

Statement by Senator Max Baucus
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Thank you for the chance to speak here today. I especially want to thank John Iglehart at *Health Affairs* and David Helms at Academy Health for the invitation to speak – and for their continued contributions to health policy and health services research.

In my remarks today, I will talk about several key problems facing our health care system and possible solutions. That is, I'll talk about problems other than the uninsured. Senator Breaux will focus his remarks this morning on expanding health coverage to the uninsured. So I will not steal his thunder.

And after listening to this morning's panel talk about all the problems in our health care system, I expect you to skip the rest of the day. Go back to work. And start helping us find solutions.

In all seriousness, I greatly appreciate your work. It's refreshing to think about the depth and level of expertise in this room today. Your contributions to health policy are large, and they are appreciated.

But despite all of your thoughtful ideas, the U.S. health system is in tough shape. Fixing these problems often takes an act of Congress. And as we know, that can be difficult, particularly in such a closely-divided Congress.

We are closer than you may expect on some of these issues. And today I will outline my vision for a solution on one of the most vexing health problems facing Congress – adding a drug benefit to Medicare.

But first, a few remarks on other aspects of our health care system. So often lately I have heard the state of the U.S. health care system described as being “on the verge of a crisis.” That the factors contributing to this crisis are the gathering of a “perfect storm.” I agree. And nowhere is that more true than in the states.

State Budget Deficits

Looming state budget deficits are predicted to reach \$60 to \$85 billion in state fiscal year 2004. The largest deficits in 50 years. And because Medicaid represents one of states' biggest expenditures, it is one of the most likely targets for cuts. These cuts could not come at a worse time. The economic downturn has added an estimated two million individuals to the Medicaid rolls – severely testing our nation's social safety net.

Nationwide, governors have proposed cutting eligibility, benefits, and provider payments. Just last week we learned that 16 states are cutting Medicaid benefits, 15 are restricting eligibility, and four are increasing cost sharing for our poorest and most vulnerable populations.

So what should we do?

In December, I proposed an economic stimulus package with a price tag of \$170 billion. My package was designed to deliver immediate, up-front stimulus, with virtually all of the spending in 2003. And it included \$75 billion in state assistance.

President Bush also has a stimulus package – a tax package costing \$674 billion that he hopes will revitalize the economy and spur future growth. Only \$39 billion of his package would be spent in 2003.

Now, this is not the appropriate forum to debate the merits of the Bush tax proposals. I supported the tax cut in 2001. And I agree with many of the tax cuts the President has proposed.

But I was disappointed that the President's package failed to provide any relief for states.

Some argue that “states got themselves into this mess, so states must find a way out.” I find that argument unconvincing. States lack the tools that the federal government has to maintain budget stability through economic downturns. And they also have a requirement – a pesky, inconvenient requirement – to balance their budgets each year.

Any plan that lacks a state relief component will ultimately fail to stimulate the economy. Attempts by Congress to spur the economy will fail if, at the same time, states are forced to raise taxes, cut spending, and eliminate jobs.

In addition to providing immediate relief to states, Congress should consider a policy to address Medicaid financing more broadly. Medicaid is a counter-cyclical program. Costs will almost always increase in bad economic times – at the same time state revenues shrink.

We should consider a policy that automatically increases the federal matching rate for Medicaid. When a state's economy hits certain triggers, it would be eligible for additional federal assistance. We already do this in TANF and for unemployment benefits.

Medical Malpractice

The recent trends of rising health care costs, increases in health insurance premiums, and state deficits are compounded by the crisis in our medical malpractice system. Many States have tried to control the growth in malpractice premiums. But with mixed results.

My state of Montana imposed damage caps a few years ago. Nonetheless, I continue to hear, on an almost daily basis, about the rapid rise in premiums.

Consider Pioneer Medical Center, an eight-bed hospital in Big Timber, Montana. Its premiums have risen from \$9,000 in 2001, to \$19,000 in 2002, to \$90,000 this year. A one-thousand percent increase over just three years.

