STRENGTHENING AND IMPROVING MEDICARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

APRIL 9, 2003

Serial No. 108–22

Printed for the use of the Committee on Energy and Commerce

Available via the World Wide Web: http://www.access.gpo.gov/congress/house

U.S. GOVERNMENT PRINTING OFFICE

87–482PDF WASHINGTON : 2003

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2250 Mail: Stop SSOP, Washington, DC 20402–0001

COMMITTEE ON ENERGY AND COMMERCE

W.J. "BILLY" TAUZIN, Louisiana, *Chairman*

MICHAEL BILIRAKIS, Florida
JOE BARTON, Texas
FRED UPTON, Michigan
CLIFF STEARNS, Florida
PAUL E. GILLMOR, Ohio
JAMES C. GREENWOOD, Pennsylvania
CHRISTOPHER COX, California
NATHAN DEAL, Georgia
RICHARD BURR, North Carolina
Vice Chairman
ED WHITFIELD, Kentucky
CHARLIE NORWOOD, Georgia
BARBARA CUBIN, Wyoming
JOHN SHIMKUS, Illinois
HEATHER WILSON, New Mexico
JOHN B. SHADEGG, Arizona
CHARLES W. "CHIP" PICKERING, Mississippi
VITO FOSSELLA, New York
ROY BLUNT, Missouri
STEVE BUYER, Indiana
GEORGE RADANOVICH, California
CHARLES F. BASS, New Hampshire
JOSEPH R. PITTS, Pennsylvania
MARY BONO, California
GREG WALDEN, Oregon
LEE TERRY, Nebraska
ERNIE FLETCHER, Kentucky
MIKE FERGUSON, New Jersey
MIKE ROGERS, Michigan
DARRELL E. ISSA, California
C.L. "BUTCH" OTTER, Idaho

JOHN D. DINGELL, Michigan
Ranking Member
HENRY A. WAXMAN, California
EDWARD J. MARKEY, Massachusetts
RALPH M. HALL, Texas
RICK BOUCHER, Virginia
EDOLPHUS TOWNS, New York
FRANK PALLONE, Jr., New Jersey
SHERROD BROWN, Ohio
BART GORDON, Tennessee
PETER DEUTSCH, Florida
BOBBY L. RUSH, Illinois
ANNA G. ESHOO, California
BART STUPAK, Michigan
ELIOT L. ENGEL, New York
ALBERT R. WYNN, Maryland
GENE GREEN, Texas
KAREN MCCARTHY, Missouri
TED STRICKLAND, Ohio
DIANA DEGETTE, Colorado
LOIS CAPPS, California
MICHAEL F. DOYLE, Pennsylvania
CHRISTOPHER JOHN, Louisiana
JIM DAVIS, Florida
THOMAS H. ALLEN, Maine
JANICE D. SCHAKOWSKY, Illinois
HILDA L. SOLIS, California

DAVID V. MARVENTANO, *Staff Director*
JAMES D. BARNETTE, *General Counsel*
REID P.F. STUNTZ, *Minority Staff Director and Chief Counsel*

SUBCOMMITTEE ON HEALTH

MICHAEL BILIRAKIS, Florida, *Chairman*

JOE BARTON, Texas
FRED UPTON, Michigan
JAMES C. GREENWOOD, Pennsylvania
NATHAN DEAL, Georgia
RICHARD BURR, North Carolina
ED WHITFIELD, Kentucky
CHARLIE NORWOOD, Georgia
Vice Chairman
BARBARA CUBIN, Wyoming
HEATHER WILSON, New Mexico
JOHN B. SHADEGG, Arizona
CHARLES W. "CHIP" PICKERING, Mississippi
STEVE BUYER, Indiana
JOSEPH R. PITTS, Pennsylvania
ERNIE FLETCHER, Kentucky
MIKE FERGUSON, New Jersey
MIKE ROGERS, Michigan
W.J. "BILLY" TAUZIN, Louisiana
(Ex Officio)

SHERROD BROWN, Ohio
Ranking Member
HENRY A. WAXMAN, California
RALPH M. HALL, Texas
EDOLPHUS TOWNS, New York
FRANK PALLONE, Jr., New Jersey
ANNA G. ESHOO, California
BART STUPAK, Michigan
ELIOT L. ENGEL, New York
GENE GREEN, Texas
TED STRICKLAND, Ohio
LOIS CAPPS, California
BART GORDON, Tennessee
DIANA DEGETTE, Colorado
CHRISTOPHER JOHN, Louisiana
JOHN D. DINGELL, Michigan,
(Ex Officio)

CONTENTS

STRENGTHENING AND IMPROVING MEDICARE

WEDNESDAY, APRIL 9, 2003

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2322, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Barton, Deal, Norwood, Shadegg, Buyer, Brown, Pallone, Stupak, Engel, Green, Strickland, and Capps.

Staff present: Steve Tilton, health policy coordinator; Kathleen Weldon, professional staff; Eugenia Edwards, legislative clerk; Amy Hall, minority professional staff; Bridgett Taylor, minority professional staff; and Karen Folk, minority special staff.

Mr. BILIRAKIS. Good morning. I now call this hearing to order.

Obviously, the rule regarding opening statements and deferring opening statements, etcetera, is in place.

Our hearing yesterday focused on designing a prescription drug benefit as part of Medicare. Today, the Health Subcommittee will consider ways to strengthen and improve Medicare with the goal of improving the financial health of the program and ensuring that future beneficiaries will be able to enjoy the security Medicare has provided millions of Americans for almost 40 years.

Today there are 34 million Americans over the age of 65, 5.5 million people with disabilities, and 240,000 people with end stage renal disease that participate in the Medicare program. The Federal Government spends nearly $250 billion annually to provide health care benefits to these people. It is estimated that Medicare will serve 77 billion Americans by 2030.

Medicare was established in 1965 by Congress and was structured around an acute patient care model to cover hospitalization and physician visits. As we all know, the program has had great difficulty keeping up with advances in medicine over the past 38 years, with the most glaring example being the fact that traditional fee for service Medicare does not provide prescription drug coverage.

Medicare also does not cover preventative services in any rational fashion. While Medicare does cover preventative services for 10 different diseases and conditions, it does not offer other preventative benefits that would seem like common sense aspects of a modern, comprehensive health insurance product.

That is why it is essential for Congress to find ways to strengthen and improve Medicare, so it is truly a 21st century benefit and to ensure its continued financial viability. As we will hear from Rick Foster, the chief actuary for the Center for Medicare and Medicaid Services, the Hospital Insurance Trust Fund will go bankrupt in the year 2026 under the current benefit structure, with HI Trust Fund revenues falling short of program expenditures beginning in 2013.

In addition, it will take significant increases in beneficiary premiums to subsidize the Supplemental Medical Insurance Trust Fund, which pays for Medicare Part B services. We are shirking our responsibility to continue to argue that the solution to our problems with Medicare is to tack on trillion dollar benefits with no hint of meaningful reforms.

As Congress continues to debate the future of Medicare, this program and other entitlements are eating up a larger and larger share of our gross domestic product. This is an unsustainable rate of growth, and no amount of partisan rhetoric on either side of the aisle is going to change that.

We have seven excellent witnesses here today. I hope that members take advantage of them and keep the grand-standing to a minimum. I know at the end of the day we all share the same goal—and that is heartwarming; we all share the same goal—and that is protecting Medicare's future while finding ways to provide comprehensive health care coverage for our seniors and people with disabilities.

I am now pleased to recognize the gentleman from Ohio for an opening statement. Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman, and I apologize for being a few minutes late.

I want to welcome my former colleague, Ms. Kennelly. Nice to see you. And Ms. Moon—thank you, Dr. Moon, for joining us, and all of you on the panel.

If yesterday's hearing is any guide, there will be discussion in addition to discussions about strengthening and improving Medicare, about whether we can afford to strengthen and approve this program or even maintain the program the way that it is. Let us dispense with that issue first.

During yesterday's hearings, several colleagues expressed concern that Medicare is simultaneously barrelling toward insolvency and jeopardizing the Nation's economy by absorbing so much of our GDP. How can a program partially funded out of general revenues be barreling toward insolvency? Does the fact that we just increased the tax dollars devoted to the Department of Defense mean that we rescued it from the brink of insolvency?

Taxes are a flexible funding mechanism. The President clearly recognizes that taxes are not set in stone. He hasn't hesitated to propose tax cuts, even when those cuts produce budget deficits or perhaps they produce insolvencies. But surely neither the President nor my friends on the other side of the aisle would propose tax cuts if we truly believe that Medicare is at risk.

In his State of the Union address, the President called Medicare the binding commitment of a caring society. I am sure the Presi-

dent wouldn't say that and then turn around and cut trillions from Federal revenues while Medicare withers on the vine.

This Nation can afford Medicare. The President's tax cuts will cost between 2.3 percent and 2.7 percent of GDP over the next 75 years. The combined deficit in Medicare and Social Security—the combined deficit in Medicare and Social Security will cost one-third to one-half of that.

To paraphrase Jeanie Lambrew, a witness at one of last year's Medicare hearings, this isn't about dollars. It is about priorities. The question then becomes: how do we strengthen and improve Medicare? Some of my Republican colleagues believe we should abandon the traditional Medicare program. Seniors would be better off, they say, choosing between and among private health plans.

The premise that insurance is like a car, that seniors would be better off customizing their coverage to fit their health care needs, is the biggest fallacy of the privatization campaign. People generally don't attempt to customize their health insurance based on their unique health care needs, because people generally can't anticipate their unique health care needs.

When people do try to pick and choose coverage based on known health care, you know, based on known health conditions, it is called adverse selection. Creating a system characterized by multiple benefit packages and adverse selection means creating a system that is unstable and unfair. Some plans will be overpaid, some underpaid. Some enrollees will bear disproportionate risk, others will get off easy.

A reliable risk adjuster would help mitigate the problem, but we don't have a reliable risk adjuster, and God knows we have tried. The fact is there is no incremental benefit to multiple benefit designs, the relative value of which is impossible for a prospective enrollee to assess.

We all need health insurance that covers medically necessary care delivered by the health care providers we trust. Sounds a lot like Medicare. And we all need coverage that lasts. Disappearing health plans and shrinking benefits are hallmarks of the privatization efforts, the Medicare+Choice Program.

Instead of alleviating uncertainty, these plans breed it. No one really wants coverage like that. Proponents of privatization argue that Federal employees have a choice of private health plans. The fact that FEHBP features a plethora of private health plans does not mean FEHBP is a better system than Medicare or the best system out there.

FEHBP programs grew 11 percent in 2003. Senior social security income grew by less than 4 percent. Last year seniors earned about $14,000 on average. There is not much cushion there for unpredictable premium increases.

Some privatization proponents argue that plan choice makes sense, not because health needs vary but because income does. The premise that we are seeing is that wealthier individuals should be able to choose less generous coverage because they can afford to pay any balance out of pocket. But as we know from the under 65 market, it won't be individuals, it won't be wealthy individuals who will go without comprehensive health insurance.

Lower income beneficiaries would be the ones relegated to inferior health plans, if we abandon traditional Medicare. It is difficult to imagine how creating a two-tier health system featuring health plans that may or may not provide lasting coverage, and may or may not provide reliable coverage, that they possibly qualify as a strategy for strengthening and improving Medicare.

We keep coming back to the same question: are we considering Medicare privatization because there is merit to it or because my friends on the other side of the aisle don't like government programs?

The Heritage Foundation launched a Mediscare campaign in 1995. The goal was to privatize Medicare. This seems to be the culmination of those efforts. Medicare, the President said, is the binding commitment of a caring society. Should ideology or should common sense guide its future?

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman. Mr. Buyer for an opening statement. I know you are chomping at the bit. Go ahead.

Mr. BUYER. No, I just—I can't believe I work in the same institution as Mr. Brown.

Mr. BILIRAKIS. Well, you do.

Mr. BUYER. I mean, I remember in April 1995 getting a letter from the Medicare trustees, many of whom were on President Clinton's cabinet, of whom said Medicare was going to go bankrupt. So let us don't advance this 6 years later and then say someone else made it up. That just—boy, I don't understand that.

I like to have a clean record, and that really bothered me, Mr. Brown. You just can't make it up as you go. And I know sometimes we get excited in the rhetoric, but, please, I would invite you to look at the April letter of 1995 from the Medicare trustees.

I will yield back, so I can retain the rest of my time.

Mr. BILIRAKIS. The gentleman yields. Ms. Capps. Let us see, no, Mr. Pallone.

Ms. CAPPS. I am going to waive.

Mr. BILIRAKIS. You are going to waive?

Ms. CAPPS. I have an opening statement to submit.

Mr. BILIRAKIS. Mr. Pallone.

Mr. PALLONE. Thank you, Mr. Chairman. I am opposed to privatizing Medicare, both in general as well as for purposes of providing a prescription drug plan. And my fear, Mr. Chairman, is that the Republicans will propose a voucher-type system under which private health plans compete with one another as well as with traditional Medicare.

And such a proposal raises several problems for me, Mr. Chairman. First, it is likely that healthier beneficiaries will be the ones to sign up for private plans, and this leaves the sicker beneficiaries in a traditional Medicare program. This will inevitably drive up the costs of traditional Medicare, and as a result the per person cost of the traditional Medicare program will escalate, putting people who need health care the most at greater risk of higher expenses and fewer benefits.

Also, private health plans have abandoned hundreds of thousands of seniors for Medicare+Choice plans, and yet the Republican proposals seem to rely on private health plans for Medicare re-

structuring. In the last 2 years, over 100 plans dropped out of the Medicare+Choice system all together, and over 100 plans reduced their service areas. And many other plans increased premiums and reduced benefits.

Compared to private health insurance plans, Medicare has done a much better job at controlling per person health care costs. Therefore, there is no reason to turn Medicare over to the private sector. Empirical data has shown over the last 30 years that per person private health insurance quotes have increased faster than Medicare. Therefore, protecting Medicare's solvency should not depend on private health plans. I don't understand the rationale.

Some of the Republican proposals give unwarranted credence to the Federal Employees Health Benefit Plan as the model for restructuring Medicare. But that system has not moderated costs better than Medicare. It serves a much smaller population that is younger, healthier, wealthier, and more attractive to private insurers. And the number of HMOs offering health coverage to Federal employees and retirees declined from 476 in 1996 to 277 in 2000.

My point, Mr. Chairman, is that the Medicare program is popular and effective. It has served seniors well for 37 years, and proposals to restructure the program seem unreliable and likely to deliver less services to seniors at essentially greater cost.

Most private health plans that provide services for seniors have unimpressive records of covering prescription drugs. Seniors should not have to rely on private health plans as proposed by President Bush to receive crucial prescription drug coverage.

In summary, Mr. Chairman, of course this is the same thing I essentially said yesterday. Whether you are talking about Medicare restructuring in general, or you are talking about trying to provide a prescription drug plan, there is no empirical evidence based on what we have seen in the last few years to suggest that privatization or competition with privatization is going to improve the situation, either in terms of an overall restructuring of Medicare or in providing prescription drugs.

And I don't understand how either the President or the Republicans think that somehow they are going to drive—they are going to operate on the experience of the last few years to improve the system using private plans. It doesn't make sense.

Mr. BILIRAKIS. The gentleman's time has expired. Had you finished?

Mr. PALLONE. Yes, thank you.

Mr. BILIRAKIS. Okay. Dr. Norwood.

Mr. NORWOOD. Mr. Chairman, I am still breathless from Mr. Brown's opening statement, so I will waive my time and ask for a lengthy 8 minutes in questioning.

Mr. BILIRAKIS. Let us see. Who is—Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman, and I will give my opening statement because I am getting ready to go to a markup in the Telecom Subcommittee. But I appreciate your continuing effort on having these hearings, particularly yesterday, and I would like to welcome a fellow Texan.

The Houstonian, Robert Buddy, who is on the panel today, lives just northwest of our district, I know in Congressman Brady's dis-

trict. And I have up until 1960 there, so you are just northwest of us.

I think we all agree, especially after yesterday's hearing on Medicare prescription drug benefit, that there is little doubt that the Medicare program needs improvement. The most obvious need is to modernize Medicare to include prescription drug benefit, although additional improvements in the area of disease management, care coordination, and prevention service should also be discussed.

I have two pieces of legislation. One, the first, the Geriatric Care Act of 2003, would make sure we have enough geriatricians physicians to treat our elderly. There is an artificial ceiling in the law, and right now there are only 9,000 certified geriatricians. And that number is expected to decline over the years, so we need to address that.

The other bill is the access to diabetes screening services for Medicare coverage for recipients. Diabetes is so important, not only in Medicare but also to our whole population, but we need to do better on screening for diabetes, particularly with senior citizens.

These two bills are examples of how we can make traditional fee for service Medicare respond to the needs, and should be considered in the context of Medicare reform.

Unfortunately, there are far too many people who disregard ideas of reform fee for service Medicare, because they want to keep Medicare program outdated to justify the desire to turn it into a premium support or defined contribution program. By shifting to a defined contribution rather than defined benefit, we can limit the amount the Federal Government will spend on health care. And we are concerned about that, but we also know with our elderly population increasing we are going to spend more money.

Mr. Chairman, I would like to read from an editorial in The Houston Chronicle just this last Monday. And I will ask unanimous consent for both my statement and the editorial to be placed into the record.

Mr. BILIRAKIS. Without objection.

Mr. GREEN. It talks about, "Take Care, President's Promise, One Health Policy and Proposes Another One. Under the President's plan, full coverage of prescription drugs should be withheld from Medicare patients who do not agree to join managed care plans. Such plans sometimes provide affordable health care precisely because they limit patient choice, discourage expensive or innovative treatment, and reserve for company bean counters many decisions once made by patients' doctors."

"Competition among private insurance plans intended to keep the Medicare program from going broke in 2030 or before. Unfortunately, competition is just as likely to produce insurance company losses leading to lost of disrupted coverage and the care for patients. That is the case in Houston where several HMOs pulled out of the market, leaving thousands of Medicare patients without a doctor and scrambling to make alternative arrangements. Nowadays many doctors—their eyes are fixed on the bottom line—refuse to see new elderly patients."

I would like to put the whole editorial into the record. And thank you, Mr. Chairman.

Mr. BILIRAKIS. Without objection.

Mr. GREEN. I yield back my time.

Mr. BILIRAKIS. The Chair thanks the gentleman. Mr. Strickland for an opening statement.

Mr. STRICKLAND. I would like to have 8 minutes for questioning. So thank you, Mr. Chairman.

Mr. BILIRAKIS. You have that right. Thank you.

Without objection, of course, the opening statement of all members of the subcommittee will be made a part of the record. We will now go into——

[Additional statement submitted for the record follows:]

PREPARED STATEMENT OF HON. W.J. "BILLY" TAUZIN, CHAIRMAN, COMMITTEE ON ENERGY AND COMMERCE

Thank you, Mr. Chairman for holding this very important hearing. The Medicare program is a critical part of our health care system, providing

health insurance for 40 million aged and disabled beneficiaries. Yet this program suffers from a number of shortcomings. Because the program has not been significantly updated since its creation in the 1960s, it does not provide many of the benefits that are now commonplace in the private health insurance sector, most notably prescription drugs.

When it was created in 1965, the Medicare program mirrored the type of insurance that was available in the private sector. But because each significant change to Medicare requires an act of Congress, the program has not adapted to the changing healthcare marketplace as quickly as private sector plans, leaving beneficiaries without coverage that is commonplace in other forms on insurance.

Medicare also faces some very serious long-term fiscal challenges. As the President notes in his budget, the present value of Medicare's unfunded liabilities totals $13.3 trillion—that's the excess of benefits promised to future retirees over the expected tax revenues dedicated to Medicare. We clearly need to add a prescription drug benefit to Medicare to meet the needs of our seniors. But we must also remain cognizant of the fiscal burden we are placing on our children and grandchildren by expanding entitlement spending.

Currently, Social Security, Medicare, and Medicaid comprise more than 40 percent of the federal budget. According to the General Accounting Office, these three programs alone could consume nearly three-quarters of the federal budget by 2030 if no changes are made. Such a scenario will leave little room for spending on other priorities.

Looking at these numbers another way, in 2000, spending on these three entitlement programs was 7.6 percent of our nation's gross domestic product (GDP). If no changes are made in these programs, by 2030 they will consume nearly 14 percent of GDP, and by 2075, more than 20 percent of our nation's resources—one-fifth of our economic output—will be going to government entitlement programs. This is simply not sustainable.

Consider also that since World War II, federal tax revenues have generally been between 17 and 20 percent of GDP. If entitlement programs alone are consuming more than 20 percent of GDP by 2075, we will either be experiencing an unprecedented level of taxation to pay for these programs—while maintaining other discretionary spending—or else all other functions of the federal government will have ceased to exist.

If we allow our entitlement programs to simply continue on their current course, without any changes, we will have one of two options. We will either have to raise taxes on working families, making it harder for those families to make ends meet, provide for their children, send their kids to college, and save for their own retirement. Or we will have to cut back on the other services the government provides, such as education funding, medical research, defense, and homeland security. These are stark choices.

Therefore, as we address the short-term concerns we have with Medicare, we must also consider the long-term implications of our actions. Simply adding to the costs of our entitlement programs, without enacting reforms to strengthen these programs for the future, will increase the burden we leave for our children and grandchildren.

As the Energy and Commerce Committee takes up its Medicare modernization legislation, we will do our best to balance the needs of both beneficiaries and taxpayers. We will be looking to improve the Medicare benefit package, increase the

choices available to our seniors, put the program on a sound financial footing, and bring Medicare into the 21st century.

Thank you. I look forward to hearing from all of our witnesses.

Mr. BROWN. Mr. Chairman, can I ask unanimous consent to place in the record this chart from the trust fund report? It shows that the 1995-96, the Medicare trust fund's life expectancy in response to Mr. Buyer, was only 5 years. Now it is 23 years, and I would just like to put that——

Mr. BILIRAKIS. Without objection, that will be the case.

All right. I want to, again, thank the witnesses for being here. Your written statement that you have submitted is a part of the record. We would hope that what you would do is supplement or complement it. And start off with, I think probably rightly so, with Mr. Foster.

Mr. Rick Foster is the Chief Actuary of the Center for Medicare and Medicaid Services. I am going to introduce all of you here at one time I guess, if I may. Dr. Robert Berenson is Senior Consultant with Academy Health, located here in Washington, D.C. Ms. Susan Rawlings is Head of the Retiree Markets with Aetna Inc. Marilyn Moon, Dr. Marilyn Moon is Senior Fellow at The Urban Institute. Ms. Mary Grealy is President of Healthcare Leadership Council. Ms. Barbara Kennelly, a former colleague of ours, longtime colleague of ours—welcome, Barbara——

Ms. KENNELLY. Thank you.

Mr. BILIRAKIS [continuing] is President of the National Committee to Preserve Social Security and Medicare. And Mr. Robert Buddy is a Medicare recipient, as I understand it.

Mr. Buddy, I hope you hear all of this rhetoric up here. We talk about wanting to improve things. We don't say what plan we want. Nowhere in my opening statement did I talk about a particular plan privatizing or anything of that nature, but we still try to get the job done in spite of the fact that a lot of the grand-standing that I had hoped we would not have has taken place. Please don't get too discouraged.

In any case, let us start off, Mr. Foster. Please proceed, sir. You have 5 minutes.

STATEMENTS OF RICHARD S. FOSTER, CHIEF ACTUARY, CENTER FOR MEDICARE AND MEDICAID SERVICES; ROBERT A. BERENSON, SENIOR CONSULTANT, ACADEMY HEALTH; SUSAN RAWLINGS, HEAD OF RETIREE MARKETS, AETNA INC.; MARILYN MOON, SENIOR FELLOW, THE URBAN INSTITUTE; MARY R. GREALY, PRESIDENT, HEALTHCARE LEADERSHIP COUNCIL; BARBARA B. KENNELLY, PRESIDENT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE; AND ROBERT BUDDY

Mr. FOSTER. Thank you. Chairman Bilirakis, Representative Brown, distinguished members of the subcommittee, thank you for inviting me to testify today about the financial outlook for the Medicare program. I will briefly summarize the most important findings from the 2003 Annual Report of the Medicare Board of Trustees.

Let me emphasize that the purpose of the trustees' report is to evaluate the financial status of the Medicare trust funds. Specifi-

cally, are the trust fund income and assets provided under current law sufficient to enable the payment of benefits and administrative expenses?

This is a fundamentally important question, because the existence of a positive trust fund balance provides the statutory authority to pay benefits. But it is not the only question. One can also ask about the long-range financial sustainability of Medicare.

Mr. BILIRAKIS. Can you pull that mike closer, Mr. Foster? I am not sure how much help it might be, but——

Mr. FOSTER. Sure. Is that any better?

Mr. BILIRAKIS. Yes. Can you hear back there? That is the point. It is a little better, yes.

Mr. FOSTER. You can also ask about the financial impact of Medicare on the Federal budget. These issues are very different, but they are often confused and treated interchangeably, which they should not be.

I will focus on the financial status of Medicare, and, in particular, I will note that the two Medicare trust funds are financed by completely different approaches. The Hospital Insurance Trust Fund, or Part A of Medicare, is financed primarily by a portion of the FICA and SECA payroll taxes on workers' earnings. And the Hospital Insurance or HI tax rate is fixed into law. It won't change without further legislation.

In contrast, supplementary medical insurance, or Part B of Medicare, is financed about 25 percent by beneficiary premiums and about 75 percent by Federal general revenues. And under the law, these amounts are, in fact, changed, updated every year, to match the current level of costs.

Now, by law, these two trust funds are distinct financial entities. There is no provision for interchanging amounts back and forth between them, and that is why you have to look at the financial status of the two funds separately.

The projections that the trustees make are made assuming that current law continues without change indefinitely. These projections are necessarily uncertain, especially over very long time horizons like the trustees' 75-year projection period. So the projections are useful for informing policy development, but they should be used only with the full awareness of their limitations and their uncertainty.

I don't think I need to tell any of you that the basic challenge in financing health care, not only Medicare but health care generally, relates to the fact that expenditures tend to grow by the increases in health care prices, utilization, and the intensity or the average complexity of health care services. And the collective growth in these factors is almost always greater than the increase in workers' earnings or the economy.

Moreover, for Medicare of course we are facing the well-known problem associated with the retirement of the baby boom, such that in the future the number of beneficiaries will increase much more rapidly than the number of workers. Together these factors give us the following projection—that total Medicare costs, as a percentage of GDP, would increase from about 2.6 percent today to over 5 percent by 2035, and over 9 percent by the end of the 75-year period.

The Hospital Insurance Trust Fund itself is in reasonably good shape for the near future. The income to the trust fund is projected to be adequate to cover expenditures for roughly the next 15 years. Thereafter, assets would have to be drawn down to cover the trust fund deficits. And as Chairman Bilirakis mentioned, the assets would be exhausted in 2026 under the trustees' intermediate projections without corrective legislation.

At the end of the 75-year period, the scheduled tax revenue for hospital insurance would be sufficient to cover only a little less than one-third of the projected benefits.

For the Supplementary Medical Insurance Trust Fund, remember, the fundamental difference from hospital insurance. Namely, we reset the financing every year, so SMI Trust Fund income will keep pace with expenditures, and the trust fund will not go broke. That is the good news.

