S. HRG. 106–231

# PRESIDENT'S PROPOSAL TO REFORM MEDICARE

## HEARING

BEFORE THE

## COMMITTEE ON FINANCE
## UNITED STATES SENATE

ONE HUNDRED SIXTH CONGRESS

FIRST SESSION

JULY 22, 1999

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

59–958—CC WASHINGTON : 1999

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-059871-0

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# PRESIDENT'S PROPOSAL TO REFORM MEDICARE

THURSDAY, JULY 22, 1999

U.S. SENATE,
COMMITTEE ON FINANCE,
*Washington, DC.*

The meeting was convened, pursuant to notice, at 2:13 p.m., in room 106, Dirksen Senate Office Building, Hon. William V. Roth, Jr. (chairman of the committee) presiding.

Also present: Senators Chafee, Grassley, Nickles, Gramm, Jeffords, Mack, Thompson, Moynihan, Baucus, Rockefeller, Breaux, Conrad, Graham, Bryan, Kerrey, and Robb.

The Chairman. The committee will please be in order.

Senator Moynihan. Mr. Chairman, before we proceed to the serious matters at hand, may I join my colleagues in wishing you a very happy birthday.

The Chairman. Thank you. [Applause.]

Senator GRAMM. I thought that was yesterday at the tax hearing. [Laughter.]

The CHAIRMAN. Needless to say, it is nice to be 39 again. So there are some things I would rather forget, but the alternative is no better in any event.

## OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Today represents an important milestone in our series of hearings on Medicare reform. For the past 4 months, we have been tracking the evolution of the Medicare program, examining its current status, and identifying aspects of the program in need of reform. We have identified various options for modernizing Medicare and strengthening it to meet the long-term challenges associated with the aging of a baby-boomer generation.

Today, the administration will join our ongoing association. And we are indeed honored to have with us Secretary Donna Shalala of the Department of Health and Human Services. I know the panel looks forward very much to your testimony.

And I also want to thank Mr. Walker and Dr. Crippen for joining us. We look forward to their analyses and observations.

Medicare reform is an incredibly complex undertaking. And it demands careful navigation of programmatic fiscal and political challenges. And as our committee begins to develop a reform package, the administration's views and technical assistance will be an im-

portant consideration. I sincerely hope the administration will rise to the challenge and work constructively with us to make responsible Medicare reform a reality this year.

We are familiar with the broad themes the President has set forth with regard to Medicare reform. The administration's goals are ones that we all share. For example, no one can deny that making Medicare more competitive and efficient should be a priority.

Similarly, it is entirely appropriate to modernize Medicare's benefit package. There is rightfully a great deal of attention focused on adding prescription drug coverage which if done properly, I support.

However, we have heard from numerous witnesses this year that more than this is required to truly put Medicare benefits on par with what is typical in private health insurance. These and other benefit improvements need to be coupled with improved incentives for efficiency with respect to deductibles and co-insurance for various services.

The administration's final goal extending the life of the Part A trust fund is more than a goal. It is a shared basic responsibility. And I would simply note that our stewardship over the fiscal stability of the Medicare program goes significantly beyond just adding revenues.

Our responsibilities are both deeper and broader. They encompass Part B as well and include creating an effective sustainable program design coupled with effective Federal administration and oversight. Despite our general agreement on principles, it goes without saying that the devil is in the detail whether we are talking about systemic reform or the structure of a new benefit. These details are what I am interested in today.

Secretary Shalala, I trust you will walk us through the specifics of the administration's proposal related to program reform because in earlier hearings we have taken the administration's testimony on broader budgetary and fiscal questions relating to Medicare reform. And we hope that today we would focus specifically on Medicare program changes.

With that, I would like to recognize Senator Moynihan for any comments he may care to make.

Senator MOYNIHAN. Mr. Chairman, might I yield my time to Senator Rockefeller?

The CHAIRMAN. Senator Rockefeller?

## OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Thank you, Mr. Chairman. And thank you particularly, the senior Senator from New York.

Welcome, Secretary Shalala. And I am very happy that we are at last here to talk about the President's proposal for Medicare reform.

I spent a year, probably not the happiest year of my life, on the Medicare Commission. I learned even more about the demographic problems that face Medicare. While Medicare has done a good job with keeping pace with private sector cost, something not realized by most people, in fact, it has outperformed the private sector, the

fact is that the population covered by Medicare will double in the next 30 years.

In order to cover this increase in population and maintain our promise to American seniors, we have no choice but to either dedicate more revenue to Medicare or drastically cut benefits. There is no in-between position.

One of my main objections to the proposal from the Medicare Commission came out of the Medicare Commission's decision to completely ignore the possibility of spending any new revenue on Medicare and thus doom it. Under that plan, Medicare benefits would have surely been slashed over time. It is an unacceptable solution.

The President's package of reforms responsibly addresses the demographic problem by dedicating part of the surplus to shoring up Medicare. In stark contrast, the majority of this committee voted yesterday for a nearly $800 billion tax cut package that will soak up all of that surplus and make it impossible to sustain let alone strengthen Medicare.

If the Republican tax package were to become law, it would have, let me say as clearly as I can, a devastating effect on Medicare beneficiaries and the millions of Americans who rely on that program. Medicare is a social insurance program, always has been.

When the program first began, as we all know, 50 percent of seniors were not covered by any health insurance in this country. The market decided they were too risky and did not cover them. That is why Medicare was created.

Even today, the private sector is highly unstable for Medicare beneficiaries. Medicare+Choice withdrawals, we have seen recently are evidence of that, another 250,000 I believe within the last several days were dumped.

Elderly and disabled people need to have a safety net that does not go away when they get sick. The President is right to propose a prescription drug benefit for all Medicare beneficiaries.

We all know insurance pools need to have both healthy and sick people in them, the way it originally was with Blue Cross before there was a Blue Shield. You made money on some, you lost on others, but everybody was in the pot.

By offering prescription drug coverage to all beneficiaries, the President is helping to reduce costs for beneficiaries while maintaining Medicare as a universal benefit.

Currently, because Medicare fails to cover prescription drugs, far too many seniors, and I would obviously first think of the ones I represent in West Virginia, but this would be true in Texas, Louisiana, North Dakota, New York, Delaware, and everywhere else, are paying for the medication themselves or they are not taking it or they are not eating and are taking it, but it is out of their pocket.

A universal prescription drug benefit would be of great significance to tens of millions of these people. I would say respectfully that Senator Kennedy and I have also struggled with how best to provide prescription drugs to Medicare beneficiaries.

Our plan, like the one before us today uses competition, not the government through pharmaceutical benefit managers to gain volume discounts in the market place. However, our plan also went

one step farther by offering a cap on out-of-pocket spending. This is one area where I think the President's plan could use improving.

Over the past year, I have spoken strongly and too strongly perhaps in my arguments against risky Medicare reform proposals. My main concerns have always been focused on how these changes would impact the people that we have as a Nation committed ourselves to protect, Medicare beneficiaries.

The President has taken the best of our work on the Medicare Commission from the past year while rejecting more risky approaches to reform. I commend the President for his efforts and look forward to working with my colleagues on this legislation. And I thank the chairman of my full committee and chairman of my side of the committee.

The CHAIRMAN. Thank you, Senator Rockefeller.

Now, Secretary Shalala, you obviously need no introduction. Again, let me welcome you. We are pleased to have you. I look forward to your remarks. Please proceed.

**STATEMENT OF HON. DONNA E. SHALALA, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC**

Ms. SHALALA. Thank you very much, Mr. Chairman, Senator Moynihan, and distinguished committee members. And again, happy birthday. Mr. Chairman, you actually share a birthday. You will note that HCFA Administrator Nancy Ann Min DeParle. She and her husband, Jason, had their first child at 12:30 a.m. this morning, a baby boy, 7 pounds, 12 ounces and 21 inches long.

The CHAIRMAN. I am both older and weigh more.

[Applause.]

Ms. SHALALA. As I said to my colleagues, and NASA has not been able to get their shuttle off yet, but HCFA was able to produce a bouncing baby boy this morning. We obviously are very pleased to be here. And my testimony requires considerable detail to explain the President's plan, but I will do it as briefly as I can. I submitted a longer testimony to the committee.

The CHAIRMAN. It will be included as if read.

Ms. SHALALA. Thank you very much.

[The prepared statement of Ms. Shalala appears in the appendix.]

Ms. SHALALA. I am very pleased to be here to discuss President Clinton's plan to modernize and strengthen the Medicare program and prepare it for the challenges ahead.

As Americans, we can all point with great pride to the legacy of the Medicare program, but if we are to keep the promise of Medicare for future generations, then a program designed in the 1960's must be modernized and strengthened to meet the challenges of the 21st century. And that is what we have tried to achieve in this proposal.

When the President took office in 1993, Medicare actually was projected to go bankrupt this year, 1999. But working with the Congress, the President has supported reforms that along with a strong economy have resulted in a projected trust fund solvency through the year 2015.

We are all gratified by the good news. And Congress should be, too. It indicates that together we have extended the life of the HI Trust Fund by a full 16 years and cut the 75-year actuarial deficit by 66 percent.

Several factors, of course, contributed to Medicare's good news. First, of course, our robust economy has held increased payroll tax revenue into the trust fund and held the line on health care cost increases.

Second, the department's rigorous management of the trust fund and our bipartisan work together to attack waste, fraud, and abuse in the program have returned more than $1.2 billion to Medicare in the last 2 years alone.

Third, the bipartisan Balanced Budget Act of 1997, we share the concerns that many members have expressed that BBA may have had untended effects. The President's plan incorporates a substantial reserve fund to address some of those effects.

But at the same time, I think that we all agree that the BBA made necessary and long overdue changes in the way Medicare pays health care providers and in the incentives we provide for important prevention services.

But if we are to strengthen and modernize Medicare for the future, we still have to do a lot more. The fact is that over the next 35 years, the size of the Medicare population.

The fact is that too few beneficiaries have access to affordable prescription drug coverage. And the fact is that in far too many instances, Medicare is prohibited by law from using market forces that could clearly make it more efficient.

By building on the work of the bipartisan commission on the future of Medicare, the President's plan responds to each of these issues. And in that regard, I want to recognize the leadership of Senator Breaux and thank the other members of the committee who served on the commission: Senator Rockefeller, Senator Kerrey, and Senator Phil Gramm.

The President's plan has three specific goals: to make Medicare more competitive and efficient, to modernize the benefit package including a long overdue prescription drug benefit, to extend the life of the Medicare Trust Fund to 2027.

I mentioned earlier that we have already enacted reforms that have helped to save hundreds of millions of dollars and extended Medicare solvency to 2015. The President's plan builds on this achievement.

As you know, Medicare has too often been barred from engaging in competitive practices that the private sector routinely uses to improve patient care, to improve quality, and to cut cost. We believe that it is time that Medicare had access to the same strategies to provide the highest quality care using the fewest taxpayer dollars.

In short, we need to finally be able to recognize and reward high quality health providers, in addition by increasing competition among contractors and fostering pertinent purchasing. The President's plan would dramatically improve the current payment system, a system which has too often led to excessive payment rates in many parts of the country and lower rates in others.

The President's proposal would also extend competition to Medicare managed care plans while maintaining a viable traditional program. Plans would be paid for covering Medicare's defined benefits, including the new drug benefit and would compete over cost and quality. This would save money for both beneficiaries and for the program.

The President's plan also sets aside $7.5 billion for adjustments to the BBA that may be necessary to smooth out payment reforms affecting beneficiaries' access to high-quality care. We will work with Congress and others to identify real access problems and to craft appropriate solutions.

Even though the BBA severely constrained our administrative flexibility, the President's plan includes several adjustments to moderate its impact on the ability of providers to deliver quality care. And these adjustments will help hospitals, particularly rural and teaching hospitals and home health care agencies.

The President's plan also includes important provisions to improve Medicare management. And chief among these is the establishment of a management advisory council to help identify and implement innovations in customer service, in purchasing, and in management.

But these steps to make Medicare more competitive and efficient simply are not enough to fully prepare the program to face the challenges ahead. We must also modernize benefits to include services that have become essential elements of high-quality medicine. In particular, we must include an affordable prescription drug benefit that is available to all beneficiaries.

As this committee knows, when Medicare was created, no one could have imagined the role that prescription drugs eventually would play in modern medicine. In fact, Senator Moynihan has showed Merck books from 1965 and to the present day. But despite their proven value, too many older and disabled Americans simply cannot afford the prescription medicines that they need.

Let me be very clear. In the wealthiest Nation on earth, a prescription drug benefit is not an option, but an obligation. And that is why the President's plan provides all Medicare beneficiaries with access to affordable, comprehensive coverage for prescription drugs.

The new drug benefit is also completely voluntary. If individuals have better prescription drug coverage, they can stay with it. It is important to remember, however, that at least 13 million Medicare beneficiaries, 1 in 3, have no coverage at all. Fifty-four percent of those without coverage are above 150 percent of the poverty line.

Millions of others who now have coverage are finding it expensive and unstable with benefits eroding over time through deductibles and premiums. And that is why our plan includes incentives for employers that currently offer retiree coverage to maintain it.

About 60 percent of the total cost of this new drug benefit will be offset through savings. The remaining cost would be offset by dedicating less than one-eighth of the amount of the surplus dedicated for Medicare under the President's plan.

The plan makes several other necessary benefit improvements to promote prevention, to rationalize cost sharing, to allow access for people over 55, to improve the coordination of care for beneficiaries

also enrolled in Medicaid. As you may notice, the plan also builds on proposals to promote disease prevention and health promotion put forth by Senator Bob Graham and others.

The President's plan also takes steps to offer coverage to older Americans who now lack any health insurance. All of our efforts to modernize Medicare will result in new efficiencies and competition. That means substantial savings.

But no responsible savings policy can address the fact that America's elderly population will double within the next 30 years. Because of this and his strong belief that the baby-boom generation should not pass Medicare's financing crisis onto its children, the President has proposed that a significant portion of the surplus be dedicated to strengthening the program.

The President's plan dedicates 15 percent of the budget surplus to the program for the next 15 years. This will ensure the financial health of the trust fund through at 2027.

It does not create an unlimited attack on general revenues, but instead invests a fixed portion of the surplus in Medicare to cover the temporary but overwhelming influx retirees.

Let me say again that Medicare's improved financial outlook has in no way diminished the pressing need to strengthen and modernize the program. For many older and disabled Americans, Medicare is not a support system. It is a lifeline. And we must ensure that it is never broken.

We have the hard work of the bipartisan commission on build on. We have the President's thought, clear, and detailed plan before us. And we have a responsibility to seize the opportunity and act now while there is no climate of crisis to distort our vision.

Mr. Chairman, before I conclude my presentation, I would like to briefly refer to several charts that help to emphasize the importance of providing an affordable prescription drug benefit for all beneficiaries.

In chart 1, the sources of drug coverage for Medicare beneficiaries, first of all, that means that about one-third, 34 percent have no coverage at all. Among those with coverage, beneficiaries use the combination of private insurance and public programs.

These sources of coverage vary widely in quality and are often subject to change. For example, employers may discontinue retiree health benefits, managed care plans may withdraw from service areas, and Medigap premiums may rise to unaffordable levels.

For public coverage, about half of those with coverage get that coverage through public programs, including Medicaid-Medicare managed care and the State Pharmacy Assistance Plan.

While Medicaid drug benefits are generous, only about 12 percent of Medicare beneficiaries receive drug coverage through Medicaid. And eligible criteria varies State by State so that not all beneficiaries have the same opportunity for coverage.

In fact, that is the story of public pharmaceutical benefit coverage.

I do not know how Senator Gramm and Senator Mack explain to Senator Conrad and Senator Nickles why the Government of the United States provides pharmaceutical benefits in their States if people joined managed care plans, but if you are in a State that has no managed care plans or very few of them, there is no chance

of getting a pharmaceutical benefit through a government program, specifically through the Medicare program.

The unevenness of how the public programs work and of the Medicare program in particular and the fairness of it ought to be of great concern to us.

For private coverage, 32 percent of Medicare beneficiaries have private insurance for drug coverage. That is really the employer-sponsored retiree health benefit plans and Medigap policies that include drug coverage.

And in 2000, about one-fourth, 24 percent of all beneficiaries will get drug coverage through plans of their former employees.

On chart 2, you see a lack of coverage for prescription drugs is a problem for Medicare beneficiaries at every income level. In fact, here is the point of why we cannot just take care of the poor. In the year 2000, 54 percent of beneficiaries without drug coverage have incomes over 150 percent of poverty.

In chart 3, it tells you something about where they live. In the year 2000, 48 percent of beneficiaries living in rural areas will not have any prescription drug coverage. Rural beneficiaries generally have more trouble paying out-of-pocket costs for drugs because they are somewhat more likely to have incomes that are pretty low and lower than their urban counterparts.

So this is not a problem of just the poor. It is a problem of the middle-class. It is a problem of where you live. It is a problem of whether you get to participate in a managed care plan or not. It is a problem of how we pay now for managed care.

If we overpay so that a plan can provide extra benefits, as we do in places in Florida, people get into managed care and are attracted to it because of the pharmaceutical benefit. But if you live in rural America or in a place where there are not many managed care plans, you do not have a chance to get a shot at a pharmaceutical benefit.

So this is an issue of fairness. Should geography determine the qualify of your health care? Is justice to be determined by geography in this program? Or are we going to provide fairness and a critical health benefit?

The first justification for pharmaceuticals is because it is important for health. But second, if we are going to provide it, we must provide it fairly. Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Madam Secretary. Madam Secretary, the Progressive Policy Institute which, of course, is the central Democratic think tank has suggested four changes that would greatly strengthen the President's proposal: first, set up a Medicare board to run the competitive system for health plans that would eventually encompass the traditional fee-for-service plan; second, direct HCFA to develop a comprehensive business plan for the traditional fee-for-service program in order to modernize its benefits, to improve its servicing quality, and to set up payments so that it could be competitive with private plans; and, three, limit prescription drug coverage to low-income beneficiaries or set a fair limit on the amount of the general revenue to be used for Medicare.

Would you please comment on these suggestions and how they might——

Ms. SHALALA. Well, if I might do it quickly. I think I have responded to the pharmaceutical drug coverage. If we focus it just on low-income beneficiaries, then we have a number of choices. We will leave out large numbers of people. We will continue the benefit to people who are high income just because they live in an area where there is managed care and it is provided through a managed care company.

It seems to me that for us to focus now on just low-income beneficiaries, we have got a large number of people who do not have access to pharmaceutical benefits and who are in fact middle class. And I have responded to that.

On the issue of setting up a medical board to run the competitive system for health plans that would eventually encompass the traditional fee-for-service plan, I would suggest that the competitive system that we recommend does not separate fee-for-service from managed care.

In fact, managed care competes against fee-for-service and competes on the basis of price and quality. And you should not want to split up that responsibility nor should we want to split the bureaucracy and create an independent new bureaucracy.

And I would think that all of us would be very concerned about transferring essential government functions that millions of seniors depend on to any kind of a private sector entity. Maintaining eligibility and enrollment records go to the heart of the entitlement of the health care system. And turning that over to a private sector board, I think we ought to be very wary about that.

The CHAIRMAN. May I——

Ms. SHALALA. And the final point about——

The CHAIRMAN. Let me interrupt if I might.

Ms. SHALALA. Yes.

The CHAIRMAN. Two points, as I understand it, the recommendation is not that the medical board be necessarily private. It could still be government, but be independent.

The other point is on the competitiveness. As I understand that, the reason they raise a question there is that there is no limit of cost as far as fee-for-service is concerned which is contrasted, of course, with the HMO programs.

Ms. SHALALA. Well, let me say a couple of points about that because one of the things they recommend is a comprehensive business plan for the traditional fee-for-service program to both modernize its benefits, and to improve its service and quality.

Within the President's plan, we in fact modernize fee-for-service. We would introduce prudent purchasing—reducing fee-for-service costs by introducing competition throughout the fee-for-service Program. One way to introduce competition is through Centers of Excellence, to actually award beneficiaries that go to places for treatment and for surgery, for example, that provide both lower price and quality. Another method is introduction of PPOs which is another private sector approach to reducing costs.

So there are substantial reforms for the first time in the history of fee-for-service program that I think reflect both private sector business practices and will hold down fee-for-service costs.

Again, going back to my testimony, we have been quite successful at holding down fee-for-service costs through a variety of different steps that we have taken.

Fee-for-service costs have grown below that of the private sector. And as you know, a combination of things have been done to get there, including extensive efforts to go after waste and fraud.

The next steps are to allow us to use private sector business practices in fee-for-service as well as economic incentives to reduce fee-for-service costs and to let managed care compete against fee-for-service so that managed care bids on the same benefit package. This can reduce the actual premium that an individual pays as a way of enticing them into managed care because it will be less expensive for them to go into managed care which over time, of course, will reduce the government's overall cost.

The CHAIRMAN. Do you want to comment on a limit of the amount of general revenue?

Ms. SHALALA. Well, we do have a limit of the amount of general revenue. I mean, in fact, the Congress of the United States sets a limit of the amount of general revenue based on what we are willing to spend.

And I think that we keep the amount of general revenue in this program down for the Part B premium in particular through a combination of these efforts plus we would index the Part B premiums. So as the cost of living goes up, the contribution from the individuals will simultaneously be covered.

So I think that we have done a good job of keeping down Medicare costs. We have a couple of problems ahead of us. Unless we are prepared to continue the fiscal discipline, costs will start going up on us after 2003. And number 2, unless we are prepared to put new money into the system, we cannot take care of the doubling of the population.

The CHAIRMAN. I would like to go back to a point I raised earlier for further comment. Now, the President has proposed a new competitive pricing system for Medicare private managed care plans. That does not include a requirement, as we said earlier, for the original Medicare fee-for-service program to compete as well.

I am not clear. How would you ensure that plans which will be receiving competitive capitated payments will not be disadvantaged compared to the traditional program which will continue to have an open-ended benefit with no budget constraints?

Ms. SHALALA. Here is how it works. First of all, the managed care plans are setting the price themselves. This is true price competition. They are setting the price themselves. And we are comparing apples with apples because the price they set is based on a standard benefit package.

So everybody is competing on the basic benefit package which is the comprehensive benefit package of Medicare, plus the prescription drug. They bid against the average fee-for-service cost in their area. And for every dollar they bid below, beneficiaries keep 75 percent and the government gets 25 percent.

The beneficiaries then can use the savings to buy back benefits they want to add. But the important point here is that the managed care plans themselves set what they want, set the bids them-

selves. We do not dictate the bids. But they are bidding against the average fee-for-service cost in their area.

The advantage of this is that we are offering positive economic incentives for people to move into managed care. And what is the incentive? Their premium comes down. They have less out-of-pocket spending because they have a lower premium than they would have under fee-for-service.

And they get that lower premium because they choose a managed care plan. The managed care plans can bid with zero premium. And that means that they would attract probably large numbers of people in their community.

But they get their market share through a bid that they determine. They determine what their bid is. And they all can participate. Each of them will have different bids.

The CHAIRMAN. Well, I just have to say——

Ms. SHALALA. It is true price competition.

The CHAIRMAN. Well, I just have to say I find it hard. I see competition among the managed care programs, but I find it very difficult to see how there is genuine competition between those programs and the fee-for-service program.

With that, I will turn it over to Senator Moynihan.

Senator MOYNIHAN. Mr. Chairman, just two general points. On the baby boom and all the facts and so forth, there was indeed a period there, post-World War II. In 1950, the fertility rate was at 3.03. By 1975, it had dropped in half to 1.77. And it has never gotten back to more than to 2.4. We have a bulge which is not necessarily going to continue. Is that right?

Ms. SHALALA. That is correct. And that is precisely what we are proposing to finance, the bulge.

Senator MOYNIHAN. The bulge.

Ms. SHALALA. By using the surplus to finance the bulge which is the doubling of Medicare beneficiaries between now and 2035. And this proposal achieves solvency through 2027.

Senator MOYNIHAN. But that does not go on indefinitely?

Ms. SHALALA. No.

Senator MOYNIHAN. That is a point to be made. Just to comment, not to rouse Senator Gramm's enthusiasms too much, but you speak of private sector business. There seems to me to be an increasing in public administration that you might want private sector business principles, but you cannot pay private sector salaries. And the rewards are not there.

And it seems to me to put a limit on what large organizations can do in government that do not have particular military rewards, as it were. I will leave you with that thought.

But the President in speaking about the 1997 Balanced Budget Act said this is the reason all these teaching hospitals are in trouble today—all these teaching hospitals are in trouble today.

Just a moment's anecdote, in 1974 as the Senate Finance Committee began to deal with health care, I realized I did not know anything about the subject. And I asked the head of Sloan Kettering, Paul Marks, if he would put on a little seminar for me. We met at 10:00 o'clock. And at about 10:15, the dean at Johns Hopkins said, you know Minnesota may have to close its medical school.

And then, I realized I have heard something. Minnesota is where all the Swedes went. And they do not close medical schools. They open medical schools. Now, how could this be? And he then explained that managed care was moving from the west coast to the east coast. It reached the high plains. All the good citizens had signed on.

And managed care does not send patients to teaching hospital. Absent a teaching hospital, you cannot have a medical school. And that seems to me a crisis of huge proportions, I mean, a real crisis, a change in the structure that created these schools and maintained them, the best in the world.

They were hit by the 1997 proposals as if we did not notice this was happening. We had already heard in this committee the phrase "the commodification of medicine," "the arrival of markets in medicine."

And these particular institutions are what economists call public goods. A public good is something everybody shares. So nobody will pay for. And that is really what government is all about.

Right, Phil? Yes. That is why you have the army.

Senator GRAMM. Stay close to the mike, Pat. This is good stuff people need to hear. [Laughter.]

Senator MOYNIHAN. But what are you going to do? You do not seem to have a concentrated concern about the most important institutions in the whole medical system. And the President now is talking about. And can you help us there?

Ms. SHALALA. I hope so, Senator. They are not only public goods, they are magnificent public goods. And they are absolutely critical, both to the success this country has had in this particularly golden age of biomedical research because they are infrastructure, of course, these investments in the National Institutes of Health as well as the private health care company investments.

And so we need these institutions in particular. And as you indicated, they have no peer. I mean, Germany has Max Pont. Japan has Keoto. England has Cambridge. But no other country in the world has the kind of concentration of great academic teaching hospitals.

And as you point out, the changing nature of the health care system, in particular the fact that they have had to take the deep discounts that managed care has negotiated with the private sector, has created for them an untenable situation and as the government moved in to more accurately pay for the patients that it was responsible for.

We did some things in the BBA. As you know, we pulled out some of the direct and indirect medical costs from the managed care to pay them directly. In this plan, we take the disproportionate share payments proposal (that you have had over the years) out to give it to the teaching hospitals and the other disproportionate share hospitals.

The President has set aside, as I indicated, $7.5 billion. There are a number of kinds of institutions that will make proposals. We must look carefully with the Congress at where there is evidence that there is a lack of access, but also that we have institutions that are important to our future that we will want to invest in.

Nursing homes, home health care, other hospitals, everybody is going to want to make a claim.

For these institutions in particular, if I might make a private point since I ran one, concentrating just on Medicare, point that you have made before as a way of fixing what are important and significant institutions may not be the only thing we need to do because they are in fact a public good.

Senator MOYNIHAN. Because something new has happened.

Ms. SHALALA. If they are in fact a public good, then the narrow base of Medicare may not be sufficient for this country. And we have to understand the seamlessness of both the institutions, the work they do from our investments in the NIH through the institutions themselves.

So I would say to you that as we work through application of this amount the President has set aside, these institutions obviously are very high on everyone's list. They are for me the most important institutions for the future of health care.

And I think frankly, whether Senator Gramm would agree or not, they may be the most important institutions for the future of our economy because our investments in biomedical research are very much responsible for some positive changes and the growth in this economy that simply do not exist elsewhere.

So obviously, the President and this administration shares your concerns. We have done some things already, some very specific things in this plan. And we have set aside some resources for the teaching hospitals as well as for some unintended consequences of the Balanced Budget Act that we must together go through extremely carefully.

Senator MOYNIHAN. Could I ask that you might send us a paper on teaching hospitals in the President's plan? Thank you.

Ms. SHALALA. I would be happy to do that, Senator.

Senator MOYNIHAN. Thank you very much.

The CHAIRMAN. Senator Grassley?

I would like to say to limit questions to five minutes. We have a large number here. And of course, we have a second panel.

Senator Grassley is next.

Senator GRASSLEY. The Chairman has identified over $200 billion out of this surplus for Medicare reform and for prescription drugs. So I think we are all talking about supporting some sort of a prescription drug program. And we would like to work with you on that, but we have some questions about your plan. And you might have some questions about some of our ideas as well.

I only say that the chairman has identified that amount of money because we voted a tax bill out of committee yesterday. And the other side of the aisle was giving speeches on the floor of the Senate this morning, denigrating that effort and saying that there was not any effort to be worried about prescription drugs and Medicare reform and saving any money for that. But we have saved money for that.

So I think that is just plain wrong to be speaking in terms of that when our chairman has been very careful about this approach of a tax decrease and still having money for Medicare.

I have five questions I want you to listen to as I give them with some explanations in between before you answer any. One of my

concerns with the President's proposal is that it will encourage employers who currently offer retirees prescription drug coverage to drop the coverage.

Can you describe the rationale for paying employers to provide what they already offer and to give them this subsidy in addition to the tax break they already have?

Second, does this make sense to spend tax dollars this way on a Medicare program that has major financial hurdles already to overcome?

Third, so why not target the benefits to those low-income seniors who need it and who need it most and who are the least likely to get an employer-sponsored coverage?

Now, before I ask my fourth and fifth questions, I want to express concern for individuals who not currently have the benefit of receiving prescription drug coverage through their employer. These plans tend to be more generous and the most coverage available to seniors.

So fourth, we also know that employers are starting to scale back some of this coverage. And do we want to encourage the scale back even further by replacing this with a much less generous Federal benefit?

And then, lastly, how did you determine what employer subsidy would be adequate to ensure that this would not occur. And what assurances can you give us that the subsidy, if it is justified would be enough?

Ms. SHALALA. Those are a very good set of questions. Let me see if I can answer them quickly. First of all, our goal was to minimize the crowd-out of employer coverage, exactly what you are talking about. How do we stop the slide of employers dropping drug coverage for their future retirees? What can we do to offer some incentives?

Under our proposal, we provide a direct subsidy to an employer's health plan that provides a comparable or better drug coverage, that is one-third smaller than what the government would otherwise pay for drug coverage of a Medicare beneficiary, about $16 a month.

So we would provide a smaller subsidy to try to stabilize that part of the market. And what we are trying to do here is not introduce a highly centralized program, but to build on what is out there.

So we directly subsidize retirees' plans by giving a smaller amount of money to employers as a way of stopping that slide of their dropping drug coverage and a way of getting some basic coverage across the country so that everybody has the same basic coverage. And many employers will, of course, add a better benefit.

Senator GRASSLEY. What about the fact that if we are spending money for this, would it not be better to spend that money on strengthening the Medicare program as opposed to subsidizing a present corporate plan?

Ms. SHALALA. Well, I think that what we are trying to do here is to add a benefit for everyone and to build on what already exists out there. In this case, it is not like some people, as my chart demonstrates, do not already have some coverage through a variety of different means.

So rather than superimposing a single plan run by the government, we take advantage of contributions that the private sector is already making in this case. And in the case of HMOs, those that are already providing the benefit, they will also get a payment that will stabilize them because they are also dropping coverage.

Every health plan in Florida that dropped out of the Medicare program had a drug benefit. And so those people, if they do not have another HMO to go to, are forced to go to fee-for-service and so making sure that managed care has a drug benefit, that people who get into their retirement plans have a drug benefit, as opposed to simply saying everybody that gets a drug benefit, and getting private sector money out of the system.

So it really is an attempt for the government not to have to pay for everybody who now gets it another way. Rather we would stabilize access to a drug benefit out there because this is a health decision, not a financing decision. We believe that no one would design a Medicare benefit today without drug coverage. So we want to make sure that everyone gets it.

Senator GRASSLEY. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Rockefeller?

Senator ROCKEFELLER. Mr. Chairman, I would yield my time to Senator Graham who has to be on the floor very shortly, if that is all right with the chairman.

The CHAIRMAN. Fine. Senator Graham?

Senator GRAHAM. Thank you very much, Mr. Chairman. And thank you, Senator, for your courtesy. I would like to ask basically two questions. The first is injecting competition into the HMO plan.

I personally believe that competition through competitive bidding is a critical new step. It is a key to bringing some of the efficiencies of the market place into health care. It is also a key to the fairness of distribution of availability of HMOs.

It is, I think, patently absurd to continue to use essentially a price list based on what fee-for-service medicine within the particular county happens to be and make that the essential element in how you reimburse health maintenance organizations.

And I would just say that Senator Mack and I did not have a conversation with Senator Nickles or Senator Conrad. We can have a conversation within our own State because we have had a list of some 20 counties that have seen a dropping of their HMOs. And now, four counties are called orphan counties in that there are no HMOs that people can sign up with. So within a single State, there are these problems.

This brings me to a point that a very serious thing happened last week when, and I would like to ask my colleagues how many were aware that, in an amendment that was part of the final so-called wraparound amendment on the HMO Patients Bills of Rights, we repealed not only the authority of HCFA to undertake the two demonstration projects in Kansas City and Phoenix, we prohibited the establishment of any additional demonstration projects.

And then, we said any future competitive programs had to be voluntary. Well, these HMOs are not going to voluntarily sign up for a plan that is economically, they consider, less advantageous than the current price list.

How many of my colleagues were aware that we did that in the HMO Patients Bill of Rights?

Senator NICKLES. Yes, I was aware of it.

Senator GRAHAM. Well, we have one person aware.

The CHAIRMAN. I was aware of it.

Senator GRAHAM. We have two people aware of it.

Senator NICKLES. No, there are a lot of people who knew it.

Senator GRAHAM. Well, you might not want to have your fingerprints too visible on that. But it was absolutely counter to everything that we say we profess in terms of fairness of HMO availability and in terms of using the market place.

I would like to ask in light of that, Madam Secretary, where do you see the future of competitive bidding for HMO reimbursement levels?

Ms. SHALALA. Well, from our point of view, we must do it. First of all, there is just no other substitute other than the old fashioned way in which we have been paying for this Medicare program. We have to have true price competition. And that competition has to be between fee-for-service and HMOs.

The difference between what we did and Breaux-Thomas is we actually put positive economic incentives. That is what the HMOs are able to do is to actually submit their prices in a way in which they drive down the cost to the beneficiary. And so they will compete. And the beneficiary will save their costs for their premium in particular.

But your point about competition is very true. As you know, we are having a very successful and competitive program with durable medical equipment in Florida in which we are demonstrating that we can save at least 10 percent if we go to competitive bids.

You are about to hear from Dr. Crippen. And he actually has written in his testimony, unless he has changed it, that he has no confidence in the political systems' willingness to allow the government to go to these kinds of competitive reforms, prudent purchasing.

He thinks that given the experience of stopping us every time that we wanted to go out to a competitive reform that there will always be interference by elected officials and lobbying by the providers to prevent us from getting competitive reforms.

I do not share his view, I have to say that. I think that once we go to these national kinds of reforms, once we agree that this is the way in which we are going to get improved, more accurate pricing and we are going to introduce true price competition if we do it across the board, we are going to be able to do it, but we must do it.

We must do it. We have no other way of controlling costs other than true price competition in our judgment.

I have a limited list written into law of who can process claims for the Medicare claims, a limited list of insurance companies. There are lots of businesses in this country now that could process those claims. It is very difficult for us to fire anyone because our list is so short in terms of who can hire.

It is difficult for us to work with contractors when we are limited in our ability to work with those contractors.

We have already demonstrated in the Medicare program that we can bring down cost, that we can reduce rates. We have cut our error rate in half in fee-for-service which no one ever expected the Medicare program to do.

So I can only plead with the Congress to give us these reforms to negotiate with us for competitive reforms so we can go out and get the best prices for the taxpayers.

Senator GRAHAM. I would just conclude here. I think it is instructive that no member on the Democratic side was aware of this provision and only two on the Republican side were aware. And I hope that the department does not give any undue weight to such a stealth attack that was launched against this very important program for the future of Medicare.

Senator NICKLES. Maybe, we should do some of those because every State that had them did not want them.

Senator GRAHAM. We have done in Florida, Senator—as the Secretary just said, Senator Mack and I did not cave in to the providers on a competitive demonstration project for durable medical equipment in Lakeland, Florida. And we are getting 15 to 20 percent lower costs because we are using the market place.

Ms. SHALALA. And demonstrating that small businesses can participate in this kind of competition, that it does not exclude small businesses. In fact, the major number of contractors in Florida are actually small businesses.

Senator NICKLES. But you are talking about——

Senator GRAHAM. Any comment you want to make on that, Senator?

Senator NICKLES. I would be happy to. The competition in durable medical equipment is a little bit different than the mandates that were imposed both in Arizona and I believe in Pennsylvania, all of which where the city council and others were saying we want out of it or we want it to be voluntary.

Senator GRAHAM. Yes.

Senator NICKLES. And frankly, that is the way we left it in the amendments to say that it would be voluntary.

Senator GRAHAM. Which means that you will never have competitive bidding because why would any provider which currently has a price list that guarantees them essentially a percentage of fee-for-service ever want to go into the competitive bidding process? They are not that stupid.

Senator NICKLES. Well, we will debate this another day. I just say that the competition was not even between fee-for-service and managed care. The competition was only with managed care versus managed care.

Senator GRAHAM. The way in which the managed care premiums are currently established is a percentage of the fee-for-service. So the question is, do you want to have a continued price list or do you bring market place competition into HMOs.

The CHAIRMAN. The time is up. We are going to have to proceed. Let me point out that we also canceled plans in the past in Maryland and Colorado because of the complaints on their Congressional delegations.

Senator GRAMM. Would the Senator yield for 20 seconds so I can give a point of information?

The CHAIRMAN. The Senator from Texas will have time in a few minutes.

Senator GRAMM. All right.

The CHAIRMAN. So we will now turn to Senator Nickles.

Senator NICKLES. Actually, the Senator from Texas was next. He beat me here by 2 minutes.

The CHAIRMAN. Well, they put the list this way. And I would like to follow it.

Senator NICKLES. All right. I will follow through.

Madam Secretary, I appreciate your coming to us today and trying to explain the President's proposal. Let me just make a couple of comments. The President yesterday in a press conference stated the following. And it sounded a lot different than what you said today.

The President said: "Tomorrow, I will release a report that shows that there is a great and growing need for prescription drug coverage. What the study shows is that 75 percent of our older Americans lack decent and dependable private sector coverage of prescription drugs. That is three out of every four seniors." And it goes on.

Now, I think I heard you say that two-thirds of seniors do have some form of prescription drugs. Is that correct today?

Ms. SHALALA. I did say that. What the President said was—it is true that probably 25 percent have a stable system, that in most of those systems it could pull out of at any time, as Medicare managed care has demonstrated that they could pull out of your area.

And if you do not have an option of another managed care plan that has a prescription drug benefit—you go back to fee-for-service and you would not have a prescription drug benefit.

Senator NICKLES. Well, my point being, I think the President's statement is very misleading. If two-thirds of seniors are now eligible and are now receiving some type of prescription drug coverage, either through Medicaid or through an employer or through a Medicare-Medicaid HMO managed care plan or through Medigap, there are a lot of different things. Some States have some prescription drug coverage.

If two-thirds of them now have it, the President makes a statement. It makes it sound like three-fourths do not. I am bothered by that. I think it is a little misleading. I mention that because I think we have to be factual. And I have not been able to totally analyze your chart, but it looks factual and it looks quite contradictory to what the President had said just yesterday.

Let me mention just one thing. And maybe, I am one of the few that seems to be concerned about it. But you talk about transferring the percentage of the surplus. And I think I heard in your statement that it was your plan to transfer 15 percent of the surplus over the next 10 years. Is that correct? Is that 15 percent of the surplus excluding Social Security? Is that a yes?

Ms. SHALALA. It is 15 percent for Medicare.

Senator NICKLES. All right. Fifteen percent of the surplus excluding the Social Security surplus?

Ms. SHALALA. Yes. It is 15 percent of the total surplus that would be set aside for Medicare.

Senator NICKLES. Then, you are trying to rob 15 percent of this. You are trying to take money away from the Social Security Trust Fund and put it into Medicare?

Senator BREAUX. Wrong.

Senator NICKLES. I am just trying to find out.

Ms. SHALALA. This is the on-budget surplus.

Senator NICKLES. On-budget excluding the Social Security surplus?

Ms. SHALALA. Yes.

Senator NICKLES. All right. Is that correct?

Ms. SHALALA. Yes.

Senator NICKLES. I think it is important. I just looked at a CBO statement. And we will have Dr. Crippen here in just a minute. But on page 10 of his statement, he says the on-budget surplus according to the administration's—these numbers are confusing, but you do not have that much money?

Ms. SHALALA. Well, as you know, the numbers are confusing. And we have just gotten his testimony. So I am sure that a member of the Economic Council, Mr. Lew, would be happy to comment on that as quickly as possible.

Senator NICKLES. But I——

Ms. SHALALA. I have not had a chance to read that testimony. And I just had a nice conversation with Dr. Crippen. We will be going through his testimony, including what he says about Medicare and about the projections.

Senator NICKLES. I want to tell you I really question taking Medicare and saying, well, we are going to fix it by having a transfusion of money from surpluses, i.e. general revenues.

Medicare is financed by payroll tax currently. Is that correct?

Ms. SHALALA. Yes.

Senator NICKLES. 2.9 percent on an individual's payroll tax with no cap. The administration increased that tax dramatically when they took it off of the Social Security base, some $70,000. And now, it is 2.9 percent on all income. And that was done in 1993. That is a humongous tax increase for people who make over some $70,000. It is 3 percent of their payroll. And yet, we still have problems.

And so I hear the administration saying, well, the payroll tax alone is not enough. And so we want to have a significant percentage of general revenue funds. And I kind of look at that as I referred yesterday to my kids. I look at tax consequences and my kids. My son is working. And he is paying a lot of Social Security and Medicare tax.

And we are really saying that is not enough, we want a lot more of your income tax to come in and help finance Medicare. It is kind of an open-ended blank check to finance an entitlement that is growing. As the CBO has estimated, I am afraid that you have grossly underestimated the cost of this program.

And I see my time is running short so I want to make this editorial comment. I do not think that the Medicare prescription drug proposal that you have, Madam Secretary, is very good. I think a lot of seniors would opt out as I think your program is voluntary. I hope that it is.

