for-service? I mean, what is going to guarantee in this plan different from what we are seeing happening already? Because you are still depending on the private market to do this, and they are only going to do it based on whether or not they can get a profit, you know, what their profit might be at the end.

Then let me ask this: Show me the relationship on the price premium as compared to what happens today with how government controls what we pay in and what potentially could happen, because I know in Breaux I, I think there was actually an idea that we could have to come back if it got over 40 percent, what was going to happen, and we would have to come back and have the debate on the floor.

Senator BREAUX. Well, Congresswoman Thurman, there are a lot of good questions in your comments.

Number one, to make a general comment, any change is very difficult, particularly for senior citizens, because change is scary to all of us, and it is certainly probably even more scary to seniors, and especially when you are talking about something that is as important as their health. I would say that that group of seniors, number one, that the current plan you have does not cover about 47 percent of your health costs. It is not adequate, it is not as good as it should be, and it is not as good as it can be made to be.

The second thing I would say to them is that I would like to give you the opportunity to have the same type of system that I have as your Congresswoman, or that the two senators from Florida have as Members of the Federal Employees Health Benefit Plan. They have always said that if it is good enough for the Members of Congress, it must be a pretty decent plan; and they are right on that, because it is.

Now, how it would work is that——

Mrs. THURMAN. But they have choices.

Senator BREAUX. That is exactly right. And we would absolutely guarantee the choices and give them, in fact, a lot more choices than they have today, because it is very, very limited and it is inadequate in its coverage. The concept would be that they would have all of these plans on Breaux–Frist I that would have to come to the Medicare Board which is like our OPM.

Mrs. THURMAN. And you guarantee it how?

Senator BREAUX. That would be the government role. I said to combine the best of what government can do with the best of what the private sector can do. The best that government can do is help pay for it, and we would guarantee to pay for it by exactly the same percentage that they would be paying under fee-for-service. It is 88 percent paid for today totally, and it is probably going up higher than that, and it would go up higher than that in our plan, too. So the government guarantees that they pay for it, and they guarantee that they are going to supervise it. It is not going to be adverse risk selected, it is not going to be a bunch of scam operators, because the Medicare Board, which is an agency of the Federal government, would guarantee that that would not be allowed.

Then, from a choice standpoint, when you have five or six or more plans being offered, they would be able to look at them and all of them would have to meet a certain standard, all of them would be basically paid for by the Federal government, and they would pick and choose. If they still do not like any of those new choices, then they would be able to stay in a traditional fee-for-service.

I think that you can tell your constituents that what you are giving them is the opportunity to have something that is a lot better than they have today.

Chairman JOHNSON. Mr. Cardin, would you like to question?

Mr. CARDIN. Just very briefly, Madam Chair. Thank you for the courtesy.

First, Senator Breaux, I share the comments; and we thank you very much for your service to our country. I think you will find that on our side of the aisle the Breaux–Frist II is what we are going to feel more comfortable with, that model.

I just have one question. As I understand it, you use as the benchmark for the payment for private insurance 100 percent of what it costs for Medicare fee-for-service, and you don't put a risk adjuster in until I think the year 2014.

I guess my question to you, and you need not fully answer it today because I guess we will have the answer when we get the fiscal costs of Breaux–Frist II, it seems to me that those changes will add dramatically to the cost of the program, that there is a good chance that the payments made for private insurance will actually exceed what it would otherwise do, and we might just be adding to the cost of Medicare without providing an additional choice or benefits to our constituents.

Senator BREAUX. Well, that is a real good question. It is a very technical question, but it is also a very important question.

The risk adjuster is something that is going to be needed. If you have a group of people who are sicker and older and cost more, you are clearly going to have to have a risk adjuster in that program which would allow them to be compensated for the extra costs that they have. In fact, I think the risk adjuster that we suggested was the one that the Clinton Administration was actually talking about and proposing. That can be refined and it can be updated and it can be modified, but that is where we got the concept of the risk adjuster from, and you would have to have that.

But then you also remember, you also have the role of the Federal government insuring against adverse risk selection. If someone submits a plan to be offered that is tailored to meet only healthier seniors, thereby throwing sicker seniors into traditional fee-for-service, that plan would not be allowed to be offered, and that would be the strong role of the Federal government. This Medicare Board in that case is a very strong Federal agency and is part of our government, but they would be also able to have a competition which we can't handle through HCFA, but they would guard against adverse risk selection. But also recognize that if there is a preponderance or a greater percentage of sicker seniors, then there would have to be a risk adjuster, and we are very open on how we craft a risk adjuster to take care of the extra cost.

Mr. CARDIN. Thank you, Madam Chair.

Chairman JOHNSON. Thank you.

In concluding, Senator Breaux, it is also true that when you talk about setting premiums, the Board setting premiums, those would take into account that these insurance policies are covering older people with higher health care needs.

Senator BREAUX. Oh, yes. The point is that, yes, they are going to be covering probably people that are obviously older and obviously sicker than we have in the Federal Employees Health Benefit Plan, so that answer is yes; and that is going to have to be accounted for in the pool of people that they are going to be insuring. They are going to be older and less healthy.

Chairman JOHNSON. That ties in with our opening comment about the Federal government's role is to help pay for the benefits that we have guaranteed the seniors.

Senator BREAUX. The final point on that—I mean, all of this is so incredibly complicated. I am not in the insurance business and don't pretend to understand it. But the average premium that we pay under Medicare combined A and B is—about 88 percent of the cost is Federal government and 12 percent is the beneficiary through part B premiums.

If—our first bill, it was interesting, we had pegged the reimbursement rate under the new plan to 88 percent; and some said, well, suppose it goes up, isn't that going to make fee-for-service go rocket high? We have changed that now. We are saying that whatever the government percentage is that they would pay under our bill is what they would pay. Whatever the government contribution, if it goes up to 90 percent, under our bill, that would be the premium contribution under the new plan.

So there is some flexibility there. It is not tied. We picked 88 percent because that is what it was at that time, but we know it is going to be higher than that, and, therefore, the new legislation says that whatever the government calculation is as a percentage would be what they would pay under our proposal as well.

Chairman JOHNSON. So the cost would not be shifted from the government to the consumers.

Senator BREAUX. Yes. They would not have an increase in their participation.

Chairman JOHNSON. Thank you very much for your time and attention.

Senator BREAUX. It is always a pleasure to come to this side of the Capitol.

Chairman JOHNSON. Thank you.

I would like to call forward the panel. Stuart Altman, it is a pleasure to have you back, Stewart; Judith Feder, who has also come before us on other occasions; Walter Francis, the independent healthcare consultant from Virginia; and Jeff Lemieux, who is the senior economist at the Progressive Policy Institute.

We thank you all for joining us, and we will move through each of you making your opening statement and then we will open the whole panel for questions.

Dr. Altman.

STATEMENT OF STUART H. ALTMAN, PH.D., PROFESSOR, SCHNEIDER INSTITUTE FOR HEALTH POLICY, HELLER GRADUATE SCHOOL FOR SOCIAL POLICY, BRANDEIS UNIVERSITY, WALTHAM, MASSACHUSETTS

Dr. ALTMAN. Thank you, Madam Chairman.

I am Stuart Altman, and I am a professor of National Health Policy at Brandeis University. I really wanted to congratulate you on taking over the Chair.

I also would like to say hello to Congressman Stark who just left, but I did have the privilege of working under him for almost 12 years when I chaired the Prospective Payment Assessment Commission. So it is really good to be back before this Committee again.

You have my complete testimony, so what I would like to do is take my 5 minutes to focus on what I consider to be some of the major components of the debate.

As Mr. McDermott knows, he and I were members of the bipartisan Commission along with Senator Breaux, I was one of those members that ultimately voted no in terms of the plan. But I want to focus on why I voted no and why I think things have changed.

I voted no because I thought our Medicare program was in serious financial shape, and while I can't say that Medicare is not going to have financial difficulties in the future, it is in much better shape today and, therefore, solvency is much less of an issue.

Second, I really do believe, and still believe, that we should have a very important and very comprehensive prescription drug benefit; and I think Breaux–Frist II goes part way toward there, although there are a number of suggestions I would like to make to make it better.

What I would really like to focus on is what this discussion has been about: Why has Medicare+Choice not worked? I would like to offer my opinion. I came into government in 1971, actually in what was then HEW; and after being there a month I was asked by the President to be responsible for controlling health care costs. I used to be 6 foot 4, Mr. McDermott.

Mr. MCDERMOTT. Great job.

Dr. ALTMAN. My boss at that time was the current Vice President, and I became one of the most hated people in America. The AMA had a special issue of their publication that made me, you know, Big Brother, Public Enemy Number One.

What the essence of this is, is that whoever tries to constrain the system is not going to be liked by the system. Managed care has been beaten up because it was responsible for constraining the system. I will tell you, if we didn't have managed care after BBA, I don't think you would find a doctor, a hospital, or a home health agency that wasn't ready to kill the Federal government. So, yes, this is a game in which whoever is taking the food away from their kids is going to be the one that is going to get yelled at.

Now, let's look at Medicare+Choice. Mr. Stark, you and I have had very good times together; and I hope you will listen a little to what I have to say. I have been looking hard at Medicare+Choice, why it doesn't work, and I would like to offer to this Committee a little different perspective. We must create a true level playing

field between the Federal government and the running of its fee-for-service system and the Medicare+Choice program.

Now, I have heard the arguments about the administrative costs of Medicare+Choice plans, and complaints that too much profits are being made, and I am not here to defend them. However, I would submit to you that we have created a very unlevel playing field where it is impossible, over the long run for a private market to work. I am in the category, of those who believe that it is good for this country to have true competition between the private market and the public sector, and I think Breaux–Frist II goes a long way to do that.

But in answer to your question, Mrs. Thurman, the current situation is such a lopsided event that it is hard to see how it can work. Why is it lopsided? It is lopsided in the following ways: First of all, Medicare, through the government, can pick and choose the prices it wants to pay. It doesn't have to negotiate with a hospital or a doctor. It tells the hospital or doctor, or home health agency what it is going to pay. The Congress is the vehicle for that choice.

Ultimately, providers could say that they are not going to provide Medicare services, but it is very difficult for a hospital that has 50 percent of its patients in Medicare to say, I am not playing because you are not paying me enough. History suggests that when Medicare has been quite generous, as it has been in several periods like in the middle nineties, it turns out that the private insurance market can come in under that generosity and get better discounts as they have done, and they wind up saving money and a lot of people joined their plan. That was the period of time when Medicare+Choice prospered.

When you introduced BBA—and I am not arguing against BBA, but why did you introduce BBA? Because you looked at the growth rates in Medicare spending and you said Medicare is paying more than the private sector and the country can't sustain that. Well, Congress thought it was going to cut $115 billion over 5 years. As it turned out, some estimates suggest that the savings amount is going to be closer to $230 billion. Of course, what happened? What happened is that Medicare spending went way down. Then you asked the managed care industry to compete with Medicare. But the premiums they received were related to Medicare paid for services. But, they don't have the same power to reduce payments Medicare has. So they are now at a disadvantage.

If you want to make competition work, and I put it if—I happen to believe it is good for our country to have competition work, you have to level the playing field.

Several other things have happened as well. Medicare can decide what a cost is and what a cost isn't. Medicare goes into a hospital or doctor's office and says, this we will pay for and this cost we won't. Again, I am not arguing that you are not making the right decisions, but the private sector can't go in and say that. It can't say to a hospital administrator, we will only cover your salary up to $150,000. If you receive $200, it doesn't count. Can't do that. Can't refuse to want all of your depreciation. You can go on and on.

The point I want to make here is that if you want competition to work—and the reason why Medicare+Choice did not work, yes,

maybe managed care oversold itself—estimates of savings of 25 or 30 percent proved to be too ambitious. Maybe the savings are closer to 15 percent. But, then when you add higher administrative costs and the fact that Medicare is paying in many parts of the country 90 or 85 cents on the dollar, it becomes impossible for a private managed care plan to compete.

I provided a chart in the last part of my testimony that shows the relationship between what Medicare pays and what the private sector pays. When Medicare margins go down, private sector margins go up. In 1992, Medicare paid 90 cents on the dollar (payment to cost ratio). Private insurance paid 131 percent. As Medicare began to pay better during the nineties, private margins came down. You watch what happens over the next couple of years. You are going to see private payment rates go way up. Again, you can't compete if you don't level the playing field.

One last piece of that puzzle. Recently, Congress passed legislation that will create a 50–50 national-regional blend so that every area gets closer to the same amount of money. Now, I happen to be very sympathetic to Seattle and Minneapolis and Portland, Oregon, which have very good health care delivery systems. I also am very sympathetic to Boston and Miami and New York. What happens when you go to 50–50? How can a managed care company in a high cost area survive?

Let's say you are right, that, in fact, in certain parts of this country like Florida, there is just too much care being provided. The providers are getting too much money. People in Seattle complain all the time. So what are you going to do? You are not going to touch the fee-for-service system. You are going to continue to pay the higher amount. But the legislation will cut back what the managed care industry in high cost areas receive. How are these groups going to be able to purchase the needed medical care? Can they change the practice of medicine? That is not possible. If you want to change the practice of medicine in this country, start with the fee-for-service system. Don't start with the managed care companies who are only 15 percent of the market. Again, I believe in competition, level the playing field.

Now, with my remaining 2 minutes, I want to talk about prescription drugs. There is nothing more important. I think everyone on this Committee has said this thing. We need to cover prescription drugs.

My sense is, my preference is that prescription drugs be covered under both plans. I think it makes much more sense both economically and for health care that a health care delivery system provide prescription drugs and that it be provided under managed care and it be provided under fee-for-service. My preference is that it not be provided by private insurance separate from coverage for other medical care. However, I would make a couple of suggestions.

First of all, my preference is that the Federal government provide more than a 25 percent subsidy as suggested by Senator Breaux. I think the subsidy rate needs to be closer to 50 percent. Why? The actuaries tell us that such a subsidy rate will eliminate adverse selection.

My other preference is that we go to more catastrophic. We should use a $500 deductible and a 50 percent coinsurance. Our plans protect low income seniors, but not through Medicare.

I believe in a Social insurance model. I think if we are going to cover low income seniors we need to do it through either a Medicaid program or some State-run program. So my preference is that all of the subsidies for people under 135 percent of poverty—and, yes, they should not pay anything—should be through a State program with mandates on the States to provide coverage according to Federal rules supported by an enhanced Federal match as in SCHIP.

Finally, this program is the most important thing we can do. I would hate to see—and, unfortunately, we have done it all too often, whether it is with the uninsured or with parts of Medicare—we go only for each of our view of the optimum type of plan. I have given you my optimum, but if the only way we are going to pass a prescription drug benefit, given the differences in the Congress, is to have it covered by a fee-for-service run by private insurance, I say go for it. But I would recommend two caveats:

First of all, give it a 5 year trial period and see if it works. And, second, guarantee that in those areas where there is no private market the Medicare program run it so that no American, regardless of what part of the country they live in, would be denied prescription drug benefits.

Chairman JOHNSON. Thank you very much, Dr. Altman.

[The prepared statement of Dr. Altman follows:]

Statement of Stuart H. Altman, Ph.D., Professor of National Health Policy, Schneider Institute for Health Policy, Heller Graduate School for Social Policy, Brandeis University, Waltham, Massachusetts

Good morning, Madame Chairman. My name is Stuart Altman. I am a Professor of National Health Policy at the Heller Graduate School, Brandeis University. It is indeed a great pleasure for me to again appear before this committee. I would like to offer my congratulations to you on assuming its Chair. I would also like to say hello to Representative Stark, who was a gracious Chairman for most of the 12 years I appeared before the committee as Chairman of the Prospective Payment Assessment Commission.

The subject of today's hearing, Medicare Reform, is an issue of critical importance to all citizens of this country and to most providers of health care services. It is also a subject in which I have been deeply involved for more than 30 years. Perhaps because of this, President Clinton appointed me as a member of the Bipartisan Commission on the Future of Medicare.

Let me say at the outset of my testimony that I believe that Medicare has been one of the most important and successful programs ever created and administered by the federal government. It has allowed millions of Americans to receive much needed medical care with dignity, free from fear of financial hardship. It has helped finance the best health care delivery system in the world.

With that said, Medicare is not a program without problems. Its design is needlessly complicated for beneficiaries to understand, and its funding system does not guarantee long-term financial viability. The health care benefits it provides have not kept pace with the changing structure of our health care system, and at times, it has been excessively expensive for both beneficiaries and the federal government. Furthermore, it has not always used the most cost-effective techniques for purchasing health care services. I know this committee has worked hard over the years to improve the program, but more needs to be done.

Senator Breaux and Congressman Thomas, the Co-chairs of the Bipartisan Commission, developed a plan to fundamentally restructure Medicare by greatly expanding the role of private health plans. Although there was substantial support for their plan, it did not receive the necessary 11 votes to make it the official recommendation of the Bipartisan Commission. Despite my support for the basic component of this plan—creating a more market oriented system—I had a number of

problems that prevented me from supporting it. Any restructured system should include a comprehensive prescription drug benefit for all beneficiaries and a funding system that guarantees the long-term financial viability of the Medicare program. The plan discussed by Senator Breaux this morning (Breaux–Frist II) plus financial events since the conclusion of the Commission go far to easing several of my concerns. Nevertheless, I offer this committee a number of recommendations that I believe will strengthen the Breaux–Frist bill or any other plan that tries to create a more competitive Medicare program.

Since the ending of the Commission 2 years ago, other issues have surfaced that must be confronted by those of us who wish to reform Medicare by expanding the role of private insurance and introducing a more competitive system. That is, to develop a true level playing field between the traditional fee-for-service Medicare program and private health insurance plans.

Most Medicare reform plans, including the one introduced by Senators Breaux and Frist, assume the continued availability of a government administered fee-for-service Medicare program similar to the one currently in operation. Such proposals also encourage competition between that program and plans operated by private companies. I also believe that it is highly desirable to maintain effective competition between privately run health plans and the one operated by government. Such competition allows each system to learn from the other and offers beneficiaries the advantages of flexibility and choice. But, events of the last few years have convinced me that unless changes are made in the way Medicare reimburses health providers, expands and reduces benefits, and pays private health plans, it will not be possible to have a viable competitive market.

Construction of a level playing field is no simple matter. This complexity has been demonstrated in the experience of the Medicare+Choice program. Much has been written about the number of managed care plans that have reduced or ended their participation in Medicare+Choice. Critics of private managed care plans attribute the decline in participation to high administrative costs, profits, and the inability to effectively manage care. Evidence also suggests that many of the plans still in operation have benefited from the enrollment of healthier then average beneficiaries. While there is certainly some validity in these concerns, the critics overlook an important feature of the health care market that has helped generate the exodus of private plans—the playing field is currently far from level.

When Medicare Managed Care was first introduced in the early 1980s, it was assumed that private managed care plans could out-perform the existing fee-for-service Medicare program by 25 percent or more. Such an advantage would have been sufficient to cover the higher administrative costs necessary to enroll beneficiaries on a one-by-one basis. It would also have covered the cost of operating either for-profit or not-for-profit managed care systems. In addition, the projected efficiencies were expected to be large enough for the government to share in the savings by reimbursing at 95% of what it would have spent under the traditional program.

Much has changed since 1982. Medicare has introduced several major changes in the way it pays health providers. Many of the advantages of managed care have disappeared as the general practice of Medicine changed to incorporate some of the more obvious efficiencies (e.g., greater use of outpatient care and reduced inpatient admissions). Managed care plans have also been prevented from using a number of techniques, at least some of which have been shown to be medically appropriate, but proved to be very unpopular with patients and physicians. As a result the cost advantage between a reasonably efficient managed care plan and the current Medicare program has narrowed.

Each type of system has its own advantages and disadvantages in terms of controlling its costs. The annual increases in Medicare spending per beneficiary at times have grown substantially faster and at times slower than the cost growth of the privately insured. Medicare out-performed the private sector through much of the 1980s and early 1990s, but beginning in 1993 the trend reversed with private sector costs rising relatively more slowly. Medicare added greatly to its spending levels as a result of double digit growth in the use of its home health and long-term care services. Not surprisingly, it was during this period that we witnessed the greatest growth in enrollment in private Medicare managed care plans. Following passage of the Balanced Budget Act of 1997 (BBA), the trends reversed themselves again and current Medicare spending growth is considerably slower than growth in the private sector.

These changes in relative spending trends are not random. In part they reflect the introduction of new services or the greater use of existing benefits paid by Medicare. For example, the Court ordered expansion of Medicare home health and long-term care benefits. But for the most part they reflect differences in what Medicare and the private sectors pay for the same service. Only the government has the legal

right to unilaterally set the prices it pays to providers and to require them to accept such payments as a condition to participate in the program. At times Medicare payments have been quite generous, leading to higher Medicare spending and the ability of private plans to secure services at lower rates. That is what happened in the mid-1990s. But ultimately your committee and others in the federal government realized what had occurred and restructured provider payments and restricted the utilization of some benefits as part of the Balanced Budget Act of 1997 (BBA). Current estimates suggest that BBA could reduce Medicare spending by as much as $230 billion over 5 years—about double of what was originally estimated. I do not believe it is possible for a private market to function with such wide swings in relative spending levels. Particularly when the payments private plans receive are in some way tied to what health care providers receive from the Medicare program.