However, there are significant adverse implications that continue in rapid growth in SMI expenditures, both for beneficiaries and for the Federal budget. A good example occurred—or a bad example—in 2002 when SMI costs increased 11.6 percent. We can talk about the reasons for that if time permits. That growth rate, together with the consolidated appropriations resolution that was recently enacted increasing physician payments, together will imply that this year we expect to run a deficit in SMI of about $7.4 billion.

So we will have to raise beneficiary premiums and general revenues for next year by over 12 percent to match this new higher level of expenditures.

Based on these projections, the Board of Trustees recommends prompt attention to the financial challenges facing Medicare, and I pledge the Office of the Actuary's continuing assistance, with the efforts by Congress and the administration, to develop effective solutions to these challenges.

[The prepared statement of Richard S. Foster follows:]

PREPARED STATEMENT OF RICHARD S. FOSTER, CHIEF ACTUARY, CENTERS FOR MEDICARE & MEDICAID SERVICES

Chairman Bilirakis, Mr. Brown, distinguished Subcommittee members, thank you for inviting me to testify today about the financial outlook for the Medicare program as shown in the recently released 2003 annual report of the Medicare Board of Trustees. I welcome the opportunity to assist you in your efforts to ensure the future financial viability of the nation's second largest social insurance program—one that is a critical factor in the income security of the aged and disabled populations.

The Trustees Report focuses on the financial status of the Medicare trust funds under current law—that is, whether these funds have sufficient revenues and assets to enable the payment of Medicare benefits and administrative expenses. This analysis compares each trust fund's statutory income, from all sources, to its expenditures and determines whether the fund is operating with a surplus or a deficit in a given year. Most of my testimony is based on this traditional "trust fund perspective." I will also comment briefly on a "budget perspective," that is, the impact of Medicare on the Federal budget.

The financial outlook for the Medicare program presents a mixed picture. Over the next 10 years, the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds are adequately financed and meet the Trustees' formal tests for short-range financial adequacy. However, HI and SMI expenditures are projected to continue to grow more rapidly than workers' earnings or the economy. HI tax revenues are projected after 2012 to fall increasingly short of program expenditures, eventually covering less than one-third of estimated costs by the end of the Trustees' 75-year projection period. The depletion of the HI trust fund, which had been projected for 2030 in last year's Trustees Report, is now projected to occur in 2026. For SMI, continuing rapid expenditure growth would place growing financial burdens

both on beneficiaries and on the Federal budget. The SMI trust fund would remain in financial balance indefinitely, however, due to the annual redetermination of program financing.

Background

Roughly 41 million people were eligible for Medicare benefits in 2002. HI, or "Part A" of Medicare, provides partial protection against the costs of inpatient hospital services, skilled nursing care, post-institutional home health care, and hospice care. SMI ("Part B") covers most physician services, outpatient hospital care, home health care not covered by HI, and a variety of other medical services such as diagnostic tests, durable medical equipment, and so forth.

Only about 22 percent of HI enrollees received some reimbursable covered services during 2002, since hospital stays and related care tend to be infrequent events even for the aged and disabled. In contrast, the vast majority of enrollees incur reimbursable SMI costs because the covered services are more routine and the annual deductible for SMI is only $100.

The two parts of Medicare are financed on totally different bases. HI costs are met primarily through a portion of the FICA and SECA payroll taxes.[1] Of the total FICA tax rate of 7.65—percent of covered earnings, payable by employees and employers, each, HI receives 1.45—percent. Self-employed workers pay the combined total of 2.90 percent. Following the Omnibus Budget Reconciliation Act of 1993, HI taxes are paid on total earnings in covered employment, without limit. Other HI income includes a portion of the income taxes levied on Social Security benefits, interest income on invested assets, and other minor sources.

SMI enrollees pay monthly premiums ($58.70 in 2003) that cover about 25 percent of program costs. The balance is paid by general revenue of the Federal government and a small amount of interest income.

The HI tax rate is specified in the Social Security Act and is not scheduled to change at any time in the future under present law. Thus, program financing cannot be modified to match variations in program costs except through new legislation. In contrast, SMI premiums and general revenue payments are reestablished each year to match estimated program costs for the following year. As a result, SMI income automatically matches expenditures without the need for legislative adjustments.

Each part of Medicare has its own trust fund, with financial oversight provided by the Board of Trustees. My discussion of Medicare's financial status is based on the actuarial projections contained in the Board's 2003 report to Congress. Such projections are made under three alternative sets of economic and demographic assumptions, to illustrate the uncertainty and possible range of variation of future costs, and cover both a "short range" period (the next 10—years) and a "long range" (the next 75 years). The projections are not intended as firm predictions of future costs, since this is clearly impossible; rather, they illustrate how the Medicare program would operate under a range of conditions that can reasonably be expected to occur. The projections shown in this testimony are based on the Trustees' "intermediate" set of assumptions.

Short-range financial outlook for Hospital Insurance

Chart 1 shows HI expenditures versus income over the last 10 years and projections through 2012. For most of the program's history, income and expenditures have been very close together, illustrating the pay-as-you-go nature of HI financing. The taxes collected each year are intended to be roughly sufficient to cover that year's costs. Surplus revenues are invested in special Treasury securities.

During 1990-97, HI costs increased at a faster rate than HI income. Expenditures exceeded income by a total of $17.2 billion in 1995-97. Prior to the Balanced Budget Act of 1997, this trend was expected to continue, with costs growing at about 8 percent annually, against revenue growth of only 5 to 6 percent. The 1995-97 shortfalls were met by redeeming trust fund assets, but in the absence of corrective legislation, assets would have been depleted in about 2001. The Medicare provisions in the Balanced Budget Act were designed to help address this situation. As indicated in chart 1, these changes—together with subsequent low general and medical inflation and increased efforts to address fraud and abuse in the Medicare program—resulted in lower HI—expenditures during 1998-2000 and trust fund surpluses totaling $61.8 billion over this period.

The Board of Trustees has recommended maintaining HI assets equal to at least one year's expenditures as a contingency reserve. As indicated in chart 2, HI assets at the beginning of 2003 represented about 150 percent of estimated expenditures

[1] Federal Insurance Contributions Act and Self-Employment Contributions Act, respectively.

for the year. The HI trust fund is estimated to continue to experience significant surpluses for roughly the next 15 years. After 2017, however, expenditures are projected to again exceed income. As shown in chart 2, assets would initially accumulate rapidly but then be drawn down to cover the resulting shortfalls. The trust fund would be exhausted in 2026 under the Trustees' intermediate assumptions.

The depletion date estimated in the 2003 Trustees Report represents a significant deterioration compared to last year's estimate (2030). The change arises both from lower projected payroll tax revenues and higher projected inpatient hospital expenditures. The lower payroll taxes are the result of a downward revision by the Bureau of Economic Analysis to their estimates of historical wage and salary disbursements. The higher inpatient hospital cost projections result from more inpatient hospital admissions in 2002 than previously estimated and a greater increase in the average complexity of admissions. Overall, Medicare payments for inpatient hospital care increased by almost 10—percent in 2002—significantly above normal rates of growth.

Long-range financial outlook for Hospital Insurance

The interpretation of dollar amounts is very difficult over extremely long time horizons like the 75-year projection period used in the Trustees Report. For this reason, long-range tax income and expenditures are expressed as a percentage of the total amount of wages and self-employment income subject to the HI payroll tax (referred to as "taxable payroll"). The results are termed the "income rate" and "cost rate," respectively. Projected long-range income and cost rates are shown in chart 3 for the HI program.

Past income rates have generally followed program costs closely, rising in a stepwise fashion as the payroll tax rates were adjusted by Congress. Income rate growth in the future is minimal, due to the fixed tax rates specified in current law. Trust fund revenue from the taxation of Social Security benefits increases gradually, because the income thresholds specified in the Internal Revenue Code are not indexed. Over time, an increasing proportion of Social Security beneficiaries will incur income taxes on their benefit payments.

Past HI cost rates have generally increased over time but have periodically declined abruptly as the result of legislation to expand HI coverage to additional categories of workers, raise (or eliminate) the maximum taxable wage base, introduce new payment systems such as the inpatient prospective payment system, etc. Cost rates decreased significantly in 1998-2000 as a result of the Balanced Budget Act provisions together with strong economic growth. The cost rate increased somewhat in 2001 and 2002 as a result of the Benefit Improvement and Protection Act of 2000 and the 2001 economic recession. In general, HI costs are expected to increase faster than taxable payroll, because increases in the prices, utilization, and intensity of health care services collectively exceed increases in workers' earnings. After 2006, cost rates are projected to increase steadily for these reasons and to accelerate significantly with the retirement of the baby boom, beginning in 2010. By the end of the 75-year period, scheduled tax income would cover less than one-third of projected expenditures.

The average value of the financing shortfall over the next 75 years—known as the actuarial deficit—is 2.40 percent of taxable payroll. This deficit could be closed by an immediate increase of 1.2 percentage points in the HI payroll tax rate, payable by employees and employers, each. (The projected deficit could also be eliminated by many other revenue increases and/or expenditure reductions.) Note, however, that such a change would correct the deficit only "on average." Initially, HI revenue would be significantly in excess of expenditures, but by the end of the period, only about one-third of the projected deficit would be eliminated.

The effect of the baby boom's retirement on Social Security and Medicare is relatively well known, having been discussed at length for nearly 30 years. Basically, by the time the baby boom cohorts have retired, there will be nearly twice as many HI beneficiaries as there are today. When the HI program began, there were 4.5 workers in covered employment for every HI beneficiary. As shown in chart 4, this ratio for 2002 is just under 4.0 workers per beneficiary. With the advent of the baby boom's retirement, the number of beneficiaries will increase more rapidly than the labor force, resulting in a decline in this ratio to 2.4 in 2030 and 2.0 in 2077, based on the intermediate projections. Other things being equal, there would be a corresponding increase in HI costs as a percentage of taxable payroll.

There are other demographic effects beyond those attributable to the varying number of births in past years. In particular, life expectancy has improved substantially in the U.S. over time and is projected to continue doing so. The average remaining life expectancy for 65-year-olds increased from 12.4 years in 1935 to 17.5 years currently, with an estimated further increase to about 22—years at the end of the long-range projection period. Medicare costs are also sensitive to the age dis-

tribution of beneficiaries. Older persons incur substantially larger costs for medical care, on average, than younger persons. Thus, as the beneficiary population ages over time they will move into higher-utilization age groups, thereby adding to the financial pressures on the Medicare program.

Financial outlook for Supplementary Medical Insurance

Chart 5 presents estimates of the short-range outlook for SMI and is generally similar to the information presented in chart 1 for the HI trust fund. Two key differences are evident: First, the income and expenditure curves for SMI are nearly indistinguishable in the future. As noted previously, SMI premiums and general revenue income are reestablished annually to match expected program costs for the following year. Thus, the program will automatically be in financial balance, regardless of future program cost trends. The second difference is that—in contrast to the decline in HI expenditures during 1998-2000—SMI expenditures increased at an average rate of 6.9 percent over this period.

As with HI, the 2002 SMI expenditures were significantly higher than expected, having increased 11.6 percent for the year. Preliminary data indicate that the rapid growth was due in part to (i) the continuing transfer of certain home health services from HI to SMI as specified in the Balanced Budget Act of 1997, (ii) a 7-percent increase in spending on physician services, despite a *negative* 5.4-percent payment update, (iii) a 20-percent increase in durable medical equipment spending, and (iv) a 25-percent rise in physician-administered drug spending. These cost increases, together with the recent enactment of legislation increasing Medicare payment rates to physicians effective March 1, 2003, will result in an estimated SMI trust fund deficit of $7.4 billion in 2003.[2] Program financing for 2004 and later will be established at levels sufficient to cover the higher expenditures. As a consequence, the monthly SMI premium is estimated to increase from $58.70 in 2003 to about $66 in 2004, with general revenue transfers increasing at a correspondingly rapid rate.

Chart 6 shows projected long-range SMI expenditures and premium income as a percentage of GDP. Under present law, beneficiary premiums will continue to cover approximately 25 percent of total SMI costs, with the balance drawn from general revenues. In the long run, expenditures are projected to increase at a significantly faster rate than GDP, for largely the same reasons underlying HI cost growth.

Although SMI is automatically in financial balance, the program's continuing rapid growth in expenditures places an increasing burden on beneficiaries and the Federal budget. In 2002, for example, about 6.8 percent of a typical 65-year-old's Social Security benefit was withheld to pay the monthly SMI premium of $54.00, and another 8.9 percent was required to cover average deductible and coinsurance expenditures for the year, for a total of 15.7 percent. Twenty years later, under the intermediate assumptions, the same beneficiary's premium and copayment costs would average 23 percent of his or her benefit.[3] Similarly, SMI general revenues in fiscal year 2002 were equivalent to 7.8 percent of the personal and corporate Federal income taxes collected in that year. If such taxes remain at their current level, relative to the national economy, then SMI general revenue financing in 2070 would represent 30 percent of total income taxes.

Combined HI and SMI expenditures

The financial status of the Medicare program is appropriately evaluated for each trust fund separately, as summarized in the preceding sections. By law, each fund is a distinct financial entity, and the nature and sources of financing are very different between the two funds. This distinction, however, frequently causes greater attention to the HI trust fund—its projected year of asset depletion in particular—and less attention to SMI, which does not face the prospect of depletion. It is important to consider the total cost of the Medicare program and its overall sources of financing, as shown in chart 7. Interest income is excluded since, under present law, it would not be a significant part of program financing in the long range.

Combined HI and SMI expenditures are projected to increase from 2.6 percent of GDP to about 9.3 percent in 2077, based on the Trustees' intermediate set of assumptions. In past years, total income from HI payroll taxes, income taxes on Social Security benefits, HI and SMI beneficiary premiums, and SMI general revenues was very close to total expenditures. Over the next 10 years, such Medicare revenues

---

[2] Financing for calendar year 2003 was set in September 2002, before data showing the full extent of the 2002 expenditure increase were available and before the Consolidated Appropriations Resolution, 2003 was enacted.

[3] The growth in average copayment costs over this period is reduced significantly by (i) the fixed $100 deductible applicable to SMI services, and (ii) the gradual correction of an excessive level of beneficiary coinsurance on outpatient hospital services, as provided for in the Balanced Budget Act of 1997 and subsequent legislation.

are estimated to slightly exceed program expenditures, reflecting the automatic financing of SMI plus an expected excess of HI tax income over expenditures. Thereafter, however, overall expenditures are expected to exceed aggregate revenues. Again, the growing difference arises from the projected imbalance between HI tax income and expenditures—since throughout this period, SMI revenues would continue to approximately match SMI expenditures.

Over time, SMI premiums and general revenues would continue to grow rapidly, since they would keep pace with SMI expenditure growth under present law. HI payroll taxes are not projected to increase as a share of GDP, primarily because no further increases in the tax rates are scheduled under present law. Thus, as HI sources of revenue become increasingly inadequate to cover HI costs, SMI premiums and general revenues would represent a growing share of total Medicare income.

"Trust fund" versus "budget" perspectives

Medicare's financial operations can be considered from two different viewpoints: a "trust fund perspective" and a "budget perspective." The Trustees Report reflects the perspective of the trust funds, since its purpose is to determine the financial status of these funds by assessing whether they have sufficient revenues and assets to enable the payment of Medicare benefits and administrative expenses. From this trust fund perspective, all types of income are equivalent, and their collective adequacy in covering expenditures is paramount.

In particular, the existence of trust fund assets provides the statutory authority to make benefit payments and cover other expenditures. Medicare benefits can be paid if and only if the relevant trust fund has sufficient assets. Congress established the trust fund mechanism for financing Medicare (as well as Social Security and certain other Federal programs) in part for the financial discipline it imposes and also to serve as an early warning if program financing and expenditures fall out of balance.

In contrast, the Federal budget focuses on taxes and other amounts received by the government from the public and on amounts paid to the public in the form of benefits, government purchases from the private sector, wages to Federal employees, etc. If aggregate receipts from the public exceed total outlays to the public, then the Federal government has a budget surplus; the opposite relationship results in a Federal budget deficit. In the context of the Federal budget, amounts paid from the general fund of the Treasury to a Federal trust fund, referred to as "intragovernmental transfers," have no impact on the overall budget surplus or deficit and consequently are excluded from consideration.

In the budget context, one can look at the public receipts and outlays associated with Medicare and determine the program's impact on the Federal budget—that is, whether Medicare is making a net contribution to the budget or is drawing from the budget. Whether the HI or SMI trust fund is running a surplus or deficit may have little or nothing to do with whether Medicare is contributing to a Federal budget surplus or deficit. Due in part to the similar terminology, however, people have sometimes confused these two different issues.

The differences between the trust fund and budget perspectives can be clarified by examining how Medicare revenues are treated under each approach. The following table shows estimated Medicare income by category for 2003 under the Trustees' intermediate assumptions and compares these amounts with expenditures under the two perspectives.

Estimated Medicare trust fund operations in calendar year 2003: ''Trust fund perspective'' versus ''budget perspective''

(In billions)

	HI	SMI	Total
Income:			
Receipts from the public:			
Payroll taxes	$155.6	—	$155.6
Income taxes on Social Security benefits	6.3	—	6.3
Premiums	1.6	$27.4	29.0
Other	0.7	—	0.7
Subtotal	164.1	27.4	191.5
Intragovernmental transfers:			
Interest on trust fund assets	15.3	2.0	17.3
General revenues	0.4	86.2	86.6

Estimated Medicare trust fund operations in calendar year 2003: ''Trust fund perspective'' versus ''budget perspective''—Continued

(In billions)

	HI	SMI	Total
Subtotal	15.7	88.2	103.9
Total trust fund income	179.8	115.6	295.4
Expenditures	156.1	123.0	279.2
Trust fund surplus or deficit [1]	23.7	-7.4	16.3
Net impact on Federal budget [2]	8.0	-95.7	-87.7

[1] Total trust fund income less expenditures.
[2] Total receipts from the public less expenditures.

As indicated in the table, all revenue categories are counted for determining trust fund financial status, and the HI trust fund is shown to have an estimated surplus of $23.7—billion in 2003. As noted previously, income from all sources to the SMI trust fund is projected to fall short of expenditures in 2003 by $7.4 billion, requiring the redemption of $7.4 billion in trust fund assets to cover the deficit.

From the budget perspective, in contrast, only tax receipts and beneficiary premiums are counted, since interest earnings and general revenue payments represent intragovernmental transfers. HI is projected to have total receipts from the public in 2003 that exceed payments to the public by $8.0 billion. For SMI, the only receipts from the public are the beneficiary premiums, which total $95.7 billion less than SMI expenditures. Accordingly, HI can be thought of as making an estimated net contribution to the Federal budget of $8.0 billion in 2003, while SMI is expected to draw $95.7—billion from the budget. Medicare, overall, is thus projected to draw a net amount of $87.7 billion from the budget.

Each viewpoint—the trust fund perspective and the budget perspective—is appropriate for its intended purpose. One point of view cannot be used to answer questions related to the other, however. Trust fund surpluses or deficits reveal nothing about the impact of Medicare on the Federal budget, and the impact of Medicare on the Federal budget offers no insight into whether a trust fund has sufficient assets to permit payment of benefits.

Conclusions

In their 2003 report to Congress, the Board of Trustees emphasizes the continuing financial pressures facing Medicare and urges the nation's policy makers to take further steps to address these concerns. They also argue that consideration of further reforms should occur in the relatively near future. The earlier that solutions are enacted, the more flexible and gradual they can be. In addition, the Trustees note that early action increases the time available for affected individuals and organizations—including health care providers, beneficiaries, and taxpayers—to adjust their expectations.

I concur with the Trustees' assessment and pledge the Office of the Actuary's continuing assistance to the joint effort by the Administration and Congress to determine effective solutions to the remaining financial problems facing the Medicare program. I would be happy to answer any questions you might have on Medicare's financial issues.

Chart 1—HI expenditures and income

(In billions)

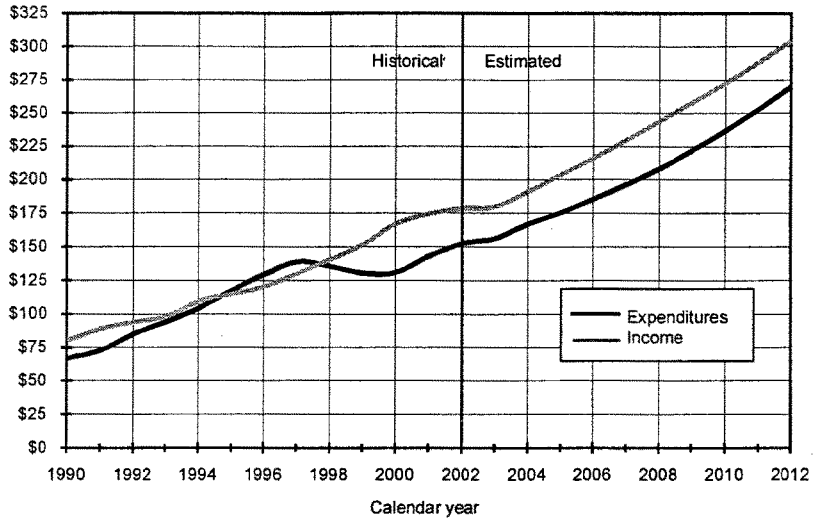


Chart 2—HI trust fund assets

(Assets at beginning of year as percentage of annual expenditures)

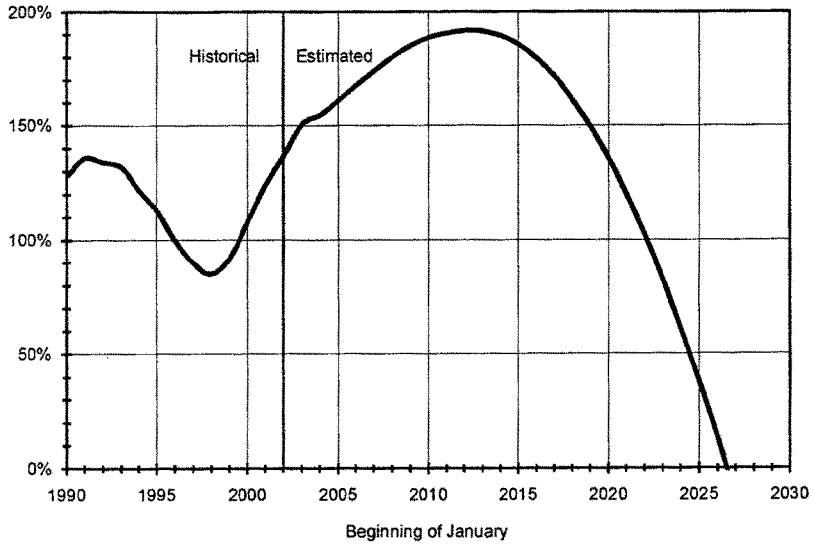


Chart 3—Long-range HI income and costs under intermediate assumptions

(as a percentage of taxable payroll)

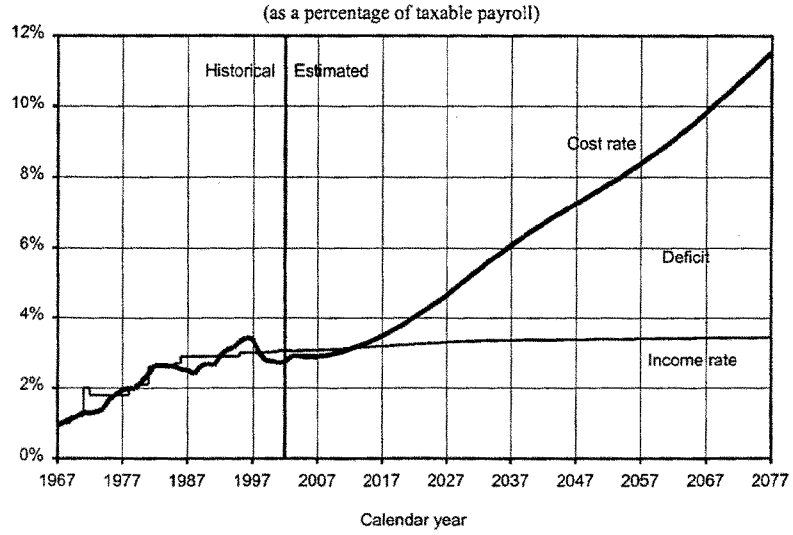


Chart 4—Workers per HI beneficiary

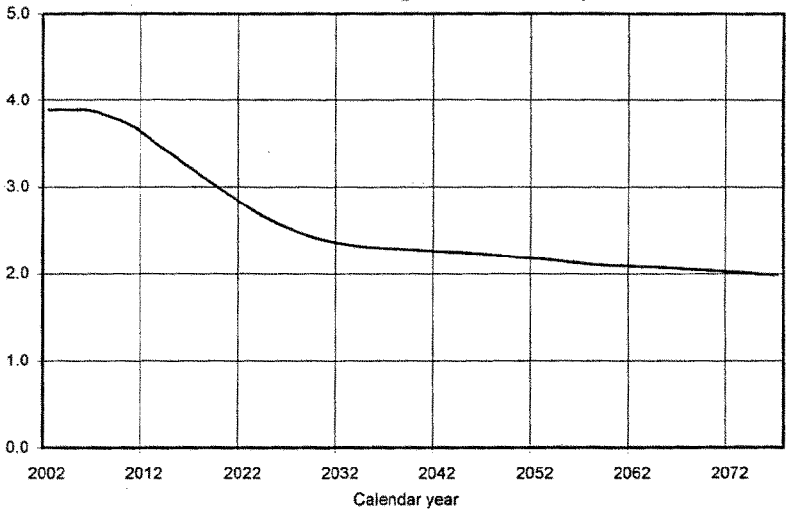


Chart 5—SMI expenditures and income

(In billions)

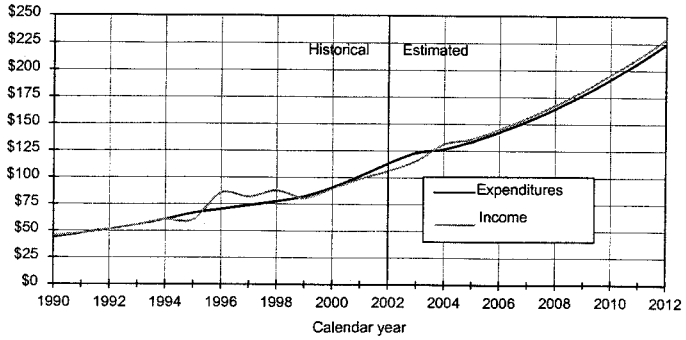


Chart 6—SMI expenditures and premiums as a percentage of GDP

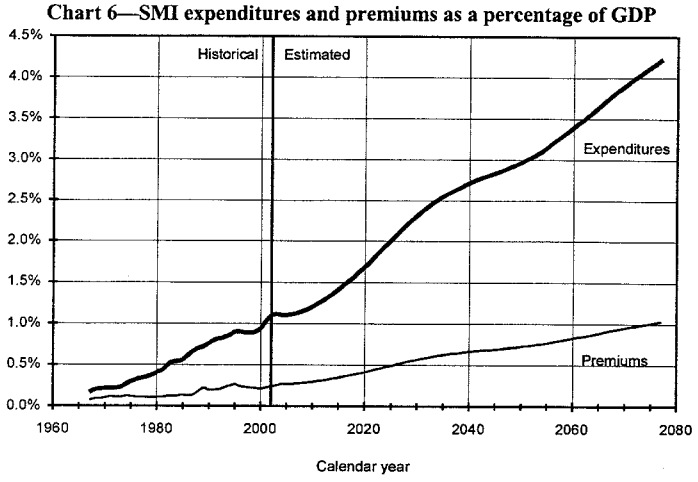
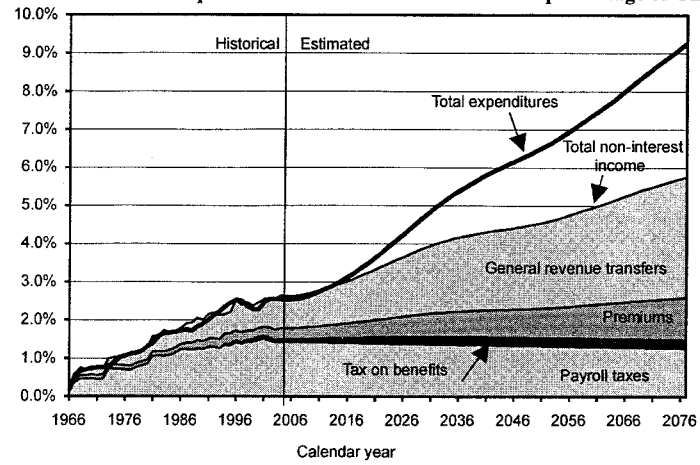


Chart 7—Medicare expenditures and sources of income as a percentage of GDP



Mr. BILIRAKIS. Thank you very much, Mr. Foster.
Dr. Berenson.

