S. HRG. 108–228

DEBATE ON MEDICARE REFORM

FORUM

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

WASHINGTON, DC

JUNE 23, 2003

Serial No. 108–14

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

89–854 PDF WASHINGTON : 2004

For sale by the Superintendent of Documents, U.S. Government Printing Office
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DEBATE ON MEDICARE REFORM

MONDAY, JUNE 23, 2003

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

The committee met, pursuant to notice, at 2:30 p.m., in room SD–628, Dirksen Senate Office Building, Hon. Larry E. Craig (chairman of the committee) presiding.

OPENING STATEMENT OF SENATOR LARRY E. CRAIG, CHAIRMAN

The CHAIRMAN. Ladies and gentlemen, thank you for coming today. Normally in this room I would rap my gavel and say "The Special Committee on Aging is now in order." That would not be in order today for the purposes of what some suggested is a debate or at least an enlightened discussion.

Today's debate brings together two of the country's most prominent and articulate advocates on the Medicare issues. On one side we have Dr. Robert Moffit of the Heritage Foundation, a strong believer in a competition-based future for Medicare, and on the other side we have Ron Pollack, Executive Director of Families USA, who I think it is safe to say is an advocate of building upon the traditional Medicare framework.

Ironically, as it turns out, Dr. Moffit and Mr. Pollack have both been quite critical of the specific Medicare reform bills now pending before Congress, although for very different reasons. Needless to say, this development was not anticipated when this event was planned some weeks ago. I am going to suggest to all of you who have chosen time in your schedules to come today, though, that between the two of these gentlemen, you will get a very aggressive and enlightened discussion.

My own role here today is much easier. I am going to be the facilitator and the referee. Each debater will be allowed opening remarks of 5 minutes, and we will determine that order by a coin toss. Then each debater has the right, at the close of the opening remarks, to rebut or make additional comments for three minutes. Next, I will ask each debater a series of questions I have prepared. Each debater will have two minutes in which to respond to the questions. Then we will return to all of you, and we are going to ask that you help us out in the filling out of a card, and we will select randomly from those cards as to the questions that will get asked.

So with that, we are going to get started, and for the next hour I think we are going to have a most enlightened discussion about

the issue of the day, Medicare reform and prescription drugs, currently being debated on the floor of the U.S. Senate, and without question, probably one of the larger and more difficult issues that the Congress of the United States has tackled in some time.

So with that, we're going to do a coin toss. I am never good at flipping coins, but I have just done so, and I have got the exposure, and gentlemen, call it.

Mr. POLLACK. Heads.

The CHAIRMAN. Well, if he calls heads.

Dr. MOFFIT. I have no choice.

The CHAIRMAN. You call tails. It is tails. With that, Dr. Moffit, you may start with your opening statement of five minutes.

STATEMENT OF DR. ROBERT MOFFIT, HERITAGE FOUNDATION

Dr. MOFFIT. Thank you very much, Mr. Chairman, and thank you very much for sponsoring this debate. I also want to publicly thank the staff and the members of the Senate Aging Committee for sponsoring this great forum, and it is good to see Ron Pollack again. We see each other quite a bit, you can imagine.

Beginning in about 8 years, the first wave of 77 million baby boomers are going to be eligible for retirement. In many ways they are very different from the current generation that now is enrolled in the Medicare program. They will have different expectations. They will have different perspectives. They will come to their retirement with very, very different experiences with the health care system.

Medicare is going to be faced with an unprecedented demand for medical services, and a rapidly advancing medical technology. The demand for medical services that Medicare will experience is going to be unlike anything we have ever seen before in history. The question before the House is whether in fact the current Medicare program can absorb this demographic shock? My argument is that it cannot.

Consider a concrete example. A few years ago Judge Robert J. Gerstung of Baltimore, my uncle, died of a sudden cardiac arrest. It is a rapid and irregular heartbeat; it usually strikes people with a history of heart disease. Two years ago the Food and Drug Administration approved an implantable cardiodefibrillator, and clinical trials show that death rates with this device were reduced by 40 percent. Many private companies recognize the value of the device and they include it in coverage. So today, Cigna, Blue Cross and Blue Shield, Aetna and Kaiser, all cover this device. But the majority of patients who might need it are over the age of 65. Medicare had not approved reimbursement for this device until very recently. Finally this month, Medicare approved it.

But while Cigna and Aetna make it available to everybody, only a portion of the Medicare population, the sickest one-third of the Medicare patients who can benefit from the coverage will be able to get it. This will effectively ration care for this medical device and ensure more deaths, but will certainly save on Medicare costs.

Does anybody think that for one blessed moment, that if in fact we have the Government control over the financing and delivery of prescription drugs or medical technology, the dynamics will be any

different? If there is any doubt about this, consider the current practices right now in Medicaid, where prescription drug coverage is being cut back through price regulation, reimbursement restrictions and formularies in virtually every State in the union. The argument might be made by some in Congress that, well, Medicare will not treat seniors in the future as bad as Medicaid routinely treats poor people today.

