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MEDICARE REFORM: ISSUES AND OPTIONS

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MEDICARE REFORM: ISSUES AND OPTIONS

THURSDAY, FEBRUARY 24, 2000

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

The hearing was convened, pursuant to notice, at 10:10 a.m., in room SD–215, Dirksen Senate Office Building, Hon. William V. Roth, Jr. (chairman of the committee) presiding.

Also present: Senators Grassley, Nickles, Thompson, Coverdell, Moynihan, Rockefeller, Breaux, Conrad, Graham, Bryan, Kerrey, and Robb.

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

The CHAIRMAN. The committee will please be in order.

I would like to welcome everyone as we pick up where we paused last fall in our efforts to strengthen and modernize the Medicare program.

We are on the threshold of a genuine opportunity to introduce seriously needed reforms to the Medicare program, a vital social program that serves almost 40 million aged and disabled Americans.

In 1997, 1998, and 1999, this committee stepped up to the plate and moved needed Medicare program changes, some very substantial. However, on each occasion we understood that, despite these considerable efforts, the Medicare program needs long-term solutions. We know that deeper structural reforms are required and we understand why.

Now, in this session of Congress, to date, we have taken expert testimony from almost 70 witnesses. That testimony addressed Medicare's looming financial and demographic challenges.

It addressed the program's seriously outmoded benefit package, including the Medigap or supplemental programs. It described the lack of sufficient health plan choices and incentives for efficiency in the program and raised significant questions about how to introduce needed innovations into the administration of Medicare.

Much of what we heard was troubling. Although we are in the midst of an era of unprecedented and sustained prosperity, the U.S. is on the verge of a massive and sustained demographic shift that will profoundly affect Medicare. Costs and resources will be strained with the retirement of the baby boom generation.

The President's budget proposes that we allocate a significant share of projected but not yet realized budget surplus to buttress the financing of current Medicare Part A obligation.

As we consider this, we must keep in mind that, absent real reform, it is projected that nearly a $1 trillion infusion of new money will be required simply to sustain the existing Part A benefits through the year 2027.

Many members are inquiring about whether we should add a major new benefit to Medicare, namely prescription drugs, an objective I strongly support. However, a drug benefit could easily cost in the realm of $30-40 billion per year, a daunting fiscal challenge.

As enormous as these challenges are, I opened today by indicating we have an opportunity to take steps now to begin to address them. The President has resubmitted his reform plan as part of the fiscal year 2001 budget.

In addition, several Senators on both sides of the aisle have contributed valuable ideas, most notably Senators Breaux and Frist, stemming from their work together on the Bipartisan Commission. I would ask unanimous consent that we include as part of the record a statement from Senator Frist.

[The prepared statement of Senator Frist appears in the appendix.]

The CHAIRMAN. These efforts are to be applauded even as they highlight the challenge of finding common ground among numerous competing and complex ideas for enhancing Medicare.

What is important now, is not that we squander precious time and work by pursuing self-seeking partisan and short-term advantages. I believe, and I know you do, Senator Moynihan, our efforts should be focused on a bipartisan pursuit of real solutions to Medicare's real problems, and must remember that this is a shared responsibility, and that the American public has every right to demand the best from us.

I would ask that my full statement be included as if read, and I would now turn to my good friend and colleague, Senator Moynihan.

[The prepared statement of Chairman Roth appears in the appendix.]

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK

Senator MOYNIHAN. Well, once again, Mr. Chairman, we are in complete accord. I am looking forward to this testimony and this commentary, especially on the work of Senator Breaux.

I would make two points. First, is that it is entirely natural that we should be reconsidering this whole subject. Medicare began as a form of hospital insurance at a time when medicine, as we know it, was just beginning to surge forward, medical science.

Hospitals were where people went who were not well, and they got better and left or they did not get better. But there was not much done. In the interval, we have had such an extraordinary change in medical practice, and obviously, it is time to address it.

A major issue, of course, is prescription drugs. I would just like to offer my own view, that we have to address that; pharmacology has so transformed the medical practice. But let us do it in the con-

text of a major reordering of the system. Prescription drugs will pull a long a lot of support that we will need for the kinds of general Medicare changes we have to make.

Second, I would say, again, we have to find a stable mode of support for medical schools and teaching hospitals. They have been almost an accidental arrangement; Medicare and Medicaid financing have kept them going. But it is not stable, and it needs to be a direct, as against an indirect, form of maintenance.

I think, here we are. Thanks to our colleague Senator Breaux who has labored at this, and Senator Frist, we are ready to move.