Hence, the government's ability to restructure prices and change the types and amounts of services it will pay for can enable Medicare to out-perform the private sector whenever it wishes. Were such actions a net benefit to society I would say, "so be it." But such savings are often illusory. What often happens is that health care providers attempt to make up for what they believe are government underpayments by charging higher prices to private patients and their insurers. Such private individuals or plans often lack the market power to stop such "cost shifting." Figure 1 shows how this has played out for hospital care. In 1992, when Medicare was paying only about 90 percent of hospital costs for the services its beneficiaries used, hospitals received 131 percent of their costs for the services they provided to private patients. As Medicare payments increased after 1992, the payment to cost ratio fell for the privately insured. In the last two years, following reductions in the rate of growth of Medicare payments imposed by BBA, private sector payments, including Medicare+Choice payments, have been under intense pressure to rise. While in some areas, Medicare+Choice plans have been strong enough to resist this pressure, most plans in most areas have not.

Hence, traditional Medicare has the power to drive the private market to pay higher prices and unbalance competition between the two sectors. Yet, savings from lower government payments are often not real because they are shifted to other payers. The manner in which government determines the prices it will pay also generates several other problems for a competitive market. First, the Medicare program in setting its payments does not recognize all of the costs incurred by health care providers. In many such situations health care providers engage in another form of cost shifting by attempting to recoup such costs from other payers.

Recently, a new and subtler issue has arisen in connection with the way Medicare+Choice plans are now reimbursed under the BBA. Since the establishment of Medicare in 1965, the federal government has been reluctant to intervene in how the medical community in a local area provides medical care. Even the Medicare utilization review systems put in place through the years relied for the most part on local standards of care. Medicare reimbursement policy for most health care services has also been based on regional factors. With the passage of BBA in 1997, a change occurred with respect to how Medicare+Choice plans were paid. Previous to BBA, plans were paid at a capitation rate equal to 95 percent of what was paid in that area for providing care to similar types of patients in the traditional Medicare program. Such a payment system resulted in some areas receiving capitated payments 45 percent or more above the national average and some areas 60 percent below the national average. Even such well-known medical areas as Seattle, Portland, Oregon, and Minneapolis received payments equal to only 83 percent of the national average. Why such differences? There are no definitive studies, but it seems likely that both cost-of-living differences and differences in physician practice patterns and patient utilization accounted for most of the variation in payments.

In the BBA, a system was developed to bring the capitated payment of all plans closer to the national average regardless of differences in regional spending under traditional Medicare. In the plan developed by the Bipartisan Commission, only cost-of-living differences were recognized in regional payments to private plans. But how are the plans in high cost regions going to pay for the more intense use of services in their area? It is unlikely that these plans will have sufficient enrollment or the political strength to force changes in the style of care in the provider or patient communities, particularly since the traditional Medicare plan will continue to pay for these extra services. The BBA called for a gradual phase-in toward paying all plans a 50–50 blend of local and national rates. If such a plan is included in any Medicare reform system, there will be few private plans that can survive in high-cost, medically intense areas. On the other hand, Medicare+Choice plans will be overpaid in low intensity areas. If Medicare wants to change the practice of medical care in either or both high cost and low cost areas it must first do so in the system it administers.

Medicare pricing below costs is not the only element against which private plans have difficulty competing. Medicare has significantly lower enrollment costs because all beneficiaries are automatically enrolled while private plans must market their services and enroll subscribers one person at a time.

To be sure, private plans also have many advantages. They can be more flexible and innovative, and they can better manage provider costs and patient utilization. They can be selective in which providers they use, and they have the potential to coordinate care in a more uniform and efficient manner. And, they can attempt to select healthier enrollees (an issue of some controversy) thereby retaining the same capitated revenue but lowering their expected costs. Recent history shows us that all of these advantages can help them compete with traditional Medicare. However, when Medicare is reimbursing below cost, is administratively efficient, and is paying private plans 95%, the playing field is too skewed and private plans, on average, simply cannot compete successfully.

Research conducted at the Schneider Institute for Health Policy at Brandeis University bears this out. We use the term "average payment rate" (APR) to represent an HMO's predicted capitation or payment rate and the term "adjusted community rate" (ACR) to represent the estimated cost of providing Medicare-covered services to beneficiaries. This study revealed that the plans that exited the Medicare+Choice market in 1998 had an APR-to-ACR ratio of 96%, indicating that, on average, costs exceeded payments. In contrast, HMOs that remained in the Medicare+Choice market had an APR-to-ACR ratio of 110%. Many plans simply could not overcome the totality of Medicare's inherent advantages detailed above.

The Brandeis study also suggested that lower payment rates as a result of the BBA were likely to have been a significant factor. A simulation showed that if payments to Medicare+Choice plans had remained on the 5-year trajectory that preceded the BBA, the probability of a plan exiting in 1999 would have been 22% less. Furthermore, if those plans had also been reimbursed at 100% of average Medicare costs rather than 95%, the predicted probability of exit in 1999 would have been lower by 43%.

Prior to the BBA, enrollment in Medicare+Choice plans was growing quite rapidly. However well intentioned, the magnitude of the spending reductions generated by BBA brought this growth to a halt and weakened the foundation of the competitive model that was being built. Many HMOs were forced to either sustain losses or exit the market. The number of plans still in operation will fall even further if the risk adjustment methodology specified by the BBA is implemented. While I would certainly support the inclusion of an appropriate "risk adjusted" premium were the playing field more balanced, in the current environment it could seriously erode the private Medicare market. Hence, I concur with the recommendations in Breaux–Frist II to limit the extent of the adjustment at least until the current system is restructured.

We now have an opportunity to re-build the weakened foundation of a private Medicare program. Such a solid foundation is critical for any competitive system that includes both private plans and a government operated program. With the hindsight of our experience and the benefit of research data, I recommend the following changes be implemented in the Medicare+Choice program prior to or in coordination with the restructuring of the entire Medicare program.

- Stabilize the Medicare reimbursement process to limit the wide swings in payment policy and set as a target that the traditional fee-for-service Medicare program will pay rates necessary to generate a 100 percent payment-to-cost ratio for all services covered under the program.
- Enact legislation to assure that if costs are deemed inappropriate for reimbursement from traditional Medicare or if utilization of covered benefits are changed, than private Medicare+Choice plans are also exempt from paying such costs or providing the reduced benefits.
- Increase the Medicare+Choice capitation payment to 100% of the average fee-for-service cost in that area for both the regional and national payment rates.
- Limit the blend of regional and national rates to 80% regional and 20% national.
- Phase in a limited risk-adjuster consistent with the recommendations in Breaux–Frist II, with the intention of implementing more strict risk-adjustment when a level competitive playing field exists.
- Restructure the enrollment process to reduce the high administrative costs imposed on private plans.

Such changes would go far to level the playing field and bring new, private Medicare+Choice plans back into the marketplace. This would establish a more solid foundation for a more extensive Medicare reform system. I fear that were we to leg-

islate major reform of the Medicare program before we fix the current system, we could seriously hamper the success of the new system.

Private plans have in the past and could again attract enrollees by offering lower premiums, reduced cost sharing, and/or additional services. In particular, such plans could offer more generous prescription drug benefits building on the plan outlined in the next section of my testimony.

Given a more level playing field and greater long-term stability in payments to both Medicare+Choice plans and providers under the traditional program, private firms can be expected to compete vigorously for this large and growing part of the population.

Assurance of Long-Term Financial Stability for the Program

One reason I could not support the plan put forth by the Bipartisan Commission is that it lacked sufficient provisions to ensure the long-term financial viability of the Medicare program. Fortunately, events of the last few years has made this less of an issue as the solvency of the Part A Trust Fund improved. Nevertheless, I want to put on the record that in my view any comprehensive Medicare Reform plan that is enacted should include provisions to ensure the financial viability of the program for at least the next 30 years. There are many ways of accomplishing this goal and time constraints prevent me from discussing this issue further today. I would be more than happy to again appear before this committee, Madam Chairman, should you wish or respond to questions today or in writing.

Provide Access to a Prescription Drug Benefit for All Americans

When the Medicare program was formulated in 1965, the capabilities of today's pharmaceuticals could barely be imagined. In 1960, the country spent less than $3 billion on prescription drugs compared to nearly $91 billion in 1998. Since 1990, national spending for prescription drugs has tripled and their share of total health expenditures increased from 5.6% in 1993 to 7.9% in 1998. Clearly, the composition of health care spending has changed significantly in this regard, but the Medicare program has not. With science on the threshold of a renaissance in biotechnology, the significance and the level of expenditure for prescription drugs is certain to increase even more.

Many beneficiaries have attempted to make up for the lack of outpatient prescription drug coverage in the basic Medicare benefit package by either relying on "wrap around" coverage from their previous employer or by purchasing Medigap coverage. Unfortunately, fewer and fewer employers now offer such coverage for retirees, and the skyrocketing costs for those Medigap plans that do offer drug coverage is prohibitive for many senior citizens. There is also ample evidence that individuals without prescription drug coverage use fewer drugs even when prescribed by their physicians. At the heart of the problem are the well-documented negative health consequences of not following prescribed drug treatment regimens. Thus, as we restructure Medicare for the 21st century, no issue is more important than expanding the basic benefits to include coverage for prescription drugs.

The difficulty of formulating a prescription drug program is that of reconciling a number of competing goals and principles that are important to various stakeholders. These basic goals and principles can be stated as follows:

- Retain the universal, non-means tested nature of the Medicare program while instituting a prescription drug program.
- Avoid, wherever possible, the cost and poor incentive structure that would result from first dollar coverage.
- Provide free or low cost access to pharmaceuticals for those who would otherwise find them unaffordable.

Medicare has always been a universal program with universal benefits and eligibility levels. Critical to the success of Medicare has been the inclusion of more generous benefits and reduced cost sharing through state-based programs to assist those seniors judged to be low income or medically needy. Maintaining this distinction protects the broad political support for Medicare. Hence, I recommend a structure in which Medicare will offer non first dollar insurance coverage on an optional basis to all beneficiaries, while those earning below 135% of the federal poverty level (FPL) will have access to free coverage through state programs supported by enhanced federal matching funds.

The Medicare portion of this prescription drug plan will include an optional subsidized drug benefit for all beneficiaries, regardless of income. The premium will be paid in a manner similar to present part-B payments, as recommended in Breaux–Frist II, but I recommend it be set at the actual cost minus a subsidy of ***50%***. I have selected a higher subsidy than Breaux–Frist II to minimize the amount of adverse selection while providing a meaningful benefit to middle class beneficiaries.

To keep the cost of the program acceptable and to maintain a cost-conscious and responsible role for patients in the types and amounts of drugs they purchase, I would set the annual deductible at $500 with a co-payment of 50%. There should also be complete stop-loss protection above $6,000.

Low-income people, below 135% of the federal poverty level (FPL), will have access to a state-based program that will cover the entire premium and all or most of the cost sharing. States will additionally be able to offer partial premium assistance for beneficiaries between 135% and 200% of the FPL. States will have limited discretion in their administration of these extra benefits in order to be eligible for an enhanced federal match. The match could be similar to the SCHIP program in which the current federal matching percentage is increased by 30% of the difference between 100% and the current federal matching percentage in each state. The enhanced match could be capped at 85%. Matching funds should include a reasonable amount for outreach and enrollment assistance, given the recent experience with SCHIP.

It is my preference that the Medicare drug benefit be delivered by the same plans that offer a comprehensive set of medical benefits, including the government operated plan, in order to best coordinate the medical needs of each patient. Separating the provision of pharmaceutical treatments from other kinds of medical treatments makes little sense from a cost effectiveness standpoint and can result in fragmented patient care. Delivery of the drug benefit by a broad based medical benefit plan could also result in lower prices by utilizing increased purchasing power and the ability to shift patients to similar types of effective alternative drugs. Furthermore, given the voluntary nature of the program, problems of adverse selection against private entities that might offer a "drug-only benefit" would be avoided.

Nevertheless, I recognize that other proposals, such as Breaux–Frist II, recommend that private companies deliver the prescription drug benefit for the government plan through a competitive bidding process in each geographical area. Such an option, although not my first preference, might be acceptable with the following caveats. First, such a program should be instituted on a five-year trial basis and be evaluated at the end of that period. Second, the Medicare program should deliver the prescription drug benefit in any area in which competitive bidding does not provide a suitable alternative. Although I prefer the first of these options, I would not hold hostage much needed reform in wont of one that might be arguably better.

On the federal side, a prescription drug benefit program of this nature would preserve the universality and popular support for Medicare. It would require sufficient cost sharing to avoid significant moral hazard, but sufficient subsidy to provide a strong incentive to enroll. Utilizing the part-B premium and payment structure already in place would not require a significantly greater administrative burden. Most importantly, it would foster competition between traditional Medicare and private plans and would enable all beneficiaries to benefit from competitive group purchasing arrangements.

On the state side, it could utilize the existing framework for pharmacy assistance programs that are already in place in 26 states. States will have some flexibility in designing programs best suited to their individual needs. Such programs may either be part of Medicaid or could be integrated with existing pharmacy programs. Being similar to existing Medicare buy-in programs such as QMB, SLMB, QI–1, and QI–2, it will not require a significantly greater administrative burden. Most importantly, it will provide totally free access to pharmaceuticals for those Americans whose income is less than 135% of the Federal Poverty Level.

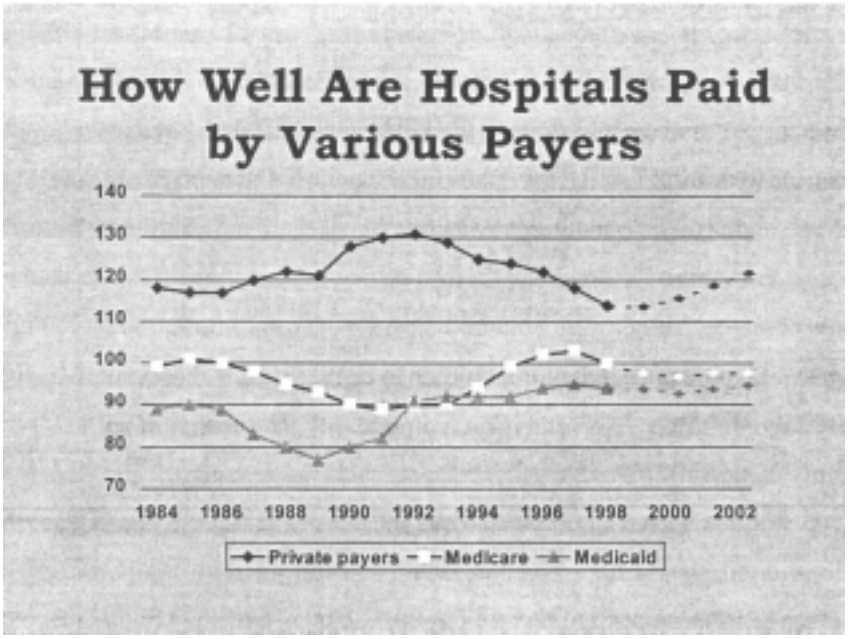
Conclusion

Reforming Medicare is a critically important and extremely complicated task. How it is structured, who pays for it, what it pays for, and how it pays medical providers, affects almost every American. I believe that a well designed competitive system that includes both private plans and a government-administered system can enhance the existing program. But creating such a structure is not easy and current history has taught us that design problems can seriously distort the end result. I have tried to explain some of the complicating issues that exist in our current system that must be changed if an effective competitive market is to work.

Among the changes I have suggested, one such change cannot wait—Medicare coverage of outpatient prescription drugs. No issue is more important! The design of such coverage I outlined in this testimony is just one approach for addressing the problem. Others have suggested alternative proposals. While I recognize that the differences in plan design are not small, such differences should not stop you from enacting a meaningful plan in this session of Congress.

Thank you, Madam Chairman, for letting me participate in this most important hearing.

FIGURE 1



Source: ProPac and Medpac through 1998. Projections are my own.

Chairman JOHNSON. Dr. Feder.

STATEMENT OF JUDITH FEDER, PROFESSOR AND DEAN OF POLICY STUDIES, GEORGETOWN UNIVERSITY

Dr. FEDER. Thank you, Chairman Johnson, for your gracious welcome. Congressman Stark, Members of the Committee, it is a pleasure to be with you this morning.

I want to begin by defining what I see as Medicare reform. That is that the goal should be to meet the health care needs of elderly and disabled Americans in a way that effectively manages taxpayer resources. The pursuit of reform in Medicare does not mean that Medicare is broken; it is not. Can we make it better? Absolutely. I want to pursue some of the areas in which we can improve it.

First and most clearly from your comments this morning, we all recognize that the primary challenge is to improve Medicare's benefits. Today, the question is not whether but how to cover prescription drugs for Medicare beneficiaries. Some proposals simply won't work. We can't just provide drug coverage for beneficiaries with low or modest incomes. That would ignore the fact that beneficiaries across the income scale experience chronic illness that requires substantial prescription drugs beyond what they are able to afford.

We can't just rely on HMOs and the private market. That would ignore our painful experience with Medicare+Choice, which I will come back to in a moment, a marketplace in which private plans and their benefits come and go. That is what competition is and it can leave beneficiaries in the lurch.

And we can't rely on a private, stand-alone drug insurance plan for beneficiaries in fee-for-service. That would not only be confusing to beneficiaries, but it would ignore the insurance industry's explicit warning about the inevitable risk selection. That will make it unworkable and ultimately unofferable.

A Medicare prescription drug benefit that works must satisfy three principles. First, the benefit must be a universal entitlement that is integral to the Medicare program in fee-for-service and in private plans. Essentially, beneficiaries ought to be able to get prescription drugs just the way they get hospital and physician care.

Second, the benefit must be affordable to all beneficiaries. And, as Stuart argued, that means significant subsidies across the income scale to make sure that we have universal participation along with universal entitlement, as well as full subsidies for those with low and modest incomes.

Third, the benefit must be specified and meaningful; perhaps not as extensive as some would like, but a defined minimum benefit that makes clear what Medicare will pay for in private plans and in fee-for-service, and that includes protection against catastrophic costs.

The second area needing improvement is in managing resources. Like all insurers, Medicare, the Nation's largest is struggling with the complexity of delivering today's health care. Some have proposed that Medicare approach that struggle by pressuring beneficiaries to move from fee-for-service into private HMOs, either by providing them extra benefits in those plans, as in Breaux–Frist II, or by requiring them essentially to pay more for the fee-for-service they now have, as in Breaux–Frist I. The strategy is pursued on grounds that HMOs can manage resources more effectively than Medicare fee-for-service. But it is by no means clear that they can, as Stuart's comments indicated. The fact is that fee-for-service is pretty good at controlling its costs and at balancing the needs of beneficiaries, providers and taxpayers.

HMOs do far more to manage costs than to manage care. That is what we have heard from some of HMO's strongest proponents. They may limit access to needed providers and needed services, and the structure of the market is to encourage them to enroll the healthy and disenroll the sick. That kind of risk selection and competition around it are very hard for any agency to control and have been a consistent problem in the Federal Employees Health Benefit Plan.

Lower costs, then, don't mean greater efficiency. They mean reduced access to quality care. HMOs' continued demands for more resources in Medicare+Choice reflect, I believe, and I believe the evidence shows, the plans' belief that they can only attract beneficiaries when they have resources to provide extra benefits. They are finding it very difficult to compete with Medicare or to be more efficient than the Medicare program. We also have evidence of quality problems for Medicare beneficiaries in HMOs, challenging

claims regarding these plans' ability to manage care efficiently and effectively.

Rather than promote HMOs, reform must address fee-for-service management, while managing HMO options for beneficiaries who want them. As you indicated, Mrs. Johnson, we need to do both.

On benefits and provider payment, that means that Congress must continue to balance the competing interests of beneficiaries, providers and plans, and taxpayers. There is essentially no way out of this responsibility. It means assuring the Medicare administrators greater investment in staff and systems and greater flexibility to use new tools like competitive pricing for equipment and care management for high-cost chronic illnesses. For HMO options, it means empowering the Medicare administrator to pay plans fairly, but not excessively, for Medicare benefits. Excess payments for extra benefits are wasteful, unfair, and unstable. The goal is to protect beneficiaries, not to protect plans.

Good management also means empowering the administrator to manage the whole program, to serve beneficiaries and taxpayers. Employers with self-funded plans and HMO options don't believe they have a conflict of interest in management. Their job is to manage the whole program, and Medicare would not be improved in its administration by creating new arrangements that make plans or pharmaceutical companies more comfortable with program administration. The responsibility is to beneficiaries and taxpayers.

The third and final area of improvement is to assure adequate financing. As we have indicated this morning, Medicare's financing problem is pretty straightforward. As the population ages and as health care costs rise, we will need more revenues to sustain and improve insurance protection for the Nation's elderly and disabled citizens. No magic, competitive or otherwise, can change this reality. But our economy can generate these revenues. The challenge is to secure them.