Ladies and gentlemen, do not bet on it, because we are going to see an unprecedented demand for services. In Medicare the Government defines every benefit, every medical treatment, every procedure. You get what they give you; every modification, every change in benefits is becoming a major political event. That's why we're having a conversation about whether to add prescription drug coverage to the current Medicare program. If it is not a congressional issue, it is worse. It is a decision that is authorized by the Medicare bureaucracy through a painful, often agonizingly slow and mysterious process.

Do we really want to continue to do things this way in the future? If the Government defines the benefit, then the Government must also price the benefit, and we know exactly how that works. Medicare is a system not only of central planning, but of price controls. Every one of the 7,000 procedures that doctors authorize for Medicare patients is controlled. Every one of the hospital procedures is controlled. As my colleague formerly with the Urban Institute, Len Nichols, once said, one thing we can be sure of: Medicare controls 10,000 prices in 3,000 counties and does not do a very good job of it. Do we want to continue doing business this way?

Every benefit, every price, everything is regulated in detail to the point where tens of thousands of pages of rules and regulations and guidelines govern the program. Do we want to continue to do business this way in the future? Then, of course, if you are a doctor, you live in fear of audits and investigations.

The CHAIRMAN. Dr. Moffit, you should begin your wrap up.

Dr. MOFFIT. Thank you.

Regardless of what you have been told, the Senate bill largely continues business as usual in the Medicare program. It is short on reform and very long on entitlement expansion. At the end of the day low-income working people are going to end up subsidizing the drug bills of Bill Gates. We can do much better.

There is a far superior model. It is the Federal employees model. Congress ought to transition to that model and be done with it.

Thank you.

The CHAIRMAN. Thank you very much for your opening comments.

Now let me turn to Ron Pollack, Families USA, for your opening comments.

STATEMENT OF RON POLLACK, FAMILIES USA

Mr. POLLACK. Thank you so much, Senator.

I want to start by making two points, one of which I hope that all three of us on this panel will actually have an agreement about, and on the other one, undoubtedly, we will have a difference.

The first point I want to make is that the exercise to get a prescription drug benefit is very carefully circumscribed. It is cir-

cumscribed by the budget resolution and, as probably all of you in this room know, the budget resolution says that there will only be $400 billion available for Medicare related changes including a prescription drug benefit over the course of the next 10 years. Now, over that same period of 10 years, the amount of money that seniors will be spending on prescription drugs is over $1.8 trillion. So even if all of the $400 billion is spent on prescription drugs—and clearly that will not be the case because there will be some relief for rural hospitals and other rural providers and some other fixes in the Medicare program—it means at best only about one out of $5 spent by seniors could be subsidized by a change in the legislation that is currently being debated.

A point I hope that we can all agree on is that when we have limited resources, especially in comparison to the amount of monies that seniors will be spending on drugs hopefully, we choose wisely in terms of what those priorities are. I would suggest to you, and I hope we actually have agreement on this one point, to the extent that we can only go an incremental step in terms of subsidizing seniors' drug costs, that we focus them most heavily on those people in greatest need, the poor. I have many misgivings about the Senate bill. It is complex. It has lots of different failures. But one of the things that the Senate bill does, and certainly does in sharp contrast with the House bill, is that it really provides some significant new relief for low-income seniors. I think that is good, and I hope that is an issue that does not divide conservatives and liberals. I hope that, on an issue where we are trying to stretch our resources as best as possible, we focus them on those with the greatest need. I would be happy to elaborate further on that.

The point where I think we depart company is on the question of traditional Medicare versus private plans. I wonder what it is that makes people think that moving to private plans is going to be any better than what we have today? Take rural communities. Eighty percent of the people who live in rural counties do not have a private plan that serves them. Private plans do not wish to serve people in rural communities. In those communities where private plans have served people, they have abandoned people left and right. Two point four million people have been abandoned by private plans because those plans said those communities were not profitable. Why is that we would want to move people into private plans when, after all, if you do that,you lose your choice of doctor? Well, maybe you can get the doctor you want, but at a higher price if that doctor is not in your network. Why is it that we think it's good for seniors to give up something they consider precious, namely the right to choose their physician, their providers? I think it would be a mistake to go in an opposite direction.

But then I think what's most telling is that you look at the data, not by some of the advocacy groups either on the left or the right, but you take a look at what CBO says or what General Accounting Office says or the Inspector General says. What you find is the cost of coverage for people in private plans is considerably more expensive than it is in the Medicare program. So what is it that has people say that to lower costs and save Medicare we should move to private plans rather than the traditional Medicare program that

most seniors want. Eighty-nine percent of seniors are on the traditional Medicare program. I think we should not push them out.

The CHAIRMAN. Right on time. Thank you very much, Ron.

Now, we'll turn to 3 minutes each of rebuttal, and we will turn back to you, Bob, for any rebut you have in relation to what Ron has said. He has laid down the challenge. Are we going to focus on the poor because that is all the money we have?

Dr. MOFFIT. I think Ron has certainly contributed to the debate. If he can convince Senator Kennedy to go along with it, I think we will have a good outcome.

The fact is 78 percent of senior citizens, according to the Joint Economic Committee, already do have prescription drug coverage. The generosity of that coverage varies. Some, of course, is not so good. Other coverage is actually quite good. So, if we are going to solve the problem, then yes. If we are going to deal with the Medicare issue and prescription drug coverage and Medicare, let's target the resources that we have to low-income people who do not have access to either Medicaid coverage or to coverage through supplemental insurance or former employers. I agree with Ron on that. That makes a great deal of sense.