STATEMENT OF ROBERT A. BERENSON

Mr. BERENSON. Thank you, Chairman Bilirakis, Representative Brown, and members of the committee. I very much appreciate the opportunity to provide comments on the important topic of strengthening and improving Medicare.

I have enjoyed a diverse professional experience from which I am basing my views about the future of Medicare. I practiced internal medicine for over 20 years, including 12 in a private practice in the Capitol Hill community about seven blocks from here.

I served 10 years as a co-founder and medical director of the National Capital PPO, a broker model PPO that was serving nearly 150,000 people when I left in 1996. In the last 3 years of the Clinton Administration, I had the privilege of serving as Director of the Center for Health Plans and Providers in the agency then known as HCFA. In that position I had the honor of testifying before this subcommittee on a few occasions. Today I am speaking only for myself.

In preparing my remarks, I relied on the White House press release of March 3, 2003, titled, "21st Century Medicare: More Choices, Better Benefits, a Framework to Modernize and Improve Medicare," which provides a glimpse of the President's ideas for Medicare restructuring.

I am troubled by the framework's clear preference for private health insurance options to the detriment of the traditional Medicare program that has served the public so well for over 35 years. It appears that the fundamental assumption underlying the President's framework is that the traditional Medicare program is incapable of controlling costs, assuring access, and improving quality.

I believe strongly that that assumption represents an ideological position, not based on objective review of the evidence. Further, unless the administration proposes a draconian defined contribution type model that shifts substantial costs onto the backs of beneficiaries, there is no reason to believe that greater reliance on private plans will actually reduce expenditures or put the program on sounder financial footing.

The framework seems designed more as part of an ongoing attack on the government's role in health care in the face of evidence showing that Medicare has been a remarkably successful social insurance program.

The framework's option 2, enhanced Medicare, calls for massive expansion in private health insurance options that are mere variations on indemnity insurance approaches. In my opinion, this option will add costly administrative expense to Medicare and will further segment detrimentally the beneficiary insurance pool.

Private plans will become financial winners if they design benefits that attract healthier than average beneficiaries, while the costs of maintaining the fallback traditional program could become unsustainable. In thinking about Medicare reform, it is important to understand crucial but rarely appreciated differences between the challenges faced by private and public employers in arranging

health insurance for their employees and covered retirees and by the Medicare program.

In distinct contrast to Medicare, even the largest national employers have limited market shares in most of the markets in which their employees reside. As a result, these employers need to rely on managed care products, which increasingly are PPOs, primarily as a way to get physicians, hospitals, and other providers to agree to negotiated contractual payment rates.

In short, PPOs and many IPA model health maintenance organizations carry out one function and one function only for employers. They negotiate prices with providers. But the traditional Medicare program has no need for private plans to negotiate prices on its behalf.

The problem private health plans have setting up provider networks in rural areas illustrates the point about the different challenges employers in Medicare face. Medicare+Choice has private fee for service plans only because Congress decided to allow these private plans to impose traditional Medicare prices on providers.

Similarly, all coordinated care, Medicare+Choice plans, get to use Medicare payment rates for out-of-network coverage. The Center for Studying Health System Change and MedPAC have documented that overall traditional Medicare pays providers substantially less than private plans do.

The point is that Medicare has no need for private plans if all they are really doing is negotiating payment rates with providers. And unfortunately, that is basically all that many private plans actually do.

Some assert that beneficiaries, when aging into Medicare, want the same set of insurance choices that they had as employees or retirees covered under employer plans. I respectfully disagree. What beneficiaries aging into Medicare want most is the ability to keep the same physicians from whom they have been receiving care, not the same insurance arrangements.

If the traditional Medicare program's benefits were improved to provide prescription drugs, catastrophic expense protection, and other enhancements that the President would provide only in private plans, beneficiaries would be able to have the kind of choice of professionals and providers that they want.

As I noted earlier, the President's framework implicitly belittles the documented successes of the traditional Medicare program. Actually, the history of Medicare is replete with innovation, many of which have been adopted by commercial market plans and payers.

Although many of us casually but inaccurately refer to the traditional program as fee for service Medicare, in fact most payment systems are now prospective—many paying per episodes of care. They are not fee for service. The physician fee schedule stands out as the exception, and that payment system similarly should be reformed.

Recently, I co-authored a Health Affairs article recommending payment innovations in the traditional program to improve the care provided to the large majority of Medicare beneficiaries who have long-standing——

Mr. BILIRAKIS. Will you please summarize, Doctor?

Mr. BERENSON. Pardon me?

Mr. BILIRAKIS. Please summarize, if you would.

Mr. BERENSON. Okay. Basically, there are a number of tools that traditional Medicare could use to innovate, to hold down costs, and perhaps a little later we will have an opportunity to talk about what some of those area. The bottom line is I see no need to privatize Medicare.

Mr. BILIRAKIS. Well, we certainly are very interested in those ideas. If you don't get it across during the inquiry, by all means submit it to us in writing.

Mr. BERENSON. Very good.

[The prepared statement of Robert A. Berenson follows:]

PREPARED STATEMENT OF ROBERT A. BERENSON, SENIOR CONSULTANT, ACCADEMY HEALTH

Chairman Bilirakis, Mr. Brown, and members of the committee. I appreciate the opportunity to provide comments on the important topic of "Strengthening and Improving Medicare." I have enjoyed a diverse professional experience from which I am basing my views about the future of the Medicare program. I practiced Internal Medicine for over 20 years, including twelve in private practice in the Capitol Hill community, about seven blocks from here. I served ten years as a co-founder and medical director of the National Capital PPO, a broker model preferred provider organization (PPO) that was serving nearly 150,000 people when I left in 1997. And in the last three years of the Clinton Administration, I had the privilege of serving as Director of the Center for Health Plans and Providers in the agency then known as the Health Care Financing Administration (HCFA). In that position I had the honor of testifying before this subcommittee on a few occasions.

My job at HCFA gave me an unusual perspective on the issues being discussed here today, as I had responsibility for contracting with Medicare + Choice (M+C) plans, as well as for payment policies in the traditional Medicare program. I was able to gain insights about the relative strengths and weaknesses of the two sides of Medicare, and I will reflect on some of those today.

In preparing my remarks, I relied on the White House press release of March 3, 2003, titled "21st Century Medicare: More Choices—Better Benefits. A Framework to Modernize and Improve Medicare," which provides a glimpse of the President's ideas for Medicare restructuring. I am troubled by the framework's clear preference for private health insurance options to the detriment of the traditional Medicare program that has served the public so well for over 35 years.

It appears that the fundamental assumption underlying the President's Framework is that the traditional Medicare program is simply incapable of controlling costs, assuring access, and improving quality. I believe strongly that that assumption represents an ideological position, not based an objective review of the evidence. Further, unless the Administration proposes a draconian defined contribution model that shifts substantial costs onto the backs of beneficiaries, there is no reason to believe that greater reliance on private plans will actually reduce expenditures or put the program on a sounder financial footing. The Framework seems designed more as part of an ongoing attack on government's role in health care, in the face of the evidence showing that Medicare has been a remarkably successful social insurance program.

The Framework's "Option 2—Enhanced Medicare" calls for massive expansion in private health insurance options that are mere variations on indemnity insurance approaches. In my opinion, this Option will add costly administrative costs to Medicare and will further segment detrimentally the beneficiary insurance pool. Private plans will become financial winners if they design benefits that attract healthier than average beneficiaries, while the costs of maintaining the "fallback" traditional program could become unsustainable.

In thinking about Medicare reform, it is important to understand crucial, but rarely appreciated, differences between the challenges faced by private and public employers in arranging health insurance for their employees and covered retirees and by the Medicare program. In distinct contrast to Medicare, even the largest national employers have limited market shares in most of the markets in which their employees reside. As a result, these employers need to rely on managed care products, which increasingly are PPOs, primarily as a way to get physicians, hospitals, and other providers to agree to negotiated, contractual payment rates. Without these insurance products that aggregate insured lives to provide negotiating lever-

age, many employers would be paying the highly inflated charges that individuals without insurance or insurers without provider contracts face.

In short, PPOs and many Individual Practice Association—model (IPA) health maintenance organizations (HMOs) carry out one function, and one function only, for employers—they negotiate prices with providers. When I was in charge of the M+C program, PPOs made it clear that they wanted to be exempt from quality improvement activities and even from basic quality reporting requirements. They told me they had no ability to affect quality, and Congress accommodated their wishes. In short, the array of indemnity-type insurance products envisioned under the Enhanced Medicare Option would offer additional choices, but not choices that add value to the Medicare program.

But the traditional Medicare program has no need for private plans to negotiate prices on its behalf. The program already has market power, and it has used its authority to set administered prices that providers accept. In setting these rates, the program has a fundamental obligation to find a reasonable balance between assuring continued access for beneficiaries and restraining provider prices. Guided by MedPAC, the General Accounting Office and the health services research and policy community, the Congress and the Centers for Medicare and Medicaid Services (CMS), for the most part, have done a good job of finding that balance.

The problem private health plans have setting up provider networks in rural areas illustrates the point about the different challenges employers and Medicare face. Medicare + Choice has private fee for service plans only because Congress decided to allow these private plans to impose traditional Medicare prices on providers. Similarly, all coordinated care, M+C plans get to use the Medicare payment rates for out-of-network coverage. Further, The Center for Studying Health System Change and MedPAC have documented that, overall, traditional Medicare pays providers substantially less than private plans do. The point is that Medicare has no need for private plans if all they are really doing is negotiating payment rates with providers. And, unfortunately, that is basically all that many private plans do.

Some assert that beneficiaries when aging into Medicare want the same set of insurance choices that they had as employees or retirees covered under employer plans. I respectfully disagree. What beneficiaries aging in to Medicare most want is the ability to keep the same physicians from whom they have been receiving care, not the same insurance arrangements. If the traditional Medicare program's benefits were improved to provide prescription drugs, catastrophic expense protection, and other enhancements that the President would provide only in private plans, beneficiaries would be able to have the kind of choice of professionals and providers they want.

As I noted earlier, the President's Framework implicitly belittles the documented successes of the traditional Medicare program. Actually, the history of Medicare is replete with innovation, many of which have been adopted by commercial market plans and payers. Although many of us casually, but inaccurately, refer to the traditional program as "fee for service Medicare," in fact, most payment systems are now prospective, many paying for episodes of care. They are not fee for service. The physician fee schedule stands out as the exception, and that payment system similarly should be reformed.

Recently, I co-authored a *Health Affairs* article recommending payment innovations in the traditional program to improve the care provided to the large majority of Medicare beneficiaries who have long-standing, chronic conditions. Currently, CMS is monitoring demonstrations of disease management programs in Medicare. If these demonstrations prove successful, traditional Medicare can contract with disease management vendors just as managed care plans do.

In addition, to help rationalize and limit expenditures, CMS should be given authority to use selected managed care tools in its administration of the program, as well as the requisite administrative resources to function as a value purchaser. Examples of tools the program should be allowed to use include promoting centers of excellence, providing incentives for beneficiaries with multiple chronic conditions to have a "medical home," and using prior authorization for select high cost, elective procedures.

For the most part, managed care failed in its execution of what were and still are potentially useful care delivery innovations. Further, managed care plans rarely provided the kind of transparency that patients and contracting professionals rightly expect and deserve. Of course, given its market power and the fact that it is the government, there is justifiable concern about how CMS and its administrative agents would function as a value purchaser. Nevertheless, from my experience, I believe that requirements for public rule-making, a commitment to fair process and disclosure, and, in general, program accountability to the Congress and the public suggest that the traditional Medicare program is actually better positioned than

most managed care plans to actually deliver on the unrealized promise of managed care to provide high quality, affordable health care.

There should be a prominent place in Medicare for innovative private health plans, particularly group and staff model HMOs, that offer true alternative delivery systems from that offered under traditional Medicare. Those plans can and should be accommodated in a modified Medicare + Choice program. However, at a time when the managed care industry has lost its credibility and when plans have reverted to being passive insurance companies, making money by charging high premiums and generating investment income on their reserves, I do not understand why Congress would want to privatize Medicare.

Mr. BILIRAKIS. Ms. Rawlings.

STATEMENT OF SUSAN E. RAWLINGS

Ms. RAWLINGS. Thank you. Mr. Chairman and members of the subcommittee, my name is Susan Rawlings. I am Head of Retiree Markets and Vice President for Aetna Incorporated. I am very pleased to be here today.

Aetna has a long history of serving the Medicare program. As a matter of fact, we processed the first Medicare claims in 1965. I am very pleased to be here to share with you our thoughts on Medicare, Medicare+Choice, and how private plans can participate successfully with you.

I should also note for you that our chairman and chief executive, Dr. Jack Rowe, is a geriatrician by training and is also a commissioner on MedPAC and is very interested in the evolution of the program.

I have submitted some written testimony for the subcommittee, and I would like to summarize that for you now.

Mr. BILIRAKIS. Please.

Ms. RAWLINGS. Aetna believes very strongly that we should work together to involve——

Mr. BILIRAKIS. Hold the mike a little—maybe down a little bit——

Ms. RAWLINGS. Down a little bit?

Mr. BILIRAKIS. [continuing] toward your——

Ms. RAWLINGS. Is that better?

Mr. BILIRAKIS. That is better.

Ms. RAWLINGS. Okay. Aetna believes we must work together to evolve the program and modernize it. As we all know, the population is growing and living longer. There is greater technology available, and there are more choices available for beneficiaries. We believe very strongly that the expertise and learnings of the private sector should be fully leveraged.

We work together successfully in many capacities today in serving other parts of the Federal Government programs such as the FEHBP, Tricare, and Medicare, as well as Medicare+Choice programs today.

Aetna believes there are five key foundational blocks to building and evolving the program. We think we are starting from a reasonably comprehensive place at the moment. But we believe as we evolve we should consider five things, key things.

The first one is adequate funding. This is critical to the stability and sustainability of any program long term, and we believe it is critical we keep that in mind as we proceed. We also believe that the government must fund Medicare programs commensurate with its promises to its beneficiaries.

Second, we do support fully the addition of pharmacy benefits into the Medicare program. We believe medication coverage is imperative for improving and maintaining health status, and we want to work with the Federal Government to help that become available.

Third, we believe access is critical for the program for beneficiaries. It should be available all over the country, which it is today, and choices should likewise be available. Health care is delivered locally. Beneficiaries need to have access to the care in their local community's choices and the ability to address their own financial resources with the choices that are available for them.

And finally, we believe very strongly in the aspect of coordination of care, which is something we believe most Medicare+Choice programs and other private plans have been able to provide over time. This particular population is very care-needy. And as people age, as we all know, we become typically more chronically ill rather than acute.

We believe promoting self-care and promoting—focusing on preventive benefits we believe we have additional benefits for beneficiaries to maintain quality of life as well as to keep costs consistent.

I would like to highlight a few things we believe the private plans bring to value today to the government and to the beneficiaries. The first one is that we provide richer benefits than the traditional program. As a matter of fact, in 2002, 72 percent of Medicare+Choice beneficiaries actually had access to prescription drugs.

We provide affordable access for low income and minority beneficiaries. Forty percent of African-Americans with no group or Medicaid coverage, as well as 52 percent of Hispanics and 40 percent of the people with incomes between $10,000 and $20,000 per year, are in Medicare+Choice today.

We provide better quality than traditional fee for service. This is not necessarily because fee for service is not a wonderful program. It is because we take a different approach. Traditional fee for service is an indemnity-style program. The Medicare+Choice programs and the private plans typically focus on more preventive care and a holistic approach, preventive services, and comprehensive benefits.

Today we also offer better choice. We have HMO options, PPO options, private fee for service options. As a matter of fact, Aetna is participating in the PPO demonstration project that was launched January 1 in 21 counties in three States.

Medicare is at a crossroads as government tries to sort out the best public and private sector roles going forward. It is Aetna's view that the private sector role must be expanded or the program will fail to grow sufficiently to keep pace with the demands of a growing and longer living population.

It wasn't too long ago that the prior—the previous program Medicare Plus—previous program to Medicare+Choice, the Medicare Risk Program, was able to offer very competitive comprehensive benefits, including pharmacy benefits, at no cost. This is something we should strive for. This semblance of quality and coverage we should strive for together.

Aetna is committed to serving Medicare beneficiaries and is ready and willing to partner with the Federal Government to develop workable solutions for this population. We appreciate the opportunity to testify today.

[The prepared statement of Susan E. Rawlings follows:]

PREPARED STATEMENT OF SUSAN E. RAWLINGS, VICE PRESIDENT AND HEAD OF RETIREE MARKETS, AETNA INC.

Mr. Chairman and members of the Subcommittee, I am Susan Rawlings, vice president and head of retiree markets for Aetna. Thank you for the opportunity to testify before you today.

Aetna believes that a modernized Medicare program must leverage the expertise and build upon the learnings of the private sector. The Medicare+Choice program—is one example of the level of quality, choice, and affordability that could be available to Medicare beneficiaries if the private sector is fully leveraged by the Medicare program. Despite a critical shortfall in government funding, about five million Medicare-eligible seniors and disabled choose to participate in Medicare+Choice, enjoying access to extra benefits—including prescription drug coverage, preventive care, wellness and disease management programs. These benefits are not available under Original Medicare.

Medicare+Choice provides Medicare beneficiaries with better benefits, better quality and better choices than the fee-for-service program. But, as I said, it is only one example of what can be accomplished when the private and public sectors work together to develop solutions for Medicare beneficiaries. Based on our experiences with this program and our knowledge of the population that it serves, we ask you to consider a number of important issues critical to the successful modernization of the Medicare program.

These issues include:

- **Adequate funding.** Increased funding is necessary for stability and sustainability of private offerings of comprehensive benefits packages year after year. The government must fund its programs commensurate with the promise made to its Medicare beneficiaries.
- **Prescription drug benefits.** Medication coverage is imperative for improving and maintaining the health status of beneficiaries. A funded prescription benefit allows treatment of the many chronic conditions of seniors in the ambulatory setting, thus avoiding unnecessary inpatient acute care stays. It simply doesn't make sense for the program to cover heart disease surgery, but not the medication that could have prevented the need for surgery.
- **Nationwide accessibility.** Health care services must be available to all beneficiaries. Flexibility in patterns of health care delivery must be created to include network and non-network private offerings—with the protection of the Medicare allowable fee schedules—to avoid excessive out-of-pocket spending by Medicare beneficiaries.
- **Choice of plan design.** Multiple private plan designs are necessary to meet the needs of seniors in terms of benefits requirements, benefits choices and financial resources.
- **Coordination of care.** Medicare beneficiaries are a care-needy population. In order to meet the multiple chronic care needs and acute care needs of beneficiaries, there must be coordination and communication across settings such as inpatient acute care, rehabilitation care to restore function, skilled nursing care and home care to improve health status. This coordination should be focused on promoting self-care and avoiding duplicative and redundant diagnostic and treatment protocols.

While we ask that you consider all of these issues as part of your efforts to modernize the program, we'd also like you to take a step back and consider the myriad successes experienced by the Medicare+Choice program. We hope that you will agree that these successes provide further proof of the importance of involving the private sector in this public program.

PRIVATE SECTOR MEDICARE PLANS PROVIDE RICHER BENEFITS

The Original Medicare program does not provide a number of benefits that are commonly covered in private sector health plans. Every Medicare+Choice plan, for example, provides enrollees with the FFS benefits package and additional benefits. According to an analysis by Mathematica Policy Research, 72 percent of all beneficiaries in Medicare+Choice plans had access to a prescription drug benefit in 2002.

Last year, health plans also provided added benefits not covered by FFS Medicare, including physical exams (100 percent of all enrollees in Medicare+Choice), vision benefits (87 percent), and hearing aid benefits (54 percent).

In addition, Medicare+Choice plans also offer a number of chronic care, wellness and preventive benefits that are so important to keeping older and disabled Americans healthy. These services often include patient education, disease management programs, calls from nurse case managers to remind patients of optimal care, phone calls from the health plan to remind members to keep their appointments and to have the screenings necessary to avoid complications, caregiver education, and reminders and reports to physicians about their patients' status and the services they have received or missed.

Aetna, for example, has a program to conduct health risk assessments for all of our Medicare+Choice members. Members who are identified in their health risk assessment as being at high or moderate risk will be contacted by an Aetna nurse case manager to determine if case management can be of assistance in helping to maintain or improve their health status. This program allows us to proactively identify health issues and work with members, their physicians and other community resources to help confirm that the member is both engaged in the right programs, and motivated to actively participate in them.

Studies demonstrate that these extra benefits reduce out-of-pocket costs for beneficiaries. According to the Kaiser Family Foundation, "M+C HMOs have typically charged lower premiums than Medigap plans and offered coverage for a variety of services that Medicare does not, potentially lowering overall costs for enrollees." (Snyder, et al. January 2003) The Kaiser study also found that total out-of-pocket spending was reduced considerably for beneficiaries in Medicare+Choice plans compared to enrollees in FFS Medicare and Medigap plans.

Medicare+Choice plans play an important role in providing health coverage to low-income and minority beneficiaries who cannot afford the high out-of-pocket costs they would incur under the Original Medicare program. A recent study reports that "about 40 percent of African-Americans with no group or Medicaid coverage are in M+C plans, as are 52 percent of Hispanics and 40 percent of those with incomes between $10,000 and $20,000 regardless of race or ethnicity." (M. Gold, Health Affairs Web exclusive, April 2003) According to an April 2002 study by Kenneth Thorpe for the Blue Cross Blue Shield Association, if the Medicare+Choice program did not exist, 42 percent of Medicare-enrolled African-Americans currently in Medicare+Choice plans would be forced to go without coverage for prescription drugs and other supplemental benefits. Aetna has a corporate initiative to reduce health care disparities, which have been documented to exist based upon race and ethnicity, and our efforts have been recognized and supported by the Department of Health and Human Services.

PRIVATE SECTOR MEDICARE PLANS PROVIDE BETTER QUALITY

Medicare+Choice plans offer a different approach to health care than beneficiaries experience under the Original Medicare program. Instead of focusing almost exclusively on treating beneficiaries when they are sick or injured, Medicare+Choice plans place a strong emphasis on preventive health care services that help to keep beneficiaries healthy, detect diseases at an early stage, avoid preventable illnesses, and improve quality of life.

Aetna, for example, has a program to proactively reach out to each member over the age of 50 to remind them to receive influenza and pneumococcal pneumonia immunizations and colorectal cancer screenings. These simple but important steps in preventive care can help Medicare beneficiaries avoid serious, life-threatening illnesses.

Research studies show that enrollees in Medicare+Choice plans receive care that is comparable to, or better than, beneficiaries enrolled in Medicare FFS:

- An analysis of data published in the *Journal of the American Medical Association* (Jencks, et al. *JAMA,* January 15, 2003) and data compiled by the National Committee for Quality Assurance finds that Medicare+Choice plans outperform Medicare fee-for-service in five of seven key HEDIS quality measures: beta blockers after heart attacks; annual flu vaccines; breast cancer screenings; diabetes testing; and diabetes lipid screening. (AAHP 2003)
- A study by CMS and the National Cancer Institute (NCI) found that Medicare managed care enrollees were less likely than fee-for-service patients to have their breast cancer diagnosed at late stages. Only 7.6 percent of Medicare managed care enrollees had a late-stage diagnosis, compared to 10.8 percent of fee-for-service patients. (G. Riley, *Journal of the American Medical Association,* Vol. 281, February 24, 1999)

- A large-scale study comparing quality of care for elderly heart attack patients covered by Medicare managed care plans and Medicare fee-for-service coverage found that health plans offer access to care equal to or better than fee-for-service coverage. All indicators of timeliness and quality of care for elderly patients with acute myocardial infarction were higher or similar under Medicare managed care coverage compared with fee-for-service coverage. Enrollees in Medicare managed care plans were more likely to receive beta blocker therapy (73 percent vs. 62 percent). (S. Soumerai, *Archives of Internal Medicine,* Vol. 159, 1999)
- Another study found that Medicare managed care enrollees were more likely to have had a mammogram in the previous year compared to fee-for-service beneficiaries (62 percent vs. 39 percent). (L. Nelson, *Access to Care in Medicare Managed Care,* November 1996)
- Research also has shown that Medicare managed care enrollees were diagnosed at considerably earlier stages, and therefore more treatable stages, than fee-for-service patients for four types of cancer: breast, cervix, melanoma and colon. Among patients with cervical cancer, 76 percent of Medicare managed care enrollees were diagnosed at early stages, compared to 55 percent of fee-for-service patients. (G. Riley, *American Journal of Public Health,* October 1994)

In recognition of the value that Medicare+Choice plans provide, the Medicare program has developed initiatives that reward Medicare+Choice plans that meet certain goals. For example, CMS has implemented a program that provides "Extra Payment in Recognition of the Costs of Successful Outpatient Congestive Heart Failure Care." Under this program, qualifying Medicare+Choice organizations that meet CMS performance criteria receive extra payments for enrollees with CHF who were not hospitalized as a result of effective management of their disease. Aetna supports this initiative and recommends that CMS consider similar programs for other disease states. Aetna participates in the Congestive Heart Failure initiative and has successfully maintained members in the ambulatory setting with appropriate medical services, medication and disease management.

PRIVATE SECTOR MEDICARE PLANS PROVIDE BETTER CHOICES

Consumers in the private sector have benefited from the widespread availability of health plan options, which has promoted access to affordable, comprehensive coverage. Despite the chronic underfunding of the Medicare+Choice program, Medicare+Choice plans are currently offering many Medicare beneficiaries innovative health plans that are targeted to meet specific needs. Almost 60 percent of all Medicare beneficiaries have access to Medicare+Choice plans. These include coordinated care plans (HMO), preferred provider organizations (PPOs), private fee-for-service plans, and plans specifically targeted to the needs of frail elderly and disabled beneficiaries.