However, some proposals would weaken, not strengthen, revenues available to Medicare. For example, a proposal to claim the current part A surplus that you have worked hard to achieve to finance part B expenses, or new prescription drug benefits, would take resources away from future beneficiaries. And the proposal for new accounting that would only serve to cap part B's access to general revenues would create a crisis atmosphere promoting an overreaction, because a crisis simply does not exist.

What is needed instead is that we take advantage of our current prosperity to pay down the debt, thereby reducing interest costs, and begin to finance prescription drugs and other social needs. That way, baby boomers contribute now to the Nation's ability to finance their needs in the future. It would be ironic indeed to take the baby boom generation, my generation, off the hook with a tax cut, rather than expecting us to pay our share to make it easier to finance our needs in the future.

In sum, as we look to Medicare's future, it is critical that any action we take in the name of reform actually secure rather than undermine Medicare's strengths. The Medicare program has assured affordable access to mainstream medical care for elderly and a substantial number of disabled people, regardless of the severity of their health care needs, and with help for Medicaid, regardless of

their income. It is very easy to underestimate that accomplishment. It is easy to propose so-called solutions that actually undermine that accomplishment. Instead, the job of reform should be to sustain Medicare's enormous achievement, both now and in the future.

Thank you, Madam Chairman.

Chairman JOHNSON. Thank you very much, Dr. Feder.

[The prepared statement of Dr. Feder follows:]

Statement of Judith Feder, Ph.D., Professor and Dean of Policy Studies, Georgetown University

Chairman Johnson, Congressman Stark, distinguished subcommittee members, thank you for inviting me to discuss my views on Medicare reform. As we all know, the Medicare program faces a number of challenges, particularly as we approach the aging of the baby boom generation. None of these challenges is new. But the good news it that our recent prosperity, which has allowed us to balance the budget, gives us the opportunity to address Medicare's challenges effectively.

In addressing these challenges, our goal must be to meet the health care needs of elderly and disabled Americans in a way that effectively manages taxpayer resources. Pursuit of this goal should not imply that Medicare is broken; on the contrary, it continues to be an enormously successful program that can and should be improved. Efforts to reform Medicare must therefore secure, not undermine, the nation's commitment to health care security for elderly and disabled people.

Since its enactment in 1965, Medicare (with some help from Medicaid for low-income beneficiaries) has succeeded in assuring affordable access to "mainstream" medical care for virtually all seniors and a substantial number of people with disabilities. Medicare has historically been more successful than the private sector in controlling health care costs, while dealing with all segments of the population, all providers and all parts of the country. Nevertheless, Medicare needs improvements—specifically in the adequacy of its benefits, the effectiveness of its resource management, and the security of its financing for an aging population.

Assuring Adequate Benefits

In today's environment, Medicare's benefit package hardly can be considered generous. Four out of five employer plans have more generous benefits, and, on average, beneficiaries spend 20 percent of income out-of-pocket on premiums, cost-sharing and services Medicare does not cover. These substantial financial burdens reflect, in part, the absence in Medicare of a number of features common to employer-sponsored health insurance for the working-aged population: protection against excessive cost-sharing, adequate preventive benefits, and—particularly important to elderly and disabled people—meaningful coverage for outpatient prescription drugs.

Increasingly, advances in medical treatment take the form of new prescription drugs that improve health outcomes, replace surgical treatments and provide therapies for conditions that were once untreatable. Medicare beneficiaries use prescription drugs at a rate that far exceeds the non-Medicare population but are much less likely to have drug coverage than are the younger, healthier population with employer-sponsored health insurance. More than one observer has noted the similarities between the current state of drug coverage for the Medicare population and the inadequate health insurance available to the elderly before Medicare was enacted. Thirty-five years ago, many elderly people were denied the benefits of medical advances—represented then, primarily, by technological breakthroughs in hospital care—because of lack of insurance. While about half the elderly population then had some form of hospital insurance, the rest either could not afford insurance or did not have access to it.

As was the case with hospital insurance in 1965, today's Medicare beneficiaries cannot count on affordable access to meaningful coverage for prescription drugs. Medicaid prescription benefits are available only to the poorest beneficiaries; employer-sponsored retiree coverage is reaching fewer retirees; Medicare+Choice plans provide very limited benefits; and Medigap policies are not comprehensive and may not even be available, let alone affordable, to beneficiaries who need prescription drugs.

It is generally recognized that the private marketplace cannot and will not address the problem of limited access to affordable coverage for prescription drugs. Concerns about adverse selection and affordability render a purely private solution unworkable. Members on both sides of the aisle have recognized the need for a public program that includes significant publicly-financed subsidies to address the problems raised by purely private approaches.

Some proposals that purport to address the prescription drug problem fall woefully short. For example, proposals to extend protection only to people with low and modest incomes ignore the fact that access and affordability problems extend well up the income scale. Over half the Medicare beneficiaries without drug coverage have incomes above 150% of the federal poverty line. Chronic illness that entails extensive use of prescription drugs affects beneficiaries at all income levels and can absorb a substantial share of income. For people with incomes just above 150% of the federal poverty level, for example, the highest drug users without coverage devote, on average, around 12 percent of income to out-of-pocket drug expenses.

Proposals that rely entirely on HMOs and other private plans to deliver prescription drug benefits ignore the maldistribution of private options and the instability that has plagued the Medicare+Choice program in recent years. Reliance on private plans will leave beneficiaries with tremendous uncertainty as to what plan or what benefits will be available at any given time.

Proposals that extend prescription drug coverage to beneficiaries in traditional fee-for-service only through a stand-alone private insurance arrangement rather than integrating new benefits into the established fee-for-service structure are complicated and problematic. Under such arrangements, fee-for-service beneficiaries with Medigap coverage would be forced to purchase two separate private plans—an arrangement that is not only inconvenient to beneficiaries but could push them into HMOs just to avoid the hassle. Even more important, the proposal ignores the insurance industry's explicit warning that such a benefit is unworkable and, ultimately, unofferable. Rather than assisting beneficiaries, this proposal seems aimed at assuaging pharmaceutical manufacturers who would prefer to bargain with a bevy of smaller private plans than with a public program.

Medicare reform to effectively assure prescription drug coverage must therefore satisfy the following principles:

First, the benefit must be incorporated in Medicare as a universal entitlement for all beneficiaries. Just as Medicare beneficiaries are entitled to benefits for hospital and physician care—in the traditional fee-for-service plan as well as in any private plans—they should be entitled to benefits for prescription drugs.

Second, the benefit must be affordable for all beneficiaries. That means significant subsidies to individuals across the income scale (as now occurs in Part B)—alongside full subsidies to the low and modest income population—to assure close to universal participation alongside universal entitlement.

Third, the benefit must be specified and meaningful for all beneficiaries. All beneficiaries must be assured a minimum defined benefit. A Medicare prescription drug benefit may not provide coverage as full as beneficiaries currently receive for physician and hospital care. And, as described below, the challenge of assuring beneficiaries access to extra benefits will continue to exist. But meaningful protection must include coverage against catastrophic expenses. Meaningful protection also requires a benefit that makes clear what Medicare will pay for, whether in traditional fee-for-service or in a private plan, with sufficient oversight to protect beneficiaries against arbitrary and hidden benefit restrictions. Approaches that permit private plans to offer "actuarially equivalent benefits" raise the specter of risk selection, especially when proposals delay the implementation of risk adjustment for an extended period of time.

Assuring Effective Resource Management

Medicare is the largest health insurance organization in the nation. All health insurance organizations are struggling with the complexity of delivering health care in today's marketplace—assuring value for the dollar, providing people with information about their health care options, promoting quality and keeping up with rapidly changing technology. Contrary to some assertions, Medicare has historically been extremely effective, relative to the private sector, in managing the price it pays for services (especially for hospital and physician care). Payment strategies pioneered by Medicare (e.g., DRGs; RBRVS) have been widely incorporated by private payers. Similarly, Medicare has always administered its benefits at very low costs.

Nevertheless, Medicare's challenges in effectively managing resources are formidable. Medicare faces responsibilities that other payers do not—most importantly, for a growing elderly population with significant health care needs. In addition Medicare, unlike private insurers, is charged with specific responsibilities for securing the health care system—for example, financing graduate medical education and stabilizing services in rural and other underserved communities. Finally, the Medicare administrator's resources, flexibility and authority to manage the program are not on a par with private purchasers' and have not kept pace with the program's growing obligations.

Specifically, the Medicare administrator has not been provided sufficient funds, staff or management tools to effectively monitor the private contractors who pay claims; to collect, manage and provide information to consumers and providers; to respond effectively to beneficiaries' concerns, questions, and problems; and to deal effectively with HMOs and other private health plans.

Critics of Medicare's resource management have proposed to address these problems in several ways. Some proposals would pressure beneficiaries to move from traditional fee-for-service into private HMOs, either by increasing premiums in the traditional fee-for-service program or by subsidizing benefits in private HMOs that are not available to beneficiaries in fee-for-service. Proposals also have been offered that would create a new administrative structure to oversee HMOs and private drug plans, without adequately addressing the administrative needs of fee-for-service. These so-called "solutions" rest on questionable assumptions and pose significant risks.

Expectations that competition among HMO options will save Medicare money rest on forcing beneficiaries to pay the difference between the costs of fee-for-service and HMOs. Savings from these proposals are more likely to result from raising premiums for beneficiaries that remain in traditional fee-for-service Medicare than from lower program costs from beneficiaries shifting into cheaper HMO options. At the same time, this structure poses high risks for beneficiaries.

HMOs can keep their costs relatively low in a variety of ways: by constraining access to providers and services, by slowing the diffusion of higher cost, new technologies and by selective enrollment or disenrollment of patients likely to need care. In these circumstances, the costs to Medicare of having beneficiaries in HMOs may be lower, but the value of Medicare to its beneficiaries may be similarly diminished. In other words, pressuring beneficiaries into HMOs protects the federal government against financial risk by shifting financial and other risks to beneficiaries and their families. Further, because access to and quality of HMOs varies considerably around the country, building a system on HMO options is fundamentally unfair to beneficiaries in rural and other underserved areas. These beneficiaries are likely to face higher costs for the traditional fee-for-service benefit, with few alternative ways to receive care.

Uncertainty about the ability and willingness of HMOs to truly manage care for an elderly and disabled population calls into question proposals to rely on these plans to provide beneficiaries adequate access to quality care. HMOs' continuing demands for more resources from Medicare, when payments are at least adequate for Medicare-covered service, challenge claims regarding these plans' ability to efficiently and effectively manage resources. Research findings of limited service and poor outcomes for beneficiaries with chronic conditions in HMOs, compared to beneficiaries in fee-for-service, reveal the risks beneficiaries face in such plans.

The wisdom of pressuring elderly and disabled beneficiaries into HMOs and other private health plans seems particularly questionable, given recent experience among the working-aged population. Proponents of managed care and managed competition for the working-aged population have been very disappointed with private plans' focus on managing costs rather than managing care. And the working-aged population has been not only dissatisfied but angry at the abrupt shift of employer-sponsored coverage away from fee-for-service toward managed care; hence the attention to better patient protections. This experience should give serious pause to the assumption that coercing people into HMO or other private delivery systems is an appropriate strategy for Medicare.

Finally, some proponents of managed care and private delivery have accused the Medicare program of a conflict of interest in overseeing private HMOs. This accusation ignores the fact that Medicare's management of both HMO options and traditional fee-for-service resembles many employers' management of self-funded plans alongside HMO offerings. Centralized management rests on the appropriate premise that an administrator's primary job is to serve beneficiaries, not to accommodate private plans.

To assure adequate health insurance protection with efficient management of taxpayer dollars, Medicare reform cannot, then, simply promote competition among HMOs and other private plans or management changes that favor those plans. Rather, reform must secure effective management of the traditional fee-for-service program, while paying appropriately for HMO options for beneficiaries who want them.

Efficient management of traditional fee-for-service Medicare requires the continued balancing of the competing interests of beneficiaries, health care providers and plans, and taxpayers. Over the years, this balancing process has enabled Medicare to effectively control growth in its payments to providers, without endangering access to or quality of care. Medicare policies on whether and how much to pay for

health care services have a profound effect not only on beneficiary access to care, but also on the economic well-being of providers and their ability to fulfill broader societal missions. For the foreseeable future, the vast majority of beneficiaries will remain in the fee-for-service program, and it is crucial that the administrator have sufficient resources to direct the program in a way that responds adequately to these competing interests.

Further, the administrator must be provided greater resources for effective management and investment in systems for claims payment, information technology, and responsiveness to consumers and providers. The administrator should have the flexibility and authority to use new tools to promote efficient purchasing—like competitive pricing to pay for durable medical equipment and care management for high cost chronic illnesses. Denying Medicare the resources and authority to manage fee-for-service well means starving the system that has most effectively assured beneficiaries access to quality care.

Efficient management of HMO options requires empowering the administrator to pay fairly but not excessively for Medicare-covered services. Experience indicates that Medicare beneficiaries are reluctant to enroll in HMOs unless plans offer substantial benefits at little or no additional premium. Historically, Medicare has overpaid HMOs for Medicare-covered benefits, effectively subsidizing extra benefits. Payment constraints in the Balanced Budget Act of 1997—both in traditional fee-for-service and in managed care plans—reduced those subsidies, HMOs' ability to offer extra benefits at little or no charge and, accordingly, HMOs' willingness to participate in Medicare. Subsequently, Congress increased the subsidies, but it is by no means clear that greater subsidies will be used to support added benefits.

Excessive subsidies—which favor beneficiaries in some areas at the expense of beneficiaries in other areas who go without adequate protection—are an unstable, unfair, and wasteful approach to assuring HMO options. Indeed, this approach protects HMOs, not beneficiaries. Effective Medicare reform means paying plans appropriately for Medicare-covered services where market conditions allow them to operate efficiently; including explicit payment (not hidden subsidies) for benefits, like prescription drugs, that all beneficiaries must have, and recognizing that HMO options, not HMO promotion, should be the goal of Medicare reform.

Finally, the goal of Medicare administration should be to better serve beneficiaries and taxpayers, not to create new administrative arrangements to make private HMOs and private pharmaceutical plans more comfortable with program administration. Proposals to create separate administrative structures, outside the administrator's authority, reduce the administrator's capacity to manage the overall program responsibly and elevate accountability to the industry over accountability to beneficiaries and the public. Such measures would undermine, not improve, Medicare operations.

Assuring Adequate Financing

Medicare's financing problem is relatively straightforward. At some point in the foreseeable future, the revenues Medicare relies upon will become insufficient to cover its expenses. Specifically, the payroll tax will fall short of fully covering Medicare's liabilities for care under Part A. The shortfall reflects two factors. First, health care costs (not just for Medicare but for the system as a whole) rise faster than payroll. Second, as members of the baby boom generation turn age 65 and become eligible for Medicare, the number of people who depend upon the payroll tax will grow much faster than the number of workers who pay it. In 1970, there were 3.7 workers for each beneficiary; in 2015, there will be fewer than 3 workers per beneficiary and by 2030, about 2. Even for Part B of Medicare, for which spending is not financed by revenue from a dedicated tax, growth in health care costs per capita and in the number of beneficiaries implies that Medicare's current protections will absorb a greater share of general revenues than they do today.

Recent policy actions have substantially slowed growth in Medicare spending and, in combination with the revenues generated by economic growth, delayed the point at which payroll tax revenues are insufficient to cover Part A expenses. Today, estimates are that the surplus in the Part A Hospital Insurance Trust Fund runs out in 2025; as recently as 1997, the estimated date was 2001. On the expenditure side, this experience shows that even a one-time reduction in spending—as occurred in the Balanced Budget Act of 1997—dramatically reduces cost projections for the future.

The lesson from recent experience is not that Medicare has no long-term financing problem; it does. Rather, the lesson is that balancing revenues and expenditures is a problem, not a crisis, and that the problem is both less predictable and more manageable than is sometimes assumed.

Unfortunately, some proposals for changes in Medicare rest on the assumption that future Medicare financing problems can be addressed simply by slowing expenditure growth. If the goal of Medicare reform is to meet the health care needs of the elderly, it is essential to recognize that we cannot maintain benefits and cut spending sufficiently to cover future costs. A recent report from a bipartisan panel of experts convened by the National Academy of Social Insurance (on which I participated) concluded that even with continued growth in the economy and cost containment of various kinds (including promotion of HMOs), Medicare will still require significant additional revenues to assure baby boomers the type of coverage current beneficiaries receive.

Making those revenues available is not beyond the capacity of our economy or our society. Economic growth at historical levels is sufficient to generate the resources necessary to meet future needs, without sacrificing standard of living for the younger population. And just as society made the resources available to educate the baby boom generation, it can make the resources available to assure that generation and future generations affordable health care.

Rather than recognize these facts and begin to address future revenue needs, some proposals have actually moved away from securing revenues. One proposal has been to claim the current surplus in Part A to finance Part B services that Medicare now covers or to finance a new prescription drug benefit. Such a proposal ignores Medicare's legitimate and continuing need for general revenues and creates a crisis atmosphere that may lead to far more dramatic action than is really required.

Another proposed "solution" to the financing problem is to make Part B funding look more like funding for Part A, by specifying some share of GDP as a ceiling on overall program expenditures. Although some proponents of this approach characterize it simply as creating an "indicator" of revenue needs, policy change is not required to provide such an indicator. The Medicare trustees already include this measure of revenue need in their annual reports.

The aim of this proposal therefore seems to be to move toward replacing Part B's historical access to general revenues as program needs require with a fixed amount of revenue, regardless of program needs. Such a cap simply limits federal spending; it takes no action to assure adequate support for health insurance for elderly and disabled people.

With respect to both proposals, it is not at all clear why it would be justifiable to limit Medicare's access to general revenues when other commitments—to tax exemptions for employer-paid health insurance premiums or pensions benefits—remain open-ended entitlements. Indeed, it is hard to regard this approach or other spending reductions as Medicare "reform"; rather, they represent an abdication of the nation's promises to provide seniors and people with disabilities adequate health insurance protection.

What's needed instead is a wise use of current resources to facilitate future financing of health insurance for seniors and people with disabilities. Specifically, we should take advantage of our current prosperity to buy down the debt and begin to finance prescription drugs and other social needs. Using current revenues to buy down debt reduces interest costs, thereby freeing up resources we will need to meet future health care needs. It would be ironic if instead we cut taxes that baby boomers are now paying—thereby reducing their obligation to contribute to the debt reduction that can help the nation more easily support their future needs.

Conclusion

In sum, as we look to Medicare's future, it is critical that any action we take in the name of reform actually secure, rather than undermine, Medicare's strengths. The Medicare program has assured affordable access to mainstream medical care for elderly and a substantial number of disabled people, regardless of the severity of their health care needs and—with help from Medicaid—regardless of their income.

Unfortunately, it is easy to underestimate the importance of this accomplishment and to put Medicare's achievements—and its protections to beneficiaries—at considerable risk. No financial "crisis" requires such action; no evidence of a superior approach justifies a departure from the means we have relied upon to achieve such success. We must therefore be wary of proposals that, in the guise of reform, risk dismantling what is probably the most successful part of the nation's health care system.

Our current prosperity gives us the opportunity and the wherewithal to strengthen Medicare's ability to provide elderly and disabled people health insurance protection, while effectively managing the taxpayers' resources—specifically, by incorporating into Medicare a meaningful prescription drug benefit, by enhancing the administrator's ability to effectively manage Medicare's resources (including payments

to private plans), and by using current surpluses to reduce interest costs and facilitate the financing of future needs. These are the kinds of reforms that will best serve the Medicare beneficiaries and the taxpayers to whom the program has been and must remain fully accountable.

Chairman JOHNSON. The Committee may have noticed that I have let each of the first two witnesses go beyond their 5 minutes. You each ended up taking 10 minutes, and I will allow the same latitude to the following witnesses. I do think it is important that when you put preparation in to come to talk to us about such a big and important issue that you have time to speak, even if it reduces our time for questioning. So I did it intentionally.

Mr. Francis.

STATEMENT OF WALTON J. FRANCIS, AUTHOR AND INDEPENDENT HEALTHCARE CONSULTANT, FAIRFAX, VIRGINIA

Mr. FRANCIS. I will try to do better.

Congratulations, Madam Chair, on your assumption of the leadership of this Committee. I think it is in very good hands.

I also want to mention that at a conservative think tank conference on Medicare reform a couple of months ago I mentioned that, in the new Congress, it looked to me pretty clearly that nothing was going to happen on Medicare reform that Mr. Stark and Mr. McDermott, for example—I named them—did not buy into. That was met with groans and moans but, you know, you are going to have to craft something that is going to work, that is going to make the Members on both sides of the aisle not hold their nose.

Chairman JOHNSON. I may not be able to satisfy all Members on both sides of the aisle.

Mr. FRANCIS. Perhaps not all.