Congressman Stark, last week, offered an amendment in the House Ways and Means Committee that the CBO estimated at $1 trillion over 10 years, to solve the problem of 8 to 10 million Americans without drug coverage. It is not necessary really to spend $1 trillion. Then the question is, what do we do about private plans? What is the value of private plans? I am not in favor of forcing anybody into anything. I am not in favor of forcing people into private plans, nor do I think that conventional private health insurance is indeed the best model for Medicare reform. In fact, as the Chairman knows, I am an advocate of a Government program. I have supported the idea of a public/private partnership based on the program that covers many people in this room and 2 million Federal retirees and 2 million Federal workers, the Federal Employees Health Benefits Program. It is a system that is based on personal choice. Nobody is forced to take anything. If you want an HMO, you can have it. Most people do not choose HMOs. They choose fee-for-service plans or PPOs and have the choice of doctor that they want. As far as rural coverage is concerned, it is nothing like Medicare+Choice. The evidence is overwhelming. In 87 percent of the rural counties in the country, retirees have at least 6 to 9 plans. The cost of coverage in FEHBP is actually competitive with Medicare. The Joint Economic Committee found that indeed comparing the cost increases over time over the past 20 years, FEHBP, a system of private competitive plans, actually outperformed Medicare.

The CHAIRMAN. Thank you very much.

Now your 3 minutes of rebuttal.

Mr. POLLACK. Thank you. Thank you, Senator.

First, I am glad that—I believe I heard you say, Bob, that we do have some agreement on focusing on low income first.

Dr. MOFFIT. Yes, we do.

Mr. POLLACK. I just want to say a word about how different the Senate and the House bills are in this respect because it is important to note. When we are talking about folks below the poverty

line, for a senior living alone, we are talking about somebody who has an annual income of $8,980, less than $9,000 a year. Now, under the Senate bill, if that senior has $3,000 in drug expenditures, then under the Senate bill that senior would only have to pay $75, a big improvement. In the House bill, that senior would have to pay $1,114. Now, if that same senior, same income level, happened to have drug expenditures of $5,000, under the Senate bill that senior would pay $138. Under the House bill they would pay $3,114, a huge difference. I would be happy to take Bob's challenge and talk to Senator Kennedy about making sure that the Senate provisions with respect to low-income seniors prevail in conference. I think it would be a great thing to do.

Now, Bob, you have talked about FEHBP and I am glad you did. Many people who like the FEHBP system say let us give seniors what members of the U.S. Senate, or the House, or the President has, and I am in favor of that. I am not in favor though of packaging it that way and not actually providing it that way. How many Senators—and I am not criticizing any single Senator or all 100 Senators for that matter—how many Senators have a doughnut hole in their coverage? First, in this bill, there is a $275 deductible. Then it pays 50 percent of the copayments, and then there is a doughnut hole which is a huge hole in which many fall. I do not think anyone who is in the FEHBP system has that kind of a system.

So, Bob, I would suggest, as long as you are promoting the FEHBP system, let us do it right. Let's actually provide America's seniors with comparable benefits that is going to cost a little more money. My hope is that you and your colleagues will support providing that additional money so that we can provide a benefit that is comparable.

But last, I guess I want to say I know that there are some faults with the traditional Medicare program, certainly there are, but I would like to stack them up against the private insurance industry. You talked about new procedures. They are very slow in approving new procedures. In 1999 there were 9 states that had no private plans with a drug benefit. In 2002, there are 15 states without a drug benefit. I do not think going to the private sector is something seniors are going to appreciate. Thank you.

The CHAIRMAN. Ron, your time is up. Your timing is excellent. Well, thank you both very much for your opening comments and rebuttals.

I will now ask a series of questions, and after 15 or 20 minutes of that, or a little less maybe, I will turn to the audience, and we hope you will have filled out the cards and have your questions available.

As I ask these questions, both of you may respond if you would, and I will ask Ron the first question because Bob got the first word out here in his opening comments.

Short of a wholesale rewriting of the legislation that is before the U.S. Senate today, could you make just two or three, or would you propose just two or three targeted changes that you think would greatly improve the current legislation?

Mr. POLLACK. I am delighted to do so, Senator. Thank you for the question.

First let us go back to the issue I raised first about low-income seniors. I would make some improvements in what we have today for low-income seniors. First, the Finance Committee bill that is now on the floor, for the first time treats the very poorest of the poor exclusively in Medicaid and not in Medicare. I think that is a mistake. I think we should put everybody into the same plan. I do not think we should isolate the poor and separate them. I think ultimately it means they are going to get treatment as if it is a welfare program. So the very first change I would make is that change. I know there is an amendment being offered on the floor to that effect. I support that.

Second, with respect to the poor once again, there is an extremely low so-called assets test for eligibility for low income benefits. Anybody who has income below the poverty line, below $9,000, probably is not sitting on a Donald Trump set of assets. Otherwise, they would probably be over the income level. The problem with the assets test is if you take a look at all of the States that have an assets test in their low-income programs, it requires enormous verification, enormous amounts of time for people to ferret together all the details about this little amount in their savings account, this little amount in a burial plot and so on. I would eliminate that because I think the income test is sufficient and it would reduce significantly the bureaucracy needed to administer.