The CHAIRMAN. Thank you, Senator Moynihan.

Our first panel consists of really two most able and dedicated public servants, and we are happy to welcome the Honorable David M. Walker, the Comptroller General, General Accounting Office; and Robert Reischauer, who is president of the Urban Institute.

Gentlemen, it is indeed a pleasure to have you here, and we look forward to your comments.

Mr. Walker?

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

Mr. WALKER. Thank you, Mr. Chairman, members of the committee. I appreciate the opportunity to appear before you again on the important issue of Medicare reform.

I would like, Mr. Chairman, for my entire statement to be entered into the record, and would now proceed to summarize some of the more important points.

The CHAIRMAN. Without objection, and this will be the practice for all witnesses.

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

Mr. WALKER. Thank you, Mr. Chairman.

Since we last spoke, both CBO and OMB have prepared updated projections that forecast an even more positive budgetary status over the next 10 years. These projections must, however, be viewed with caution, since not many years ago both agencies were projecting deficits rather than surpluses.

In addition, CBO's most recent projections demonstrate that a return to historical spending trends and slightly faster growth in Medicare costs would change the on-budget surplus to a growing deficit.

Before I address the two major Medicare reform plans, namely the President's proposal and the Breaux-Frist bill, I would like to reset the stage in connection with a need for comprehensive Medicare reform. I do not think that we can say this enough.

The first chart demonstrates that Medicare Part A, or the HI program, experienced a negative cash flow from 1992 to 1998, and it is projected to have rapidly escalating annual deficits beginning when baby boomers start retiring in the year 2011.

The second chart will demonstrate that the combined OASDI, or Social Security, and HI payroll tax shortfalls are also expected to increase rapidly once the demographic tidal wave begins to hit in the year 2011.

The next chart will demonstrate that total Medicare spending—and it is important to look at both Part A and Part B—is expected

to consume an ever-increasing percentage of our economy in the future. You can see it growing as a percentage of the overall economy.

The next chart, I believe, is extremely important and cannot be stressed enough. If we save the entire Social Security surplus, which there appears to be a bipartisan consensus to do, and if the on-budget surplus is spent either through tax cuts and/or spending increases, this shows you what our fiscal future is likely to look like in the year 2030 and 2050, based upon the trustees' latest projections for Social Security and Medicare, as well as the assumptions of CBO.

The bottom line is, by the year 2030, we have incredible pressure being placed on discretionary spending. By the year 2050, we do not have resources for any discretionary spending or to pay interest on what the reemerging debt obligation would be.

This is extremely important because, when you get right down to it, this is not just a debate about Medicare reform, it is a debate about what type of future are we going to pass on to our children, our grandchildren, and future generations. It is about choices, it is about flexibility, and it is a major, major issue.

My full statement notes that both the President's and the Breaux-Frist proposal are designed to take a more comprehensive approach to Medicare reform rather than just simply adding a prescription drug benefit, for which there appears to be consensus on the need to do.

The e proposals, in fact, are similar in three key respects. First, they both introduce a competitive premium model. Second, they both would preserve the traditional fee-for-service Medicare program with enhanced opportunities for adopting prudent purchasing strategies. Third, they both would propose to modernize Medicare's benefit package to include an option for prescription drugs and catastrophic Medicare costs.

These proposals also have their differences, the extent to which traditional Medicare could face competitive pressure from private plans and who will administer and oversee the programs.

There are at least three other important differences that are contained in my testimony as well. First, whether the Medicare trust funds should be combined or not; second, to what extent and how general revenues should be used to finance Part A; and three, what fiscal triggers or alarm devices should be used in connection with the Medicare programs.

As I have stated before, Mr. Chairman, trust fund solvency is not enough. We need to focus on the sustainability of the overall Medicare system rather than the solvency of Part A alone.

To do this, we will require new fiscal triggers and alarm signals that measure the size of Medicare programs as a percentage of general revenue financing that is required, as a percentage of the budget, and as a percentage of our economy.

The Breaux-Frist proposal proposes one such trigger as it relates to the percentage of general revenues that would be required to fund the combined Part A and Part B program.

And you will see that depicted in this last chart, where using that 40 percent trigger, it is estimated that in the year 2008 you would hit that 40 percent trigger and decisions would have to be

made. Do you raise the trigger? Do you modify provider reimbursements? Do you somehow change cost sharing? Do you go for additional revenues? Do you modify benefits?