Chairman JOHNSON. You may have noticed the range of opinion on this Committee is 180 degrees.

Mr. FRANCIS. But I think you will find there is some middle ground here that will work.

To summarize a few key points from my testimony, writing hurriedly last weekend I lost two very important points I think in the details toward the end that I want to emphasize. First, what we are embarked on here is improving a vital program, and I think that is the way this needs to be perceived. Whether you do go to something very close to Breaux–Frist I or II or you do something a little different, I think that is what it is all about. We can improve Medicare and include making the program actuarially sound in the long run to the extent possible. But we should not be kidding ourselves about how much we can do in one set of reforms. In any event, I think the whole debate and discussion ought to be starting from that premise.

Second, I have said a fair number of harsh words about the Health Care Financing Administration, and I am going to say some more in just a second, but I do want to emphasize that I worked with people in that agency for many years. Many of them are good friends of mine. It is full of able and dedicated civil servants. I think, unfortunately, the whole is much less than the sum of its parts; and it is a big problem in what is going on. I would add to

that, I think the Congress is a big problem in a whole raft of ways, several of which have been mentioned, I think quite eloquently, by Senator Breaux.

I think that perhaps the single most important thing to achieve—and I will assume we are going to be fiscally sound and so on—is to establish the Federal government as a reliable business partner with private health insurance plans; and that is a tall order. Harry Cain wrote a wonderful article in Health Affairs 2 years ago called "How to Make an Elephant Fly" in discussing and adopting the FEHBP model for Medicare, and he didn't think it could be done. I am not at all sure it can be done, but this means less micromanagement; less frequent changes in the annual OBRA, COBRA, et cetera; less endless tinkering; fewer surprises that turn out to make it impossible to do business; and fewer executive decisions, many of which are on their own terms reasonable but which could have the cumulative effect of virtually wiping out Medicare+Choice in half the country.

In this regard, when I wrote my testimony last weekend I noted that Secretary Thompson had not acted on the midnight regulations. He now has, and I congratulate him for putting the midnight regulation that imposed Medicare HMO rules on Medicaid HMOs on the table for in-depth scrutiny. I am delighted. I just hope he also adds to that the underlying Medicare+Choice rules which are an abomination, in my view.

I think it is obvious that adding a prescription drug benefit available to every senior, which means adding it to traditional Medicare as well as in the context of a reform program, is vital for any number of reasons, one of which, though, is to provide the lubricating oil to make reform work. I hope you can construct—and you had several suggestions and there will be others—a drug package that will make some otherwise unpalatable changes go down a little easier.

In this regard, I cannot overemphasize how important I think it is to preserve, in a general way, the pricing and reimbursement of drugs in this country and not move toward a system of administered prices similar to that used in Medicaid. I studied that in some depth a dozen years ago and was appalled at the system they used. It was clearly inefficient, unworkable and kind of silly; and it hasn't gotten any better in recent years.

Two final points. I testified before this Subcommittee almost exactly two years ago on the subject of consumer information on health plans in Medicare. I castigated HCFA for its dismal performance, both in its printed materials and its electronic materials on the Internet.

Speaking as someone who is a very successful purveyor of information comparing health plans, and in my perspective also as the previous co-webmaster at HHS, I know a lot about what can be done and how it can be done. And they were doing an awful job, including making a website available that most people on most computers couldn't even read the information or download it. HCFA was requiring equipment that most people didn't have and software that most people didn't have.

Well, I revisited their website and their print materials before coming here today and I want to tell you that, though they have

greatly improved the website in many respects, it still fundamentally fails in its most central purpose, which is to make it easy for consumers to get important, comparative plan information.

This clock says I have lots of time left. That is going the other way now.

Chairman JOHNSON. In comparison to the other speakers, you have about 3, 4 minutes left.

Mr. FRANCIS. I will not belabor you with the details, but it may take three dozen or more mouse clicks to get the information on one health plan off that website, and that is just unacceptable. It is absolutely unacceptable.

Like Senator Breaux, I brought the FEHBP Consumer "Guide." It is 55 pages in 2001. It includes detailed but summary benefit information on 300 health plans across the country. I brought with me "Medicare & You," 2001 version. It is about 85 pages, 17 of which appear to give details on health plans, but the format is so verbose, if you will, that there is hardly any actual information included. It is unbelievable, but true, that you cannot in this 85-page book find out what the prescription drug benefits are for any of the dozen local HMOs in the four States that it covers. This particular one covers Delaware, Maryland, D.C. and Virginia. The one set of facts seniors most want to know, what is the drug maximum, what are the drug copays, are left out of this book.

Let me stop there, and I will be glad to answer any questions.

Chairman JOHNSON. Thank you very much. We do have five consecutive votes, so we are going to give Mr. Lemieux equal time. Frankly, I think our time was better spent listening to your thoughts, since you have long had very good experience, than a long question period. We will have maybe a couple of minutes for questions.

[The prepared statement of Mr. Francis follows:]

Statement of Walton Francis, Independent Healthcare Consultant, Fairfax, Virginia

Madam Chairman and Members of the Subcommittee, I am honored to be invited to testify on Medicare reform. My experience in providing health insurance information to consumers, in regulatory reform, and in analyzing the Federal Employees Health Benefits Program and Medicare as health insurance systems, all contribute to my views on this vital issue.

Over twenty years ago I conceived the idea of providing Federal employees and annuitants with information on the costs, benefits, and customer service of 50 or so health insurance plans then participating in the Federal Employees Health Benefits Program (FEHBP). As a private author, I worked with the Washington Center for the Study of Services (usually called CHECKBOOK); a non-profit organization dedicated to providing objective consumer information, on developing the most useful possible publication for participants in the FEHBP. To date, we have sold well over one half million copies of *CHECKBOOK's Guide to Health Insurance for Federal Employees* and have saved both the Federal government and program participants billions of dollars by encouraging the choice of more cost-effective plans. We cover some 300 plans across the entire nation, with comparative information on cost, coverage, and quality.

For many years I served as the chief regulatory review official in the Department of Health and Human Services (HHS). I led efforts to comply with laws and executive orders requiring that proposed regulations achieve their objectives while minimizing unnecessary burden on the public. I am just completing, in collaboration with the CONSAD Research Corporation of Pittsburgh, a study for the Chief Counsel for Advocacy of the Small Business Administration entitled *An Evaluation of Compliance with the Regulatory Flexibility Act by Federal Agencies*.

Because of my FEHBP expertise, I have been asked several times to analyze it as a model for Medicare reform. My most recent publication on this topic was "The FEHBP as a Model for Reform" (in *Medicare in the Twenty-First Century*, edited by Robert B. Helms, 1999). My general conclusion has been best stated by Harry Cain of Blue Cross: "The FEHBP has outperformed Medicare every which way—in containment of costs, both to consumers and to the government, in benefit . . . Innovation and modernization, and in consumer satisfaction" (from "Moving Medicare to the FEHBP Model, or How to Make an Elephant Fly," in *Health Affairs*, July–August 1999).

It is from these perspectives that I provide my views on reform options and reform implementation. I believe that if, as Senator Breaux and Chairman Thomas have proposed, Medicare can be transformed to a system looking much more like the FEHBP, then the financial viability of the program can be extended and its inadequate benefits can be improved. However, there are numerous issues and problems that need to be addressed to make this happen and to make it work well. Experience with Medicare reform to date is not encouraging.

I think that there are several essential issues—some interrelated—that need careful attention. These are:

- consumer information dissemination,
- using competition rather than price controls or administered prices to control costs,
- creating structural reforms that remove most incentives for political micromanagement,
- actuarial rather than enumerative approach to guaranteeing benefit levels,
- regulatory reform,
- avoiding paralysis by analysis,
- organization and management reform, and
- semantic reform and reining in the rhetoric.

Consumer Information Dissemination

Two years ago I testified before this Subcommittee on the provision of consumer information in Medicare. At that time HCFA had two main methods of providing information to help consumers choose among Medicare+Choice Plans. First, it had a summary pamphlet comparing plans entitled *Medicare & You*. Second, it had a World Wide Web site called "Medicare Compare." A third key "leg" of essential consumer information, detailed, current, and plain English brochures in a common format from each participating health plan, was not required by HCFA and did not exist.

In my testimony in 1999, I castigated both of the existing legs, and noted the vital necessity of the missing leg.

I criticized the pamphlet for containing only 5 pages of comparative plan information out of 42 pages, while containing 4 pages devoted simply to telephone numbers of government agencies. In contrast, the comparable OPM Guide contained 42 pages of comparative plan information out of 60 pages.

I characterized Medicare Compare as the "Web site from Hell." It required a level of computer and browser power that the great majority of Web-using seniors did not have. Graphical information that was claimed to be on the Web site did not register with Netscape browsers at all. Legally required disenrollment data was not available. Plan information was bloated in verbiage and extremely difficult to use to compare plans because it avoided "Yes/No" or other simple comparisons.

Worst of all, it was an act of extreme masochism to attempt to download summary plan-specific information. It took 62 printed pages to download the information on just one health plan, information that could have been presented in 2 typewritten pages. It took 10 minutes and 72 mouse clicks just to find the pages to tell the computer to download and print the information on just that plan. (HCFA staff later told me that they disagreed: it took "only 50" mouse clicks to get the information on one plan.)

Unbelievably, the only copy of *Medicare & You* on the Web site in 1999 was one that contained NO comparative plan information, not even the measly 5 pages of summary information that had been mailed out to seniors.

That spring, HCFA staff briefed then Under Secretary Kevin Thurm on the status of their consumer information efforts, and provided him a rebuttal of my testimony. Among other things, they told him that:

- "feedback has been overwhelmingly positive" on their unusable Web site (obviously impossible unless the testing did not include actual efforts to obtain comparative information on plans in an area),
- that their site was accessible to the blind (which it was not because it relied heavily on PDF files—a problem that was illegal then and illegal today),

- that their consumer research showed that their population prefers the unnecessary verbiage that even I, an expert interpreter of health plans, can barely decipher,
- that *Medicare & You* was available on the Web (versions including the comparative plan information which is the main purpose of the publication were not in fact available),
- that it was acceptable that America On Line users could not use their site because only 20 percent of the site visits come from AOL users, and that
- HCFA had minimized the number of clicks to the extent allowed by current technology. (In contrast, the OPM Web site to which I compared the HCFA site allowed all information on any health plan to be downloaded with 3 mouse clicks).

In my testimony I had cited several excellent GAO reports that showed how HCFA could improve consumer information. Subsequently, GAO produced one more, focusing on plan-specific brochures (*Medicare+Choice: New Standards Could Improve Accuracy and Usefulness of Plan Literature*).

I dwell on these details because they are vital to understanding the problems facing Medicare+Choice and any even more far-reaching reform proposal. The fundamental engine driving the success of the FEHBP model or any close cousin is consumer choice. Choice depends on easily accessible and comprehensible information comparing plans.

Since 1999, HCFA has improved its Web site. The graphics information now displays on a majority of browsers in use. Disenrollment information is available. Printing works better. However, it still relies heavily on programming tricks, visual displays, and PDF files that make it effectively and illegally unusable by the blind. Plan benefit details are somewhat standardized, but still presented in far too many words and in ways too complicated to facilitate comparisons. Few high school dropouts would be able to understand the HCFA Web site.

Most frustratingly, it still requires many dozens of mouse clicks to access and print what amounts to 2 pages of information on one health plan. (Printing is essential because the human brain cannot remember the details when moving from one comparison to another, repeatedly, for a half dozen or more comparisons).

Remarkably, in 2001 the state-specific versions of *Medicare & You* that include plan comparisons are still not available on the Web. Providing these would be trivially easy as a technical matter. Every Federal agency provides HTML and PDF versions of its regulations to the Government Printing Office. If HCFA would do the same for *Medicare & You* consumers would simply have to click once to indicate their state and click again to get the appropriate version in a format of their preference, either HTML or PDF. Of course, this is only beneficial if the plan specific information is what beneficiaries want and need.

To use a simple gauge of progress, consider the print version of *Medicare & You 2001*. The version for DC/Delaware/Maryland/Virginia has about 85 numbered pages of information. Of these, 17 pages provide plan specific information on Medicare+Choice plans and the remaining pages other information about Medicare. (Telephone numbers take up 7 pages, even more than in 1999). The 17 printed pages of information, however, provide only 9 specific facts about each of 13 covered plans: company name, plan name, telephone number, service area, premium, whether or not any prescription drug coverage, percent rating their care highly, percent of women receiving mammograms, and percent disenrollment. All of this information for all of these plans could have fit on one typewritten page. **In sum, HCFA uses 85 pages to produce one page of plan comparison information.**

In contrast, the OPM *Guide* for 2001 contains 55 numbered pages of information, of which 44 present plan specific information. Those 44 pages present 18 specific facts about every one of about 300 plans, covering all 50 states. Thus, HCFA could have provided twice as much information on each plan, in a single edition covering the entire nation, in one-third fewer pages and millions of dollars less in printing and postal costs, had it simply used the OPM approach and format. (In fact, OPM saves even more money because it sends only about 10 pages of information to every retiree, and gives each several easy ways to get *Guide* information.)

HCFA provided summary information on prescription drugs in 1999, including copay and maximum. Surprisingly, it does not do so in 2001. In contrast, the OPM *Guide* tells enrollees the copayments for prescription drugs. Thus, the single subject on which virtually every Medicare beneficiary most wants and needs summary comparative information is virtually omitted from its publications by HCFA. Not one page in the 85 that are published is as important as this missing page.

HCFA does tell beneficiaries to "call the plan to get all the details of prescription drug coverage," but in a world of impenetrable automated answering services, and without comparable plain language brochures available at the end of that travail,

HCFA has made getting this essential information a journey into frustration. The near insurmountable practical problems facing beneficiaries in getting this essential information are amply documented in GAO reports. Again, in sharp contrast, OPM makes it simple for annuitants to get complete brochures laying out prescription drug benefits in detail for every available plan, by mail, 800 number, or the Web.

In sum, a HCFA bureaucracy whose every employee is provided complete, simple, clear, and timely information for choosing among Federal employee health plans, is seemingly incapable of providing the same service to its beneficiaries. This problem has persisted over decades of providing HMO plan choices. It has survived years of repeated criticisms from the GAO and critics such as me and members and staff of this Committee (see the 1996 GAO report entitled *HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance*). And it has persisted despite a generous earmarked budget that gives the agency *carte blanche* to produce consumer information at the expense of the plans themselves. Not only does HCFA fail to provide the information; it even denies that it has a problem. And to the extent that it admits a problem, it blames it on technology rather than its own bad judgment.

Thus, HCFA itself is a continuing major obstacle to consumer choice in Medicare.

Using Competition Rather Than Price Control or Administered Prices to Control Costs

The essential mechanism by which free markets control costs is competition among sellers. Competition not only controls costs, but also allows consumers to decide how much cost they are willing to trade for amenities such as benefits and service.

One way to think about this problem is to consider the automobile. There are literally hundreds of different models available and, with options, many thousands of possible purchases. Few of us are automotive engineers or racecar drivers, yet who else is qualified to evaluate those complex engines or evaluate brakes and emergency handling? The market creates lemons, such as the infamous Edsel and Jugo. Seductive advertisements permeate the airways. Not one government agency provides objective and unbiased advice on which cars function best (with the minor exception of mileage statistics on purchase stickers). A wrong decision can cost $20 or $30 thousand, or even cost one's life. Yet, somehow, things go well. Better cars get more market share. Losing manufacturers reinvent themselves. Lemons go out of business. Over time, valuable improvements are added to all makes of autos and the hours of work needed to purchase an auto decrease. Government regulation provides a floor for safety, and sometimes stimulates valuable improvements (crash resistance, seat belts, and air bags), but is neither necessary nor sufficient to create most safety enhancing improvements (better braking systems, better handling, better headlights, better tires), and impedes others (air bags too strong for children to survive deployment).

I surmise that one of the most important safety innovations of the last decade is improved cup holders. Surely many thousands of accidents have been avoided because drivers did not spill hot coffee on their laps, or become distracted while looking for a place to put their cups. Yet no government regulation has mandated the size, location, and quantity of cup holders.

Health insurance is a simple product compared to an automobile. What can we learn from the auto purchasing and FEHBP experiences when we consider Medicare+Choice or more fundamental reform? First, only a small fraction of consumers have to be highly informed to "drive the market." We all benefit from the people who do their homework and advise the rest of us. Second, cost, service, and product performance are inextricably linked in highly complicated ways that are difficult to describe and whose value is impossible to estimate in advance. No one could have specified in a government regulation in (say) 1990 how to build the better cars available in 2000. Third, progress is a complex process, not one of lock step "one size fits all" or "once and for all" improvements. Fourth, government mandates can stultify performance.

We have a famous example of a "once and for all" and "one size fits all" government designed automobile: the jeep. We have a successor: the humvee. Surely, no one would want to pass a law requiring every elder in America to buy a humvee or jeep. Yet traditional Medicare is just like these vehicles.

The FEHBP provides ample evidence, directly relevant to Medicare, that cost, performance, and service can all be simultaneously improved over time. The FEHBP moved painlessly to catastrophic coverage, to HMOs, to prescription drug coverage, to drug reimbursement reform, and to PPOs. Medicare remains locked in a mid-1960s time warp.

As documented in my studies, over decades the FEHBP has grown in cost about one percent a year less than Medicare, while improving benefits in major ways, and despite a rapidly aging covered population. Even the last several years, where Medicare costs have been level and FEHBP costs have gone up about 10 percent a year, reflect nothing more than the rapid rise in access to new, expensive, life saving and life enhancing drugs in the FEHBP program, and the concomitant reduction in Medicare's actuarial value compared to real world health care expenses.

In fact, taking into account the recent huge increases in Medigap premiums for plans covering prescription drugs, the FEHBP substantially outperforms Medicare for any 10 year period, even including the last several years of level Medicare costs induced by provider fear of criminal charges for previously legal behaviors. (For Medigap costs, see the story in *The New York Times* of February 8, 2001, concerning **annual** Medigap rate increases in the 20 and 30 percent range). Medigap premiums for plans that cover only one-half of the cost of prescription drugs, up to a maximum of only $1,250 a year reimbursed, are now on the order of $2,000 to $3,000 a year (depending on age and plan). In this context, the recent premium increases in the FEHBP of about 10 percent annually for plans that cover prescription drugs with minimal coinsurance and without maximums, are positively anemic.

The FEHBP has achieved these results while making consumers pay only 25 percent (or less, for postal employees) of the excess cost of unduly expensive plans and recouping only 25 percent (or less) of the savings from frugal choices. Unfortunately, in the future the FEHBP's already weak rewards to cost conscious consumers will be further attenuated by the recent granting of tax deductibility to both employee and employer share. Costs will rise considerably faster than would otherwise have occurred, and the dynamic advantage over Medicare will erode over time.

In this context, the sterile and necessarily imperfect calculations of HHS auditors and the GAO arguing that in the short run HMOs are somehow being paid a few percent more than the calculated "just price" for the assumed (not proven) cost of hypothetically identical enrollees become as irrelevant as theological disputes. No one knows if HMOs are being overpaid (the debatable statistical evidence of the GAO) or underpaid (the hard evidence of market withdrawals). But in a defined contribution approach, this all becomes irrelevant. Consumers pay the excess for plans with above average costs; the government's costs are fixed by formula regardless of short term cost changes. In Open Season, consumers adjust their choices. Over the long run frugal plans are rewarded and the rate of cost increase declines.

For a defined contribution and market competition approach to Medicare reform to succeed, the entire mindset of government budgeting and auditing will need to change. As opponents of reform fear, but perhaps should welcome, controlling the government contribution to the premium rather than controlling the amounts paid to providers will radically change the budgetary calculus. In the short run, costs may be marginally higher or lower. (Higher, for example, if drug benefits are added.) In the long run, budgetary performance will depend essentially on three variables, only two of which are controlled by the government:

- the dynamic ability of health plans to control costs, using literally hundreds of ingenious approaches, all evolving over time;
- the initial level of the government contribution; and
- the formula used to determine how the government contribution changes over time, and changes in that formula to reflect experience.

This last variable can be either more or less generous than present law and the unpredictable likelihood of changes in that law over time. And it can be more or less generous depending on beneficiary income. Nothing about Medicare reform presumes adverse results to lower income seniors.

Structural Reforms to Reduce Incentives for Micromanagement

The most striking contrast between the FEHBP and Medicare is that in the former law and regulation establish virtually no medical benefit details. In Medicare, almost all important benefit details are set in law. The essential difference is that in the FEHBP these decisions are made plan by plan. Some plans offer chiropractic, acupuncture, and cardiac rehabilitation coverage; others do not. Some deductibles are zero, others $200 or more; OPM and the Congress do not dictate this vital benefit dimension. Some plans cover drugs the same whether by mail order or local pharmacy; others do not. Some offer dental or vision coverage; others do not. And so on.