Aetna is currently participating in the Centers for Medicare and Medicaid Services' (CMS) Preferred Provider Organization (PPO) demonstration project. Through this demonstration project, which began operating in January of this year, Aetna is offering new choices to Medicare beneficiaries in 21 Maryland, New Jersey and Pennsylvania counties. Our Aetna Golden Choice Plan is an HMO-based point-of-service plan that allows members to receive care within or outside the Aetna provider network, without obtaining referrals or selecting a primary care physician. Notably, the plan also provides coverage for prescription drugs, which are not covered under Original Medicare. Aetna Golden Choice Plan members receive generic drug coverage with no annual dollar limit, paying only a $15 copay per prescription.

Medicare is at a crossroads as government tries to sort out the best public and private sector roles. Going forward it is Aetna's view that the private sector role must be expanded or the program will fail to grow sufficiently to keep pace with the demands of a growing and longer-living population. At one time " before the now infamous Balanced Budget Act of 1997 " Aetna provided Medicare beneficiaries with a comprehensive benefits package that included vision and dental coverage, preventive, wellness and disease management programs, and prescription drug coverage " all for a zero-dollar premium. Competitive markets and adequate funding allowed for this, and returning to some semblance of this level of quality coverage should be our mutual goal.

CONCLUSION

Aetna is committed to serving Medicare beneficiaries, and ready and willing to partner with the federal government to develop workable solutions for this population. However, we need to recognize that, in order to provide a strong foundation

of expanded choices for beneficiaries, private sector Medicare programs must be adequately funded.

Since 1998, many Medicare+Choice beneficiaries have been enrolled in health plans to which payments increased by only the minimum annual update—which has been set at two percent since 1998 (but was temporarily increased to three percent in 2001 only). To underscore the inadequacy of government payments to Medicare+Choice plans, it is useful to compare Medicare+Choice to other government health programs and private sector health coverage. In 2003, funding for the health benefits of *all* Medicare+Choice enrollees increased by only two percent. The following facts highlight the inadequacy of this increase:

- The Office of Personnel Management (OPM) has estimated that, on a per-enrollee average, total premiums collected by health plans in FEHBP increased by **10.5 percent** in 2001 and by **13 percent** in 2002;
- PricewaterhouseCoopers has estimated that health insurance premiums increased by an average of **13.7 percent** for large employers between 2001 and 2002; and
- The William M. Mercer consulting firm has released survey findings showing that spending for employer-sponsored health coverage increased by an average of **11.2 percent** in 2001 and **14.7 percent** in 2002.

Any effort to modernize the Medicare program must directly address these concerns by committing a significant level of additional funds to support the health benefits of Medicare enrollees. Over the past two years, more than 120 Members of Congress " including 79 Democrats and 43 Republicans " have cosponsored bills or signed letters indicating their support for legislation to address the Medicare+Choice funding crisis. The Bush Administration has also proposed additional funding to stabilize the Medicare+Choice program. Building upon this strong base of bipartisan support, it is critically important for Congress to pass legislation to provide additional funding to protect the health care choices and benefits of Medicare+Choice enrollees.

Aetna appreciates this opportunity to testify before the subcommittee today. Private sector Medicare plans provide benefits, quality and choices that are not available to enrollees in Original Medicare. This is why we believe that a modernized Medicare should be built upon increased private sector involvement in the program. We are pleased that Congress is considering expanding the range of choices available to Medicare beneficiaries. As Congress moves forward it should ensure that the government will provide funding sufficient to allow individuals a reasonable level of choice within an area, and that the choices should remain available and stable over time.

Any Medicare reform proposal should also include prescription drug benefits, nationwide accessibility, choice of plan design and coordination of care.

Finally, Congress should also ensure that a reformed Medicare program is administered under a framework designed to achieve a fair and sound balance between the need for regulatory oversight and the promotion of innovative, quality coverage solutions for all Medicare beneficiaries.

Mr. BILIRAKIS. Thank you very much, Ms. Rawlings.

Dr. Moon.

STATEMENT OF MARILYN MOON

Ms. MOON. Thank you, Mr. Bilirakis, Mr. Brown, members of the committee. I am very pleased to be here today to be able to testify on this very important issue. My testimony essentially makes five points, and I am going to talk primarily about one of them, because I think a number of the other issues have been raised already today.

First, the drivers of health care costs for Medicare beneficiaries are essentially the same drivers of health care costs for people in the private sector. We know that technology and the improvements in health care that have come along have not come cheaply in the United States, and this is true for Medicare beneficiaries as well as for anyone else.

It is not Medicare's problem. It is Medicare's problem, but it is not Medicare's fault that health care costs on a per capita basis are rising for the most part.

Second, and where I want to put much of my emphasis, is on alternative measures of affordability, and when people talk about whether or not Medicare is affordable over time. I would underscore Rick Foster's testimony that the trust funds and part of Medicare are separate. Part A and Part B are separate and need to be thought of that way. We need to be very careful not to inappropriately put them together in looking at issues.

Part A is better off than many people have believed and has been for the last few years. I served as a public trustee for 5 years, just after 1995, and to the year 2000. I would like to argue that I am responsible for the great improvements in the trust fund, but that is not the case.

What happened is that the Congress and other factors going on in the economy conspired to help the Medicare program look a lot better. We had strong economic growth, which is crucial, and we had efforts, continuing efforts to change the program over time, which is also a crucial factor in terms of looking at how things will do well over time.

I would also point out that over the next 10 years revenues are expected to exceed what the spending will be in Part A by over $500 billion—a much better track record than we are seeing for much of the activities of the Federal budget at the moment.

But I also understand people's interest and desire to look at Medicare in terms of the full cost of the program. It is important to think about both Part A and Part B and not focus just on one part of the program. And there are ways in which people have done that—sometimes to look at the worker-to-retiree ratio, sometimes to look at the share of GDP.

Those are both valuable measures, but they don't capture the fact that over time the share of the pie will have to rise to support Medicare. That is absolutely right. But that pie is going to be much larger.

We will have the resources to provide that support. The question is: will we have the willingness to do so?

If you control for inflation and look into the future of the Medicare program, you will find that on a per worker basis GDP, using the assumptions in the 2003 trustees report, that GDP will rise after controlling for inflation by about 54 percent, 54.9 percent over the next 35 years, or until 2035 at least. It is not quite 35 years.

And what that means is that workers, on average, will have command of resources 1½ times greater than today, even after controlling for inflation. If you take out of that the burden that Medicare will mean for workers over time, and treat, then, what the resulting net growth will be, it will have fallen because Medicare will have risen as a share of GDP, but only to 51 percent.

This is an affordable program. The question is: are we willing to put the resources into that? And if so, how will we do so?

The third point that I make in the testimony is that we do need to have change in Medicare, but that it is not necessarily private sector changes that will do a good job of that. And I think that Bob Berenson's testimony bears credit for a lot of that, and I would refer you to him.

Fourth, we do need to have change in the basic Medicare program. And I think that that program should change in ways that

many people have talked about. Certainly, prescription drugs are very important, and that is a key factor. It should be a factor for traditional Medicare as well as for the program as a whole in terms of use and reliance on the private sector.

But I would like to see the private sector used for presumably what the private sector is supposed to be good at, and that is coordination of care, which we have seen them do very little of in practice. If they were doing a good job, I think then we would have a very different story.

Finally, traditional Medicare also needs to look at a lot of ways to improve coordination of care. It is going to be the default mechanism for many years to come, and it needs to change as well and we need to be creative there.

Thank you very much.

[The prepared statement of Marilyn Moon follows:]

PREPARED STATEMENT OF MARILYN MOON,[1] SENIOR FELLOW, THE URBAN INSTITUTE

Mr. Chairman and Members of the Committee: Thank you for inviting me to testify at this hearing.

The long term financing challenges facing Medicare are formidable. Largely because of advances in medicine and technology, spending on both the old and the young has grown at a rate faster than spending on other goods and services. Combining a population that will increasingly be over the age of 65 with health care costs that will likely continue to rise over time is certain to mean an increasing share of national resources devoted to this group. In order to meet this challenge, the nation must plan how to share that burden and adapt Medicare to meet new demands.

But this should not lead to the conclusion that Medicare cannot continue nor that it must be dramatically altered. Medicare's future will require additional financing, but the demands on society are within our resources. The bigger long term challenge will be in deciding how the rising costs of healthcare for this population need to shared.

In my testimony today, I raise five major issues:

- First, the drivers of healthcare costs are not unique to Medicare, and it is important to recognize that Medicare needs to grow in concert with changes in the healthcare system as a whole.
- I offer an alternative measure of affordability to illustrate that even with no changes in the basic program, the burdens from Medicare are not excessive in the context of reasonable expectations about economic growth in the future.
- While society can afford to spend more on healthcare for older and disabled persons, passing greater costs onto older and disabled Americans must be done with caution.
- Change in Medicare will be needed but the answer may not rest with turning the program over to the control of the private sector. Medicare actually has a better track record over the last thirty years than does private insurance.
- Traditional Medicare can and should remain a major part of the overall program; but it too needs a number of changes.

REASONS FOR RISING COSTS

Projections from the 2003 Medicare Trustees Report indicate that Medicare's share of the Gross Domestic Product (GDP) will reach 4.75 percent in 2030, up from 2.56 percent in 2002. Although this is a substantial increase, it is actually smaller than what was being projected just a few years ago. In 1996, for example, the projection for 2030 was 7.39 percent of GDP—or 56 percent higher than the projection made this year. This slowdown in growth does not eliminate the need to act, but it does allow time for study and deliberation before putting substantial changes into place.

Projected increases in Medicare's spending arise because of growing numbers of people eligible for the program and the high costs of health care. The beneficiary

[1] The material presented in this testimony represents the opinions of the author and not of the Urban Institute, its officers or funders. Much of the research reported here was funded by the Commonwealth Fund and the Henry J. Kaiser Family Foundation.

population is rising because of increased life expectancy (in part reflecting the success of the Medicare program) and that growth will be accelerated in the future by the retirement of the baby boom. The number of younger disabled beneficiaries is also expected to remain high. This creates challenges for Medicare and represents a major component of spending projection increases. By 2030, for example, the number of beneficiaries will reach 79 million—nearly double today's number.

Technological advances that raise the costs of care are the primary reason for higher per capita spending over time, and this phenomenon occurs systemwide, not just in Medicare. The problems driving Medicare costs upward are not unique to the public sector. They are found throughout our nation's healthcare system, and the crisis of rising healthcare costs affects all payers: individuals, businesses, and governments. And just as Medicare is influenced by the overall healthcare system, the opposite is true as well. Medicare has been a leader in experimenting with options for curbing the costs of care, both in terms of increasing prices and use of services. Further, while costs continue to rise, efforts through time to hold down these costs have led to a better outlook than was the case in the mid-1990s. Similar re-evaluation of the program to make changes where needed will be an important part of Medicare's future.

MEASURING MEDICARE'S FINANCIAL BURDENS

Medicare is currently financed in a variety of ways. Part A relies mainly on payroll taxes with a modest contribution from part of the taxes imposed on Social Security benefits. Part B, on the other hand, is financed by enrollee premiums set at 25 percent of the costs of Part B benefits for elderly beneficiaries and by general revenue contributions sufficient to cover the remaining costs.

Medicare's financial health can be viewed from several perspectives. The appropriate question over time is whether, *as a society,* we can afford to support Medicare. But the measures often used actually focus on a narrower issue of solvency, particularly that of the Part A Trust Fund. That measure does point to the need for some type of policy change in the future, but that could simply mean increasing the revenues going into the trust funds, for example.

Solvency Measures

Solvency, as measured by the date of exhaustion of the Part A Trust Fund, is one of the most commonly reported statistics about Medicare.[1] This is just one of many measures reported in the Medicare Board of Trustees annual reports on Medicare's financial outlook. Critics of Medicare often emphasize the solvency of the Part A Trust Fund as an indicator of affordability as well as solvency. This implicitly treats the Part A Trust Fund as establishing a limit on what can be spent on Part A.

The Part A Trust Fund was designed to assure that the specified payroll tax contribution would be used specifically for Part A spending. As dedicated revenues, payroll and other revenue sources that exceed the amount necessary to cover Part A benefits go into the Trust Fund and collect interest. When the trust fund forecasts indicate a declining balance, this serves as an early warning of the need for an adjustment either in revenue contributions or spending on the program. Over the next ten years, Medicare revenues will exceed spending by over $500 billion.

Projections of the Medicare Part A trust fund in the most recent Trustees' Report indicate that it will maintain a positive balance through 2026. Considered in historical context, the date of projected insolvency historically is far into the future as compared to what it has been in earlier years (Figure 1). The trust fund is expected to grow until 2014, after which the trust fund's balances will begin to decline. At that point, payroll tax and other receipts are insufficient to cover all expenditures. After 2014, Part A of Medicare must supplement tax revenues with funds accumulated in the Part A Trust Fund.

Another solvency measure that was contained in the Administration's budget documents for this year indicated that there was a $13.3 trillion unfounded liability facing Medicare over the next 75 years. But this is based on very misleading figures. The text implies that payroll taxes are the only revenue source from which Medicare is allowed to draw to cover its costs. While Part A is largely funded by payroll taxes, Part B by law has always relied on general revenues. Including its costs in an analysis of the adequacy of the current payroll tax has as much validity as treating any other expenditure covered by general revenues (such as defense) as having large unfounded liabilities as well. If done correctly, the "unfounded promises" under Medicare would be much lower, more in the range of $5 trillion.

---

[1] Although there is also a Part B Trust Fund, it serves a much different purpose and is intentionally kept at a small positive level.

That is not to say that this is not a large amount, but rather that the size is more manageable than the $13.3 trillion implies. It is important to note, for example, that in the next ten years, Part A revenues will exceed Part A spending by over $500 billion.

Affordability Measures

Assessing affordability using the solvency of the Part A Trust Fund as the measure is analogous to individuals arguing that they cannot pay all their bills because the balance in one of their checking accounts is too low. Affordability is a broader issue that turns on whether we as a society can support Medicare into the future. The need for healthcare for this segment of the population will not go away simply because we decide to cut back on government's contribution. But the ability of Medicare beneficiaries to absorb higher healthcare costs if no new revenues are forthcoming would be in serious doubt.

The Medicare Trustees Annual Report offers two broader measures of affordability described below, although each are limited in scope. Thus, an alternative measure presented here proposes a more comprehensive way to examine affordability.

The Worker-to-Beneficiary Ratio. The ratio of workers contributing to Medicare at any point in time compared to the number of beneficiaries shows that the number of younger persons relative to older ones will decline in the future given the aging of society. This declining ratio of workers to retirees indicates that each worker will have to bear a larger share of the cost of providing payroll tax-financed Medicare benefits.

Between 2002 and 2030 (about the time when most Baby Boomers will have become eligible for Medicare), the ratio of workers to beneficiaries will fall from 3.9 to 2.4. Indeed, this is one of the statistics commonly cited by those who claim the program is "unsustainable." This measure does signal the need for more revenues per worker—a legitimate issue for debate. However, it fails to assess the level of burden relative to ability to pay from each future worker, ignoring any improvement in the economic circumstances of workers over time due to per capita economic growth.

Medicare Spending as a Share of GDP. A second measure is the sum of Part A and B spending as a share of GDP. In 2002, Medicare's total share was 2.56 percent and is projected to rise to 4.75 percent in 2030. This represents a doubling of the GDP share. Such an increase reflects the fact that health care costs per capita are expected to continue rising, and the number of people covered will double over that time period. But again, this measure is not as helpful in the debate on Medicare's future because it does not consider how well off we will be as a society as the level of GDP grows. Some goods and services, like health care, may appropriately grow as a share of GDP in response to higher living standards and preferences of the population. What is needed is more information to be able to understand the consequences of devoting a higher share of society's resources to Medicare.

A More Comprehensive Measure of Affordability. Another way to look at affordability is to focus not just on the number of workers that contribute to payroll and income taxes or on aggregate GDP, but instead on how the Medicare per capita burden will affect workers over time. While the share of the pie (GDP) going to Medicare is likely to rise, if the pie (on a per capita basis) is also much larger, then an increasing share is less of a burden. If the future leads to increased national well-being, additional resource sharing would be affordable. Thus, another way to examine affordability is to focus on whether taxpayers of the future will be better off even after they pay higher amounts for Medicare.

This approach measure begins with computing per worker GDP over time, resulting in a measure of the nation's output of goods and services divided across the working population. This provides the base for assessing Medicare's burden on workers, who pay for the bulk of support for the program. Per worker GDP—even after adjusting for inflation—rises substantially, from $69,000 per worker in 2002 to just under $107,000 in 2035 (in 2003 dollars).[2] This is an increase of 54.9 percent in per worker GDP, a substantial increase in financial well-being.

What about Medicare's costs over this period? The burdens from Medicare spending on each worker are projected to rise at a faster rate than per capita GDP because both numbers of beneficiaries and their inflation-adjusted spending will rise over time. But because per worker GDP is a much larger dollar amount than the dollars of Medicare burdens, the reduction in well-being that this entails for workers is modest.

---

[2] The figure used here is based on the intermediate projections from the 2002 Trustees Report, which assumes a 1.1 percent real growth in per worker wages each year. Over the past 50 years, productivity has been higher than this amount, averaging over 1.5 percent per year.

To calculate this per worker burden from Medicare, several adjustments are necessary. First, each worker will bear an increasing share of Medicare over time because of the change in the ratio of workers to retirees. Further, per capita Medicare costs are expected to rise by 90 percent in real terms by 2035, also increasing the real dollar burden on workers. But not all of Medicare's costs are borne by workers. Thus, costs are adjusted downward by the contributions that will be made by beneficiaries themselves. The Part B premium accounts for about 10 percent of Medicare's costs. In addition, beneficiaries make further contributions because some of the taxation of Social Security benefits goes into Part A and older and disabled persons also pay income taxes that help support Part B. Thus, those costs need to be netted out.

The resulting real per worker burden estimates range from $1,556 in 2002 to $4,993 in 2035 (in 2002 dollars). In Figure 2, the bar graph indicates per worker GDP in inflation-adjusted dollars, and the line graph indicates how much would be left after accounting for the Medicare burden.

From 2002 to 2035, the increase in net (after subtracting Medicare) per worker resources would be 51.0 percent as compared to the 54.9 percent increase in per worker GDP. That is, workers would still be substantially better off than today, even after paying the full projected costs of Medicare. The pie will indeed have gotten larger, making it possible to absorb Medicare's higher costs. Essentially our estimates indicate that Medicare's greater burdens would "consume" about 7 percent of increased well-being for workers over that period. There will, of course, be other demands on these resources as well, but this approach puts demands from Medicare into a broader perspective. This measure for examining affordability takes into account Parts A and B of Medicare, and it puts the issue of the burdens of the program into a per worker context.

This more comprehensive measure of net per worker output also suggests that, as a society, we will be able to afford Medicare without an inordinate burden on workers or taxpayers once even modest estimates of productivity growth over time are taken into account. A greater challenge will be for society to decide whether it is *willing* to share these costs.

HOW MUCH SHOULD BENEFICIARIES BE ASKED TO PAY?

The burdens of higher health care costs in the future will likely need to be shared between beneficiaries and younger taxpayers in some manner deemed reasonable. The numbers above already give a sense that future workers will be in a reasonable position to pay more. What about beneficiaries?

Options for passing more costs of the program onto beneficiaries, either directly through new premiums or cost sharing or indirectly through options that place them at risk for health care costs over time, need to be carefully balanced against beneficiaries' ability to absorb these changes. Just as Medicare's costs will rise to unprecedented levels in the future, so will the burdens on beneficiaries and their families. Even under current law, Medicare beneficiaries will be paying a larger share of the overall costs of the program and more of their incomes in meeting these health care expenses. In 2003, beneficiaries will spend about 23 percent of their incomes on average for acute health care. In a study I did with Stephanie Maxwell and Misha Segal, we projected per capita out-of-pocket spending based on projected Medicare growth into the future and found that the average beneficiary in 2025 would likely have to pay nearly 30 percent of her income on health care because the costs of care grow faster than incomes over time. Figure 3 also indicates how these burdens would grow for other groups of the Medicare population.

Thus, a difficult question to answer will be how much more can be shifted onto beneficiaries over time? If incomes rise faster than anticipated and health care spending moderates, there will certainly be room for greater contributions. But a full shifting of additional costs does not seem to be a viable option. Moreover, it will be very important to take special care with the most vulnerable beneficiaries.

In addition, options to increase beneficiary contributions to the cost of Medicare further increase the need to provide protections for low-income beneficiaries. The current programs to provide protections to low-income beneficiaries are inadequate, particularly if new premium or cost-sharing requirements are added to the program. Participation in the Medicare Savings programs is low, likely in part because these programs are run by Medicaid and are thus tainted by association with a "welfare" program. Further, states, which pay part of the costs, tend to be unenthusiastic about these extra program and likely discourage participation.

WOULD RELYING ON THE PRIVATE SECTOR MAKE MEDICARE A MORE VIABLE PROGRAM?

Much of the debate over how to reform the Medicare program has focused on broad restructuring proposals, moving the management and oversight increasingly under the control of private insurance. What are the tradeoffs from increasingly relying on private plans to serve Medicare beneficiaries? Most important, there is little evidence to suggest even modest savings to Medicare from increased competition and the flexibility that the private sector enjoys. Further, the effort necessary to create, in a private plan environment, all the protections needed to compensate for moving away from traditional Medicare seems too great and too uncertain.

Claims for savings from options that shift Medicare more to a system of private insurance usually rest on two basic arguments: first, it is commonly claimed that the private sector is more efficient than Medicare, and second, that competition among plans will generate more price sensitivity on the part of beneficiaries and plans alike. Although seemingly credible, these claims do not hold up under close examination.

Looking back over the period from 1970 to 2000, a recent study I completed with Cristina Boccuti found that Medicare's cost-containment performance has been better than that of private insurance even after controlling for coverage of comparable services. Starting in the 1970s, Medicare and private insurance plans initially grew very much in tandem, showing few discernible differences (See Figure 4). By the 1980s, per capita spending had more than doubled in both sectors. But Medicare became more cost-conscious than private health insurance in the 1980s, and cost containment efforts, particularly through hospital payment reforms, began to pay off. From about 1984 through 1988, Medicare's per capita costs grew much more slowly than those in the private sector.

This gap in overall growth in Medicare's favor stayed relatively constant until the mid 1990s when private insurers began to take seriously the rising costs of health insurance. At that time, growth in the cost of private insurance moderated in a fashion similar to Medicare's slower growth in the 1980s. Thus, it can be argued that the private sector was playing "catch up" to Medicare in achieving cost containment. Private insurance thus narrowed the difference with Medicare in the 1990s, but as of 2000, there was still a considerable way for the private sector to go before its cost growth would match Medicare's achievement of lower overall growth. When comparison is made on rates of growth for comparable benefits, Medicare's cumulative rate is 19 percent below that of private insurance.

Technological change and improvement represents a major factor driving high rates of expenditure growth. To date, most of the cost savings generated by all payers of care has come from slowing growth in the prices paid for services and making only preliminary inroads in reducing the use of services or addressing the issue of technology. Reining in use of services will constitute a major challenge for private insurance as well as Medicare in the future, and it is not clear whether the public or private sector is better equipped to do this.

Reform options such as the premium support approach also seek savings by allowing the premiums paid by beneficiaries to vary such that those choosing higher cost plans pay substantially higher premiums. The theory is that beneficiaries will become more price conscious and choose lower cost plans. This in turn will reward private insurers that are able to hold down costs. And there is some evidence from the federal employees system and the Calpers system in California that this has disciplined the insurance market to some degree. Studies that have focused on retirees, however, show much less sensitivity to price differences. Older persons may be less willing to change doctors and learn new insurance rules in order to save a few dollars each month. Thus, what is not known is how well this will work for Medicare beneficiaries.

For example, for a premium support model to work, at least some beneficiaries must be willing to shift plans each year (and to change providers and learn new rules) in order to reward the more efficient plans. Without that shifting, savings will not occur. In addition, there is the question of how private insurers will respond. (If new enrollees go into such plans each year, some savings will be achieved, but these are the least costly beneficiaries, and may lead to further problems as discussed below.) Will they seek to improve service or instead focus on marketing and other techniques to attract a desirable, healthy patient base? It simply isn't known if the competition will really do what it is supposed to do.

In addition, new approaches to the delivery of health care under Medicare may generate a whole new set of problems, including problems in areas where Medicare is now working well. For example, shifting across plans is not necessarily good for patients; it is not only disruptive, it can raise costs of care. Some studies have shown that having one physician over a long period of time reduces costs of care.

And if it is only the healthier beneficiaries who choose to switch plans, the sickest and most vulnerable beneficiaries may end up being concentrated in plans that become increasingly expensive over time. The case of retirees left in the federal employees high-option Blue Cross plan and in a study of retirees in California suggest that even when plans become very expensive, beneficiaries may be fearful of switching and end up substantially disadvantaged. Thus, the most vulnerable may stay in plans that become inordinately expensive. Further, private plans by design are interested in satisfying their own customers and generating profits for stockholders. They cannot be expected to meet larger social goals such as making sure that the sickest beneficiaries get high quality care; and to the extent that such goals remain important, reforms in Medicare will have to incorporate additional protections to balance these concerns as described below.

Ultimately, projected cost savings from a private insurance initiative arise from passing costs off onto beneficiaries through higher premiums or increased cost sharing requirements. If that indeed is the case, then this approach merely represents an elaborate way to avoid an honest debate about how to share future burdens.

CHANGES TO IMPROVE MEDICARE

Making changes to Medicare that can improve its viability both in terms of its costs and in how well it serves older and disabled beneficiaries should certainly be pursued. Further, it makes little sense to look for a solution that takes policy makers permanently out of Medicare's future. The flux and complexity of our healthcare system will necessitate continuing attention to this program. At present a number of areas in Medicare need attention.

What I would prefer to see instead is emphasis on improvements in both the private plan options and the traditional Medicare program, basically retaining the current structure in which traditional Medicare is the primary option. Rather than focusing on restructuring Medicare to emphasize private insurance, I would place the emphasis on innovations necessary for improvements in health care delivery regardless of setting.

Critics of Medicare rightly point out that the inadequacy of its benefit package has led to the development of a variety of supplemental insurance arrangements which in turn create an inefficient system in which most beneficiaries rely on two sources of insurance to meet their needs. It is sometimes argued that improvements in coverage can only occur in combination with structural reform. And some advocates of a private approach to insurance go further, suggesting that the structural reform itself will naturally produce such benefit improvements. This implicitly holds the debate on improved benefits hostage to accepting other unrelated changes. That logic actually should run in the other direction. It is not reasonable to expect any number of other changes to work without first offering a more comprehensive benefit package for Medicare. In that way, payments made to private plans can improve, allowing them to better coordinate care. And the fee for service system will also be able to change in ways that might encourage better care delivery. For example, it is not reasonable to ask patients to participate in a program to reduce hypertension (which can save costs over the long run) without covering the prescription drugs that are likely to be an essential part of that effort. In addition, a better benefit package will also allow at least some beneficiaries to forego the purchase of inefficient private supplemental insurance. That itself should be a goal of reform.