These are choices that would have to be made, just as choices have to be made today when you hit the solvency trigger of Part A, but it is a more macro view of looking at this on a combined spending basis rather than just HI trust fund solvency standing alone.

In this regard, I think it is important to note that we should not add new, unfunded promises before we begin to deal with the existing unfunded promises, which amount to over $2.9 trillion in present value terms for Part A alone. We have huge unfunded promises that already exist and that are demonstrated by some of these charts.

In this regard, any action to add prescription drug coverage should be coupled with other reforms designed to assure that the net result will not make the situation worse, will not end up increasing the net present value of unfunded obligations.

In addition, even if the Congress decides to move forward and to meet this modest test—and frankly, while it would be difficult, it is a modest test—basically, do not make it worse. The fact of the matter is, ultimately, more comprehensive Medicare entitlement reform will be needed if we expect to close the gap between promised and funded benefits and leave our children, grandchildren, and future generations with some reasonable fiscal flexibility and choices for their own future.

In closing, Mr. Chairman, the budget surplus presents us both with an opportunity and an obligation. We have an opportunity to help better prepare us for the future, but we also have an obligation to get on with meaningful entitlement reform while the economic sun is shining and before the known coming demographic title wave hits us.

Thank you, Mr. Chairman, members of the committee. I appreciate the opportunity to answer questions after Dr. Reischauer speaks. Thank you.

The CHAIRMAN. Thank you.

Dr. Reischauer?

STATEMENT OF ROBERT D. REISCHAUER, PH.D., PRESIDENT, URBAN INSTITUTE, WASHINGTON, DC

Dr. REISCHAUER. Mr. Chairman and members of the committee, I appreciate the opportunity to discuss Medicare restructuring with you.

I applaud this committee for the work it has done to strengthen this program, and the work it is doing even though the traditional conditions that usually motivate a look at the Medicare program, namely the imminent insolvency of the HI trust fund or a desire to balance the budget, are really nowhere in sight.

But, as you know better than most, if we wait until those traditional conditions reappear, the options that policymakers will have will be severely constrained, the adjustments that will have to be made will be more wrenching, and the deleterious consequences of those adjustments on both our society and our economy will be more profound.

I want to stress, before I begin my remarks, that I am speaking not on behalf of the Urban Institute or the National Academy of Social Insurance, but rather in my capacity as an individual analyst who has studied Medicare issues for a number of years.

I am going to submit my statement for the record, but rather than summarizing it, I would like to talk just briefly on a different plane.

I would like to talk about the questions that policymakers and the nation have to grapple with when they consider the future of Medicare. There are four, and they are interrelated. I think they should be dealt with sequentially because the options that should be considered when answering later questions depend crucially on the answers that were given to the earlier questions.

A lot of the confusion and controversy that has arisen over the last several years has occurred because Medicare reform proposals attempt to answer all of these questions at the same time without clearly explaining the nature of their interrelationship.

What is the first question? The first question, is, "What will it mean to provide adequate health insurance coverage to the elderly and disabled of the 21st century and provide that insurance coverage in an adequate, efficient, and equitable manner?"

In addressing this question, you have to discuss and define the terms "adequate", "efficient", and "equitable". With respect to the first of those, adequate, I would say that adequacy means coverage similar in scope and depth to that enjoyed by the balance of the population in other words, those who get their coverage through employer-sponsored plans, coverage like that provided government workers through FEHBP, or through employer- sponsored policies of medium- and large-sized companies. Clearly, on that basis, the Medicare program, as it now stands, is deficient. It is not an adequate policy.

With respect to the term efficient, I would argue that the answer lies in the practices that we find in the private sector. Medicare, in some respects is quite efficient, in other respects is not, and has a long way to go, because it cannot employ many of the tools that effective private insurers employ.

With respect to the term equity, I am going to leave that in your hands and will just leave it at that.

The second question that has to be addressed and can only be addressed once you have decided what it is that you think you want to provide, is, "How should the cost of that coverage be divided?"

How much should be borne by workers through the payroll tax, how much should be provided through general revenues, how much should be borne by participants through premiums, co-insurance, and out-of-pocket costs?

The answer to this question can change over time. It will depend on the relative ability to pay of participants versus workers, and through time that has changed and will continue to change.

Right now, we answer this question in a very accidental way. Whatever is covered by HI is paid for through the payroll tax. Does that really make a whole lot of sense? Clearly, no.

The third question that has to be addressed, is, "How much of the cost should be prefunded and how much of it should be paid for on a year-to-year basis?" This question arises because we have

big waves in the population of workers versus participants beneficiaries over time. If we did not, we would not have to answer this question, but it is one that the society and policymakers have to deal with.