There is also an amendment I believe on the Senate floor to deal with that.

I guess, Senator, to answer your question in a larger sense, the reality is that——

The CHAIRMAN. Wrap up with this if you would.

Mr. POLLACK. With $400 billion in the budget resolution, when seniors are going to be spending over $1.8 trillion, many of the gaps I think will be very difficult to fill.

The CHAIRMAN. Thank you very much. Now we turn to you, Dr. Moffit. Same question.

Dr. MOFFIT. My suggestion would be to strike everything in Title I and replace it with a low income assistance for prescription drug purchases. I would structure it in the same way that the American Enterprise Institute has proposed to do it, which is: provide a prescription drug card to senior citizens, attach a subsidy to that prescription drug card at some amount between $600 and $800, and establish a catastrophic coverage for those seniors. That would target the people who do not have prescription drug coverage today. If we wanted to add money later on or if we felt it was necessary to add money later on for hardship cases, we should do it. But, in any event, target the funding for drugs that way.

With regard to the other provisions, I think the best thing for Congress to do would be to start the transition to a genuinely competitive system where drug coverage is fully integrated into insurance, set up the structure now under the Senate bill and the House bill and create a system where you would have a competitive market, and start the transition in about 2007. There are several ways to do this. One would be to give new retirees the option as to whether they want to stay in traditional Medicare or go into a private system administered much like the Federal employee system is administered, with a Medicare administrator. At the same time

give opportunities to employees: You want to have a situation where people who want to take their private employment based health insurance with them into retirement can do so and get a premium offset or a premium subsidy to support that. That would be another way to go.

The idea is not to separate out the drug benefit, but to create a system where the drug benefit is fully integrated into a system of insurance just like normal human beings have in the private market. That's a much better idea.

The CHAIRMAN. Well, doctor, we are going to stay with you to begin the second question, and we would ask that both of you respond to it, setting aside bill specifics for a moment.

Many argue that greater competition in Medicare will improve quality, innovation and long-term cost management, while others say that the reverse is true. What is your view and why?

Dr. MOFFIT. I think Adam Smith was right. I think when you have competition, you will improve efficiency, you will increase the quality of services and you will increase the productivity of services, whether it is in other sectors of the economy or the health care sector of the economy. The most important thing is that this sector of the economy be consumer-driven, not driven by third party payment decisions; not made by other parties who, in fact, actually do not make the decisions about consuming care. I think it is critical, if we are going to try to create a competitive market, that we do not do what we do today in employer based health insurance. We create a division between the customer for the service and the consumer for the service. Ideally the customer for a service and the consumer of the service should be the same personality.

The CHAIRMAN. Ron.

Mr. POLLACK. Senator, I believe in competition, but I very strongly disagreed with the President's proposal because I think it was anticompetitive. The President's proposal was labeled as being a competitive model. But what did the President do? The President said, let us provide significant amount of additional goodies to private plans. Let us give them a significant prescription drug benefit. Let us give them a catastrophic benefit. But let us not provide those same things to the traditional Medicare program. Well, I do not call that competition. I call that stacking the deck. Now, if the private plans can do better than the public traditional Medicare program, so be it. Then they deserve people going into those plans. But I do not think people deserve going into those plans if they are pushed into those plans by virtue of stacking the deck. Clearly, if a senior citizen knows that they are going to get very substantial prescription drug benefits in a private plan but not in traditional Medicare; if they know they are going to get a whole host of other benefits in a private plan but not in traditional Medicare; then of course, they are going to go to a private plan. But that is not a triumph of competition. That is a triumph of stacking the deck.

So I am hopeful that we are going to see a system where each of the plans and the traditional Medicare program can compete with one another. I would suggest to you when that happens, I think the traditional Medicare program is going to come out in pretty good shape, and that is because the cost of the traditional Medicare program is considerably cheaper than it is for the private

plans. Traditional Medicare does not have to pay for marketing and advertising and the same administrative costs. They do not have to pay for agents fees. They do not have to pay for profits. They do not have to pay for profligate salaries of chief executives of those private plans. For that reason, I think that the traditional Medicare program can compete very well in this competitive model.

The CHAIRMAN. Thank you. We are going to stay with you, Ron, to begin the third question round. In your view is drug coverage provided in the Senate bill too much or too little or just enough to meet the true needs of our seniors today?

Mr. POLLACK. Well, I think it is too little. I spoke somewhat about that a moment ago.

The CHAIRMAN. You did.

Mr. POLLACK. I do not think it is anywhere comparable to the FEHBP system at all. It is not only, I think, too little and only covers a tiny fraction of the cost that seniors are going to experience, it is extremely confusing. You and I talked about this a moment ago, Senator. You have got the premium, then you have got a deductible. Then you have got a certain kind of copay. Then you fall within the doughnut hole. Then you have a catastrophic benefit, and then you have different levels of subsidies. The subsidies depend on whether you are below poverty, you are below 135 percent of poverty, or you are below 160 percent of poverty. It is very confusing. I believe that most seniors are going to feel that this does not provide them with enormous relief. For most seniors, between now and 2006, when the benefit first is implemented, I think we are going to see that the prices of drugs will have risen so substantially that they are going to more than consume the relatively small benefit that most seniors will receive.