I think a lot of seniors will say, wait a minute, we are not buying that much today. For us to make money on this deal, we would have to purchase I think, what, $800 and some odd dollars worth of drugs. There is a break-even point.

And so they are saying, hey, this is going to work plus you are increasing my Part B $24 this year, going to $48 in a few years on top of the escalations that are already in the system that go to $96. You add those two together, that is about $140 a month in Part B just to pay Part B and prescriptions. And I just do not think it is a very good deal, especially for the two-thirds that already have it.

I think a lot of them would rather stay with the program that we have now. This is not that good a deal.

Ms. SHALALA. Well, Senator, let me make two comments. First, on your last point, it is in fact an insurance scheme. I mean, the point is that you invest now so that it is there for you when you need it. So the pharmaceutical benefit that we have, this is the concept of insurance.

And our actuary, we actually asked our actuary how much we would have to subsidize of a Medicare pharmaceutical benefit to get most people in, to get almost everybody in. And he said 50 percent. So that is where we set it.

On your previous point, I am not sure we have a choice. If we double the Medicare population, the effect of not using the surplus would require, without that transfer that we are talking about, a 20 percent cut in Part A spending to have the same effect on the trust fund to get us out to 2027.

I do not think that anyone has a plan to cut Medicare Part A spending by 20 percent, if we think that we have heard from the providers already for what we have done, a 20 percent cut on Part A would be extremely difficult.

Again, back to the fundamental point, if you are going to have double the number of beneficiaries, you need to add new money to the system. We need to get savings at the same time.

And the Balanced Budget Act, the savings that we present in this proposal introducing competition, all of those things help to slow the growth. And in the case of the pharmaceutical benefit, we actually pay for 60 percent with savings.

Senator NICKLES. Madam Secretary, I see my time is up. I will just echo something that Senator Grassley mentioned. I think it is utterly absurd for us to come up with a program to subsidize employers that are currently providing for a benefit, for us to say, well, we want to make sure that you keep it so we are going to pay for two-thirds of it. I think that shows a real—I think there is a serious mistake or flaw in the program.

Ms. SHALALA. Well, thank you, Senator. As you know, we have never income tested a benefit of the history of Medicare. The concept of social insurance would be fundamentally flawed if we did that. All beneficiaries get all benefits in the Medicare program.

As we thought through a way to do it we didn't want to pull everything out of every place already providing the benefit. We also wanted to reduce to the Federal Government's cost at the same time. So we chose to simply subsidize some places where beneficiaries currently get the benefit.

The CHAIRMAN. Senator Rockefeller?

Senator ROCKEFELLER. Madam Secretary, I would like to get you to talk a little more about what you are talking about before when Senator Graham was here. And that is the matter of getting more innovation.

And you in a sense were saying that you have been handicapped in terms of medical technology, etcetera, because Congress sort of says who you can go to and what you can do. And that is enormously frustrating to you because there are other people out there that you could go to and you could perhaps get a better price.

One, could you explain that again? And secondly, could you say how it is that the President's program fixes that?

Ms. SHALALA. Well, we are limited in the kind of competitive pricing and the discounts that we can negotiate on behalf of Medicare. And the example I gave was claims processing.

The Congress of the United States has actually listed in the law the insurance companies that we can use. And my point was there are other people that can do claims processing in this country. And we ought to be able to have a wider group of people that we can pull from.

In addition, everything that Medicare purchases, we tend to pay sticker price. We had to come here last year on the oxygen issue to get a reduction in what we were paying for oxygen over the objections obviously of providers.

There is too much rigidity on what Medicare purchases and how it prices. And we need to act as a large purchaser to be able to get reasonable discounts for what we purchase on behalf the taxpayers. They are spending money they do not need to spend. And we need this flexibility.

The people that provide goods and services will not like it because they would prefer for Congress to write in that kind of detail.

I will also pledge to you because I know of all your interest in small businesses that I believe that we can do much of this, providing opportunities for small businesses in the demonstration that we did in Florida on durable medical equipment.

Senator ROCKEFELLER. Madam Secretary.

Ms. SHALALA. We did demonstrate that.

Senator ROCKEFELLER. I just want to be able to use my 5 minutes. But you are also saying it is not just claims processing. It is medical technology.

Ms. SHALALA. It is medical technology.

Senator ROCKEFELLER. That you are precluded from having an opportunity to make professional decisions about that.

Ms. SHALALA. Exactly.

Senator ROCKEFELLER. And how is it that the President's program changes that?

Ms. SHALALA. Well, it gives us an opportunity to go out and get bids on everything that we purchase and to have professionals make the decisions. We actually set up a new panel with public involvement on a number of things that we do in the system, including introducing private sector people that can help us introduce better management and better purchasing techniques.

Senator ROCKEFELLER. All right. The second question. It was brought up before that there are those who would argue that a lim-

ited prescription drug benefit for Medicare would be less likely to crowd out, as was mentioned, private health care dollars because it is believed that many seniors have access to health benefits on the retiree basis. And therefore, why would you be paying for them?

There is, however, among others, a Hewett Associates study that found that large employers are eliminating or reducing retiree health benefits altogether. Now, the word "altogether," I want you to help me understand.

Secondly, there is evidence that the quality and the comprehensiveness of the supplementary coverage available is inadequate in those plans.

So would you contrast scope and eligibility requirements of the President's prescription drug benefit plan with that of the Medicare Commission's proposal?

Ms. SHALALA. Well, the Medicare Commission proposal we have adopted. And that is to go to 150 percent of poverty as a way of subsidizing those who are low income. We have added to that access to middle-income people, people in rural areas because you really do not handle a very large percentage of people who are in Medicare.

I think I pointed out that 54 percent of Medicare beneficiaries without pharmaceutical have incomes above 150 percent of poverty. So we have not rejected what the Breaux-Thomas commission did. We have accepted it, but built on it because we would leave out 54 percent of the people without benefits.

And as I have pointed out, many of them are in rural areas. And access does not have to do as much with income, but with geography. And that seems to us fundamentally unfair.

Senator ROCKEFELLER. And my final comment. I will not ask for a response because my time is up. You have indicated that medical people come to us. And you did not make the implication, but I will make it for you that we give weight to their decision to have stuff fixed into law.

Ms. SHALALA. I wish it was medical people, Senator.

Senator ROCKEFELLER. And others. It is, however, an absolute fact which is at least universal on our side of the aisle that we have been overwhelmed in our States on our visits, not sought out, not programmed by people who feel they have really been hurt by BBA cuts.

Now, every single government organization says, oh, it is too early to tell because we still have two years to run, etcetera. You are proposing $7.5 billion. How does the administration have any idea that $7.5 billion would solve that problem which to us is very real?

Ms. SHALALA. Let me point out that we do more than $7.5 billion, that we in fact do not just stretch out the cuts beyond 2003 that the BBA did. We smooth out some of those differences. We make some choices where we think there have been some unintended consequences.

In addition to that, every bit of flexibility that the Congress gave me in the BBA I have used to try to smooth out or make appropriate changes where there were unintended consequences, but there are some things that actually need legislation.

The therapy caps were put in place for scoring reasons. They had nothing to do with health care. The health care people objected to them, including us at the time. They clearly are having a serious health care access affect to appropriate care. Those are the kinds of things where we already have evidence. We are accumulating evidence.

Why we have put $7.5 billion, we are obviously making a judgment about what we think and where we think we are going to have evidence that we are denying people access. For the providers, that will not be enough.

But we need to reach agreement in a bipartisan way about what have been the unintended consequences that have a detrimental effect on the health care, on access to health care. And we are in the middle of analyzing that now. And we will be providing to Congress what we know at the time.

But as you also know, there are many analysts, including our own, that think in some areas we should not make changes even though the providers are concerned.

And again, if you listen to my conversation on what Senator Moynihan said about academic health centers, they are profoundly affected, not necessarily by Medicare. We are probably their best payer, but the discounts negotiated by private HMOs have put them in a situation in which, when combined with what we did in the BBA they have no place to cost-shift to.

So for some institutions, it is a more complex issue, but we do need to do some things. Some of them will be transitional, but we cannot unravel the BBA. So it is going to be tricky and tough, but we are going to have really hard analysis.

And we did the BBA together. This administration believes that whatever changes we make, we are going to have to do those together, too.

The CHAIRMAN. Senator Gramm?

Senator GRAMM. Well, Mr. Chairman, let me set the record straight. I mandated the sixth test where you are competitively bidding medical equipment. You were not doing it. When I went to Houston to announce the program, the White House called and ordered the head of the VA in Houston not to participate in my program. So you are doing what I as chairman of the Health Subcommittee mandated. And you are taking credit for it.

The reality is that I did it. I mandated it. And the White House tried to disrupt my announcement of the program.

Now, I would like to make several points that I think are very important. First of all, I want to set this debate in the context of the tax cut. Our President for 2 years talked about saving Social Security first, save Social Security now. But in the final analysis, he adopted a totally phony proposal that was denounced by Democrats and Republicans alike.

When we had a chance to do something about Medicare under the leadership of Senator Breaux, the same President who in the cabinet room challenged every member, do not let this fail because of you. It failed because of the President because every one of his appointees voted against it. And if one of them had voted for it, it would have become a recommendation to Congress.

Now, having killed Social Security reform, and Bill Clinton killed it, having killed Medicare reform, and Bill Clinton killed it, he now says we cannot cut taxes because we need to do these two things.

My point is, he is about as disingenuous as you can be on all of these issues.

Senator ROCKEFELLER. Would the Senator yield?

Senator GRAMM. No, I will not yield.

Now, secondly, this proposal that when we are looking at Medicare which now is running into problems with a 2.9 percent payroll tax, rising at a minimum to 12 percent of payroll, a 12 payroll tax in 25 years, and that is without overturning any of BBA. You want to overturn part of it. And that is without any prescription drugs.

It seems to me under those circumstances to be talking about providing a drug benefit to everybody instead of the people who really need it is political. It is not economic. This proposal of yours may be good politics. I am sure somebody did a poll. I am sure there have been focus groups. But it makes no sense at all economically.

And you cut off benefits after the government has provided $1,000 when people really need it. By covering everybody, you are going to produce a cost which is going to force you ultimately to fix prices and to ration and to kill off the growth in medical technology and pharmaceuticals.

And when you set it up, you have no deductible. So that when people have choices early on, you have little incentive for them to control cost. And then, when they reach $1,000, they cut off the government payment.

Again, it makes absolutely no sense economically to structure it the way you have structured it. So I have to conclude that, (a), you all do not know what you are doing—and I reject that because I think you have plenty of smart people, including the President. Or, (b), which is more reasonable, it fits the facts better, this is totally political.

Let me make the final point I wanted to make, Mr. Chairman. And that is we need to go back to the Breaux proposal. The Secretary talks about competition, but she is not talking about competition. She is talking about government controls and regulation. When you are the only buyer, that is not competition. That is monopoly.

What Senator Breaux did in his proposal was to set up a cafeteria-type system like we have for Federal employees and let people choose and have competition. I would be perfectly happy to build into that a system like you are proposing in one area where people get to keep some of the money they save. I think that is a good idea.

But Mr. Chairman, finally, to conclude, I think what we have here is a political proposal from beginning to end. I think we have to reform Medicare or we will never be able to pay for it.

And the idea of the administration proposing to bring the nonelderly into Medicare, that same old chestnut, they are still proposing, talking about adding pharmaceutical benefits for everybody instead of focusing it on the people who cannot pay for it today.

I just think this has become a cruel, political hoax and that we need to put it out of its misery by throwing it out and by going

back to the Breaux commission and to see if we cannot put together a bipartisan proposal that helps people with pharmaceuticals that need it, that sets up real competition.

But it is not competition when the Federal Government through HCFA dictates price and engages in rationing. That is not competition. I think your problem, Madam Secretary, is that your administration has no real concept of what competition is. Competition is private producers competing against each other.

Senator ROCKEFELLER. Would you say that again so we can write it down? I do not want to miss a word of that. What is competition?

Senator GRAMM. All right. Let me say it again. Competition is private producers competing against each other on the basis of price. It is not a monopoly buyer dictating price and ultimately dictating technology. Competition is not rationing and price controls. It is competition among private sellers.

Senator ROCKEFELLER. Thank you, Senator Gramm.

The CHAIRMAN. Your time is up. Let me say to our distinguished Secretary, we want to give you the opportunity to answer if you feel it is appropriate.

But really the purpose of the hearing today is to try to discuss specifics with regard to Medicare. And there have been some on both sides who have talked policy. And we did a lot of that yesterday. And I think we will do a lot of it next week, but I would urge in the time we have remaining that we try to keep discussions to the specific proposal.

And with that, Madam Secretary?

Ms. SHALALA. Thank you, Senator. Let me respond to Senator Gramm very quickly, first, by saying that I obviously, Senator Gramm, disagree with your characterization of the point, but also what we are trying to do here.

In fact, the Breaux-Thomas plan has the same fee-for-service competitive reform, the plan that you signed onto that we are introducing here.

And second, our managed care proposal is competition, but achieves the savings through voluntary incentives. And that is people move to managed care because it is going to save them money as opposed to being forced to move to managed care because fee-for-service costs go way beyond what they could possibly afford.

So we are trying to introduce what I thought most economists felt was the best way to do it and that is positive economic incentives as opposed to negative incentives.

And third, let me say about the pharmaceutical benefit, the reason for it is a solid health care reason. The reason that there is no deductible is because we are trying to save money in the long run in the health care system by getting people to use their pharmaceutical benefits from the beginning and use them accurately. And people do save money in the long run when everybody has it because they can continue to buy discounted drugs as part of the plan.

So I would be happy to come to your office and explain this at some level of detail. I think I can give you enough of an economic argument for what we are trying to do here and at least soften you up for the open debate that we are going to have.

Senator GRAMM. I do not think so. [Laughter.]

The CHAIRMAN. I have to say I vote with Gramm on that one. Senator Jeffords, please?

Senator JEFFORDS. Madam Secretary, a lot of attention has been focused on the prescription drug coverage included in the President's plan. I am concerned that the President's drug benefit does nothing for seniors until the year 2002 and is not fully implemented until 2008.

That is why I have drafted legislation that will provide prescription drug coverage for those Medicare beneficiaries who can least afford it. My proposal will build on the drug benefit that was included in the bipartisan commission's proposal by creating a new, drug only, Medigap plan which will be offered to needy seniors at no cost.

Does the President have a plan to help the low-income beneficiary before 2002?

Ms. SHALALA. No. We basically kick in this plan, as you know, a couple of years down the pike in part because of the number of transactions that take place, the need to put the contracting in place. We obviously are going to administer through the private sector through benefit managers.

And knowing what we know about what it takes, the number of transactions that are involved, we believed it would be prudent to set it up very carefully and also to phase it in very slowly. So this was a question of us knowing our managerial capacity to put this in place in looking at the complexity of doing that.

But I do understand your proposal. And that you would phase in the low income part of the coverage earlier, the shared piece with the States. And I fully understand that, but we were being prudent managers in our recommendations.

Senator JEFFORDS. Now, I want to turn to home health care if I could for a moment. It is clear from the President's plan that he shares my concerns about maintaining high quality of home health care services. The President's plan underscores my position that sequential building needs to be eliminated to alleviate cash flow problems experienced by small, cost-efficient agencies.

I am glad that we could work with you to achieve HCFA's April 19th repeal of sequential building. Are there any further steps planned to prevent closure of home health agencies and to guarantee that beneficiaries will continue to have access to their much-needed home health care?

Ms. SHALALA. Well, as you probably know, I have sent teams to a number of States to look in great detail at what is happening in home health care, to see what beyond where we have administrative flexibility we can do to make sure we are not denying access. And the GAO has taken a look at this issue at the same time.

So we may well have some other proposals beyond what we have done, but at the moment, we have obviously set aside $7.5 billion. And we are exercising our administrative authority here as well as trying to look very carefully at where we might be creating access problems.

Senator JEFFORDS. Thank you, Mr. Chairman.

The CHAIRMAN. Next, Senator Chafee?

Senator CHAFEE. Thank you very much, Mr. Chairman.

Madam Secretary, I am personally prepared to use part of the surplus to extend the solvency and to provide for a drug benefit. If we are serious about making some structural changes to the program, I believe we need more competition. You have discussed that. And I believe we need to means test this program.

I agree with the President that a Medicare prescription drug should be available to all beneficiaries. I am concerned with the long-term sustainability of this program.

Rather than making an important benefit like drugs available to only the lowest income through Medicare, I believe that prescription drugs should be available to everyone, everybody be eligible, but there ought to be a means test.

I do not understand why a taxpayer, the woman who comes in here and vacuums these rooms at night, should be paying for Dr. Warren Buffett's doctor's bills. And what you are going to do is extend that.

And I believe that all beneficiaries should be available for all benefits. And the prescription drug would fall in that category, but it is perfectly possible to means test the program. And why do you balk at that?

Ms. SHALALA. Senator, if I can ask a question? Are you talking about means testing just the pharmaceutical benefit or means testing the entire——

Senator CHAFEE. No, the pharmaceutical benefit would be available for everyone.

Ms. SHALALA. Yes.

Senator CHAFEE. Just like the Part B is available, the Part A.

Ms. SHALALA. Yes. We have never means tested any individual benefit in the Medicare program. As you know, the——

Senator CHAFEE. But that is not a rationale. I heard you use that before. We have not done it so therefore we should not do it. We have not had prescription drugs in there before.

Ms. SHALALA. All right. You are asking the Medicare program to set up a whole bureaucracy to means test a specific benefit. What the President has said is that he is open to the concept of some means testing of the Medicare program itself as opposed to individual benefits. Right now——

Senator CHAFEE. I have tried to say that. I tried to say that the prescription drug should be available to everyone. So you are not means testing the prescription drug. You are means testing eligibility for the program.

Ms. SHALALA. All right. I think, Senator, that we believe that would lead us down the pike. Should we means test the flu shots that we propose to make free to everyone in Medicare? Should we means test colon rectal screening or mammograms? Should we means test prostrate screening because some people that may use it have incomes over $100,000 a year?

I mean, where do we pick and choose among the benefits that we provide that we should means test? And why drugs versus some other benefit that we want to provide?

The Medicare system was set up in a way in which everyone would get the same benefit package. And anything else they wanted to purchase on top, they would have to pay for.

Senator CHAFEE. Madam Secretary, I tried to say it. It is funny, the sermon last Sunday in church was throwing the seed out on barren ground. And that seed I have thrown has not sprouted.

Ms. SHALALA. That is correct. I honestly have had no effect on either you or Senator Gramm today.

Senator CHAFEE. Well, I like the company. Now, let us try again. I am not saying you are means testing the benefit, neither prescription drugs nor rectal colon cancer or whatever treatments, whatever it is. All I am saying is that the eligibility for the program for Medicare should be means tested.

Ms. SHALALA. I think what the President said and what I have tried to respond to, is the President has said that he is open to means testing the Part B, to means testing the Part B premium which is not inconsistent with what you are talking about. So the President has indicated—we do not have it in this proposal—but he has indicated and he has said consistently that he is open to proposals to means test the Part B premium.

Senator CHAFEE. All right. We are making some progress. I believe in that. And I think you ought to include it because we are getting into a very, very expensive program here.

I mean, you yourself have said that economically, it is going to be fine. Or you have indicated that there are going to be economic benefits. People are going to take their pills and thus stay out of the hospital. So dollar-wise, it is going to be a winner. I do not believe that.

Ms. SHALALA. Well, I have not said that, Senator Chafee. In fact, I have been extremely careful not to make those kinds of claims for the drug benefit. The one thing that I have learned in this business is to not make those kinds of claims for a benefit.

The benefit is a critical part of modernizing the health care program, but we do not know yet. There are individual studies, but we should not oversell this other than improvements in the quality in the outcomes, but not oversell it in terms of how much money we are going to save. And this administration is not going to do that.

Senator CHAFEE. Well, I think you are right.

Ms. SHALALA. It will improve health outcomes from the point of view of——

Senator CHAFEE. It is a quality of life for a lot of people. And it is worthwhile doing. And they will be better off. But I agree with you that the savings in not going to hospitals, it is not going to be a winner that way. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator CHAFEE. Thank you, Madam Secretary.

The CHAIRMAN. And now, Senator Breaux?

Senator BREAUX. Thank you, Mr. Chairman. And thank you very much, Madam Secretary. We will continue our discussions on this subject I am sure for a long period of time. I have been handed the secret answer to all of these problems from our colleague, Senator Rockefeller. He suggested that we form a Medicare commission to study this problem and report back our findings. [Laughter.] However, I am not certain that is the direction we should go.

We have spent a lot of time this afternoon, Mr. Chairman and my colleagues, talking about one of the easiest things to do with

Medicare. And that is to add more benefits to it in the form of prescription drugs. I mean, that is not reforming the system. It is a still a 1965 model. And we are talking about adding more prescription drugs.

I think the President is right to do that. I disagree with what he has proposed. It is not nearly as good as it should be. I mean, it is not means tested. It is first dollar coverage which I think is a mistake. It does not cover catastrophic drug problems.

I mean, I will ask the Secretary to comment on these things. Number 1, as I understand it, the way the program would work is that half of the drug costs are being paid by the beneficiary. That is a pretty big hit.

In addition to that, they are going to be asked to pay a premium. In addition to that, after they pay the first $1,000 of drugs, after that the whole thing is 100 percent on their backs.

It would seem to me that it would be much better to design a program with the same amount of money that would have a small deductible upfront, that have a smaller co-insurance amount, and have some type of a stop-gap loss that says that after $3,000 the government pays for all of it.

So I understand you on all of this. I agree that we should have a prescription drug program, but I disagree on the design of it. It is not nearly as good as it should be. I mean, Nan Griffin is going to say that 36 percent of the people that would benefit from it are going to hit the $1,000 loss and have to pay all of it themselves. That is 36 percent of the people according to their figures.

And after the $5,000 figure kicks in, their estimate is that 25 percent of the people are going to hit the maximum that they can get. And then, after that, when they really need the help the most, they are going to have to pay 100 percent of the drug cost. So I mean, we differ on that, but I think the program should be designed better.

And I think John Chafee is absolutely right. We are not talking about means testing who gets the drugs. We are not talking about means testing who gets the prostate test. We are talking about means testing how much you pay for it.

I mean, that is not a good Democratic document to say that we are now going to subsidize someone in Ross Perot's financial category the same thing for drugs that we subsidize a poor woman who is barely outside of the poverty line. It is just not good politics. And it is not good policy.

So I commend the administration for having the drug program. I think it could be designed at the same price far better and more efficient than it has been designed. And Madam Secretary, if you would like to comment on that?

Ms. SHALALA. Yes, just quickly, Senator. And I appreciate your comments as well as your leadership. First of all, we project in the year 2000, less than 3 percent of the beneficiaries will have costs over $5,000 and 17 percent will have costs over $2,000. Now, that is the HCFA actuary projections.

In addition to that, we do indeed provide for people after $5,000 in this proposal because they are able to purchase drugs on whatever the discount is that has been negotiated on their behalf.

So they will continue to be able to purchase drugs. Our estimates are at least a 10 percent discount. So they will in the first instance have that discount up to $5,000, but be able to continue that discount.

And while we did not deal with the major catastrophic issue, we did provide for that discount right through the process.

On the issue of deductibility, I would be happy to show you some of the runs that we did. You do not raise a lot of money with some of these other pieces, but it becomes very expensive.

We wanted a modest benefit to get started, a benefit that we knew we could manage. And again, this is the concept of insurance. For some people, they will not get a benefit immediately, particularly when they sign up at 65, but they are in fact buying into the program to take care of themselves when they are 70 and 75 and 80.

Senator BREAUX. Well, I appreciate that. I just think that we can do a much better drug program. Mr. Chairman, I think we ought to cover catastrophic costs. And it should not be first dollar coverage. And it should be means tested.

I mean, that is my feelings on the subject, but I think we both agree that there should be a prescription drug program. How we craft it and what the makeup of it is, is the real test. That is the easy part.

I mean, the real problem is how do we make the program more functional? We in the commission recommended a premium support competition where everybody had to compete. The administration I think is faulty in their recommendation.

And they say we are going to have competition, but only the managed care people have to compete against each other. Traditional Medicare is going to have a fence built around it. It does not have to compete. And I think everybody should have to compete.

I mean, our savings on the competition was $65 billion over 10 years. The scoring, is it not correct, that I have from the President's proposal is that you get more savings?

You get more savings out of the President's proposal from your co-payments for clinical labs than you get through your competition. For co-payments on clinical labs, you get $9 billion of savings. For all of this competition, you get $8 billion.

I mean, that is hardly a drop in the bucket from competition if you get more savings from co-payments for clinical labs.

So I think that if we are going to go to a competitive system, both traditional Medicare has to compete with managed care with a set amount of benefits that protect the beneficiary, but everybody is going to have to compete if we are going to get any real savings from competition.

And you are welcome to have the last word on that.

Ms. SHALALA. Yes, I would like to. Senator, first of all, remember that the managed care plans themselves would pick their prices. So they are going to bid their prices in relationship to the average premium for the fee-for-service program. The fee-for-service program is part of that bidding process because they bid against that.

We believe that this promotes very fair competition by assuring that the beneficiaries pick similarly-priced private plans and pay the same premium. The plans will then be competing against tradi-

tional Medicare for better a price and market share. Now, that is true price competition. We call it a competitive defined benefit proposal.

And we do not have real price competition among managed care plans now. They would be competing with the same benefit package. So people really would understand the difference in terms of what they would save.

We achieve competition in savings through an incentive for beneficiaries to choose the lower cost plan. In your proposal, the difference, the contrast here is that you do get savings, but you get it by running up the cost of fee-for-service.

That is if you have one managed care in Montana, the fee-for-service program cost goes way up. What we are doing is trying to make sure that the managed care plans can run their costs down so they can attract beneficiaries. So it is a positive economic incentive.

It is important to remember though that we make that the fee-for-service program more competitive through the use of market-oriented approaches, too. But I think the fundamental difference here is that we have positive incentives to pull people into managed care because they save money, their premium goes down if they move into managed care against fee-for-service.

The other proposal that we have looked at which came out of the commission forces them into managed care by running up the fee-for-service cost. And we are both trying to get to the same place, Senator Breaux. And I think that enticing people that positive economic incentives is the way to go.

And in this case, the managed care plans price themselves. And the beneficiaries will not be confused because the benefit package will be the same. They will have pharmaceuticals in there.

If they want to purchase more benefits in a managed care plan, they are going to save money going into that plan. So they will have the cash to purchase some additional benefits.

But we are comparing apples with apples here. And the important thing I think is that it is a positive incentive as opposed to shoving people in as fee-for-service goes up. Shoving is too strong a word.

But you are basically using an economic negative incentive here as opposed to what we believe we are using which is a positive incentive. And you do get more savings from doing that because you run up fee-for-service.

The particular problem, as you well know, in rural areas where a new plan may come in though, you protect rural areas where there are no plans. And I recognize that.

But I think, Senator, will all due respect, we are both trying to get to the same place, to introduce competition. We have taken all of your fee-for-service recommendations. We obviously have gone to 150 percent of poverty in your recommendations on pharmaceuticals. We honestly believe that we are building on your proposals.

Senator BREAUX. I think you did that without taking a breath. [Laughter.] Thank you very much.

The CHAIRMAN. Senator Bryan?

Senator BRYAN. I believe, Mr. Chairman, that Senator Baucus preceded me.

Senator BAUCUS. No, no, you are next.

Senator BRYAN. I am next. All right. I will be happy to.

Madam Secretary, I know you have endured a lot of lecture from us today here. So let me continue with that tradition. The Senate does this very well when they have a captive witness.

Let me preface my comments by saying that I do applaud the efforts of you and the President to come forward with a program to provide a prescription drug benefit. You cited an example of the disproportionate coverage of rural versus urban America.

Each summer, I spend most of August in rural Nevada. And I can tell you that there is no change in the Medicare program that those people in rural Nevada would like to see better than to have a prescription drug benefit. So I think you are on the right track in terms of where we want to try to reach.

I want to make a couple of observations if I may. We are sitting on a demographic time bomb. In the year 2011, the first of the baby boomers turn 65. 76 million Americans will be part of a tidal wave that will flood the system in terms of eligibility.

That is going to be true whether the Democrats are in the White House, Republicans in the White House, Whigs in the White House, that the vegetarian party re-surges and becomes the dominant political force in America. That is inevitable.

And we know that there are going to be some medical breakthroughs of which appear to be just over the horizon. And we as Americans are going to demand that coverage that will come as a cost.

Now, I guess in terms of the broad alternatives, we could reduce the benefits. You and I know that that is simply not going to happen. Indeed, we are talking today about adding a very important benefit. We are going to need some additional revenue. And that involves the dreaded "T" word as I understand.

But we do want to talk about some structural reforms. And I want to just at least share my view. I would endorse and associate myself with the comments that the chairman of the retiree caucus and my good friend, the Senator from Rhode Island.

This committee in a bipartisan way overwhelmingly voted to means test Part B in 1997 and it carried on the floor of the United States by an overwhelming margin. I think we need to look at that. And that would be part of the message that I would encourage.

The second thing I think needs to be pointed out, and you did so very effectively, what we say and what we do here in the Congress are profoundly different. We worship at the shrine of competition.

And yet, at the very moment that you try to engage in some competitive strategies, we do the el caveo, the el foldo, and try to put additional restraints upon you. And this is our fault. And that is to our discredit.

And you need to be provided more flexibility to adopt those programs. I do not have the details of the program in Florida, but, Senator Bob Graham, you have indicated some savings. We need to provide that flexibility.

I guess my question really is in terms of providing this benefit. What are the implications for those who have collective bargaining agreements? How does that factor in? I mean, that has been a negotiated benefit. If we are going to provide this coverage, what are the impacts of that?

Ms. SHALALA. Well, I think that what we have tried to do in the pharmaceutical benefit is just stabilize the situation that already exists and for people who would get their retiree benefits. And that would include a pharmaceutical benefit.

As long as it is at least as good as what we are offering for people who do not have the benefit, we would give their company, or actually it would probably go to the health plan that they are in, a subsidy for keeping it, but it would be less than what we would pay if we were doing it directly.

So it is an incentive for our employers who are increasingly dropping retiree pharmaceutical coverage, a 25 percent droppage over the last couple of years, an incentive to keep that coverage. And so anything that was negotiated, the employers would obviously gain some resources to keep that benefit.

I should point out that in most of the major companies, they are providing a lot more than this benefit. So while this would be of some help in some subsidy to keep it, it would at least keep a minimum benefit for everyone across the country.

Senator BRYAN. Have you given some thought in terms of devising the formula? Yesterday, those of us who serve on the Aging Committee were exposed to some testimony from individuals who are Medicare recipients who discussed situations that occur with respect to their HMOs changing the formula, that is whole classes of medication, no notice being given to them with potential serious adverse health consequences.

Clearly, there needs to be notice given and an opportunity to respond to that sort of thing. What if anything do you do with this aspect which apparently is a major concern out there?

Ms. SHALALA. Well, first of all, anyone that is currently in a Medicare+Choice plan ought to be notified appropriately of any formulary changes.

Senator BRYAN. That is right, but that is not occurring now.

Ms. SHALALA. And HCFA is taking steps to ensure that the health care plans are adequately doing that. And at the hearing this week, we were present and we heard those comments.

Under the President's plan, we would include rules for establishing, changing, and notifying beneficiaries and the doctors of the formularies and any subsequent changes in any kind of contracting rules.

They would be required to provide adequate advance notification. And we would protect the right of a doctor if he insists that a patient get a drug that is not on the formulary. We would protect that doctor's right to get that drug. And our plan would pay for it.

Senator BRYAN. Finally, let me just say that we would certainly enlist your help and guidance. You correctly pointed out and I am persuading that in doing the Balanced Budget Act of 1997, with respect to physical therapy caps that those have had unfortunate consequences and we need to adjust that. But as you know the en-

trepreneurial spirit is alive and well in terms of health care providers in America.

And now that that door has been opened up a little bit and we have heard testimony in this committee from Ms. Walenski that indeed we should make an adjustment, are you going to provide us any data or information as to what other adjustments we ought to consider because as you know, right now there is a full scale media blitz in which every provider in America has suggested and perhaps there is merit to it, I do not know, that we have cut back too much, that we need to change the reimbursement formula? If we do that, that is going to have a serious impact upon the solvency of Medicare. What can you tell us about that?

Ms. SHALALA. Well, we will be working with this committee and with other committees in the House on what information we have and specifically about whether there is an unintended health consequence particularly denying access to an individual to appropriate health care because of a change that was made.

I pointed to the therapy cap because it is the one example where we actually objected at the time and argued that it would have health consequences.

There obviously may be others. And we have heard in this committee today about the possibility. But we will show you what analyses we have. The GAO will have analyses. I am sure the CBO will have some analyses.

I think the important point that we have made, that the President has made over and over again, is that no one should expect us to want to participate in any discussion that would unravel the fiscal discipline that has been introduced through the Balanced Budget Act, but it is very clear that we ought to consider unintended consequences that are denying access to Medicare beneficiaries and we ought to look at very carefully.

Senator BRYAN. Thank you very much. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman. Mr. Chairman, I want to first thank you for trying to bring this discussion back into the realm of stability where it was not at an earlier point in this debate. A Senator characterized the administration as being disingenuous.

Mr. Chairman, I do not think you will agree with me, but frankly the Republican tax cut is essentially 792 and interest in that 10-year period will be 179, that adds to 971 out of a on-budge surplus of less than that, 964. I think any fair person would say that is disingenuous because there is nothing left for Medicare, for veterans, or other priorities. We have put that aside.

I have two questions for the Secretary. One, is there any way to accelerate the reimbursement blend for managed care, particularly providers in rural areas? As you know, Madam Secretary, it is about 70/30 national/local now. And I think the law accelerates that to 50/50 in a few years.

But we only have, I think, one or two managed care companies in my State. And we would like more. And there are not more because the reimbursement just is not there, in particular when the

formula is now, as I mentioned, 70 percent local is what it is and 30 percent national.

And so if you could give us some indication of whether there is some hope perhaps of accelerating that phase-in so that managed care is viable in rural areas.

Ms. SHALALA. Well, there are a number of things we are actually doing in the plan that will help rural hospitals, for example. I mean, there is a long list where I have exercised administrative flexibility that will actually help some of the providers. And I will not go into that here.

But let me say that I actually think that a combination of what we are doing on the blend, paying managed care to provide prescription drug benefits and allowing managed care to put the price on themselves will attract managed care to rural areas, that there actually will be simply more money in the system.

I think the geographical adjustment may help. And of course, we intend to follow through with the BBA requirements that you are talking about in terms of the blending.

But the problem now is that we just need to get more money into fee-for-service through the kinds of adjustments that we did in the BBA as well as adding the drug benefit to get that number up high enough so that the plans will see rural areas as attractive places to come and bid.

And I think a combination of things that we are doing will help to attract managed care to rural areas. We actually think this proposal will help.

Senator BAUCUS. Yes. I have some legislation, too, that I hope helps, but I must say it is a major problem. There is no managed care currently for all intents and purposes because it——

Ms. SHALALA. Well, Senator, I think we are increasingly recognizing that both density and sparsity cost more money.

Senator BAUCUS. Well, it does. But we are here to provide service. And rural America is part of America. And so that is the reason.

Ms. SHALALA. Well, that is the point though that it does take new investments. And we have done a number of things on the hospital payments, for example, using our flexibility, including delaying the expansion of the hospital transfer policy, delaying the implementation of outpatient department volume control mechanism, I mean, a whole list of things.

Using the inpatient wage index to pay outpatient departments, that will help. Again, all of this is a matter of getting higher reimbursements into rural areas which will, of course, directly affect the fee-for-service.

Senator BAUCUS. Is it the administration's view that the changes that you have made and recommended with respect to Medicare are enough to keep the trust fund, say, Part A as well as Part B viable? I think you have estimated that Part A will remain viable until the year 2027. Do you think that is enough, that no more structural reform is necessary in your judgment?

Ms. SHALALA. Well, if we could get all these structural reforms——

Senator BAUCUS. That is the administration's structural reforms?

Ms. SHALALA. Yes. If we could get all of these structural reforms, we believe that they would have a major effect on the Medicare program, both in bringing down cost through the competition and in strengthening the health care and introducing for the first time real price competition.

Senator BAUCUS. Therefore, it is the administration's view that the administration's proposed structural reforms are sufficient, that is the additional structural reforms as recommended by the Breaux commission and others that are not contained in the administration's proposal are not necessary?

Ms. SHALALA. Well, the fundamental difference is in how we do price competition. And we have suggested that we should use economic incentives, positive economic incentives for people to choose managed care.

That is the effect on the Part B premium by allowing managed care to bid in a way in which they can reduce the Part B would attract people as opposed to raising the fee-for-service costs in an area just because of a managed care plan.

We think we present a real choice and that more people will move into managed care. They will have more money in their pockets. There will be good economic incentives for them to pull into managed care.

In addition to that, there are reforms here we have not talked about. And they have to do with managing chronic disease and introducing for the first time in fee-for-service some fees for case management.

Most of the cost in Medicare increasingly is people who have chronic diseases who have complex problems that need some management. And managed care hopefully, as it moves to more integrated systems, will be able to do that.

We need that in fee-for-service, too, because that is a way of driving down the cost of fee-for-service, but we need to pay the managers, the doctors who are managing these complex cases a little bit more money to do that kind of management to bring these teams together.

There are a number of changes here that have to do with good health practice, with quality changes that we think will make a difference.

Senator BAUCUS. I appreciate that. There is still though, as you well know, not a meeting of the minds yet on whether those proposals are sufficient. I grant you some of the objection is political on both sides of the aisle probably.

But I am asking you to step back for a moment in the spirit of Senator Chafee hoping some seeds will spout. How do we better get closer agreement on both ends of Pennsylvania Avenue and also in the Congress?

I know this is naive, taking some of the politics out of it, to get a more solid solution that more people in the Congress and in the White House agree is likely to achieve solvency in the trust fund that we want?

Ms. SHALALA. I think obviously we are going to start working with Congressional committees to turn this proposal into legislation and to work through it with the appropriate Congressional committees.

But let me say, first, we have to agree on some of the fundamentals that the solvency of the trust fund has to be a critical part of whatever we do and that we cannot get to solvency by trying to get savings out of the existing program. It does take an infusion of new money when you double the number. So we have to agree on some of the fundamentals.

Second, we have to agree that we are going to lock arms and hang tough on the introduction of these modern business practices, prudent purchasing, the use of centers of excellence.

There are going to be lots of objections to us trying to get savings by moving Medicare away from paying sticker price for everything. And that is going to take both Democrats and Republicans deeply committed to turning this program into a much better purchaser of services and a better manager of services.

Senator BAUCUS. My time is up. I just want to ask a very quick question. There just is a sense that the Medicare program is still quite inefficient, that there is some waste. And I know you have discussed this with other Senators. And I am not going to ask you to respond unless you want to.

But it is my feeling that what HCFA has done so far still does not yet sort of pass the smell test. And there is lots that can and should be done within the——

Ms. SHALALA. Senator, we are the people that have a very high smell test. And we have said very clearly that there are restraints on us for getting the best prices and introducing competition into the Medicare program. We have listed in great detail what those restraints are.

Senator BAUCUS. I am not talking only about prices, but also just management and personnel and just delays within HCFA. And that is not just price I am talking about.

Ms. SHALALA. And in fact, we can show you some of the most remarkable improvements in the history of the program. We have cut error rates in half.

Senator BAUCUS. Good.

Ms. SHALALA. And no administration has done more on waste, fraud, and abuse than this administration.

Senator BAUCUS. I appreciate all of that.

Ms. SHALALA. If we are not perfect in terms of the management, no one will concede that faster than me. But what we have asked for is more management strength as part of this proposal.

Senator BAUCUS. All right. I am just telling you what I feel in talking to people out in the field in my State of Montana. We have a little way to go yet. Thank you.

The CHAIRMAN. Madam Secretary, earlier on, you said you would be speaking with Dr. Crippen about—oh, I am sorry.

Senator Mack?

Senator MACK. It is a long way over to this end.

The CHAIRMAN. Yes.

Senator MACK. Thank you, Mr. Chairman.

The CHAIRMAN. I can barely see you.

Senator MACK. We will see what we can do about that. Anyway, I want to touch on the issue of cancer clinical trials. Senator Rockefeller and I have introduced legislation to have Medicare cover rou-

tine patient cost with respect to Medicare for cancer. A majority of this committee has——

Ms. SHALALA. I have to go back and take a look at it. Let me also say that we believe that including Medicare recipients in cancer clinical trials is in fact a quality issue that will improve the quality of cancer treatment.

Senator MACK. I still do not understand why it would have been included in this modernization of the program.

Ms. SHALALA. Because we have other Medicare changes in the President's original submission that affect the Medicare program that we——

Senator MACK. This is not a substitute for the original.

Ms. SHALALA. No. It is not a substitute for the original proposal. So you combine the two.

Senator MACK. All right.

Ms. SHALALA. I am sorry. There was some misunderstanding of that, but we are not substituting for our original proposal, our original budget proposal which included a number of different things. I am testifying only on the latest proposal from the President that includes the solvency, the pharmaceutical benefit.

This is in fact is in direct response to the Breaux commission reporting. We said that we would come back with our own plan in the areas that they covered, plus dealing with the solvency issue.

Senator MACK. I was just surprised with the modernization plan.

Ms. SHALALA. Well, I bet you were. So I think we are on the same page.

Senator MACK. All right. Well, I am glad to hear that. Let me go to the prescription drug area as well.

Ms. SHALALA. All right.

Senator MACK. When I look at the cost estimates of both OMB and CBO, I see a rather significant difference in their projected cost. I believe yours or at least OMB's is about $118 billion. CBO is, at least what I have been able to determine, is about $168 billion. That is a 43 percent difference in the estimated cost.

I suspect that you are probably not the one to ask, but yesterday we talked about, at least some members raised the importance of having extended data available, not just 5 years.

Do you have information as to what this would cost over the first 10 years, what it would cost for the first 15 years, what it would cost for the first 20 years? I mean, the numbers I have seen would indicate to me that this is going to cause an explosion in the cost of the Medicare program?

Ms. SHALALA. No. We actually have done some of those projections. And we will share what we have. In terms of what CBO has done, as you know, we saw the first details this morning. Dr. Crippen and I have already—that is not a criticism of him. We have just talked. We will be going through their estimates and their assumptions to see what they did.