This has a profound influence on governance. In Medicare, any given medical profession or provider type can achieve its ends only by lobbying the Congress to change the law, or by persuading HCFA to change regulations. Every year, hundreds of changes are proposed and dozens are enacted. In the FEHBP, there is always a sweet smile answer to these pressures: "If you want benefit X that is not

covered well in Plan A, join another plan." When the inevitable Congressional hearing arises, OPM can always say "the matter is decided by consumer and plan decisions. If consumers want benefit X, plans will offer it to get their business." In most years, there are no coverage or benefit decisions mandated either by law or regulation.

As ably documented by Bruce Vladek, the "medical industrial complex" and its lobbyists hugely benefit from the current design of the Medicare program ("The Political Economy of Medicare," *Health Affairs*, January–February 1999). These same pressure groups fare poorly at the FEHBP table.

This is not to say that such pressures do not exist in a competitive, market-based system. And in recent years activist OPM directors have been uncharacteristically active in fostering benefit mandates. But the differences between the two programs are huge. And they result largely from the essential design distinction between a program where consumers vote with their dollars to decide benefit and reimbursement details and a program where legislators vote on the floor to decide those details.

To return to the automobile analogy, Medicare is like the jeep: the government decides every specification, including the unfortunate lack of either a hard top or cup holders. FEHBP is like the regular consumer market for automobiles: consumers migrate to the plans that offer the combination of features that they like.

Nothing would improve governance in America more than taking health plan and benefit decision decisions that properly belong to consumer-driven markets out of the realm of politics. If the disciplines of Economics and Political Science prove anything about democracy's strengths and weaknesses, it is that consumers maximize their own preferences; politicians maximize their chances for reelection. For far too long Medicare has been hostage to the latter rather than the former.

Actuarial Rather Than Enumerative Approach to Guaranteeing Benefit Levels

Medicare is an "entitlement" program in two senses. First, every aged and disabled American, as defined in law, is entitled to a substantial package of benefits and subsidies defined in law. Second, the details of those benefits and subsidies are exhaustively enumerated in mind-numbing detail, also in law. To be sure, the Congress may change the law and not infrequently does, but any pedant can open a law book, open the Code of Federal Regulations, read a court decision, and discover that, indeed, Medicare does indeed cover so many pints of blood transfusions, so many home health visits, and not so many prescriptions.

As a result of these benefit and subsidy entitlements, we have a grossly inferior health insurance program, design vintage 1965. To be sure, seniors do not die for lack of basic medical care in hospitals or by physicians, or go bankrupt through inability to pay catastrophically expensive medical bills (except for drugs, expenses incurred while traveling abroad, and, in very rare cases, particularly long hospital stays). The overall package is substantial, and vital to the well being of elderly Americans. But the entitlement is also deeply flawed, and inferior to any mainstream health insurance plan in America.

Nothing about Medicare reform implies that the underlying, core promise should be broken. American seniors should continue to have most major medical bills paid. Indeed, those bills should be better paid with existing gaps closed. Why should an elderly person who happens to have a heart attack while traveling to Mexico or Europe be subject to tens of thousands of dollars in uninsured costs? (Or, alternatively, why should an elderly person be offered a one size fits all Medical plan that does not include travel coverage or prescription coverage?)

The implicit guarantee in the FEHBP, and one that should be explicit in a reformed Medicare program, is that every plan available will pay:

- on average no less than 80 percent (or slightly more or slightly less, based on detailed design decisions) of the total amount spent by all beneficiaries for reasonable, necessary, non-experimental medical bills of any kind, from any licensed provider, whether for hospitals, doctors, or prescription drugs; and
- 100 percent of all such bills in excess of $5,000 (or somewhat more or somewhat less) incurred in a year.

A guarantee of this kind is compatible with a deductive of zero, $100, or $500 dollars; with coinsurance of zero, 10, or 20 percent; with a low deductible for hospital expenses and a high deductible for drug expenses, or vice versa; and with a host of other differences in benefit design and coverage. A guarantee of this kind is compatible with a 100 percent paid HMO or a Medical Savings Account with a high deductible, if properly drafted to accommodate differences in plan design.

Properly drafted, a guarantee of this kind is also a far superior entitlement than the current Medicare program.

Regulatory Reform

The brute fact is that the Congress dictates in excess of 90 percent of the content of the thousands of pages (by some estimates over 100,000 pages) of Medicare regulations. The annual revisions in reimbursement regulations, driven by the latest Omnibus Budget Reconciliation Act (by whatever name), aimed at fine-tuning budgetary targets based on fictitious spending projections, would be ludicrous if they did not affect the livelihoods of hundreds of thousands of medical care providers.

Medicare reform will never work if Congress does not learn to change the rules of the game far less frequently. This does not mean that oversight and midcourse corrections will not remain necessary; it does mean that a stable insurance market can never flourish if the stroke of the pen can, and is likely, to undo settled expectations. The Constitution guarantees the sanctity of settled contracts; the Congress has learned to evade these provisions by assuring that no Medicare rules are ever set by long-term contract.

The Congress limits the HCFA role in regulation, but the agency has nonetheless found many ways to create regulatory excess. And the two institutions reinforce each other's bad habits. Senior HCFA staff several years ago came up with a slogan, "surety bonds," as a feel-good approach in a new regulation to reduce fraud in the provision of durable medical equipment. The same internal draft regulation also contained provisions to ban the use of cellular telephones as primary business phones. This plan rested on the observation that many crooks had no fixed address and used cellular phones. An overworked Office of the Secretary reviewed the draft regulation and concluded that the Secretary would be made a laughing stock if she were perceived, half correctly, as seeking to ban cellular telephones in the health care sector. Unfortunately, after exhausting large bureaucratic capital in fighting this silly scheme, OS acquiesced in the plan to require a new kind of surety bond that had never been available to businesses and never would be. Before implementation attempts proved this scheme unworkable, Congressional staffers, ever alert to seemingly bright ideas, put the surety bond idea into law.

Average Adjusted Per Capita Costs (AAPCC) as a regulatory scheme for the reimbursement of HMOs has persisted for two decades. AAPCC rests on two demonstrably false premises: that costs paid by Medicare in particular counties differ in roughly the same proportion as the underlying costs of health care delivery differ; and that these underlying cost differences are large—ten, twenty, thirty, and forty percent or more from one county to its neighbor. Under AAPCC, the government has officially declared that HMOs should be paid roughly 50 percent more for enrolling seniors in the Washington DC suburb of Prince Georges County than in the nearby suburb of Fairfax County. The premises of AAPCC have long been discredited, particularly as they apply to HMOs (see Stuart Schmid, "Geographic Variation in Medical Costs: Evidence from HMOs, *Health Affairs*, Spring 1995). Unfortunately, this misconceived regulatory scheme has prevented the effective integration of HMO competitors into Medicare for the same two decades. In some parts of the country HMOs were grossly overpaid; in other parts no HMOs participated because they would have been grossly underpaid.

While the egregious flaw of the Balanced Budget Act of 1997 in tying HMO payment to fee-for-service cost levels that were about to decline in an unprecedented reversal of historic trends was largely unforeseeable, the underlying premise was much like that of AAPCC: assuming that the "right" level for payment could somehow be divined from the costs of traditional Medicare.

In the specific context of Medicare reform, the 1998 HCFA regulations on Medicare+Choice, comprising hundreds of pages of highly prescriptive and costly mandates devised by bureaucrats determined to protect against every imaginable problem, may have been the single most excessive set of regulations ever devised in HCFA. So draconian were these regulations that a year after issuance HCFA issued a modest set of revisions; admitting that few if any health plans could possibly have complied with the original regulations. Some observers believe that these regulations were deliberately designed to cripple the competition of traditional Medicare. My own view is that they reflect ignorance of private insurance markets and practices, and of the practicalities of health care and business administration, rather than actual malice. And, of course, they reflect the "nanny state" mindset of most government regulators.

The underlying problem is that the bureaucratic impulses of HCFA, whether conscious or unconscious, seem yet again to have had the seemingly unintended effect of sabotaging rather than favoring Medicare choice.

Avoiding Paralysis by Analysis

There are any number of vital issues that need to be addressed in Medicare reform. To mention several, some alluded to earlier:

- What cost sharing mechanisms will create the best incentives for plans and beneficiaries to reduce the rate of cost increase, improve services, and improved benefits over time?
- What role, if any, should be given to presumed differences in underlying health care delivery costs among and between geographic areas?
- What mechanisms should be used to avoid destabilizing risk selection, or to prevent "cherry picking" to obtain the healthiest beneficiaries?
- Are there ways to prevent large scale shifting of costs to beneficiaries as Fortune 500 companies discover that an improved Medicare program makes Medigap insurance subsidies superfluous?
- What consumer protections should be provided to prevent abuse of elderly beneficiaries who are vulnerable to errors of omission or commission?

My take on these issues, and others, is that fine-tuning is a serious mistake. For example, actuaries and economists and budgeters have been agonizing over the problems of creating the perfect scheme for risk adjusters for decades. Year after year, the glaringly obvious problems in AAPCC were not even partially corrected because "we haven't finished the studies to determine the best possible system." As another example, all the procedural protections and appeal rights in the world will not protect beneficiaries one tenth as much as the simple expedient of making sure that no participating health plans are predominantly comprised of Medicare beneficiaries, and that consumer information and other attributes of a well managed Open Season let consumers vote with their feet.

A recent study of the National Academy of Social Insurance (*Structuring Medicare Choices*, 1998) recommended "a program of research, demonstrations, and evaluations to inform decisions about structuring choice in Medicare. Systematic research to address specific technical issues is essential to the success of structured competition. . . ." The report recommends "an aggressive program to develop and implement risk adjusters" and research to "assess the benefits of standardized benefit options, in terms of beneficiary understanding." In other words, the Academy recommended no Medicare reform until years of research. Yet, we have the experience of current Medicare policy to demonstrate that risk adjusters can never be perfect and can greatly interfere with orderly plan participation and competition. We also have the experience of the FEHBP to demonstrate that a program with no risk adjusters of any kind (a huge defect) can proceed reasonably successfully for decades. And we have the knowledge and experience of the professions of Political Science and Economics, and the observed reality of both Medicare and state mandates, to tell us that standardized benefits are an invitation to political mischief and micromanagement of the worst kind.

On another front, there is much hand wringing that the Congress blocked the competitive bidding demonstration. In theory, there are competitive bidding models that will save much more money than any consumer choice approach. We can give health plan X a monopoly in area Y for a year, and squeeze the pips to save money. But why would anyone think that the primary object of Medicare is to save money in the short term, no matter what the cost in consumer choice or dynamic innovation? Who thinks that government procurement models of any kind have ever proven in practice to be an effective and efficient model to obtain services of any kind? Would we apply such a model or practice to selection of automobiles for consumers, or housing, or grocery stores? Just think of the announcement: "Today the Automobile Financing Administration announced that in the greater Denver area all consumers buying automobiles next year will get two-door Ford Escorts. The government obtained a five percent discount from the wholesale price. To prevent fraud, civil money penalties to prevent Nevada dealers from selling Hondas or four-door models to Colorado consumers have been increased, with Justice Department enforcement financed by an unlimited tap on the transportation payroll tax. . . ."

There are many key issues in reform that require careful analysis of options, and objective appraisal of the likely effects of alternatives. But Medicare reform should not be a playing field for hypothetical concerns of little real world relevance.

Organization and Management Reform

Several Medicare reform proposals, including the Breaux/Thomas and Breaux/Frist proposals, envision removing much or the entire locus of decision making from HCFA. In this regard, it is worth recalling that HCFA as an organization violates one of the most famous organizational principles of Public Administration, one most famously used by Franklin Delano Roosevelt: making sure that no one Federal bureaucracy has a monopoly on an entire area of responsibility. With competing bureaucracies, the ability of the decision-maker to detect incompetence, error, and falsification grows exponentially.

To take an example one step removed from Medicare reform, implementation of the Health Insurance Portability and Accountability Act (HIPAA) has been frustrating to participants both within and without the government because it has been dominated by HCFA. The convenience of one health plan, albeit the largest single health plan, has dictated the main options presented, and most of those selected, in a sector of the economy with hundreds of billions dollars at stake quite apart from the interests of the administrators of traditional Medicare. Under HIPAA, HCFA has gradually assumed the role of regulator of American health insurance, to the point where it routinely issues regulatory pronouncement on such subjects as "Circumstances Under Which Health Insurance Regulated As 'Individual' Coverage Under State Law Is Subject to the Group Market Requirements Of . . . HIPAA" (a copy of this impenetrable issuance can be found at www.hcfa.gov/medicaid/hipaa/content/bulletins.asp).

To take another subject removed from Medicare reform, what Federal government agency is charged with thinking creatively about the use of tax credits or grants to states or other options to improve health insurance coverage for 40 million uninsured Americans, and what expert resources is that agency devoting to creating workable proposals to mesh with tax reform and the existing employer-based insurance system? The answers presumably are "HCFA, and close to zero resources."

My recommendation is that HCFA be dismantled or, at the very least, competing agencies created. I have some difficulty with the proposition that competitors to traditional Medicare, paid from the same trust funds, should not come under the stewardship of the agency in charge of the trust funds. I think that a better reform might be to separate all quality and protective regulation from operation of the Medicare health plan itself (what used to be called the Health Standards and Quality Bureau of HCFA is in financial impact probably the third or fourth largest regulatory agency in the Federal government). Alternatively, all regulation of managed care, of Medicaid, and of private sector initiatives such as tax credits might be placed in a separate HHS agency.

But the difficulty lies in the details of the solution, not in the problem addressed. Clearly, HCFA is not capable of reforming itself more or less out of business. Clearly, HCFA is not a student of ways to regulate private health insurance with a light hand, and of ways to avoid regulation entirely. Clearly, HCFA is incapable of providing the most important consumer protections, such as readily accessible information, and all too capable of devising complex regulatory schemes so cleverly burdensome that they drive health plans out of the Medicare market. And above all, HCFA has proven over and over again that the convenience of traditional Medicare as perceived by ease of HCFA administration and HCFA's parochial interest is the dominant principal driving all decisions large and small.

In other words, HCFA behaves just as public administration theory suggests that any agency or bureau should behave. It protects its turf, as it perceives that turf. During the formative years of Medicare, when a new program needed nurturing and then fiscal discipline, HCFA's motives and the larger public interest coincided. But that behavior, however congenial to the interests of HCFA as a bureaucracy, does not now meet the larger public interest. The problem is compounded because HCFA is far from incompetent. To the contrary, the senior staff are among the most able and dedicated in the Federal government. They control access to information, the regulatory agenda, the computer systems, and far more. They decide which studies get done, and which do not, and who writes the studies. They share common interests and a common view of the world (one in which private health plans play at most a marginal role). They succeed routinely in protecting their interests from outside interference, such as pesky oversight by the Secretary and his or her staff, or the Congress, or OMB, or even the President.

Whatever organizational reform is selected, I believe it should result in at least two agencies, and possibly three or more agencies within HHS, charged with somewhat overlapping responsibilities for health insurance matters, so that the Secretary (and ultimately the President and the Congress) will have the benefit of differing views, information, and perspectives presented on key issues.

The bottom line is that no matter what organizational and managerial model is chosen, Medicare reform based on consumer choice among competing health plans is highly unlikely to succeed if it is not placed in the hands of an agency whose basic purpose and mission, incentives, and even staff promotions rest on making the reformed program a success. HCFA as it exists today is not such an agency.

Semantic Reform and Reining in the Rhetoric

The debate over Medicare reform is highly vulnerable to grandstanding and shrill accusations. To many, the word "vouchers" has become a rallying cry for opposition. A year ago, AARP issued a report, *Medicare Benefits: a Comparison with the*

FEHBP, that could not get past the point that Medicare benefits are individually specified in law (i.e., "guaranteed" subject to the decisions of the next Congress) whereas FEHBP benefits seem to be only those that consumers drive the plans to offer. In this comparison of "legal guarantees" with "plan offerings" the superiority of FEHBP benefits, and their far better improvement over time, got lost.

Another rhetorical swamp lurks in the opprobrium that has come to be attached to managed care. Paul Elwood, often credited with inventing the term "health maintenance organization," saw the essence of his idea as one of empowering consumers. Elwood is bitter about the Clinton Administration's decision to foment hostility against HMOs, and uses terms such as "perversion and political destruction of our ideas" to describe the terms of debate in recent years (as quoted in the *Orange County Register*, February 16, 2001).

Next Steps

The next steps for the Congress must await Bush Administration decisions. Bills can be introduced, hearings be held, proposals tested, and debates held—but these will be in a vacuum until the Administration makes concrete proposals. In the meantime, the Administration has important choices. Will Secretary Thompson engage in a meaningful review of Medicare+Choice regulations and clean them up, both in reality and symbolically? Will Clinton "midnight regulations" expanding burdensome Medicare procedures to Medicaid HMOs be rescinded? Will the current consumer information system for Medicare beneficiaries be put on a sensible track that actually provides consumers easy access to information needed to choose health plans? Will health care financing responsibilities be reorganized (former Secretary Joe Califano created HCFA by a stroke of the pen shortly after taking office)? Will political appointees in HCFA and the Office of the Secretary be consumer and market oriented?

For both the Congress and the Administration, it seems to me that prescription drug coverage is the vital lubricant. It is popular, it is needed, and it is expensive. What reforms can be obtained with drug coverage as the sweetener? Can a package be devised that will not involve Kafkaesque price controls and discourage future research and innovation? Can some form of drug coverage be added to traditional Medicare so that it will have at least a partially competitive position as other health plans compete for business?

The answers to these questions, and the Congressional initiatives and responses, will determine whether Medicare reform becomes a reality or an empty slogan.

Chairman JOHNSON. Mr. Lemieux.

STATEMENT OF JEFF LEMIEUX, SENIOR ECONOMIST, PROGRESSIVE POLICY INSTITUTE

Mr. LEMIEUX. Thank you very much, Madam Chairman, Mr. Stark and Committee Members.

I may be a little naive, but I think that, working on the technical details of some of these proposals and thinking them through, there may be a lot more movement toward political compromise and technical compromise and accommodation than you would have known from the rest of this hearing. I think that both sides are moving toward a stable, competitive approach that would fix the deep flaws in Medicare+Choice that we have heard so much about; and there seems to be a burgeoning political agreement to really do a good job in improving Medicare's benefits, mostly for prescription drugs but also for the other gaps in its benefits, especially the financial gaps, the biggest concern to me.

Let me talk about my ideas for solutions in the context of Medicare's problems.

We have heard the fee-for-service benefits are out of date and inflexible, and that is virtually a consensus opinion. Four out of five beneficiaries are in that program, and they face large out-of-pocket

costs which they often try to insure by purchasing gap coverage, sometimes at great expense.

We have also heard correctly that Medicare's system of HMO is a total mess, and I agree with that assessment 100 percent. Right now, what we fundamentally ask HMOs to do is to compete on the level of benefits they are going to offer and whether or not they are just going to play ball, whether or not they are going to enter a market or withdraw from a market. When they face competitive pressures, their response under the rules of Medicare+Choice is to adjust their benefits, which is very inconvenient to seniors or, even more problematic, to just leave the market altogether or come back if it looks like the profits will be there.

It would make so much more sense to have them competing mostly on price instead of benefits, and staying in the market more permanently. That is the great beauty of a Federal employee's plan: there has been a trust built up between many of the plans and the agency running it. Sure, people have a choice. They can disenroll from a plan they do not like, but they have an even better choice, and that is they can stay with a plan that they like, because the plans can adjust to market competition through changes in their prices rather than just withdrawing from the market.

I think that both of these two problems, Medicare's fee-for-service benefit inadequacy and the problems with the HMO program, are fundamentally caused by the superstructure of Medicare: the fact that Congress dictates exactly how Medicare is to run and HCFA perceives its role as administering the law, often with very detailed regulations. HCFA does its best, but it is very difficult to keep up with the health sector and all of the laws being passed in Congress.

As a result, fee-for-service benefits are really not very well integrated. I learned that firsthand when my grandmother was sick last fall. It is a hodgepodge of benefits that have been crafted over the years, and you would never have done it that way if you set out to remake it from scratch today. The same thing is true of the Medicare+Choice program. You would never have such a program if you sat down this year and decided, here is how we are going to try to encourage private plans to offer a choice to Medicare beneficiaries.

Of course, the fourth problem is the cost problem. I have worked in the past at the bipartisan Medicare Commission at the Congressional Budget Office and at HCFA; and I have been involved, either directly or indirectly, with a great many of the erroneous forecasts that have been used over the years regarding the BBA, regarding health care spending, regarding the Medicare Commission's decision that the average government contribution was going to be 88 percent, and so on and so forth. All of those forecasts, I assure you, were extremely reasonable, highly sophisticated and well thought through; and they were vetted with the greatest minds in Washington and around the country; and most of them were wrong. So I encourage you to be very careful about the potential costs of this. It looks to me like the costs of all of these plans—Breaux–Frist II are going to go up, the House Republican plan are going to go up, so that will be an important consideration.