In addition, better norms and standards of care are needed if we are to provide quality of care protections to all Americans. Investment in outcomes research, disease management and other techniques that could lead to improvements in treatment of patients will require a substantial public commitment. This cannot be done as well in a proprietary, for-profit environment where dissemination of new ways of coordinating care may not be shared. Private plans can play an important role and may develop some innovations on their own, but in much the same way that we view basic research on medicine as requiring a public component, innovations in health delivery also need such support. Further, innovations in treatment and coordination of care should focus on those with substantial health problems—exactly the population that many private plans seek to avoid. Some private plans might be willing to specialize in individuals with specific needs, but this is not going to happen if the environment is one emphasizing price competition and with barely adequate risk adjustors. Innovative plans would likely suffer in that environment.

A good area to begin improvements in knowledge about the effectiveness of medical care would be with prescription drugs. Realistically, any prescription drug benefit will require efforts to hold down costs over time. Part of that effort needs to be based on evidence of the comparative effectiveness of various drugs, for example. Establishing rules for coverage of drugs should reflect good medical evidence and

not just on which manufacturer offers the best discounts. Undertaking these studies and evaluations represents a public good and needs to be funded on that basis.

Within the fee-for-service environment, it would be helpful to energize both patients and physicians in helping to coordinate care. Patients need information and support as well as incentives to become involved. Many caring physicians, who have often resented the low pay in fee for service and the lack of control in managed care, would likely welcome the ability to spend more time with their patients. One simple way to do this would be to give beneficiaries a certificate that spells out the care consultation benefits to which they are entitled and allow them to designate a physician who will provide those services. In that way, both the patient and the physician (who would get an additional payment for the annual or biannual services) would know what they are expected to provide and could likely reduce confusion and unnecessary duplication of services that go on in a fee for service environment.

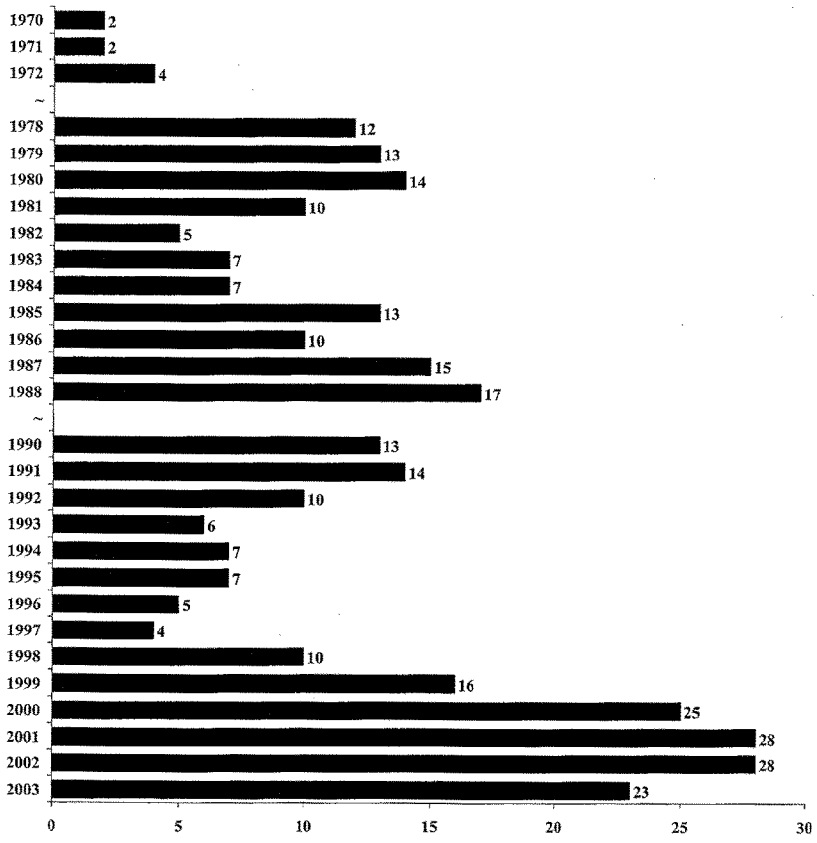
Additional flexibility to CMS to manage and develop payment initiatives aimed at using competition where appropriate also could result in long term cost savings and serve patients well. In the areas of durable medical equipment and perhaps even some testing and laboratory services, contracting could be used to obtain favorable prices.

These are only a few examples of changes, none of which promise to be the magic bullet, but which could aid the Medicare program over time.

CONCLUSION

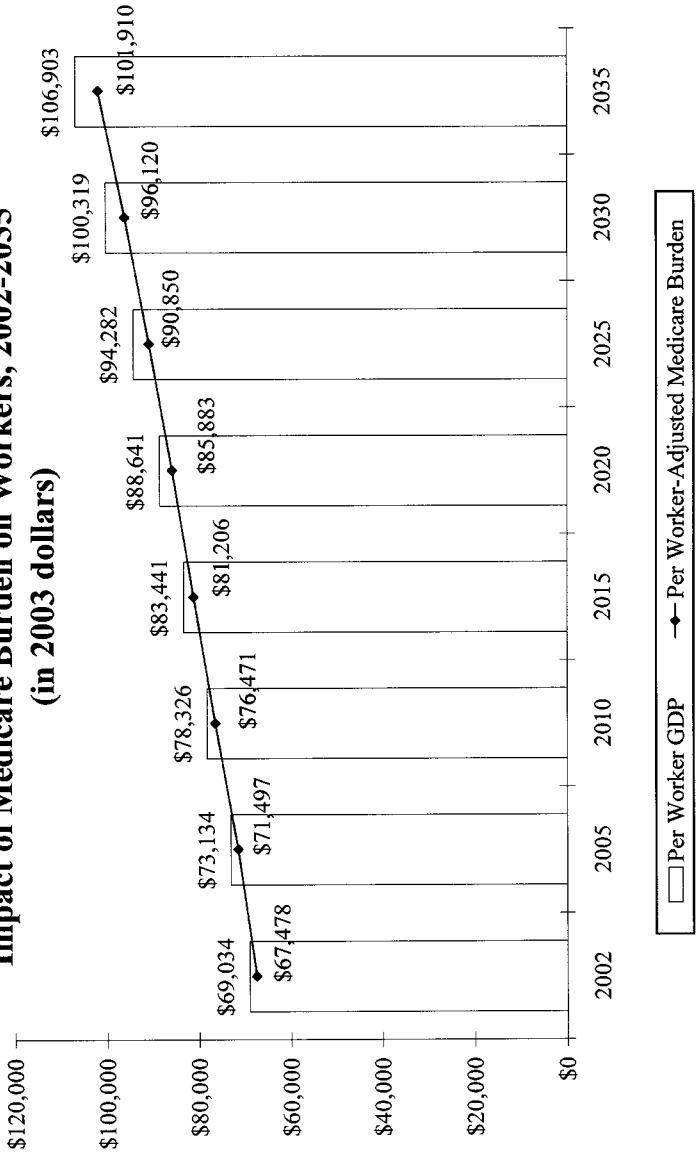
It is important to consider the broader issue of affordability in thinking about Medicare's future and not just the usual measures of solvency on which people often depend. And while Medicare at its current level is certainly affordable, a number of changes will need to be made. Over the years, the financial viability of Medicare has been improved by enacting a range of changes in the program. Further improvements in the program will be needed in the future. Nonetheless, we simply cannot expect as a society to provide care to the most needy of our citizens for services that are likely to rise in costs and to absorb a rapid increase in the number of individuals becoming eligible for Medicare without taking the financing issue head on. As a successful program, it makes sense to continue Medicare for the future, but that will require additional revenues.

Figure 1
Number of Years Before HI Trust Fund Projected to be Exhausted



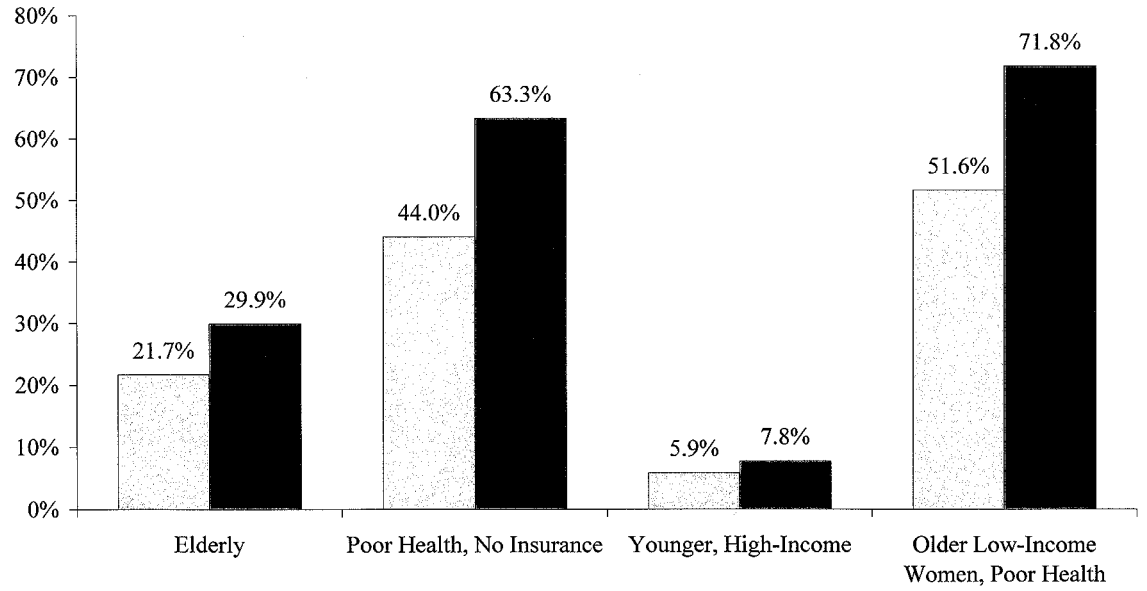
~ Missing Data for Years 1973-1977 and 1989
Source: CRS 1995 and Medicare Trustees Reports

Figure 2
Impact of Medicare Burden on Workers, 2002-2035
(in 2003 dollars)



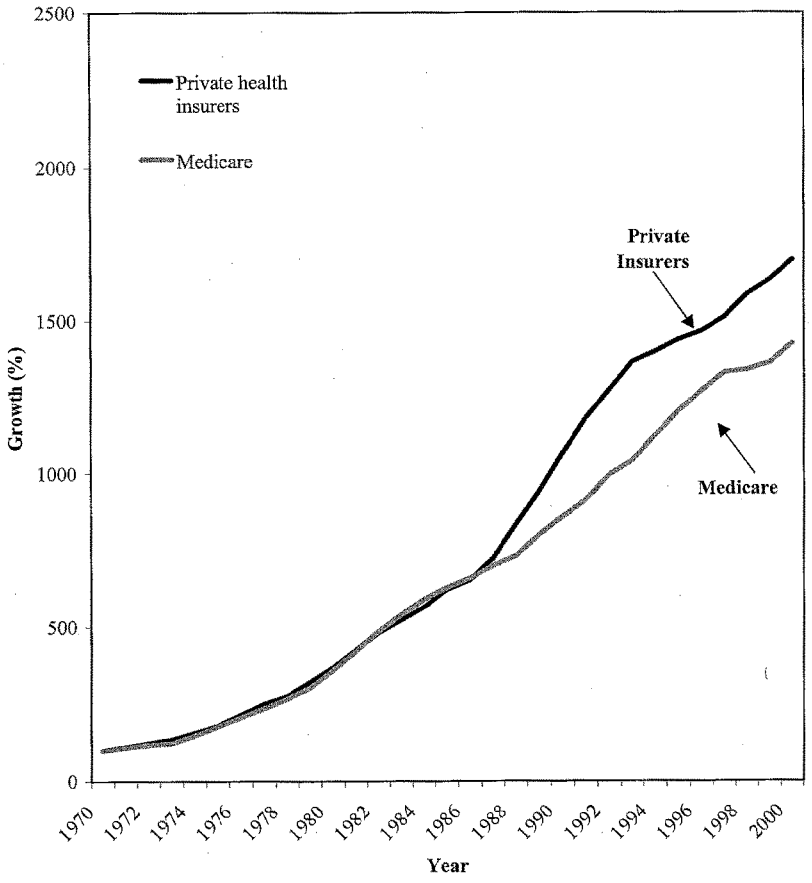
Source: 2003 Trustees Report

Figure 3
Projected Out-of-Pocket Spending as a Share of Income Among Cohorts, 2000 and 2025



Source: The Urban Institute's 1999 Medicare Projections Model

Figure 4
Cumulative Growth in Per Enrollee Payments for Comparable Services, Medicare And Private Insurers, 1970-2000*



* Includes hospital care, physician and clinical services, durable medical equipment, and other professional services.
Source: Urban Institute analysis of National Health Expenditures data from CMS.

Mr. BILIRAKIS. Thank you very much, Dr. Moon.
Ms. Grealy.

STATEMENT OF MARY R. GREALY

Ms. GREALY. Chairman Bilirakis, Congressman Brown, members of the subcommittee, thank you for your invitation to testify today. And thank you for the commitment and energy you are bringing to this very necessary goal of strengthening and improving Medicare.

The Health Care Leadership Council is a coalition of chief executives of some of our Nation's most important and innovative health care companies and institutions. Our members share a commitment to a patient-centered health care system that is characterized by innovation, value, and constantly improving quality. We believe these are words that should be used to describe our Nation's Medicare program.

I think we can all agree upon certain goals for the health program that serves older and disabled Americans. Medicare should have a prescription drug benefit. In fact, we support President Bush's budget request for a drug benefit. Medicare should offer a high level of health care quality and innovation to its beneficiaries. Medicare should offer good value to both beneficiaries and to taxpayers.

We believe that Medicare can be improved in both financial and health care quality terms by moving toward a delivery model that utilizes competition and invests beneficiaries with the power of consumer choice. This model works well today for tens of millions of people who are either in large employer-sponsored health plans or in the Federal Employees Health Benefit Program.

These programs deliver better benefits, including prescription drugs, lower out-of-pocket costs, and the ability to choose a plan that is best suited to individual needs.

This morning I would like to make three critical points about what can be gained from a competitive Medicare model. First, there is a level of quality that can be achieved through a market-based incentive that simply does not occur in a price-controlled, regulated environment.

Mr. Chairman, there is no question that Medicare beneficiaries are missing out on quality health care innovations that are being delivered to millions of health care consumers throughout the country. Private health plans and other providers have created effective care management programs that lead to better health outcomes, greater patient satisfaction, and cost efficiencies.

By contrast, Medicare does have an inherent difficulty in keeping pace with the changing state of health care. Changing the Medicare benefit package requires an act of Congress, and the administrative process for determining whether Medicare should cover a new treatment or procedure is painfully complex.

And, consequently, Medicare beneficiaries did not then have access to the most effective preventive care available. Within the FEHBP program, health plans respond quickly to changing beneficiary needs, to new treatments, and to the availability of new technologies.

My second point concerns the undeniable linkage between choice and quality. Consumers influence the quality of their care by choos-

ing health plans that demonstrate better outcomes. Consumers can also influence the value of their care by choosing health plans that offer the best product for the lowest price.

Doesn't it stand to reason, then, that Medicare beneficiaries, given this power of choice, can be the drivers of greater quality and greater value. Some have said that it would be a confusing imposition to give seniors these choices. We should not sell older Americans short. And with more retirees having experienced some form of managed care during their working years, modern Medicare beneficiaries will be increasingly comfortable with, and accustomed to, selecting and joining private health plans.

Finally, I would like to say a word about the financial aspects of Medicare and how best to move the program toward sound footing for future generations. Some would argue that the right answer for Medicare involves government price controls and periodic spending reductions like those that were included in the 1997 Balanced Budget Act legislation.

And, yes, those actions have kept Medicare spending growth at a comparatively lower rate. But at what price? Today's Medicare program can control spending growth, because it does not provide an outpatient prescription drug benefit. And it does not always keep up with new health technologies as quickly as the private sector does.

And providers can only continue to meet and treat Medicare patients at low reimbursement rates by making up for that through some of—or making up for some of their losses through other payers. You can find savings through price controls and spending cuts, but you pay through an erosion in access and in quality.

It would make far more sense and be better for Medicare beneficiaries to use market-based incentives to increase value and to use the power of consumer choice to simulate cost efficiencies and to use preventive care and health innovations to reduce the need for costly acute care and lengthy hospitalizations.

We can have a Medicare program that offers both quality and value, and that is geared to meet the needs and challenges of this century. We look forward to working with this committee to pursue these essential goals.

Thank you.

[The prepared statement of Mary R. Grealy follows:]

PREPARED STATEMENT OF MARY R. GREALY, PRESIDENT, HEALTHCARE LEADERSHIP COUNCIL

Thank you, Chairman Bilirakis, Congressman Brown, members of the subcommittee for your invitation to testify today. The Healthcare Leadership Council shares your commitment to a strong Medicare program, and I look forward to sharing our members' views on how this valuable program can be improved.

The Healthcare Leadership Council (HLC) is made up of chief executives of the nation's premier health care companies and institutions. Our members are health industry leaders who share a vision of a patient-centered health care system characterized by innovation, value and constantly-improving quality. The HLC is one of the governing members of the Alliance to Improve Medicare—a broad-based coalition of health, employer and retiree organizations dedicated to a stronger Medicare program that embodies the best qualities of American health care.

Clearly, steps must be taken to improve Medicare, in both financial and health care quality terms. Today, Medicare spends an average $6,200 annually for each beneficiary in the fee-for-service program. Ten years from now, that cost will increase to about $9,500. That's a 50 percent increase in cost to simply maintain the

program we have today, with no outpatient prescription drug coverage, no significant overall quality improvements or added value for beneficiaries.

I think we can all agree that Medicare should have a prescription drug benefit. In fact, the HLC supports President Bush's generous $400 billion budget request for a prescription drug benefit and the work done last year by the Committee. Medicare should also offer a higher level of health care quality and innovation, and should offer greater value to both beneficiaries and taxpayers.

We believe these goals can be achieved if Medicare moves toward a delivery model that utilizes competition, flexibility and invests beneficiaries with the power of consumer choice. This model works well today for the tens of millions of Americans who receive their health care through large employer-sponsored plans or through the Federal Employees Health Benefits Program (FEHBP). People enrolled in these programs generally receive better benefits, including prescription drugs, lower out-of-pocket costs and the ability to choose a health plan best suited for their needs.

Medicare, as it is structured today, bound by government micromanagement, cannot offer these advantages.

REGULATED QUALITY VERSUS INCENTIVE-BASED QUALITY

Today's Medicare program has inherent barriers that prevent it from offering the same kind of coordinated care, medical innovation and continuous quality improvement offered in the private health insurance market.

Medicare's administered pricing system and its complex regulations don't provide incentives for quality improvements. Medicare's regulations achieve a defined, and often outdated, regulatory standard—in essence, a "ceiling" of health care quality. This regulatory rigidity doesn't recognize that quality improvement is never static. It is constantly evolving. Today's best practices, which regulations lock into place, could be outdated a few months from now.

Medicare beneficiaries are missing out on quality achievements taking place elsewhere. Private health plans, pharmacy benefit managers and other health care providers have created effective care management programs that lead to better health outcomes, greater patient satisfaction and cost efficiencies. Members of one nationally-known health plan can, for example, use the Internet to compare hospital quality information for a wide variety of medical conditions and surgical procedures, compare prescription drug choices for cost and potential side effects and access information on thousands of health and medical topics. Additionally, beneficiaries can utilize a 24-hour telephone service to get professional case management services for serious and complex medical conditions. This is emblematic of the efforts and innovations being undertaken by health plans to keep Americans healthier. Medicare simply does not have any built-in incentives to guide beneficiaries toward the few preventive benefits the program covers.

And private plans, not conventional Medicare, utilize the services of pharmacy benefit management companies, which have developed impressive programs to improve the quality and safety of pharmaceutical regimens while also containing costs.

Competition, flexibility and consumer choice create these positive results. Health plans must pursue and develop constant improvements in order to compete for employers shopping for greater quality and value in health coverage.

The Medicare+Choice program, its flawed structure notwithstanding, has provided us with valuable information on the steps private health plans will take to keep patients well. Ninety-five percent of Medicare+Choice plans have diabetes management programs. Three of every four have asthma and coronary heart disease management programs. And, every single Medicare +Choice plan provides annual physical examinations. By contrast, fee-for-service Medicare has just started implementing limited disease management demonstrations.

In a recent paper, Dr. John Wennberg, author of the renowned Dartmouth Atlas, discussed the linkage between a health system's organizational structure and the usage of effective health care practices. For example, the percentage of female Medicare beneficiaries who received a mammogram at least once over a two-year period fell below the "best practice" benchmark in every geographic region of the country—ranging from a high of 77 percent to a disturbing low of 21 percent.

Why is there such variation in effective care? Dr. Wennberg wrote that a critical factor is the lack of infrastructure to ensure compliance with well-accepted, evidence-based standards of practice.

Dr. Wennberg's analysis is extremely important in discussing the future of Medicare. We can't automatically improve the quality of care for Medicare beneficiaries by adding new benefits, on an ad hoc basis, to the existing fee-for-service program. Even the few preventive benefits covered by Medicare are used sporadically, according to a 2002 General Accounting Office report. There are a lack of incentives and

organizational systems to encourage beneficiaries to take advantage of services that can keep them healthier.

THE LINK BETWEEN QUALITY AND CHOICE

Beneficiary choice is a highly effective regulator of quality. Consumers influence the quality of their care by choosing health plans that demonstrate better outcomes. Consumers influence the value of their care by choosing plans that offer the best product for the lowest price. It stands to reason that Medicare beneficiaries, given the power of consumer choice, will be the drivers of greater quality and value within a modernized Medicare program.

In fact, beneficiaries who are provided user-friendly, customized information on health care choices can bring about greater efficiency in the overall Medicare program by reducing the need for top-down federal micromanagement.

We object to the contention that Medicare beneficiaries would not be up to managing a greater degree of consumer choice. This argument sells today's seniors short. With more retirees having experienced some form of managed care during their working years, and with fewer employers offering retiree health benefits, "modern" Medicare beneficiaries will be increasingly more willing to join private plans.

Statistics bear out this trend. In 1992, about 63 percent of the under-65 population with health coverage were enrolled in traditional fee-for-service health plans, with the remainder enrolled in HMOs, preferred provider organizations and point-of-service plans. By 1999, fee-for-service enrollment had decreased to only nine percent of the under-65 covered population, with the other categories having greatly expanded participation. These newer beneficiaries will enter Medicare eligibility experienced in choosing health plans based on quality measures, tailored benefit packages and cost-sharing advantages.

Further, moving Medicare toward an FEHBP model would likely open a greater variety of plan options, as has happened in the private sector. One can assume the emergence of preferred provider organizations and private fee-for-service plans, as well as the more organized systems of delivery already discussed. In a truly competitive environment, beneficiaries will have different plan structures, premium differentials and, very importantly, quality comparison information. Just as federal employees do today, beneficiaries and their families will have the information conveniently at hand to choose a plan and benefits that best suit their individual needs.

Debate over whether a more competitive Medicare model should be developed inevitably includes discussions of the Medicare+Choice program. We can learn a great deal from the flaws of the Medicare+Choice structure, and use that knowledge to shape Medicare reform that will attract plan participation in Medicare and make health plans attractive to Medicare beneficiaries.

MEDICARE+CHOICE: LEARNING LESSONS TO AID TRUE REFORM

Some have made the assertion that a competitive model for Medicare cannot work. They use Medicare+Choice as an example. That is a flawed argument.

It is true that Medicare+Choice has not yielded enough participating plans to generate meaningful competition. This is largely due to the fact that Medicare+Choice plans have not had the opportunity to offer a competitive alternative to the Medicare fee-for-service program.

Over the last five years—the time frame during which the Medicare+Choice program has phased in—there has been an increasing gap between what the traditional fee-for-service Medicare program spends on a beneficiary and the amount a Medicare+Choice plan is paid to provide care to a Medicare beneficiary in the same geographic area. This widening payment differential forced Medicare+Choice plans to reduce extra benefits they could use to attract beneficiaries. It has also forced increased beneficiary cost-sharing. The concept of fair competition was rendered impossible.

An important lesson learned from Medicare+Choice is that competition based on quality and value cannot take place in an environment of price controls and inflexibility. It is critical to keep this in mind in designing a better Medicare program. Medicare+Choice could not achieve its full potential because it ran into the impassable barrier of unbalanced competition. Lawmakers will be faced with the task of creating a level field of competition while maintaining the current fee-for-service program. This will be difficult, both politically and technically. It is, however, absolutely essential to inject competition into the Medicare program if we are to provide current and future beneficiaries with comprehensive, high-quality health care.

A SUPERIOR MEDICARE MODEL

Our society has changed tremendously since Medicare was created in 1965. The Medicare of that time offered seniors what they needed most—the acute care that so many older Americans required not long after they reached retirement age.

Today, though, our senior population is greatly changed. Thanks to modern medicine and greater knowledge about healthy lifestyles, life expectancy is much greater than it was in 1965. Now, what seniors need most is to better manage, or even prevent, chronic disease. Today's Medicare, though, is still offering a 1965 prescription for a 21st century diagnosis.

Creating a competitive FEHBP-style model for Medicare would directly address many of the inherent flaws that prevent senior citizens from receiving the benefits of health care innovation and advancements.

Today's Medicare program is highly regulatory and inflexible, although HHS Secretary Thompson deserves considerable credit for his efforts to address this problem. The program is still afflicted with over 100,000 pages of regulations, rules, manuals, instructions, letters, alerts and notices. The administrative process for determining whether new medical treatments or procedures merit coverage under the Medicare benefits package is excruciatingly complex. Consequently, Medicare is always a few steps behind the current state and quality of American health care, and patients pay the price for this lag.

We have to ask ourselves, should seniors have to wait for an act of Congress to modify the Medicare benefit package in order to have access to the most effective preventive health services available?

HLC members believe an FEHBP-style model for Medicare would represent the best possible partnership between the public and private sectors to provide quality health care to America's seniors. In this model, it would be a proper and essential role for government to provide oversight of private health insurance programs, as is the case with FEHBP.

We can draw a sharp contrast, though, between the FEHBP model and conventional Medicare, in that the former requires a minimal amount of regulation. This competitive model would provide better benefits, lower out-of-pocket costs and much quicker access to lifesaving and life-enhancing medical innovations. In the FEHBP model, health plans respond swiftly to changing beneficiary needs, to new treatments and to the availability of new technologies. Medicare, under this model, could better keep pace with advances in health care and, most importantly, prevent and manage disease instead of simply responding to individual episodes of illness. That is the care today's seniors need.

CONCLUSION

Mr. Chairman, in discussing Medicare reform, there are important facts that should come to the forefront of consideration—facts about care management programs, about preventive care, about pharmacy benefit management programs, about all of the beneficial approaches and innovations that private plans are utilizing and Medicare is not. It is possible to modernize Medicare to better serve the health needs of America's seniors and to do so cost-efficiently.

As we look at Medicare's financial challenges, some will argue that the right answer for Medicare involves government price controls and periodic spending reductions such as those legislated in the 1997 Balanced Budget Act. They will say that these tools have traditionally kept Medicare spending growth at a lower rate than private health care spending.

But, looking at the health care economy as a whole, these savings are false. In the bifurcated world of Medicare versus private health care, payment reductions in Medicare just result in shifts from one side of the payment world to the other. Providers are only able to continue treating Medicare patients at such low rates because they make up for some of these losses through other payers.