As you know, the HCFA actuary and this administration's economic forecasts have been right on target. And we have been particularly on target with our health care estimates over the last 6 years.

So I am pretty confident in what we have done. And we will be reviewing what CBO did to find out why they came to the conclu-

sions they did. But we stand by our actuary and by the projections that we have presented to this committee.

Senator MACK. Well, I do know that there has been a pretty interesting concentration of effort with respect to this committee's focus on the failure to estimate the cost of what the BBA was. So I am not sure that we are all confident in people's expectations about what these assumptions are.

Ms. SHALALA. And, Senator, if I might say, I will repeat that we were accurate on the BBA. The Senate chose to take other projections.

Senator MACK. The other area, and this may have been covered earlier, but as I understand the way this would work out in the out years where the cap is at $5,000——

Ms. SHALALA. Right.

Senator MACK. Is it unfair or inaccurate to say that in order to receive this $5,000 benefit that an individual would have out of pocket expended $2,500?

Ms. SHALALA. Yes.

Senator MACK. And under your estimate would have paid $528 in premiums?

Ms. SHALALA. Yes.

Senator MACK. Which means that the person is getting something less than $2,000?

Ms. SHALALA. Well, let me say, they are also getting these drugs at a discount. As part of that, they are actually getting a chance to purchase more as part of that.

Senator MACK. I am not making a point about that. I am trying to——

Ms. SHALALA. Yes.

Senator MACK. I think the average person who listens to this thinks that their benefit is $5,000. But in order to get that benefit, they are paying somewhere in the neighborhood of $3,000?

Ms. SHALALA. No. It is very clear. We are going to subsidize 50 percent of $5,000. And to get that, you pay a premium every month in addition to what you are paying for your 50 percent for the drugs.

This is an insurance scheme which will be helpful, but it is quite modest. And we should not overstate what this will do. It will help lots of people reduce their drug cost, but it will not eliminate their drug cost.

Senator MACK. I guess my last point here would be, the prescription drug proposal in fact is I believe as it is written a scheme that will explode the cost of Medicare which says to me because I happen to believe that we ought to include prescription drugs in a Medicare program, but would it not make more sense to target these benefits in the early years so that we get a sense about how the whole system is going to work?

I think others have suggested maybe even the idea of means testing it. To go into this at full bore, seems to me to be quite risky.

Ms. SHALALA. Senator, we actually do phase it in. I mean, we start with $2,000. And we are phasing it in. And the problem with——

Senator MACK. I must say, you are not answering my question. Let us not get——

Ms. SHALALA. If you are suggesting that we should start with people at 150 percent of poverty?

Senator MACK. Well, I think it was suggested 135 would be closest to it.

Ms. SHALALA. Actually, the Breaux commission I think has changed their position to 150 percent. We include that as part of our proposal. We also I think a combination of—you will have to look at our projections and our assumptions.

If we thought this was going to spin out of control, that the wedge was going to go like this, we would have never recommended it.

One of the reasons that there is a large contribution by the individual, one of the reasons that there is a premium here is a way of making sure that it does not spin out of control. And therefore, we have described it as a modest benefit.

It obviously is an insurance scheme which lots of people participate that may not get as much back in the early years as they will later when they get genuinely ill, but I would not overcharacterize this other than that this is a critical element of modern health care.

I would like to go back to the point that I made about Florida. Large numbers of Medicare recipients in managed care in Florida get this benefit now.

And if you live in a rural area, you do not get it. So how you would phase it in so that you would continue to get it in Florida and not get it in Montana, I mean, you are going to have trouble explaining that to your colleagues on both sides of the aisle I would think.

So the current system in our judgment is unfair, but more importantly this is about good health. And we need to include this benefit if we are going to modernize the benefit package.

The CHAIRMAN. Senator Robb?

Senator ROBB. Thank you, Mr. Chairman. Madam Secretary, I thank you for coming. I am delighted that you are still here. I had to depart for a few minutes. So I will just make an observation and ask a general question if I may.

When I left, as I recall, you were being implicitly criticized or the plan at least was being implicitly criticized for not having enough assets devoted to covering the prescription drug benefit that was available in the President's plan.

And indeed, given the fact that the cost of prescription drugs is going up faster than the overall cost of medical services or health care services generally and the fact that the population eligible is going to increase, that is a problem.

But I would contrast that to the fact that there was a tax bill reported out of this committee yesterday that did not preserve any dollars for that particular identified need by the committee. That is just an editorial comment in passing.

Well, let me ask a broader question though because what I think that what you and the President have proposed clearly is a good first step, but it is not the full systemic reform of Medicare that we talked about at one point.

I wonder if you could if you have not already done so, talk for just a minute about some of the things that you would like to see

incorporated in a long-term systemic reform of Medicare that would sustain its viability and its ability to both continue and to meet the needs of our aging population in the next years.

Ms. SHALALA. Well, the fundamental theme that we need to run through, whether it is a reform of fee-for-service or the new competitive reforms that we are suggesting that we introduce is that we need to move to price and quality. And we need to convince beneficiaries to go to places where they can get both price and quality.

In the long run, the system is inefficient unless we can move large numbers of people to integrate the systems of care to better management of chronic and long-term diseases. And we can move the management of Medicare to stop paying sticker prices and get better prices for everything we purchase.

But the concept of the centers for excellence, for example, where Medicare beneficiaries would be enticed actually because they would save money on co-payments and various fees to go to a place to have a surgery, for example, or some other kind of treatment that provided high quality and we would have identified them as providing that and good prices.

So moving the system towards a quality system is absolutely key here. And we believe that the way to do that is through economic incentives and through the introduction of competition at every stage in the Medicare program.

Senator ROBB. Let us assume, Madam Secretary, that this committee, and this is a rather ambitious assumption, were to approve the President's plan in its entirety at this point. In the remaining year and a half in the administration, would it be your hope that we could incorporate any additional systemic changes?

Clearly, there is no quarrel with getting higher quality at lower cost and to control some of the difficulties that you just alluded to. But is there anything else that you would like to see us consider in terms of putting in place to deal with that challenge over the long term if we accept your goal as higher quality and more competitive price?

Ms. SHALALA. Well, I think actually if I was to add one more piece, it would have to do with how we fund the management of these large health care programs and whether there actually are incentives in the funding for building in more efficiencies.

We strangled them with the amount of management. We run these programs at less than 3 percent of overhead. No private sector company manages health care at less than probably 10 percent. And if we want to introduce these kind of changes, we have to properly fund the manages.

And I am not talking about higher salaries. I am talking about the systems we need to put in place, our ability to do contracting, both with private sector managers to manage large parts and our ability frankly that we are restrained now to fire companies that are not performing and to be able to go a broader list, whether it is processing claims or the pharmaceutical benefit managers that we want to use in the private sector.

We just have to have a lot less rigidity in our ability to manage this program. That takes a combination of resources and flexibility. And that will be key as to whether any of this, no matter what

competitive plan you chose, our ability to manage it will depend on what you do on the management side at the same time.

Senator ROBB. That sounds a little bit like a chancellor of a university system might discuss the tenure system from time to time, but I will not ask you to——

Ms. SHALALA. No. I am actually deeply committed to tenure. What I do not want to do is to tenure in a limited list of private sector companies or prices into the system as opposed to giving us a better chance at getting better prices and better management that we contract for in the system.

Remember, we administer Medicare basically through the private system. Let us loose to actually do that in a fair and honest way. Whether it is large businesses or small businesses, I think we can do that if we have a broader flexibility.

Senator ROBB. Distinction accepted. And I thank you. Mr. Chairman, my time is complete.

The CHAIRMAN. Thank you, Senator Robb.

Madam Secretary, earlier on, you said you were going to speak with Dr. Crippen about the CBO estimates of the cost of reform. It would be very helpful if the committee received from you a full statement of how your actuaries develop their estimates. So I would appreciate those being submitted.

And second, the record is open. I will have a number of questions to submit to you tonight. And it would be very, very helpful if we could have answers to those questions some time next week. And, of course, the record is open for everybody to submit questions. We are in the midst of trying to develop a program. So I would appreciate the answers, as I say, some time next week.

[The questions and answers appear in the appendix.]

The CHAIRMAN. Thank you for being here and for your patience. It has been a long day. And we shall continue to look forward to working with you on this most important piece of legislation.

I would say that it is my intent to move ahead very promptly in September when we return after the August recess. Thank you very much.

Ms. SHALALA. Thank you, Mr. Chairman.

The CHAIRMAN. Now, I would like to call on our second panel both of whom, of course, are frequent visitors to our committee. We are always pleased to have David Walker, the Comptroller General of the United States. And then, we will turn to Dan Crippen who, of course, is the Director of the Congressional Budget Office.

Gentlemen, it is always a pleasure to welcome both of you and we look forward to your testimony.

And we will start with you, Mr. Walker, please.

## STATEMENT OF HON. DAVID M. WALKER, COMPTROLLER GENERAL, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Mr. WALKER. Thank you Mr. Chairman and members of the committee. I am pleased to be here today to discuss the President's recent proposal to reform Medicare. According to the President, his proposal is intended to make Medicare more efficient, modernize the benefit package, and extend the program's long-term solvency.

I would like to make a few summary points before delving into more specifics in regard to the proposal. In that regard, Mr. Chairman, first let me note that the President's proposal contains a financing proposal as well as several programmatic reforms that are intended to advance the Medicare reform debate.

It provides a baseline for further debate and consideration of reforming Medicare. Specifically, the President's proposal will result in significant reductions in debt held by the public over the next 15 years which will be very good. Secondly, it would extend the solvency of the HI Trust Fund on paper from 2015 to 2027.

It would not, however, help to assure the long-range sustainability of the Medicare program. The President' also proposes to include a voluntary prescription drug benefit in Medicare and to have health plans compete based upon price. These are two of the programmatic reforms that I will discuss in more detail.

With regard to the prescription drug benefit, the Congress and the President may ultimately decide to include some form of prescription drug coverage as part of Medicare reform. Given this expectation and the future projected growth of the program, some additional revenue sources may in fact be a necessary component of Medicare reform.

However, it is essential that we not take our eye off the ball. The most critical issue facing Medicare is the need to ensure the program's long-range financial integrity and sustainability. Given the size of Medicare's unfunded liability, it is realistic to expect that reforms to bring down future costs will have to proceed in an incremental fashion.

The time to begin the difficult but necessary steps to engage in comprehensive reform of Medicare is now when we have budget surpluses and a demographic holiday where retirees are a far smaller portion of the population than they will be in the not too distant future.

Ideally, the unfunded promises associated with today's programs should be addressed before or at least concurrent with proposals to make new unfunded promises. To do otherwise might be politically attractive, but not fiscally prudent. If additional benefits are added, policymakers need to consider targeting strategies and fully offsetting any related cost.

To qualify as meaningful reform, in our view a proposal should make a significant down payment toward ensuring Medicare's long-range financial integrity and sustainability. Solvency in and of itself is not enough.

As we testified before this committee in March and again in June, proposals to reform Medicare should be assessed against several criteria, namely, affordability, equity, adequacy, feasibility, and acceptance.

Importantly, in making these fiscal decisions for our Nation, we believe that policymakers need to consider the fundamental differences between wants, needs, and what both individuals and our Nation can afford.

This concept applies to all major aspects of govern, from major weapons systems acquisitions to domestic program issues. It especially applies to the area of health care where there is unlimited

demand, unlimited wants, and yet very different needs and practical limits as to what individuals and the Nation can afford.

It is also important to keep in mind the fiduciary and stewardship responsibility that we all share to ensure the sustainability of Medicare for current and future generations within a broader context of providing for other important national needs and continued economic growth.

The President's latest proposal is projecting to virtually eliminate publicly-held debt by 2015. This indeed would be a significant accomplishment. However, based upon our latest budget long-term simulation model, even if all future surpluses are saved and the current discretionary spending caps are complied with, we would nonetheless be saddled with a budget over the longer term that at current tax rates could fund little less but entitlement programs for the elderly population.

Reforms reducing the future growth of Medicare as well as Social Security and Medicaid are vital under any fiscal and economic scenario to restoring fiscal flexibility for future generations of taxpayers.

Mr. Chairman, let me just show you a few quick charts that are in my testimony if I can. The first chart talks about the solid line represents the HI Trust Fund. The bars underneath represent annual deficits. You will see that the HI Part A has been in a deficit position since 1992. We started the descent to trust fund insolvency by 2014. We face rapidly escalating deficits going into future years.

The next chart, please. The solvency issue, Mr. Chairman only deals with the trust fund, the solid line. What is important is to focus on sustainability. Is this program sustainable?

To look at a few charts that are relevant there, this chart demonstrates the projected increase in the composition of Medicare funding as a percentage of the gross domestic product, scheduled to more than double over the 75-year projection period.

The next chart shows what the budget outlook looks like in the year 2030 if we do not save the surplus, but even if we do assume that we stick with the discretionary spending caps. And in the year 2030, you will see that the discretionary spending has all but been eliminated.

Unfortunately, discretionary spending in our current vernacular includes things like national defense, the infrastructure, the judicial system, etcetera. The reason that this happens is because of the explosive growth, projected growth in Social Security, Medicare, and other entitlement programs that we must begin to get control of.

And the last chart, Mr. Chairman, represents a projected increase in the payroll taxes associated with the Medicare program if the program continued to be funded based upon a payroll tax structure for Part A. Social Security and Part A, you can see there will be a dramatic escalation of the tax burden on future generations.

Mr. Chairman, I have a significant amount of information contained within my statement which I would ask that it be included for the record.

The CHAIRMAN. The full statement will be included.

Mr. WALKER. Thank you, Mr. Chairman.

[The prepared statement of Mr. Walker appears in the appendix.]

Mr. WALKER. What I would like to do, if I can, since I know that you and the other Senators have had a chance to look at that is to now just come to the bottom line. Mr. Chairman, I believe that it is important to note the historic opportunity presented by the recently projected budget surpluses, but to note that they are projected budget surpluses.

As recently as 2 years ago, they were projected budget deficits. And I think it is important that we keep that in mind. I think it is especially important if we keep that in mind when we are talking about potential real spending increases in an entitlement program that would be hard coated for the future.

The bottom line is that surpluses represent both an opportunity and an obligation. We have an opportunity to use our unprecedented economic wealth and fiscal good fortune to address today's needs, but an obligation to do so in a way that improves the prospects for future generations.

This generation has a stewardship responsibility to future generations to reduce the debt burden they inherit, to provide a strong foundation for future economic growth, and to ensure that the future commitments are both adequate and affordable.

Prudence requires making the tough choices today while the economy is healthy and the cohort of workers is relatively large. National savings pays future dividends over the long term, but only if meaningful reform begins soon. Entitlement reform is best done with considerable lead time to phase in the changes and before the changes need to become dramatic and disruptive.

The prudence use of the Nation's currently projected budget surpluses combined with meaningful Medicare and Social Security program reforms can help us to achieve these objectives.

Mr. Chairman, that concludes my summary remarks. I will be more than happy to answer questions after Dr. Crippen has had a chance to make his statement.

The CHAIRMAN. Thank you.

Dan, do you want to proceed?

## STATEMENT OF HON. DAN L. CRIPPEN, PH.D., DIRECTOR, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC

Dr. CRIPPEN. Mr. Chairman, Senator Moynihan, and other members of the committee, the last time we were together, we discussed the nature and the size of the reforms needed for the Medicare program, particularly as the baby boomers swell the ranks of the retired.

The President's latest proposals address some desirable reforms, including the addition of a pharmaceutical benefit for the elderly. It is worth noting, Mr. Chairman, that these issues are not new.

Soon after Medicare was enacted in 1965, the cost of the program began to exceed all estimates. We have been chasing that tail ever since. And in 1969, only 3 years after the program began, there was serious consideration of a proposal to add pharmaceutical benefits to the coverage—coverage that has been considered at least once a decade ever since.

The President's proposal provides a framework for making significant changes to the Medicare program. It is intended to mod-

ernize Medicare's benefits, enable the Federal Government to become a more prudent purchaser of health services, and encourage price competition among health plans to slow the growth of Medicare spending in the longer term.

The CBO estimates that the President's Medicare reform plan would increase Federal outlays by $111 billion over the next 10 years. I will be referring now to Table 1 in my prepared statement, which is also reproduced on the chart up here, Mr. Chairman.

There are three components to our analysis and the resulting differences with the President's estimates. The most significant is obviously the cost of the pharmaceutical benefit. The President proposes a new prescription drug benefit that would provide first-dollar coverage of an annual limit of $2,500 in 2008, when fully phased in. Although most Medicare enrollees are to receive some benefit, the average is a 25-percent subsidy up to the limit. The proposal would not substantially protect those in poor health who incur very large out-of-pocket expenses for prescription drugs.

Before we go much farther, I would like to discuss what may be the nature of the problem here. According to HCFA, as we just heard from the Secretary and have read about in past publications, about 35 percent of Medicare beneficiaries lack drug coverage. That percentage probably has not changed much in the recent past. More beneficiaries are enrolled in managed care plans and most of them have coverage, but fewer retirees are likely to have coverage from their employers now, as the Secretary noted. Moreover, some beneficiaries, especially those who are purchasing Medigap coverage, have quite meager benefits. The coverage offered in the President's proposal would be more generous than Medigap. Concerns about the adequacy of drug coverage are growing as Medicare HMOs are now also cutting back their drug benefits.

The other side of the story is that 65 percent of beneficiaries do have coverage. And those who have employer-sponsored retiree plans usually have generous benefits, including protection against catastrophically high drug expenses.

Our estimates are higher than the administration's, for what we think are three good reasons. First, our estimates have the advantage of reflecting data released by HCFA only a few days ago that clearly indicate more cost growth than was previously estimated. Moreover HCFA assumes that this growth will slow sharply over the next few years. We also assume that the slowdown will occur but that it will not be quite as dramatic as those projections suggest.

Second, we have included drug costs for Medicare beneficiaries who are in nursing homes—something the actuaries do not currently account for.

Finally, we expect that the cost of Medicaid will be substantially higher, largely because some of the elderly who are currently eligible for Medicaid but are not enrolled will enroll to take advantage of the drug benefit. Currently, approximately 2.6 million elderly people are potentially eligible for Medicaid but are not enrolled.

The President proposes a number of cost-saving measures for the traditional fee-for-service program, including the extension of some provisions of the BBA that limit payment updates beyond 2002. The President would provide a small amount of additional funds to

reduce the more immediate impact of the payment reductions through as—yet—unspecified legislation. On balance, payments to providers would be reduced from baseline levels, although those reductions would accrue only after 2002. The President also proposes to change some of the beneficiary cost-sharing requirements with a net increase in contributions by recipients.

We estimate that the total savings in the traditional program proposed by the President would be somewhat lower than his estimates suggest. Most of the difference is in the estimated effects of new authorities to be given to the Secretary of HHS. Some of the difference stems from skepticism about how both beneficiaries and providers would react to new incentives that may be implemented by the Secretary, and some stems from lack of specificity in proposals made by the President.

The proposed competitive defined benefit would provide new opportunities for Medicare's managed care plan to compete on the basis of price as well as quality of service. Although the President's proposal would introduce new elements of competition among health plans that could help slow the growth of Medicare spending, it would fall short of a fully competitive program. By establishing the fee-for-service sector as the benchmark for defining Medicare benefits and setting premiums for health plans, it would blunt the incentives for efficiency. For that reason, CBO has serious reservations about the magnitude of savings that could be expected from the competitive defined benefit.We have not, however, completed an independent estimate of that part of the proposal. And for purposes of today's testimony, we have used the savings estimated by the administration as a placeholder.

Finally, the President proposes to pay for the Federal share of the prescription drug benefit through transfers from the general fund. As both the Comptroller General and I have testified in the past and as he said just a few moments ago, those transfers are promises to pay future benefits with future general revenues. How burdensome that commitment might be depends on both the growth of future spending for prescription drugs and the growth of the economy over the coming decades.

Overall, the President's proposals provide incremental changes in some promising directions. They fall short of fundamental reform, however. For example, reducing payments for fee-for-service providers would yield Medicare savings without contributing to the program's efficiency, but improving the efficiency of the fee-for-service sector is key to achieving short-term cost savings and longer-term reform. Fee-for-service is likely to remain a plan of choice for most Medicare enrollees over at least the next decade, even under the most favorable assumptions about the growth of enrollment in managed care plans. Successful adoption of the contracting and payment methods that private health plans use to manage their cost could establish the basis for a competitive fee-for-service sector. But recent efforts to test such methods have not found much acceptance among providers, and the President's proposal treads lightly on that issue.

Another element of many reform proposals is rationalizing cost-sharing requirements. The President's provisions would modestly increase some of those requirements and lower others, without re-

ducing their complexity. A more thorough reform might subject all Medicare-covered services to a single deductible and uniform coinsurance rates, at the same time placing an annual limit on the amount that enrollees pay in cost sharing for all covered services—including drugs if that is part of the benefit package.

In conclusion, Mr. Chairman, the overall effect of the President's proposal is an increase in Medicare spending, largely funded with general revenues. The proposed pharmaceutical coverage would give a small benefit to most enrollees but would not provide catastrophic coverage to those with unusually high drug costs. The proposed reforms would move toward a more competitive system in the Medicare+Choice program but would do little to reform the traditional fee-for-service sector. Thank you, Mr. Chairman.

[The prepared statement of Dr. Crippen appears in the appendix.]

The CHAIRMAN. Thank you. Dave, in your prepared testimony, you expressed concern that financial controls, such as cost sharing in the Medicare program historically have eroded over time and that we have not always been successful in predicting the cost of program expansion.

You further suggest the discussion of funding thresholds that require a periodic congressional review, what you call threshold triggers, has led to criticisms that this conflicts with the entitlement concept of Medicare.

So I have two questions. One, how do you respond to such criticism? And can you elaborate on any specific threshold mechanism that you may have in mind?

Mr. WALKER. A couple of things, Mr. Chairman. First, we have been down this road before with regard to voluntary expansion of Medicare based on funding in part through general revenues. And that was Part B.

When we started out with Part B, it was anticipated that 50 percent of the costs would be paid for by the beneficiaries and 50 percent of the costs would be paid for by general revenues.

Today, 75 percent of the costs are paid for by general revenues and 25 percent of the costs are paid for by beneficiaries. So we really do not have a very good track record of being able to maintain fiscal discipline over these types of programs.

Secondly, we are talking about projected budget surpluses here. And the proposal would say that it is designed to pay for 60 percent of the estimated cost, but in large part based upon these projected budget surpluses and in the premiums that would be there.

I think we have to realize that these surpluses may or may not occur. And therefore, we have to have some mechanism that if in fact they do not occur, what can be done in order to try to restrain the escalating cost of this program.

In addition, there are a number of estimates, differences of opinion. Reasonable people can differ on what the real cost of this benefit is going to be, the difference between what HCFA's actuary, OMB, and CBO have projected.

I know that there is great uncertainty here. For example, I was just out on the west coast with Cal Pers which is probably the largest public employee retirement system in the country, California system, about 2 months ago. And I know that prescription drugs

is the fastest growing part of their health care costs. And they are trying to figure out how they going to get control of these costs in the future.

So I think we have to have mechanisms in place that not just look at percentages, but look possibly at hard dollar limits, that look at percentages of the economy with regard to Medicare and certain other factors because there is a difference between what people want, what they need, and what we can afford.

And that is one of the problems quite frankly with regard to health care. We have not made a distinction between those. And we need to because if we do not, we are never going to control the costs.

The CHAIRMAN. Do you have any specific suggestion as to technique, process, or mechanism we should use?

Mr. WALKER. Well, I think several things. I think, one, the President in his proposal with regard to prescription drugs has tried to do some things to control utilization. I mean, he has a co-pay, but I think you can obviously look at the possibility of a deductible. You can look at whether or not the premium ought to be modified based upon ability to pay, how you might be target this benefit more.

And then, whoever you decide that you are going to target the benefit for, somehow consider some type of hard dollar limit or some type of mechanism, such as point of order or whatever to relook at this if we do create a new in effect Part D which is prescription drug benefit under Medicare.

The CHAIRMAN. Let me turn to another matter. The GAO has issued, I think, two reports recently indicating the Medicare+Choice plans are still overpaid after implementation of BBA revisions and that payment amounts are not the primary cause of ongoing Medicare+Choice plan withdrawal.

Now, I happen to believe that if plans were currently making excessive profits, they would not be withdrawing from the program. Can you correlate your findings with the large number of plan withdrawals we have been witnessing?

Mr. WALKER. Mr. Chairman, as you know, there is a difference between the urban areas and the rural areas with regard to this. I mean, there is a problem to begin with in trying to get these types of plans to go into the rural areas to begin with.

But with regard to Medicare+Choice, I think we have to keep in mind that a vast majority of these plans are making enough on them such that in addition to making a profit, they can offer beneficiaries enhanced benefits, in many case prescription drug benefits, for example, as a way to entice coverage under these programs.

So in many cases, I think what you are finding is that they can still make a profit, but they cannot provide as much of an enticement as otherwise they could do to attract coverage or they have to decide that they are going to take less than a profit if they are going to maintain the same benefit level.

And part of the issue is what is their target with regard to profit margin here? And I think in time, this thing with settle out. I think we had a lot of people rush into it. In some cases, they did not do enough economic analysis.

There was an over supply. And now, with some of the corrections that are occurring now, they are making more determinations on what makes economic sense based on their profit motive. In time, I think it will settle out.

The CHAIRMAN. And let me ask you, I am very much concerned that the President's plan may cause employers to drop retiree prescription drug coverage. Would you elaborate on those implications and the potential cost to the Federal Government?

Dr. CRIPPEN. We know, Mr. Chairman, that the cost will be at least 67 percent of the average cost in the program. That is the subsidy the administration proposes to use to keep employers offering their plans. That, coupled with the tax deductibility, as I think you pointed out in your opening remarks, may be enough to keep many employers in the game. Many of those benefit packages are more generous than what the President's proposal would be.

So between the 67 percent subsidy and the tax deductibility, we expect that most employers who have coverage today would continue the coverage at least for the foreseeable future, but doing so would have a cost because of the 67 percent subsidy off the top.

Mr. WALKER. Mr. Chairman, can I clarify one thing?

The CHAIRMAN. Yes, please.

Mr. WALKER. One of the things that we are talking about here is comparing the benefit package and what do you compare the benefit to in the case of Medicare. What is an appropriate comparison?

I think one thing just to note for the record, the comparisons that are being are comparing to benefit packages typically for active employees for the private sector. Only about 15 to 16 percent of employers in the private sector have any retiree health care whatsoever for their retirees.

A vast majority of employers are out of that business. And to the extent that they are in the business at all, they may or may not provide prescription drug coverage.

And so to the extent that individuals are getting this coverage now, in many cases they are getting it through Medicare+Choice. They are getting it through Medigap policies. Or they are getting it through other types of arrangements because for the most part, they are not getting prescription drug coverage through employer-sponsored programs in part because of the cost.

The CHAIRMAN. Senator Mack.

Senator MACK. Thank you, Mr. Chairman. He stayed, Mr. Chairman. I went back. I learned all I was going to learn from the Secretary. So I went back and I came back.

What are the unknowns with respect to prescription drugs that could affect the cost of the program? What are the things that both of you worry about as you try to project those costs?

And just so you know where I am going with this, as I said to the Secretary, I thought it made a lot more sense to begin the prescription drug coverage in a much more targeted way. And that targeted way would be to those at the lower end of the income ladder.

And one of the reasons in addition to the obvious is to try to get a sense about how it is all going to work. How are you going to

provide the prescription drugs to the pharmaceuticals? How is it organized?

And so what I am asking you is as you both looked at making your estimates, what are the concerns out there? What would you like to have more information about in order to have a better understanding of the impact?

Dan, will you start?

Dr. CRIPPEN. Well, a primary concern, Senator, is, of course, the base we start with—what it includes, what the level of benefit is, and how the subsidy adds to Federal cost. But more critical is the growth in cost. What are the trends? As in the Medicare program at large, the demographics are important, and the baby-boom numbers are critical.

Senator MACK. You are talking about utilization?

Dr. CRIPPEN. Both utilization and price. But as in the Medicare program itself, the critical factor is the cost per person and its growth, not just the number of people in the program.

So with these estimates, the most important driving factor is how fast the drug costs and utilization go up. And as we have found from the recent data, which are just days old, they are rising dramatically, even compared with the pace of growth a year ago. The assumptions on which the actuaries based the administration's estimates were that the drug costs and utilization for this program would go up by about 8 percent. They now have numbers that are double digits. And that is just the change from last year.

There are some design questions in this particular program that one also has to be concerned about. First, the limit is relatively high, as you pointed out, but not catastrophic in nature. So there is going to be a temptation to change the limit. That limit is indexed only to the consumer price index, not to drug costs or health care costs. So again, there will be pressure, I suspect, to legislate a higher limit at some point if this became law.

It is also important to keep Medicare current drug expenditures, in mind. Some limited drug expenditures now paid for in Part B will stay in Part B, with a 75 percent subsidy, but the drugs that will be included in Part D will have a 25-percent subsidy. So there will be a temptation to try to move drugs from D to B.

There are a number of things to worry about in the design of the program. But in terms of its implementation and experience, the single most important concern is the growth of cost.

Mr. WALKER. Three things, Senator, first utilization, secondly——

Senator MACK. Let me stop you there. I assume there are factors. They are several layers of things that can affect utilization. Is that right?

Mr. WALKER. Well, and obviously one of the things can affect is what kind of financial incentives exist for the individual to decide whether or not they are going to seek an additional prescription drug benefit or whatever and whether or not they are going to be covered to begin with. I think that is the second point, and/or selection.

One of the concerns that you have to guard against is my understanding of the President's proposal, it would be a voluntary program. People would make an election at the point in time that they

become eligible for Medicare, e.g., age 65 as to whether or not they want to participate in this program or not. They can get out, but they could not get in after that point in time.

So it would be a one-time election. So therefore, people would then have to make a judgment based upon the design of this program and based upon how much prescription drug coverage they expect they are going to need as to whether or not they want to play or not.

Depending upon the design, you could have a circumstance in which people are expecting much higher prescription drug cost would play. And the people that don't would not.

And the last one I guess would be, the major one would be the fact that a lot of the benefit is being funded based upon a projected surplus which may or may not occur. And therefore, what kind of safety valves are there in the event that this surplus does not occur.

Senator MACK. Let me just touch upon another subject I know a little bit about. So I could be dangerous. The competitive defined benefit, and we hear the word "competition" used over and over and over again in the presentation of the President's proposal.

As I understand it though, that competition is a fairly small portion of the overall Medicare program. That is for the managed care portion of it. Is that correct?

Dr. CRIPPEN. It is correct, Senator. And the administration does not claim to get a lot of savings out of that either. But the flip side is that the administration does not propose a lot of new competition for the fee-for-service program, which, as I said in my opening remarks, is the most important program in the foreseeable future.

Senator MACK. There would be an establishment of this defined benefit. It would be an invitation to bid on those benefits. Then, there would be the effort by the provider to enroll beneficiaries in the program.

And then, after that, there will be a risk adjustment done by, I will say, HCFA. I am not sure who does it, but someone does a risk adjustment. Is that going to entice providers into this form of business?

I guess what I am raising here is, will they not kind of see this last step as risk adjusted process something that could put them very much at risk about whether they actually go into the program?

Dr. CRIPPEN. Certainly, there is now the risk adjuster, Senator. I think the overall assumption behind the President's plan is that there will be providers here who will meet the needs of any beneficiary. I do not know if that is a safe assumption.

Part of the calculus that you did not mention is that individuals would have an incentive to join these managed care plans because the difference between the price the plans charge and the reference price would be shared by the government and the individual. But that assumes that the individual is willing to trade in $1 of insurance benefits for $0.75 in cash and maybe pay a premium somewhere else. So it is far from clear.

As I said in my opening statement, we are not sure exactly how the President's proposal is going to work. But for the moment, we

have assumed that the administration's estimates are probably about right because they are not making strong claims.

Senator MACK. My time is about up. And so if you have a real quick answer.

Mr. WALKER. Senator, risk adjustment is a double-edged sword. On one hand, it could have an impact on whether or not insurance companies are willing to play and on what basis they are willing to play, including how long they are willing to play which we are seeing with regard to Medicare+Choice to a certain extent.

On the other hand, it is essential in order to avoid adverse selection because otherwise what you can have is creaming, where you can go out and try to preselect your population and try to design it since you are getting the people that are less likely to need the coverage. That leaves a lot more room for profit margin, if you will. So it is a double-edged sword.

Dr. CRIPPEN. Part of the problem, Senator, with risk adjusters is that they are certainly nice in theory but very hard to implement. The current proposal that HCFA has, for example, accounts for about 9 percent of the variance in health expenditures. So it accounts for little of the differences in expenditures among individuals.

The CHAIRMAN. Senator Gramm?

Senator GRAMM. Well, Mr. Chairman, first of all, thank you very much for the hearing. I just would like to express a frustration that this is at least the second and probably the third time that we have had our two official estimators or checkers of reality appear after we have had an administration witness where for all practical purposes most people are gone by the time we get the reality check.

And I would like to just suggest, Mr. Chairman, that maybe in the future we ought to have the administration one day and then have the reality check the next so that people have an opportunity to hear the facts after we have heard what unfortunately has become the propaganda.

I would like to outline a scenario that worries me about the prescription drugs. And just bear with me until I get through. And then, I would like to see if I can entice you to comment to see if you share some of the concerns.

Number one, today for people who are getting full payment of their pharmaceuticals in programs like Medicaid, we know that the level of average spending on pharmaceuticals, I think the number is $711. For people who have no third-party payment, it is less than $350.

So the one thing we know for sure is the demand for pharmaceuticals is pretty price elastic in terms of the price to the person that is consuming. If you are going to make them free or nearly free, people are going to increase consumption dramatically.

Secondly, there is some new data that suggests that half of seniors do not spend $500 a year on drugs. So they would have no incentive to join the administration's program, especially when they are younger seniors. I have seen figures as high as 40 percent of seniors do not spend $200 a year on pharmaceuticals.

So I think it is clear we are going to have a tremendous amount of adverse selection of people who are older, sicker, and heavier

users are going to tend to join the program. Younger people are not.

We started out with a 50/50 cost sharing on Part B. It is down to 25. We are not going to hold a 50/50 cost share. We are not going to be hold a $1,000 cap. In fact, the administration's program cuts on when you do not need it and cuts off when you do.

So we are going to end up increasing the amount that the government will pay. And I am concerned that if we have a universal system where everybody is involved, that we are going to end up with costs that ultimately will dictate, especially when we are already looking at the cost of the current program without repealing any of the Balanced Budget Act provisions and without adding pharmaceuticals, we are looking at in 25 years, Medicare costing at least 12 percent of payroll.

I do not see how if we adopt the President's program we can avoid spiraling costs, ultimately price controls, and ultimately rationing. Could I get you all to be so bold as to comment on that?

Dr. CRIPPEN. Senator, you have the luxury of making those assertions. I think, to be prudent, I should not.

Mr. WALKER. Senator, I think I have pointed out in the previous question that one of the things that we have to be concerned about is dependent upon the desire of the program as to whether they might be an opportunity for adverse selection.

And I think one of the things you are reinforcing is that you think in your opinion there would be under this program.

Senator GRAMM. And a lot of it.

Mr. WALKER. And utilization, obviously, there is tradeoff. I think one of the things candidly that we need to do in health care which I get concerned about when we approach health care incrementally is that issue that I talked about before, the wants, the needs, versus afford.

Everybody wants unlimited health care, whether it be prescription drug, whether it be acute care, whatever. They want unlimited. They need certain basic things. Arguably, they need to access to health care at group rates. They might need protection against catastrophic illness or whatever. I mean, they need that. I mean, whether they want it, they need it.

And then, we have to somehow to figure out how we can break this down to say, look, let us differentiate between what people want and what they need. Let us recognize that there is a difference between giving people access to health care at group rates so they can get insurability versus who is going to pay for it, how much they ought to pay, how much the taxpayers ought to pay.

And I think that is something we really have not done. And I think it is important that we do. I think the other thing we have to keep in mind is we have a consumption problem in health care. It is going out the roof. And yet, we are sending health care in many ways, including through the tax code big time.

And so we have a break. We have a disconnection between what we are trying to accomplish which is to make people more sensitive to the cost versus risk tradeoff to try to control consumption and utilization to try to prevent adverse selection. I think we need to look at it more comprehensively.

Senator GRAMM. Let me, Mr. Chairman, do one final question. In looking at the data that came out yesterday from the CBO on your mid-session review of the President's budget, you estimate that over the next 10 years as I read your numbers that the President will have basic spending up $207 billion, additional discretionary spending up $328 billion, the USA accounts which are outlays as you probably note of $245 billion, Medicare prescription drugs of $111 billion. Debt service will go up as a result of all of this spending.

And in total, the President, as I read your charts, would spend $1.33 trillion in additional spending as compared to what we are looking in terms of the budget that we have adopted if you projected it out 10 years. Am I reading that right?

Dr. CRIPPEN. Yes, sir. It is relative to our standard baseline which at the moment assumes that the caps are met through 2002 and that the amount of discretionary spending will go up with inflation thereafter .

Senator GRAMM. Well, Mr. Chairman, I would just like to note that with all of the whining and gnashing of teeth yesterday about your $794 billion tax cut, that even if you funded the President's Medicare plan with $111 billion, you are still with the tax cut and Medicare substantially below the total level of new spending the President is talking about.

So the incredible paradox is that while we have our Democrat colleagues screaming and hollering about us using the non-Social Security surplus for tax cuts, the President has in fact submitted a budget that spends far more in new spending than we are talking about in terms of tax cuts.

So every horror they talk about if we cut taxes by $794 billion in terms of not having the money for other things, if we spend $1.33 trillion, we will not have it for other things either. And the important thing is you can raise taxes and get the money back as we have proven on many occasions.

But if you start all these new programs, I do not see corresponding evidence that we can eliminate programs and save money. So I wish we had had this mid-session review a week earlier that we could have used in this debate. The facts would only confuse our critics and probably not help us. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Grassley?

Senator GRASSLEY. Thank you, Mr. Chairman. Dr. Walker, I would like to start with you about one of the main differences between the plan of the administration and the model that was put forth by the Medicare Commission. And that is that the administration would not force traditional Medicare programs to compete with private plans.

The commission suggested that including the fee-for-service program in this competition was necessary in order to modernize it. And so I would appreciate a comment from you on the effects of this aspect of the administration's plan.

Mr. WALKER. Well, Senator, my main comment that I would give you is that the President's proposal I think represents an attempt to get the debate going on reform, but it does not do nearly enough on sustainability. And it does not do anything hardly at all with

regard to the fee-for-service program which is where a vast majority of the dollars that we are dealing with here now.

And I think that is something that we are eventually going to have to come to grips with. We are going to have to come to grips with not just the issue of solvency, but also the issue of sustainability.

And we are also going to have to come to grips with meaningful reforms in the fee-for-service program. That is one possibility. What the Medicare Commission talked about is one possibility for coming at that.

Senator GRASSLEY. And both to you and Dr. Crippen, about the estimates that vary so much on the prescription drug benefit from the way that you have designed the benefit to who is covered. We have two very different estimates from the CBO and from OMB on the President's proposal, a difference of about $50 billion. And of course, this is not a small amount of money.

And it is why we need to proceed, of course, with caution when we decide how to provide a prescription drug benefit so we do not end up promising something that we cannot sustain. I am concerned that we may be relying on a strong economy's surpluses, the current level of Medicare savings which may not be sustainable to finance a program.

How can we craft the benefit in a responsible manner avoiding a financing disaster should the picture change?

Mr. WALKER. I think that you are correct. I think the differences between the numbers that HCFA has come up with and what OMB has come up with and what CBO has come up with serves to reinforce the inherent uncertainties, variability, the volatility associated with prescription drug cost.

We have to proceed with caution. Secondly, I think we have to recognize that this is an expansion of benefits in a program where we already have significant unfunded promises. And part of the expansion of benefits here is proposed to be funded by projected surpluses that may or may not occur.

So I think we need to look at, if the Congress decides that it is going to move forward on a prescription drug benefit, on targeting, targeting it to those that need it, on making sure that the design is such that there are adequate incentives to avoid adverse selection, and to control utilization and that there be some safety valves to make sure that if these surpluses do not occur that we can relook at the financing of this program to decide what, if any, adjustments are necessary.

And last, I think we have to shine a light on any program that the Congress would decide to go forward as the financial integrity of this benefit by itself because recent data has shown that this part of the health care costs is escalating much more rapidly than overall health care cost. And that is a matter of concern.

Senator GRASSLEY. Dr. Crippen, did your estimate include any suggestions of how to approach it so you do not avoid that $50 billion difference?

Dr. CRIPPEN. No, Senator. The difference in our estimates really reflect the last point that the Comptroller General made, which is that increases in both utilization and prices of drugs are much more rapid than we expected.

And so much of the difference between the estimate of CBO and the administration can be traced to the more current data, which show that prices are rising more rapidly.

Senator GRASSLEY. Dr. Crippen, do you see that as the administration plans on, at least one of the assumptions, a big downturn in the price of drugs? And that coincides obviously with the introduction of the drug benefit. I suppose it is a rationale for being able to pay for it and sustain it. Do you see that happening?

Dr. CRIPPEN. It is possible, Senator. The administration assumes that organizing this large a benefit would give benefit managers some power to negotiate discounts with pharmaceutical providers. And that is probably a reasonable assumption. Certainly, the present pharmacy benefit managers can do that. However, if every purchaser, including Medicare, received some discount, would the actual selling prices be lower or higher than if Medicare had not offered a drug benefit? Exactly how much pharmaceutical benefit managers could get through negotiation is unclear. But more important, Senator, is what the initial costs are going to be and how quickly will they grow. The discount, through an important factor in those initial cost estimates, does not have much to do with the out-year costs.

Senator GRASSLEY. Yes.

Mr. WALKER. Senator, I think the other issue is that while clearly due to the number of persons likely to be involved in a prescription drug benefit under Medicare, that would give one a significant amount of leverage to negotiate.

The question is, at what price? What price with regard to research and development and some other activities that are going on in the area of prescription drugs. And so there is no free lunch.

I mean, there is going to be an effect. And I know that even parts of the government have expressed concern about what the potential implications might end up being on the discounts that they are getting.

So I think we have to proceed with caution. I mean, I think there is increasing recognition that there may be a need to modernize the benefit package, but I hope that we just do not take a step backwards on the financial integrity of this program. I hope that we can make a step forward.

Senator GRASSLEY. Thank you, Mr. Chairman. Thank you, gentlemen.