The fourth, and last question, is, "How to create some mechanism for reconsidering the answers to the first three questions should things not turn out the way one expects?" We need a mechanism because there is tremendous uncertainty in the health care system, how fast spending is going to grow and what technology is going to provide us.

We have had a rather accidental mechanism, namely, solvency of the HI trust fund, in place which has motivated Congress and others to look periodically at the financing issue.

But this is haphazard and accidental because the evolution of technology affects how much total medical services go through HI versus SMI. Policy also changes from time to time, Congress has chosen to shift things from Part A to Part B, or from Part B to Part A.

So comparing the 1970 to 2000 period; in 1970, about 30 percent of total disbursements were accounted for by SMI, today it is about 40 percent.

That is not necessarily because we have decided that 40 percent should come from non-payroll taxes versus 30 percent. We have changed the fraction of that portion that is paid for by participant premiums; it was 50 percent of SMI, it is now down around 25 percent.

I think it would be good to have a more comprehensive mechanism, one that dealt with the entire Medicare program rather than just one component as we have now.

Let me conclude by saying, simply, that I think the President's proposal and S. 1895 represent very constructive first steps in attempting to answer these fourquestions and move forward.

Like Mr. Walker, I believe that there is a lot of similarity between these two proposals and compromises can be reached to provide us with an adequate, efficient, and equitable Medicare program for the future.

Thank you.

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

The CHAIRMAN. Thank you.

Mr. Walker, as a follow-up question to the testimony of Dr. Reischauer, you, too, in your written testimony indicated that both the President's plan and the Breaux-Frist plan are useful conceptual markers on Medicare reform ideas, but that significant design decisions still need to be made.

Now, given your admonition that the greatest risk lies in doing nothing to improve the program's sustainability or in jeopardizing it even further, could you advise us what steps you would recommend that we take this year?

Mr. WALKER. Well, first, I think the most important thing is not to make the situation worse, not act to include additional coverage that would exacerbate the unfunded obligations associated with this problem without doing something to make some program reforms. So that is the first thing, not make it worse.

Second, I think that pursuing actions in a number of areas, for example, additional purchasing strategies for traditional Medicare, enhancing consumer information such that they are more aware of what costs are being incurred and looking at ways that they can be more sensitized with regard to the cost of health care, I think, frankly, that is a problem not just for Medicare, it is a problem overall with regard to health care.

One can look at the management and oversight structure with regard to Medicare, gathering additional data and information for analysis to try to find out what works and what does not work.

It is amazing to me, with Medicare being such a significant percentage of the Federal budget and health care being such a significant percentage of the economy, the lack of adequate, timely, and useful information about what is going on in the health care sector in order to try to find out what is working and what is not working.

So those would be some guidelines. I do think that ultimately, I think the Congress may want to do what I recommended for the Senate Budget Committee and the House Budget Committee, specifically, now that we are not fighting annual deficits and we have won the cold war, we have an opportunity to look forward.

What is the role of the Federal Government, what Federal programs make sense for the future, and which ones are working, which ones are not working, which ones should be enhanced, which ones should be terminated or cut back?

I really think that we need to look at these questions, and Medicare is a big part of that. Ultimately, we are going to have to do that to close that gap between promised benefits and funded benefits, which gap is huge.

The CHAIRMAN. Let me turn to you, Dr. Reischauer. Late yesterday, we received an analysis of possible premiums if the Breaux-Frist proposal were implemented. This analysis was prepared by HCFA's Office of the Actuary for Representative Pete Stark.

I have to say, the analysis has caused me considerable concern because it seems to indicate that beneficiary premiums could grow sharply under the proposal.

Now, one of my key goals in looking at Medicare reform options is to ensure seniors have the highest quality coverage at the lowest possible price.

Could you comment on this analysis and add your expertise to this question?

Dr. REISCHAUER. Let me start by saying that I have a tremendous amount of respect for Rick Foster and his staff, the professionalism of that unit, and the sophistication of their analysis. I have not seen the details of how they worked out their estimate, and so what I am going to say is, in a sense, a bit preliminary.

As you noted, they projected that the increase would be roughly, 47 percent in Part B premiums, but 22 percentage points of that was attributable to the fact that the Breaux-Frist proposal has the average beneficiary premium set at 12 percent of the average premium.