Let me just run down very quickly how I view the progress on Medicare reform. First, there was the bipartisan Medicare Commis-

sion. The Commission set up a full "level playing field" competition between the fee-for-service plan and managed care plans. It offered subsidies for drugs only for the poor and near poor, and it would have saved a fair amount of money, I think. I think that some of the commentators who suggested that it was going to put fee-for-service out of business were exaggerating a little bit—I think the probability of that was very slight, but it was a true level playing field competition that would have probably saved a lot of money.

President Clinton came back with a proposal that was a partial competition. In a sense, rather than having the taxpayers save money from competition in Medicare, the beneficiaries were going to essentially have the opportunity to save money by reducing their premiums. So it didn't save the taxpayers much.

Then the President's plan had a pretty large subsidy for drugs. It was 50 percent of the package, and the overall cost over 10 years, rather than saving $100 billion like the Medicare Commission's plan, it probably would have cost about $300 billion.

The Breaux–Frist I plan was full competition like the Medicare Commission proposed, but it took out some of the cost-saving features like raising the eligibility age, and it also added subsidies for drug and other supplemental benefits to about 25 percent, even if you weren't poor or in that near poor range. I think that the cost of Breaux–Frist I—I thought at that time it would probably be about budget neutral. Now, it might be a little more than that.

As the Senator said, the cost of Breaux–Frist II is about $200 billion now with the updated estimates. It raised the subsidies from 25 percent to approximately 35, a little closer to what the President had proposed last year; and it includes a partial competition or a beneficiary competition like the Clinton plan as an interim step, rather than the full level playing field envisioned by the Commission.

Now, my take on where you go from here is that I think that getting the formulas for competition, coming to agreement on that, ought to be pretty easy. It seems to me like both sides have agreed to protect the fee-for-service program for a considerable period of time, and that means the taxpayers are not going to save much money, but it seems like we have reached an agreement on that sort of Breaux–Frist II approach to this. Regarding the amount of subsidies, whether it is 25 or 35 or 50, it seems like there is a range there that Members of Congress can probably get together on reasonably quickly. The harder issues are issues of governance and issues of how to structure the drug benefit in fee-for-service. So let me just make a couple of quick comments about that.

On governance, I think that it is very important to create a new agency of some sort to oversee the competition and to create a new market for supplemental benefits for fee-for-service beneficiaries. I think that we have had a political situation where many Democrats have said that we really want a drug benefit in Medicare; and many other people, Senator Breaux and many Republicans and others, have said what we really want is to work with market forces to the best of our ability and not have Congress dictate how the drug benefit is going to work. I think there is a way to bridge those two approaches.

I think the only way to guarantee that drug benefits and other supplemental benefits are available to everybody is to empower the government in a very strong way to make that happen, but I think the way to get political agreement to do that is to create a new agency that is fundamentally knowledgeable about and experienced with competition, rather than the way that HCFA operates with regulations and fee-setting.

So, just to sum up, I think the right mix of Medicare benefit expansions and competitive reforms requires both strong government and flexible private markets. I think that conservatives have to agree to protect fee-for-service for a while and allow the Medicare agency or whatever this new administrator is going to be called a great deal of latitude in creating supplemental benefits. I think that the conservatives need to support pretty high subsidies and make room in budgets for such things to make the system work. Liberals, on the other hand, have to acknowledge, I believe, that HCFA isn't suited for competitive systems—it really never has been—that market approaches really should be the goal for drug benefits, that we ought to try to make that work, and that costs cannot get out of hand.

One final comment. I think that, last year, the House-passed plan was a little too narrow in the sense that it envisioned a drug-only benefit. I think it is really important and more convenient for seniors and more practical for health plans if we link a supplemental drug benefit with other benefits that seniors need like these financial protections against cost-sharing that they would otherwise have to face in fee-for-service. I think, by linking those two markets and subsidizing that, you create a much more viable market and give seniors a one-stop shop for their supplemental coverage if they are in fee-for-service.

[The prepared statement of Mr. Lemieux follows:]

Statement of Jeff Lemieux, Senior Economist, Progressive Policy Institute

Thank you, Madam Chairman, Representative Stark, Committee members, for inviting me to offer ideas on how to take the final steps toward Medicare reform. My name is Jeff Lemieux, and I am the senior economist for the Progressive Policy Institute (PPI). Prior to this position I worked for the Bipartisan Medicare Commission chaired by Senator John Breaux (D–La.) and Representative Bill Thomas (R–Ca.), the Congressional Budget Office, the Health Care Financing Administration (HCFA), and an economic forecasting firm then known as DRI/McGraw-Hill.

I believe most Democrats and Republicans in Washington could quickly come to agreement on a compromise approach to Medicare reform that remakes Medicare's competitive system for private health plans and expands the program's benefits, especially for prescription drugs and other items that form "gaps" in Medicare's current benefits. This year, I hope Congress will rise above the usual partisanship and close the deal for a durable, truly improved Medicare system.

My statement touches on several areas: problems in Medicare, a vision for a reformed Medicare system, my recommendations for solutions to Medicare's problems, the legislative steps that have been taken toward Medicare reform, some difficult issues that must be dealt with, and a compromise idea or two. I have attached an outline at the end of the statement that lists those components.

Problems

To launch the process of Medicare reform and improvement, I believe we must expand benefits *and* create a new, market-based approach to how Medicare actually delivers benefits. The solution should address the program's four big problems:

1. ***Medicare's fee-for-service benefits are inflexible and out-of-date.*** Most seniors (about 5 of 6) face large out-of-pocket costs for prescription drugs and other items not covered by the traditional fee-for-service program; many pur-

chase additional insurance to fill in the gaps in Medicare's fee-for-service benefits, sometimes at great expense.

2. ***Medicare's system for HMOs is on the verge of collapse.*** About 1 in 6 Medicare beneficiaries has joined an HMO to get better benefits and avoid high out-of-pocket costs. But Medicare's system for HMOs is similar to its administration of the fee-for-service program: a bewildering array of government-set prices and a dense thicket of regulations. Faced with lower reimbursements and higher costs, many HMOs are slashing benefits or dropping Medicare participation altogether.
3. ***Medicare's fee-setting and regulatory approaches are inefficient and stifle innovation.*** Medicare's inadequate fee-for-service program and its dysfunctional system for HMOs are not the result of bureaucratic ineptitude or bad motives. They are the inevitable and direct result of how Medicare is structured. The way Medicare currently works, Congress is required to dictate virtually all of Medicare's fees and rules. Then the Health Care Financing Administration (HCFA) adds layer upon layer of regulations in an increasingly futile attempt to apply those fees and rules to a fluid, constantly-changing health sector.
4. ***Medicare's costs will mushroom when the baby boomers retire.*** The backdrop for any Medicare reforms, including adding needed (but expensive) new benefits, is the fact that as 70 million baby boomers retire, high Medicare spending is likely to crowd out other government initiatives, prompt a return to deficits, or force tax increases. Without reform, Medicare spending could easily jump from over 10 percent of the federal budget today to 30 percent of the budget by 2030. Combined with Social Security and Medicaid (a program for the poor, including many elderly people in nursing homes), the total cost of entitlement programs for the baby boomers could suffocate progressive government.

The first two problems, inadequate benefits and insufficient choices, directly hurt seniors. Seniors are largely unaware of the third problem—Medicare's administrative inefficiency and structural obsolescence—but that problem is the root cause of the first two. Furthermore, Medicare's internal inefficiency contributes to its high costs, which should never be far from policymakers' minds.

The bottom line is that Medicare's creaky internal workings are becoming politically unacceptable. Medicare was designed in the 1960s. Its benefits have not kept up with medical advances and seniors' needs precisely because of its top-down government controls and old-fashioned administration. Sen. Breaux likes to compare Medicare to an old car: powerful, but inefficient and always in need of maintenance or repair. Medicare was not designed for modern benefits or competitive approaches, and recently Congress has had to enact legislation fixing parts of its payment systems virtually every year.

A Vision of a Reformed Medicare

In my opinion, a truly reformed, high value Medicare program will have two primary characteristics:

- ***Good choices of comprehensive private health plans*** such as HMOs or PPOs for as many beneficiaries as possible. The system of competition should encourage private plans to stay in the Medicare program, adjusting their premiums as necessary to be competitive. That is in direct contrast to Medicare+Choice, which causes plans to compete by changing their benefits (often at great inconvenience to seniors) or by moving into or dropping out of Medicare altogether. Private plans' benefits should include currently covered items plus drug coverage and out-of-pocket protections. Health plans should be able to innovate broadly on benefit design, but they should be given the incentive to compete as much as possible on price, not benefits. Plans should feel as though they are long-term competitors for seniors' business, not come-or-go government contractors.
- ***A fee-for-service plan that can improve itself***, and requires considerably less Congressional micromanagement. HCFA should operate the fee-for-service plan in a more businesslike manner, under a much more transparent and planning-oriented process. Over time, Congress' role should shift from making laws concerning Medicare's every detail to oversight and quality assurance. Current fee-for-service benefits should be continually improved and truly integrated, and beneficiaries in the fee-for-service program also need seamless drug and gap coverage, without hassle or needless complexity.

Possible Solutions

Here is my list of the essential changes and reforms Congress could enact this year to get started toward that vision:

- ***Competition.*** I believe Medicare needs a new style of competition patterned after the federal employees' system both to expand and stabilize seniors' choices and to temper Medicare's future costs.
- ***Modern Benefits.*** We should add prescription drug benefits and new limits on seniors' out-of-pocket costs, and we should subsidize those new benefits sufficiently to encourage most seniors to enroll.
- ***A New Attitude and Process.*** We should change the culture of Medicare first by establishing a new executive agency outside of HCFA that is familiar with competitive systems to oversee the new competitive approach. Second, we should hammer out a new process under which HCFA has the flexibility to make the traditional fee-for-service program more modern and accountable.
- ***Innovation and Choice for Drug Benefits and Gap Coverage for Fee-For-Service Enrollees.*** The new executive Medicare Agency should have the power and financial flexibility to guarantee that seniors enrolled in Medicare's traditional fee-for-service program will have access to choices of affordable private coverage for prescription drugs and other out-of-pocket costs. I believe markets for private coverage will work well, and that in general the government should not dictate prices and detailed coverage rules for prescription drugs.

Almost There: The Path to Medicare Reform

Comprehensive Medicare modernization is a relatively new idea. In 1998 and 1999, the Medicare Commission formed a plan to remodel Medicare based on the federal employees' system of choices and competing health plans. In addition to the new competitive system, the plan added benefits for prescription drugs and it limited beneficiaries' out-of-pocket costs for hospital and physician services. To save money, however, the Commission's plan would have raised Medicare's eligibility age and added some new beneficiary co-payments. Furthermore, it subsidized prescription drug benefits only for beneficiaries under or just above the poverty line.

The Medicare Commission didn't account for the rapidly improving budget outlook in Washington, and its plan did not spark the hoped-for political consensus. As budget deficits switched to surpluses in 1998 and 1999, President Clinton and many in Congress refused to embrace such penny-pinching measures.

In June of 1999, the Clinton Administration countered with its own reform proposal. Clinton's proposal also embraced the federal employees system as a model for competition, but it added measures to protect the traditional fee-for-service from the full force of market prices. In so doing, it allowed the new competitive system to save beneficiaries money, but limited the amount the government would save. The Clinton plan also dropped the plank raising the eligibility age. Finally, the Clinton plan generously subsidized prescription drug benefits for all seniors and formed the new drug benefit on the traditional fee-for-service model, with the government poised to dictate payment policies and rates.

Senator Breaux's first legislative proposal, cosponsored by Senator Bill Frist (R–TN), included the Medicare Commission's version of full competition, also dropped the increased eligibility age, and added a modest ($200) annual premium subsidy for beneficiaries above 150 percent of poverty (beneficiaries with incomes below that level received larger or full subsidies).

The second Breaux–Frist proposal, which was released last Summer, accepts Clinton's milder form of competition as an interim step, and raises the subsidies for drugs to almost three-quarters of Clinton's proposed level. Unlike Clinton's approach, however, both of the Breaux–Frist proposals create a market for prescription drugs, so that Medicare beneficiaries in the fee-for-service program would have a choice of drug plans and so the Congress would be more removed from the setting of drug prices and fees.

Sticking Points

Since both sides basically agreed to protect fee-for-service beneficiaries from the full force of competition and to subsidize the new benefits even for those above poverty, coming to final agreement on those issues should be straightforward. However, sticking points remain on how the new competition and benefits will be administered. Should the new competition be administered by HCFA, or a new executive agency? In my opinion, the only way to resolve the most crucial outstanding issue—ensuring that fee-for-service enrollees will have access to drug benefits—is to create a new executive Medicare Agency to oversee the new Medicare marketplace.

Here's the problem: market solutions for drug benefits are a much better idea than the sort of price controls that have distorted and politicized the hospital indus-

try and other sectors of the health economy. But how do we ensure that solid markets will spring into existence and that all seniors—including those in the fee-for-service program—will have good choices? By definition, free markets are impossible to predict.

Many Democrats approve of market solutions for HMOs and other comprehensive health plans, but assume that markets couldn't be made to work for drug benefits in the fee-for-service program. That's why their proposals generally put HCFA in charge of the benefit. Government control is the only way to be sure the benefit will be there for all beneficiaries, under that assumption.

Senator Breaux's plan relies on a new Medicare Agency to run the program's market systems, both for comprehensive plans and for extra benefits for fee-for-service beneficiaries. He would create a mini-market of plans specializing in drug and other gap benefits, and seniors would be able to pick from those plans based on price and benefit levels. Markets are the only way to ensure continued innovation, efficiency, and dynamism in the health industry, Breaux argues.

In last year's campaigns Democrats liked to say their drug benefit was "in Medicare," meaning that it would operate just like the other parts of Medicare's fee-for-service program. The Breaux–Frist plan would add a drug benefit to Medicare, but only in the context of market competition and choice, not direct government management.

Fortunately, there is a bridge between the two approaches. Senator Breaux is right to prefer competition to an HCFA-administered program, but other Democrats are right that full government authority is the only way to be absolutely sure a benefit will be there for all seniors.

The essential compromise is clear: allow the government sweeping authority to ensure drug benefits are available under any circumstance, but give that authority to a new government agency that knows how to work with market systems and private companies, not to HCFA, which only knows price controls and regulations. Sen. Breaux's plan should be more explicit about exactly what tools the new Medicare Agency could use to ensure that drug benefits would be available even if markets were slow to form. The Medicare Agency should be given full authority to share risk with private companies to ensure that markets develop and choices are available to all beneficiaries, but it should be structured so that any significant government risk sharing would be temporary—a true last resort, not a first option. That way any government-private risk partnerships would be less likely to devolve into arrangements where the government became the regulator and micromanager and the private company was reduced to a contractor status, with no stake in benefit innovation or competitive outcomes.

Finally, the House Republican bill from last year concentrated on creating a market for drug-only supplemental coverage. That was a mistake, I think. It would be much more convenient for seniors and more practical for health plans to offer a combination of drug and other gap coverage, such as protections against unlimited out-of-pocket costs. In essence, Congress should create a new market for comprehensive gap coverage for fee-for-service enrollees, and subsidize that market sufficiently to make it appealing both to health plans and seniors. Creating a new market for all-in-one drug and gap coverage would not interfere with current gap or retiree coverage that seniors have purchased or otherwise receive, but over time it would probably become an attractive option for many beneficiaries.

Conclusion

The right mix of Medicare benefit expansions and competitive reforms requires the best of both strong government oversight and flexible private markets. Conservatives must agree to protect the fee-for-service plan for a time, allow the new Medicare Agency a great deal of latitude in creating a market for drug benefits and gap coverage for fee-for-service enrollees, and support higher subsidies for those products. Liberals must acknowledge that HCFA is not suited to run competitive systems, that market approaches must be the goal for drug benefits, and that costs cannot be allowed to get out of hand.

The political partnership for that sort of deal is shaky, but it does exist. By improving benefits, we can help America's seniors now. By using market forces and competition to shore up Medicare's creaky inner workings, we can assure seniors that we will be able to afford excellent health benefits in Medicare for their children and grandchildren as well.

Chairman JOHNSON. Thank you very much, panel. I welcome your ideas; and I would urge you, as we move through this, to try to be as tough with yourself as we are going to have to be. We all know this is going to cost more money, I do not care what anybody is saying. We all know fee-for-service is going to have to be there, because there are just lots of parts of the country where that may always be the only form.

But we do have to find a much better way of doing a lot of things. If you read through Mr. Francis' testimony, it is just simply awesome what a bad job of just some very simple things that HCFA has done. Now, we are loading them up with things to do. If you had to do as many new things as they have had to do, you might not do such a good job either.

So this is not about blame, but it is about reality, and it is about where we spend our new money. I want you all to think about the fact that neither the plan of the Republicans nor the plan of the Democrats delivered prescription drugs as an integral part of Medicare. It was a Part D. It had another premium. It was just like Part B. It was an entitlement, but it was an additional plan with an additional premium. A lot of the people, that one-third of seniors who have no prescription drugs, folks, they are the people, a lot of them, that are not going to be able to pay the premium in the Democrats' plan or to pay the premium in the Republicans' plan.

So you have to be a little tougher now with us; you got to be a little tougher with yourselves. Where do we put the premium? Is it fair to pass a prescription drug bill with a $4,000 or a $6,000 catastrophic provision for people who will never spend $4,000 because they can't? Should we be putting our money into a more variable catastrophic level and relying on our market power to create discounts in the market, rather than a government-paid benefit for all those others? Remember how many of which are already getting prescription drugs, at least 50 percent of whom have pretty good plans. So we are going to have to be more realistic, because this plan is going to carry extraordinary financial weight into the future, no matter what we do.

Senator Breaux said his plan just simply slows the rate of growth in spending. That is all BBA did, remember? All BBA 97 did was control the rate of growth for the future 6 years, so it would be the same as the rate of growth in the preceding 6 years——

And anyone who wants to go vote can. You got 3 minutes left. I am going to quit in just a second.

I think we have to be serious about what BBA 97 did. What it did in fact and what it was intended to do are two different things, and that is what caused the havoc. But we do have a very important responsibility to fulfill, and it will not help if you are not tough on yourselves.

Dr. Feder, I want to know exactly what you think ought to be in that benefit plan. I want you to be part of costing it out, and I want you to be a part of taking responsibility. I do not want to hear we have a little problem of solvency. You know we have a big

problem of solvency. So I would really appreciate your continued thoughts.

All of you had excellent comments in your testimony, and I thank you for working with the Committee today.

The hearing is adjourned.

[Whereupon, at 12:05 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of Advanced Medical Technology Association

AdvaMed represents over 800 of the world's leading medical technology innovators and manufacturers of medical devices, diagnostic products and medical information systems. Our members are devoted to the development of new technologies that allow patients to lead longer, healthier, and more productive lives. Together, our members manufacture nearly 90 percent of the $68 billion in life-enhancing health care technology products purchased annually in the United States, as well as 50 percent of the $159 billion products purchased internationally.

AdvaMed applauds the willingness of the Congress to review the current inadequacies of the Medicare program and to plan a future for Medicare that is more responsive to beneficiary needs. We believe it is essential to restructure Medicare to ensure that beneficiaries have access to high-quality health care, which includes lifesaving and life-enhancing medical technologies.

We support the creation of a system that would provide Medicare beneficiaries with a broader choice of competing health plans. HCFA's role in such a system should be to administer Medicare's fee-for-service system, which should continue to be available to beneficiaries. The dynamic and creative forces of the marketplace and competition will lead to innovative alternatives and the individual options and choices that Medicare consumers need. Given clear choices, Medicare beneficiaries will choose the best quality and value offered in a competitive, patient-centered health care system. In addition, we believe that a competitive market system for Medicare will foster and reward innovations that improve outcomes, reduce costs, and enhance the quality of life for patients.

Until such comprehensive reforms are fully implemented in Medicare, AdvaMed believes changes must be made to the existing fee-for-service program to make coverage, coding and payment decisions more predictable and improve beneficiaries' access to new medical technologies. Specifically, we support greater transparency in national and local Medicare coverage processes, more efficient and timely coding policies, and more frequent payment determination updates.

With or without major reforms, Medicare should be encouraged to capitalize on advanced technologies, which have revolutionized the U.S. economy in many other sectors. Significant advances in health care technologies—from health information systems that monitor patient treatment data to innovative diagnostics tests that detect diseases early and lifesaving implantable devices—improve the productivity level of the health care delivery system itself and vastly improve the quality of the health care delivered. New technologies can reduce medical errors, make the system more efficient and effective by catching diseases earlier—when they are easier and less expensive to treat, allowing procedures to be done in less expensive settings, and reducing hospital lengths of stays and rehabilitation times.

AdvaMed applauds Congress for the initial reforms it recently legislated to make the coverage, coding and payment systems more effective and efficient. HCFA has also recently taken some steps to modernize its coverage and payment systems. However, there is still more work that needs to be done. AdvaMed encourages additional measures to make the coverage process more transparent and predictable, the coding processes less complex, and the payment systems more timely and efficient.

While the Medicare program faces the challenge of a rapidly growing aged population, it is presented with the opportunity of unprecedented advances in innovation. We look forward to participating in the Medicare reform debate and will review all plans carefully to ensure that they will foster, rather than impede, the delivery of innovative therapies for patients.