The CHAIRMAN. Well, gentlemen, as always, your testimony is extremely useful. And we do hope to proceed with reform. So we will be counting on your continued advice and recommendations. Thank you very much.

The committee is in recess.

[Whereupon, at 5:23 p.m., the hearing was concluded.]

# APPENDIX

## ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

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### PREPARED STATEMENT OF DAN L. CRIPPEN

Mr. Chairman and Members of the Committee, I am pleased to be here today to discuss the President's recommended changes to the Medicare program. Those recommendations build on several of the major Medicare provisions in the President's budget proposal for fiscal year 2000. They also reflect some of the ideas generated by the Bipartisan Commission on the Future of Medicare, which completed its work in March. In addition, the President's proposal takes into account the growing concerns that some groups of health care providers have about the effects of the Balanced Budget Act of 1997 on Medicare payments.

Key features of the President's proposal include adding a prescription drug benefit to Medicare, making broad changes to the traditional fee-for-service program, converting the Medicare+Choice program into a competitive defined benefit program, and transferring revenues from the general fund to Medicare. The proposal lacks specificity in several important areas, however. That vagueness limits the Congressional Budget Office's (CBO's) ability to estimate the costs of some parts of the proposal and makes the estimates that CBO has been able to produce more uncertain.

My testimony today describes the major provisions of the President's proposal as outlined in the July 2, 1999, report from the Domestic Policy Council. It then discusses CBO's analysis of those provisions and provides cost estimates where feasible.

#### OVERVIEW OF THE ESTIMATE

CBO estimates that the President's proposal would increase outlays for Medicare and Medicaid by $111.1 billion over the 2000-2009 period (see Table 1). By comparison, the Administration estimates the 10-year cost of the proposal at $45.7 billion. In CBO's view, outlays for the prescription drug benefit would be $168.2 billion, offset in part by $57.1 billion in savings from fee-for-service changes and from greater price competition among managed care plans (see Table 2). More than one-quarter of the net increase in federal spending would occur in the Medicaid program, including new spending for prescription drugs that would be paid for entirely by the federal government.

#### PRESCRIPTION DRUG BENEFIT

The President's proposal would create a voluntary outpatient prescription drug benefit under a new Part D of Medicare. The benefit would begin in 2002 and would be fully phased in by 2008. The benefit would pay half of the cost of prescription drugs (up to a specified cap) and would be financed by premium payments from enrollees and general revenues. Taking cost sharing and premiums into account, the average enrollee would pay about 75 percent of the cost of covered drugs up to the cap.

## TABLE 1. TEN-YEAR ESTIMATES OF THE PRESIDENT'S MEDICARE PROPOSAL (In billions of dollars)

| | Administration | CBO |
|---|---|---|
| Benefit Payments[a] | | |
| Prescription drug benefit | 118.8 | 168.2 |
| Changes to fee-for-service Medicare | -64.2 | -48.2 |
| Competitive defined benefit[b] | -8.9 | -8.9 |
| Subtotal | 45.7 | 111.1 |
| Transfers from the General Fund | 327.7 | 327.7 |
| Total | 373.4 | 438.8 |

SOURCES: Congressional Budget Office (based on the July 1999 baseline) and Office of Management and Budget.

a. Includes effect on Medicaid.

b. Administration's estimate.

TABLE 2. ESTIMATED COST OF THE PRESIDENT'S MEDICARE PROPOSAL (By fiscal year, in billions of dollars)

| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | Total, 2000-2004 | Total, 2000-2009 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Prescription Drug Benefit | | | | | | | | | | | | |
| Medicare outlays | 0 | 0 | 14.1 | 20.9 | 26.4 | 29.9 | 34.6 | 38.3 | 44.3 | 48.8 | 61.3 | 257.3 |
| Medicaid outlays | 0 | 0 | 0.8 | 1.6 | 3.0 | 4.6 | 5.1 | 5.4 | 5.8 | 6.2 | 5.3 | 32.4 |
| Part D premium receipts | 0 | 0 | -7.1 | -9.9 | -12.5 | -14.1 | -16.3 | -17.9 | -20.8 | -22.8 | -29.5 | -121.5 |
| Subtotal | 0 | 0 | 7.8 | 12.6 | 16.8 | 20.5 | 23.3 | 25.8 | 29.3 | 32.2 | 37.2 | 168.2 |
| Changes to Fee-for-Service Medicare | | | | | | | | | | | | |
| Adjustments to providers' payments | 0.4 | 1.7 | 0.9 | -1.1 | -2.3 | -3.3 | -4.3 | -5.5 | -6.8 | -8.1 | -0.3 | -28.3 |
| Adjustments to beneficiaries' cost sharing | 0 | 0 | -0.1 | -0.3 | -0.4 | -0.6 | -0.7 | -0.9 | -1.0 | -1.2 | -0.9 | -5.3 |
| New options for paying providers | 0 | -0.2 | -0.3 | -0.3 | -0.4 | -0.4 | -0.4 | -0.5 | -0.5 | -0.5 | -1.2 | -3.5 |
| HMO and Medicaid interactions | a | 0.4 | 0.1 | -0.5 | -0.9 | -1.6 | -1.9 | -2.7 | -3.6 | -4.5 | -0.8 | -15.1 |
| Part B premium interaction | -0.1 | -0.2 | -0.1 | 0.1 | 0.3 | 0.5 | 0.6 | 0.8 | 1.0 | 1.2 | -0.1 | 4.0 |
| Subtotal | 0.4 | 1.7 | 0.5 | -2.1 | -3.8 | -5.4 | -6.7 | -8.8 | -10.8 | -13.1 | -3.3 | -48.2 |
| Competitive Defined Benefit[b] | 0 | 0 | 0 | 0 | -0.4 | -1.0 | -1.5 | -1.8 | -2.0 | -2.2 | -0.4 | -8.9 |
| Total | 0.4 | 1.7 | 8.3 | 10.5 | 12.6 | 14.1 | 15.1 | 15.2 | 16.4 | 16.8 | 33.5 | 111.1 |
| Medicare | 0.4 | 1.6 | 7.5 | 8.9 | 9.7 | 9.5 | 10.1 | 9.8 | 10.7 | 10.7 | 28.1 | 78.9 |
| Medicaid | a | a | 0.8 | 1.6 | 3.0 | 4.6 | 5.0 | 5.4 | 5.7 | 6.1 | 5.4 | 32.2 |

SOURCE: Congressional Budget Office based on the July 1999 baseline.

NOTE: Numbers may not add up to totals because of rounding.

a. Less than $50 million.

b. Administration's estimate.

DESCRIPTION OF THE PROPOSAL

In 2002, all Medicare enrollees would have a one-time opportunity to purchase the new benefit. In later years, enrollees would be permitted to choose the Part D option only when they first became eligible for Medicare, with two exceptions: beneficiaries whose primary coverage was employer sponsored would have a one-time opportunity to enroll after retirement (or after the retirement or death of the working spouse), and beneficiaries with employer-sponsored retiree health plans would have a one-time option to enroll if their former employer dropped prescription drug coverage for all retirees.

The new drug benefit would be administered by a pharmaceutical benefit management company (PBM) in each geographic area, selected through competitive bidding. All Part D enrollees would gain from the below-retail prices that PBMs can typically negotiate. The benefit would include no deductible and would generally pay 50 percent of an enrollee's prescription drug costs, up to an annual cap per enrollee. That cap would be set at $1,000 in 2002 and would gradually rise to $2,500 in 2008. Thus, in 2008, a beneficiary who purchased $5,000 in prescription drugs would receive the maximum reimbursement of $2,500. That beneficiary would also pay $634.80 in Part D premiums that year. After 2008, the cap would be indexed to annual changes in the consumer price index (CPI). Assuming that the cost of prescription drugs continued to rise more rapidly than the CPI, the real value of the benefit cap would shrink, thereby eroding the benefit.

Low-income participants would receive subsidies through the Medicaid program. Medicaid would pay both the premiums and the cost-sharing expenses, at the usual federal/state matching rate, for participants who were also fully eligible for Medicaid (so-called dual-eligibles) or who had income below the poverty line. The federal government would pay all of the premiums and cost-sharing expenses for other Part D enrollees with income less than 135 percent of the poverty line and part of the premiums for Part D enrollees with income between 135 percent and 150 percent of the poverty line (see Table 3).

Eligibility for those subsidies would be determined by state Medicaid agencies. Neither the federal nor the state governments would be liable for covering any drug expenses above the Part D benefit cap for low-income beneficiaries who were not fully eligible for Medicaid.

The President's proposal also includes an incentive that is intended to retain employer-sponsored drug coverage for retirees. Medicare would pay employers 67 percent of the premium-subsidy costs it would have incurred if their retirees had enrolled in Part D instead. In addition, enrollees in Medicare's managed care plans would receive their prescription drug coverage through those plans, which for the first time would be paid directly for providing such coverage (for enrollees who opted for the Part D benefit).

TABLE 3. GOVERNMENT SUBSIDIES FOR DRUG COSTS UNDER THE PRESIDENT'S PROPOSAL (In percent)

| Benefit Status | Percentage of Costs Covered by Government Payments | |
|---|---|---|
| | Part D Costs[a] | Costs Above the Part D Cap |
| Eligible for Full Medicaid Benefits | 100 | 100 |
| Eligible for Partial Medicaid Benefits or Not Eligible | | |
| Income less than 100 percent of poverty level | 100 | 0 |
| Income between 100 percent and 135 percent of poverty level | 100 | 0 |
| Income between 135 percent and 150 percent of poverty level | 25-50 | 0 |
| Income more than 150 percent of poverty level | 25 | 0 |

SOURCE: Congressional Budget Office.

NOTE: Includes government payments for drug costs in effect under current law as well as proposed new government payments.

a. Premiums and coinsurance.

Medicare now pays for a limited list of drugs provided on an outpatient basis. Those drugs would continue to be covered under Part B. Consequently, their costs would not be included in the cap on Part D benefits.

### CBO'S ESTIMATE

CBO estimates that the new Part D provisions would add a total of $168 billion to federal costs through 2009. (By comparison, the Administration's estimate of Part D costs is about $119 billion.) CBO estimates that Medicare outlays (net of premium receipts) would be $136 billion, and federal outlays for Medicaid would be $32 billion (see Table 4). States would also face additional Medicaid costs—totaling some $12 billion through 2009. CBO estimates that the premium for Part D would start at $25.20 a month in 2002 and rise to $52.90 in 2008 when the program was fully phased in (see Table 5).

CBO's cost estimate assumes that most people who are enrolled in Part B of Medicare would also enroll in Part D. But some of those who have employee-sponsored drug coverage for retirees would keep that coverage rather than enroll in the new program. CBO assumes that such people account for about 20 percent of Part B enrollees. In addition, about 7 percent of those eligible for benefits under Part B do not actually enroll. CBO assumes that they would also not enroll in Part D. Under those assumptions, about 31 million people would enroll in Part D in 2002, representing approximately 80 percent of total Medicare enrollment.

TABLE 4. ESTIMATED COST OF THE PRESIDENT'S PROPOSED PRESCRIPTION DRUG BENEFIT
(By fiscal year, in billions of dollars)

| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | Total, 2000-2004 | Total, 2000-2009 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medicare | | | | | | | | | | | | |
| Benefits | 0 | 0 | 13.0 | 19.3 | 24.4 | 27.7 | 32.1 | 35.5 | 41.0 | 45.2 | 56.6 | 238.1 |
| Part D premium receipts | 0 | 0 | -7.1 | -9.9 | -12.5 | -14.1 | -16.3 | -17.9 | -20.8 | -22.8 | -29.5 | -121.5 |
| Subsidy to health plans for retirees | 0 | 0 | 1.1 | 1.6 | 2.0 | 2.2 | 2.6 | 2.8 | 3.3 | 3.6 | 4.7 | 19.2 |
| Net outlays | 0 | 0 | 7.0 | 11.0 | 13.8 | 15.9 | 18.3 | 20.4 | 23.5 | 26.0 | 31.9 | 135.8 |
| Medicaid (Federal) | | | | | | | | | | | | |
| Part D benefits and premiums | 0 | 0 | 0.6 | 1.3 | 2.4 | 3.8 | 4.2 | 4.7 | 5.1 | 5.6 | 4.3 | 27.7 |
| Part A/B benefits and premiums | 0 | 0 | 0.2 | 0.2 | 0.5 | 0.9 | 0.8 | 0.8 | 0.7 | 0.6 | 1.0 | 4.7 |
| Net outlays | 0 | 0 | 0.8 | 1.6 | 3.0 | 4.6 | 5.1 | 5.4 | 5.8 | 6.2 | 5.3 | 32.4 |
| Net Effect on Federal Spending | 0 | 0 | 7.8 | 12.6 | 16.8 | 20.5 | 23.3 | 25.8 | 29.3 | 32.2 | 37.2 | 168.2 |
| Memorandum: | | | | | | | | | | | | |
| Medicaid (Federal) | | | | | | | | | | | | |
| Net outlays at usual federal/state match rate | 0 | 0 | 0.6 | 0.9 | 1.5 | 2.3 | 2.4 | 2.6 | 2.7 | 2.8 | 2.9 | 15.8 |
| Net outlays at 100 percent federal match rate | 0 | 0 | 0.2 | 0.7 | 1.5 | 2.3 | 2.6 | 2.8 | 3.1 | 3.4 | 2.4 | 16.6 |
| Medicaid (State) | | | | | | | | | | | | |
| Part D benefits and premiums | 0 | 0 | 0.3 | 0.5 | 0.7 | 1.1 | 1.2 | 1.4 | 1.5 | 1.7 | 1.5 | 8.4 |
| Part A/B benefits and premiums | 0 | 0 | 0.1 | 0.2 | 0.4 | 0.7 | 0.6 | 0.6 | 0.5 | 0.5 | 0.7 | 3.6 |
| Net outlays | 0 | 0 | 0.4 | 0.7 | 1.1 | 1.8 | 1.8 | 2.0 | 2.0 | 2.1 | 2.2 | 11.9 |

SOURCE: Congressional Budget Office based on the July 1999 baseline.

NOTE: Numbers may not add up to totals because of rounding.

TABLE 5. ESTIMATED MEDICARE COST PER PARTICIPANT OF THE PRESIDENT'S PROPOSED PRESCRIPTION DRUG BENEFIT (By calendar year, in dollars)

| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|---|---|---|---|---|
| Monthly Part D Premium | n.a. | n.a. | 25.20 | 26.30 | 34.70 | 36.70 | 43.10 | 45.40 | 52.90 | 55.50 |
| Cap on Benefits | n.a. | n.a. | 1,000 | 1,000 | 1,500 | 1,500 | 2,000 | 2,000 | 2,500 | 2,565 |
| Percentage of Participants over Cap | n.a. | n.a. | 36 | 39 | 30 | 32 | 26 | 29 | 25 | 26 |
| Average Benefit per Participant | n.a. | n.a. | 599 | 619 | 825 | 857 | 1,049 | 1,089 | 1,277 | 1,345 |
| Average Out-of-Pocket Expense per Participant[a] | 1,652 | 1,835 | 1,506 | 1,688 | 1,714 | 1,919 | 1,988 | 2,208 | 2,304 | 2,533 |
| **Memorandum:** | | | | | | | | | | |
| Monthly Part B Premium | | | | | | | | | | |
| Under current law | 49.50 | 53.90 | 58.00 | 64.10 | 70.70 | 76.80 | 80.90 | 88.20 | 94.60 | 101.20 |
| Under the proposal | 49.60 | 54.50 | 58.20 | 63.90 | 70.10 | 75.80 | 79.60 | 86.40 | 92.50 | 98.80 |

SOURCE: Congressional Budget Office based on the July 1999 baseline.

NOTE: n.a. = not applicable.

a. Average out-of-pocket expense before reimbursement by medigap, employer-sponsored insurance, or Medicaid.

In 2002, about 36 percent of participants would have drug expenses exceeding the $1,000 cap on Part D benefits. By 2008, when the benefit cap would be $2,500, about 25 percent of participants would have expenditures exceeding the cap. Part D benefits paid per participant would average about $600 in 2002, rising to around $1,280 in 2008.

CBO is estimating higher costs for the Part D benefit than the Administration. Both CBO and the Administration base their estimates of future drug spending on patterns reported in Medicare's Current Beneficiary Survey, and both adjust the amounts reported by noninstitutionalized people by approximately the same factor to account for underreporting. However, CBO's estimate also attempts to account for spending on prescription drugs by residents of nursing homes. The estimates also differ in their assumptions about the rate of growth in enrollees' spending on prescription drugs. The latest projections of national health expenditures indicate that the recent rapid rates of growth in drug spending will slow sharply over the next few years. CBO, however, assumes that the slowdown will not occur as rapidly as those projections suggest.

## OTHER ISSUES

Estimating the cost of a service not now covered by Medicare is inherently more difficult than estimating the cost of a change in the way a current service is paid for. The cost of the President's proposal for covering prescription drugs is uncertain because many design aspects of the new benefit have not yet been fully specified.

*Nature and Value of the Benefit.* Per capita spending for prescription drugs has been growing at double-digit rates in recent years—faster than other components of health care spending. Whether that rapid growth will continue, accelerate, or moderate is uncertain. A number of innovative drugs are likely to be cleared for marketing in the near future, which would tend to increase both the use and the average price of prescription drugs. However, a number of heavily used brand-name drugs are about to lose their patent protection (allowing entry of generic substitutes), which would tend to reduce prices. Hence, projections of the rate of growth

in drug use and prices are highly uncertain even in the absence of changes in insurance coverage. For this estimate, CBO assumes that recent growth trends will continue for several years and then moderate somewhat.

Another area of uncertainty is the extent to which the coverage provided under the President's proposal would increase drug utilization by enrollees. Half of Medicare enrollees already have coverage for prescription drugs (typically through a retiree health plan or Medicaid) that is at least as generous as the coverage offered under the President's plan. For the other half, the new Part D coverage would increase drug utilization by up to 25 percent, CBO estimates.

Part D is designed to ensure that most enrollees would receive some benefit. However, because of the cap on benefits, it would not protect enrollees with drug-dependent chronic conditions from very large out-of-pocket expenses. Although the benefit cap would reduce Medicare's exposure to increases in prescription drug costs, it would also limit the value of the benefit to people who are especially vulnerable to those costs. Alternatively, insurance that provided no first-dollar coverage but limited an enrollee's out-of-pocket costs would be less likely to cause increased utilization and more likely to protect enrollees from catastrophic expenses. Under such an alternative, however, fewer enrollees would expect to benefit.

*Effectiveness of the PBMs.* The President proposes to administer the drug benefit through private-sector PBMs, which private health plans commonly use to negotiate price discounts and control utilization. A single PBM, selected through competitive bidding, would administer the benefit in each geographic area. CBO's cost estimate assumes that those PBMs would reduce costs below the level that an uninsured retail purchaser would face by about 12.5 percent—savings that are smaller than PBMs now generate for large, tightly managed health plans. That estimate could change, however, as details of the proposal's design emerge.

PBMs produce savings for private health plans in four main ways. First, they negotiate discounts with pharmacies that agree to participate in their networks. Second, they obtain rebates from manufacturers of brand-name drugs in exchange for preferred status on the health plan's formulary. (A formulary is a list of drugs preferred by the plan's sponsor, in part on the basis of their lower prices.) Third, PBMs use mail-order pharmacies, which are often better able than retail pharmacies to save money. Mail-order pharmacies are likely to have lower average operating costs, and they can substitute generic or other lower-cost drugs for the ones prescribed. Finally, PBMs establish differential copayment requirements that encourage beneficiaries to select lower-priced options such as generic, preferred formulary, or mail-order drugs. Some PBMs also use management techniques such as on-line utilization review and prior approval to evaluate care and encourage the most cost-effective treatment practices.

It is uncertain whether the PBMs chosen to administer the Part D benefit under the President's proposal would have as much freedom to use those cost-saving techniques as they have in aggressive private insurance plans. For example, the proposal specifies that PBMs would have to set dispensing fees high enough to ensure participation by most retail pharmacies, which could reduce their ability to negotiate substantial discounts from pharmacies. The proposal also specifies that beneficiaries would be guaranteed access to off-formulary drugs when medically necessary, reducing PBMs' ability to negotiate rebates from manufacturers. Further, the proposal would limit their ability to encourage beneficiaries to choose lower-cost drugs through differential copayments. Although PBMs would not be prohibited from charging differential copayments, those copayments could not exceed 50 percent. Some private drug plans require enrollees to pay the full difference between the cost of a brand-name drug and its generic equivalent (if one exists) unless the prescribing physician specifically states that the brand-name drug is medically necessary. Such an approach would apparently not be permitted in the Part D program.

Indeed, how much incentive PBMs would have to generate savings under the program is uncertain. The President's proposal envisions competitive bidding to select the PBM for each geographic area, but it is unclear what financial risks, if any, the winning PBM would bear beyond the costs of processing claims. The proposal indicates that contractual incentives (such as performance bonuses) might be used to encourage PBMs to focus more aggressively on generating savings, but those mechanisms have not yet been specified. Nor is it clear how savings would be measured. Actual savings could disappear, even while nominal discount and rebate rates were unchanged, if the prices against which discounts and rebates were calculated rose as a consequence of the new benefit.

*Program Participation.* CBO's estimate assumes that everyone who participates in the Part B program would also participate in Part D, with one exception: most people who have drug coverage through retiree health plans would remain with those

plans. Those assumptions are quite speculative, however, and participation rates might well be lower or higher.

As noted above, employers would receive federal payments equal to 67 percent of the Part D premium subsidy for eligible retirees if they retained (or instituted) prescription drug coverage at least as good as the new Part D benefit. That subsidy payment, together with the tax deductibility of their health plan costs, would help induce employers to keep full drug coverage in their retiree health plans rather than eliminate it or wrap their plans' benefits around the new Part D package. (Employers with a wraparound plan would require Medicare to be the primary payer for prescription drugs, with the employer's plan serving as a supplement.) For their part, most retirees in employer-sponsored plans would probably prefer to continue with those plans rather than Medicare Part D, for two reasons. First, they would generally pay a lower premium for equivalent drug coverage in a retiree health plan than in Part D because employers typically pay more than 50 percent of the benefit costs. Second, retiree health plans usually provide much more generous drug coverage than Part D would, and getting all drug benefits through the retiree plan would avoid the problems associated with coordinating benefits. Nevertheless, CBO assumes that about one-quarter of Medicare enrollees who now have drug coverage through a retiree health plan would enroll in Part D because some employers would eliminate their drug coverage altogether.

The benefits provided under Part D would be very limited because of the 50 percent coinsurance rate and the benefit cap. Moreover, through their premium payments, enrollees would pay half of whatever benefits were paid out. Consequently, the federal subsidy under Part D would amount to less than one-quarter of enrollees' drug costs, on average. Despite those limitations, Part D would offer a more generous drug benefit package than standard medigap plans do, and at a lower premium. As a result, the three medigap plans that now offer drug coverage would no longer be competitive and might ultimately be replaced by a plan that supplemented the coverage offered under Part D.

Because of the one-time option to enroll and the 50 percent subsidy of premium costs, CBO expects that all Part B enrollees with medigap coverage or with no supplementary coverage would choose to enroll in Part D. People receiving Medicaid benefits under the proposal would also enroll in Part D because states would be required to cover their drug costs if they applied.

*Effects on Medicaid Costs.* As Table 4 showed, the President's proposal would increase Medicaid's costs for drugs and other benefits—substantially in the case of federal costs and less sharply in the case of state costs. Although Medicaid would no longer have to pay all drug costs for Medicare beneficiaries who now receive full Medicaid benefits, those savings would be more than offset by additional Medicaid spending on behalf of other Medicare beneficiaries.

Part D would pay for a portion of the drug costs that Medicaid now pays for Medicare enrollees at all income levels who are also fully eligible for Medicaid. That expansion of Medicare's role would lower both federal and state Medicaid costs by shifting them to Medicare. But the savings would be partly offset by the Part D premiums that Medicaid would have to pay for those dual-eligibles.

Low-income Medicare beneficiaries who are ineligible for full Medicaid benefits would also become eligible for assistance to pay for their Part D premiums and cost sharing. As noted above, the federal and state governments would share those costs for people with income below the poverty level. But the federal government alone would pay the premiums and cost sharing for beneficiaries with income between 100 percent and 135 percent of the poverty level, without any financial participation by the states. It would also pay a portion of the Part D premium costs for beneficiaries with income between 135 percent and 150 percent of the poverty level. To receive those benefits, however, eligible Medicare beneficiaries would have to enroll in the Medicaid program, and not all of them would choose to do so.

Medicaid spending would rise by more than the cost of the new prescription drug benefit. Many low-income Medicare beneficiaries who are ineligible for full Medicaid benefits are eligible to have their Medicare premiums paid by Medicaid—and in some cases, their cost sharing as well. A sizable number of them do not enroll in Medicaid, however. In 1998, an estimated 1.3 million Medicare beneficiaries with income below the poverty level were eligible for partial or full Medicaid assistance but did not participate in the program.[1] A further 1.3 million beneficiaries with income between 100 percent and 120 percent of the poverty level who were eligible to have their Part B premiums paid by Medicaid did not participate. The availability of a free drug benefit, made possible by enrollment in Medicaid, would attract more Medicare beneficiaries into the Medicaid program, boosting spending for other Medicaid benefits as well as for prescription drugs. Participation in Medicaid by bene-

ficiaries who are eligible for full Medicaid benefits might also increase somewhat, although their participation is already greater than that of other groups.

For this estimate, CBO assumes that the price of drugs under the proposed Medicare benefit for Medicaid beneficiaries would be similar to the price that Medicaid obtains under current law (including Medicaid rebates). If Medicare received deeper discounts and rebates, Medicaid costs would be lower. Conversely, if Medicare paid more for drugs, Medicaid costs would be higher.

FEE-FOR-SERVICE CHANGES

The President is proposing a host of policy changes for the traditional fee-for-service sector of Medicare. Those changes include modifying the pricing rules that govern payments to providers, changing beneficiaries' cost-sharing requirements, and permitting the Secretary of Health and Human Services (HHS) to supplement certain administered pricing systems with new options for paying providers. Together, those fee-for-service policies would reduce federal spending by an estimated $48 billion through 2009. (The Administration's estimate of fee-for-service savings is $64 billion.)

ADJUSTMENTS TO PROVIDERS' PAYMENTS

The proposal would increase payments to certain providers beginning in 2000, redirect some payments to hospitals that serve a large number of low-income patients, and reduce the growth in payment rates for many services after 2002. The net effect of those provisions would be to lower payments to fee-for-service providers by an estimated $28 billion through 2009

To relieve some of the financial pressures that the Balanced Budget Act of 1997 imposed on providers, the President proposes changing how certain provisions of that act are put into effect. Those changes can be made administratively and do not require legislative action. They include allowing more rural hospitals to be reclassified as urban hospitals to receive higher payment rates; delaying collection of past overpayments from home health agencies; increasing payments to certain hospitals for outpatient services; and delaying the expansion of the "transfer policy," which would have reduced some hospital payments. CBO does not "score" those changes in administrative policy because they do not involve a change in law, even though they would increase baseline spending. CBO will take the policy changes that the Administration implements into account in its next baseline projection of Medicare spending under current law.

The President is also proposing to establish a "quality assurance fund" to pay for future legislative changes that would increase payments to certain providers beginning in 2002. But his proposal does not specify policies to accomplish that increase in spending. Thus, CBO's estimate of the net impact of policies to adjust provider payments includes the Administration's figure of $7.4 billion, although that amount could change depending on specific legislative proposals.

Another proposed change is designed to help hospitals with large caseloads of indigent patients. The portion of payment rates for Medicare's managed care plans that reflects disproportionate share hospital (DSH) payments would be eliminated. (DSH payments are additional payments that Medicare makes when beneficiaries receive inpatient care from hospitals that serve a large number of low-income patients.) Instead, Medicare would make DSH payments directly to those hospitals when they provide inpatient care to patients enrolled in managed care plans. CBO estimates that redirecting DSH payments in that way would have a negligible effect on Medicare spending.

The President's proposal would also significantly reduce payments to certain providers in the longer term by continuing payment reductions imposed by the Balanced Budget Act beyond 2002. For many services, the act holds the increases in payment rates below the rate of inflation through 2002, with full adjustment for inflation resuming in 2003. The proposal would hold those increases below inflation through 2009 for hospital inpatient care, ambulance services, prosthetics and orthotics, hospice care, ambulatory surgical center care, durable medical equipment, clinical laboratory services, and parenteral and enteral nutrition. In addition, the proposal would extend a 2.1 percent reduction in payment rates to hospitals for capital-related costs through 2009.

ADJUSTMENTS TO BENEFICIARIES' COST SHARING

Other provisions of the President's proposal would require fee-for-service enrollees to pay more for Medicare services by indexing the Part B deductible to inflation and instituting coinsurance for clinical laboratory services. At the same time, the proposal would eliminate coinsurance for certain preventive services. The net effect of

those changes would be to reduce Medicare outlays by an estimated $5 billion through 2009.

The deductible for Part B has been $100 since 1991. Under the proposal, it would increase by the percentage change in the consumer price index beginning in 2002.

Medicare currently pays 100 percent of the approved fee for clinical laboratory services. Except for preventive services, the proposal would impose the standard Part B deductible and 20 percent coinsurance requirement on clinical laboratory services beginning in 2002.

By contrast, the President's proposal would waive both the deductible and the 20 percent coinsurance requirement for certain preventive services. That change would substantially increase the use of those services and would also increase demand for other services—particularly those furnished by physicians. However, much of the increase in spending for physicians' services would be offset by other policies that would reduce updates to the physician fee schedule.

NEW PAYMENT OPTIONS

Under current law, Medicare has limited authority to contract selectively, establish payment rates through competition or negotiation, or use many of the other techniques that private plans employ to manage spending and quality of care. The President's proposal would give the Secretary of HHS authority to adopt some of those techniques, including contracting with preferred provider organizations (PPOs), negotiating discounted rates for specific services, and developing systems to manage the care (in a fee-for-service setting) of certain diseases or beneficiaries.

The potential savings from those changes are substantial. The Administration estimates that granting the Secretary additional flexibility to manage pricing and utilization would save $25 billion over the next decade. However, major impediments stand in the way of realizing those savings. Thus, CBO estimates that the provisions would reduce payments to fee-for-service providers by less than $4 billion.

Providers often contract at a discount with private plans in the expectation of treating more patients. In turn, plans often require patients to pay substantially higher prices when they use providers who have not granted price concessions. As currently structured, Medicare's fee-for-service program does not have the tools that private plans use to extract such price concessions. About 85 percent of Medicare enrollees are indifferent to changes in cost-sharing requirements because they are insulated from those requirements by supplemental coverage—through employer-sponsored insurance, medigap insurance, a Medicare managed care plan, or Medicaid. More-over, the 15 percent of enrollees without supplemental coverage might have little incentive to switch to providers granting discounts. Under current law, Medicare's coinsurance mechanism for Part B services would limit their savings to no more than 20 percent of the discount. Consequently, it is not clear that the proposal for Medicare to contract with existing PPOs is feasible. Given the limited potential for increasing their market share, PPOs would probably not be willing to offer substantial discounts to Medicare.

Other contracting options proposed by the President might yield more savings to the extent that they promoted the efficient delivery of health services by high-quality providers. Those options include the Centers of Excellence proposal (which bundles payments for facilities and physicians for certain inpatient services, including treatment of heart conditions and joint surgeries); the global payment proposal (which bundles payments for facilities, professionals, and suppliers for all care provided at a specific site); and the proposal to coordinate care for certain high-cost conditions. Those proposals account for about two-thirds of CBO's estimate of savings from granting the Secretary additional flexibility.

The President also proposes that the Secretary be given authority to contract selectively for some Part B services other than those furnished by physicians. That proposal would expand on a demonstration project in Polk County, Florida, in which Medicare is selecting suppliers through a competitive bidding process for five types of products: oxygen equipment and supplies, hospital beds and accessories, enteral nutrition products and supplies, urological supplies, and surgical dressings. The demonstration, which is still in the development stage, has produced bids between 13 percent and 31 percent lower than Medicare's existing fee schedule for those supplies. However, negotiations with bidders—including some who were unsuccessful in the first round—are continuing, and CBO anticipates that some of those potential savings will erode over time.

Moreover, the Secretary faces substantial challenges in expanding competitive bidding to other areas and other services. In recent years, providers and elected representatives have voiced significant opposition in communities in which the Secretary has tried to reduce spending through competitive bidding and selective con-

tracting. CBO assumes that such opposition will continue to be a substantial impediment to expanding the competitive bidding model and realizing the potential savings from selective contracting.

### COMPETITIVE DEFINED BENEFIT PROGRAM

The President proposes to give Medicare's managed care plans various incentives to compete on the basis of price as well as quality. This "competitive defined benefit" proposal is extremely complex, and many of its details are unclear. CBO has not yet estimated the costs of the proposal and, for the present, is using the Administration's estimate as a placeholder. That estimate indicates that Medicare would save $8.9 billion through 2009.

*Description of the Proposal*

Beginning in 2003, the premium that Medicare beneficiaries paid would depend on the plan they chose. Beneficiaries who stayed in the traditional fee-for-service sector would pay the regular Part B premium. But those who chose cheaper plans would generally pay a lower premium, and those who opted for more costly plans would pay the extra costs of that choice. Managed care plans would submit a premium offer for the standard Medicare benefit package, enabling beneficiaries to make price comparisons among plans.

The actual amount that beneficiaries paid would depend on the difference between the premium of the plan they chose and a reference price, which would be 96 percent of the average costs in the fee-for-service sector. If they enrolled in a plan with a premium below the reference price, their Part B premium would be reduced by 75 percent of the difference (with the remaining 25 percent accruing to the government). What they would pay if they chose a plan with a premium above the reference price is less clear. But the proposal indicates that the federal payment would be capped at the amount the government would pay a plan whose premium was equal to the reference price. Consequently, beneficiaries would apparently pay the full difference between the cost of the plan and the reference price, which is more than the difference between the cost of the plan and the average fee-for-service cost. That requirement would mean that enrollees in plans with a premium just below the average fee-for-service cost—say, at 98 percent of that cost—would have to pay more than the Part B premium. More generally, beneficiaries choosing plans with premiums above the reference price could face hefty additional premium payments.

Suppose, for example, that average costs in the fee-for-service sector were $7,000 and the annual Part B premium for beneficiaries enrolled in that sector was $840, or $70 a month. The reference price would be 96 percent of $7,000, or $6,720. Beneficiaries choosing a less expensive plan with a premium, say, of $6,300 would have their Part B premium reduced by 75 percent of the difference ($420), or $315. So their annual premium would be $525, or $43.75 a month. The government would capture 25 percent of $420, or $105, and would pay a total of $5,775, which is the difference between the plan's premium and the beneficiary's payment.

In this example, if beneficiaries enrolled in plans with premiums at or below 80 percent of average fee-for-service costs, or $5,600, their contributions would be reduced to zero and the government would pay the full premium. By contrast, if they chose a plan with a premium at 110 percent of fee-for-service costs, or $7,700, their Part B premium would be $1,820 (about $152 a month)—more than double the fee-for-service premium. The government's contribution would be capped at $5,880, the difference between the reference price and the fee-for-service premium. That premium structure would give beneficiaries strong incentives to choose lower-cost plans if any were available in their market.

Managed care plans would receive their full premiums for the defined benefit package regardless of whether those premiums were above or below the reference price. But given the price structure that beneficiaries would face, plans would have a strong incentive to keep their premium offers below the reference price; otherwise, they would have difficulty competing against the traditional fee-for-service program. In markets with multiple plans, they would also have an incentive to compete against other managed care plans on the basis of price.

The government would adjust the payments to health plans to reflect differences in risk and geographic differences in cost. Plans enrolling beneficiaries with greater-than-average health risks and plans in high-cost areas would receive higher federal payments than other plans. Payments by beneficiaries would not be adjusted for those factors, however. Rather, beneficiaries would face premiums calculated as if all plans had average risk selection and were in average-cost areas.

Risk adjustment has been considered a perennial problem for the Medicare program, and full implementation of Medicare's new risk-adjustment system is not expected until after 2003. Geographic adjustments have also been problematic. Under

this proposal, the government would increase payments to managed care plans in high-cost areas to reflect "full local costs." Payments in low-cost areas would not be reduced, however, below the levels mandated by the Balanced Budget Act.

Although the basic benefit would nominally be standardized, plans would be given the flexibility to reduce or eliminate Medicare's cost sharing as long as the value of cost-sharing reductions did not exceed 10 percent of the value of the benefit package. Plans could offer additional benefits for a separate premium. Both of those options would give them other means to compete against the fee-for-service sector and other managed care plans.

*Other Issues*

Promoting greater price competition in the Medicare program could broaden the options available to beneficiaries and slow the rate of growth of Medicare spending. Those outcomes are by no means guaranteed, however. Much would depend on the details of the proposal, many of which are unclear, and on the responses of beneficiaries and health plans to new incentives, which are uncertain. Moreover, the potential for effective price competition among health plans varies from market to market across the country. Experience with the Medicare risk program to date suggests that competition is more likely to occur in large, high-cost urban markets, although the nature of the geographic payment adjustment could modify that conclusion.

Under current law, there is effectively no price competition among Medicare+Choice plans. Medicare uses an administered pricing system to set its payments to plans, and plans are not permitted to offer cash rebates or other financial incentives to encourage enrollment. Instead, they have incentives to increase optional benefits rather than to reduce costs. Consequently, even though beneficiaries gain if they enroll in managed care plans that are more efficient than the fee-for-service sector, Medicare does not. Moreover, beneficiaries who might prefer less generous benefits for a lower price do not have that option. The President's proposal would remove that bias and allow both beneficiaries and the Medicare program to benefit from less costly choices.

The proposal goes only part way, however, toward establishing a competitive model for Medicare. The traditional fee-for-service sector—in which the large majority of Medicare beneficiaries are still enrolled—would not be required to compete fully on price with the private plans participating in Medicare. The special status of the fee-for-service sector could result in lower savings than other competitive strategies might yield.

Unlike a competitive model in which the reference premium was based on some average premium in the market, beneficiaries would not have to make payments in addition to the Medicare premium to remain in the fee-for-service sector. Moreover, the presence of low-cost plans would not affect the savings that other plans could offer beneficiaries, because the reference premium would be unaffected. Nonetheless, because the Medicare premium would be based on fee-for-service costs, if those costs rose faster than the costs of managed care plans, those plans might be able to offer beneficiaries significant premium discounts relative to the fee-for-service sector.

How plans would structure their offerings in this new type of competitive environment is very uncertain. It would depend on how responsive beneficiaries proved to be to changes in premiums. To date, what has attracted beneficiaries to switch from fee-for-service Medicare to managed care plans has been the lower cost-sharing requirements and additional benefits (especially coverage of prescription drugs) that those plans offer. With prescription drug coverage available in the fee-for-service sector under the President's proposal, managed care plans would lose one of their major comparative advantages, potentially slowing the growth of enrollment in managed care. How far reduced premiums might offset those effects is unknown. But if medigap premiums continue to rise as rapidly as they have in recent years and employers continue to limit their retirees' health benefits, plans with lower premiums that also offered reduced cost sharing would become increasingly attractive.

The mechanics for bidding and setting prices in the President's proposal are unclear, which adds to the difficulty of predicting the effects of the proposal on plans' behavior. With regard to the hold-harmless provision, for example, the proposal states that the increases in payments to low-cost areas included in the Balanced Budget Act would be maintained, but it does not provide details. The nature of the geographic adjustments for high-cost areas is also unclear. The effects on payments to plans would vary considerably if those adjustments reflected only price differences or if they also included differences in utilization patterns.

In particular, if the geographic adjustment took both price and utilization effects into account, efficient plans in high-cost areas might be able to use high payment rates to subsidize packages of supplemental benefits as well as offer the basic Medi-

care package for a low or zero premium. (Although plans would be required to charge a separate premium for supplemental benefits, there is no indication that such a premium would have to be anything more than nominal.) Under those circumstances, plans in high-cost markets would be able to compete against the fee-for-service sector and each other on both price and covered benefits. Such competition would be less possible in low-cost markets. Thus, although the proposal intends to reduce the current disparities in benefits among Medicare+Choice plans across the country, that outcome would be quite uncertain.

Another novel factor affecting plans' behavior is the new prescription drug option. The proposal would require plans to offer Part D benefits to beneficiaries who chose to participate in the program. Plans would receive a premium payment from Medicare for those beneficiaries, and they could also offer a separate prescription drug benefit for an additional premium. The premium offers that plans would make would apparently cover both Part B and Part D benefits for those choosing to enroll in Part D. Plans might compete by offering Part D coverage at a low rate or offering additional drug coverage for only a modest extra premium.

Given all of the uncertainties about how the proposal would be implemented and how plans and enrollees might respond, predicting future enrollment trends in Medicare's managed care plans is hazardous. In the short term, the growth of managed care enrollment might slow or even reverse if beneficiaries saw less need to switch from the fee-for-service sector once a prescription drug benefit was available. Even if beneficiaries proved to be highly responsive to reductions in the Part B premium and plans chose to compete on that basis, the effects of the proposal on the growth of Medicare spending are quite speculative. Would there be one-time savings—possibly stretched out over several years—as beneficiaries in fee for service shifted to managed care plans, essentially accelerating the current enrollment trend? Or would competitive forces be strong enough to foster efficiencies throughout the system, slowing the growth of costs in the future? That debate has been going on in the private sector since the mid-1990s, when many enrollees in employer-sponsored plans began to shift from fee-for-service to more tightly managed plans. It has yet to be resolved.

### TRANSFERS FROM THE GENERAL FUND

The President is proposing to augment Medicare's financing by making transfers from the general fund of the U.S. Treasury to the program's trust funds. Consistent with the policy outlined in the President's budget for fiscal year 2000, CBO estimates that $288 billion would be transferred from the general fund to the Hospital Insurance (HI) Trust Fund over the next decade. That transfer would delay by several years the projected date on which the HI trust fund will become insolvent by committing future general revenues to the program. It would do nothing to address the underlying rapid growth in spending for Medicare that will eventually outrun the revenues dedicated to the program.