Nationwide, in 2002, malpractice rates in the U.S. increased 25 percent for internists and surgeons, and 20 percent for obstetricians.

Such increases are clearly unsustainable, whatever their source. We must find solutions. Solutions that don't compromise patient safety, quality of care or access. And we must act quickly.

The Montana experience with strict caps on damages suggests that tort reform alone will not work.

This does not mean that some type of tort reform should not be part of the solution. But tort reform is not a panacea. We must address the malpractice problem intelligently and reasonably. We must look carefully at what the data tell us.

And one thing the data tell us is that swings in the insurance cycle affect malpractice premiums. Congress could play a role in stabilizing the insurance cycle. For example, a national reinsurance program could result in more fair and sound pricing.

Congress could also provide additional reinsurance subsidies or assistance for high-risk specialists or providers in under-served areas.

Part of a comprehensive solution also should address medical errors, as the Institute of Medicine suggests. The IOM proposes demonstrations that encourage providers to identify and admit mistakes, and to offer fair compensation to patients. In return for such offers, providers would be protected from certain litigation risks.

Medicare Prescription Drugs and Reform

While the issues I've described will generate much debate, I expect that the major focus of the Congress this year will be on Medicare prescription drugs.

We will also hear a lot more about Medicare reform. Bush administration officials have already hinted about their plans to make significant reforms to the program. And the President will likely outline a framework for reform next week.

In moving forward, the barriers to a compromise on Medicare fall into three categories: dollars, delivery system, and reform – which, as I mentioned, will play an even more prominent role in the debate this year.

Dollars

How much should we spend to deliver prescription drugs to seniors? The ten-year cost estimates of the drug plans considered last year in the Senate ranged from about \$340 to \$600 billion. That difference may sound like a lot. But I believe the gap can be bridged.

It goes without saying, however, that the less we spend, the less generous the benefit. And given what we know about seniors' expectations for a drug benefit, less in this case, is not more. In fact it could be catastrophic.

We must ensure that a new drug program provides a meaningful and affordable benefit – so that Medicare beneficiaries will participate. Otherwise, the program is doomed.

Delivery system

The second big sticking point. How should we structure the delivery model? The primary difference between the two different approaches can be summed up by answering the question of risk.

Should the government bear the risk for the benefit? Many Democrats contend this would ensure stability and uniformity. Or should competing private plans bear the risk for the benefit? Many Republicans contend this would mean better incentives for cost-containment.

It's interesting to note that the Democrats' proposal is not entirely public. It envisions multiple, competing private entities administering the benefit. And the Republicans' proposal is not entirely private. The government would bear some risk through reinsurance and direct subsidies.

Another point worth noting. Few, if any, private insurers have come forward and told Congress that they would be willing to participate in a Medicare drug benefit – even with reinsurance subsidies. An important point if you are relying solely on these plans to participate in order for the plan to work.

These disagreements on the ideal delivery model are not easy to settle. As someone who has worked hard to broker a compromise over the past few years, I can assure you that the issues are complex and the differences significant.

One seemingly obvious solution is to have both public and private entities compete. Government-backed plans with a standard premium and fixed benefits competing along-side private plans with varied premiums and actuarially-equivalent benefits. Let the most efficient and best option for beneficiaries prevail.

But this approach has been rejected by the Congressional Budget Office. In its capacity as the official cost estimator for the U.S. Congress, CBO has advised us that a side-by-side approach is the least efficient option.

CBO contends that private plans would only serve in areas where profit potential is highest – thereby driving up costs to the system as a whole. Not an unreasonable conclusion, but one that leaves us with fewer options for finding middle ground.

Today I want to make clear that I am willing to go down the road toward a private insurance model. But there are certain principles that must be met in order to create a system that works. For Medicare beneficiaries. For private plans. And for American taxpayers.

With that, let me present my vision for a compromise.