Statement of Alliance to Improve Medicare

Introduction

The Alliance to Improve Medicare (AIM) is the only organization focused solely on fundamental, non-partisan modernization of the Medicare program to ensure more coverage choices, better benefits (including prescription drug benefits), and access to the latest in innovative medical practices, treatments and technologies through the Medicare system. AIM coalition members include organizations representing seniors, hospitals, small and large employers, insurance plans and providers, doctors, medical researchers and innovators, and others.

The structure of the traditional Medicare program has changed little in more than three decades and, consequently, has not kept pace with many of the dramatic improvements in health care delivery. AIM is dedicated to achieving comprehensive modernization of the traditional Medicare program through policy research and educational programs for Members of Congress and their staff, the media, and the American public.

Key Principles for Medicare Modernization

AIM has identified seven key principles to guide Medicare modernization efforts. These principles seek to improve both the administration of the Medicare program and the benefits provided to program beneficiaries.

First, AIM supports improvement of health care coverage through better coordination of care including health promotion and disease prevention efforts. The traditional Medicare program has not kept pace with private sector benefits and plans offering preventive health care and screening measures such as annual physicals, hearing and vision tests, and dental care. Medicare beneficiaries, more so than other population age groups, can benefit from these preventive measures which can help reduce long-term costs and ensure appropriate, early treatment of health problems. Private sector Medicare providers should have the flexibility to incorporate these measures as part of basic health care services. Unfortunately, an act of Congress has previously been required to provide routine screening tests under the Medicare fee-for-service program. For example, health management programs are offered by a variety of health plans (including HMOs) and pharmaceutical benefit managers (PBMs), companies who supply and manage prescription drug benefits for health care companies. Health management programs reduce overall health costs and improve the quality of life by helping beneficiaries better understand and manage conditions such as asthma and diabetes.

Second, AIM supports improvement of health care coverage through increased consumer choice. Medicare beneficiaries should have the option to choose from a range of coverage options similar to those available to Members of Congress, federal employees and retirees, and millions of working Americans under 65 years of age who are covered by private plans. The Medicare managed care program, Medicare+Choice, seeks to provide these types of coverage options to seniors nationwide. Unfortunately, inadequate payments and excessive regulation of private sector providers participating in Medicare+Choice have seriously constrained the ability to expand coverage areas and have caused numerous plans to withdraw from coverage areas where reimbursement was inadequate to cover even the costs of basic care. Between 1998 and January 2001, these withdraws affected over 1.5 million beneficiaries. One Medicare+Choice program participant, Oschner Health Plan (OHP) of Louisiana, cited inadequate payments in July 2000 when announcing withdrawal from nearly 6,000 OHP Medicare+Choice beneficiaries or 16% of OHP's Medicare+Choice beneficiaries in Louisiana. OHP projected 2001 losses of nearly $6.8 million as a result of inadequate payment rates for basic coverage for these beneficiaries.

Third, AIM supports improving coverage through increased competition among all plans and providers in the Medicare program. Medicare's managed care option, the Medicare+Choice program, is an alternative to and competitor with traditional fee-for-service Medicare. The federal government, through the Health Care Financing Administration (HCFA), currently regulates Medicare+Choice plans while also acting as a participant itself through the traditional fee-for-service program. AIM believes this dual role is anti-competitive. Medicare reform and modernization efforts must be evaluated based on success in increasing market competition and availability of basic, affordable coverage to Medicare beneficiaries, not on increasing HCFA's regulatory powers and oversight activities. The U.S. General Accounting Office (GAO) and former HCFA Administrators have identified several areas of conflict

between HCFA's broad responsibilities and management structure including the dichotomy of the traditional fee-for-service program with the Medicare+Choice program. These conflicts include the lack of separate management offices and directors for each program.

Fourth, AIM believes prescription drug coverage should be provided to all Medicare beneficiaries as part of comprehensive, market based Medicare modernization. The opportunity for reform and modernization is presented by the recognized need to cover prescription drug benefits for Medicare recipients. Congress should take this opportunity and not simply layer a new, stand-alone drug program onto the traditional Medicare program without addressing the program's outdated and inadequate financial and structural systems. The program in its current form cannot meet the coming challenges presented by the retirement of the baby boom generation which will more than double the number of Medicare beneficiaries. Any Medicare reform proposal must address the real structural and financial problems of the Medicare program. For example, Medicare currently does not cover simple screening tests to detect high cholesterol among beneficiaries. Without modernization, Medicare will pay for only the drugs to treat high cholesterol but will continue to deny payment for detection of high cholesterol problems in seniors. Under a drug benefit as part of modernization, Medicare would ensure early detection and treatment, including drug therapy, as part of a comprehensive disease management approach.

Fifth, AIM urges Congress to continue to review and address the financial crisis facing health plans and providers. Adequate financing is necessary to establish a solid foundation upon which to build a better Medicare and ensure the long-term financial integrity and solvency of the Medicare program. Payment cuts in the Balanced Budget Act of 1997 (BBA '97) directly undermined patient care and progress toward a modernized program. These cuts were originally estimated to be $103 billion over five years but recent Treasury Department and Congressional Budget Office (CBO) reports project cuts of almost $300 billion—nearly triple what was intended. Health plans, hospitals and doctors have been hit hard and patient care has been and will continue to be affected. Congress recognized the damage caused by BBA '97 and has provided over $30 billion in restorations over the next five years. These small repayments represent a good start at addressing the financial crisis caused by the cuts. AIM encourages Members to ensure appropriate and timely payments for these providers and plans to ensure appropriate care for Medicare beneficiaries.

Sixth, AIM believes that the current rigid and outdated Medicare benefit structure and bureaucracy must be replaced. Program administrators must be provided with the flexibility to make new health care innovations and technologies more readily accessible to Medicare beneficiaries. Currently, Medicare beneficiaries wait a minimum of 15 months after patients in private health plans, including Medicare+Choice plans, to gain access to new medical devices and technologies, and sometimes the wait is as long as five years. HCFA's approval, coding and reimbursement procedures are largely responsible for this delay. Quality health care for Medicare beneficiaries requires these new technologies to be available for all patients. For example, more than half the patients who could use cochlear implants, which restore hearing to the profoundly deaf, are Medicare age. Unfortunately, few Medicare patients have received the device because HCFA hasn't updated its inadequate payment rate in 14 years. Current payment rates for cochlear implants cover less than half of actual costs.

Finally, AIM believes Medicare administrators must reduce excessive program complexity and bureaucracy caused by the more than 110,000 pages of federal rules, regulations, guidelines and mandates. While AIM supports the elimination of real fraud and abuse in Medicare, our members believe this can be achieved without relying on unnecessarily complex and heavy-handed regulation. Providers and plans must not be forced to divert resources from patient care in order to respond to ever-changing regulations. For example, Medicare+Choice plans announcing withdrawals in July 2000 frequently cited the large volumes of Operational Policy Letters (OPLs) as one reason for withdrawal. These plans reported increasing needs to devote additional employees to regulatory issues instead of health care delivery and management, increasing costs to plans at the same time as health care costs increased but payment rates from HCFA remained stagnant.

Conclusion

AIM urges the 107th Congress to consider sensible, long-term solutions to the problems confronted by the Medicare program and by Medicare beneficiaries and we urge Members to work together on a bipartisan basis to achieve comprehensive Medicare reform. AIM appreciates the opportunity to submit this statement for the

hearing record and we look forward to working with the Committee as they examine options for Medicare.

Statement of Citizens Against Government Waste

Citizens Against Government Waste (CAGW) appreciates the opportunity to provide testimony to the House Ways and Means Subcommittee on Health on reforming Medicare. CAGW is a non-profit, non-partisan 501(c)3 organization that accepts no funds from the government. The organization has more than one million members nationwide. CAGW was founded in 1984 by J. Peter Grace and nationally syndicated columnist Jack Anderson to build public support for implementing the Grace Commission recommendations and other waste-cutting proposals, and has long been interested in making Medicare more efficient and responsive to its beneficiaries.

For several years, one of the major policy issues in Washington and across the country is how to provide Medicare beneficiaries with an outpatient prescription drug benefit. Prescription drugs have become a major component of modern health care and are routinely covered in private plans. Medicare, unfortunately for seniors, is not a modern healthcare plan. It is still based on how private health insurance was structured and delivered in the 1960's. At that time, there were few innovative drugs and health insurance focused mostly on hospital stays and expensive surgery. Simply put, Medicare has not kept pace with the advances in modern healthcare technology.

Medicare must be placed on sound financial footing and seniors should have access to a prescription drug benefit. CAGW is not in favor of simply throwing additional money to Medicare Part A and adding a prescription drug benefit, such as creating a Part D as in Senator Daschle's plan (S. 10), to the current Medicare structure. Not only is Medicare in desperate need of modernization, it is financially unstable. It would be unwise to allow the Health Care Financing Administration (HCFA) to directly manage and control a drug benefit. CAGW agrees with the comments of Senator John Breaux (D–LA) at the last meeting of the Bipartisan Commission on the Future of Medicare:

> "As I've said before, I think putting surplus dollars into the Part A Trust Fund doesn't fix Medicare's underlying program. I've likened it to putting more gas in an old car—it still runs like an old car and doesn't have any of the features of a new car."

Medicare must be converted into a modern healthcare system that can provide innovative and up-to-date healthcare for our seniors. CAGW believes that the solution to modernizing Medicare is what a majority of members on the Bipartisan Commission on the Future of Medicare recommended to fix the program. Medicare should be restructured to resemble the Federal Employees Health Benefit Program (FEHBP) that provides healthcare to members of Congress and nine million federal employees, including the president. FEHBP offers about 245 privately run healthcare plans nationwide. All the plans provide drug coverage and the program uses customer choice to keep prices down and quality up.

Under this FEHBP-styled plan, seniors would be given the financial and institutional assistance necessary—better known as premium support—to buy government-approved private health insurance of their own choice. Seniors in economic need would be given more assistance to purchase a plan. If this is not what they want, they could choose to stay in the current government-run system.

An FEHBP model for Medicare would provide a wide range of choices for our nation's seniors, from HMOs to PPOs to fee-for-service plans. Just as FEHBP allows federal employees to pick a new health plan each year, seniors would be allowed to pick a new one on an annual basis, as well.

Contrarily, Medicare uses price controls and rationing to control costs. Seniors cannot shop for a new health plan each year and must accept HCFA's choice on what will be covered or not. As a result, Medicare effectively denies seniors access to the most innovative technology. If supporters of a HCFA-run Medicare drug benefit have their way, it will not be too long before Congress and the agency begin to ration and reduce payments to control pharmaceutical costs and usage, just as has been done in prior years for other benefits and medical procedures.

If anyone doubts that Medicare would not deny coverage, ration or institute price controls for a pharmaceutical benefit, one only needs to look how HCFA covers medical devices.

Medical devices can cover a wide range of technology used in healthcare. They range from a simple test strip that is used to find how much glucose is in blood, to a coronary angioplasty catheter, to a hip implant, to a Computerized Axial Tomography (CAT) scan that is used to view the inner workings of the human body. Each has various degrees of complexity and vastly different functions.

Medical devices essentially go through two approval processes before they are marketed to seniors. First, they must receive approval from the Food and Drug Administration (FDA) before they can be marketed to the general public. Then they have to go through HCFA to win approval to be covered by Medicare.

One of the most important things for a medical device company to do is to obtain a Medicare billing code for their product. When a medical device is used, the associated code will determine how much will be paid by HCFA and their contractors for the procedure. If there is no appropriate code, reimbursement can be delayed and doctors will be less likely to use the product.

Unfortunately for seniors, the process of getting an innovative device covered and paid for is more complex and challenging in Medicare than in the private sector. It often takes months or even years to get a code for a FDA-approved product. Without a code, proper payments are either delayed or uncertain. When this happens, seniors often do not have access to the newest and best technologies.

It literally takes an act of Congress to get Medicare to cover some innovative technologies that are already used in the private sector insurance market. For example, in 1997, there was a concerted bipartisan effort to pass a law to require Medicare to cover:

- an annual screening mammography for women over age 39;
- triennial screening pap smear and screening pelvic exam for any woman (annually for a woman with cervical or vaginal cancer or other abnormality, or who is at high risk of developing such a cancer), while providing for a waiver or deductible;
- annual prostate cancer screening tests;
- colorectal cancer screening tests, subject to prescribed frequency and payment limits; and
- diabetes outpatient self-management training services, including blood-testing strips glucose monitors for individuals with diabetes.

Fortunately, the bill was passed with bipartisan support, and signed into law by President Clinton in December 2000. Now seniors are provided coverage for these important diagnostic tools. But this should not be how Medicare is run or how seniors get access to important healthcare devices.

It is already a matter of life and death in that seniors must wait for HCFA's approval so that Medicare provides access to a medical device. If this same protracted process occurs regarding prescription drugs, this untenable scenario will be compounded.

According to the most recent report by the Medicare Trustees, the Medicare HI trust fund (Part A) is estimated to go bankrupt in 2025. While this is much improved from prior estimates, the forecast is entirely dependent on future economic trends and healthcare cost trends. Furthermore, by 2010, it is expected there will be 3.6 workers for each HI beneficiary, and this will swiftly decline to 2.3 workers for every HI beneficiary by 2030 when the last baby boomer reaches 65.

The Bipartisan Commission found that their FEHBP model proposal for Medicare would be approximately budget neutral in its first five years (between 2000 and 2004 at the time the commission wrote the report.) Over the 10 years following, the proposal would save approximately $100 billion. Over the longer term, the proposal would reduce the growth of Medicare spending by approximately 1 percent a year. The savings would accumulate slowly over time and by 2030 the annual budgetary savings would range from $500 to $700 billion.

Prescription drug coverage for seniors must be made available, but simply adding such coverage to the current Medicare system won't work in the long run. First, more needs to be done to make Medicare more efficient, agile, responsive and financially sound. CAGW believes the best way to save Medicare for the future and to give control and choice back to our nation's seniors is to modernize Medicare and make it work like the plan that provides healthcare to our nation's federal employees. After all, if FEHBP is good enough for Congress, it should be good enough for our nation's seniors.

Statement of Healthcare Leadership Council

The Healthcare Leadership Council applauds Chairwoman Nancy Johnson for her courageous efforts to maintain the goal of Medicare reform and bring the program into the 21st Century.

The past couple of years have seen Medicare's precarious bankruptcy date extended and the immediate pressure to reform the program lifted from Congress. Chairwoman Johnson is to be applauded for continuing the dialogue on the issue of Medicare reform and working toward a long-term solution, despite opportunities for a short-term reprieve.

Even more dire than Medicare's budgetary problems is Medicare's inability to keep up with private insurance coverage or with advances in health care technology. An explosion in research has made the control and prevention of disease more veritable than ever. Yet Medicare beneficiaries do not have access to prescription drugs, limits on catastrophic out-of-pocket spending, many preventive benefits, and a number of other health care products and services that are now enhancing and saving the lives of those with employer health insurance including those enrolled in the Federal Employees Health Benefits Program.

The HLC believes it is unrealistic to expect the federal government to finance a comprehensive program with prescription drugs and other benefits under Medicare's currently flawed structure. Recent estimates of spending on prescription drugs by the Congressional Budget Office (CBO) have sharply increased, with spending on drugs by Medicare beneficiaries in 2001 7 percent higher than estimated last year and 23 percent higher by 2010.

Adding a costly drug benefit to today's Medicare while it is facing insolvency, even before peak enrollment by the baby boom generation, would further cripple the program. Instead, Medicare must embrace the innovations in health care delivery, benefit design, and cost management techniques that have occurred in the private sector in order to expand its benefit package and best serve its beneficiaries.

The Healthcare Leadership Council urges Chairwoman Johnson to continue her efforts to work in a bipartisan manner and develop a plan for restructuring Medicare for the long term so that current and future beneficiaries can access the high quality care and benefits they deserve. A reformed Medicare program that includes a wide selection of private health plans competing for Medicare beneficiaries would offer the highest quality of care and services, including prescription drugs and preventive benefits, at the most affordable price.

For the immediate future, HLC encourages Congress to begin incorporating elements of reform into the current Medicare program including a new streamlined regulatory process that is neither burdensome nor complex, an accelerated coverage process to ensure beneficiaries the latest medical technologies, a new independent administering entity to encourage the success of the Medicare+Choice program and any new benefits, a new method of measuring Medicare solvency for *all* Medicare spending, and an improved Medicare+Choice payment methodology to increase the availability of this program for Medicare beneficiaries.

The members of the Healthcare Leadership Council stand ready to assist the Chairwoman and her subcommittee with their efforts to move Medicare toward assuring that, in the near future, its beneficiaries are able to take advantage of the full potential our health care system has to offer.

Statement of National Association of Chain Drug Stores, Alexandria, Virginia

Introduction

Madame Chairman and Members of the Subcommitee. NACDS represents about 170 chain pharmacy companies that operate about 33,000 retail pharmacies all across the United States. Chain pharmacy is the single largest segment of pharmacy practice. We filled about 60 percent of the 3.1 billion prescriptions provided across the nation last year.

NACDS appreciates this opportunity to provide comments today to the subcommittee on important Medicare reform issues. We are particularly interested in sharing with the subcommittee our perspectives on providing prescription drug coverage to seniors. We believe that our experience in delivering and managing pharmacy benefits can be of value to the subcommittee as you begin your important

work this year in determining what works, and doesn't work, for seniors in helping them obtain their vital prescription medication and pharmacy services.

Develop a Pharmacy Benefit, Not Only a "Drug" Benefit

Today, when a patient arrives at their local community pharmacy, be it a chain pharmacy or an independent, they come into contact with one of the most accessible and trusted providers in the entire health care system. It is estimated that 95 percent of Americans live within five miles of a retail community pharmacy.

Thus, the vast majority of Americans are never far from a highly trained health professional that can provide medications or advice on a wide range of health care issues. Convenient access to community pharmacies makes us a critical part of society's health care safety net.

Prescription medications are the most widely used and cost-effective health care interventions used by patients today. Modern prescription drugs have extended and improved the lives of millions of Americans and saved millions of dollars through shortened length of illnesses, increased productivity, and reductions in hospitalization and medical procedures. Community pharmacy is proud of the role we have in assuring the safe and effective use of these therapies.

That is why we believe that any new program to expand prescription drug coverage to seniors should be a pharmacy benefit, not just a prescription drug benefit. Too often, we think of a prescription drug benefit as only providing a "drug product" to seniors. We believe that this is a serious mistake. Seniors take three times more prescription medications than younger individuals. For that reason, seniors need ready access to community-pharmacy-based education, counseling, and medication therapy management, in addition to the drug product, so they can take their medications appropriately to achieve the intended medical outcomes.

We believe that insurers, payors, pharmaceutical manufacturers, and seniors themselves can agree that these important community-based pharmacy services help make better use of prescription products. To play off a popular catch-phrase, "pharmacy doesn't make the drugs, but pharmacy does make the drugs work more effectively."

We applaud forward thinking members of this subcommittee who supported inclusion of medication therapy management services in various prescription drug proposals introduced last year. It is absolutely critical that any Medicare prescription drug benefit that Congress approves includes coverage for these services.

Don't Over Promise Seniors *and* Understand the Market

Regardless of how seniors obtain their prescription drugs, whether through public or private prescription programs or by paying out of pocket, community retail pharmacies are in a good position to help evaluate for the subcommittee the effectiveness of various options for prescription drug coverage.

When considering approaches to prescription drug coverage, we believe that two good principles for the subcommittee to keep in mind are: first, don't over promise seniors; and second, make sure that you understand how all the pieces fit together in the pharmacy marketplace.

For example, many of you often receive mail from constituents asking the simple question: "Why do my drugs costs so much?" Currently, reimbursement for almost 85 to 90 percent of all prescriptions is set by third party plans, such as insurance companies, HMOs or PBMs. Third party plans keep squeezing down reimbursement rates in order to control exploding costs, but these policies do little to control escalating expenditures. Under these plans, most patients simply pay a copay for these prescriptions. Patient copays have been increasing over the last few years also because of the escalating costs of prescription benefit programs.

Having said this, we are concerned about policy approaches, both at the Federal level and the state level, that would seek to target retail prescription prices as the solution to the high cost of prescription drugs for seniors. The subcommittee should be aware that almost 80 percent of the cost of the average retail prescription price represents costs to the pharmacy over which we have absolutely no control. These are predominantly the costs of acquiring the drug product from the manufacturer, which is passed through to the consumer, and thus reflected in the retail price charged.

The remaining 20 percent of the prescription price represents our operating costs, such as heat, light, rent, salaries, computers, counseling, and other overhead expenses. Currently, our salary budgets are experiencing significant upward pressures as a result of the critical pharmacist shortage. We look forward to working with you this year, Madame Chairman, on alleviating this shortage and assuring an adequate supply of pharmacists exists to serve all Americans, including Medicare beneficiaries.

With this as background, we will now provide some of our perspectives and cautions on other approaches that you may consider this year.