An additional $40 billion would be transferred from the general fund to the Supplementary Medical Insurance (SMI) Trust Fund to finance part of the cost of the new prescription drug benefit. (For administrative purposes, Medicare's spending for prescription drugs and beneficiaries' premiums for that benefit would be accounted for in the trust fund.) The transfer would not materially alter the financial status of the trust fund. SMI benefits are funded by premiums, which cover 25 percent of costs, and general revenue, which covers the rest. The statutory formula allows SMI to maintain a small reserve to cover unforeseen contingencies, but the trust fund does not build up substantial reserves. Thus, the additional transfer associated with the prescription drug benefit simply means that the government's costs will be paid for out of general revenues.

### OTHER INITIATIVES

The President's proposal includes provisions outlined in his last two budgets to allow people under age 65 to buy into Medicare. Although the buy-in provisions have not changed significantly, other facets of the President's proposal might alter the estimates that CBO made earlier this year of participation in the buy-in program and associated costs. The proposal also calls on the National Association of Insurance Commissioners (NAIC) and the Secretary of HHS to develop new supplemental insurance options to protect beneficiaries from catastrophic costs. Such options could fundamentally alter the market for private medigap plans, which supplement Medicare.

The buy-in would be open to two groups: people ages 62 to 64 who do not have access to employment-based health insurance, Medicaid, or other public coverage; and displaced workers age 55 or older who have lost their health coverage because

of a job loss. The Administration's description of the provisions, including the estimates of the premiums that participants would pay, is essentially unchanged from the description in the President's budget. But the Medicare program itself would change significantly as a result of the other reforms that the Administration is proposing, especially the addition of a prescription drug benefit. The proposal does not address how the buy-in provisions would be modified by those changes or whether participants would be able to purchase prescription drug coverage. If prescription drugs were included in the benefit package, the buy-in premiums would probably be significantly higher than the Administration is suggesting, and problems of adverse selection in the buy-in program would be exacerbated.

The President's medigap provisions partly address a significant limitation in Medicare benefits—the absence of stop-loss coverage that would protect beneficiaries from catastrophic health expenses. Those provisions would mandate several actions, short of restructuring Medicare benefits.

First, the NAIC would be asked to develop a new medigap option that would limit out-of-pocket expenses and reduce, but not eliminate, beneficiaries' payments for deductibles and coinsurance. (The President's proposal assumes that prescription drug costs would not be covered by the new option.) Such a plan could provide important financial protection while maintaining some cost sharing, which would discourage unnecessary use of covered services. The medigap plans that are now available cover most of Medicare's cost-sharing requirements, and Medicare must bear the cost of the additional use of services induced by such coverage. If people who buy medigap insurance switched to the lower-cost, more basic coverage option, Medicare might reap significant savings.

Second, the Secretary of HHS would be authorized to review the standard medigap packages to determine whether changes should be made to their content or number. The Secretary would also report to the Congress on policy options for improving supplemental coverage for Medicare beneficiaries, including the possibility of having Medicare offer additional, optional coverage to limit out-of-pocket spending. A Medicare-sponsored supplemental plan would probably be extremely popular with beneficiaries, who might view it as more valuable than private insurance because it would be backed by the federal government. Such an insurance policy would severely limit the market for the slimmed-down medigap option that the NAIC is being asked to develop.

## CONCLUSION

The President's proposal provides a framework for making significant changes to the Medicare program. It is intended to modernize Medicare's benefits, enable the federal government to become a more prudent purchaser of health services, and encourage price competition among health plans to slow the growth of Medicare spending in the longer term. CBO estimates that the President's Medicare reform plan would increase federal outlays by $111 billion over the next decade.

The President proposes a new prescription drug benefit that would provide first-dollar coverage, with an annual limit of $2,500 in 2008, when the benefit was fully phased in. Although most Medicare enrollees would receive some benefit, the proposal would not substantially protect those in poor health who incurred very large out-of-pocket expenses for prescription drugs.

The President proposes to pay for the federal share of the prescription drug benefit through transfers from the general fund. Those transfers are simply promises to pay future benefits with future tax dollars. How burdensome that commitment might become depends on both the growth of future spending for prescription drugs and the growth of the economy over the coming decades.

The President proposes to extend some provisions of the Balanced Budget Act that limit payment updates beyond their 2002 expiration date. The President would also provide a small amount of additional funds to reduce the impact of the act's payment reductions through as-yet-unspecified legislation. On balance, payments to providers would be reduced from baseline levels, although those reductions would accrue only after 2002.

Reducing payment rates for fee-for-service providers would yield Medicare savings without contributing to the program's efficiency. But improving the efficiency of the fee-for-service sector is key to achieving short-term cost savings and longer-term reform. Fee for service is likely to remain the plan of choice for most Medicare enrollees over at least the next decade, even under the most favorable assumptions about the growth of enrollment in managed care plans. Successful adoption of the contracting and payment methods that private health plans use to manage their costs could establish the basis for a competitive fee-for-service sector. But recent efforts

to test such methods have not found much acceptance among providers, and the President's proposal treads lightly on that issue.

The President's provisions for rationalizing cost-sharing requirements would modestly increase some of those requirements and lower others, without reducing their complexity. A more thorough reform might subject all Medicare-covered services to a single deductible and uniform coinsurance rates, at the same time placing an annual limit on the amount that enrollees paid in cost sharing for all covered services (including drugs if that benefit was added to the program).

The proposed competitive defined benefit would provide new opportunities for Medicare's managed care plans to compete on the basis of price as well as the generosity of benefits and the quality of service. Although the President's proposal would introduce elements of competition among health plans that could help slow the growth of Medicare spending in the longer term, it would fall short of a fully competitive program. By establishing the fee-for-service sector as the benchmark for defining Medicare benefits and setting premiums for health plans, it would blunt the incentives for efficiency. For that reason, CBO has reservations about the magnitude of savings that could be expected from the competitive defined benefit. CBO has not completed an estimate of that part of the proposal, but the modest savings predicted by the Administration may be reasonable.

The overall effect of the President's proposal is to increase Medicare spending, largely funded with general revenues. Although it would move toward a more competitive system, the proposal would do little to reform the traditional fee-for-service sector.

ENDNOTES

[1] Ellen O'Brien, Diane Rowland, and Patricia Keenan, *Medicare and Medicaid for the Elderly and Disabled Poor* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, May 1999), p. 9.

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PREPARED STATEMENT OF HON. BOB GRAHAM

Thank you Mr. Chairman.

I want to thank you and Senator Moynihan for holding this important hearing on the President's Medicare reform proposal.

I am more optimistic than I have been in recent months that we are finally moving in the right direction toward a real, substantive debate over how best to reform the Medicare program. However, my optimism is tempered by our recent experience with the so-called debate" over the Patient Bill of Rights.

I hope that, unlike the managed care debate, we can work in a bipartisan manner to forge a compromise that modernizes the Medicare program and strengthens its fiscal integrity for our children and grandchildren.

As we engage in shaping a bipartisan reform bill, I have four priorities that I believe must be included in any final bill:

*1. My highest priority is building upon the efforts that we started back in 1997, by increasing Medicare's focus on health promotion and disease prevention for all Medicare beneficiaries.*

It is critical that we change the focus of the program from one that simply treats illness to one that prevents or delays the onset of illness.

This approach will slow the growth in costs to the program in the future and will improve quality of life.

While the President's proposal makes some important progress in this area, notably in eliminating cost-sharing for all current preventive benefits and initiating an education campaign for pre-Medicare beneficiaries, it is not sufficiently aggressive. I will work to ensure that any bill does more to promote healthy behaviors and to prevent or delay the onset of illness and disability.

*2. Second, Medicare must include a prescription drug benefit.*

I am encouraged that the debate has moved from the question of " If' we need a drug benefit to one of "What Type" of drug benefit is best.

While a universal benefit must be our final goal, I am also aware that there are fiscal constraints within which we must operate.

The President has proposed one version of a universal benefit.

It has some attractive features, particularly the absence of a deductible and relatively low premiums.

But I do have some reservations as to whether the benefit as proposed is attractive enough to trigger the level of voluntary enrollment needed to offset concerns

about adverse selection, particularly among beneficiaries with low annual drug expenditures.

*3. Third, any reform package must encourage an increased use of competitive bidding for all services and supplies, exclusive of physician services.*

This includes such program elements as Medicare + Choice and durable medical equipment.

Injecting competition into the Medicare program is essential to ensuring efficiency and innovation.

In this regard, I must applaud the President's proposal for moving Medicare in the right direction.

I also find it more than a little ironic that I find myself applauding the President's initiative less than a week after the Republican version of the Patient Bill of Rights passed the Senate with a provision that killed the Medicare Competitive Pricing Demonstration Program.

I hope that this important initiative does not face the same fate as its cousin in the Republican managed care bill.

*4. Finally, we must address Medicare's inability to keep itself modem and competitive over time.*

We can do this by employing a proposal which I put forward as part of my Healthy Seniors Promotion Act."

My bill would instruct the Institute of Medicine (IOM), on a five year cycle, to review the Medicare benefit package in light of current science and medicine, and make any recommendations for modifications in the benefit package to Congress.

The IOM's recommendations would be presented in legislative form and be placed on a "fast track" review process modeled after the Trade Act of 1974.

The IOM's recommendations would be subject to an up or down vote by Congress.

This proposal would leave the medical decisions to the experts and would get Congress out of the business of micro-managing the Medicare program.

Mr. Chairman, I look forward to working with you, the members of this Committee, and the Administration to craft a Medicare reform bill that constitutes true reform, true program modernization, and true fiscal discipline.

Thank you Mr. Chairman.

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PREPARED STATEMENT OF HON. DONNA E. SHALALA

Chairman Roth, Senator Moynihan, distinguished Committee members, thank you for this opportunity to testify before the Committee today. I am pleased to discuss President Clinton's plan to modernize and strengthen the Medicare program to prepare it for the health, demographic, and financing challenges that we face in the 21st century.

As we near the end of the 20th century, we can all point with great pride to the legacy of the Medicare program. Since it was enacted in 1965, Medicare has helped to lift and keep a generation of Americans out of poverty, while extending and improving the quality of their lives. During this time, the average life expectancy of Americans at age 65 has increased by 20 percent. Poverty among the elderly has dropped by nearly two-thirds, and access to care has increased by one-third.

But if we are to keep the promise of Medicare for future generations, then a program designed for the 1960's must be modernized and strengthened to meet the challenges of the 21st century.

President Clinton has a passionate commitment to strengthening Medicare for the future. When he took office six years ago, Medicare actually was projected to go bankrupt by this year. Working with the Congress, he has supported administrative and legislative changes that, along with a strong economy, have resulted in projected trust fund solvency through 2015. The Administration is gratified by this good news. The Congress should be too.

These projections represent a substantial improvement from 1997 and, based on current projections, they indicate that we have extended the life of the HI trust fund by a full 16 years and cut the 75-year actuarial deficit by 66 percent.

According to the Medicare Trustees and our independent actuaries, several factors have contributed to the economic good news for Medicare.

First, the robust national economy with its combination of low unemployment and low inflation has helped to increase payroll tax revenue into the trust fund and hold the line on health care costs.

Second, the Department's rigorous management of the Medicare trust fund and our historic attack on waste, fraud and abuse in the Medicare program have yielded

some remarkable results. Over the last two years alone, our efforts to halt these practices have returned more than $1.2 billion to the Medicare trust fund. This is the first time in the history of the program that an Administration's efforts to end waste, fraud and abuse have been identified as having a positive impact on the life of the trust fund.

Third, is the bipartisan Balanced Budget Act of 1997 (BBA), which is an important legacy of this Committee and the Congress. We share the concerns that many members of Congress have expressed about the unintended effects of the BBA on beneficiary access to certain services, and have included in the President's plan a specific reserve fund to deal with demonstrated access and quality problems. At the same time, I think we all agree that the BBA made necessary and overdue changes in the way Medicare pays doctors, hospitals, nursing homes, home health agencies, and other health care providers. These new systems, while challenging to develop, will help to make Medicare a more prudent purchaser of health care services.

While we modernized our payment systems, we also modernized the Medicare benefit package to include important new prevention services, including annual screening mammograms for women over 40, prostate cancer screening, colorectal cancer screening and diabetes management. These changes made Medicare more like the benefit packages offered to working-age Americans.

These are great accomplishments—accomplishments of which we can all be proud. But, as the President has repeatedly said, there is a pressing need to take additional bipartisan steps to strengthen and modernize the program for the future. Over the next 35 years, the size of the Medicare population will double from 39 to 80 million beneficiaries. Too many Medicare beneficiaries today are being forced to choose between food and medicine, and too few have access to affordable prescription drug coverage, the therapy of choice for tomorrow. And too often, Medicare cannot make use of private sector tools that can enhance market competition and efficiency in the program.

The President's Medicare plan builds on the hard work of the Bipartisan Commission on the Future of Medicare. I want to recognize, in particular, the leadership of Senator Breaux in bringing into focus for Congress and the American people the challenges facing Medicare in the 21st century. I also want to thank the other members of this Committee who served on the Commission—Senators Rockefeller, Kerrey and Gramm—for their work and notable contributions.

The President's historic initiative would: (1) make Medicare more competitive and efficient; (2) modernize and reform Medicare's benefits, including the provision of a long-overdue prescription drug benefit and cost sharing protections for preventive benefits; and (3) make an unprecedented long-term financing commitment to the program that would extend the life of the Medicare trust fund until 2027.

Mr. Chairman, let me discuss these three areas in more detail.

### MAKING MEDICARE MORE COMPETITIVE AND EFFICIENT

First, the President's proposal recognizes that if we really want to prepare Medicare to face the challenges of a new century, then we must first make the program more competitive and efficient.

As I mentioned earlier, President Clinton has worked to enact several Medicare reforms that, along with the strong economy and highly successful efforts to fight fraud, waste and abuse, have saved hundreds of billions of dollars and extended Medicare solvency from 1999 to 2015. The President's new plan builds on this success in several ways.

*Competition in Fee-for-Service:* The President's plan uses competition and negotiation to pay providers in the traditional Medicare fee-for-service program. Unfortunately, Medicare generally has been barred from engaging in competitive bidding and other "prudent purchasing" practices that the private sector has used to improve patient care quality and costs. In the current system, fee-for-service rates for some goods and services are above payments made by other purchasers, because they are determined by formulas set in law. These rates are the same for all providers, with no incentive for improved quality and efficiency. We believe Medicare should have access to the same proven strategies that private sector health care purchasers use so that we can get the highest quality care while spending the fewest taxpayer dollars.

One of the most exciting aspects of the President's proposals is that Medicare will be able to both recognize and reward high-quality providers while maintaining beneficiary choice. Under the President's plan, traditional Medicare will be able to establish preferred provider arrangements, with special rates and discounted beneficiary copayments for the highest quality and most efficient health care providers. We have had some experience with these types of purchasing techniques including the

"Centers of Excellence" demonstration project for coronary artery bypass graft surgery in which we recognize exceptional quality providers while at the same time reducing costs. Medicare will be able to make a single payment for certain procedures or conditions, provide incentives for qualified integrated delivery arrangements, and develop innovative pricing arrangements to promote quality and savings, as is commonly done in the private sector.

In addition, Medicare beneficiaries with multiple chronic health conditions will be able to select primary care case managers to help make sure they get the care they need while avoiding unnecessary procedures. We also will use disease management firms to truly manage a patient's condition and health care needs.

*Competition among Contractors:* The President's proposal also will increase competition among contractors who process fee-for-service claims. Current law severely restricts our ability to select fiscal intermediaries and carriers, and does not provide for competition in the selection process. This limits the types of companies with which we are able to contract and can create conflicts of interest with their private insurance business. Current law also requires us to pay contractors based on costs, which limits our ability to use market competition to get a better deal for taxpayers, and it includes special provisions that strictly limit our ability to terminate contracts.

The President's proposal will allow Medicare to contract with any company qualified to process claims. Payment to these contractors will be set through competition and will no longer rely on cost-based reimbursement that has no incentives for efficiency. And these contracts could be terminated on the same basis as any other government contract without regard to existing procedural requirements unique to the Medicare program that slow our efforts to obtain high quality, responsive contractor services.

*Competition in Managed Care:* The President's plan also uses competition to determine payment for HMOs and other private plans in the Medicare+Choice program, rather than the current system of government administered prices. Such payments now are based on complicated formulas set in law that result in excessive payment rates in many parts of the country and lower rates in others.

Many studies have shown that, because most plans operate where payments are excessive, actual Medicare payment for beneficiaries in managed care exceeds the true cost of the Medicare benefits delivered in these plans by billions of dollars each year. The Balanced Budget Act of 1997 made important adjustments to these formulas, but payments still vary widely and, according to the General Accounting Office, they are still excessive. A June 1999 GAO report says that, even with BBA reforms, plans received excess payments of $1.3 billion in 1998 and the amount of excess payments to plans will increase each year under BBA payment rules.

The President's proposal would extend competition to Medicare managed care plans by establishing a "Competitive Defined Benefit" program while maintaining a viable traditional program. The Competitive Defined Benefit (CDB) proposal would, for the first time, inject true price competition among managed care plans in Medicare. Plans would be paid for covering Medicare's defined benefits, including a new subsidized drug benefit, and would compete over price and quality. Price competition would make it easier for beneficiaries to make informed choices about their plan options and would, over time, save money for both beneficiaries and the program. The CDB would produce savings by providing beneficiaries with 75 cents of every dollar of savings that result from choosing health plans whose premiums are less than the traditional program. Beneficiaries choosing lower cost plans could reduce their Part B premium while beneficiaries opting to stay in the traditional fee-for-service program would be able to do so without an increase in current law premiums. This is important, because beneficiaries will be joining private plans by choice, and not through financial coercion.

*Smoothing and Extending BBA Discipline:* The President's plan also promotes efficiency by building on the fiscal discipline in the BBA and ensuring that its payment reforms are implemented prudently and effectively.

The President's plan sets aside $7.5 billion over 10 years for adjustments to the BBA that may be necessary to smooth out payment reforms that are affecting beneficiary access to high quality care. The Administration will continue to work with Congress, outside groups, and experts to identify real access problems and the appropriate legislative policy solution. In cases where there is credible evidence that adjustments are necessary to protect access to care, we have identified reserves to fund those adjustments.

While the BBA greatly constrained our administrative flexibility, the President's plan does include several administrative adjustments designed to moderate the impact of BBA on the ability of some health care providers to deliver quality services to beneficiaries. For example, we are considering budget-neutral adjustments during

a three-year transition to the new outpatient prospective payment system to increase payments to low-volume rural hospitals, low-volume urban hospitals, teaching hospitals, and cancer hospitals that otherwise will be disproportionately affected by the new system. To help all hospitals adjust to outpatient prospective payment, we are considering postponing implementation of the "volume control mechanism" specified by the BBA for the new system.

To ensure that program growth does not significantly increase after most of the Medicare provisions of the BBA expire in 2002, the proposal includes out-year policies that protect against a return to unsustainable growth rates, but have been developed to be more modest than those included in the BBA. The plan will reduce projected average spending growth from 4.9 percent to 4.3 percent per beneficiary between 2002 and 2009 through several prudent steps. For example, it limits rate increases for inpatient care payments over this period, but it varies these limits to recognize the distinct circumstances facing many rural hospitals. Similar prudent limits on rate increases are included for hospital outpatient care, laboratories, durable medical equipment, ambulances, ambulatory surgical centers, and other providers and suppliers.

*Improving Medicare Management:* The President's plan includes important provisions to improve Medicare management. Chief among these is establishment of a Management Advisory Council. Private and public sector experts will help the Health Care Financing Administration identify, adapt, and adopt innovations in customer service, purchasing, and management. The Council will improve service and strengthen accountability by creating a conduit to private sector savvy and by holding public meetings to air Medicare management issues. Similar advisory councils already are being developed to improve management in specific areas. A Citizens Advisory Panel on Medicare Education, with experts in medicine, health policy, and consumer education, will help make sure beneficiaries have timely, understandable and useful information about their rights and options in Medicare. And a Medicare Coverage Advisory Committee, with experts in medicine and science, along with consumer and industry representatives, will help to guide a new open, understandable, and predictable process for determining when new treatments and devices should be covered. This will serve to make Medicare more competitive and efficient.

The President's plan also includes structural reforms to improve communication and coordination with HCFA's regional offices and HHS, as well as provisions for increasing HCFA's management and personnel flexibilities.

MODERNIZING MEDICARE'S BENEFITS

The steps I have just outlined to make Medicare more competitive and efficient simply aren't enough. To fully prepare the program to face the challenges of the next century, we also must modernize the benefit package to include those services that have become essential elements of high-quality medicine. In particular, we must include an affordable prescription drug benefit that is available to all beneficiaries.

As this Committee well knows, when Medicare was created, no one could have imagined the role that prescription drugs eventually would play in modern medicine. Today, they are just as important as hospital care was at Medicare's inception. In fact, many argued in 1965 that Medicare was not necessary because a majority of seniors already had basic hospital and doctor coverage. Many make the same argument today against an affordable drug benefit available to all beneficiaries.

The prudent use of prescription medication can help older and disabled Americans minimize lengthy hospital and nursing home stays. Coverage of medications is absolutely essential to preventing, treating, and curing diseases. But despite the proven value of prescription drugs in keeping people healthy, many older and disabled Americans simply cannot afford them. In the wealthiest nation on earth, too many of our citizens are forced to choose between putting food on the table or filling their prescriptions. A drug benefit is not an option—it is an obligation.

This is why the President's plan provides all Medicare beneficiaries with access to affordable, comprehensive, optional coverage for prescription drugs. This retains the essential compact between our government and America's senior citizens; a lifetime of contributions during their working lives entitles them to equal access to the full range of Medicare benefits when they age into the program. A universal benefit also helps to ensure a true insurance product with a healthier risk pool and less adverse selection. But the new drug benefit is also completely voluntary. If individuals have better prescription drug coverage, they can stay with it.

It is important to remember, however, that at least thirteen million Medicare beneficiaries—one in three—have no coverage at all. They are forced to pay exces-

sively high costs for necessary medications because they do not get the deep discounts offered only to insurers.

Fifty-four percent of beneficiaries without drug coverage have incomes above 150 percent of the poverty level—about $12,750 for a single individual, $17,000 for a couple. And nearly half of all rural beneficiaries have no drug coverage—a much higher proportion than for all beneficiaries.

Moreover, millions of those who now have coverage find it expensive and unstable, with benefits eroding over time through deductibles and premiums. Only about one-quarter of beneficiaries have solid private insurance. Employer-based retiree health insurance covers about 25 percent of beneficiaries and is declining. Between 1994 and 1998, the number of large firms offering retiree health benefits for Medicare eligibles dropped 25 percent.

In addition, Medigap, which is an individually purchased supplemental policy, provides drug coverage for less than 10 percent of beneficiaries. Medigap premiums have been rising rapidly due in part to increasingly poor risk pools, and the additional costs for drug coverage are typically at least twice as much as the premium in the President's plan. Medigap premiums tend to go up as beneficiaries age, which makes maintaining coverage more difficult as beneficiaries get older. Finally, 12 million beneficiaries live in areas without access to Medicare managed care plans, but even for those with access to plans, the coverage is typically limited—nearly 60 percent of plans cover less than $1,000 in costs. Many plans are raising premiums and limiting coverage.

For beneficiaries who choose to participate in the new drug plan, Medicare will pay half the program costs and beneficiaries will pay monthly premiums to cover the other half. Beneficiaries will pay half the discounted cost of each prescription they fill, with no deductible. The benefit will cover up to $2,000 of prescription drugs when coverage begins in 2002, rising to $5,000 by 2008. After that, the dollar amount of the benefit cap will increase each year by the increase in the Consumer Price Index. For low-income beneficiaries, State Medicaid programs will pay premiums and cost sharing. And we will extend assistance to more low-income beneficiaries—up to 150 percent of the federal poverty level. Financing will be handled through a new "Part D," and premiums will be collected the same way that Medicare Part B premiums are collected, as a deduction from Social Security checks for most beneficiaries who choose to participate.

Private pharmacy benefit management firms will administer prescription drug coverage for beneficiaries in original fee-for-service Medicare. These firms will bid competitively for regional contracts to provide the service. They—not the government—will continue to negotiate discounted rates with drug manufacturers, and beneficiaries will receive these discounted rates even after they exhaust the Medicare benefit coverage. These private sector firms will be required to meet access and quality standards. For example, they will have to use programs designed to prevent adverse drug interactions. And their contracts will include incentives to keep costs and utilization low. However, the government will bear most of the financial risk.

Our plan also includes incentives for employers who currently offer retiree coverage to maintain that coverage. After all, we want beneficiaries to be able to maintain their current employer-sponsored drug benefit if it is at least as good as the Medicare benefit. These incentives will discourage employers from substituting the new Medicare benefit for existing private sector coverage and minimize disruptions in parts of the market that are working effectively. This incentive plan is a good deal for employers, beneficiaries, and the Medicare program.

Beneficiaries enrolled in Medicare managed care will receive this Part D coverage through their health plans. These plans will be allowed to offer supplemental drug coverage in addition to the Part D benefits as they can do with any benefit under our proposal.

Each pharmacy benefit firm may establish a formulary, or list of preferred drugs, in accordance with basic requirements that every therapeutic class covered under Medicaid be covered, and they will have to cover off-formulary drugs when a physician has reason to request the dispensing of a specific off-formulary drug. Coverage for the handful of drugs that are now covered by Medicare will continue under current rules and will not be included as part of the new drug benefit package.

To ensure that the benefit remains affordable, beneficiaries will not have the option to wait until they have significant pharmaceutical needs before they enroll. Enrollment will be allowed only in the first year the benefit is offered, the first year in which a beneficiary is eligible for Medicare, the first year after retirement if a beneficiary continued working after age 65 and kept employer-sponsored drug coverage after becoming a Medicare beneficiary, or the first year after an employer-sponsored plan drops drug coverage for all retirees.

About 60 percent of the total cost of the drug benefit will be offset through savings from increased competition and efficiency. The remaining cost would be offset by dedicating less then one-eighth of the amount of the surplus dedicated for Medicare under the President's plan. The amount of surplus funds dedicated for the drug benefit is less than the reduction in Medicare baseline spending between January and June of 1999.

*Other Benefit Improvements:* The President's plan makes several other necessary improvements to the Medicare benefits package. These will promote prevention, rationalize cost sharing, allow access for the near-elderly, and improve coordination of care for beneficiaries also enrolled in Medicaid. The President's plan builds on proposals to promote disease prevention and health promotion put forth by Senator Bob Graham and others, and we are grateful for their leadership in this area.

To promote prevention, no cost sharing will be required for any preventive benefits. Existing copayments and deductibles for every preventive service covered by Medicare, including colorectal cancer screening, bone mass measurement, pelvic exams, prostate cancer screening, diabetes self management benefits, and mammograms, will be eliminated.

The President's plan will rationalize cost sharing by extending the Medicare Part B standard 20 percent coinsurance requirement to clinical laboratory services, except those that are preventive services, and indexing the Part B deductible to inflation. The modest lab copayment will help prevent overuse and fight fraud. Indexing the deductible will guard against revenue losses in real terms over time due to inflation.

The President's plan also calls for updating all supplemental Medigap plans to be consistent with our changes to Medicare. We propose creating a new Medigap option that will feature nominal, rather than no, cost sharing. We will work with the National Association of Insurance Commissioners to develop a policy that will be less costly, and therefore more affordable for many beneficiaries, relative to the first dollar coverage of current policies. The plan also will strengthen access to Medigap for beneficiaries with disabilities and end stage renal disease and for those in a Medicare+Choice plan that withdraws from the program. Also, we plan to examine the feasibility and advisability of allowing beneficiaries to purchase catastrophic coverage through Medicare.

The plan includes the President's proposal to offer Americans between the ages of 62-65, without access to employer-sponsored insurance, the choice to buy into the Medicare program for approximately $300 per month, if they agree to pay a small payment to cover cost of risk-selection once they become eligible for traditional Medicare at age 65. Displaced workers between 55-62 who involuntarily lose their jobs and insurance could buy in at a slightly higher premium (approximately $400). And retirees over age 55, who were promised health care in their retirement years, would be provided access to "COBRA" continuation coverage if their old firm reneged on their commitment.

To improve coordination of care for beneficiaries also enrolled in Medicaid, an issue that I know members of this Committee consider very important, Medicare will conduct a demonstration project for those with significant care needs. These beneficiaries will qualify for special case management from a team of providers, receive a geriatric assessment and obtain advice on the best type of care. Medicare also will offer a special "Welcome to Medicare & Medicaid" package when beneficiaries become dually eligible that will explain the unique benefits available to them and how these services can be coordinated.

## SECURING MEDICARE'S FINANCING

All of our efforts to modernize Medicare will result in enhanced efficiency and competition—and that means substantial savings. But no responsible savings policy would be sufficient to address the fact that the elderly population will double within the next 30 years. Every respected expert in the nation recognizes that additional financing will be necessary to maintain basic services and quality for any length of time. Because of this and his strong belief that the baby boom generation should not pass along its inevitable Medicare financing crisis to its children, the President has proposed that a significant portion of the surplus be dedicated to strengthening the program.

The President's plan dedicates 15 percent of the budget surplus to the program for the next 15 years. This will assure the financial health of the trust fund through at least 2027, and will eliminate the need for excessive cuts and radical restructuring that would be inevitable in the absence of these resources. The surplus was largely created by the baby boom generation, and it makes sense to use the surplus as a one-time funding source to help Medicare meet baby boom needs. It does not

create an unlimited tap on general revenues, but instead invests a fixed portion of the surplus in Medicare to cover the temporary yet overwhelming influx of retirees.

CONCLUSION

Medicare's improved financial outlook has in no way diminished the pressing need to strengthen and modernize the program. For many older and disabled Americans, Medicare is not just a support system—it is a lifeline. We must ensure that the lifeline—and the promise of Medicare—is never broken. We must ensure that elderly and disabled Americans continue to enjoy the very best health care in the world. And we must ensure that Medicare will be able to meet the health, financial and demographic challenges of the 21st century.

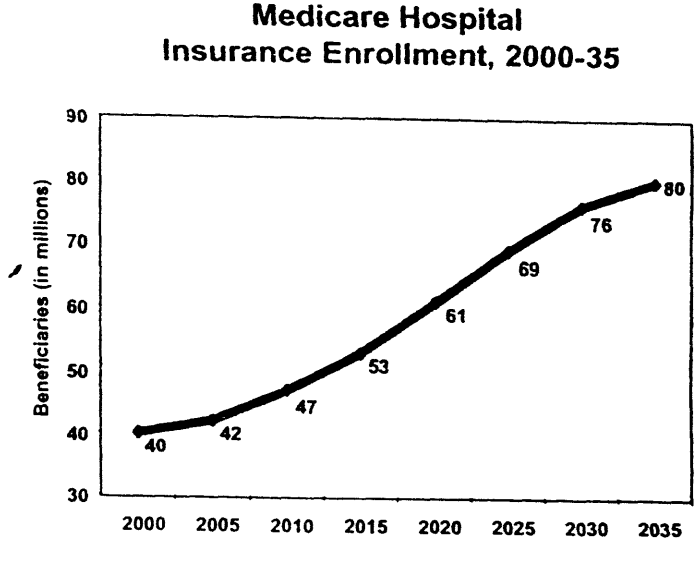
We have the hard work of the Bipartisan Commission to build on. We have the President's thoughtful, clear, and detailed plan before us. And we have a responsibility to seize this opportunity to act, now, while there is no climate of crisis to distort our vision.

By working together, I have no doubt that we will be able to preserve the promise of Medicare for the baby boom generation—as well as for generation "X," generation "Next," and every generation.

Thank you.

# Number of Medicare Beneficiaries Will Double by 2035

- By 2035, Medicare beneficiaries will grow from 14% to 22% of U.S. population
- Over one-half of long-term real HI growth (over inflation) is attributable to demographics
- To support increasing beneficiaries, new financing sources will be needed

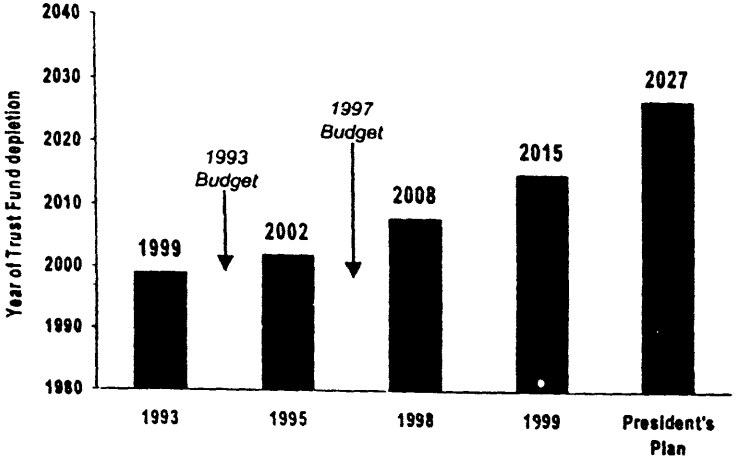


# President's Plan to Modernize and Strengthen Medicare

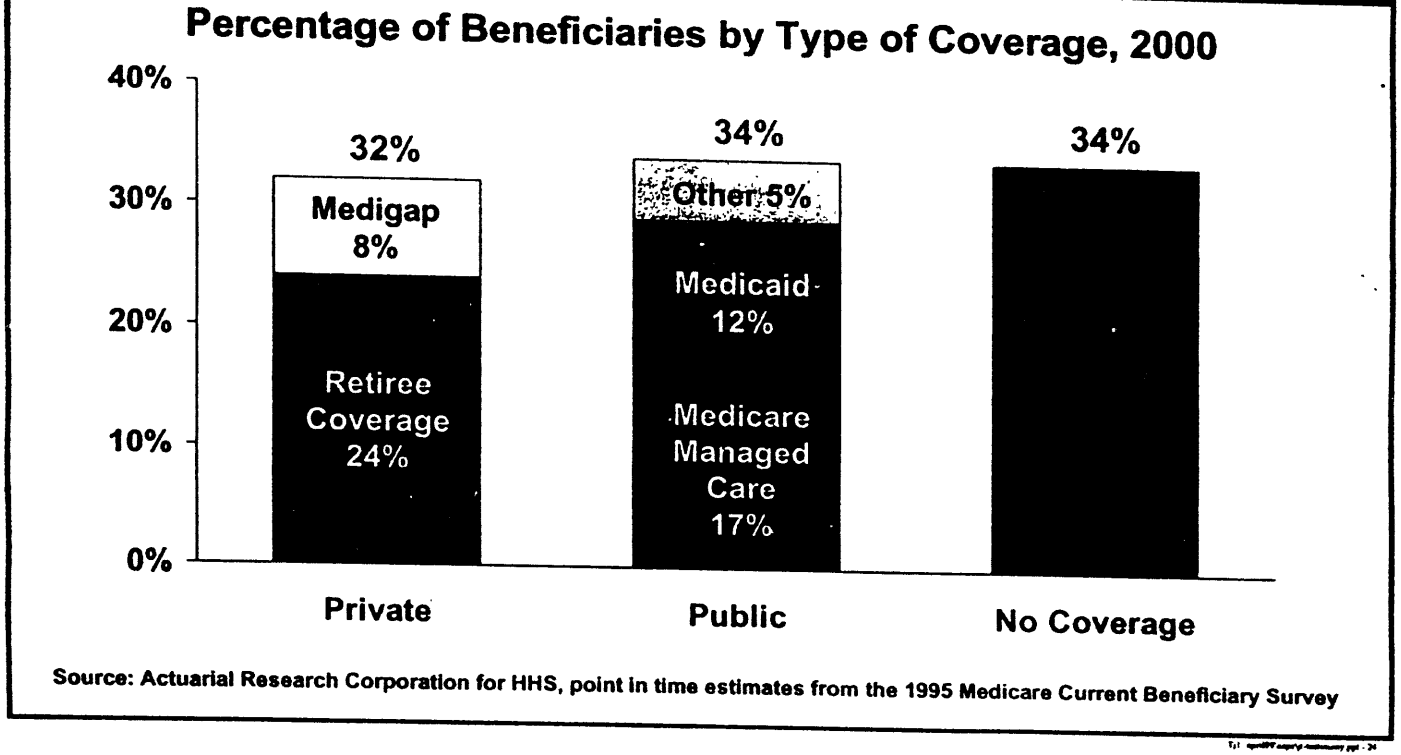
- **Make Medicare more competitive and efficient**
- **Modernize Medicare benefits, including a long-overdue prescription drug benefit**
- **Strengthen Medicare's financing for the 21st century**

# President's Plan Extends Medicare Solvency to 2027

- **The Administration's campaign against Medicare fraud and waste has reduced spending and extended the solvency of the Medicare Trust Fund**
- **Medicare budget reforms in 1993 and 1997 have extended Medicare solvency**
- **The President's plan extends Medicare solvency to 2027**



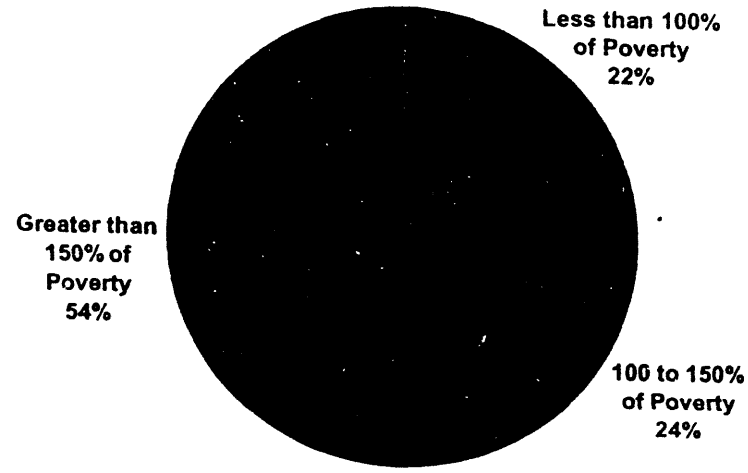
# Only About One-Third of Medicare Beneficiaries Have Private Drug Coverage




Source: Actuarial Research Corporation for HHS, point in time estimates from the 1995 Medicare Current Beneficiary Survey

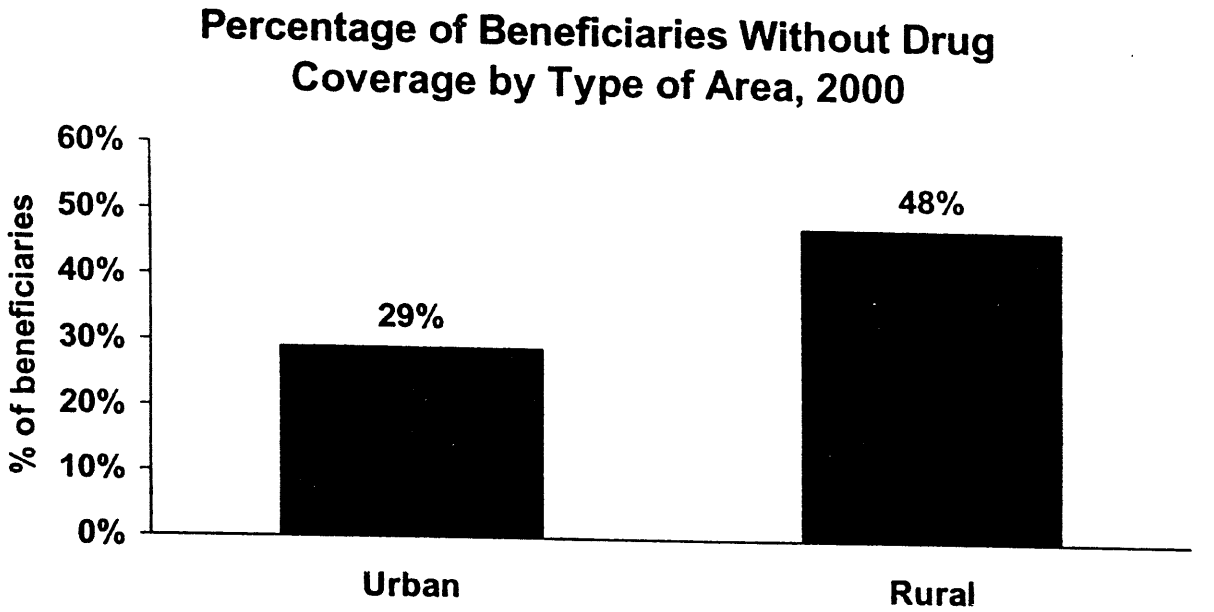
# Over Half of Beneficiaries Without Drug Coverage Are in the Middle Class

## Medicare Beneficiaries without Drug Coverage by Income, 2000




Source: Actuarial Research Corporation for HHS, point in time estimates from the 1995 Medicare Current Beneficiary Survey
In 2000, poverty for a single person is about $8,500, for a couple is about $11,400

# Almost Half of Beneficiaries in Rural Areas Lack Coverage




Source: Actuarial Research Corporation for HHS, point in time estimates from the 1995 Medicare Current Beneficiary Survey

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
for Legislation

Washington, D.C. 20201

AUG 12 1999

The Honorable Frank Murkowski
709 Senate Hart Office Building
United States Senate
Washington, D.C. 20510

Dear Senator Murkowski:

Thank you for the opportunity for Secretary Shalala to testify before the Senate Finance Committee regarding the President's Medicare Proposal on July 22, 1999.

Enclosed please find our answers to your additional questions for the record along with copies of answers to questions submitted by Chairman Roth, Senator Kerrey, and Senator Grassley.

If you have any additional questions or need assistance, please do not hesitate to contact me at (202) 690-7450.

Sincerely,

Jane Horvath
Deputy Assistant Secretary
for Health Legislation
Office of the Assistant Secretary
for Legislation

Attachments

**MEMORANDUM** August 9, 1999

FROM: Richard S. Foster
Office of the Actuary
Health Care Financing Administration

SUBJECT: Estimated Financial Impact of the President's Plan To Modernize and Strengthen Medicare for the 21st Century

This memorandum provides the estimated financial impact of the subject Medicare reform proposals. The financial effects estimated here include changes in Medicare benefit expenditures and premium revenues, and Federal Medicaid outlays, but do not include changes in administrative expenses. In the attached tables showing the detailed estimates, negative amounts represent savings (either reduced expenditures or increased income from premiums) and positive amounts represent costs (either increased expenditures or reduced premium revenues). These estimates are based on our understanding of the plan provisions as of August 9, 1999, and have been revised slightly from previous estimates as a result of subsequent clarification of the plan's provisions. The estimates are based on the assumptions underlying the 1999 reports of the Medicare Board of Trustees to Congress.