So I believe it is too small. I believe we should get started, however. I do not think we should have gridlock, but I do not think seniors are going to be tremendously happy. With one exception and that is, I do think that a reasonable start was made for low-income seniors, and I treasure that and I hope we build on that. To the extent we have any resources that are discretionary, I would put it into that. I hope that is something where liberals and conservatives really join hand in hand.

The CHAIRMAN. Thank you. Dr. Moffit.

Dr. MOFFIT. Well, the Senate benefit and the House benefit, has been described by Bob Reischauer of the Urban Institute, as plans that do not exist in nature. They do not exist in nature because you actually could not buy such a benefit. Nobody would sell it. Consider the benefit structure of the Senate bill. I mean who would actually go out and buy that thing?

The Senate and the House are trying to set up a stand-alone drug benefit and try to make it cost effective. That is tough. Administratively it is very, very tough. This is a complicated benefit. It will probably result in an explosion of regulatory detail in the administration of the benefit, and my concern is, at the end of the day, that it may not prove politically successful. The unintended consequences are going to hit the senior citizen population good and hard. The evidence is now that 37 percent of retirees will be dropped out of their private drug coverage under the Senate bill, about 32 percent out of the House bill. This is rotten public policy.

The right way to do this, once again, is to integrate the drug benefit into insurance and allow people to pick an insurance package which makes sense.

I want to mention one thing that Ron raised, and that is the administrative cost of Medicare. You have heard it 50,000 times, that Medicare's administrative costs are very low, I think between one and two percent. Ladies and gentlemen, if you believe that Medicare is a model of administrative efficiency, you are a candidate for membership in the Flat Earth Society. [Laughter.]

The Medicare program is in fact enormously complex and the administrative costs are not showing up in the Federal budget. The administrative costs are pushed over to doctors and hospitals and home health agencies and other providers who have to comply with Medicare's regulatory regime and that cost is huge.

The CHAIRMAN. We are going to stay with you for the next question, doctor. Experts at CMS and the CBO differ significantly in their prediction of how many seniors will choose to enroll in the new competitive Medicare Advantage program, with CMS predicting enrollment upwards of 40 percent, and CBO predicting only 2 to 10 percent. Whose estimates do you believe are more accurate, and what is your prediction for the future of the Senate's Medicare Advantage Program?

Dr. MOFFIT. Well, Senator, they both cannot be right. We know that. You have a wildly different estimate based on very, very different assumptions. My own view is that the structure of the Senate bill is such that it is not likely to encourage widespread participation of private plans. Let me tell you why.

One of the things that is overlooked in this debate is the whole question of payments. Medicare+Choice was not successful largely because of the payment structure of the Medicare+Choice system. Health care costs were going up 8, 9, 10, 11, 12 percent, but under the administrative pricing of the Medicare program they would get cost increases on an annual basis of 2 percent. But beyond that, there was another problem with Medicare Choice. There was not one aspect of plan operation in Medicare Choice that did not come under the regulatory juggernaut of the CMS. That means that virtually every aspect of plan business activity was subjected to the regulatory reach of the CMS. They could not even make normal business decisions. The regulatory regime and lower payment discouraged plans from staying in the program.

In this particular case, Medicare payment to the new Medicare Advantage programs is based not on anything that looks like a market formula. It is based, rather, on the administrative pricing of the current Medicare program. In other words, the benchmark is the fee-for-service system in the current Medicare program. As health care costs increase and as the demand for the baby boomers creates a greater demand on the system, what will the government do? Well, basically what they will do is what they have always done in the past, start to reduce reimbursement. This means they will also reduce reimbursement for the private plans.

Second, looking at the actual structure of the bill, Title II and Title III, what you have is a highly prescriptive statutory program. It looks much more like Medicare+Choice than it does the Federal

Employees system, which in fact is low on regulation and bureaucracy.

The CHAIRMAN. Is it 40 percent of 2 percent, Ron?

Mr. POLLACK. I think it is relatively small, but if I may, Bob offered me a membership in one of his favorite clubs. I thought I would return the favor. [Laughter.]

Bob, if you believe that the private insurance companies can do a much better job in keeping administrative costs down, I am prepared to sell you all the bridges, all the tunnels and all the ferry boats leading into Manhattan. The private insurance industry has not distinguished itself in terms of administrative costs compared to the public sector.

Senator, I believe that there will be relatively few people, Bob and I agree on this, who are going to go into the private plans, but not for the reason that Bob indicated. You know, we have seen a precipitous drop in the number of people who are in private plans, the Medicare+Choice plans, and this is despite the fact that Congress, with each passing year, has showered those plans with increasing amounts of money. The Congressional Budget Office, the General Accounting Office, the Inspector General's Office, all three, none of whom have got an ax to grind in this debate, have been saying that it costs more to serve people in these private plans than it has in the public plans. It is not surprising that after the Medicare+Choice plans initially offered fairly generous drug benefits, they have been reducing those benefits. They have been increasing premiums and they have been reducing benefits. So people have been voting with their feet.