That 12 percent number, as I understand it, was chosen because that was HCFA's projection last Spring of what Part B premiums would amount to relative to total costs. Presumably, knowing the new estimates from HCFA that the Part B premiums under cur-

rent policy would only be about 9.8 percent, the sponsors of the bill would lower the number.

Of course, I am not speaking for Senator Breaux, but that would be an expectation because that was the justification given in the National Bipartisan Commission's report.

So we are really left with a 25 percent increase and that sounds like a whole heck of a lot. It catches one's attention. But let me just try and put this in perspective. If it is right, let us remember that monthly premiums will be about $58, under current policy, in 2003. That is about $700 a year. A 25 percent increase would be $174, or $14.50 a month. That is real money, but it can be viewed as a manageable amount, I think.

Also, we should keep this in some kind of historical perspective. The historical perspective I would call to your attention, is what have you done in the past? The Balanced Budget Act of 1997 increased Part B premiums by 50 percent by 2004.

Now, it is a little bit of a phony comparison because the Part B premium at 25 percent of Part B cost was going to expire and you kept it at 25 percent. Let me be a little fairer in the comparison and ask, what was the impact of the shift that you approved of home health from HI to SMI? By CBO's estimates at the time, that increased, the Part B premium by 2004 in 23 percent. In other words, by about the same amount.

So if this is a good estimate, it is not out of line with what has occurred in the past. Now, you can argue that maybe this is too much for the elderly to bear, but somebody has to pay for Medicare.

As I said, we should go back to my second question: we need to have a debate—How much payroll tax? How much general revenues? How much Part B premiums? How much out-of-pocket costs?

The CHAIRMAN. Yes. Mr. Walker, I would like to have your comments.

Let me just make this observation. We have already asked for CBO to make an analysis, so I think it is very important for all of us to understand, this is the first analysis we have had. I think the timing was a little unfortunate, coming last night just before this hearing.

The CHAIRMAN. But in any event, Mr. Walker, I would also like to ask GAO to make its analysis because I think it is important we have the best advice possible as to what is implied.

I know you have not had a chance to study it very carefully, Dr. Reischauer, because we just got this analysis. I would appreciate any additional comments you may care to make.

But, Mr. Walker, please proceed.

Mr. WALKER. Thank you, Mr. Chairman.

As you know, we just got it, because it just came out last night. We will be happy to take another look at it. Like any projections, assumptions are the key and you have to get behind the assumptions. Even in ours, for example, we make some assumptions and we fully disclose those assumptions.

I would reinforce one thing that Dr. Reischauer said, and that is, percentages can be deceiving. When you talk about a 25-percent increase, 47 percent increase, or whatever, it is based on what? That 25-percent increase, for example, could work out to be about a $12

difference between the Breaux-Frist bill and current Medicare policy.

Well, that is $144 a year. That is not inconsequential, but in the scheme of things, I don't think it is that great. Frankly, it is nothing compared to what we are going to have to start looking at to close the gap between promised and funded benefits. Something is going to have to give.

Thank you, Mr. Chairman.

The CHAIRMAN. I see my time is up. I am going to very strictly apply the time today because we have a vote at 11:30, and I want to give everybody an opportunity to ask a minimum of questions.

So, Senator Moynihan?

Senator MOYNIHAN. Let me be brief in my questions, and I am sure the answers will be such as well.

Mr. Walker, you remarked that Medicare represents a much greater and more complex fiscal challenge than even Social Security over the long run.

I just would like to introduce a thought, that there is a lot of delusion going on about both of these programs and an unwillingness to somehow get right down to the specifics.

We have persuaded ourselves as a government, I suppose, that we are saving the Social Security surplus for Social Security. Now, we are not doing anything of the sort, are we?

Mr. WALKER. I think the only thing that has been agreed to, is that the surplus that is associated with the Social Security system standing alone, would be used to pay down debt.

Senator MOYNIHAN. That is right. It does not touch Social Security.

Mr. WALKER. It does not change the program in any way.

Senator MOYNIHAN. Right. And we could change the program, but we would prefer not to. We prefer to suggest we sort of are. You do not have to answer that. Thank you.

One question, again, to you, sir, and Dr. Reischauer, if you will. You said, the first thing is, do not make matters worse, as the Hippocratic oath states: "primam non nocare." Would I be wrong in thinking that that would include, do not get a prescription drug benefit until you have a general program reform?

Mr. WALKER. I think you need reforms that, combined with whatever revenues might come from prescription drugs, would at least pay for the prescription drug benefit. I think otherwise you are making matters worse. You are making those trillions of unfunded promises even higher.