Additionally, Medicare's slower growth is partially due to the fact that it does not provide an outpatient prescription drug benefit and it does not keep up with new technologies as well as the private health care sector does.

Using draconian payment cuts to control Medicare spending, instead of building in incentives to increase the value of care, cheats Medicare beneficiaries out of the potential quality innovations being achieved by providers and plans competing for millions of federal employees and private sector workers. Such cuts ignore also the fact that providers deserve and must have adequate payment in order to provide high quality health care to Medicare beneficiaries.

The Healthcare Leadership Council compliments this committee for its efforts to look toward a future for Medicare that embraces both long-term financial health for

the program as well as better health care for its beneficiaries. We look forward to working with you to achieve these important goals.

Thank you again for this opportunity to share our views.

Mr. BILIRAKIS. Thank you very much, Ms. Grealy.

Ms. Kennelly.

STATEMENT OF BARBARA B. KENNELLY

Ms. KENNELLY. Thank you, Chairman Bilirakis and ranking member Mr. Brown, and other distinguished members of the committee. I am honored to be here to comment, and I thank you very much for holding this very important hearing.

The national committee of which I am president is a membership organization. It is a nonprofit, and it is bipartisan. And I am here today to tell you a little bit about it. We have a lobbying division. We have a grass-roots division. But we also have a membership division, which receives 600 calls a week. And this is what our members tell us consistently.

Our members want preventive benefits which help keep them healthy and out of the hospital. They favor reforms that keep Medicare as a program in which everybody contributes, everyone gets the same benefits, and those benefits are guaranteed.

The national committee supports a prescription drug benefit that is universal, voluntary, and affordable. It should be readily adjusted to account for inflation and offered as a standard benefit under Medicare. We support chronic disease management and preventive benefits, and, most importantly, we are committed to preserving the social insurance nature of Medicare.

We all want meaningful prescription drug coverage, yet it seems when I look at what the administration is proposing that this would not give seniors the assurances that they need. Instead, it uses the promise of prescription drug coverage for some to restructure Medicare, and eventually undermine its social insurance principle.

We recognize that the country faces a deficit and fiscal constraints. We also recognize the administration's suggestion of spending $400 billion—and that is a lot of money—in 10 years, probably will not do it because we know CBO tells us that $1.8 trillion will be spent by seniors on medications. But we hope that Medicare is improved in a way that allows us to build on this beginning and provide meaningful prescription drug coverage to every senior who needs it.

Can private insurance models provide these seniors the affordable, predictable, and reliable health coverage they say they need? Let us examine this scenario. Beneficiaries in different plans would have different benefits and costs. These costs and benefits would have—could dramatically change, as they have done in managed care plans in the past.

Your premiums and costs increase. Poor and sicker beneficiaries might not be able to afford the same coverage as others. So far evidence does not indicate that private insurance can promise seniors that premiums will not fluctuate substantially from year to year.

Our seniors, who like 85 percent of Medicare beneficiaries enrolled in traditional fee for service Medicare, tell us how much they depend on Medicare and on its quality care. The administration's

plan creates a new category of private Medicare insurance to deliver prescription drug coverage, and this could be problematic.

The shortcomings are well documented. We recently had one of our members testify in front of another committee—Lucille Bryson. She joined a Medicare+Choice program 5 years ago. Paying $19.98 a month, she thought she really had a good deal. Over 3 years, her premium increased to $80 a month, and her benefits were cut. Mrs. Bryson is not unique.

I look at the proposals that claim to model the FEHBP plan, of which I am a member, as a delivery model, which the administration advocates. Also, we don't think that meets the test of evidence. Seniors are much older and tend to have a higher rate of chronic illness than the FEHBP working population.

The average age of an FEHBP employee is 47, and the average annual income is over $54,000. This is hardly comparable to a senior over 65 years of age whose annual income is $22,000.

Chairman Bilirakis, I would also like to associate myself with the remarks yesterday of Bruce Vladeck. I know you have worked very closely with him on one of the bipartisan commissions, and you have disagreed with him. But you also understand that he is an expert, as Dr. Moon is an expert.

And I read his testimony last night, and I really would like to associate myself with it, because he spoke eloquently about the importance of the universality of Medicare. He also said how this has to be a meaningful benefit. One-third of those on Medicare have under $500 spent in a year on drugs. Ten percent spend over $6,000. So the majority spend $2,500, and they are the ones that really need the help.

We also—I read some interesting things that I hadn't even thought of, that we really would find it very difficult to mean test Medicare, because we are so unknown exactly what senior incomes are, and so many seniors have low income.

And then, I look to Aetna here, Mother Aetna, who I live right down the block from, and they are a wonderful company and I want them to succeed. But they don't have a very good record with seniors. We know so far they haven't saved any money for Medicare. We know they don't work very well in rural areas. And we also know that if they don't make a profit, they have to get out of the business, because they have shareholders and they have to make a profit.

So I come here this morning not as an expert but as an advocate for 1.5 million seniors to say that I really think Medicare has worked and will continue to work.

But, Chairman Bilirakis, what I really want to thank you is for all of your hundreds and hundreds of hours of hard work. I sit and look at you and think of the time you have spent trying to solve this problem, and I say with Bruce Vladeck, as he said yesterday, don't think about the ideology, don't think about the philosophy or the theories. Take all of your knowledge and put it together and fix Medicare with a prescription drug.

Thank you, Mr. Chairman.

[The prepared statement of Barbara B. Kennelly follows:]

PREPARED STATEMENT OF BARBARA B. KENNELLY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Good morning, Chairman Bilirakis, Ranking Member Brown and distinguished members of the committee. I appreciate the opportunity to comment today about proposals to change Medicare and what that means for seniors. Thank you for holding this very important hearing.

The National Committee averages more than 600 calls per week from seniors throughout the country. For our seniors, Medicare reform means getting a comprehensive drug benefit under traditional Medicare, and—like most seniors, who are living on fixed incomes—coverage that is affordable and does not fluctuate substantially in price. They like preventive benefits, which help keep them healthy and out of the hospital. They favor reforms that keep Medicare as a program in which everyone contributes, everyone gets the same benefits, and those benefits are guaranteed.

The National Committee supports a prescription drug benefit that is universal, comprehensive in coverage, affordable, regularly adjusted to account for inflation, voluntary, guaranteed to all who want it regardless of income or health status, and offered as a standard benefit under Medicare. We support chronic disease management and preventive benefits and advocate for such improvements. And, most importantly, we are committed to preserving the social insurance nature of Medicare.

Seniors are spending an average of $200 a month on prescription drugs [1] and they need the assurance of meaningful prescription drug coverage. This is something we all recognize and wish to do something about. Yet the administration's Medicare proposal, as well as other legislative proposals, would not give seniors this assurance. Instead, they use the promise of prescription drug coverage for some to restructure Medicare and eventually undermine its social insurance principle—the same social insurance principle that now assures all seniors a defined set of benefits and should guarantee all seniors a defined prescription drug benefit.

We recognize that the country faces a deficit and fiscal constraints, just as we all recognize that the administration's suggestion of spending $400 billion over 10 years for Medicare changes, including drug coverage, covers a fraction of the $1.8 trillion seniors will be spending on drugs over the next decade.[2] But we hope that Medicare is improved in a way that allows us to build on this beginning and provide meaningful prescription drug coverage to every senior who needs it.

Can private insurance models provide these seniors the affordable, predictable and reliable health coverage they say they need? Let's examine the scenario. Beneficiaries in different plans would have different benefits and costs. Those costs and benefits could dramatically change every year, as they have done in managed care plans in the past five years, and seniors would not be able to plan for their healthcare costs. If premiums and costs increased, poorer and sicker beneficiaries might not be able to afford the same coverage as others. So far, evidence does not indicate that private insurance can promise seniors that premiums would not fluctuate substantially from year to year.

Our seniors—who like 85 percent of Medicare beneficiaries who are enrolled in traditional fee-for-service Medicare—tell us how much they depend on Medicare and on quality care. There is an underlying assumption operating in a number of Medicare proposals that private plans give better care. Certainly this assumption is present in the administration's plan, which creates a new category of private Medicare insurance plans and uses private plans to deliver prescription drug coverage.

That private plans give better care is unsupported by historical evidence. The shortcomings are well documented, from the earliest unsuccessful Medicare-risk HMO demonstration projects to today's uncertain Medicare+Choice. Since the enactment of the Balanced Budget Act of 1997 that created Medicare+Choice, managed care plans have dropped more than 2.4 million seniors,[3] many of whom enrolled for the drug coverage the plans provided. When plans drop seniors, there often is not another Medicare managed care plan in the area, especially in a rural setting. Many in this position fall back on traditional fee-for-service Medicare because other plans did not work out.

Medicare+Choice premiums have increased dramatically, by 37 percent,[4] compared to an 8 percent increase in Medicare Part B premiums. For example, one of our members, Lucille Bryson, joined a Medicare+Choice program five years ago, pay-

---

[1] "Medicare and Prescription Drug Fact Sheet," Kaiser Family Foundation, February 2003.

[2] "Projected spending for prescription drugs by and on behalf of Medicare enrollees," Congressional Budget Office, February 3, 2003.

[3] "Medicare Privatization: Bad for Seniors and People with Disabilities," Public Citizens, February 2003.

[4] "Average Out-of-Pocket Health Care Costs for Medicare+Choice Enrollees Increase Substantially in 2002," Issue Brief, Commonwealth Fund, November 2002.

ing $19.98 a month. Over the next three years, her premiums increased to $80 a month and she says that her benefits are now being cut. Mrs. Bryson is not unique.

Also, HMOs have spent, on average, between 10 and 15 percent of their revenue on administrative costs,[5] compared to Medicare's 2 percent. The dramatic increase in premiums and sizable administrative costs are further evidence that the private sector does not have the track record to support the assertion that it can provide seniors adequate prescription drug coverage for a reasonable cost.

Even now, managed care plans continue to ask Congress for more money to run the Medicare+Choice programs or they threaten to no longer cover seniors. When Congress did increase payments of $1 billion to plans in 2000 through the Benefits Improvement and Protection Act, more than 544,000 beneficiaries still lost coverage.

And, according to a recent Urban Institute study by Marilyn Moon, private health insurance companies spend more per beneficiary than does Medicare.[6]

This information gains significance when considering whether to divert prescription drug coverage to the hands of private plans and funnel beneficiaries to private Medicare plans. The administration's plan could result in seniors who wanted more than just a drug discount card leaving traditional fee-for-service and going to a private insurance plan. Plans, if modeled after Medicare+Choice, could perform in a manner similar to that of managed care: Evidence indicates that they would be likely to participate in favorable risk selection by offering Medicare beneficiaries low-cost, low-coverage plans that attract younger, healthier seniors, leaving the sickest and oldest unable to afford the more generous plans.

Proposals to use the FEHBP program as a delivery model, which the administration has advocated, also do not meet the test of evidence. Seniors are much older and tend to have a higher rate of chronic illnesses than the FEHBP working population. The average age of an FEHPB employee is 47 and the average annual income over $54,000. This is hardly comparable to a senior over 65 years of age, with an average, and usually fixed, annual income of $22,000.[7]

The National Committee supports a prescription drug benefit that is universal, comprehensive in coverage, affordable, regularly adjusted to account for inflation, voluntary, guaranteed to all who want it regardless of income or health status, and offered as a standard benefit under Medicare. We also support disease management and preventive measures, and we are pleased that Department of Health and Human Services Secretary Tommy Thompson recently announced a three-year, 10-state demonstration proposal for chronic disease management for Medicare beneficiaries. According to the Centers for Medicare and Medicaid Services, 73 percent of women and 65 percent of men who are Medicare beneficiaries have two or more chronic conditions,[8], and many of them are among the six percent of Medicare beneficiaries that account for more that half the program's spending.[9] Improvements such as care coordination, chronic disease management and preventive services not only are very important to keeping seniors healthy and out of the hospital, they also have the potential to save the program a significant amount of money. These improvements can be added to traditional Medicare right now. It's not necessary to create private plans to implement them.

As we move forward, let us keep in mind that before Medicare, only 50 percent of seniors had health insurance. Today, 99 percent of seniors are covered. Society has benefited and we are all better off. This is what the social insurance principle, on which Medicare is based, is all about.

Ultimately, if we want to improve Medicare, we have no choice but to consider it in the context of the health care system of which it is a part. That system has 41 million Americans under 65 with no health insurance, and they are forcing hospitals to absorb costs and helping to drive double-digit health inflation.[10] We must look to the source of everybody's inflation—the 41 million uninsured, new medical testing and devices, and research and development—if we are to improve the components of the healthcare system that the inflation affects, including Medicare.

In conclusion, I want to thank Chairman Bilirakis, who has tried so hard to address seniors' needs and continues to work to address the needs of his constituents in Florida. And I want to thank all of the members of this body and their staff who are carefully considering how the Medicare proposals would impact seniors. I appre-

---

[5] "Medicare Privatization: Bad for Seniors and People with Disabilities," Public Citizens, February 2003.

[6] "Comparing Medicare and Private Insurers: Growth Rates in Spending Over Three Decades," *Health Affairs,* March/April 2003.

[7] *Federal Civilian Workforce Statistics: The Fact Book,* Office of Personnel Management, 2002.

[8] "Characteristics and Perceptions of the Medicare Population," Centers for Medicare and Medicaid Services, 1999.

[9] *Medicare Chart Book,* Kaiser Family Foundation, Fall 2001.

[10] "The Uninsured and their Access to Healthcare," Kaiser Family Foundation, January 2003.

ciate the opportunity to appear before you today and I look forward to any questions the distinguished members of this committee may have. Thank you for your time.

Mr. BILIRAKIS. Thank you for that, Ms. Kennelly. You know, this would be a much more interesting hearing I think if we just allowed you all to debate to each other.

I have always wanted to do that, to be perfectly honest with you.

Mr. Buddy, please pull the mike over, sir, and speak into it, if you can.

STATEMENT OF ROBERT BUDDY

Mr. BUDDY. Good morning, Mr. Chairman and members of the committee. My name is Robert Buddy, and I am a highly satisfied member of a Medicare+Choice health plan in Houston, Texas.

Mr. BILIRAKIS. We can't——

Mr. BUDDY. Can you hear me? Okay. Not too well.

I would like to take this opportunity to thank the committee for inviting me to participate in this hearing on behalf of all seniors. It is a privilege and an honor to attend, and I sincerely hope that my comments can make a constructive contribution to the proceeding.

I will describe as concisely as possible how my wife and I have benefited from the Medicare+Choice program and why I believe this important program should be preserved.

While certain aspects of our experience are unique, the important point is that millions of seniors have had similar experiences. My objective, then, is to try to put a human face on a Medicare program that is working for me and for millions of other seniors who have chosen to join a Medicare+Choice health plan.

My wife and I are now both 76 years of age. In 1993, when we both turned 65, we became eligible for Medicare, and we were relieved and delighted to become eligible for this benefit. We purchased a Medicare supplement policy to supplement the Medicare benefits at a combined cost of about $4,000 a year.

A year later we were introduced to the idea of a privatized version of Medicare through an HMO. Today this program is known as Medicare+Choice, soon possibly to be Medicare Advantage. The advantages of this plan were the emphasis on early detection and treatment of illness, its promotion of wellness, the opportunity it provided us to become active participants in our medical care with our primary care provider as a partner.

Because this approach resulted in a more efficient utilization of resources, the plan offered broader benefits, including both brand name and generic prescription drug coverage at a lower cost—in fact, at no cost at all, in terms of premium, that is.

The emphasis on early detection and treatment had particular appeal to me because of what had happened to my father. The traditional way of dealing with medical problems was to wait until there were symptoms. Unfortunately, by the time symptoms appear, it is usually very late and possibly too late.

In my father's case, just when he was at the peak of his career, he became severely disabled by an acute case of glaucoma at the age of 55. There had been no symptoms whatsoever. After a series of unsuccessful operations, he became totally blind at the age of 63. He also suffered from serious, but undetected and, therefore, un-

treated, hypertension, the silent killer, and died of a massive heart attack at age 69.

Thus, the lack of proper preventative medical care resulted in his being blind-sided by a major disabling illness and the resulting total destruction of his ability to lead a productive life. Since both of these illnesses tend to be hereditary, I assumed that I would suffer a similar fate at some time in the future.

Thanks to the significant emphasis on early detection and treatment inherent in the Medicare+Choice program, that fate did not become a reality. Instead, my primary care physician carefully monitored my progress and made periodic referrals to appropriate specialists.

As a result of having the ophthalmologist monitor the pressure in my eyes, I was able to get laser surgery in both eyes which saved my eyesight. As a result of careful monitoring of my blood pressure, my primary care physician has gradually phased in three separate medications, and the pressure has stabilized at a normal level with good control.

As a result of detecting an elevated PSA, prostate screening, we were able to treat my prostate cancer in a timely fashion, and the followup has shown stability of the PSA at a very low level. As a result of detecting an abnormal-looking lesion on my right leg, a malignant melanoma was detected and treated immediately with an incision, and there has been no recurrence in 5 years.

Had I not had the benefit of early detection and treatment, I would either be blind or terminally ill, or perhaps both. So this experience has, understandably, made a believer out of me.

However, this is not the only benefit. By using managed care, my wife and I have saved an estimated $60,000 over the years, taking into consideration the cost of Med sup premiums, the cost of drugs, the benefits in the form of eyeglasses and drastically reduced dental costs.

We have used some of these savings to invest in ourselves with a wellness program, including a vigorous cardiovascular routine and resistance training at the local YMCA, and a heart healthy diet long on fresh fruits and vegetables, no fat dairy products, with lots of protein and more exotic items like veggie burgers and salmon burgers.

Most important of all, we have benefited from a very high quality of medical care from our primary care providers, our specialists, and our medical facilities. We believe that we have benefited from an approach that emphasizes disease management programs and enables patients to play a larger role in their own care.

By making the necessary changes in our lifestyle, we have attempted to monitor our progress through fitness through a gradual process wherein we are partners with our physician and our health, rather than relying on him after symptoms appear or expecting a major bullet.

We are extremely fortunate to be living in a society that has made such great strides in medical research, and we are very grateful for Medicare. What we need to do now is strengthen the Medicare+Choice program so that it continues to provide incentives for prevention, so that seniors can hold up their share of the bar-

gain by being proactive in wellness and early detection and treatment.

With adequate funding, the Medicare+Choice program offers the potential for seniors to remain not only healthy but also productive and active contributors to their families, their communities, and to society as a whole.

Thank you for providing me this opportunity to testify.

[The prepared statement of Robert Buddy follows:]

PREPARED STATEMENT OF ROBERT BUDDY

Good morning, Mr. Chairman and members of the committee. My name is Robert Buddy and I am a highly satisfied member of a Medicare plus Choice health plan in Houston, Texas. I would like to take this opportunity to thank the committee for inviting me to participate in this hearing on behalf of all seniors. It is a privilege and an honor to attend, and I sincerely hope that my comments can make a constructive contribution to the proceedings.

I will describe as concisely as possible how my wife and I have benefited from the Medicare plus Choice program and why I believe that this important program should be preserved.

While certain aspects of our experience are unique, the important point is that millions of seniors have had similar experiences. My objective, then, is to try to put a human face on a Medicare program that is working for me and millions of other seniors who have chosen to join a Medicare plus Choice health plan.

My wife and I are now both 76 years old. In 1993, when we both turned 65, we became eligible for Medicare, and we were relieved and delighted to become eligible for this benefit. We purchased a Medicare Supplement policy to supplement the Medicare benefits, at a combined cost of about $4,000 a year.

A year later, we were introduced to the idea of a privatized version of Medicare through an HMO. Today, this program is known as "Medicare plus Choice." The advantages of this plan were its emphasis on early detection and treatment of illnesses, its promotion of wellness, and the opportunity it provided us to become active participants in our medical care with our primary care provider as a partner. Because this approach resulted in a more efficient utilization of resources, the plan offered broader benefits, including both brand name and generic prescription drug coverage, at a lower cost—in fact, no cost at all.

The emphasis on early detection and treatment had particular appeal to me because of what had happened to my father.

The traditional way of dealing with medical problems was to wait until there were symptoms. Unfortunately, by the time symptoms appear, it is usually very late and possibly too late.

In my father's case, just when he was at the peak of his career, he became severely disabled by an acute case of glaucoma at the age of 55. There had been no symptoms whatsoever. After a series of unsuccessful operations, he became totally blind at age 63.

He also suffered from serious, but undetected, and therefore untreated hypertension—the "silent killer"—and died of a massive heart attack at age 69.

Thus, the lack of proper preventive medical care resulted in his being blindsided by major disabling illness and the resulting total destruction of his ability to lead a productive life.

Since both of these illnesses tend to be hereditary, I assumed that I would suffer a similar fate at some time in the future.

Thanks to the significant emphasis on early detection and treatment inherent in the Medicare plus Choice program, that fate did not become a reality. Instead, my primary care physician carefully monitored my progress and made periodic referrals to appropriate specialists.

As a result of having the ophthalmologist monitor the pressure in my eyes, I was able to get laser surgery in both eyes in time, which saved my eyesight.

As a result of carefully monitoring my blood pressure, my primary care physician has gradually phased in three separate medications, and the pressure is stabilized at a normal level with good control.

As a result of detecting an elevated PSA (prostate screening), we were able to treat my prostate cancer in a timely fashion and the follow up has shown stability of the PSA at a very low level.

As a result of detecting an abnormal looking lesion on my right leg, malignant melanoma was detected and treated immediately with an incision, and there has been no recurrence in 5 years.

Had I not had the benefit of early detection and treatment, I would be either blind or terminally ill—or perhaps both—so this experience has understandably made a believer out of me.

However, that is not the only benefit. By using managed care, my wife and I have saved an estimated $60,000 over the years, taking into consideration the cost of Med-sup premiums, the cost of drugs, the benefits in the form of eyeglasses, and drastically reduced dental costs.

We have used some of these savings to invest in ourselves with a wellness program, including a vigorous cardiovascular routine and resistance training, at the local YMCA and a heart healthy diet long on fresh fruits and vegetables, no-fat dairy products with lots of protein, and more exotic items like veggie-burgers and salmon burgers.

Most important of all, we have benefited from a very high quality of medical care from our primary care providers, our specialists, and our medical facilities.

We believe that we have benefited from an approach that emphasizes disease management programs and enables patients to play a larger role in their own care. By making the necessary changes in lifestyle, we have attempted to monitor our progress toward fitness through a gradual process wherein we are partners with our physician in our health—rather than relying on him after symptoms appear or expecting a magic bullet.

We are extremely fortunate to be living in a society that has made such strides in medical research and we are very grateful for Medicare. What we need to do now is strengthen the Medicare plus Choice program so it can continue to provide incentives for prevention and so seniors can hold up their share of the bargain by being proactive in wellness and early detection and treatment.

With adequate funding, the Medicare plus Choice program offers the potential for seniors to remain not only healthy—but also productive and active contributors to their families, their communities, and to society as a whole.

Thank you for providing me this opportunity to testify.

Mr. BILIRAKIS. Thank you. Thank you, Mr. Buddy.

Well, I guess I would prefer a nice debate.

Mr. Buddy, you are, by your own admission, 10 years from 19—from when you turned 65——

Mr. BUDDY. Yes, sir.

Mr. BILIRAKIS. [continuing] you are about mid-70's now.

Mr. BUDDY. 76.

Mr. BILIRAKIS. Yes, 76.

Mr. BUDDY. And so is my wife.

Mr. BILIRAKIS. You apparently feel that you are able to make choice, you are able to study different—a variety of plans. Is that what you did, you studied a variety of plans to decide what plan would be best for you?

Mr. BUDDY. Yes, I did. I have been in a health insurance program for many years, and my wife is, too, and so we had had some practical experience in the commercial area.

Mr. BILIRAKIS. All right. You had the experience.

Mr. BUDDY. Yes, sir.

Mr. BILIRAKIS. Okay. Now, if you had not had that experience, or let us say if you were 4 years older—I mean, nobody knows when you are going to—what things will be 4 years from now, but are you concerned, based on your personal experience, not from your personal experience but experience maybe with neighbors, with friends, and what not, who might be older, who might be—maybe had the same background that you have had, maybe the same education, and what not, are you conserved that they may not be able to well determine what choice they should choose, what

plan they should choose, be able to study the plans adequately, etcetera, etcetera? Do you get my question?

Mr. BUDDY. I do, and it is an excellent one. I think the seniors are surprisingly sophisticated as a matter of necessity. Health care at this age is such an urgent thing that they can't afford to make a mistake, so they scrutinize these plans relatively carefully.

And we have been able to exchange—communicate with perhaps several hundred seniors through various programs, senior programs. And I find that, generally speaking, they are very rational in their choices, and they appreciate the benefits, particularly of a Medicare+Choice plan. The one concern that is experienced—it seems almost too good to be true. So if anything, there is a little bit of credibility gap. But in terms of the merits of the relative programs, they are sophisticated enough to make rational and prudent decisions.

Mr. BILIRAKIS. So you feel that the average senior is sophisticated enough and knowledgeable enough and would have the wherewithal to be able to make an intelligent decision.

Mr. BUDDY. Very much so. Yes, sir.

Mr. BILIRAKIS. Well, you should know, I would think.

Mr. Foster, do you feel that it is incumbent upon us to make sure that Parts A and B remain separate, as Dr. Moon indicated?

Mr. FOSTER. No, sir, I don't think it is necessary to keep them separate. Legislative historians will recognize that the two parts of Medicare were actually separate proposals way back when, artfully put together by Wilbur Mills to consolidate political support. The two parts are very different. There is no particular reason they have to be that way. If Congress chose to combine them, there is no particular reason not to.

Mr. BILIRAKIS. Thank you.

Coordination of care—certainly, a number of you have placed emphasis on that. Certainly, Ms. Rawlings did when she discussed her emphasis on wellness, preventative medicine, and chronic disease management. Ms. Grealy, of course, referred to it. I think it was Dr. Moon who made the comment that—I don't know whether you were referring to Aetna or in general—managed care plans would not do—or do not do a good job—I think those are your exact words—regarding coordination of care.

So let us have a little bit of a—I don't have much time left. But, Ms. Rawlings, respond quickly. I want to hear from Ms. Grealy and maybe from Dr. Moon, too, if we have time.

Ms. RAWLINGS. I think—in fairness, I think private plans historically have made efforts at coordination of care, but I think there have been significant improvements over the last several years as awareness of aging and awareness of what that means to health plans and to beneficiaries as our customers—what that means and how significant that is. And I know in Aetna's case, in particular, we have made significant strides in the last 2 years to significantly improve our coordination of care efforts to improve the beneficiaries' experience of the plan.

Mr. BILIRAKIS. And fee for service, there is no emphasis at all on that, is that right?

Ms. RAWLINGS. Not to my knowledge. I am not exactly sure how that would be constructed. There is not an infrastructure there. It

is more of an insurance—traditional indemnity insurance type program.

Mr. BILIRAKIS. Ms. Grealy?

Ms. MOON. I agree that——

Mr. BILIRAKIS. All right. Since you have the mike in possession——

Ms. MOON. I am sorry.

Mr. BILIRAKIS. Go ahead.

Ms. MOON. I agree that there are valuable plans that are out there that do a good job of coordinating care. But if you look at a large number of commercial plans that were put together not necessarily to really coordinate care but to get discounts from doctors and hospitals and operate in that fashion, that has never been a strong suit of theirs, and it has been a problem for many beneficiaries that are in those plans.