People are happy with the traditional Medicare program and I think they are going to be loath to give up their freedom of choice of physician to go to a private plan.

The CHAIRMAN. I will ask one more question, and then we will turn to you, the audience, and get response to some of your questions.

Both of you have been reasonably or very critical of the Senate and House bills that are before us, for a variety of different reasons. However, do you believe there are any positive aspects to the current legislation? If so, why?

Ron, we will stay with you.

Mr. POLLACK. Well, I hate to sound like a broken record on this question but, on the Senate bill, I think that the one very significant achievement in that bill is it does provide very substantial relief to low-income seniors. Now, as I said, "I think there are some significant improvements that still need to be made on that score, particularly the elimination of the assets test and making sure that low-income people are in Medicare not just in Medicaid." But I think that is the singular important achievement in the Senate bill, and I think people, irrespective of ideology, should take pride in that. I think it is a step in the right direction.

I am also pleased that we did not do what the President had asked, namely that we load the decks on behalf of private plans at the cost of the traditional Medicare program. Even though that is a negative I think it was a step in the right direction, and it enables the Senate to pass legislation potentially on a bipartisan basis.

The CHAIRMAN. Doctor.

Dr. MOFFIT. I would say that probably the best single provision in both Houses is the proposal in the House Ways and Means Committee to transition to a competitive system in the year 2010 with a real premium support system. That, frankly, makes the best sense to me. I think that is where we have a greater opportunity for change. My suggestion would be to accelerate that, speed it up. Instead of waiting to 2010, go earlier and go in 2006 or 2007, and get this show on the road. That would be my suggestion.

The CHAIRMAN. Thank you, gentlemen, both very much.

Now, we will turn to you, the audience, and while I have your question in front of me, I would ask that you come to the microphone right over here and ask the question of either one or both of the gentlemen. We have got about four of you or five of you already, and any more who have not submitted your questions, please do, if you would.

Ms. CAMERON. Joy, would you come forward and ask your question?

Ms. CAMERON. My question was about dual-eligibles——

Mr. POLLACK. About what?

Ms. CAMERON. Dual-eligibles, people that are eligible for both Medicaid and Medicare. My question had to do with on the House plan, there is a Federal plan to phase in the dual-eligibles over 14 years, where they take to FMAP rate and increase it by 6⅔ percent every year to essentially Federalize a program as a way of offering relief to the States. The Senate offers to pay their premiums for Part B for States that already have a prescription drug plan.

I was just wondering if the Senate would consider adopting the House plan because it provides more fiscal relief for the States and——

The CHAIRMAN. Your question is?

Ms. CAMERON. My question is, is it cost or what is hindering something like that?

The CHAIRMAN. Both gentlemen.

Mr. POLLACK. Well, I am happy to. This is a pretty arcane subject, but a very important one, so I am glad you raised it. The question of dual-eligibles is not just a question for the beneficiaries of the program, but also has a big impact on the States. The States have been complaining about extraordinary costs that they bear as a result of these dual-eligibles, people eligible for Medicaid and Medicare. The States have said, with ample justification, that they thought, since they are in effect wrapping around the Medicare program, that this should be a Federal expense, not a State-Federal expense.

I believe that is the right thing to do. I think it would provide the States with significant relief, and in the process it would put less pressure in cutting back Medicaid programs, which many States are experiencing.

I think my only caveat about that is that we have got a very limited amount of money that is available under the budget resolution, $400 billion. So we have a zero sum game that we are playing with in terms of the amount of money. If you spend it on one thing, you cannot spend it on another thing. So to the extent that fiscal relief

is provided to the States, less money is available to provide help to low-income seniors or other seniors. So while I think the cause is just and I think it does make sense to try to have the Federal Government ultimately assume those costs, I would like to see it happen on a slower basis so that more of the dollars can be used to help people who right now do not have drug coverage.

The CHAIRMAN. Doctor.

Dr. MOFFIT. I was just going to say, as far as the dual-eligibles are concerned, it makes sense. The House provision makes sense in terms of addressing that question. Once again, what I would do of course is I would stress the opportunity here. There is an opportunity here to create a real market, and I would subsidize them directly rather than the way they have it in the House bill. I would create something that looks like the AEI drug account. I just think it is a much better way to go.

Ms. CAMERON. Thank you.

The CHAIRMAN. Thank you.

Now, let's have Craig Principi, is it? Craig? A tantalizing question, please ask it.

Mr. PRINCIPI. My question is for Mr. Pollack. I am 23-years-old right now, and I would like to know from your perspective, when I am 43 and ready to put my own kids through college, what percentage of my income do you think I should have to pay for other people's medical care?

Mr. POLLACK. I presume, given the context of our discussion, we are talking about our parents and grandparents, people who might be on Medicare.

I am not sure I have a precise answer to that. I do know my parents benefited from the Medicare program and in the process I felt I benefited as well. I actually do not look at it generation by generation, although that is important to do. I do not discount at all the thrust of your comment. But I like to look at it as the whole family. When my parents get helped or your grandparents get helped, I think it actually does help all of us. So I am in favor of having a program like Medicare and like Social Security. I think it enhances the well being of all of us, even though from a generational standpoint it might well be a money transfer from the young to the old. But I think in terms of our well being as a society, I think it does something very important and helpful.