*Summary of provisions*

A detailed description of the President's Medicare legislative package is available from the Health Care Financing Administration's Office of Legislation and can also be found on the White House internet site at http://www.whitehouse.gov/WH/New/html/Medicare/index.html. The legislative package includes the following proposals:[1]

- Reductions in provider payments—The Balanced Budget Act of 1997 (BBA) included reductions in the payment updates applicable to many health care providers in 1998-2002. The President's plan would implement additional reductions in 2003 through 2009 for certain payment categories.
- Fee-for-service modernizations—HCFA would be granted increased authority and flexibility in contracting with health providers, insurance organizations, and administrative organizations, including the authority to establish preferred provider organizations, to implement global purchasing arrangements with providers, and to expand the use of competitive bidding arrangements.
- Modifications to SMI cost sharing—Beneficiary cost sharing requirements under Supplementary Medical Insurance (SMI, or "Part B" of Medicare) would be modified to waive deductible and coinsurance requirements on all preventive services, require the standard 20-percent coinsurance on diagnostic lab tests, and to index the SMI deductible (currently $100) by the CPI starting in 2002.

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[1] The estimates shown in this memorandum relate only to the proposals outlined herein; the Medicare proposals submitted earlier as part of the President's Fiscal Year 2000 Budget are not reflected.

- Competitive defined benefit—Medicare capitation payments to private managed care plans would be based on the plans' total premium submissions (referred to as "bids") and a formula for allocating total plan premiums between beneficiaries and the Medicare program. Beneficiaries selecting lower-cost plans would pay lower SMI premiums—as little as zero if plan costs were sufficiently below average fee-for-service costs.

  The capitation payments to plans would be risk-adjusted (to reflect the health status of plan enrollees) and geographically adjusted (to reflect the prevailing cost of health care in the area). The Medicare share of total payments would incorporate the full amount of risk adjustment in all cases and the full geographic adjustment in areas with above-average costs; in areas with below-average costs, the Medicare share would reflect partial geographic adjustment.[2] These adjustments would reduce variation in beneficiary premiums, since such premiums would not vary by an individual's health status or (to a large degree) by geographic differences in costs.

  Competitive defined benefit plans would be required to offer the standard Medicare fee-for-service benefit package but could reduce beneficiary cost-sharing requirements so long as the resulting increase in the plan's actuarial value did not exceed 10 percent of the value of the standard package.

- A "Quality Assurance Fund" of $7.5 billion would be established to provide unspecified modifications to the BBA if its provisions are determined to have caused significant problems with beneficiary access to care or with the quality of care.

- The Medicare benefit package would be expanded to cover, on an optional basis, outpatient prescription drugs. All beneficiaries would be given a one-time opportunity to select this coverage and would pay premiums designed to finance 50 percent of the cost of the coverage. There would be no deductible for this coverage, a 50-percent beneficiary coinsurance requirement, and annual Medicare reimbursement for an individual would be limited to $1,000 in 2002-03, $1,500 in 2004-05, $2,000 in 2006-07, and $2,500 in 2008 (indexed by the CPI in later years). A special Medicare payment would be available to employer-sponsored retiree health plans as an incentive for employers to continue their retiree drug coverage.

- The Medicaid program would be modified (i) to permanently extend the current "QI-1" provision and eliminate its maximum outlay limits, (ii) to cover the cost of the new Medicare drug premium and drug coinsurance for beneficiaries with incomes between 100 and 135 percent of the Federal poverty guidelines, and (iii) to cover, on a declining scale, the cost of the drug premium for beneficiaries with incomes between 135 and 150 percent. The Federal share of costs would be set at 100 percent for each of the latter two provisions.[3] As under present law, the cost of the QI-1 benefit would be paid from the SMI trust fund.

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[2] The partial geographic adjustment would be made in a way corresponding to the "blending" of Medicare+Choice capitation rates under present law.

[3] Beneficiaries would also be required to meet the asset limits applicable to the respective SLMB and QI categories under present law. Dual and QMB beneficiaries (who have incomes below 100 percent of the poverty guidelines) would qualify for Medicare drug premium and coinsurance assistance under existing rules; the cost of this assistance would be shared between the Federal and State governments.

- Specified amounts would be allocated from the general fund of the Treasury for purposes of Medicare financing during 2000-2014. The total allocation, shown in the first column of table 1 (attached), is derived from current projections of the Federal "on budget" surplus.[4] A portion of these amounts would be used implicitly to meet the additional general revenue financing requirements of the SMI trust fund under these proposals, as shown in the second column.[5] Similarly, an additional portion would cover the increased Federal Medicaid outlays resulting from the Medicare and Medicaid provisions, as shown in the third column. The remainder, shown in the last column of table 1, would be transferred explicitly to the Hospital Insurance (HI) trust fund as a new form of financing, to improve the fund's financial status. The amounts of the general fund transfers to the HI trust fund would be specified in legislation and would not vary if actual future budget surpluses differed from current projections.

*Estimated financial impact of provisions on HI and SMI programs*

Table 2, attached, summarizes the estimated provision-by-provision HI financial impacts of the proposals in the President's reform package. As indicated, the various provisions are estimated to have total net HI savings of about $69 billion during fiscal years 2000 through 2009 before consideration of the general fund transfers. About $43 billion of this total would result from the additional reductions in provider payment updates during 2000-09, the largest contributor being the proposal to set the payment update for most hospitals reimbursed under the inpatient prospective payment system at the market basket increase less 1.1 percentage point.

The fee-for-service modernization proposals would generate estimated HI savings totaling about $18 billion over this period, primarily through global purchasing arrangements ($10 billion) and implementation of Medicare PPO's by HCFA ($4 billion). The competitive defined benefit proposal is estimated to reduce HI expenditures by a total of about $17 billion.

The proposed quality assurance fund would increase HI expenditures by $3.7 billion, assuming (somewhat arbitrarily) that the total amount of $7.5 billion would be allocated evenly between HI and SMI expenditures. The actual allocation would depend on the steps taken to address any quality and access problems arising from BBA provisions and could differ substantially from the estimates shown in this memorandum.

Interactions among proposals are estimated to reduce the overall savings during 2000-09 by a total of $6.3 billion.[6]

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[4] The "on budget" surplus is calculated excluding certain categories of Federal outlays and receipts, principally those associated with the Social Security program.

[5] This use is characterized as "implicit" because there would not be an explicit transfer of funds from the general fund of the Treasury to the SMI trust fund. Rather, the SMI program would be financed in its usual way, through beneficiary premiums and matching general revenue appropriations, and the additional general revenue requirements under the Medicare reform package would be considered to be offset by the allocated funds, from an overall budget accounting perspective.

[6] The estimates for individual proposals are generally shown on a "stand alone" basis, that is, relative to present law and in the absence of any other changes. The interactions line in the attached tables adjusts for the financial interaction among the various proposals.

Through 2009, the specified general fund transfers to the HI trust fund amount to about $259 billion. Thus, the total HI impact of the reform proposals over this period equals $327 billion, comprised of estimated expenditure reductions of $69 billion together with the $259 billion increase in revenues from the transfers.

The estimated financial impacts of the individual provisions on the SMI program are shown in table 3. The net impact on the SMI program, excluding the costs of the outpatient prescription drug proposal, is estimated to be a slight savings totaling $3.1 billion over fiscal years 2000-09. Within this total, the fee-for-service modernization and cost sharing proposals are estimated to result in savings of $6.6 billion and $8.1 billion, respectively. The reductions in provider payments would contribute an additional $1.9 billion in estimated savings.

The competitive defined benefit would reduce SMI expenditures by an estimated $13.5 billion over this period, in addition to the HI reduction of $17.4 billion described previously. However, roughly 3/4 of the total reduction, or $22 billion over 2000-09, would accrue to beneficiaries in the form of reduced monthly premiums, which results in an SMI revenue loss that exceeds the savings from reduced SMI expenditures by $8.5 billion. The estimated effects of this provision on HI, SMI, and Medicare overall are summarized in the following table, in billions:

| | HI trust fund | SMI trust fund | Medicare total |
|---|---|---|---|
| Reduction in expenditures ..... | $17.4 | $13.5 | $30.8 |
| Reduction in premium revenues ... | — | $22.0 | $22.0 |
| Net savings* ..... | $17.4 | ($8.5) | $8.9 |

* Reduction in expenditures minus reduction in premium revenues.

Through 2009, beneficiaries in competitive defined benefit plans would pay an estimated 6 percent of total plan costs (other than for drugs) through their beneficiary premiums. The corresponding estimate for fee-for-service beneficiaries under present law is 10.5 percent. The balance of private plan costs (excluding drugs) would be paid (i) from the HI trust fund (roughly 55 percent of the total, financed primarily by the HI payroll tax) and (ii) from the SMI trust fund (the remaining 39 percent of the total, financed by general revenues).

The extension of the Medicaid QI-1 provision would increase SMI outlays by an estimated $0.9 billion and the quality assurance fund would add roughly $3.7 billion to costs. The financial interactions among the SMI provisions, and the associated impact on SMI premium revenues, are relatively minor and have approximately offsetting impacts on net savings.

Table 3 also shows the net SMI financial impact of the outpatient prescription drug proposal, estimated to total about $109 billion through fiscal year 2009. When combined with the slight net savings from the other SMI provisions, the overall impact on the SMI trust fund is an increase in costs of about $106 billion through 2009.

The components of the outpatient drug estimate are presented in table 4. In the absence of the employer subsidy provision, we estimate that virtually all beneficiaries would enroll for the optional Medicare drug coverage and SMI expenditures would increase by an estimated

$243 billion through 2009.[7] Approximately 50 percent of this cost would be financed through increased beneficiary premiums totaling about $129 billion during this period. With the employer subsidy, however, an estimated 5 million beneficiaries would opt instead for drug coverage through their employer-sponsored retiree health plans, resulting in employer-incentive payments totaling $10.9 billion through 2009, together with reductions in Medicare drug expenditures and premium revenues of $31.9 billion and $16.5 billion, respectively. The net cost of the outpatient prescription drug benefit to the SMI program would thus be approximately $109 billion and would be financed through general fund appropriations.

Table 5 shows the combined HI and SMI financial estimates, which are the sums of the corresponding figures from tables 2 and 3. Prior to consideration of the SMI outpatient drug benefit and the general fund transfers to the HI trust fund, the package is estimated to generate total net Medicare savings of about $72 billion through fiscal year 2009. Addition of the net increase in SMI costs under the drug proposal yields a net overall increase in Medicare costs of $37.5 billion through 2009. Further inclusion of the general fund transfers to HI results in an overall savings of about $221 billion from the perspective of the combined HI and SMI trust funds. The overall Medicare financial impact is characterized by (i) small net costs in 2001 and 2003-05 (when the general fund transfers are insufficient to offset the net cost of the HI and SMI provisions), (ii) substantial net savings in 2006-14 (during which time the general fund transfers significantly exceed the combined HI and SMI net cost), and (iii) a significant net cost in 2015 and later (after the general fund transfers have ended). The net cost after 2015 is the difference between the increase in Medicare costs due to the prescription drug benefit and the net savings from the other provisions, which offset roughly 80 percent of the drug cost.

*Estimated financial status of HI and SMI trust funds under President's reform plan*

The general fund transfers to the HI trust fund through 2014 (as shown in table 1), together with the net reductions in HI expenditures due to the provider payment reductions, modernization, and competition proposals (as shown in table 2 for 2000-09), would significantly improve the financial status of the HI program. Under the President's reform plan, the assets of the HI trust fund would increase at a faster rate than under present law and are estimated to reach the level of annual program expenditures within 5 years and to remain above annual expenditures through calendar year 2009. Thus, the HI trust fund would meet the Board of Trustees' test for short-range financial adequacy. This test is not met under present law, although it fails by a relatively small margin.

The savings provisions and general fund transfers would delay the estimated year of exhaustion for the HI trust fund to calendar year 2027. This would represent an improvement of 12 years compared to the estimated depletion date of 2015 under present law, based on the intermediate set of assumptions from the 1999 Trustees Reports. In practice, the estimated year of exhaustion

[7] We estimate that virtually all beneficiaries would opt for the Medicare drug coverage, given the one-time enrollment opportunity and coverage that, on average, is worth twice the required beneficiary premium. A significant exception would be beneficiaries with access to an employer-sponsored retiree health plan with equivalent or better drug coverage.

is very sensitive to relatively minor changes in economic or programmatic trends and the actual year of exhaustion under the proposed reform package could be significantly different.

The estimated impact of the President's plan on the long-range HI actuarial deficit is shown in table 6. Under present law, the long-range deficit is estimated to be 1.46 percent of taxable payroll.[8] The HI savings provisions and general fund transfers would reduce the deficit by about one-third (0.52 percent of taxable payroll), with the resulting deficit under the package estimated to be 0.94 percent of taxable payroll. Thus, the long-range deficit would be significantly improved under the reform proposals but a sizable deficit would still remain.

The SMI trust fund would continue to be automatically in financial balance, as under present law. The cost of SMI services, excluding the new outpatient drug benefit, would be reduced significantly but SMI premium revenues would be reduced under the competitive defined benefit provision by a roughly comparable amount. Thus, before consideration of the drug proposal, the SMI trust fund would require approximately the same level of general revenue financing as under present law.

The increased SMI expenditures attributable to the drug coverage would be financed in equal shares by the monthly drug premium paid by beneficiaries electing this coverage and by general revenues. Both the regular premium and the drug premium would be redetermined annually so that premium revenues, together with the associated general revenue financing, would match the following year's estimated expenditures. Estimated monthly SMI premium amounts under present law and the proposal are shown in table 7 for 2000-09. The premiums shown under the reform proposal would be applicable to fee-for-service beneficiaries only; beneficiaries in competitive defined benefit plans would pay varying amounts depending on plan cost (relative to fee-for-service costs) and geographic area.

*Estimated financial impact on Medicaid program and on overall Federal budget*

Table 8 summarizes the estimated net increase in Federal Medicaid costs that would result from the Medicare reform proposals. As indicated, the interactions with the HI and SMI savings provisions are estimated to be minor. The Medicare drug coverage would reduce Federal (and State) Medicaid expenditures for drugs for dual beneficiaries but would increase expenditures for covering the drug premium and coinsurance for dual and QMB beneficiaries. The net effect of these impacts is estimated to be an increase in Federal Medicaid costs of $3.0 billion over fiscal years 2002-09.

The provision to at least partially cover the drug premiums and drug coinsurance for Medicare beneficiaries with incomes up to 150 percent of the Federal poverty guidelines would further increase Federal Medicaid expenditures beyond the normal interactions with the Medicare drug proposal as described above. The additional expenditures are estimated to total $5.6 billion through fiscal year 2009.

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[8] "Taxable payroll" is the total amount of wages, salaries, and net earnings from self-employment that is subject to the HI payroll tax.

Table 9 presents the estimated impact of the President's Medicare reform proposals on the overall outlays and receipts of the Federal budget, reflecting the combined Medicare and Medicaid financial effects. Estimates are shown separately for the impact of (i) the HI provisions, excluding the general fund transfers, (ii) the non-drug SMI provisions, and (iii) the outpatient prescription drug benefit. As shown in table 9, the Medicare reform package is estimated to increase Federal outlays by a total of $132.7 billion over fiscal years 2000-09, with partially offsetting increases in revenues of $86.5 billion, for a net cost of $46.2 billion over this period.

The general fund transfers to the HI trust fund are excluded from this analysis on the grounds that they are "intragovernmental transfers" and thus do not affect Federal outlays or revenues. Under proposed accounting changes, however, the transfers to the HI trust fund would be shown as reducing the unified budget surplus.

*Conclusion*

The President's Medicare reform proposal represents a complex package of changes to the Medicare program and poses numerous challenges in estimating the likely financial impact. Accordingly, our estimates are necessarily uncertain and the following limitations should be carefully considered:

- The estimates shown in this memorandum are based on our understanding as of August 9, 1999 of the specifications for the package. If our understanding of these provisions is incorrect or if the specifications continue to evolve over time, then the estimates would be subject to change accordingly.

- As the scope of changes to an existing program increases, the program's past experience becomes progressively less relevant in estimating the impact of the changes and the estimates become progressively less certain. The fee-for-service modernization, competitive defined benefit, and outpatient prescription drug proposals would each substantially modify certain key aspects of the Medicare program.

- Beneficiaries would face different options for receiving health care under the Medicare reform package and substantially different options for the cost of care. Predicting their behavior in selecting plans is very uncertain. Similarly, the behavior of insurance organizations in deciding whether to offer coverage and (if so) what type, cannot be anticipated with certainty. In addition, the behavior of employers would have an impact on the experience of the Medicare program under these proposals. The data available for estimating such behavioral issues are very limited.

- The estimates in this memorandum were prepared under tight time constraints and in some cases reflect less refined methodology than the significance of the package merits. In particular, the interactions among proposals are very complex and would benefit from further analysis.

- We have assumed that the proposals could be administratively implemented within the specified time frames. In some instances, administration would be significantly more complex than under present law. Any delays in implementation would generally affect the estimated financial impact of the proposal in question.

For the reasons listed above, actual future Medicare expenditures and revenues under the proposals described here could differ substantially from these estimates. Nonetheless, the estimates represent our best effort in the time available to fairly assess the proposal's financial impact. These estimates provide, in my opinion, a reasonable assessment of the most likely financial impact on Medicare expenditures and revenues and Federal Medicaid outlays.

Richard S. Foster, F.S.A.
Chief Actuary

Attachments (9)

## Table 1—Proposed general fund allocations to Medicare under the President's Medicare reform package

(In billions)

| Fiscal year | Proposed general fund allocations to Medicare[1] | General revenues required to cover... SMI trust fund costs[2] | General revenues required to cover... Federal Medicaid costs[3] | General fund transfers to HI trust fund[4] |
|---|---|---|---|---|
| 2000..... | $5.1 | $0.2 | $0.0 | $4.9 |
| 2001..... | $1.5 | $0.5 | $0.0 | $0.9 |
| 2002..... | $16.4 | $4.1 | $0.8 | $11.6 |
| 2003..... | $13.5 | $10.0 | $1.0 | $2.4 |
| 2004..... | $13.9 | $11.6 | $1.0 | $1.4 |
| 2005..... | $16.4 | $12.7 | $1.1 | $2.6 |
| 2006..... | $36.0 | $14.4 | $1.1 | $20.6 |
| 2007..... | $64.6 | $15.8 | $1.2 | $47.6 |
| 2008..... | $88.1 | $17.6 | $1.2 | $69.3 |
| 2009..... | $118.1 | $19.3 | $1.3 | $97.5 |
| 2010..... | $145.5 | $21.1 | $1.5 | $122.9 |
| 2011..... | $70.6 | $22.9 | $1.6 | $46.1 |
| 2012..... | $72.3 | $24.7 | $1.8 | $45.8 |
| 2013..... | $69.4 | $26.7 | $1.9 | $40.8 |
| 2014..... | $62.5 | $28.7 | $2.1 | $31.8 |
| 2015+..... | — | $30.7[5] | $2.2[5] | — |
| 2000-04.... | $50.4 | $26.3 | $2.8 | $21.2 |
| 2000-09.... | $373.6 | $106.2 | $8.7 | $258.7 |
| 2000-14.... | $793.9 | $230.2 | $17.6 | $546.3 |

[1] Amounts of projected Federal Budget surpluses allocated (i) to cover increased SMI and Federal Medicaid costs under the Medicare reform package, and (ii) to provide general fund transfers to the HI trust fund to improve the fund's financial status.

[2] Estimated increases in SMI general revenue financing requirements under Medicare reform package (see table 3).

[3] Estimated increases in Federal Medicaid outlays under Medicare reform package (see table 8).

[4] Specified amounts to be transferred each year from the general fund of the Treasury to the HI trust fund. Represents difference between total general fund allocation shown in first column and general revenue amounts required to cover increased SMI and Federal Medicaid costs (columns 2 and 3, respectively).

[5] Amount shown is for 2015 only.

Note: The amounts shown for general fund transfers to the HI trust fund would be specified in legislation and would not be affected by variations in actual future Federal Budget surpluses, SMI general revenue requirements, or Medicaid outlays associated with reform package.

Office of the Actuary
Health Care Financing Admin.
August 9, 1999

**Table 2—Estimated short-range HI savings (–) or costs (+) under the President's Medicare reform package**
(In billions)

| Proposal | Fiscal year | | | | | | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2000-04 | 2000-09 |
| Provider payment changes: | | | | | | | | | | | | |
| PPS inpatient capital | — | — | $0.0 | -$0.2 | -$0.2 | -$0.3 | -$0.2 | -$0.3 | -$0.3 | -$0.3 | -$0.4 | -$1.8 |
| PPS exempt capital | — | — | $0.0 | -$0.1 | -$0.1 | -$0.1 | -$0.1 | -$0.1 | -$0.1 | -$0.1 | -$0.2 | -$0.7 |
| PPS inpatient update | — | — | $0.0 | -$0.9 | -$2.0 | -$3.2 | -$4.4 | -$5.9 | -$7.6 | -$9.4 | -$2.9 | -$33.4 |
| PPS exempt update | — | — | $0.0 | -$0.1 | -$0.3 | -$0.5 | -$0.6 | -$0.8 | -$1.1 | -$1.3 | -$0.4 | -$4.7 |
| Hospice update | — | — | $0.0 | $0.0 | -$0.1 | -$0.1 | -$0.2 | -$0.2 | -$0.3 | -$0.3 | -$0.1 | -$1.2 |
| Interactions | — | — | $0.0 | -$0.1 | $0.0 | -$0.1 | -$0.2 | -$0.3 | -$0.2 | -$0.3 | -$0.1 | -$1.2 |
| Total, provider payment changes | — | — | -$0.1 | -$1.4 | -$2.7 | -$4.3 | -$5.7 | -$7.6 | -$9.6 | -$11.7 | -$4.2 | -$43.1 |
| Fee-for-service modernization | — | -$0.2 | -$0.7 | -$1.2 | -$1.8 | -$2.5 | -$2.7 | -$2.9 | -$3.0 | -$3.2 | -$3.9 | -$18.2 |
| Beneficiary cost sharing | — | — | — | — | — | — | — | — | — | — | — | — |
| Competitive defined benefit | — | — | — | -$0.8 | -$1.7 | -$2.2 | -$2.7 | -$3.0 | -$3.3 | -$3.6 | -$2.5 | -$17.4 |
| BBA "quality assurance fund" | $0.2 | $0.8 | $0.5 | $0.3 | $0.3 | $0.3 | $0.3 | $0.3 | $0.4 | $0.4 | $2.1 | $3.7 |
| Interactions | — | $0.0 | $0.0 | $0.3 | $0.6 | $0.8 | $1.0 | $1.1 | $1.2 | $1.3 | $0.9 | $6.3 |
| Net HI impact before general fund transfers | $0.2 | $0.6 | -$0.3 | -$2.9 | -$5.4 | -$7.9 | -$9.8 | -$12.1 | -$14.4 | -$16.8 | -$7.7 | -$68.7 |
| General fund transfers | -$4.9 | -$0.9 | -$11.6 | -$2.4 | -$1.4 | -$2.6 | -$20.6 | -$47.6 | -$69.3 | -$97.5 | -$21.2 | -$258.7 |
| Total net HI impact | -$4.7 | -$0.3 | -$11.9 | -$5.3 | -$6.7 | -$10.5 | -$30.3 | -$59.7 | -$83.6 | -$114.3 | -$28.9 | -$327.4 |

Notes: 1. HI trust fund "savings" are defined as either expenditure reductions or increases in income from general revenues. "Costs" represent expenditure increases.
2. Amounts shown as "$0.0" indicate savings or costs of less than $50 million.
3. Estimates are based on the intermediate set of assumptions from the 1999 Medicare Trustees Reports and are subject to change if the underlying proposal specifications are modified.

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## Table 3—Estimated short-range SMI savings (–) or costs (+) under the President's Medicare reform package

(In billions)

| Proposal | Fiscal year | | | | | | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2000-04 | 2000-09 |
| Provider payment changes: | | | | | | | | | | | | |
| Lab update | — | — | — | $0.0 | -$0.1 | -$0.1 | -$0.1 | -$0.2 | -$0.3 | -$0.3 | -$0.1 | -$1.1 |
| ASC update | — | — | — | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | -$0.1 | $0.0 | -$0.2 |
| Ambulance update | — | — | — | $0.0 | $0.0 | $0.0 | -$0.1 | -$0.1 | -$0.1 | -$0.1 | $0.0 | -$0.4 |
| DME, PEN, P&O updates | — | — | — | $0.0 | $0.0 | -$0.1 | -$0.1 | -$0.2 | -$0.2 | -$0.3 | -$0.1 | -$0.9 |
| Premium offset | — | — | — | $0.0 | $0.0 | $0.1 | $0.1 | $0.1 | $0.2 | $0.2 | $0.0 | $0.6 |
| Total, provider payment changes | — | — | — | $0.0 | -$0.1 | -$0.2 | -$0.3 | -$0.3 | -$0.5 | -$0.6 | -$0.1 | -$1.9 |
| Fee-for-service modernization | — | -$0.1 | -$0.3 | -$0.4 | -$0.6 | -$0.9 | -$0.9 | -$1.0 | -$1.1 | -$1.2 | -$1.5 | -$6.6 |
| Beneficiary cost sharing | — | — | -$0.4 | -$0.7 | -$0.8 | -$0.9 | -$1.0 | -$1.2 | -$1.4 | -$1.6 | -$1.9 | -$8.1 |
| Competitive defined benefit: | | | | | | | | | | | | |
| Expenditures | — | — | — | -$0.6 | -$1.3 | -$1.7 | -$2.0 | -$2.4 | -$2.6 | -$2.9 | -$1.9 | -$13.5 |
| Premiums | — | — | — | $1.5 | $2.5 | $2.8 | $3.2 | $3.6 | $4.0 | $4.3 | $4.0 | $22.0 |
| Net impact | — | — | — | $0.9 | $1.2 | $1.2 | $1.2 | $1.3 | $1.3 | $1.4 | $2.1 | $8.5 |
| Extension of QI-1 provision | — | — | — | $0.1 | $0.1 | $0.1 | $0.1 | $0.1 | $0.2 | $0.2 | $0.2 | $0.9 |
| BBA "quality assurance" fund | $0.2 | $0.8 | $0.5 | $0.3 | $0.3 | $0.3 | $0.3 | $0.3 | $0.4 | $0.4 | $2.1 | $3.7 |
| Premium offset | -$0.1 | -$0.2 | $0.1 | $0.3 | $0.4 | $0.4 | $0.5 | $0.5 | $0.6 | $0.7 | $0.5 | $3.2 |
| Interactions | — | $0.0 | $0.0 | -$0.3 | -$0.4 | -$0.4 | -$0.4 | -$0.4 | -$0.4 | -$0.5 | -$0.7 | -$2.8 |
| Net SMI impact before prescription drug benefit | $0.2 | $0.5 | -$0.2 | $0.1 | $0.0 | -$0.3 | -$0.5 | -$0.7 | -$0.9 | -$1.2 | $0.6 | -$3.1 |
| Prescrip. drug benefit (net impact) | — | — | $4.3 | $10.0 | $11.5 | $13.1 | $14.9 | $16.5 | $18.5 | $20.5 | $25.8 | $109.3 |
| Total net SMI impact | $0.2 | $0.5 | $4.1 | $10.0 | $11.6 | $12.7 | $14.4 | $15.8 | $17.6 | $19.3 | $26.3 | $106.2 |

Notes: 1. SMI trust fund "savings" are defined as either expenditure reductions or increases in premium revenues. Similarly, "costs" represent either expenditure increases or reductions in premium revenues.

2. Amounts shown as "$0.0" indicate savings or costs of less than $50 million.

3. Estimates are based on the intermediate set of assumptions from the 1999 Medicare Trustees Reports and are subject to change if the underlying proposal specifications are modified.

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## Table 4—Components of estimated short-range SMI financial impact of the outpatient prescription drug benefit under the President's Medicare reform package

(In billions)

| Proposal | Fiscal year | | | | | | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2000-04 | 2000-09 |
| Prescription drug benefit, excluding employer subsidy[1]: | | | | | | | | | | | | |
| Expenditures | — | — | $12.4 | $21.8 | $25.8 | $28.7 | $32.8 | $36.1 | $40.5 | $44.6 | $60.0 | $242.7 |
| Premiums | — | — | -$8.2 | -$11.4 | -$13.7 | -$15.0 | -$17.3 | -$18.8 | -$21.2 | -$23.2 | -$33.3 | -$128.8 |
| Net impact | — | — | $4.1 | $10.5 | $12.0 | $13.7 | $15.5 | $17.3 | $19.3 | $21.5 | $26.6 | $113.9 |
| Employer subsidy[2]: | | | | | | | | | | | | |
| Incentive payments | — | — | $0.7 | $1.0 | $1.2 | $1.3 | $1.5 | $1.6 | $1.8 | $1.9 | $2.9 | $10.9 |
| Benefit expenditures | — | — | -$1.7 | -$2.9 | -$3.4 | -$3.8 | -$4.3 | -$4.7 | -$5.3 | -$5.8 | -$8.1 | -$31.9 |
| Premiums | — | — | $1.1 | $1.5 | $1.8 | $1.9 | $2.2 | $2.4 | $2.7 | $2.9 | $4.3 | $16.5 |
| Net impact | — | — | $0.1 | -$0.5 | -$0.5 | -$0.6 | -$0.7 | -$0.8 | -$0.8 | -$0.9 | -$0.9 | -$4.6 |
| Net SMI impact | — | — | $4.3 | $10.0 | $11.5 | $13.1 | $14.9 | $16.5 | $18.5 | $20.5 | $25.8 | $109.3 |

[1] Estimated financial impact if 100 percent of beneficiaries enrolled in optional prescription drug benefit.

[2] The employer subsidy provision would (i) increase SMI costs as a result of the incentive payments to employers, but (ii) reduce both benefit expenditures and premium revenues as a result of beneficiaries who opt to participate in their former employers' retiree health plans rather than enrolling in the Medicare prescription drug benefit. The overall savings shown for this provision reflect the net impact of these effects.

Notes: 1. SMI trust fund "savings" are defined as either expenditure reductions or increases in income from premiums. "Costs" are expenditure increases for benefits or incentive payments to employers, or reductions in premiums.

2. The reform package also includes a Medicaid proposal to cover (in full or in part) the cost of the Medicare drug premium and drug coinsurance for certain low-income beneficiaries. The Federal Medicaid costs associated with this proposal are shown in table 8.

3. Estimates are based on the intermediate set of assumptions from the 1999 Medicare Trustees Reports and are subject to change if the underlying proposal specifications are modified.

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## Table 5—Estimated total Medicare savings (–) or costs (+) under the provisions in the President's Medicare reform package

(In billions)

| Proposal | Fiscal year | | | | | | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2000-04 | 2000-09 |
| Provider payment changes: | | | | | | | | | | | | |
| Expenditures | — | — | -$0.1 | -$1.4 | -$2.8 | -$4.4 | -$5.8 | -$7.8 | -$10.0 | -$12.2 | -$4.3 | -$44.5 |
| Interactions | — | — | $0.0 | -$0.1 | $0.0 | -$0.1 | -$0.2 | -$0.3 | -$0.2 | -$0.3 | -$0.1 | -$1.2 |
| Premium offset | — | — | — | $0.0 | $0.0 | $0.1 | $0.1 | $0.1 | $0.2 | $0.2 | $0.0 | $0.6 |
| Net impact | — | — | -$0.1 | -$1.4 | -$2.8 | -$4.5 | -$6.0 | -$7.9 | -$10.1 | -$12.3 | -$4.3 | -$45.0 |
| Fee-for-service modernization | — | -$0.4 | -$1.0 | -$1.7 | -$2.5 | -$3.3 | -$3.6 | -$3.9 | -$4.1 | -$4.4 | -$5.4 | -$24.8 |
| Beneficiary cost sharing | — | — | -$0.4 | -$0.7 | -$0.8 | -$0.9 | -$1.0 | -$1.2 | -$1.4 | -$1.6 | -$1.9 | -$8.1 |
| Competitive defined benefit: | | | | | | | | | | | | |
| Expenditures | — | — | — | -$1.4 | -$3.0 | -$3.9 | -$4.7 | -$5.4 | -$6.0 | -$6.5 | -$4.4 | -$30.8 |
| Premiums | — | — | — | $1.5 | $2.5 | $2.8 | $3.2 | $3.6 | $4.0 | $4.3 | $4.0 | $22.0 |
| Net impact | — | — | — | $0.0 | -$0.5 | -$1.0 | -$1.5 | -$1.8 | -$2.0 | -$2.2 | -$0.4 | -$8.9 |
| Extension of QI-1 provision | — | — | — | $0.1 | $0.1 | $0.1 | $0.1 | $0.1 | $0.2 | $0.2 | $0.2 | $0.9 |
| BBA "quality assurance" fund | $0.4 | $1.7 | $0.9 | $0.6 | $0.5 | $0.5 | $0.6 | $0.6 | $0.7 | $0.8 | $4.2 | $7.4 |
| Premium offset | -$0.1 | -$0.2 | $0.1 | $0.3 | $0.4 | $0.4 | $0.5 | $0.5 | $0.6 | $0.7 | $0.5 | $3.2 |
| Interactions | — | $0.0 | $0.0 | $0.0 | $0.2 | $0.4 | $0.6 | $0.7 | $0.8 | $0.9 | $0.2 | $3.5 |
| Subtotal for above provisions | $0.4 | $1.1 | -$0.5 | -$2.8 | -$5.3 | -$8.3 | -$10.3 | -$12.8 | -$15.3 | -$18.0 | -$7.1 | -$71.8 |
| Prescrip. drug benefit (net impact) | — | — | $4.3 | $10.0 | $11.5 | $13.1 | $14.9 | $16.5 | $18.5 | $20.5 | $25.8 | $109.3 |
| Subtotal for above provisions | $0.4 | $1.1 | $3.8 | $7.1 | $6.2 | $4.8 | $4.6 | $3.7 | $3.2 | $2.6 | $18.6 | $37.5 |
| General fund transfers to HI | -$4.9 | -$0.9 | -$11.6 | -$2.4 | -$1.4 | -$2.6 | -$20.6 | -$47.6 | -$69.3 | -$97.5 | -$21.2 | -$258.7 |
| Total net Medicare impact [1] | -$4.5 | $0.2 | -$7.8 | $4.7 | $4.8 | $2.2 | -$16.0 | -$43.9 | -$66.1 | -$94.9 | -$2.6 | -$221.2 |

[1] In addition to the "direct" financial impacts shown in this table, there would be an increase in annual general revenue appropriations to finance the increase in SMI trust fund expenditures in excess of the increase in SMI premium revenues under the reform package. The additional general fund appropriations are estimated to total $106.2 billion in fiscal years 2000-09, as shown in table 1.

Notes: 1. "Savings" are defined as either expenditure reductions or increases in premium or general revenues. Similarly, "costs" represent either expenditure increases or reductions in premium revenues.

2. Amounts shown as "$0.0" indicate savings or costs of less than $50 million.

3. Estimates are based on the intermediate set of assumptions from the 1999 Medicare Trustees Reports and are subject to change if the underlying proposal specifications are modified.

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**Table 6—Estimated impact of the President's Medicare reform package on the long-range HI actuarial deficit**
(As a percentage of taxable payroll)

| Proposal | Estimated long-range impact of proposal |
|---|---|
| Actuarial deficit under present law | 1.46% |
| HI provisions: | |
| Provider payment changes | -0.22% |
| Fee-for-service modernization | -0.06% |
| Beneficiary cost sharing | — |
| Competitive defined benefit | -0.08% |
| BBA "quality assurance" fund | [1] |
| Interactions | 0.03% |
| Subtotal: Net impact of above provisions | -0.33% |
| General fund transfers to HI trust fund | -0.19% |
| Total impact of HI provisions | -0.52% |
| Actuarial deficit under reform package | 0.94% |

[1] Increase in cost of less than 0.005 percent of taxable payroll.

Notes: 1. Negative figures represent savings and improve the actuarial deficit. Positive figures are costs and worsen the deficit. See 1999 HI Trustees Report for definitions of actuarial balance and taxable payroll.

2. Estimates are based on the intermediate set of assumptions from the 1999 Medicare Trustees Reports and are subject to change if the underlying proposal specifications are modified.

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## Table 7—Estimated SMI premiums for fee-for-service beneficiaries under the President's Medicare reform package

(Monthly premium amount per beneficiary)

| Category | Calendar year | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 |
| Present law premiums | $48.50 | $52.30 | $56.50 | $61.50 | $66.30 | $69.90 | $74.80 | $80.00 | $85.00 | $90.30 |
| Fee-for-service premiums under Medicare reform package: | | | | | | | | | | |
| Standard premium | $48.80 | $52.60 | $56.40 | $60.90 | $65.50 | $69.00 | $73.70 | $78.80 | $83.70 | $88.80 |
| Drug premium | — | — | $24.20 | $24.90 | $31.00 | $32.30 | $37.60 | $39.10 | $44.10 | $46.60 |
| Total | $48.80 | $52.60 | $80.60 | $85.80 | $96.50 | $101.30 | $111.30 | $117.90 | $127.80 | $135.40 |

Notes: 1. Premiums shown for Medicare reform package are for fee-for-service beneficiaries only. Premiums for beneficiaries who enroll in competitive defined benefit plans would vary depending on plan cost (relative to fee-for-service costs) and by geographic area.

2. Amounts shown for drug premiums under Medicare reform package exclude administrative costs.

3. Estimates are based on the intermediate set of assumptions from the 1999 Medicare Trustees Reports and are subject to change if the underlying proposal specifications are modified.

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## Table 8—Estimated Federal Medicaid costs under the provisions in the President's Medicare reform package

(In billions)

| Category | Fiscal year | | | | | | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2000-04 | 2000-09 |
| **Increase in Federal Medicaid outlays attributable to:** | | | | | | | | | | | | |
| Interactions with HI provisions | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 |
| Interactions with SMI provisions, excluding drug proposal | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.1 | $0.1 |
| Interaction with SMI drug proposal | — | — | $0.4 | $0.4 | $0.4 | $0.4 | $0.4 | $0.4 | $0.3 | $0.3 | $1.3 | $3.0 |
| Drug premium and coinsurance assistance for low-income beneficiaries | — | — | $0.3 | $0.6 | $0.6 | $0.7 | $0.7 | $0.8 | $0.9 | $1.0 | $1.5 | $5.6 |
| Total increase in Federal Medicaid outlays | $0.0 | $0.0 | $0.8 | $1.0 | $1.0 | $1.1 | $1.1 | $1.2 | $1.2 | $1.3 | $2.8 | $8.7 |

Notes: 1. Figures shown for Federal Medicaid impacts represent net increases in Federal outlays for the Medicaid program.
2. Amounts shown as "$0.0" indicate costs of less than $50 million.
3. Estimates are based on the intermediate set of assumptions from the 1999 Medicare Trustees Reports and are subject to change if the underlying proposal specifications are modified.

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## Table 9—Estimated overall Federal budget savings (–) or costs (+) under the provisions in the President's Medicare reform package

(In billions)

| Category | Fiscal year | | | | | | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2000-04 | 2000-09 |
| **Impact on overall Federal budget outlays and receipts:** | | | | | | | | | | | | |
| HI provisions, excl. general fund transfers:[1] | | | | | | | | | | | | |
| Outlays | $0.2 | $0.6 | -$0.3 | -$2.9 | -$5.4 | -$7.9 | -$9.8 | -$12.1 | -$14.4 | -$16.8 | -$7.7 | -$68.7 |
| Receipts | — | — | — | — | — | — | — | — | — | — | — | — |
| Net | $0.2 | $0.6 | -$0.3 | -$2.9 | -$5.4 | -$7.9 | -$9.8 | -$12.1 | -$14.4 | -$16.8 | -$7.7 | -$68.7 |
| SMI provisions, excluding drug proposal: | | | | | | | | | | | | |
| Outlays | $0.2 | $0.7 | -$0.2 | -$1.7 | -$2.9 | -$3.7 | -$4.3 | -$5.0 | -$5.7 | -$6.4 | -$3.9 | -$28.8 |
| Receipts | -$0.1 | -$0.2 | $0.1 | $1.8 | $2.9 | $3.3 | $3.8 | $4.3 | $4.7 | $5.2 | $4.5 | $25.8 |
| Net | $0.2 | $0.5 | -$0.2 | $0.1 | $0.0 | -$0.3 | -$0.5 | -$0.7 | -$0.9 | -$1.2 | $0.6 | -$3.0 |
| SMI and Medicaid drug proposals: | | | | | | | | | | | | |
| Outlays | — | — | $12.2 | $20.8 | $24.5 | $27.2 | $31.1 | $34.1 | $38.2 | $42.1 | $57.5 | $230.2 |
| Receipts | — | — | -$7.2 | -$9.9 | -$12.0 | -$13.1 | -$15.1 | -$16.4 | -$18.5 | -$20.2 | -$29.0 | -$112.4 |
| Net | — | — | $5.0 | $11.0 | $12.6 | $14.1 | $16.0 | $17.7 | $19.7 | $21.8 | $28.5 | $117.9 |
| Total impact on Federal outlays and revenues: | | | | | | | | | | | | |
| Outlays | $0.4 | $1.3 | $11.6 | $16.3 | $16.3 | $15.6 | $17.0 | $17.0 | $18.2 | $18.9 | $45.9 | $132.7 |
| Receipts | -$0.1 | -$0.2 | -$7.1 | -$8.1 | -$9.0 | -$9.8 | -$11.3 | -$12.1 | -$13.8 | -$15.1 | -$24.5 | -$86.5 |
| Net | $0.4 | $1.1 | $4.5 | $8.1 | $7.2 | $5.9 | $5.7 | $4.9 | $4.4 | $3.9 | $21.4 | $46.2 |

[1] Since the general fund transfers to the HI trust fund would be intragovernmental transfers, they would not affect Federal budget outlays or receipts. Under proposed accounting changes, however, they would be shown as reducing the unified budget surplus.

Notes: 1. Negative amounts represent savings (either outlay reductions or revenue increases), which add to the Federal budget surplus. Positive amounts represent costs (outlay increases or revenue reductions), which reduce the surplus. See footnote 1 regarding the budgetary impact of the general fund transfers to the HI trust fund. Estimates reflect changes in outlays and receipts for both Medicare and Medicaid.

2. Estimates are based on the intermediate set of assumptions from the 1999 Medicare Trustees Reports and are subject to change if the underlying proposal specifications are modified.