Mr. BILIRAKIS. Can a good coordination of care—and this is so very important. And believe it or not, that is part of our discussions constantly when we talk about reforming Medicare. So it isn't always concern about privatizing, etcetera, etcetera. It is doing some real good things.

Can, under fee for service, we do that?

Ms. MOON. I believe that there are ways in which you can do it. It is clearly harder than in a capitated world. There is no doubt about it. But I believe that most people have demonstrated that they prefer the fee for service world. And the lack of ability of a lot of plans to do it that are presumably HMOs suggests to me we should give that a try as well.

Mr. BILIRAKIS. Ms. Grealy, very briefly, please. Thank you.

Ms. GREALY. Well, I think a critical distinction is we are seeing these things in the private sector. And the ability to quickly respond to consumer demand, consumer preference, is something that we don't have in the existing Medicare program.

We see the existing Medicare program, I think, playing catch up, seeing that disease management programs are beneficial, and perhaps we should look at those, do a demonstration project. So I think the real value of looking at some of these private sector models, again, is how quickly they can respond and the flexibility that they have to respond to their customers, their beneficiaries.

Mr. BILIRAKIS. Thank you very much. Five minutes does go awfully quickly.

Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. Buddy, thank you for your comments especially, and I hope that we can reform Medicare, that traditional Medicare can offer that kind of preventive care and management of care and coordination of care. So thank you for that.

There was an article in The Wall Street Journal about 2 weeks ago. I want to read one paragraph. "The Congressional Budget Office Chief tells Republican Senators the Medicare overhaul plan could add hundreds of billions of dollars in costs. Administration cost-saving claims for its plan also are belied by early data from a demonstration project. Small savings from encouraging seniors to opt for private plans are offset by high administrative costs." Ms. Moon, the people that argue for FEHBP tell us that seniors should

have an incentive to choose plans with lower premiums. That would save the government money. Would restructuring Medicare in an FEHBP-like program save Medicare from insolvency?

Ms. MOON. No, I don't believe that it would. I think that it is very difficult to imagine that you can double the number of people in this program for a product that people value and which the costs we assume are going to continue to rise over time will come about through any kind of greater efficiency alone.

I also believe that we have to be very careful in making the distinction between passing off higher costs on to beneficiaries through higher premiums, higher out-of-network expenses, and so forth, and referring to that as reform or as improving the program necessarily.

Mr. BROWN. So if, in fact, it would save money, you are suggesting the cost—it would save the government money ultimately, if, in fact, it would, you are suggesting that the way that—the only way to really do that is to shift costs more onto seniors?

Ms. MOON. I wouldn't say the only way. I think there are modest savings that can be gotten from improving coordination of care, and so forth. But that takes a lot of attention and time, and the administrative costs are higher. And so to do it well, you have to have higher administrative costs, sort of by necessity.

So I have not seen evidence that suggests massive savings from that kind of an approach, but, rather, more modest savings.

Mr. BROWN. Those who argue for privatization often talk about their—I think it is an ideology more than it is a practical decision based in—or practical suggestion based, in part, on their belief that the private sector, by definition, does things more efficiently than the public sector. I think Medicare shows that is not really true.

You authored a paper recently that I would like to insert in the record that arrives at a different conclusion. Would you share that with us?

Ms. MOON. We used national health expenditure data over the last 30 years, essentially said let us start with everyone at a value of 100, private insurers at 100, Medicare is 100, recognizing that on a per capita basis Medicare does cost more, but really compare the rates of growth over time.

And the rates of growth on a per capita basis for Medicare are better than the per capita rates of the private insurance companies. That is even after you control for the differences in what is covered, particularly by taking out prescription drugs, for example, and on the Medicare side by taking out home health and skilled nursing care.

Mr. BROWN. Ms. Grealy, you mentioned Medicare's administered pricing system. How does this system differ from the way private health insurers pay providers?

Ms. GREALY. Well, I think this is a nice segue. And when we are talking about the relative growth in the Medicare program versus the private sector, it is very easy to control growth when you can administer prices. I think throughout many of the testimony that I read in preparation for the hearing today, we see that Medicare is such a large presence. It is the, you know, 500-pound gorilla. It establishes a price. Then, everyone has to accept that price. There is no negotiation.

The difference between administered pricing and negotiation in the private sector is just that word. There is a negotiation that occurs, so that the providers at least have some power in the private sector that you just don't find. And that is why we are able to control growth in Medicare through things like the Balanced Budget Act of 1997, which we are still continuing to do givebacks because those cuts were so deep at that time.

So I would say the big distinction is administered pricing, no negotiation on behalf of the providers.

Mr. BROWN. Could we do the same kind of negotiation if Medicare would use the 40 million beneficiaries to negotiate prescription drug prices for beneficiaries?

Ms. GREALY. I am not sure that that is a negotiation. That is establishing the price. I think it would be great if there were some competition in the——

Mr. BROWN. So it is a negotiation if it is private sector, but it is price control if it is the public sector?

Ms. GREALY. Well, if there is true competition, and, yes, you do have an ability to negotiate with the government, that it is not we are going to establish the price, and you take it or leave it. That is the distinction.

Mr. BROWN. Thank you.

Mr. BILIRAKIS. Mr. Buyer. Eight minutes, 7 minutes, 7½ minutes.

Mr. BUYER. Thanks. Seven and a half minutes.

Mr. BILIRAKIS. Seven and a half.

Mr. BUYER. First of all, I would like to thank Mr. Brown for placing in the record Figure 1. That helps correct the fiction in his earlier statement.

That is reiterated by testimony presented by Mr. Foster on page 3, the second paragraph, which is also very similar to testimony provided to the U.S. Senate in year 2001. So I think, Mr. Brown, what you have done by inference is compliment the Congress in passing the Balanced Budget Act that would have, in fact, saved Medicare. So I appreciate that, even though you probably voted against it.

Let me move and ask—I want to exclude Mr. Foster and Mr. Buddy. You are out of the political arena, all right? And I am going to go down and ask a series of questions, and I don't have the time to get into a whole bunch of discussion on them.

Some things that are in front of us with regard to proposed changes come from many different sectors with Medicare, and they have been discussed before the bipartisan commission and Breaux and Thomas. One would be increasing the program's eligibility age. When Social Security did this in 1983, it moved it to age 67, it excluded Medicare.

Let me go right down the line whether or not you would increase—support increasing the age to 67, and even if we were to do it on a graduated scale. Dr. Berenson, would you——

Mr. BERENSON. I would oppose it. If anything, one of the major——

Mr. BUYER. That is all I need to know.

Mr. BERENSON. Okay.

Mr. BUYER. Whether you oppose it or support it.

Ms. Rawlings?

Ms. RAWLINGS. Aetna does not have a position either way.

Ms. MOON. I would oppose it, because it doesn't save much money.

Mr. BUYER. That is all I need to know.

Ms. Grealy?

Ms. GREALY. Speaking personally, it may be one of the tools we might have to look at, personally.

Mr. BUYER. Yes. It is on the table.

Ms. KENNELLY. I would oppose it, sir.

Mr. BUYER. Oppose. All right.

Next question is with regards to—Ms. Kennelly had brought this up earlier about means testing. Someone yesterday used the language "income relation." Is this a discussion that we should be having? Would you support this concept, for us to look at this, into Part B on Medicare?

Doctor?

Mr. BERENSON. No, I wouldn't.

Mr. BUYER. Ms. Rawlings?

Ms. RAWLINGS. We would be willing to discuss it.

Mr. BUYER. Dr. Moon?

Ms. MOON. No.

Ms. GREALY. Should examine it.

Ms. KENNELLY. Not yet.

Mr. BUYER. Not yet. All right.

I understand and respect the universe—making sure that it is universal, but obviously we also have to examine that there are people who are lower income brackets that have been paying into the system for over years and are subsidizing millionaires, and we need to really self-examine that.

The other question I have is the increased beneficiary cost-sharing. Part B coinsurance, 20 to 25 percent, and Part B deductible, from 100 to make it comparable to private plans. Is this something that we should be considering?

Dr. Berenson? May I have order? I can't hear.

Mr. BERENSON. Yes, I think we should be looking at cost-sharing.

Mr. BUYER. Thank you.

Ms. RAWLINGS. I think we need to consider it. Absolutely.

Mr. BUYER. All right. Thank you.

Ms. MOON. I think particularly the deductible you need to look at. The other cost-sharing I believe is high enough.

Mr. BUYER. All right. Thank you.

Ms. GREALY. Yes, it should be looked at.

Mr. BUYER. Thank you.

Ms. Kennelly?

Ms. KENNELLY. It should be looked at, but it should be balanced when you look at the statistics of how many use the 100 and how many the 840.

Mr. BUYER. That is fair.

With regard to introduction of market-based innovations, into the current key for service—fee for service program, such as case management programs for heart disease, diabetes, chronic pain, etcetera, is this an innovation that we should be considering into the present model?

Mr. BERENSON. Absolutely.
Mr. BUYER. Thank you.
Ms. RAWLINGS. Absolutely.
Ms. MOON. Absolutely.
Mr. BUYER. Thank you.
Ms. GREALY. Yes.
Ms. KENNELLY. Yes.
Mr. BUYER. All right. With regard to the issues on major structural reforms, Senators Breaux and Thomas had introduced to the bipartisan commission the idea of combining Parts A and B in the programs into a single $400 deductible. Is this something that we should be considering?
Mr. BERENSON. I don't have an opinion.
Ms. RAWLINGS. We believe it is worthy of consideration.
Mr. BUYER. Thank you.
Ms. MOON. I think it should be looked at as well.
Mr. BUYER. Thanks.
Ms. GREALY. I agree.
Ms. KENNELLY. I still believe in trust funds, and I think Part A is a trust fund. And if you put it into Part B, you lose it.
Mr. BUYER. Put it in Part B. All right.
The other comment I have—Ms. Kennelly, you had made a comment on the issue on means testing, and you cited the difficulty in determining seniors' income was your statement. The only currently operational system to identify income is the IRS, that I know of.
The Senate version of the DBA had a proposed means testing that went to conference, and it used a parallel system of the IRS to be created through CMS to identify levels of income. If we end up in that approach, should we turn to the IRS to be the operator of that system, or should we create a separate parallel system within CMS, or is that too bureaucratic? Your opinion.
Ms. KENNELLY. Well, Congressman, having seen the news last night at how much we are now collecting through the IRS because of, really, the changes that have happened over the last few years, I don't want to put any more burden on them. But I am afraid if we just rely on the IRS, we won't find out an awful lot because so many seniors don't have an income high enough to pay taxes. And that is one of the reasons it is so hard to find out what the income is.
So if we ended up in this path, you would advocate not having the IRS, but to create a parallel system within CMS that turns to the IRS for the shared data, but it really should be run through CMS.
Ms. KENNELLY. I think my point was when I saw how Bruce Vladeck explained how hard it was to find these income numbers, the administration cost could go up because we were looking for those numbers.
Mr. BUYER. Right.
Ms. KENNELLY. And we won't get anything out of it.
Mr. BUYER. Well, I recognize that as a point. Sometimes I have to decipher, is that a point or an argument? And I have—no, I am just trying to say if we have this in front of us, how do we work through it? And that is the point of my question.

Ms. KENNELLY. I think that is my concern about income related, because I think it is a slippery slope. You cut it off at a certain point, and then later when things aren't good you cut it off lower. And where does it start and——

Mr. BUYER. But when things are great, you increase it even higher.

Ms. KENNELLY. Well, you know, it was not that many years ago that things were pretty great.

Mr. BUYER. Well, and that is the challenges that we have in Medicaid——

Ms. KENNELLY. Yes. Yes.

Mr. BUYER. [continuing] for example. States saw this money coming and increased the percentage above poverty and eligibility, and now they come to us to pay the bill.

All right. Thank you for your testimony.

Ms. KENNELLY. Thank you, Congressman.

Mr. BUYER. Appreciate your service here.

Mr. BILIRAKIS. I thank the gentleman.

Mr. BUYER. I yield back.

Mr. BILIRAKIS. Let us see, Mr. Pallone.

Mr. PALLONE. Thank you, Mr. Chairman.

I wanted to talk about the lack of a defined benefit. In other words, if you change Medicare into a voucher system, which is what I believe that the Republican leadership is proposing, it would mean that seniors in different parts of the country would pay different premiums and receive different benefits.

For example, under the President's vision for reform, which I think, again, is a voucher, Medicare would operate very differently than it does today. Each senior would receive a contribution from the government that can be used to help pay the premium of the plan of their choice. In the Federal employees' program, the government's contribution is equal to 72 percent of the average premium.

I guess what I am saying is that this geographic variation in price could create equity problems if we restructured Medicare into a voucher model. And I just wanted—I would ask initially Barbara Kennelly, and then Mr. Berenson, what are some of the problems that could result from a system where seniors in different parts of the country pay different premiums and receive different benefits? That is a concern, and if you would comment. We will start with Barbara.

Ms. KENNELLY. Well, I think we already know, Congressman, that that is exactly what has happened and will continue to happen, because of geography, because of all sorts of different things. So I think that is one of the reasons that so many seniors—you know, I listened to Mr. Buddy talk, and, you know, his thing was perfect. It all worked out.

And, really, you know, many of the people that are in the private plans like them. But I still have to come back to the question of if it is so good across the—you know, across the surface, why are only right now something like 11 or 12 percent of the people in these plans? Why do we get these frantic calls, people willing to spend out-of-pocket one-third to stay in Medicare?

So I think that not being able—you know, I know that the chairman said that, you know, was leading into that seniors can make decisions and can understand choice, but what I——

Mr. BILIRAKIS. I didn't say that. Mr. Buddy said it.

Ms. KENNELLY. Okay. And let me tell you, he could have sold me my policy, just the few minutes we talked this morning. But I just think consistency is what seniors are looking for. They want to be able to rely on something, and that is why when they do the polls that you people mention that they say they are satisfied.

And they are willing to pay more because they want to be sure that they have what they want. What they want in choice, Congressman, is they want choice of their doctors. And we saw that so dramatically when that—two sentences in the State of the Union. Just our phones rang off the hook, so we know they want choice of doctor. But I am not so sure they are asking for choice of plan. I think they like their Medicare.

Mr. PALLONE. Let me ask Mr. Berenson, and then we will go back to Mr. Buddy.

Mr. BERENSON. Very briefly, I came to HCFA in April 1998, and by June plans started withdrawing from the Medicare+Choice program. I didn't attribute that to my coming necessarily.

But what we faced in Medicare+Choice was dramatic geographic variation in how much plans would get because of this artifact of paying them based on how much private—I mean, how much traditional Medicare was paying on the fee for service side. It is still a problem. There are some parts of the country where plans can provide very generous benefits and do a good job, although the trust fund is losing money, and in other places plans can't get in there at all and can't offer benefits.

If you are trying to define a government contribution based on these local variations in fee for service spending, you would then formalize this kind of geographic inequity, and I think you would have increased problems over what you have today in trying to justify that kind of horizontal inequity across the country.

Mr. PALLONE. I know that Mr. Buddy had his hand up. I just wanted to say one thing, though, and I hope nobody takes offense at this, but I have to use my free lobster dinner analogy.

When I—because I know Mr. Bilirakis raised the issue about, you know, can seniors make choices? I mean, obviously, seniors are able to make choices. Nobody suggests that they are not. But there is just a lot of misinformation that is out there.

I mean, I have said before the committee before, we had the case where, you know, there was an ad in the paper, a free lobster dinner if you came down and listened to the HMO. And I had all of these seniors going down there and signing up, and there is just a lot of misinformation and incentives that are used. So even though people are, you know, intelligent, they may not get the right information in terms of making those choices.

If you want—you wanted to say something.

Mr. BUDDY. Yes. I don't want to encroach too much on your time. No. 1——

Mr. PALLONE. Well, there is almost no time left.

Mr. BUDDY. First of all, lobster dinners can be a lot of fun, and I don't know if that alone is going to influence their decision. I hope not. If I am right, that won't, but that is not necessarily true.

Second, I would love to have Ms. Kennelly as a client. She would make, I am sure, a very good——

Third, I would like——

Ms. KENNELLY. I have Medicare.

Mr. BUDDY. Okay. We need to talk. At any rate, the second thing I would like to say is I perhaps spoke too quickly when I responded to the chairman's first request for information as to whether seniors are able to make rational decisions. I, too, read that editorial since it, by pure coincidence, happened to appear in The Houston Chronicle just as I was leaving.

I did write to the editor. I have never written a letter to the editor before and probably never will again, but it was—my ran five pages. And my wife says that now probably we will be desubscribed from The Houston Chronicle. There were a number of misstatements, and I think there have been some misstatements.

Your point is absolutely correct. Seniors do become confused by misstatements, and there were a number of things in that editorial—I am not trying to pillory The Houston Chronicle, but I think unfortunately created a misperception that—there are a number of them. I identified 4 or 5 in my rebuttal, and I don't want that necessarily to be entered into the minutes of this proceeding.

But one of the things that I think caused seniors to have tremendous inhibitions about the Medicare+Choice program was I don't think we can really necessarily fault the Medicare carriers that have made a valiant effort on—you are well aware of the 2 percent cap and the fact that Medicare expenses are going at 10 percent. They have made a valiant effort to stay the course and to make—become a viable option.

Unfortunately, that has proved to be very difficult, and as a result there has been a steady deterioration of their financial situation to the point where they had to evacuate the market. And one of the principal reasons was not competition or it wasn't a lot of other things. It was simply the fact that the money wasn't there.

And I think seniors have become very apprehensive. There is one HMO carrier that left the market. There are about 20,000 seniors who were in that program who now aren't, because they simply have refused to believe anymore. And I think you are probably——

Mr. BILIRAKIS. We have all had plans in our districts that have——

Mr. BUDDY. The same thing.

Mr. BILIRAKIS. [continuing] canceled out.

Mr. BUDDY. And I think really——

Mr. BILIRAKIS. No question about that. If we were to do anything like that, by gosh, we would have to make sure that there are safeguards in some way or other. I will be darned if I—that is why we hold those hearings, so we can learn.

Mr. BUDDY. I do have a possible solution on that. Wellness is bipartisan——

Mr. BILIRAKIS. Well, why don't you write it down for us and furnish it, or possibly respond to maybe one of the other inquiries.

Mr. Deal to inquire.

Mr. DEAL. Thank you, Mr. Chairman.

Dr. Berenson, I would like to follow up on your last comments about the disparaging—disparity between regional plans that were offered. Would you elaborate on why you think that exists, and how does it exist in a competitive environment?

Mr. BERENSON. The regional variations in payments to the health plans in Medicare?

Mr. DEAL. I was thinking you were talking about the availability of services.

Mr. BERENSON. Well, they run together. Basically, ever since the TAFRA Act was passed in the early 1980's to set up private plans, risk plans in Medicare, the basis for payment to them has been based on how much the traditional program pays in fee for service at the county level.

There are huge geographic variations in how much we pay. In fact, to me, that is one of the unexamined questions, is how the fee for service program can get some control over those variations. But basically——

Mr. DEAL. I agree with that, too.

Mr. BERENSON. [continuing] if you are in a part of the country where the traditional program has a lot of spending per capita, if you are an HMO, you can come into that market, get a pretty generous payment, although it is obviously decreasing as rates have gone up only at 2 percent, and be able to, one, come in and offer a product, and, two, offer pretty good benefits such that somebody would leave traditional Medicare. And so that is sort of basically a function of those payment levels.

Mr. DEAL. I see. So you are saying that that is precipitated by the variability in the fee for service schedule by regions as it exists now.

Mr. BERENSON. Yes. And then one of the problems, then, for—on the financial side is plans will go into the generous payment areas, not go into the other areas, and so, therefore, we lose money. We are paying plans more in the one area, and without an effective risk adjuster are paying even more, but aren't getting the commensurate savings on the other side. So the net is that the—we lose money on the Medicare+Choice program.

Mr. DEAL. Of course, you could make the same argument in the fee for service, that that is the reason some physicians are withdrawing from the program is because of those inadequate reimbursements as well. So——

Mr. BERENSON. Well, you know, and, in fact, I think it has—that has gotten everybody's attention recently, which to me is one of the countervailing pressures on administrative prices. Medicare has to find the balance between paying prices that will get providers to participate and not deny access to beneficiaries.

And so I actually think that there are some protections. And to restate what I said earlier, Medicare gets lower rates than private payers do for the most part.

Mr. DEAL. Dr. Moon, one of the comments that you made was to take issue with the fact that under the alternate plans that are available, Medicare+Choice, etcetera, that there were variable premiums from plan to plan. And I presume those variable premiums

are in part based on the options that are afforded under those plans.

Would you agree that that is basically the difference in the fees that are charged?

Ms. MOON. Well, that is right. At the present time, private plans can charge additional premiums and offer additional benefits. They must, if they are providing just the basic Medicare services, live within that rate. But otherwise——

Mr. DEAL. Well, is that bad, that those who wish to pay more premiums and get better services shouldn't be allowed to do that? Is that your argument?

Ms. MOON. No.

Mr. DEAL. So you favor that.

Ms. MOON. In answering the question about the variation or the potentially high cost of services, my concern is that that will be the mechanism that people use to save dollars for Medicare, and that is have the government underfund the program and then pass the higher premiums off pretty much universally on to beneficiaries.

Mr. DEAL. Well, I think that assumes quite a bit, to assume that that would be the case.

Let me ask you about one comment that you had. It is—you were talking about the fact that fee for service doesn't let people spend as much time with the patients. And you say one simple way to deal with that is to give the beneficiaries a certificate that spells out the care consultation benefits. Are you talking about just a certificate that will say you can spend X amount more minutes or hours with your doctor just to talk and feel good about it?

Ms. MOON. No. I am talking about the issue that people have objected to the fact that it is very difficult for physicians to spend the time with Medicare patients, because there is a bias toward keeping the charges at a relatively low level and not essentially allowing the really high levels to be reimbursed periodically for beneficiaries.

I think that an assessment by a physician is a good idea periodically. I don't think that you should just do it across the board by raising fees to physicians, but, rather, think of ways to get beneficiaries themselves to be interested in saying, okay, I can go to you and have this expectation. It is a contract that the two would have—would engage in.

Mr. BILIRAKIS. The gentleman's time has expired.

Ms. Capps for 8 minutes.

Ms. CAPPS. Thank you, Mr. Chairman.

A quick point to follow up on Mr. Buyer's questions about means testing Medicare. Almost half—45 percent of the seniors in Indiana, Mr. Buyer, are low income, meaning that they earn less than $18,000 a year. It doesn't sound like there is a lot of money to be saved in that State for means testing. You would have to start charging people more money pretty low on the income scale to get much savings.

A question for you, Dr. Moon. Medicare+Choice plans, in much of my district, have cut benefits, raised cost-sharing, and, in fact, pulled out entirely. This has happened all over rural America. Do you believe that private plans can offer current Medicare benefits, plus a prescription drug benefit, plus preventive care services, to

rural America for less than or even the same as traditional Medicare?

Ms. MOON. No, I——

Ms. CAPPS. I know this is a big topic. If you could be brief, because I have a couple more questions.

Ms. MOON. So I should just say no.

Ms. CAPPS. You can say no, but——

Ms. MOON. I believe that private plans can do a very good job of trying to be efficient in the right circumstances. But I don't think even very good private plans can provide prescription drug benefits that now run in the hundreds of dollars for the amount that Medicare pays, if they are being paid appropriately.

They were able to do so in the past because the payments were actually higher than what those plans needed to provide basic Medicare benefits, and they offered extra benefits. So I believe that realistically we have to assume that private plans or traditional Medicare, if we are going to add prescription drug benefits, we have to add dollars.

Ms. CAPPS. Thank you.

And, Dr. Berenson, this is your topic, too. Could you address the same point? But also, you know, we are talking about Medicare+Choice now not just as an option for prescription drug coverage but as a way to try to update and modernize a hopeless, outdated Medicare. And I don't agree with that, but that seems to be what the administration is doing.

Would you respond to my rural district, and also talk about how—some of the things you weren't able to do in your opening statement.

Mr. BERENSON. Yes.

Ms. CAPPS. Just also briefly, though, because I have one more question.

Mr. BERENSON. Let me just focus on the rural issue. One of my jobs in the PPO I worked at was involved with negotiating with physicians and hospitals, and we wound up paying lower rates to Georgetown and George Washington than the few rural hospitals we had, because they were the sole hospital out there.

The only way that a private plan actually goes into rural areas now in private fee for service plans is being able to use the Medicare fee schedule, because they don't independently have any negotiating leverage.

They don't have an infrastructure to do some of the good stuff that managed care actually does, so my sense is that what we would be doing is permitting a private plan to put in the same rules that traditional Medicare has, but they take their 8 or 10 percent of administrative costs off the top. I am not sure what advantage we have provided to anybody.

Ms. CAPPS. And this is rural America. Are there some other parts of America that would face the same challenges?

Mr. BERENSON. Well, again, this does go somewhat to the issue of the function of a lot of private plans for private employers is to negotiate rates. Some private plans only survive—I mean, Medicare+Choice plans because for out-of-network care they are able to use the Medicare fee schedule, and on their own wouldn't be able to have any mechanism to not be paying charges right now.

So it just doesn't make sense. There are private plans in Medicare+Choice, like group and staff model HMOs, and certain kinds of HMOs that truly do provide state-of-the-art disease management which we should have in Medicare. We should figure out how Medicare+Choice can be redesigned to do that.

But to bring in this whole variety, array of private plans that are sort of there, would be there to figure out how to create benefit packages to attract healthy people, serves no useful purpose as far as I can tell.

Ms. CAPPS. Thank you.

Finally, Barbara Kennelly, from your days of being our colleague here, I remember you speaking often about women living longer, earning less, having less retirement security, generally also going to the doctor more often. If we make changes to Medicare that reduce stability in the program and lead to different benefits and cost-sharing in different areas, tell me—tell us, now probably not a lot of time remaining—and this, again, is a big topic. But this is about women, widows and others who——

Ms. KENNELLY. Congresswoman, even though we have made vast advances in the——

Mr. BILIRAKIS. Your mike, your mike.

Ms. KENNELLY. Congresswoman, though we have made, you know, incredible advances in the women—look at the women sitting at this table—advances in who is college educated, women's life experience has stayed pretty much the same. They still earn less than men. They still—you know, they haven't found any way for anybody but us to have the children. So we go in and out of the workforce.

And I have got to tell you, Mr. Chairman, we women live forever. So it is really important, the universality of the Medicare, because you can't live too long for it. It stays right with you until the day you die, and that is one of the good arguments for staying with the fee for service.

Often women have much less money. As we know, one out of four unmarried women only have Social Security, and they live on it, and they have to take care of their health out of it. So yes, I do still give those speeches of why it is so important to have a universal program for Medicare and Social Security.

Ms. CAPPS. Thank you.

And I still have a little time left. I bet you, Mr. Buddy, you would like to make a comment on this as well. And we shouldn't be restrictive to women, should we?

Mr. BUDDY. The reason she would make an excellent client is that she——

Ms. CAPPS. Oh, you are not going to use my time to——

Mr. BUDDY. She made a very interesting comment, and I think it is very relevant. She said illness by seniors is a bipartisan type of thing. And essentially, whether it is public or private, I think it is very important that we stress the wellness idea, which is a win-win deal for everyone.