I want to remind you, in 1965 when the Medicare program was enacted, almost no insurance companies were willing to sell insurance to seniors. Why is that? Because they make high claims. They are sick. They are more likely to need health care. I think that one of the things we should cherish was in 1965 we passed Medicare and we provided relief for seniors, who are now living longer and I think live a much better life. In the process, their children can rest assured that their parents will be taken care of.

The CHAIRMAN. Now, Craig, in the element of fair play, we are going to return to Dr. Moffit to respond to that. In turning to him, in this room about 2 months ago we had that noted expert on health care, Alan Greenspan. Chairman Greenspan said, "As a percentage of total income today, there is still a margin that could be spent on health care that is not." He is claiming that the average

American today is getting more for their money than they are actually paying in. Interesting comment.

Doctor.

Dr. MOFFIT. I think the question is a fair question because it really goes to the heart of the current debate. The current debate is not about the current World War II generation. The current debate is about how we are going to be able to absorb the costs of the next generation of retirees. Now, we have an idea about what those costs are going to be, and they are very, very unpleasant. According to Public Trustee, Tom Saving, he made a projection that if we did nothing, if we just kept the current Medicare program, the current Medicare entitlement system as it is today, by 2026 when the Medicare Part A program goes bankrupt, actually goes under, roughly 24 or 25 cents out of every Federal dollar that is collected in income taxes will go to the Medicare system.

If we added a prescription drug benefit, said Professor Saving, and we had, let us say, the Federal Government pick up 75 percent of the cost of that drug benefit, then 35 cents out of every Federal dollar would be going to pay for Medicare.

We have to ask ourselves a very, very big important question today and in the next couple of weeks. Can we afford the entitlement program that so many in Congress seem hellbent on establishing? A more important question—at least at a preliminary level Ron and I agree is whether the focus should be on low income people who do not have access to health insurance and drug coverage. Why should a low income working family that is struggling to put their kids through school, struggling with a mortgage, struggling to make ends meet, have the responsibility of paying the drug bills of six-figure retirees living in Boca Raton, FL? Are we going to establish a universal entitlement? It seems irresponsible to do so.

The CHAIRMAN. All right. Now, Dave from New Jersey. If you would ask your question relating to orphan drugs.

Audience participant. This question goes, I am addressing both of you. How do you plan to include orphan drugs under each plan? Are you familiar with the——

Mr. POLLACK. Yes, but I have not frankly thought about how to—so I am happy for Bob to take that first. [Laughter.]

The CHAIRMAN. It is the "doctor" in front of his name that gives him the chance to lead on this one.

Dr. MOFFIT. Right. I am not a real doctor. [Laughter.]

I have not got a clue really about orphan drugs, except that I think it is a question of what kind of a system we set up. I mean if you have a competing system of private plans and you have orphan drugs in the private plans, that is fine.

Audience participant. Well, my concern is I personally am on a drug, an orphan drug, and I do not fall under the poverty line, but I still have to worry about coverage. So for certain situations where someone needs coverage that is above and beyond the typical cost, how do you plan to provide to people——

Dr. MOFFIT. I think there is a simple answer to that. I do not think they should sell any kind of insurance in this country, whether it is in the private sector, or for that matter in a public program or a public/private partnership, which does not have catastrophic requirements. If you are talking about catastrophic coverage, yes.

Mr. POLLACK. I would go a step further than that, I think, Bob. Any medically necessary drug, whether it is an orphan drug or some other, should be part of a prescription drug regimen. So that is the real question. Is it medically necessary? If it is an orphan drug or not is irrelevant.

The CHAIRMAN. Thank you very much, Dave. You almost stumped the panel. [Laughter.]

Joe Mosier. Joe.

Mr. MOSIER. My question was specifically for Ron Pollack. I was wondering if you support targeted benefits for the low income seniors, how can you oppose the President's plan which includes a $600 subsidy for first-dollars drug expenses for the low income, and full premium support for low income seniors?

Mr. POLLACK. I appreciate that question. Providing only $600 in subsidies for low-income seniors means that a senior, say, who has $3,000 in expenditures, is going to have to pay $2,400 out of pocket. Now, a low income senior has an income of less than $9,000, $8,980 or lower, so if you are saying that a senior with $3,000 expenditures should be paying $2,400, you are in effect saying it is appropriate to charge such a senior somewhere between a quarter and maybe 30 percent of their income just on drugs. I think not only is that inappropriate, it is clearly unaffordable.

So it is not the idea that the President said he wanted to do something special for low-income seniors that I am quarreling with. It is that what he is doing is wholly inadequate, and for most seniors is simply going to leave those costs unaffordable.

The CHAIRMAN. Thank you, Joe.

Dr. MOFFIT. I would just like to respond. I would think——

The CHAIRMAN. Joe directed it at Ron, but I control the microphone. You wish to respond?

Mr. POLLACK. You paid for the mike?

The CHAIRMAN. No, I just control it.

Dr. MOFFIT. No, Ron, we all pay for the mike. [Laughter.]

The CHAIRMAN. Any further comment there?