Prescription Drug "Cash Discount Cards": Unfulfilled Promise

Retail pharmacies have no upward negotiating leverage with brand name drug manufacturers, so any initiatives that seek to control or limit our retail charges do nothing to affect our cost of buying the drug. For example, so-called prescription "cash discount" card programs essentially require pharmacies to provide a discount on the retail prescription price, without lowering our cost of providing the product. In other words, the pain doesn't flow upstream.

We also believe that these prescription cash discount cards create unfulfilled promises for seniors. If a senior cannot afford a drug at $100, it is very unlikely that the senior can afford it at $90. In addition, as stated above, many of our pharmacies already give senior citizen discounts, which reduce the retail price essentially to the price that the senior would pay under the cash discount card. Finally, many of these cash discount card programs also often use out-of-state mail order as an incentive to steer patients to certain drugs that may be inappropriate for the senior. Mail order also takes the senior out of the neighborhood pharmacy setting.

On this topic, we'd like to draw your attention to a recent report from the Massachusetts Institute of Technology that said, "the individuals who face the greatest burden lack insurance coverage for prescription drugs are in relatively poor health with severe chronic conditions, have relatively low income, and do not qualify for existing state prescription drug coverage programs. These individuals need benefits that far exceed the savings attainable from a pure discount card program." [1]

The Myth of Volume Pharmaceutical Purchasing

Some may say that you can obtain better prescription prices for the elderly by "pooling their purchasing power" so that they can get the same volume discounts obtained by other pharmaceutical purchasers. Be wary of this line of argument, because the pharmaceutical marketplace doesn't work that way. Volume purchasing does not drive pharmaceutical manufacturers to give discounts—you have to move a manufacturer's "market share" to obtain these discounts.

If "volume purchasing" drove manufacturer discounts, then why do the largest pharmaceutical purchasers, such as large chain pharmacies, as well as many of the independent pharmacies that belong to large buying groups, pay higher prices for brand name drugs than smaller pharmaceutical purchasers who buy less volume?

Here's what the proponents of "volume purchasing" for seniors don't and won't tell you. All this really amounts to is simply discounting the retail prescription price that seniors pay at their pharmacy, without affecting retail pharmacy's cost of buying the drug, or without requiring the insurance plan or PBM to "pass through" to the senior any and all of the financial incentives that are given to them by the manufacturer. If these plans were required to pass through all the discounts that they negotiate, both pharmacy discounts and manufacturer discounts, the senior would truly benefit from lower prescription drug prices. Without requiring full "pass throughs," from the manufacturer, the entire burden of so-called "volume purchasing" falls squarely and unfairly on the shoulders of community pharmacies.

We also believe that some of the estimates being made of the size of the discounts that volume pharmaceutical purchasing would attain for seniors are unrealistic and will create serious unfulfilled promises. For example, there were several numbers floating around last year that indicated that private sector entities, or PBMs, would be able to lower retail prescription prices paid by consumers by 25 percent, with some estimates as high as 30 to 39 percent.[2]

We do not know where these numbers come from or how they are calculated. The only remotely conceivable way that this discount size could be attained is if the PBM is required to pass along to the consumer any and all financial incentives (e.g. rebates or discounts) that they negotiate with pharmaceutical manufacturers. This does not happen today in the marketplace and is creating false and unrealistic expectations.

"Drugs Only" Plans and Insurance-Based Models

We recognize that there is support among Members of Congress for creating "drugs only" insurance-based models to provide prescription drug coverage to seniors. Recent experience in the state of Nevada, however, should tell us that, just because you "build it," doesn't mean that "seniors will come." In a genuine effort to

[1] Massachusetts Institute of Technology, The HOPE Plan and the Section 271 Discount Drug Purchase Program for Massachusetts: An Economic Analysis. December 21, 2000.

[2] Price Discounting Practices for Pharmaceuticals in the U.S. The Lewin Group, April 2000.

help seniors obtain prescription drugs, Nevada embarked upon establishing an insurance-based model to provide prescription drug coverage. After several attempts to finally find a company that wanted to administer the program, reports are that only a handful of seniors have signed up because of the high premiums and significant cost sharing in the program.

We are concerned about a similar fate if such an approach is tried at the Federal level. In general, these programs are subject to significant "risk selection," and tend only to attract those seniors that need protection against high prescription drug bills. Many seniors will not see the benefit in obtaining this coverage because of the significant deductibles and premiums that have to be paid before any benefit is derived from the coverage. Thus, because the cost will keep many seniors out of the "risk pool," premiums will keep increasing for those remaining in the pool, making it less and less affordable for those that need the coverage.

Moreover, the cost of these private-sector insurance plans can also be prohibitive, as was recently reported in the *New York Times*. The premiums for Medigap plans with prescription drug coverage, the model on which these insurance-based programs are based, will increase 31 percent in New York, 26 percent in Illinois, 24 percent in Wisconsin, 16 percent in Arizona, and 14 percent in Ohio.[3]

Finally, only one entity to date has indicated interest in creating an insurance product in the market that would operate by assuming risk for senior drug coverage. The insurance and PBM industry has demonstrated little enthusiasm for this concept. So, with only one competitor, it is difficult to see how competition would or could actually work under this model. Moreover, we all should be concerned that this one entity is a subsidiary of a drug manufacturer, which increases the likelihood that these manufacturers' drug products, rather than the one that is best for the patient, will be more frequently dispensed than others.

"Premium Support" Models, Risk-Based Capitated Financing, and PBMs

We also believe that the subcommittee should consider the implications for quality of care and cost of using a competition-based "premium support" model for Medicare beneficiaries, financing the benefit through risk-based capitation, and delivering the benefit through pharmaceutical benefit managers, also known as PBMs.

Almost all proposed models, to provide a prescription drug benefit to seniors, use a PBM in some way, shape, or form. For example, some proposals would require that an agency of the Federal government contract with one or more PBMs to provide a pharmacy benefit.

Other proposals would establish "prescription drugs only" insurance policies for Medicare beneficiaries that could be voluntarily purchased in the private marketplace. Many of these proposed insurers would likely partner with PBMs to administer these plans. PBMs can serve several useful functions in the design and delivery of a new pharmacy benefit for seniors. However, NACDS believes that policymakers need to evaluate the implications for quality of care and cost of several management tools currently used by PBMs.

PBMs Achieve Savings by Focusing on Squeezing Pharmacy Reimbursement: How effective are PBMs at reducing the cost of drug products? How do PBMs achieve most of their savings? Our experience is that they achieve the overwhelming majority of their savings by squeezing down on pharmacy reimbursement, not by aggressively negotiating rebates and discounts from drug manufacturers.

Evidence suggests that PBMs are relatively ineffective at managing drug costs, and actually add expense to the system that could otherwise be passed along to the consumer. For example, a 1997 GAO study said: "*Much of the savings that PBMs achieve appear to come from the lower prices paid to pharmacies rather than from the rebates offered by drug manufacturers.*"[4] The study found that 50 percent to 70 percent of the drop in the plans' spending on prescription drugs resulted from lower retail prescription prices. Only 2 to 21 percent of the savings resulted from manufacturer rebates that the PBMs shared with the health insurance plans.

This study reflected the experience of the three largest PBMs that manage the 9-million member Federal Employees Health Benefits Program (FEHBP). Members of Congress should be aware that this program, which is being talked about as the basis for a future Medicare "premium support" model, has been experiencing double-digit increases in prescription drug expenditures over the last several years, 22 percent for 1998 alone.

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[3] Insurers Push Rates Higher for Medicare Supplement. Milt Freudenheim, *New York Times*, February 8, 2001.

[4] Pharmacy Benefit Managers, GAO/HEHS–97–47, U.S. General Accounting Office, February 1997.

We believe that the experience of FEHBP should be instructive to Members of Congress as they consider the "premium support" model for Medicare. Please note that these prescription drug cost increases are occurring in a population that is not representative of the Medicare population. FEHBP generally serves a younger population that uses fewer prescription drugs than the Medicare population. More significant increases are likely to occur in an older, Medicare-based population.

Risk-Based Financing: Some proposals would finance a senior drug benefit by shifting "full or partial financial risk" to the private sector entity managing the benefit. Under these approaches, a plan would receive a fixed or "capitated" amount to provide all the beneficiaries' prescription drug needs, regardless of the cost of those drugs, or the number of drugs being taken. These "full or partial financial risk" capitation approaches have significant potential negative implications for quality of care.

That is because providers are placed at risk for the cost of purchasing and dispensing drug products and providing pharmacy services, over which they have no control. For example, to stay below the reimbursement "cap," drugs that are less expensive but less effective may be provided to the patient. Ironically, under this model, the drug manufacturers, who are driving the overwhelming majority of the increases in drug spending due to DTC advertising and higher drug prices,[5] bear none of the risk.

Because of the unpredictability in prescription drug utilization, there are very few private-sector prescription drug benefit programs that are fully or partially capitated, and there are none for older Americans that uses this type of approach. Past experiences in using capitation models for pharmacy benefits have been unsuccessful. There is no reason to believe that they would be any more successful today, given the impact that manufacturer direct-to-consumer advertising has had on fostering increased prescription drug use.

Of further concern are recent reports that the Congressional Budget Office has sharply increased its estimates of prescription drug spending by the elderly, escalating the cost of potential new Medicare drug benefit by one-third. This phenomenal growth in drug spending by the elderly should give us more pause to really question the impact of a capitated drug benefit on seniors, and whether PBMs really have the ability to manage these exploding costs.

Finally, providing "drugs only" capitated policies results in a serious "disconnect" in the integrated financing of health care. That is because under a capitated drug benefit approach, insurers or PBMs only have incentives to hold down their drug spending, without assessing how increasing (or decreasing) drug spending will impact overall health care spending for a patient. This leads to fragmented and disjointed health care for the patient, and thus could potentially compromise quality of care.

Participation by Pharmacies as "Eligible Entities": It is important to note that many of the bills would allow "networks of pharmacies" or "retail pharmacy delivery systems" to contract directly with a Federal government agency or an insurance company to provide a capitated drug benefit to seniors. While we appreciate the interest in enabling pharmacies participating as "eligible entities," it is highly unlikely that we will do so for two reasons.

First, many retail pharmacies (or retail pharmacy networks or delivery systems) are not licensed in states as "insurers," and would unlikely be willing to assume capitated "risk" for the delivery of a drug benefit. This is especially the case since pharmacies have little ability to control physician prescribing patterns or drug manufacturer advertising.

Second, even though retail pharmacies purchase, at significantly larger volume, greater quantities of pharmaceuticals than most other pharmaceutical purchasers, drug manufacturers charge them much higher prices for the same prescription drugs than other smaller purchasers, such as Medicare+Choice plans. This will place community retail pharmacies at a competitive disadvantage to these other entities that may want to bid to offer a drug benefit.

This market distortion is a fundamental inequity in the system, which belies the whole premise that "competition" actually exists or even works in the pharmaceutical marketplace. If retail pharmacies were given the same access to the discounts that drug manufacturers make available to other, smaller purchasers, the overall cost of the Medicare drug benefit would be reduced by billions of dollars. Prescription drugs would also be more affordable for other private prescription drug plans, as well as millions of uninsured non-elderly Americans.

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[5] Drug manufacturer direct to consumer advertising spending increased to $1.9 billion for the period January–September 2000.

Medication Therapy Management: Almost all Medicare proposals would require that quality assurance, drug use review, and medication therapy management services be provided to Medicare beneficiaries under these plans. Medication therapy management services include disease state management, medication compliance programs, and drug use review. These programs have been documented to improve prescription use, reduce medication errors, and save money.

Community retail pharmacy believes that the provision of medication therapy management services is an important part of a Medicare pharmaceutical benefit. As prescription medication therapy becomes more potent and complex, the need for these services will only increase. Pharmacists have been performing these functions for many years to improve quality patient care.

However, most PBMs do not incorporate medication therapy management programs into their benefit packages. Pharmacists are usually paid for *dispensing* pharmaceuticals only, not for the important activities involved in helping to *manage* the appropriate use of pharmaceuticals by patients. While it is the local community pharmacist that provides these services, insurance companies and PBMs continue to squeeze down on the pharmacist reimbursement for prescriptions—so much so, that it is impossible for them to provide these important patient care services. We have to make sure that Medicare beneficiaries have access to these services, and that pharmacists are compensated for providing them.

So . . . What Works for Seniors?

What works for seniors in terms of providing them a meaningful pharmacy benefit?

For the short term, we believe that the best course that Congress can take is to provide Federal funds to states to help low income seniors obtain this pharmacy benefit. We know that there are many mixed feelings among Members of Congress about this approach. However, given that almost every state is now considering enacting or developing some form of prescription assistance program for seniors, we believe that states are in a good position, right now, to help those most in need.

And data indicate that 60 percent of those seniors without prescription drug coverage, or about 7.2 million seniors, have incomes of less than 200 percent of poverty.[6] We see many of these seniors in our pharmacies every day, struggling to pay their prescription bills. For them, they just want some help to get them their medications.

For the long term, we want to work with this Committee, the rest of the Congress, and the Administration to achieve long term reform of the Medicare program to provide the type of quality pharmacy benefit that seniors need and deserve.

We believe that this benefit should:

- promote the utilization of generic drugs when appropriate;
- provide seniors with access to meaningful, community-based medication therapy management services with appropriate compensation for pharmacies;
- not be financed through risk-based capitation because of an inability to control prescription utilization, with a potential negative impact on seniors' quality of care;
- give seniors access to the community-based pharmacy provider of their choice;
- not economically coerce seniors to use other prescription delivery mechanisms, such as out-of-state mail order;
- not include price controls on retail pharmacy prices, including prescription cash discount card programs; and,
- assure that community pharmacies are adequately compensated in providing services to meet the needs of our nation's seniors.

We look forward to working with you and the Committee on these issues, and thank you for the opportunity to submit these comments today for the record.

Statement of TREA Senior Citizens League, Alexandria, Virginia

Chairman Johnson and members of the Subcommittee, we thank you for holding this series of hearings to discuss Medicare reform and a prescription drug benefit. TREA Senior Citizens League (TSCL) is a national group of over 1.3 million politically active seniors concerned about the protection of their earned Social Security, Medicare, military, and other retirement benefits. Our supporters are among the poorest of the poor and the oldest of the old. Every day we receive letters and mail

[6] Kaiser Family Foundation. "The Medicare Program" Issue Brief, October 2000.

urging us to help these folks get by. A huge part of the problem they face is in covering prescription drug costs.

Poverty in our country is defined as individuals having incomes below $8,350 and couples with incomes of $11,250 or below. Many of our members, who have no other financial resources except Social Security and Medicare, already live below, or are at risk of falling below, the poverty line.

Think for a minute about how you would live on $8,350 a year.

Why We Need Medicare Reform Now

The Medicare program has been responsible for a major reduction in poverty in our country and improvement in the health of American seniors, but the safety net is unraveling. The program needs modernization to cover prescription drug and catastrophic costs. In addition changing demographics pose tremendous future financial challenges.

Forty million Americans receive Medicare benefits. Currently Medicare recipients are often forced to piece together a patchwork of stop-gap measures in order to afford health care. Currently, only one in four employers provides health care benefits for retirees, down from 40% in 1994. Since 1998, more than 1.6 million Medicare recipients have been forced to find other health care plans when their private managed care plan raised premiums, cut benefits or withdrew from Medicare altogether.

According to our studies of the insurance industry, Medigap health care premiums are expected to rise this year by an average 18%, following increases in 2000 of 10%–30%. Spending on prescription drug costs is expected to rise by about 21% in 2001 after an increase of about 18.4% in 2000. The average senior spends $3,142 a year in out-of-pocket health care costs. Those in poor health and with no supplemental insurance must spend even more—$4,478.

Nationally, about one third of all Medicare recipients have some prescription drug coverage, but approximately 44% of TSCL members report that they have no prescription drug coverage.

How We Should Proceed

Currently, the debate over reforming Medicare and adding prescription drug coverage has centered on the following three approaches:

- Adding a universal prescription drug benefit to traditional fee-for-service Medicare and Medicare+Choice plans now, and reform the program later.
- Providing temporary block grants to the states for prescription drug assistance for low-income Medicare recipients until the program can be reformed.
- Offering a universal prescription drug benefit within the context of an overall Medicare reform. This would include a Federal Employee Health Benefit Plan "premium-support" model in which a fee-for-service Medicare program would compete for business, along with private plans.

TSCL favors adding a voluntary universal prescription benefit now, with some modernization. More extensive reform could be implemented slowly and incrementally. TSCL feels temporary block-grants to the states are only a stop-gap measure that would take too much time to implement to be effective. To date, only 22 out of 50 states already have prescription drug plans. States without the programs would have to go through the legislative process of setting one up and by that time the four-year funding would be over. Statistics show that a large majority of seniors who are eligible for such programs do not receive the help to which they are entitled, some, because they don't know it exists—others because they don't want to feel they must accept welfare.

On the other hand, Medicare reforms should not be rushed. In 1997 Congress and President Clinton passed the most sweeping reforms since the Medicare program was enacted. Those reforms led to the unintended consequences of widespread nursing home bankruptcies, severe cut-backs in home health services, and more than 1,634,000 Medicare managed care patients being forced out of their Health Maintenance Organizations (HMOs)—all of which translated to higher out-of-pocket costs for beneficiaries.

Regardless of what features a reformed Medicare takes, however, prescription drugs will be part of it. Therefore, adding the benefit now would be the critical first step. TSCL feels that the following criteria are essential to designing a prescription drug benefit. A prescription drug benefit should be:

Universal—Medicare serves 40 million Americans. The benefit package is universal, and therefore any new benefits must also be universal, not just offered to one group, or in one region of the country.

Voluntary—Medicare recipients who are happy with their current prescription drug coverage should not be forced to give up. In like manner, the government should not create perverse incentives for employers to REDUCE retiree health care

and prescription drug benefits, but should give incentives for retention of benefit plans.

Provides choice—Although much attention is given to reforming Medicare along the lines of private managed care and the Federal Employee Health Benefit Plan, it has not been proven that either model saves the government money. The majority of Medicare recipients continue to receive their care through traditional fee-for-service Medicare. Medicare recipients should have the freedom to remain in the type of health care plan of their choice.

Affordable—Driven by rising prescription drug costs, many health plans are reducing prescription drug benefits. Prescription drug coverage is increasingly an option available only to higher income retirees or those on Medicaid. TSCL favors prescription drug plans that provide full support to seniors below 135 percent of the poverty line. In addition, TSCL supports plans priced so that middle income seniors, (individuals with incomes of $15,000 to $20,000) can afford to purchase coverage. A plan that is so expensive that no senior will purchase it is no protection at all.

Guarantees a standard basic drug benefit—Seniors need a reliable basic benefit. Such coverage should include an affordable deductible, fair and reasonable cost-sharing arrangements, and catastrophic coverage for those with large drug costs. Medicare recipients should not be forced to comb through the fine print of marketing materials to ensure their plan actually covers their needs.

Provides greater cost efficiencies—Modern drug coverage plans use private pharmacy benefit managers (PBMs) to negotiate lower prices and administer drug plans. In like manner, such PBMs can help Medicare contain costs either under a traditional or modernized program. TSCL also believes that greater use of generics, alternative treatments, and improved management of prescription drug therapies to reduce over-medication and dangerous drug interactions would lead to better health care outcomes at lower cost.

How Will We Pay For A Prescription Drug Benefit?

TSCL thanks President Bush and the members of Congress from both parties who have promised to provide prescription drug benefits and protect Medicare. While our nation still has the finances to do so, we urge Congress not only to set aside the $400 billion of surplus in the Medicare lock box, we also urge Congress to set aside an additional amount to finance a new prescription drug benefit.

This is important because Medicare is financed to two parts. Hospital costs (Part A) are financed out of Medicare payroll taxes. This is the lock box surplus. Part B Medicare, however, is financed 75% from the general revenues (the non-trust fund surplus) and 25% from premiums paid by Medicare recipients. Part B currently represents about 40% of total Medicare expenditures and is growing faster than Part A expenditures. A new prescription drug benefit will add new costs. TSCL therefore urges Congress to set aside a reasonable portion of the budget surplus from the general revenues PRIOR to enacting a tax cut in order to shore up Medicare Part B and to pay for a prescription drug benefit.

TSCL further believes that Congress should consider that U.S. taxpayers, through taxpayer-subsidized research, are "co-investors" with the pharmaceutical companies that have profited financially from drug patents. We therefore feel it appropriate to consider measures that would more equitably "share the profits" of taxpayer-subsidized research with Americans most in need of the product—Medicare recipients.

We are honored for this opportunity and thank you again for your leadership.

TSCL appreciates all efforts of the Bush Administration and Congress. We look forward to working together to find solutions that would best benefit all older Americans.

TSCL is registered as a 501(c)(4) citizens action organization. Open to anyone concerned about protecting earned benefits, TSCL is registered to conduct grass roots lobbying, public education, and fundraising activities in nearly every state. No government moneys are accepted or utilized by TSCL.