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## QUESTIONS SUBMITTED FOR THE RECORD BY SENATOR CHARLES GRASSLEY

**Grassley 1-**

**One of my concerns with the President's proposal is that it will encourage employers who currently offer their retirees prescription drug coverage to drop this coverage. Can you describe the rationale for paying employers to provide what they may already be offering, and to give them this subsidy in addition to the tax break they already have?**

We share your concern with the decline that is already occurring in employer-sponsored coverage of prescription drugs. One of our goals is to slow the decline in private coverage. We also want to minimize any "crowd out" of employer coverage, by strengthening the incentives for employers to maintain and improve their drug benefits. We do this through a partial subsidy for employers who provide coverage that is as good or better than the basic Medicare drug benefit. This policy benefits the Medicare program, by encouraging employers to retain their coverage, thus reducing the costs to Medicare of providing drug coverage to beneficiaries.

This subsidy can be less than the full Medicare subsidy and still be financially more attractive for employers and their retirees because the employer would continue to benefit from the tax deductibility of their expenses for providing drug coverage. That is, employers would receive a partial direct subsidy from Medicare plus a tax subsidy, rather than only a tax subsidy as they do today.

The result is that the partial subsidy plus the tax subsidy makes employers and retirees better off, and still allows Medicare to provide drug coverage for all beneficiaries at a lower cost than if employer spending was truly and entirely "crowded out."

**Does this make sense to spend tax dollars this way on a program that has major financial hurdles to overcome?**

The President's proposal takes significant strides towards addressing those financial hurdles – by making Medicare more competitive and efficient, and dedication of a portion of the surplus to Medicare's Part A trust fund. As a result the President's proposal extends the life of the Trust Fund until at least 2027 – adding 12 years to the current depletion date.

To give you a sense of the breadth of the proposal, it allows us, for the first time, to recognize and reward high quality and efficient providers and give beneficiaries financial incentives to use these providers to lower Medicare costs. Our proposal would allow the traditional program to use the same tools as the private sector to create greater efficiency and improve quality. The proposal would allow managed care plans to bid competitively and compete for market share based on price, saving Medicare $8 billion over ten years.

The New York Times called this proposal "The most substantial change to Medicare since its creation."

The proposal also includes an optional and affordable prescription drug benefit as well as other benefit improvements and modernizations. I believe these improvements are essential to putting Medicare on the proper footing for the 21st century, and they are fully paid for in the President's plan.

**Why not target the benefit to those low-income seniors who need it most and who are the least likely to get employer-sponsored coverage?**

Less than one-fourth of Medicare beneficiaries have retiree drug coverage. About one-third of Medicare beneficiaries – at least 13 million beneficiaries – have no drug coverage at all. Another 8 percent purchase Medigap with drug coverage – but this coverage is expensive and inadequate. About 17 percent have it through Medicare managed care, but plans are severely limiting coverage. The remaining beneficiaries are covered through Medicaid and other public programs.

The limited private coverage that exists is declining and becoming more unaffordable. The number of firms offering retiree health coverage has declined by 25 percent in just the last four years. Premiums for Medigap prescription drug coverage are extremely expensive and increase with age. The most frequently purchased Medigap policy is typically priced at two to three times the President's option, has a $250 deductible, and limits plan payments to $1,250. Medigap premiums usually increase dramatically with age, just when beneficiaries need the coverage the most and are least likely to have the income to afford it. This is a particular problem for women who make up over 70 percent of those over age 85.

Public coverage is decreasing in value and becoming more unreliable. Nearly three-fifths of all Medicare managed care plans are reporting that they will cap their drug benefits below $1,000 in 2000. In fact, the proportion of plans with $500 or lower benefit caps will increase by 50 percent between 1998 and 2000. Medicaid coverage is meaningful, but is available only for those with the lowest incomes (generally less than about $6,200 for a single elderly person). And, because of "welfare" stigma and other reasons, this program only enrolls 40 percent of the low-income elderly who are eligible.

The President's proposed drug benefit offers all beneficiaries another option. Beneficiaries can choose to take it, choose to keep their current coverage, or choose to remain uncovered. The same critics opposing this proposal are usually the advocates of more health care choices. This benefit is simply a new option.

**Grassley 2**

**I am also concerned for individuals who do currently have the benefit of receiving prescription drug coverage through their employer. These plans tend to be more generous than most coverage available to seniors. We also know that employers are starting to scale back this coverage, and do we want to encourage this even further by replacing this with a much less generous federal benefit? So my question is this: How did you determine what employer subsidy would be adequate to ensure that this would not occur, and what assurance can you give that this subsidy will be enough?**

The easiest way to explain the employer subsidy is with an example. In 2002, the beneficiary premium for those who elect Part D is expected to be $24 per month. The total cost per beneficiary is $48 per month, so an enrollee in the drug benefit administered through traditional Medicare would receive a government subsidy of $24.

In general, employers offer drug coverage that is more generous than the proposed basic Medicare benefit. This means that they generally spend more per retiree than the Medicare benefit would cost.

Under our proposal, the direct subsidy to an employer's health plan that provides comparable (or better) drug coverage would be about one-third smaller, or $16 per month.

For employers spending at least as much as the Medicare benefit would cost, the tax deductibility on this additional spending is worth more than $8, making their total subsidy greater than $24.

**Grassley 3**

**I appreciate your desire to add competition to Medicare by proposing a Competitive Defined Benefit program. While many of the details have yet to be worked out, I understand that the geographic adjustment mechanism for the plan payment will lead to radically different premiums for comparable plans in high- and low-cost areas. Is it the case that beneficiaries in low-cost, efficient areas of the country will pay higher premiums for the same plan than beneficiaries in high-cost areas? If so, do you believe that is wise?**

No, beneficiaries will not pay more for a comparable plan in a low cost area - the government would pay for all geographic variations plus more in low-cost areas to encourage plans and beneficiaries to participate. This is more favorable to managed care than the BBA geographic adjustments.

**Grassley 4**

**HCFA has had consistent problems implementing reforms. It took until 1995 for HCFA to implement many of the nursing home enforcement provisions passed in OBRA '87 and we are now being told that portions of the Balanced Budget Act of 1997 can not be implemented for administrative reasons. Are you confident that HCFA would be able to implement the changes suggested in this proposal?**

Yes. The Administration carefully considered implementation in developing the President's Medicare plan and is confident it can be administered as proposed. Despite the Year 2000 workload, HCFA continues to make considerable progress in implementing the more than 335 provisions of the BBA and its other priorities. HCFA has fully implemented the majority of the BBA provisions and has made substantial progress on the remainder. The implementation of the OBRA '87 reforms you mentioned languished under the previous administrations but have been one of the highest priorities of this Administration. As you know, we fully implemented those provisions in 1995 and are working with you to ensure their success.

## QUESTIONS SUBMITTED FOR THE RECORD BY SENATOR FRANK MURKOWSKI

**Murkowski 1**

**The Administration's plan seeks to achieve cost savings of $8 billion over ten years through a re-implementation of beneficiary copayments for clinical laboratory service. Congress eliminated this practice as part of DEFRA'84, with the support of HCFA. The Administration is seeking a 20% copayment from beneficiaries for clinical laboratory services. Could you explain why the Administration has decided to revisit a policy which Congress and HCFA have rejected in the past that simply increases the out-of-pocket expenses for beneficiaries?**

We believe modest coinsurance will reduce inappropriate utilization. Physicians do take beneficiary costs into account when ordering services or making treatment decisions, and this will help reduce overuse.

Clinical laboratory services represent a fast-growing Medicare service. About 24 million beneficiaries used diagnostic lab services in 1997, at a rate of about 14 services per user and an annual cost of $200 per user. Having beneficiaries contribute towards their lab services would make cost-sharing requirements under Part B more uniform and easier to understand. It also would encourage beneficiaries to pay more attention to the lab tests they receive which could cut down on fraud and help reduce over-use.

**Murkowski 2**

**I am aware that in 1997 the average charge for clinical laboratory services to a Medicare Part B enrollee was $9.66 (HCFA Office of the Actuary). A 20 percent co-payment for $9.66 would be $1.93. The cost to produce an invoice and bill for that amount would be $1 to $3 greater than the cost of the actual co-payment. Does it make sense to implement a previously rejected co-payment policy that costs more to bill and collect that the actual cost of the co-payment?**

According to our analysis, it should be relatively easy and inexpensive to collect the majority of the coinsurance. Sixty-four percent of lab services are provided in outpatient settings or in physician offices where collection of coinsurance payments is routine and inexpensive.

Approximately 36 percent of Medicare lab services are furnished by independent labs that currently do not collect coinsurance. The costs of collecting coinsurance here could be expensive relative to the price of the lab test. We are considering several proposals to minimize or eliminate the costs that independent labs might have in collecting coinsurance.

For example, current law allows piggybacking of claims for Medigap policies. This means that if the claim that the lab submits to Medicare identifies the Medigap insurer, the Medicare carrier could automatically bill the Medigap insurer for lab coinsurance and the Medigap insurer would be required to pay the lab directly. The lab would not have to bill the Medigap insurer. This also would be applicable for Medicaid beneficiaries. The Medicare carrier would submit a bill to Medicaid. Labs would not have to bill the State. We are also considering the feasibility of

extending these types of piggyback arrangements to other types of policies that fill-in Medicare coinsurance (e.g., employer wrap-around coverage).

**Murkowski 3**
**The Administration's plan seeks to waive existing co-payments and deductibles for many preventive/screening services covered by Medicare. Could you explain why the Administration is waiving random screening tests, while at the same time increasing out-of-pocket expenses for necessary tests ordered by physicians to assist in patient diagnosis.**

The rationale is straightforward. The President's plan would improve access to potentially life-saving preventive services by waiving *all* co-payments and deductibles for preventive services for which cost sharing is not already waived under current law. This also applies to those lab services which are also preventive services (e.g., pap smears and fecal occult blood lab tests for colorectal cancer screening).

**Wouldn't this policy discourage patients who actually have a physician-identified need for clinical laboratory services from seeking such services?**

We believe modest coinsurance will reduce inappropriate utilization. Physicians do take beneficiary costs into account when ordering services or making treatment decisions, and this will help reduce overuse. Clinical laboratory services represent a fast-growing Medicare service. About 24 million beneficiaries used diagnostic lab services in 1997, at a rate of about 14 services per user and an annual cost of $200 per user.

## QUESTIONS SUBMITTED FOR THE RECORD BY SENATOR J. ROBERT KERREY

**Kerrey 1**
**What proportion of beneficiaries have pharmaceutical needs that exceed the capped benefit level within the drug benefit proposal?**

When fully phased-in, the Medicare Part D drug benefit will cover $5,000 in total pharmaceutical spending. In 2000, fewer than 3 percent of Medicare beneficiaries will have drug expenses that exceed the limit. Because of the effect of inflation on drug prices, we expect that number to rise by 2008 but the percentage of beneficiaries that will have costs that exceed the cap still will be relatively modest.

**Kerrey 2**
**We are hearing from a lot of providers about the damaging effect that BBA payment cuts have had on our health care delivery system -- and I'm particularly concerned about rural beneficiaries' access to health services. Why have you chosen to partially finance your proposal through various extensions of BBA payment cuts?**

We are certainly not ignoring the concerns that have been raised by providers in the wake of the implementation of the BBA. At the President's direction, HHS will implement administrative actions that would relieve unnecessary burdens that could undermine the ability of providers to deliver quality services. In addition, the proposal explicitly provides for a $7.5 billion quality assurance fund to help smooth out problems that Congress and the Administration decide, based on objective evidence, have resulted in harm to beneficiaries. Although the reform proposal includes proposals to constrain out-year spending, they are much more moderate than those included in the BBA and those recommended by the Republicans on the Medicare Commission. They do not include any hospital outpatient department savings, disproportionate share hospital payment reductions, nursing home savings, nor new home health care provider savings.

**Kerrey 3**
**Please provide the Committee with an analysis of how the $39 billion you anticipate saving through the BBA extenders is distributed by provider type. I would also be interested in the distribution across rural and urban providers.**

I will forward an actuarial memo that specifies the anticipated savings achieved through the BBA extenders by provider type. We do not have, however, a breakdown of the savings in rural and urban areas.

**Kerrey 4**
**The Administration has stated that it will "geographically adjust" payments to health plans. How would this work, and what will this mean for beneficiaries who live in low-cost areas?**

No, beneficiaries will <u>not</u> pay more for a comparable plan in a low cost area - the government would pay for all geographic variations plus more in low-cost areas to encourage plans and beneficiaries to participate. This is more favorable to managed care than the BBA geographic

adjustments.

## QUESTIONS SUBMITTED FOR THE RECORD BY CHAIRMAN ROTH

**Roth 1**
**You mentioned that you are limited by statute to the number and type of contractors you can use to help administer the traditional fee-for-service plan. Can you make specific recommendations for statutory changes that would remedy this situation?**

We submitted a legislative package to Congress in May of this year. A copy of that package is attached for your consideration.

The contracting reform proposal would:

- Allow the Secretary increased flexibility in contracting for claims processing and payment functions beyond the current list of insurers.

- Allow the Secretary to determine, on a case-by-case basis, the most appropriate contract arrangement, including payment methodology (for example, paying contractors on an other-than-cost basis, as is currently the case).

- Give the Secretary greater administrative flexibility in replacing poor-performing contractors promptly.

- And, achieve efficiencies by giving the Secretary clear authority to hire contractors that can perform the functions of both carriers and intermediaries.

The contracting reform proposal is vital to Medicare's future. It is designed to give the Secretary more flexibility in the contracting process, and to bring Medicare contracting more in line with the standard contracting procedures used across the Federal government. The proposal also would provide HCFA with additional leverage to better manage the Medicare contractors. Finally, the proposal would allow the Secretary to supplement the existing and steadily shrinking pool of contractors by creating an open marketplace.

United States General Accounting Office

GAO

Testimony

Before the Committee on Finance, U.S. Senate

For Release on Delivery
Expected at 2:00 p.m.
Thursday, July 22, 1999

# MEDICARE REFORM

## Observations on the President's July 1999 Proposal

Statement of David M. Walker
Comptroller General of the United States



GAO/T-AIMD/HEHS-99-236

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the President's recent proposal to reform Medicare. According to the President, his proposal is intended to make Medicare more efficient, modernize the benefit package, and extend the program's long-term solvency.

When I last testified before you to discuss this topic in March,[1] there appeared to be an emerging consensus that substantive financing and programmatic reforms were necessary to put Medicare on a sustainable footing for the future. The long-term cost pressures facing this program remain today. Fundamental program reforms are vital to reducing the program's growth, which threatens to absorb ever-increasing shares of the nation's budgetary and economic resources. Modernizing and upgrading Medicare's benefit package may be important, but such initiatives need to be considered in light of the broader financial challenges facing this program and the nation.

Against this backdrop, I want to acknowledge this Committee's efforts on Medicare reform over the past several months. The Committee has been diligent in exploring difficult issues pertaining to proposed options as well as the impact of reforms included under the Balanced Budget Act of 1997 (BBA). To date, this Committee and the Congress as a whole have remained steadfast in the face of intense pressure to roll back BBA's payment reforms and are waiting until strong evidence demonstrates the need for modifications. The President also deserves credit for looking out over a 15-year period in formulating budget proposals and proposing an historic reduction in publicly held debt that will help future generations better afford future commitments.

These initiatives are important because we must be especially prudent during this period of prosperity, even as recent estimates of budget surpluses have been increased. At the same time, we must remember that these are projected budget surpluses, and we know that the business cycle has not been repealed. Current projected surpluses could well prove to be fleeting, and thus we should exercise appropriate caution when creating new entitlements that establish permanent claims on future resources. While I don't relish being the accountability cop at the surplus celebration party, that's part of my job as Comptroller General of the United States.

Moreover, while the size of future surpluses could exceed or fall short of projections, we know that demographic and cost trends will, in the absence of meaningful reform, drive Medicare spending to levels that will prove unsustainable for future generations of taxpayers. Accordingly, we need to view this period of projected prosperity as an opportunity to address the structural imbalances in Medicare, Social Security, and other entitlement programs before

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[1]See Medicare and Budget Surpluses: GAO's Perspective on the President's Proposal and the Need for Reform (GAO/T-AIMD/HEHS-99-113, Mar. 10, 1999).

the approaching demographic tidal wave makes the imbalances more dramatic and meaningful reform less feasible.

As the foregoing suggests, the stakes associated with Medicare reform are high, for the program itself and for the rest of the federal budget, both now and for future generations. Current policy decisions can help us prepare for the challenges of an aging society in several important ways: (1) reducing public debt to increase national savings and investment, (2) reforming entitlement programs to reduce future claims and free up resources for other competing priorities, and (3) establishing a more sustainable Medicare program that delivers effective and affordable health care to our seniors.

In this context, I'd like to make a few summary points before delving into the specifics of Medicare's financial health and the President's July 1999 proposal.

- The President's proposal contains programmatic reforms that reflect a good faith effort to advance the reform debate. It provides a baseline for further debate and consideration of reforming Medicare. As such, it is an important step in the goal of reaching a national consensus about how we are going to deal with the explosive cost of medical care for our elderly population in the decades to come. We understand that several Members of Congress, including Members of the Senate Finance Committee, plan to introduce their own reform proposals later in this session.

- The Congress and the President may ultimately decide to include some form of prescription drug coverage as part of Medicare. Given this expectation and the future projected growth of the program, some additional revenue sources may in fact be a necessary component of Medicare reform. However, it is essential that we not take our eye off the ball. The most critical issue facing Medicare is the need to ensure the program's long-range financial integrity and sustainability. The 1999 annual reports of the Medicare Trustees project that program costs will continue to grow faster than the rest of the economy. Care must be taken to ensure that any potential expansion of the program be balanced with other programmatic reforms so that we do not worsen Medicare's existing financial imbalances.

- Given the size of Medicare's unfunded liability, it is realistic to expect that reforms to bring down future costs will have to proceed in an incremental fashion. The time to begin the difficult but necessary steps to reclaim our fiscal future is now when we have budget surpluses and a demographic "holiday" where retirees are a far smaller proportion of the population than they will be in the future.

- Ideally, the unfunded promises associated with today's program should be addressed before or concurrent with proposals to make new ones. To do otherwise might be politically attractive but not fiscally prudent. If additional benefits are added, policymakers need to consider targeting strategies and

fully offsetting the related costs. They may also want to design a mechanism to monitor these and aggregate program costs over time as well as establish expenditure or funding thresholds that would trigger a call for fiscal action. Our history shows that while benefits are attractive, fiscal controls and constraints are difficult to maintain. In addition, any potential program expansion should be accompanied by meaningful reform of the current Medicare program to help ensure its sustainability, and the President's package of reforms provides a useful starting point.

- To qualify as meaningful reform, a proposal should make a significant down payment toward ensuring Medicare's long-range financial integrity and sustainability. As we testified before this Committee in March and again in June, proposals to reform Medicare should be assessed against the following criteria: affordability, equity, adequacy, feasibility, and acceptance. (See fig. 1.)

Figure 1: Criteria for Assessing the Merits of Medicare Reform Proposals

- Affordability: A proposal should be evaluated in terms of impact on the long-term sustainability of program expenditures.
- Equity: A proposal should be fair across groups of beneficiaries and to providers.
- Adequacy: A proposal should include the resources to allow appropriate access as well as provisions to foster cost-effective and clinically meaningful innovations that address patient needs.
- Feasibility: A proposal should incorporate elements to facilitate effective implementation and adequate monitoring.
- Acceptance: A proposal should be transparent and should educate beneficiary and provider communities about its costs and the realities of trade-offs required when significant policy changes occur.

- People want unfettered access to desired health care, and some have needs that are not being met. However, health care costs compete with other legitimate claims in the federal budget, and their projected future growth threatens to crowd out future generations' flexibility to decide which of these competing priorities will be met. Thus, in making important fiscal decisions for our nation, policymakers need to consider the fundamental differences between wants, needs, and what both individuals and our nation can afford. This concept applies to all major aspects of government, from major weapons system acquisitions to domestic program issues. It also points to the fiduciary and stewardship responsibility that we all share to ensure the sustainability of

Medicare for current and future generations within a broader context of providing for other important national needs and economic growth.

- The President's latest proposal is projected to virtually eliminate the publicly held debt by 2015—this would be a significant accomplishment. Such an initiative would provide a substantial fiscal dividend by reducing interest costs, raising national savings, and contributing to future economic growth. This initiative would help us better afford our future commitments, but it would not alone be sufficient. Even if all future surpluses were saved, we would nonetheless be saddled with a budget over the longer term that at current tax rates could fund little else but entitlement programs for the elderly population. Reforms reducing the future growth of Medicare as well as Social Security and Medicaid are vital under any fiscal and economic scenario to restoring fiscal flexibility for future generations of taxpayers.

At this time, I would like to discuss the competing concerns at the crux of Medicare reform, in general, and issues to consider in assessing the President's proposal, in particular.

## COMPETING CONCERNS POSE CHALLENGES FOR MEDICARE REFORM

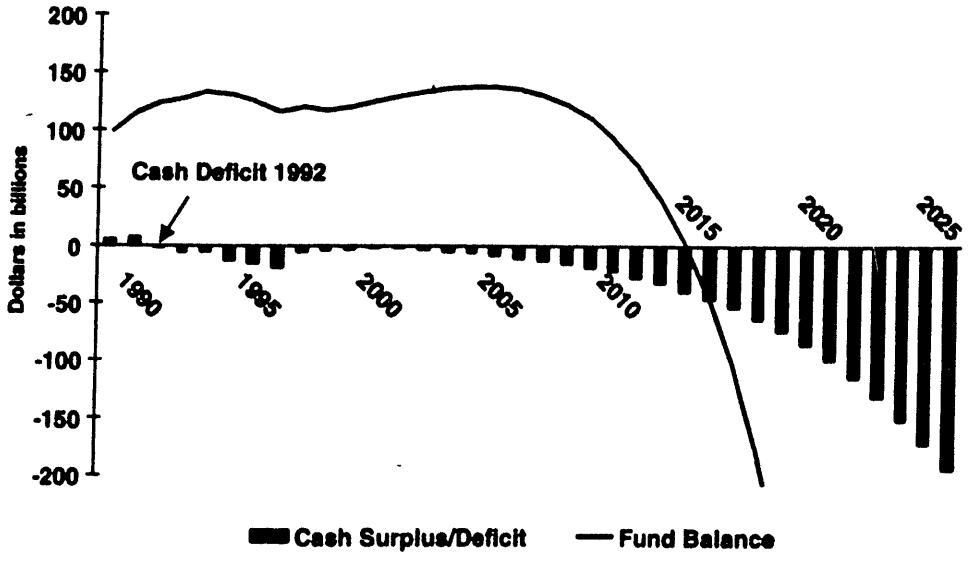
The current Medicare program, without improvements, is ill-suited to serve future generations of seniors and eligible disabled Americans. On the one hand, the program is fiscally unsustainable in its present form, as the disparity between program expenditures and program revenues is expected to widen dramatically in the coming years. On the other, the program is outmoded in that it has not been able to adopt modern, market-based management tools, and its benefit package contains gaps in desired coverage. Compounding the difficulties of responding to these competing concerns is the sheer size of the Medicare program—even modest program changes send ripples across the program's 39-million-strong beneficiary population and the approximately 1 million health care providers that bill the program. Balancing the needs of these interests requires hard choices that this Committee, the Congress, and the National Bipartisan Commission on the Future of Medicare have had brought before them in their deliberations.

### Medicare Is Already in the Red

Unlike private trust funds that can set aside money for the future through investments in financial assets, the Medicare Hospital Insurance (HI) Trust Fund—which pays for inpatient hospital stays, skilled nursing care, hospice, and certain home health services—is essentially an accounting device. It allows the government to track the extent to which earmarked payroll taxes cover Medicare's HI outlays. In serving the tracking purpose, annual Trust Fund reports show that Medicare's HI component, on a cash basis, is in the red and has been since 1992. (See fig. 2.) Currently, earmarked payroll taxes cover only 89 percent of HI spending and, including all earmarked revenue, the Fund is projected to

have a $7 billion cash deficit for fiscal year 1999 alone. To finance this deficit, Medicare has been drawing on its special issue Treasury securities acquired during the years when the program generated a cash surplus. Consequently, Medicare is already a net claimant on the Treasury—a threshold that Social Security is not currently expected to reach until 2014. In essence, for Medicare to "redeem" its securities, the government must raise taxes, cut spending for other programs, or reduce the projected surplus. Outlays for Medicare services covered under Supplementary Medical Insurance, or SMI (physician and outpatient hospital services, diagnostic tests, and certain other medical services and supplies), are already funded largely through general revenues.

Figure 2: Financial Outlook of the Hospital Insurance Trust Fund




Without meaningful reform, the long-term financial outlook for Medicare is bleak. Together Medicare's HI and SMI expenditures are expected to increase dramatically, rising from 12 percent in 1999 to more than a quarter of all federal revenues by mid-century. Over the same time frame, Medicare's expenditures are expected to double as a share of the economy, from 2.5 to 5.3 percent, as shown in figure 3.



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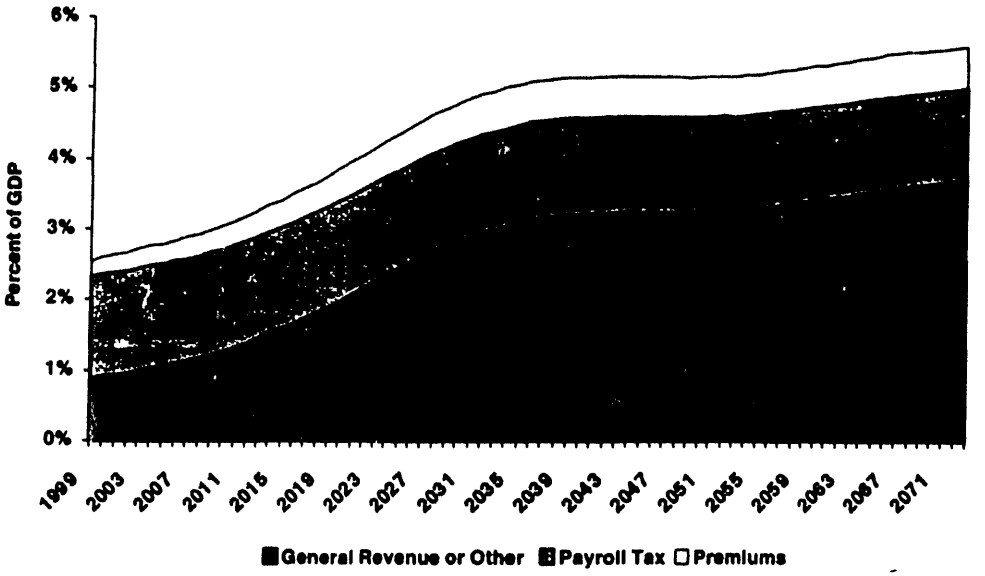
Figure 3: Composition of Medicare Funding as a Percent of Gross Domestic Product (GDP)



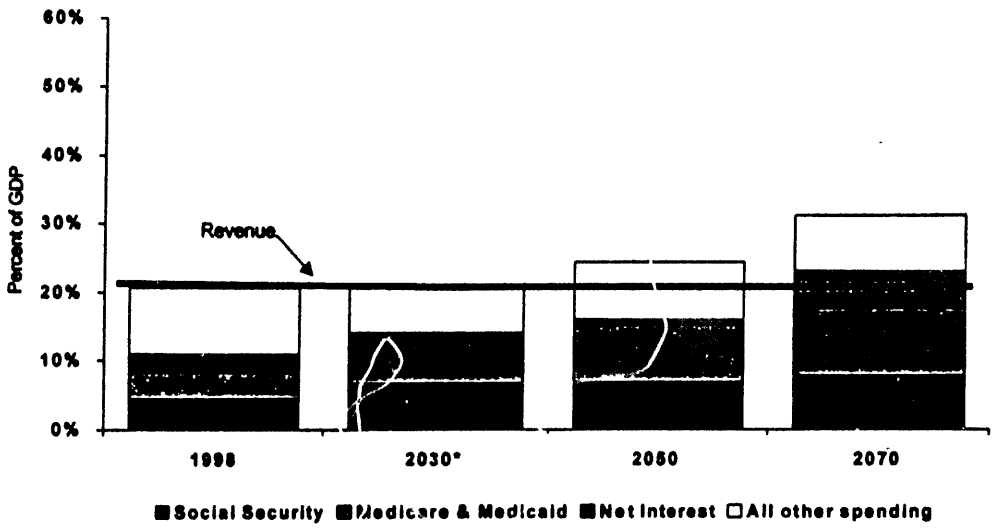

The progressive absorption of a greater share of the nation's resources for health care, like Social Security, is in part a reflection of the rising share of elderly in the population. Medicare's rolls are expanding and are projected to increase rapidly with the retirement of the baby boom. Today's elderly make up about 13 percent of the total population; by 2030, they will comprise 20 percent as the baby boom generation ages and the ratio of workers to retirees will have declined from nearly 4 to 1 today to roughly 2 to 1.

However, Medicare growth rates also reflect the escalating growth of health care costs at rates well exceeding general rates of inflation. Increases in the number and quality of health services have been fueled by the explosive growth of medical technology. Moreover, the actual costs of health care consumption are not transparent. Third-party payers generally insulate consumers from the cost of care decisions. In traditional Medicare, for example, the impact of the cost-sharing provisions designed to curb the use of services is muted because about 80 percent of beneficiaries have some form of supplemental health care coverage (such as Medigap insurance) that pays these costs. For these reasons, among others, Medicare represents a much greater and more complex fiscal challenge than even Social Security over the longer term.

When viewed from the perspective of the entire budget and the economy, the growth in Medicare spending will become progressively unsustainable over the longer term. GAO's updated budget simulations shows that to move into the future without changes in the Medicare, Social Security, and Medicaid programs is to envision a very different role for the federal government. Even assuming that

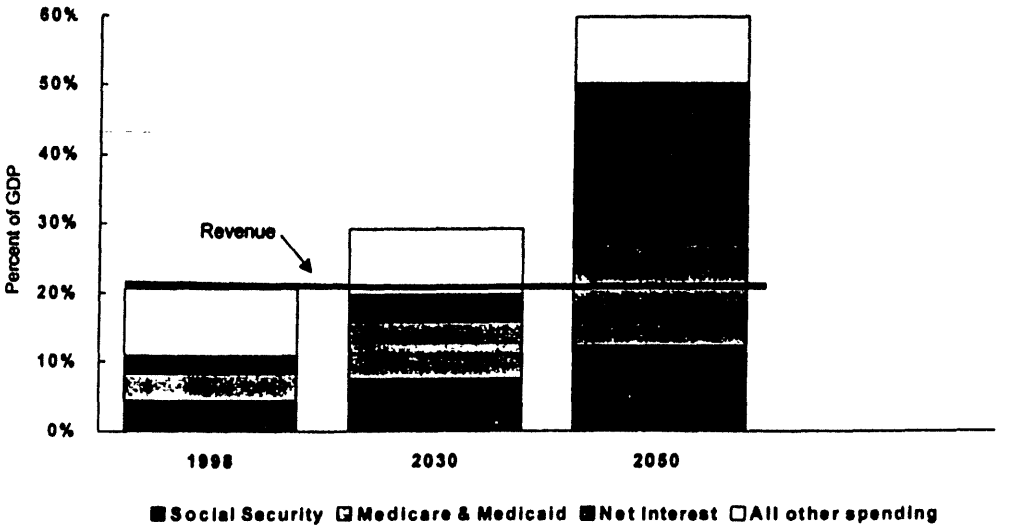
all projected surpluses are saved and existing discretionary budget caps are complied with, our long-term model shows a world by 2030 in which Social Security, Medicare, and Medicaid increasingly absorb available revenues within the federal budget. (See fig. 4.) If none of the surplus is saved, the long-term outlook is even more daunting. (See fig. 5.) Budgetary flexibility declines drastically and there is little or no room for programs for national defense, the young, infrastructure, and law enforcement—i.e., essentially no discretionary programs at all.

Figure 4: Composition of Spending as a Share of GDP Under "Save the Unified Surplus" Simulation



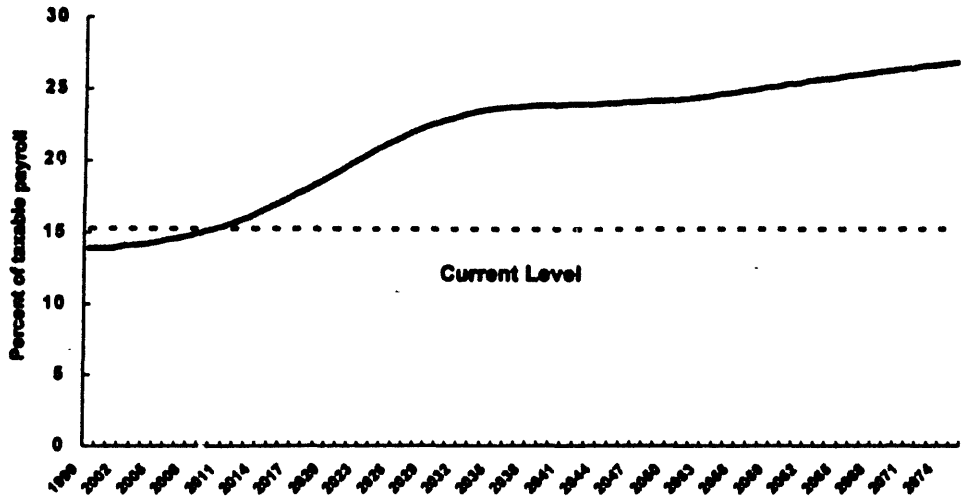

*In 2030, all other spending includes offsetting interest receipts.

Figure 5: Composition of Spending as a Share of GDP Under "No Unified Surplus" Simulation



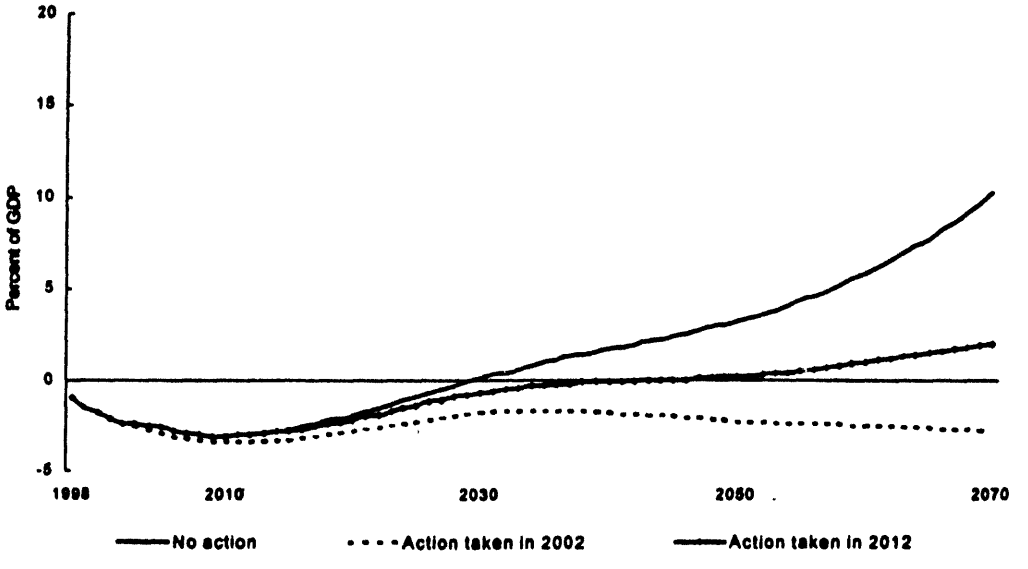

When viewed together with Social Security, the financial burden of Medicare on the future taxpayers becomes unsustainable. As figure 6 shows, the cost of these two programs combined would nearly double as a share of the payroll tax base over the long term. Assuming no other changes, these programs would constitute an unimaginable drain on the earnings of our future workers. This analysis, moreover, does not incorporate the financing challenges associated with the SMI and Medicaid programs.

Figure 6: Social Security and Medicare Part A as a Percent of Taxable Payroll




Early action to address the structural imbalances in this program is critical. First, ample time is needed to phase in the kinds of changes needed to put this program on a more sustainable footing before the baby boomers retire. Second, timely action to bring costs down pays large fiscal dividends for the program and the budget. Our long-term budget simulations, as shown in figure 7, illustrates how critical early action on Medicare reform is to our long-term fiscal future. Any reforms slowing Medicare's per person growth rate from a projected average annual rate of 4.5 percent to 4 percent over a 70-year period would yield the kind of savings needed to truly establish a sustainable budget policy for the long term. Because of the high projected growth of Medicare in the coming years, the earlier the reform begins, the greater the savings due to the effects of compounding. Reforms fully phased in by 2002 would enable us to maintain surpluses over the entire 70-year simulation period.

Figure 7: Federal Deficits as a Share of GDP Under Alternate Medicare Simulations




## Medicare Out of Date Relative to Other Health Care Payers

In addition to its significant financial imbalance, Medicare is unsatisfactory from a programmatic perspective. BBA reforms were designed in part to modernize the program's pricing and payment strategies, but Medicare has not yet become a prudent purchaser. In its current form, the program lacks the flexibility to readily adjust its administered prices and fees in line with market rates and lacks the tools to exercise meaningful control over the volume of services used.

In addition, concerns continue to be voiced about the current coverage gaps in protections for Medicare beneficiaries, which contrast with what is available for younger Americans with private employer-based coverage. Medicare's basic benefit package largely reflects the offerings of the commercial insurance market in 1965 when the program began. Although commercial policies have evolved since then, Medicare's package for the most part has not. For example, unlike many current commercial policies, Medicare does not cover routine physical examinations or outpatient prescription drugs or cap beneficiaries' out-of-pocket spending. Two-thirds of Medicare beneficiaries obtain prescription drug coverage by participating in the Medicaid program (if they are eligible), obtaining a supplemental insurance policy privately or through an employer, or enrolling in a Medicare+Choice plan. However, in some cases, these options do not provide adequate coverage, leaving high users with significant out-of-pocket costs; for many of the remaining third of beneficiaries, these options are inaccessible

altogether, either because they are not available—in the case of a Medicare+Choice plan—or are not affordable. In short, many reform advocates believe that Medicare's basic benefit package should be brought into line with current commercial norms.

The challenge facing the Congress today is to identify reform options that satisfy the need to make Medicare's costs more sustainable while addressing certain gaps in coverage. With respect to prescription drug coverage, striking this balance is particularly difficult. On the one hand, financing a prescription drug benefit would be a costly proposition. From 1992 to 1997, prescription drug spending grew on average by 11 percent a year, compared with a 5-percent average growth rate for health expenditures overall. As a result, drug spending during that same period consumed a larger share of total health care spending—rising from 5.6 percent to 7.2 percent. In addition, the elderly population, which constitutes the majority of Medicare beneficiaries, consists of relatively high users of prescription drugs. In 1995 (the most recent year for which data are available), annual drug costs were $600 per elderly person, compared to just over $140 for a nonelderly individual. On the other hand, the lack of a prescription drug benefit creates a significant burden for those who have little or no supplemental coverage. In 1999, an estimated 20 percent of Medicare beneficiaries—some of whom lack any supplemental coverage—will have total drug costs of $1,500 or more.

Number and Size of Affected Parties
Make Medicare Reform Exceptionally Difficult

The fact that changes to Medicare can create seismic reverberations is not surprising. Health care spending accounts for one-seventh of the nation's economy, and Medicare is the nation's single largest health care payer. The program's beneficiary populations consist of roughly 35 million seniors and 4 million disabled individuals under age 65. HCFA estimates that the program's billers—physicians, hospitals, equipment suppliers, and other providers of medical services—number about 1 million.

BBA payment reforms are the latest case example illustrating the intensity of reactions from providers affected by legislative changes. BBA sought to lower future payments to Medicare's managed care plans and to providers historically paid through cost reimbursement. Affected providers are currently seeking to repeal various BBA provisions, with some relying on anecdotal evidence rather than systematic analysis to make their case. A recent illustration is the reporting of health plan withdrawals from the Medicare+Choice program. Plans cite, and the press reports, inadequate payment rates as the reason for dropping out of Medicare or reducing enrollees' benefits. GAO has another point of view based on our fact-gathering and analyses.

BBA sought to moderate Medicare's payments to managed care plans because, ironically, Medicare managed care cost, not saved, the government money. That is, the government was paying more to cover beneficiaries in managed care than it

would have if these individuals had remained in the traditional fee-for-service program. In our recent published work, we noted that BBA has reduced, but not eliminated, excess payments.[2] In fact, Medicare's payments to some plans are generous enough to finance prescription drugs and other extras not available to the majority of senior and disabled beneficiaries that remain in traditional Medicare. We have also reported that factors additional to or even exclusive of payment rates—including competition and other market conditions—played a significant role in plan dropouts.[3] The question this raises for policymakers is to what extent should they be concerned about health plan dropouts from Medicare when plan participation means that the government finances non-Medicare benefits for a minority of beneficiaries while paying more for these beneficiaries than for those in traditional Medicare. Among other lessons, however, the intensity of pressure to roll back BBA's curbs on managed care rate increases teaches us the difficulty that this Committee and the Congress as a whole face in making appropriate Medicare payment reforms.

## PRESIDENT'S MEDICARE REFORM PROPOSAL

The President's proposal to reform Medicare is intended to function on two levels: first, as a Medicare financing strategy and, second, as a package of programmatic reforms. On the basis of GAO's work on these topics, I would like to discuss several key issues.

### Financing Aspect of President's Proposal

The President proposes to use 13 percent of the projected budget surpluses over the next 15 years to provide additional Treasury securities to the HI Trust Fund and partially offset the cost of the proposed prescription drug benefit.[4] This aspect of the proposal has important implications for the budget as a whole as well as for Medicare financing in particular.

With regard to its more general budgetary significance, the President's proposal is part of a broader initiative that would save a major share of the surplus to reduce debt held by the public. Most of the surplus transferred to Medicare would be invested in federal Treasuries and the President is proposing budget enforcement

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[2]See Medicare+Choice: Reforms Have Reduced, but Likely Not Eliminated, Excess Plan Payments (GAO/HEHS-99-144, Jun. 18, 1999).

[3]See Medicare Managed Care Plans: Many Factors Contribute to Recent Withdrawals; Plan Interest Continues (GAO/HEHS-99-91, Apr. 27, 1999).