Dr. MOFFIT. I would just say that the issue here has to do with high drug cost. Once again my response is the same as the response I made earlier. I do not believe that we should have any kind of a drug program or a drug insurance program without catastrophic coverage, so catastrophic coverage should kick in. There should be a stop loss to cover high costs. There is nothing wrong in concept with the idea clearly. If we go to low income people with insufficient resources, we can set up an account. There is no reason why they should not have the option to pick and choose what they think is best for them.

We have a very, very diverse senior population. The senior population is diverse in terms of its needs, it is diverse in terms of its health status, it is diverse in many, many different ways. We should not set up a system that straitjackets their options.

The CHAIRMAN. Larry Litman, to ask of both of our participants.

Mr. LITMAN. The reform proposals on the table are based on two assumptions. One, that private insurers will offer a drug-only benefit, and two, that people will sign up for these plans. You talked about the second part already. Could you talk about the validity of the drug-only benefit?

Mr. POLLACK. Well, I think Bob and I have somewhat of an agreement on that score. Bob quoted Bob Reischauer earlier, saying these plans do not exist in nature. Not only is that true, it is also true that the insurance companies do not want to offer these plans.

As you know, Larry, I developed a friendship with my ideological opposite, Chip Kahn, when he was head of the Health Insurance Association of America. When he was CEO of HIAA, Chip was very forthright and said the insurance companies he represented had no interest whatsoever in providing a drug-only policy. The reason he said that, aside from the data he had been receiving from his membership, was that what the insurance industry believes is that when you provide a drug-only policy, the only people who are going to buy into them are the people who have a high predictability of needing drugs. He was terribly worried that the insurance companies would therefore have to ratchet up the premiums over time, and that the insurance industry would be blamed for this.

I do not think it makes a lot of sense to have drug-only policies. Bob, I think, is right. They should be integrated into a full insurance package, but they should be available both under traditional Medicare and in private plans. My hope is that ultimately that is the direction we are going to go.

The CHAIRMAN. Dr. Moffit.

Dr. MOFFIT. Well, no. I think it is a risk, a drug-only policy. I do not think there is going to be a lot of enthusiasm for it, but we will see. I mean this is an opportunity to actually find out. This is a creation of both the House and Senate, and it is a creation which is grounded in the desire to establish a separate standing drug benefit. The question is, can we make this work, either in the public sector or the private sector. I do not think you can make it work in either one.

We did, a few years ago, try to create a drug benefit in Medicare. It turned out to be a political debacle. We had a situation where we said, OK, fine, we are going to have senior citizens covered by prescription drugs. That was back in 1988. We enacted it. Everybody was in it. The projected premiums went through the roof. Utilization, the projections went through the roof, and within one year the program was repealed.

My view on this is that we have got to get beyond the drug benefit issue and start thinking about Medicare reform. That is the real issue facing the country. It is not just simply the provision of prescription drugs. I think where I agree with my colleague here is that we should start focusing on low income people who do not have access to private options or who are not eligible for Medicaid.

The CHAIRMAN. There you have it.

Let me turn to you gentlemen. We will give you one minute each in wrap up. Let us see, you had the first word. We will allow Ron the last word, so we will come back to you for that minute of wrap up.

Dr. MOFFIT. My turn.

The CHAIRMAN. Your turn.

Dr. MOFFIT. OK. We are in a historic debate. At the end of the day, the outcome of this debate is going to determine the character and quality of American life for as long as we live. If we do the right thing we can create a responsible targeted prescription drug

benefit to the senior citizens who really need the help, and at the same time create a transition to a superior health care system where people will have an opportunity to be able to enjoy high quality health care in their final years. We can do that.

We have to recognize that, in the meantime, Congress cannot provide an artificially cheap drug benefit. It is not going to happen. We have to recognize that when we talk about how Medicare has superior cost control what that means is that Medicare is going to reduce the supply of services to senior citizens, and will do it through price regulation and restrictions on access. We do not need to go that way. Too many countries have. We can do much better.

The CHAIRMAN. Thank you, doctor.

Now let me turn to Ron.

Mr. POLLACK. Senator, thank you for inviting me. I am glad I did not bring my flak jacket. At superficial glance, I think all of our major parts are still in order. I appreciate that.

I look forward to this debate moving forward. It is high time that seniors got prescription drug coverage. Everyone else in the population essentially has it. I hope we do it in a way that achieves true competition among private plans and public plans. There is no reason to move toward private plans by tipping the scales toward them. They do not serve rural communities. They have pulled out of a lot of places. You lose your choice of doctors. It costs more money, and it provides less satisfaction to America's seniors.

I think we can provide a decent prescription drug benefit, at least make a decent start. I am glad we agree on starting with low-income seniors and disabled. Hopefully we can do better for other seniors as well.

Thank you, Senator, for inviting us.

The CHAIRMAN. Well, gentlemen, thank you. Dr. Bob Moffit of Heritage and Ron Pollack of Families USA.

Now if this were a hearing I would rap the gavel and say the committee is adjourned. But it is not a hearing. It is a debate or a discussion, and if you enjoyed it, you may applaud. [Applause.]

Thank you gentlemen both, and thank you all for coming today. We hope you enjoyed it.

[Whereupon, at 3:30 p.m., the proceedings were adjourned.]

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