First, insurance risk should be phased in over time. This goal can be accomplished over a multi-year period with interim steps, providing a smooth transition and incentives to secure adequate plan participation. In the initial phase of the benefit, private plans would bear little, if any, insurance risk.

Over time, partial risk would be carefully phased in as plans build reserves and experience in managing drug costs for the Medicare population.

Second, the drug benefit must have a defined and strong government back-up system. A fallback. A safety net. A fail-safe plan that would enroll beneficiaries if two or more private plans are not available in a given area. This fallback plan should have a standard benefit and a national premium.

Third, a private insurance drug benefit should have extended contract periods of at least three to five years. This would ensure stability and more consistent options for beneficiaries. Some argue that plans should be free to come in and out of the program on a yearly basis. But I fear that such frequent plan turnover would be disruptive for seniors.

Fourth, plans should be required to serve large geographic areas of at least two or more states. This will ensure the availability of plans in rural areas – thereby protecting seniors in states with fewer beneficiaries.

Montana's population, for example, includes only about 140,000 seniors and disabled. These folks would be better off and have more options if the service area included multiple states. And for plans, a larger geographic service area will assure a broader risk pool.

Fifth, beneficiaries should be able to qualify for low-income assistance without being subjected to an assets test. Our experience with existing programs for low-income seniors is that the paperwork and humiliation of an assets test discourages participation. A senior citizen at 200 percent of the federal poverty level – less than \$18,000 in annual income for an individual – is not harboring substantial assets or living in luxury.

Finally, any compromise legislation should also have adequate consumer protections. Such protections include prohibitions against price gouging on premiums and co-payments. Ensuring that beneficiaries have access to drugs in every therapeutic class. And strong appeals protections to guarantee beneficiary access to medically-necessary drugs.

Medicare reform

Of course, many argue that a prescription drug benefit should not be enacted without also addressing Medicare reform. This issue has generated the least amount of attention over the past couple of years. But I predict that it will generate the most partisan wrangling from here on out.

We all know that Medicare could be improved:

- The current program does a poor job of managing care, focusing too much on acute care, not enough on prevention.
- There is significant regional variation in spending that cannot be explained by health status.
- And supplemental coverage distorts out-of-pocket spending and encourages over-use of services.

Many argue that the program also faces long-term financing problems. Medicare spending is projected to increase dramatically in the next thirty years due to a combination of factors. Rising health costs. A doubling of beneficiaries as the baby-boom generation retires. And significant growth in the number of “oldest-old,” who require more care.

These factors will all affect the long-term financial health of Medicare.

And yet, it may surprise the American public to learn that none of the reform proposals under consideration would address Medicare solvency.

Instead, the reform options on the table would focus on improving the cost-sharing structure for traditional Medicare benefits and increasing private plan participation in Medicare. In fact, many of these policies, at least in the short run, would cost money rather than save.

In recent weeks, the White House has talked about taking a more aggressive stand on reform. Early indications are that the administration may resurrect the notion of “premium support,” the reform proposal supported by a thin majority of the Bipartisan Medicare Commission in 1999.

Under this approach, Medicare would be fundamentally restructured. The current fee-for-service program would compete along-side private health plan plans. The federal government would contribute a fixed amount based on premiums charged by competing plans.

Beneficiaries who choose a lower cost option would be rewarded. Those electing a more costly plan would pay higher premiums – potentially much more than they pay now.

My concerns about premium support are two-fold.

First, given Medicare’s recent experience with Medicare+Choice, I do not support a reformed system based on managed care and private plans.

I recognize that many beneficiaries have been and continue to be satisfied with their plan. But in rural areas, where plans are sometimes paid 120 percent of fee-for-service, Medicare+Choice has still not materialized. Even the new PPO demonstrations do not hold much promise for Medicare beneficiaries in rural areas. The new plans are mainly serving areas that already have managed care plans.