[4]In the Midsession Review, the President proposes to transfer $794 billion of the projected 15-year surpluses to Medicare—$723 would be used to acquire additional Treasury securities for the HI Trust Fund and the remainder would help pay for the proposed drug benefit. Excluding financing costs associated with the President's proposed new spending, this amount represents 15 percent of projected surpluses. However, when computed to include these costs, the transfer represents 13 percent of total projected surpluses.

mechanisms—"lockboxes"—that would ensure that these transfers be used solely to reduce publicly held debt. As the President himself has suggested, debt reduction plays a critical role in enhancing our economic capacity to finance our burgeoning commitments over the long run. The President's June Midsession Review projects that his proposals would reduce debt held by the public by $3.6 trillion over the next 15 years, virtually eliminating publicly held debt by 2015. Approximately two-thirds of total projected unified budget surpluses would be used to reduce the debt through lockbox provisions dedicating all of Social Security's surpluses, and about a quarter of the on-budget surplus would be transferred to Medicare for debt reduction. However, because of the transfers to Medicare, debt held by government accounts would increase by about $1 trillion over the 15-year period.

The reduction in publicly held debt proposed by the President —although less than the baseline, which assumes that all surpluses would be saved—would confer significant short- and long-term benefits to the budget and the economy. Our own work on long-term budget outlooks illustrates the benefits of maintaining surpluses for debt reduction. Interest on the debt represents today the third largest expenditure in the federal budget. Reducing the publicly held debt reduces these costs, freeing up budgetary resources for other programmatic priorities. Under the President's plan, interest expense would fall from $229 billion in 1999 to about $10 billion in 2014. For the economy, lowering debt increases national saving and frees up resources for private investment. This in turn leads to stronger economic growth and higher incomes over the long term.

Over the last several years, our simulations illustrate the long-term economic consequences flowing from different fiscal policy paths.[6] Our models consistently show that saving all or a major share of projected budget surpluses ultimately leads to demonstrable gains in GDP per capita over a 50-year period. GDP per capita would more than double from present levels by saving most or all of projected surpluses, while incomes would eventually fall if we failed to sustain any of the surplus. Although rising productivity and living standards are always important, they are especially critical for the 21st Century, for they will increase the economic capacity of the projected smaller workforce to finance future government programs along with the obligations and commitments for the baby boomers' retirement.

With regard to the Medicare program itself, the proposed "transfer" of surpluses would extend the solvency of the HI Trust Fund on paper from 2015 to 2027. This initiative, however, represents a major departure in financing for the HI program. Established as a payroll tax funded program, HI would now receive an explicit grant of funds from general revenues not supported by underlying payroll tax receipts. Treasury securities held by the Trust Fund have always represented the

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[6]See Budget Issues: Long-Term Fiscal Outlook (GAO/T-AIMD/OCE-98-83, Feb. 25, 1998) and Budget Issues: Analysis of Long-Term Fiscal Outlook (GAO/AIMD/OCE-98-19, Oct. 22, 1997).

value of the loan provided by the HI program's prior payroll tax surpluses to the Treasury. Under the Presidents' proposal, the value of securities held by the HI Trust Fund would exceed that supported by earlier payroll tax surpluses and this grant would constitute a new claim on the general fund for the future. In effect, the proposed transfer would make the HI Trust Fund financing look more like that of the part B SMI Trust Fund, which obtains 75 percent of its funding from the general fund.

As the foregoing suggests, this is a major change in the theoretical design of the HI program that deserves full and open debate. The size of the imbalances between Medicare's outlays and payroll tax revenues for the HI program may well justify the need for additional financing from general revenues. The President argues that Medicare should be guaranteed a share of the benefits resulting from the fiscal improvement that debt reduction and lower interest costs would bring about. However, using surpluses to finance Medicare entails significant risks.

The President's proposal to grant Medicare additional Treasury securities creates the risk of reducing transparency about the underlying financial condition of the HI Trust Fund. Although arguably justified as a way to lock in debt reduction, the transfers are not necessary to do this. What concerns me is the transfers extend the solvency of the HI Trust Fund on paper without making the hard choices needed to make the whole Medicare program more sustainable in economic or budgetary terms. Increasing the HI Trust Fund balance alone, without underlying program reform, does nothing to make the Medicare program more sustainable—that is, it does not reduce the program's projected share of GDP or the federal budget. From a macro perspective, the critical question is not how much a trust fund has in assets, but whether the government as a whole has the economic capacity to finance all of Medicare's promised benefits—both now and in the future.

In fact, the transfer would interfere with the vital signaling function that trust fund mechanisms can serve for policymakers about underlying fiscal imbalances in covered programs. The greatest risk is that the proposed transfer will reduce the sense of urgency that impending trust fund bankruptcy provides to policymakers by artificially extending the solvency of the HI program through 2027—well into the peak of the baby boomers' retirement. Furthermore, increasing the Trust Fund's paper solvency does not address cost growth in the SMI portion of Medicare, which is projected to grow even faster than HI in coming decades.

The President's proposal to transfer funds to the HI Trust Fund would, in effect, increase the general fund contribution to total Medicare funding. Increasing the balances of Treasury securities owned by the HI Trust Fund alone would increase the formal claim that the Trust Fund has on future general revenues since the Trust Fund's securities constitute a legal claim against the Treasury. These are resources that will not be available for competing priorities in either domestic or defense areas. When considering both HI and SMI programs together, the share of general fund financing would grow under the President's proposal from its current

level of 34 percent to about 57 percent by 2027. Although the programs' costs are projected to grow to these levels in the absence of any changes, the proposals would lock in general fund financing of these costs through the transfer of additional Treasury securities. In effect, the proposal would likely ensure that projected Trust Fund shortfalls through 2027 will be financed through the general fund rather than through Medicare program reforms.

Finally, any proposal to allocate surpluses is vulnerable to the risk that those projected surpluses may not materialize. Commitments often prove to be permanent while surpluses can be fleeting. Although recent budget forecasts have proven to be too pessimistic, the history of budget forecasts should remind us not to be complacent about the certainty of these large projected surpluses. In its January 1999 report, the Congressional Budget Office (CBO) compared the actual deficits or surpluses for 1988 through 1998 with the first projection it produced 5 years before the start of each fiscal year. Excluding the estimated impact of legislation, CBO says its errors averaged about 13 percent of actual outlays. Such a shift in 2004 would mean a swing of $250 billion and about $300 billion in 2009. Accordingly, any permanent commitments that are dependent on the realization of a long-term forecast should be considered carefully.

Programmatic Aspects of President's Proposal

The President's reform plan also consists of several programmatic changes—most notably, a proposal for health plans to compete on the basis of price and the addition of a prescription drug benefit. The plan also calls for measures intended to help Medicare operate more efficiently or strengthen future financing, including the following: create a preferred provider option in which beneficiaries would be rewarded with lower cost-sharing requirements when choosing providers preferred by Medicare; expand the use of centers of excellence, in which providers that specialize in performing such procedures as coronary artery bypass surgery receive a global fee for all services provided rather than a separate fee for each service; extend certain BBA provisions that reduce provider payment rate increases, thus helping to slow future program spending; impose a 20-percent copayment for clinical laboratory services; and index the part B deductible for inflation.

Overall, the Office of Management and Budget estimates that the changes in price competition and cost incentives would achieve savings of $72 billion over 10 years. However, these savings would offset only 60 percent of the total projected $118 billion for the new prescription drug benefit, with the remainder being financed through a portion of the general fund transfers, as discussed earlier. CBO's re-estimate of the President's proposal—projecting a higher cost for the drug benefit and smaller savings—underscores the uncertainty and volatility inherent in health care cost estimates. This argues for proceeding cautiously in expanding the Medicare program to include new benefits.

Now I would like to elaborate on the competitive pricing of health plan premiums and the addition of a prescription drug benefit.

Provisions for Proposed Health Plan Competition

Under the President's proposal, private health plans serving Medicare beneficiaries would compete on the basis of cost and quality to provide Medicare-covered benefits. Instead of administratively established payment rates, plans would set their own premiums for a standard package of benefits. The government's contribution would be limited to 96 percent of the estimated fee-for-service costs of enrolled beneficiaries. Beneficiaries choosing plans priced under the 96-percent level would pay reduced part B premiums and could retain these savings or use them to buy optional benefits. Beneficiaries choosing plans exceeding the 96-percent level would pay an amount additional to the standard part B premium.

In principle, the competitive pricing of managed care plan premiums has considerable merit and could help produce savings for both the program and beneficiaries. Using market forces to set prices would constitute a major advance. Price competition among plans is more likely to lead to payments that appropriately compensate efficient plans rather than the excessive payment levels that have resulted from administratively set prices. Taxpayers would benefit in two ways: first, because the government's contribution would be lower than if beneficiaries remained in traditional Medicare and, second, because the government would net 25 percent of the savings achieved through the enrollment of beneficiaries in plans priced below the government contribution cap.

However, the extent to which price competition among health plans would produce savings depends on the design and implementation particulars—which the Administration has not yet made available. Our previous work demonstrates conclusively that health plan payments must take into account the health status of enrolled beneficiaries—that is, be risk adjusted—if savings are to be realized.[6] Also critical is how Medicare will estimate average fee-for-service spending and calculate its contribution to health plan premiums. Currently, average fee-for-service spending varies dramatically across geographic areas, due primarily to differences in beneficiaries' use of medical services and, to a lesser extent, differences in local prices. Some of the variation can reflect an area's inappropriate use of services—either too low or too high. Because such inappropriate utilization is embedded in the fee-for-service expenditure data, benchmarking plan payments against current fee-for-service spending levels requires careful scrutiny. The Administration indicates it will incorporate a

[6]See Medicare Managed Care: Better Risk Adjustment Expected to Reduce Excess Payments Overall While Making Them Fairer to Individual Plans (GAO/T-HEHS-99-72, Feb. 25, 1999) and Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments (GAO/HEHS-97-16, Apr. 25, 1997).

geographic adjustment that will take into consideration these local differences, but it has released few details on how this process would work.

Provisions for Proposed Prescription Drug Benefit

The second major programmatic element of the President's proposal is the addition of a prescription drug benefit. Essentially, the prescription drug benefit would be voluntary, requiring a premium separate from the current part B premium and 50-percent copayment from beneficiaries for each prescription. Beneficiaries would be permitted to enroll for the benefit, generally, only when they are first eligible. The benefit is designed to be phased in. In 2002, the beneficiary's premium would be about $24 per month, with Medicare paying up to $1,000 per-beneficiary annually. By 2008, the premium would rise to about $44 per month, with Medicare paying up to $2,500 per-beneficiary annually. The poorest beneficiaries would not pay premiums or copayments, and other low-income beneficiaries would receive premium assistance.

Enrollees in Medicare managed care plans would receive their prescription drug benefit as they do currently. Beneficiaries in traditional Medicare would get their benefit through private companies called "pharmacy benefit managers" (PBM) or through entities that essentially operate like a PBM. In the private sector today, PBMs under contract with third-party payers administer and manage enrollees' prescription drug benefit. As proposed for Medicare, PBMs would be paid a fee for managing the drug benefit and would competitively bid to manage the benefit for a particular geographic area. They would negotiate prices with drug manufacturers.

Several of the prescription drug benefit provisions contain elements of fiscal discipline, transparency, and economy. For example, the separate premium—for which the government's share must be calculated each year—serves as a mechanism to track the benefit's aggregate costs. The 50-percent copayment and the annual cap are likely to help control excessive utilization. The one-time enrollment opportunity encouraging beneficiary participation would help spread risk across a larger pool of individuals, not just among the high users. This provision would help prevent a situation in which a greater contribution from the government would be needed to finance the benefit if only frequent users chose to enroll. Finally, premium and copayment subsidies would help relieve low-income beneficiaries from some of the burden of high out-of-pocket costs.

We note, however, the following design and implementation concerns regarding the drug benefit as proposed.

- Cost of the benefit. This new benefit is not fully paid for by other offsetting program changes. General funds from the projected surpluses make up the difference; but as I said earlier, this would finance a permanent benefit expansion with an uncertain revenue stream.

- Targeting of the benefit. A primary means of allocating limited resources is to target them on the greatest needs. With the exception of greater federal subsidies for certain near-poor Medicare beneficiaries, the proposed coverage is not targeted to need. The proposal provides first-dollar coverage rather than using a deductible that would make beneficiaries more cost-sensitive and would reduce total program expenditures. In addition, it would cap the benefit at $2,500, leaving some beneficiaries incurring catastrophic drug expenses without coverage.

- Substitution for employer-provided. The proposed benefit could mean that some costs borne by employers and retirees through retiree health benefit plans would become the responsibility of the federal taxpayer. A partial subsidy to employers—equaling two-thirds of what the program would pay for Medicare drug coverage—aims at minimizing the number of employers and retirees dropping employer-sponsored coverage. How effective the subsidy works in preventing substitution remains to be seen. Some employers may still find it advantageous to drop coverage. Retirees may actually approve if they prefer to obtain the full drug benefit from Medicare and receive alternative benefits from their former employers, including "wrap-around" drug coverage that fills some of the gaps in the Medicare benefit.

- Uneven impact across states. In assisting low-income Medicare beneficiaries with premiums and cost-sharing of the new drug benefit, the President's proposal would build on existing Medicare "buy-in" programs, in which the federal government and the state together subsidize—through Medicaid—some combination of Medicare premiums, deductibles, and copayments. For individuals between 100 and 150 percent of the federal poverty level, the President's proposal provides for full federal funding of the prescription drug benefit; for those below 100 percent, the proposal calls for shared funding between the federal government and the state.[7] States would experience varying levels of fiscal relief or additional burden, depending on the extent to which they ensured that these individuals receive their benefit.

  More than 40 percent of low-income individuals eligible for the current Medicare buy-in benefits are not enrolled, and enrollment is particularly low among eligible individuals above the federal poverty level. The inclusion of the drug benefit would create a greater incentive for these beneficiaries to enroll in the Medicare buy-in program. Further, the full federal funding of the drug benefit for those above the federal poverty level could help reduce the disincentives that states face when considering whether to actively encourage beneficiaries to enroll in a federally mandated program that is not fully funded by the federal government. At the same time, significantly greater enrollment in the Medicare buy-in programs resulting from the new drug benefit and outreach efforts would increase a state's financial exposure for matching

[7]Beneficiaries with income between 135 and 150 percent of the federal poverty level would pay a partial, sliding-scale premium based on their income.

funds that subsidize beneficiaries' Medicare part B premiums. States with eligibility standards for full Medicaid benefits that are well below the federal poverty level would be more likely to incur additional obligations.

- Obstacles to realizing the savings potential of PBMs. In the private sector, the negotiations between PBMs and drug manufacturers and PBMs and pharmacies are determined privately, whereas Medicare—as a public program—is required to have transparent policies that are determined openly. If a PBM, as a Medicare contractor, has to conduct such negotiations in public, achieving meaningful discounts for Medicare may be difficult. Moreover, a PBM's span of control, not specified in the President's proposal, could have mixed effects on the PBM's ability to control drug costs. On the one hand, the greater the number of beneficiaries within that span, the greater the potential for moving market share to take advantage of manufacturers' discounts; on the other hand, the greater the number of affected providers, the greater the pressure for the PBM to include all willing providers, which would undermine its ability to negotiate with selected manufacturers or providers offering the best terms.

Finally, I would caution that the creation of a new and compelling benefit for this program not exacerbate Medicare's financial problems and should include a way to monitor future costs to the government. Although the President's proposed 50-percent copayment could serve to control excessive utilization, that copayment rate and other financial control mechanisms are subject to erosion. As you know, the part B premium originally was set at a level to finance 50 percent of the part B program costs. However, less than 10 years later, the method for setting the part B premium was tied to changes in cost of living, resulting in premiums dropping below 25 percent of the program costs. Under current law, the premium is set at 25 percent of premium costs, far from the original cost-sharing arrangement, and the projected costs of the part B program are expected to continue to escalate, with general Treasury revenues paying 75 percent of those costs.

Given this history, it would be prudent to target the benefit to those most in need and include additional safety valves to check excessive program cost growth. If expenditure or funding thresholds were established, they could be used to trigger periodic congressional reviews and could prompt legislative action if spending projections showed that the thresholds were likely to be exceeded.

## CONCLUDING OBSERVATIONS

I would like to conclude by pointing to the historic opportunity presented by the recently projected surpluses. Some advocate spending the surpluses to address a host of pent-up demands on the spending and/or revenue sides of the budget, built up from years of struggling with and finally succeeding in eliminating deficits. Updating Medicare's benefit package is but one of a number of legitimate claims being made for the use of these surpluses.

It is my hope that in considering all of these competing claims in the present we also think about the unprecedented challenge facing future generations in our aging society. Relieving them of some of the burden of today's financing commitments would help fulfill this generation's fiduciary responsibility: it would also serve to preserve some capacity to make their own choices by both strengthening the budget and the economy they inherit. While not ignoring today's needs and demands, we should remember that surpluses can be used as an occasion to promote the transition to a more sustainable future for our children and grandchildren.

In this regard, I think the President's proposal has the advantage of putting forth a long-term plan that would help promote future growth by paying down the publicly held debt. Many in the Congress putting forth constructive reform proposals for Social Security and Medicare also deserve credit—a sustainable future involves both fiscal policies that would improve national savings as well as real programmatic reforms to reduce the burdens of obligations and commitments on future generations.

In determining how to finance the Medicare program, much is at stake—not only the future of Medicare itself but also preserving the nation's future fiscal flexibility to pursue other important national goals and programs. Mr. Chairman, I feel that the greatest risk lies in extending the HI Trust Fund's solvency while doing nothing to improve the program's long-term sustainability, or worse, in adopting changes that may aggravate the long-term financial outlook for the program and the budget.

General fund infusions and expanded benefits may well be a necessary part of any major reform initiative. Updating the benefit package is probably a key part of any realistic reform program to address the legitimate expectations of an aging society for health care both now and in the future. The President's proposal also includes a broader package of reforms that provide a good point of departure for addressing Medicare's current fiscal imbalance. However, more needs to be done to ensure the program's longer term sustainability. In addition, the Congress should consider adequate fiscal incentives to control costs and an enhanced targeting strategy in connection with any proposal to provide a prescription drug benefit.

I am under no illusions about how difficult Medicare reform will be. Experience shows that forecasts can be far off the mark. Benefit expansions are often permanent, while the more belt-tightening payment reforms—vulnerable to erosion—could be discarded altogether. Recent experience implementing BBA reforms provides us some sobering lessons about the difficulty of undertaking reform and the need for effectiveness, flexibility, and steadfastness. Effectiveness involves collecting the data necessary to assess impact—separating the transitory from the permanent and the trivial from the important. Flexibility is critical to make changes and refinements when conditions warrant and when actual outcomes differ substantially from the expected ones. Steadfastness is needed

when particular interests pit the primacy of their needs against the more global interest of making Medicare affordable, sustainable, and effective for current and future generations of Americans. This makes it all the more important that any new benefit expansion be carefully designed to balance needs and affordability both now and over the longer term.

The bottom line is that surpluses represent both an opportunity and an obligation. We have an opportunity to use our unprecedented economic wealth and fiscal good fortune to address today's needs, but an obligation to do so in a way that improves the prospects for future generations. This generation has a stewardship responsibility to future generations to reduce the debt burden they inherit, to provide a strong foundation for future economic growth, and to ensure that future commitments are both adequate and affordable. Prudence requires making the tough choices today while the economy is healthy and the cohort of workers is relatively large. National saving pays future dividends over the long term, but only if meaningful reform begins soon. Entitlement reform is best done with considerable lead time to phase in changes and before the changes needed become dramatic and disruptive. The prudent use of the nation's current and projected budget surpluses combined with meaningful Medicare and Social Security program reforms can help achieve both of these goals.

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Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other Members of the Committee may have.

GAO CONTACTS AND ACKNOWLEDGEMENTS

For future contacts regarding this testimony, please call Paul L. Posner, Director of Budget Issues, at (202) 512-9573 or William J. Scanlon, Director of Health Financing and Public Health at (202) 512-7114. Other individuals who made key contributions include Linda F. Baker, Hannah F. Fein, James R. McTigue, and Deborah Spielberg.

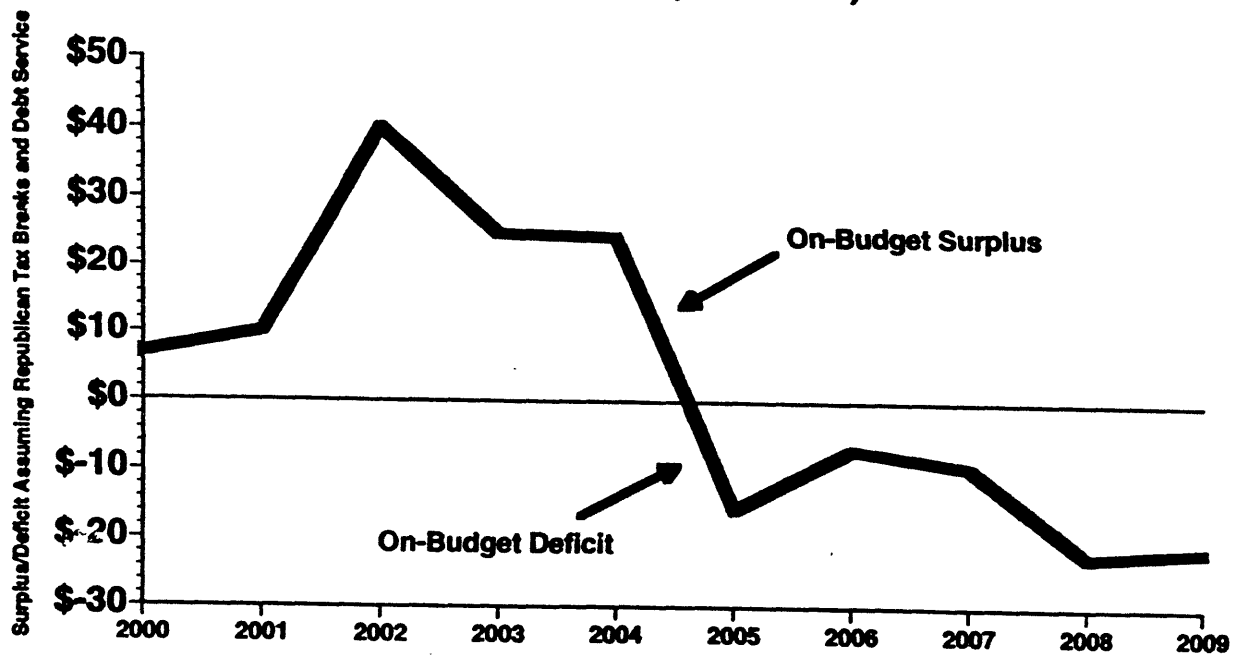
(935325/101871)

# Democrats:
# Tax Cuts for Working Families

- 60% increase in the standard deduction
  - Provides marriage penalty relief
  - Reduces taxes for a typical family by $650
  - Removes 3 million people from the tax roles
  - Makes it easier for 9 million taxpayers to file taxes
  - More than 73% of all Americans will get a tax cut
- Targeted tax cuts:
  - Long-term tax credit makes it easier to care for elderly and disabled family members
  - Tax incentives to build 6,000 schools
  - Makes R&E tax credit permanent
  - Tax relief for farmers and small businesses

# GOP Tax Breaks Raid Social Security Surplus

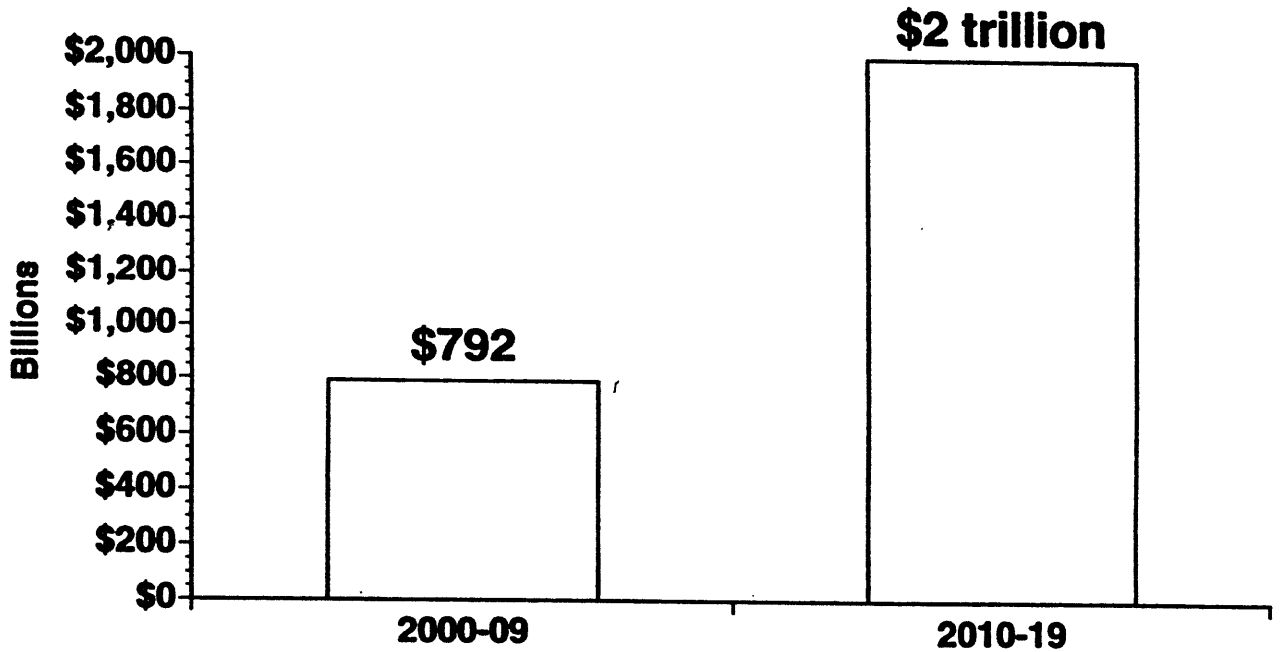
(FY 2000-2009; $ billions)




*Source: CBO and Joint Tax Committees*

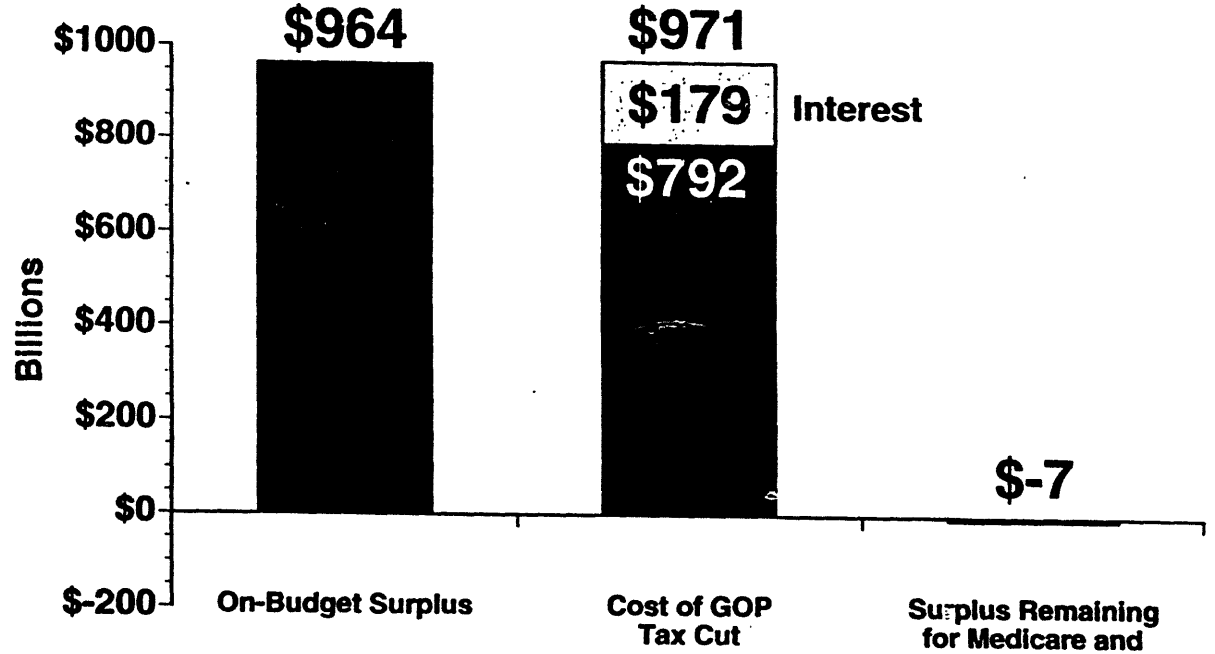
# A Return to Fiscal Irresponsibility

## Republican Tax Cuts Explode When Baby Boomers Retire




*Source: Joint Tax Committee, Dept. of Treasury*

# Republican Tax Cut: Leaves Nothing for Medicare and Other Priorities




*Source: Joint Tax Committee and Center on Budget and Policy Priorities*

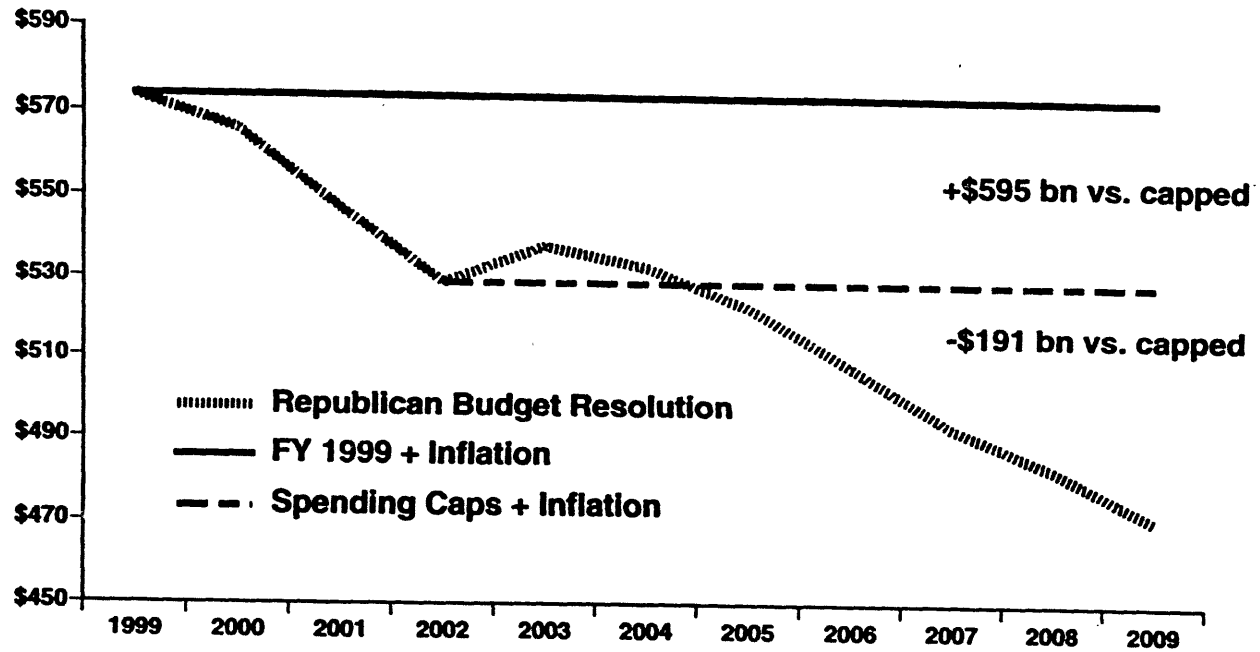
# Republican Budget Would Devastate Key Priorities

- 375,000 children would lose access to Head Start
- 1.4 million veterans would lose VA Medical Care
- NIH would be cut by $8.6 billion,
  14,000 fewer biomedical grants would be funded
- 6,342 fewer FBI agents

*Cuts from FY 2009* **Source: OMB**

# Discretionary Spending Paths, 2000-2009

## (in billions, constant 1999 dollars)




Source: CBO and Republican Budget Resolution

# Tax Cuts: A Zero-Sum Game
# One Example

**Assume: Medicare Solvency through 2025 + Rx Drug Benefit**
**Assume: Fund Discretionary at FY99 Levels + Inflation**

| | |
|---|---|
| **Non-SS Surplus** | **$ 964 Billion** |
| **Medicare** | **-374** |
| **Discretionary** | **-595** |
| **Interest** | **-170** |
| **Available for Tax Cut** | **-$174 Billion** |

# The Democratic Economic Record

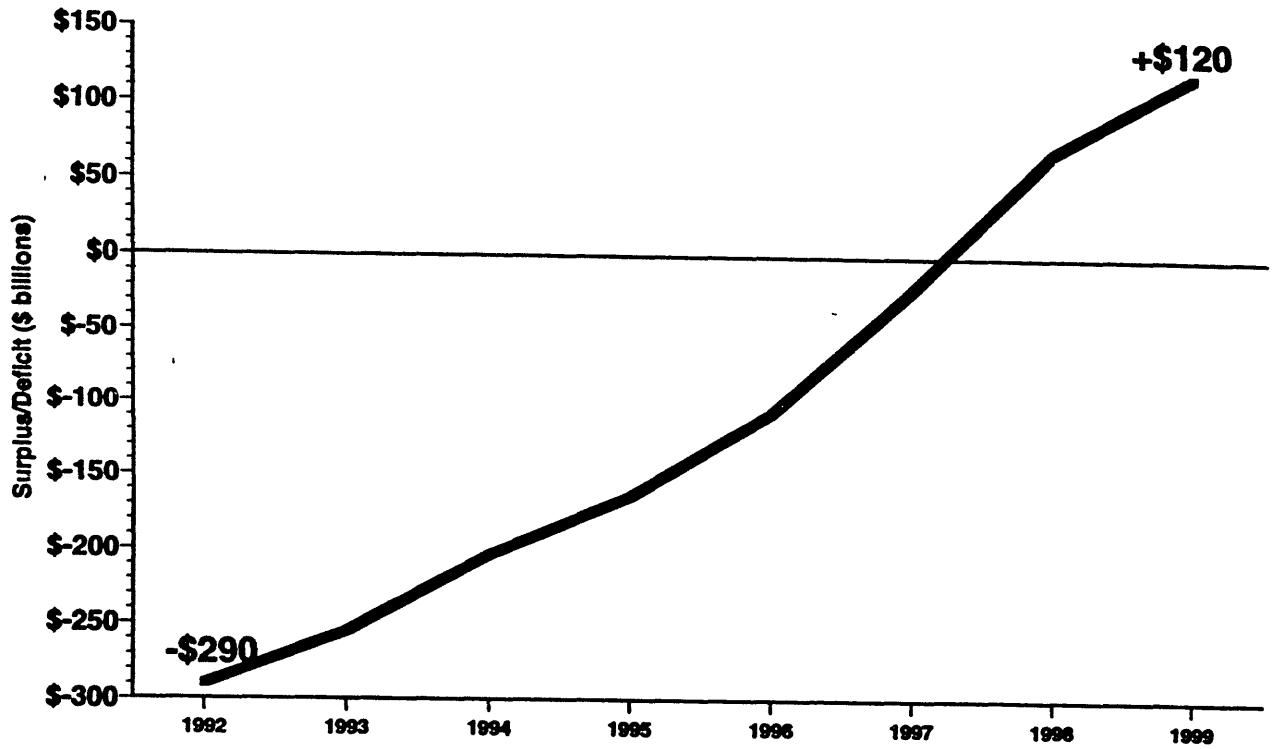
| | Then | Now |
|---|---|---|
| *Deficit* | $290 billion in 1992—the highest dollar level in history | $70 billion surplus in 1999—the largest dollar level ever |
| *Economic Growth* | Economic growth averaged 2.4% annually under Reagan and Bush | Economic growth has averaged 3.5% annually since 1993 |
| *Jobs Growth* | 1998-1992—one of the worst four-year periods in history | 18.9 million new jobs since January 1993 |
| *Unemployment Rate* | Averaged 7.1% annually from 1981-1992 | Currently at 4.3%—the lowest level in 29 years |
| *Home ownership* | Fell over the 1981-1992 period | The highest in history |
| *Median Family Income* | Fell by $1,825 from 1988-1992 | Increased by $3,517 since 1993 |
| *Real Wages* | Fell 4.3% from 1981-1992 | Grew 6.2% since 1993 |
| *Welfare Rolls* | Increased 22% from 1981-1992 | Decreased by 35% between 1994-1998 |
| *Competitiveness* | 5th most competitive economy in the world in 1992 | Most competitive economy in the world: 1995, 1996, 1997, and 1998 |

# Democrats Seize an Historic Opportunity

- Save Social Security
- Provide significant and responsible tax cut for working families
- Protect and modernize Medicare; extend soivency and provide prescription drugs
- Protect investments in education and health

# Democratic Record:

## From Record Deficits to Record Surpluses




*Source: CBO*

# COMMUNICATIONS

## STATEMENT OF THE HEALTH INDUSTRY DISTRIBUTORS ASSOCIATION

The following statement is submitted to the Senate Finance Committee behalf of the Health Industry Distributors Association (HIDA). HIDA is the national trade association of home care companies and medical products distribution firms. Created in 1902, HIDA represents 700 companies with approximately 2000 locations nationwide. HIDA Members provide valueadded services to patients in their homes as well as virtually every hospital, physician office, and nursing home in the country. HIDA is pleased to be able to provide the Committee with our evaluation of the Administration's proposal to reform the Medicare Program.

### WHAT IS AN HME PROVIDER?

Home medical equipment (HME) providers are an integral component of the Medicare healthcare delivery chain. HME providers supply medically necessary equipment and allied services that help beneficiaries meet their therapeutic goals. Pursuant to the physician's prescription, HME providers deliver medical equipment and supplies to a consumer's home, set it up, maintain it, educate and train the consumer and caregiver in its use, provide access to trained therapists, monitor patient compliance with a treatment regimen, and assemble and submit the considerable paperwork needed for third party reimbursement. HME providers also coordinate with physicians and other home care providers (e.g., home health agencies and family caregivers) as the consumer improves and his/her needs evolve. Specialized home infusion providers manage complex intravenous services, including chemotherapy, in the home. Numerous studies[1] have shown that HME providers are an integral part of a cost-efficient healthcare delivery system, as they help keep beneficiaries out of costly inpatient programs.

### RESIST THE RUSH TO COMPETITIVE BIDDING

HIDA urges the Committee to withhold support for competitive bidding for Medicare Part B durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) until the results of the current demonstration project can be fully evaluated.

As the Committee is aware, the first site of the first demonstration project testing competitive bidding for DMEPOS services is just beginning in Polk County, Florida. This project is a necessary first step to determine whether Medicare can effectively administer a competitive bidding program, whether it will achieve savings, and whether it will maintain access to quality HME services. Currently, very little is known about the administration or long-term impacts of such a complicated change to the DMEPOS benefit. In fact the project will not even be fully implemented until this fall, and will not be completed until the end of 2002. At present, it is not at all apparent when the next two sites of the demonstration will be chosen, much less implemented

Our concerns about the undue rush to implement national competitive bidding are bolstered by the fact that competitive bidding for HME services has been tried and rejected in the Ohio, Montana, and South Dakota state Medicaid programs. These states cited increased administrative costs and serious management problems as reasons for dropping competitive bidding. Each state also experienced an actual reduction in competition among providers (and, consequently, higher bid prices) and reduced access to provider support services.

### THE POLK COUNTY DEMONSTRATION

HIDA is concerned that the competitive bidding demonstration design will eliminate the current true market competition that encourages the provision of high

quality medical services. It is important to understand that once this demonstration is under way, only a very limited number of HME providers will be allowed to provide HME services to Medicare beneficiaries who require home oxygen services, hospital beds, wound care supplies, enteral nutrition, and incontinence supplies. The average HME provider is a small "Mom and Pop" operation, with fewer than 20 employees and less than $3 million in annual revenue. As soon as the Medicare competitive bidding demonstration gets underway, the vast majority of these businesses will lose the ability to provide Medicare beneficiaries with these services, a dramatic change that will amount to a loss of approximately 27% of their annual revenue. Few businesses will be able to withstand this loss, and many HME providers will be forced to close their doors. By driving these HME providers out of business, the demonstration will likely create monopolistic forces that will permanently impact the market and may ultimately increase Medicare prices.

HIDA is particularly concerned that HCFA's current competitive bidding plan threatens access to important health services. Home medical equipment (HME) such as oxygen equipment cannot be dropshipped to patients; the therapeutic support services offered by HME providers are as crucial to positive health outcomes as the equipment itself. We are concerned that the 'winning' bidders in Polk County will face budget pressures that lead them to eliminate these important therapeutic services that are not separately reimbursed by Medicare (e.g., preventative maintenance, patient education, 24hour on call service, the professional care of respiratory therapists, and the furnishing of supplies). If these services are eliminated, beneficiaries will be much more likely to experience health problems.

Importantly, beneficiaries in the demonstration area will lose their ability to choose their own HME provider. These beneficiaries will not be granted the option to "opt out" of the demonstration, they will have to use the "winning" bidders if they want Medicare to continue to cover their HME needs. A beneficiary who is dissatisfied with the quality level of the services and products provided to them through the bidding program will have very limited alternatives. Medicare's winning bidders, therefore, will not be subject to the market forces of consumerism.

## CONCLUSION

As competitive bidding has the potential to directly impact the healthcare services of thousands of Medicare beneficiaries, it is urgently important for HCFA to conduct a well-reasoned, responsive program. We urge the Committee to review the final results of the HME competitive bidding demonstration before expanding the program to other areas of the country.

## ENDNOTES

[1] For recent studies, please see:

- Styring, William & Duesterberg, Thomas, *The Cost Effectiveness of Home Health Care: A Case Study on Indiana's In-Home/CHOICE Program* (Vol. 1, No. 11), November 1997, (Hudson Institute, Indianapolis, IN).
- Mann, Williams C. et al., "Effectiveness of Assistive Technology and Environmental Interventions in Maintaining Independence and Reducing Home Care Costs for the Frail Elderly," *Archives of Family Medicine,* May/June 1999 (Vol. 8, pp. 210-217).

# Progressive Policy Institute
# The President's Medicare Reform Proposal
## *Advancing the Debate*

*David Kendall and Jeff Lemieux*

## Strengthening the President's Proposal

- *Set up a Medicare Board to run the competitive system for health plans that would eventually encompass the traditional fee-for-service plan.*

- *Direct HCFA to develop a comprehensive business plan for the traditional fee-for-service program in order to modernize its benefits, to improve its service and quality, and to set a premium so that it can be competitive with private plans.*

- *Limit prescription drug coverage to low-income beneficiaries.*

- *Set a fair limit on the amount of general revenue to be used for Medicare.*

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