And one of the things I should mention, the THI, the Total Health Initiative sponsored by the YMCA, they have six pilot projects that will make it feasible to implement, utilizing their facilities and their staff. They would be receptive to a joint venture

with the government in terms of making it feasible to make available to all people, whether private or public, the wellness needs analysis and specialized treatment.

So I think the main thrust should be a bipartisan approach to try to deal with things like disease management, which I think can be beneficial to all segments of the population.

Ms. CAPPS. I know that consumers would wish that we would be bipartisan as we respond to the needs to modernize Medicare.

I just have a few seconds. Ms. Rawlings, can you address this issue of your own company's ability to stay in a rural area?

Ms. RAWLINGS. I am glad you asked me. I think I would agree with Dr. Berenson. I think there are challenges in the way we contract with physicians and hospitals in those rural areas. It is difficult to negotiate, and we do have abilities around providing—using the Medicare fee schedule for some cost protection.

I think the more critical issue, though, as you are thinking about coordination of care is what is required in that is an integrated delivery system. And many times, if your enrollment in rural California——

Ms. CAPPS. Right.

Ms. RAWLINGS. [continuing] you don't have those integrated delivery systems available to you. You might have to drive 80 miles to see a nurse for your, you know, geriatric exam. It makes it very difficult to deliver comprehensive, coordinated care in those markets. So I think that is a limitation for a coordinated care system.

I think, however, private plans can provide value in working with the government and finding ways to enhance the fee for service programs in those areas, or maybe looking at hybrid products that take the best of both worlds.

Ms. CAPPS. Can I get a yes or no from Dr. Berenson? I know I am over my time.

Mr. BILIRAKIS. The gentlelady's time has expired. But if it is important for you to get a yes or no, as long as it is not followed by——

Mr. BERENSON. Very briefly, I basically agree. My point is: why have 3 or 4 plans trying to work with a physician to coordinate care instead of a single plan, traditional Medicare, working to do that, perhaps with private sector contracting.

Mr. BILIRAKIS. Yes or no.

Ms. CAPPS. I got my answer.

Mr. BILIRAKIS. All right. I am sure you liked that answer, yes.

Mr. Strickland, 8 minutes.

Mr. STRICKLAND. Thank you, Mr. Chairman. And I want to thank the witnesses.

I was in the chamber of the House of Representatives when the President gave his State of the Union address. And I started to applaud—I applauded several times during that address, but at one time I started to applaud and then I stopped.

The President said something to the effect that if a senior citizen likes traditional Medicare and wants to keep it just the way it is, they should be able to do so. And I stopped my applause, because I realized that traditional Medicare, just the way it is, is without a prescription benefit.

And then, the President said that the Nation should take control of our health care away from the bureaucrats, the trial lawyers, and HMOs, and return it to doctors, nurses, and patients, and I applauded. And then, the President described his plan, and under his plan, as I understand it, if Medicare or an older person is going to get comprehensive prescription drug coverage, they are going to be forced into basically an HMO, because if they stay in traditional Medicare what is available to them is going to be terribly limited.

I think there were contradictions in what the President said. I hope they weren't purposeful contradictions, quite frankly, because they were basic and fundamental to what we are dealing with.

I have here a publication from the Center on Budget and Policy Priorities, and I would like to read this statement. "The 75-year cost of the administration's tax cuts is more than three times the long-term deficit in Social Security and larger than the long-term deficits in Social Security and Medicare combined." And that leads me to something that I said yesterday in a hearing on prescription drug coverage. Our problem is a value problem, not a monetary problem, because if we truly were determined to make a prescription drug benefit that was affordable to all of America's senior citizens, if we truly were committed to that, we would do it. And we would be cost conscious, certainly, but we wouldn't let the financial obligations of doing so keep us from proceeding.

So I have a question for you, Ms. Kennelly. The President argues that we really can't afford Medicare as it is, and improve it, and make prescription drug benefit as a part of it, and so on. People argue that we can't afford to spend more than $400 billion for a prescription drug benefit.

However, this argument seems a little disingenuous when you look at the size of the tax cuts the administration is proposing. And as I said, according to the Center on Budget and Policy Priorities, it is disturbing information. It seems that there are—the people who are saying we can't afford to improve and keep traditional Medicare for everyone are the same ones who would divert our existing resources to tax cuts. In fact, these tax cuts, I think, are going to jeopardize our ability to preserve Medicare, let alone improve it.

If these tax cuts were enacted, we would be running up more deficits instead of paying down the national debt. The interest on these deficits would eat up precious revenue.

And my question to you, Ms. Kennelly, is, do you believe that the administration's proposed tax cuts could jeopardize the future of the Medicare program? And do seniors in your organization—do seniors in your organization think that some of these tax cuts should be used to add a drug benefit to Medicare instead?

Ms. KENNELLY. Well, Congressman, I have been known to use that exact quote that you quoted recently, at a large convention of elderly services in Chicago last week. What you say is the truth. I had hoped we wouldn't get into this discussion, because I understand the budget resolution passed by the House. It does have a very large tax cut in it.

I am sure that I would probably—my organization is bipartisan, but I am sure I will go back to my roots and say yes, I think the tax cut is too large. Yes, I think the sustainability of Medicare and

Social Security will be challenged if that tax cut passes at the height that it is right now. There is no doubt about it. You just have so many dollars, and right now we are in deficit situation, budget deficit situation, and we will increase that deficit, if, in fact, those high tax cuts are passed.

I also want to see a democracy, and I understand that the President is the President, and the Republicans have the majority in both the House and the Senate. So this is a difficult situation.

And, yes, I can tell you, when you look at senior incomes, and when you see that only 19 percent of seniors earn over $40,000 or even have over $40,000, they are going to get a very small tax cut. Obviously, that is the fact. And so, of course, they would much rather have a prescription.

Mr. STRICKLAND. Thank you.

I would like, if we could, just to go down the table, beginning with Mr. Foster, if you could give me a brief response, yes or no, or if you want to make it a little longer—the same question.

Mr. FOSTER. I would pass on the desirability of the tax cuts from offering an opinion either way. I would mention that the primary source of revenue for the Hospital Insurance Trust Fund is payroll taxes, which would be unaffected. The real issue is the general revenue financing for Part B of Medicare. The law provides for that revenue. How you get it is the challenge, and that would be the real issue.

Mr. STRICKLAND. But it is true that we have a limited amount of resources. And if we chose, we could use some of those resources to enrich Medicare beyond even the amount available in the trust fund. I recall maybe 3, 4 years ago members of both parties were pledging to use at least part of the deficit to do that.

Yes, Dr. Berenson.

Mr. BERENSON. My priority would be on Medicare and Medicaid and not—I mean, Medicare, Medicaid, and Social Security, rather than the tax cut. But my point would be that I think we can find some savings, significant savings, in the traditional Medicare program if the program had new authorities to do so. And that we don't have to just assume that we have to spend what we have to spend. We can add prescription drugs and find offsetting—not fully offsetting but some savings.

Mr. STRICKLAND. Thank you.

Ms. RAWLINGS. I would add that Aetna does not actually have a position on that specifically, but I would comment on that I do believe that whatever program is developed and evolved, we believe if we can evolve the program and maintain a competitive playing field that we can make it more effective from a cost perspective and quality perspective as well.

Mr. STRICKLAND. Thank you.

Ms. MOON. I believe that one of the important things to think about is that there will be a need for additional revenues. And my generation of baby boomers will be the folks who are advantaged by the tax cut, and who should be contributing to our future in terms of Medicare and Social Security.

Mr. STRICKLAND. My time is up. If just the two of you could make a quick——

Mr. BILIRAKIS. Very brief, please.

Ms. GREALY. Well, I agree with Ms. Rawlings. Regardless of what happens with the budget resolution, No. 1, there is money in there for a prescription drug benefit. But more importantly, we need to look at how we are going to sustain this program over time. We need to bring competition and more efficiencies into it.

Mr. STRICKLAND. Mr. Buddy?

Mr. BUDDY. I have to agree wholeheartedly. I think there is definite room for improvement in the Medicare system, and so I am enthusiastically in favor of that. The jury is out on the other. I am not sure what we can afford, but I think that we can all agree on——

Mr. STRICKLAND. Thank you.

And thank you, Mr. Chairman.

Mr. BILIRAKIS. Mr. Shadegg.

Mr. SHADEGG. Thank you, Mr. Chairman. Thank you for holding this important hearing. I apologize I have not been here for the entire testimony.

I want to thank our panelists. I appreciate their thoughtful testimony.

Ms. Rawlings, I want to follow up on the questioning of my colleague from Ohio. Have you studied the President's plan, or looked at what the President proposed?

Ms. RAWLINGS. We have, yes.

Mr. SHADEGG. Does Aetna offer both an HMO product and a PPO product?

Ms. RAWLINGS. We do under the Medicare+Choice program today, yes.

Mr. SHADEGG. And there are substantial differences between the HMO product and the PPO product, are there not?

Ms. RAWLINGS. Well, there is probably 2 or 3 key differences. What we have done is, in our PPO—in the PPO demonstration, which was just launched in January, as you know, we offered in 21 counties and 3 States enhanced benefits, including prescription drugs. We offered no referrals, out-of-network coverage——

Mr. SHADEGG. I want to stop right there. First of all, no referrals means no gatekeeper.

Ms. RAWLINGS. That is correct.

Mr. SHADEGG. So when he was talking about the President would force you into an HMO product, in point of fact, one of the things that makes HMOs very unattractive is you have to go through a gatekeeper who decides whether you can go to a second doctor. You are saying that in your PPO product you can go straight to the doctor of your choice, is that right?

Ms. RAWLINGS. That is correct, yes. I would——

Mr. SHADEGG. And then you were about to say the second distinguishing feature.

Ms. RAWLINGS. Well, the one thing I wanted to add is I think as we have heard and talked about today, the element of coordination of care is not lost in the PPO. We still do our health risk assessments. We have our comprehensive case management units that are looking to work with these patients in this product as well, so we get the additional benefit of that.

But it is very—it meets the customers' needs, allows them to travel, allows them to have direct access. They seem to like it.

Mr. SHADEGG. And it also allows them choice of doctors. They can pick any doctor——

Ms. RAWLINGS. That is correct.

Mr. SHADEGG. [continuing] in the plan, and that is covered. And then, if they want to go outside the plan, they can do that for a slight additional fee?

Ms. RAWLINGS. That is correct. It is a slight difference in benefits. That is correct.

Mr. SHADEGG. One of the things that I think is—and I would encourage my colleague from Ohio to study the differences between HMOs and PPOs. I think one of the things that was underappreciate about the President's plan is the fact that what he was proposing—enhanced Medicare—was a PPO and not an HMO. And I think there is a world of difference.

Indeed, across America, more Americans are choosing now PPOs than HMOs, precisely because of those very important distinctions. And so I think that is an important part to understand about the President's plan.

I also would echo what you said, and that is the PPOs that I talk to tell me that they can manage care, they can improve care and improve quality of care, without, for example, having a gatekeeper that denies people care or some bureaucrat back in an office that denies them care.

Ms. RAWLINGS. I think that is true, but I think the critical thing to remember, too, is, you know, we are talking about an aged and disabled population. You know, you mentioned—Ms. Capps mentioned the women and aging, and, you know, there is a significant social change and environmental change when people age. You know, spouses of 55 years or so die, and one is left alone, children move away, etcetera.

I think the critical thing to think about is it is different when you are 25 and when you are 75. And some people say, "Well, gosh, I don't want to have anybody calling me. I don't want any part of that." When seniors are sick, they need help. They appreciate it. They respect it. And we have found that we have—we develop excellent partnerships which really improve quality, and we can get that on the PPO.

Mr. SHADEGG. Mr. Berenson, I want to focus on this issue of PPO with you. You indicate in your testimony that the PPOs you dealt with did not want to work toward quality improvement. Were any of those non-risk PPOs, or were they all risk PPOs?

Mr. BERENSON. Well, most PPOs were non-risk PPOs that I talked to. I mean, I——

Mr. SHADEGG. They weren't insurance-based PPOs?

Mr. BERENSON. Some were insurance-based and some were rental or broker PPOs that did not manage risk. But I think there is some history here that is illustrative and that——

Mr. SHADEGG. I appreciate that. I would like to hear the history, but I am going to run out of time, and I want to ask Mr. Foster a series of questions.

Mr. Foster, we are being asked, or at least my—one of my key goals is to reform Medicare and to make it more efficient. One of the things I want to do is I am of the belief that by adding prescription drug coverage to the current Medicare program, you can,

in fact, reduce overall cost by reducing both doctor visits and hospitalizations.

Have you studied that question, or do you know of anyone that has studied that question?

Mr. FOSTER. Yes, we have. Clearly, with the right medications, people can stay out of the hospital in certain circumstances or have lower costs than they would otherwise have. The question is whether the availability of a Medicare prescription drug benefit would generate some partial offsetting savings through such actions?

We have not estimated a significant offsetting amount of that type, in part because the great majority of beneficiaries already have some level of drug coverage one way or another, and in part because in the case of most folks, if you can stay out of the hospital by getting a certain drug, you are going to try very hard to get that, even if you don't have coverage.

Mr. SHADEGG. Assuming that in fact, though, having—the entire Medicare population have access to drugs would bring down some costs. That means it would bring it down if it were a benefit added both to fee for service and if it were a benefit added to other options, for example, a PPO. Would that be correct?

Mr. BERENSON. Yes. The impact that you mention would apply regardless of the setting.

Mr. SHADEGG. Okay. The second question—and you heard Ms. Rawlings refer——

Mr. BILIRAKIS. The time has expired.

Mr. SHADEGG. I apologize. Could I ask the one last question, then?

Mr. BILIRAKIS. Well, ask it, but a very brief answer.

Mr. SHADEGG. Have you also looked at the question of whether, because there is some element of managed care in a PPO, have you tried to estimate what could be—what savings could be achieved if people were encouraged to move from traditional fee for service into a PPO-type structure?

Mr. FOSTER. Yes, sir. We have estimated both the management savings directly and the savings potentially you could get from having beneficiaries with a financial incentive to move from a more expensive plan to a less expensive plan.

Mr. SHADEGG. I would like to see that information. Thank you for your testimony.

And thank you for your indulgence, Mr. Chairman.

Mr. BILIRAKIS. Thank you.

Mr. Stupak.

Mr. STUPAK. Well, thank you, Mr. Chairman. I am sorry I have been popping in and out, but we had a markup down in T&I Subcommittee.

Mr. BILIRAKIS. Yes, I know we did.

Mr. STUPAK. So I have been in and out, but——

Mr. BILIRAKIS. Have you had any votes down there yet? Because I am stuck up here.

Mr. STUPAK. No, but we had to do some amendments, so—but thank you.

Dr. Berenson—and I know Mr. Brown put in The Wall Street Journal article. I want to ask you just on this one paragraph in particular where it says, "The Congressional Budget Office Chief

tells Republican Senators the Medicare overall plan could add hundreds of billions of dollars in cost. The administration cost-saving claims for its plan also are belied by early data from a demonstration project. Small savings from encouraging seniors to opt for private plans are offset by high administrative costs." Do you care to comment on that at all?

Mr. BERENSON. Well, we do know that Medicare+Choice plans typically have about 8 percent to 10 percent higher administrative costs than traditional Medicare does. And there is no—the way we would pay plans under the—the way we pay plans under Medicare+Choice, again, results in a net loss to the government.

The only way you can restructure this to save money would be to fix the government contribution at a relatively low level, so that people are paying out of their pocket for the various choices. And we haven't seen the details, but there—I think most people don't view that there are inherent inefficiencies in most private sector alternatives to traditional Medicare.

Mr. STUPAK. Well, in these—if you go into a PPO, is that—you went into a PPO, that is good for a year, right? The contract you would enter into if you are a beneficiary, you would sign up for the PPO——

Mr. BERENSON. Well, presumably, if there was a 1-year open season the way we do now—we currently in Medicare Choice have a non-lock-in situation. We presumably have—that is another issue that would have to be dealt with is whether we are locking people in.

Mr. STUPAK. And the benefits could change yearly, then?

Mr. BERENSON. Presumably, it would be done on an annual basis.

Mr. STUPAK. See, the other problem I have with these PPO and HMO—and I know Mr. Shadegg dwelled on it, so I want to bring this up. The State of Michigan just went—used to be—have a defined benefit plan for their retirees who are not in Medicare. So they went to a PPO. And if your physician is part of that PPO, they still pay the 80/20. You pay 20 percent out of pocket.

Well, what happens up in my district, which is real northern Michigan, none of the doctors are in the PPO. So if we want to get the 80/20, 20 percent payout, we have to drive hundreds of miles to find a doctor who is in the PPO. The issue is really choice of doctors here. It is not necessarily PPO or HMO. You want to stay with your doctor.

Since we don't have PPO physicians up in my neck of the woods, we have got to pay a 50/50. They will pay 50 percent, and we pay the other 50 percent. So it costs us more money underneath the PPO for the beneficiaries, too.

Mr. BERENSON. And that is one reason why the data from recent years suggests that the differential between what private plans are paying their network physicians and hospitals are going up in relationship to Medicare, because networks are simply not adequate, and to have an adequate network you have to pay more.

Very briefly on the history of PPOs, the BBA set up PPOs as a coordinated care plan and had to do quality improvement and reporting. And the PPO industry said they can't do that, and they came to Congress and got relief. So I don't think we have a good

track record of seeing that PPOs actually would be doing the kinds of things we need for Medicare beneficiaries.

Mr. STUPAK. Ms. Grealy, if I can ask you a question. You were—Mr. Brown was asking you some questions, and he basically said when the government does it, it is called control. When private industry does it, it is called negotiations. And your answer to Mr. Brown was, well, that is true competition. That is really what you are looking for, right, was true competition?

Ms. GREALY. Yes.

Mr. STUPAK. Then, to have true competition, should we not take away the antitrust exemption enjoyed by the insurance industry? They are not subject to antitrust laws. Therefore, you can put your rates anywhere you want.

Ms. GREALY. Highly regulated by the States, and I think that is sort of the safety net.

Mr. STUPAK. Well, you are really not highly regulated by States, because you have got 50 different States who have insurance commissioners. And if you look at the laws of insurance commissioners, some of them are political appointees, others are elected, some have strong regulations, some have very little, like my State of Michigan. It is like a paper tiger.

So shouldn't we really—if you really want to get true competition, shouldn't we really take that exemption away, make it nationwide, so the regulations are the same through all States, and, therefore, we could really promote some competition within the insurance industry?

Ms. GREALY. I think if you have that balance of Federal and State regulation. I mean, what you don't want to do is withdraw it in one area and yet leave in place those 50 different mechanisms. I know on many issues that we work on we are looking for those single Federal standards, whether it be the HIPPA privacy regulation or whether it be in health care liability reform.

So often times there is something to be said for having one set of rules, so that we all know that we are competing effectively and fairly.

Mr. STUPAK. So if we took away that exemption, then it would be easier because you would just have one set of rules for all States. So you would be supportive of our legislation?

Ms. GREALY. As I said, if it is balanced with—I am not there. It would have to look at what else is done in conjunction with that, so I wouldn't be willing to put on the record, "Let us repeal the antitrust exemption" without some of those other qualifiers that I think are critical.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. STUPAK. Thank you.

Mr. BILIRAKIS. Mr. Barton has just joined us.

Mr. BARTON. Thank you, Mr. Chairman. I am not going to ask any questions, since it is lunchtime. But I would yield to Mr. Buyer.

Mr. BILIRAKIS. But it is still lunchtime, and yet you are yielding.

Mr. BARTON. This is my lunch.

But I will be happy to yield to Mr. Buyer.

Mr. BUYER. Thank you, Mr. Barton.

In an attempt to keep the record clear, I went back to see if I could find the letter in 1995 from the trustees. I was unable to. What I did find, and that I am going to ask to be placed in the record, is the 1995 Annual Report from the Board of Trustees of the Federal Hospital Insurance Trust Fund. The communication to Congress was from the Board of Trustees of the Federal Hospital Insurance Trust Fund.

I stand corrected. I used the word "bankruptcy." They did not. So I stand corrected. They used the word "insolvency," and the threatened impending insolvency of the program, which set in course our action that led to the BBA in 1997.

Referring to the testimony of Mr. Foster, again, on page 3, his chart shows in 1995, 1996, and 1997, that expenditures exceeded income. So I ask unanimous consent that the summary of the Medicare trustees 1995 be placed in the record.

Mr. BILIRAKIS. Okay.

Mr. BARTON. I would announce while we have been holding the hearing that they are toppling the statues of Saddam Hussein in Baghdad. At least the press is reporting that it is a liberated city, so it has been a pretty eventful morning.

And I would yield to the chairman.

Mr. BILIRAKIS. Well, I just have—thank you for yielding.

Mr. Foster, regarding the Part B deductible of $100, that hasn't changed in approximately 10 years, approximately, would you say?

Mr. FOSTER. I believe it was 1991 or 1992. Is that right?

Mr. BILIRAKIS. Yes, so approximately 10 years. So would you know, what would be the impact on Medicare's finances of simply indexing that deduction for inflation?

Mr. FOSTER. If you indexed it prospectively, then the existing amount, the $100 today, would keep pace, depending on your index, either with something like the CPI or the level of health care costs and would represent its—it would continue to represent its current meaning or level, as opposed to gradually being watered down over time, which would happen otherwise and which has happened over the last 10 years.

If you would like we could estimate for you a specific proposal, the financial——

Mr. BILIRAKIS. I guess if you have—do you have any dollars in mind? What would be the impact in terms of additional revenue coming into the program?

Mr. FOSTER. I can provide that for the record, sir.

Mr. BILIRAKIS. Okay. You don't know off the top of your head?

Mr. FOSTER. Well, it is non-trivial, but it depends a whole lot on the specific proposal. If you just index it, you don't get a lot of savings because it takes considerable time for the amount to vary from what it would have been. If you raise it and index it simultaneously, that saves quite a bit more.

Just for comparison, if you took the original $50 amount from way back when, and said what would that amount be today if you had indexed it all the way along, if you had used the CPI, then the amount is somewhere in the range of $250 to $300 today. If you had used per beneficiary Part B cost growth, the answer is fairly staggering. It would be $1,500 today.

Mr. BILIRAKIS. Okay. I am not sure that I wanted to hear that answer. Never ask a question you don't want to hear the answer to.

Well, I think that completes our hearing. We will have questions in writing to you. We would appreciate a timely response to them.

Dr. Berenson, you talked about—you wanted to get into savings that you think can be realized by reforming the traditional Medicare fee for service system. You know, any ideas like that are only helpful, and I raise that point to all of you, any ideas you may have.

Mr. Buddy was chomping at the bit to go into something, too, and, you know, I want you all to feel free to write us as soon as you can. Help us out here, because you would be surprised. Sometimes some of the information we get can be helpful.

That having been said, thank you so very much. It was a good hearing, and you made it so.

[Whereupon, at 12:10 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

PREPARED STATEMENT OF THE ALLIANCE TO IMPROVE MEDICARE

The Alliance to Improve Medicare (AIM) is pleased to submit this statement to the hearing record to the Energy & Commerce Health Subcommittee. We applaud the Subcommittee and Chairman Bilirakis for their continued attention to this issue. AIM has identified six principles to guide Medicare modernization efforts and we are pleased to share these with the Subcommittee. These principles seek to improve both the administration of the Medicare program and the benefits provided to program beneficiaries.

KEY PRINCIPLES TO STRENGTHEN AND IMPROVE MEDICARE

First, Congress should enact comprehensive, market-based Medicare modernization as a mechanism for providing access to prescription drug coverage. Prescription drug benefits should be offered to all Medicare beneficiaries as an integral part of Medicare health coverage and the benefit should be added as part of broader efforts to strengthen and improve both the fee-for-service program and Medicare+Choice. Expanding Medicare to include prescription drug coverage should be a stepping stone toward comprehensive program reform with prescription drug coverage as part of an integrated benefit package. Finally, a Medicare prescription drug benefit program should ensure that private health plans have flexibility in designing prescription drug benefits to include proven, private-sector management tools to improve quality of care and to better manage costs.

Second, Congress should ensure the long-term financial integrity and solvency of the Medicare program when considering program reforms and additional benefits. A stand-alone drug program should not be simply layered onto Medicare. The program's financial and structural systems must be strengthened to ensure adequate long-term financial stability to meet the challenges presented by the retirement of the baby boom generation and the projected doubling of the Medicare population. Congress should address these problems first, or at least concurrent with, adding a prescription drug benefit.

Third, Congress should address the financial crisis facing health plans and providers in order to establish a solid foundation upon which to build a better Medicare. Patient care has been adversely affected by inadequate reimbursements to health plans, hospitals, doctors and other providers. Further, these inadequate provider reimbursement levels have directly undermined progress toward a modernized program. Congress should ensure appropriate and timely payments for these providers and plans to ensure appropriate care. Further, prescription drug benefits should be designed with adequate financial support and effective management tools to ensure reliable coverage and long-term success.

Fourth, an improved Medicare program should improve coverage options through increased consumer choice and health plan competition. Medicare beneficiaries should have the power to choose from a range of coverage options similar to those available to Members of Congress, federal employees and millions of working Americans under 65 years of age. Options can include both fee-for-service Medicare as

well as a variety of private plans. The Medicare+Choice program seeks to provide these types of private coverage options to seniors nationwide. However, inadequate payments and excessive regulation of private sector providers participating in Medicare+Choice have seriously constrained the ability to expand coverage areas. Numerous plans have withdrawn from areas where reimbursement was inadequate to cover even the costs of basic care.

Fifth, a modernized Medicare program should improve coverage through better coordination of care and the inclusion of health promotion and disease prevention efforts. The traditional Medicare program has not kept pace with private sector benefits and plans offering disease management programs, preventive health care and screening measures such as annual physicals, hearing and vision tests, and dental care. Medicare beneficiaries, more so than other age populations, can benefit from these preventive measures which help reduce long-term costs and ensure appropriate, early treatment of health problems. Medicare+Choice plans have the flexibility to provide these measures as part of basic health care services whereas an act of Congress has been required to provide routine screening tests under the Medicare fee-for-service program.

Finally, an improved and strengthened Medicare program would replace the current rigid and outdated benefit structure and bureaucracy and ensure flexibility to make new health care innovations more accessible. An example of efforts to ensure flexibility in the program is H.R. 810, the "Medicare Contracting and Regulatory Reform Act," recently approved by the full Energy & Commerce Committee. AIM members support this effort to create a more collaborative relationship between CMS and the providers who serve Medicare beneficiaries, to address provider concerns, and to improve beneficiary and provider education. Additionally, the HHS Secretary's Advisory Committee on Regulatory Reform has issued a final report and recommendations to streamline regulatory burdens and improve Medicare and other HHS programs. Congress should encourage the HHS Secretary and CMS officials to continue to work toward reducing potential obstacles to patient's access to care and improve communications with both beneficiaries and providers. This effort should also seek to ensure that Medicare has the flexibility to make new health care innovations and technologies more readily accessible to beneficiaries. Quality health care for Medicare beneficiaries requires these new technologies to be available for all patients.

CONCLUSION

We appreciate the opportunity to submit this statement and we look forward to working with the Subcommittee and other members to ensure passage of Medicare prescription drug and reform legislation in the 108th Congress.