In short, since Medicare+Choice has not fared well in rural areas, we must give careful consideration to the impact of reform proposals on those areas. Rural beneficiaries should not suffer increased Medicare premiums while having fewer choices than their urban counterparts.

Second, we do not have adequate risk adjustment or geographic adjustment methods to support this approach. Such adjustments would be absolutely necessary to protect seniors with chronic conditions and higher spending from the ill-effects of risk selection. These adjustments are also necessary to assure fair payments in both high-cost and low-cost areas.

Let me be clear: I do not and will not support a Medicare reform proposal that takes the program down the path toward premium support or privatization. It is the wrong solution and the wrong policy at the wrong time. It is an ideological and not a pragmatic solution for what ails Medicare. And it does nothing to prepare the system for future generations.

I appreciate the vision that my colleagues who champion premium support have for the program. But I do not share it.

Nor do I support reform efforts that would prod beneficiaries into managed care or private plans through stacked-deck policies providing enhanced benefits or lower premiums.

But I do agree that Congress must act soon to improve the program. On several fronts.

- We should focus on improving and strengthening the traditional fee-for-service program. The traditional program will continue to be the prevailing Medicare plan for a vast majority of beneficiaries under any reform scenario.
- Congress should improve coordination of care for the chronically ill. We should focus on disease management efforts that reduce costs and improve health outcomes for certain high-cost, chronic diseases. How to pay for such initiatives is another issue, and more research needs to be done. That's where all of you come in.
- We should build stronger incentives into Medicare payment systems to ensure that delivery of high quality care is rewarded. We should test new payment methods that reward providers for reducing the incidence of errors.
- We must continue our efforts to strengthen the administration of the program so that it serves both beneficiaries and providers well. Last year there were bipartisan bills pending in both the House and the Senate to improve Medicare's customer relations with health care providers. I intend to continue this effort and also work to improve the Medicare appeals system.
- Finally, we need to have an honest dialogue about the ability of our country to finance the retirement demands of the baby boom generation. It seems that we often take as gospel that Medicare is imbalanced and will soon become unaffordable. The problem is that these discussions are often based on incomplete information and partisan bias. Unless we have an open debate about the true burden of Medicare, efforts to improve the program and ensure our commitment to future generations will not succeed.

Let me add a final point on Medicare. Any Medicare bill that passes should have wide bipartisan support. The last major Medicare bill – BBA of 1997 – passed with 80 votes in the Senate. And the bill creating Medicare itself passed 70-24. Major legislation to create a new drug benefit and restructure Medicare should *not* be done through the budget reconciliation process.

For those of you not familiar with reconciliation and its implication, the method provides important procedural protections in the Senate. For example, legislation passed in the Senate under reconciliation rules is subject to limited debate and cannot be filibustered. It only requires 51 votes, not the 60 votes generally required to pass most legislation.

These procedural shortcuts were designed to pass

deficit-reducing legislation on a fast track basis. Reconciliation was not intended to routinely circumvent the time-honored rules of the Senate.

The day after the November elections, the *Des Moines Register* had a byline that read: “The winners’ choice; Will they stick with perpetual partisanship, or actually try to govern?”

This headline sums up the pivotal question Republicans in Congress and the White House face on Medicare. Will they choose a path knowing that there will be little Democratic support and pass a controversial bill by the smallest of margins? Or will they recognize that there is strength in numbers and reach out to Democrats?

I hope they choose the latter. I look forward to working with my colleagues toward the best possible outcome for our nation’s seniors and the future of Medicare.

Conclusion

And the same holds true for the problems I outlined earlier. Certainly the problems are many. Enough to keep you in business for years. But if we don’t work together, I do know this: we will be back here next year, re-hashing what went wrong.

Thank you for your attention. And thank you for your continued contributions to improving health care quality and access for all Americans. Regretfully, I am not able to stay to answer questions. My chief health advisor, Liz Fowler, will be on the next panel and will be able to answer your questions.