Senator MOYNIHAN. Dr. Reischauer, would you care to respond?

Dr. REISCHAUER. As I stated in my testimony, I think it would be a mistake to enact a stand-alone prescription drug benefit, for reasons of complexity, confusion, and the fact that I think it will delay legislative action on more significant reforms. I believe very strongly that, the sooner we make those reforms, the less disruptive they will be to our society.

Senator MOYNIHAN. Good. Thank you both.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Next, we have on the list Senator Robb. We are really jumping over a lot.

Senator ROBB. Thank you. I am making great progress here, Mr. Chairman. Thank you.

First of all, let me just thank you for persisting in calling hearings, notwithstanding the fact that there are many who suggest that we will not make meaningful progress in the area of the kind of structural, systemic reform that both of our distinguished witnesses this morning clearly advocate. If we are going to do anything, we should not do something that is transitory and, as the Ranking Member suggested, do no harm is the first order of business.

Let me just observe that I think that, if we paint the big picture—I was interested in your remarks this morning because both of you were good enough to focus on the long-term forest and not get bogged down in trees.

I must tell you, every time that I try to grapple with some of the trees, I want to go out and look at the forest again with respect to some of the reforms that are projected here.

I think it is very clear, and I hope we will continue to underscore the fact, that we are talking about major demographic shifts. You have both made that point, the charts make the point. But I do not think that many people who were looking at some of the trees, if you will, are aware of this tidal wave that you describe.

To the extent that we can continue to do that, I think that you do a major service up front. I think it is something that is simply not fully realized, and yet demographics are one of the few areas where speculation, at least in the near term, if somebody is 10 years old today, we know next year they are going to be 11 years old, and we know how many people are coming into this particular crisis, or this challenge that we have. We also have a very dated system.

The system that was put in place in 1965 was a remarkable change and it made us the envy of the modern world in terms of the quality of life and expectations. But, like the Model T when it was introduced, it was a great invention, but ultimately, today's automobiles do not look a whole lot like the Model T and the current system has to be changed.

Some of the things that do involve the question of prescription drugs, preventive care, and whatever, are an integral part of modern medicine. So if we are going to make changes, we have got to figure out a way to incorporate those, but I agree that there is danger if we move independently.

Let me just ask you one brief question for right now. That is, in terms of transition to either the administration plan or the Breaux-Frist plan at this point, can you highlight the specific difficulties?

Let me back up one second and say that I am an advocate, given the complexity of what we are dealing with in trying to describe an optimum system today and then developing a transition plan for how we get from where we are to where we would like to be rather than just looking at each incremental change and then coming back and figuring out what we can change next.

But if we were to use the two plans that are on the table for today's discussion, what would be the major transition difficulties that we would experience if we were to go to one or the other of those plans?

Dr. REISCHAUER. I concur with your cautious words. I am a believer that moving from where we are now to a competitive structure will take at least a decade. It will take at least a decade because of political considerations, but more because of technical considerations. We need an institutional infrastructure that does not exist at this time and we need tools that we have in some form but not to an adequate degree.

Namely, we need better risk adjustment mechanisms than we have now, we need better ways of measuring cost differences across areas, we need better ways of measuring plan quality, we need better ways of informing participants about their options and the consequences of the decisions they will make when they choose one plan over another.

These things cannot be rushed, they should not be rushed. They need a lot of analysis and data, and we should do it slowly. We should also do it slowly because there is huge uncertainty about where the medical marketplace is going.

What you want, is a Medicare system that fits well with the employer-based system that is out there. But the employer-based system has been through a couple of real gyrations, and so you want to adopt a plan, an implementation policy, but you want to have a lot of exit ramps off that highway so if things turn out differently from what you now project, it can be modified.

I think we know where the employer-sponsored world is now and we sort of know the direction it is going in. Making Medicare more like that would be good, but this is a 10-year journey.

Mr. WALKER. I think there are a number of details that would have to be worked out under both the President's plan, as well as Breaux-Frist, that are not worked out now.

Second, we would have to transition to this over time. I would say that, based on our testimony and Dr. Reischauer's, if you focused your efforts on the three areas where there are common denominators, and if you couple that with the need for a trigger or an alarm bell that goes beyond Part A trust fund solvency, which I think, frankly, can be misleading depending upon what is done with the Part A program. If you focus your efforts there, recognizing that you have got to work out the details and it is going to take some time to transition into it, that might be the best hope for making some progress this year.

Senator ROBB. Thank you, gentlemen. My time has expired.

Thank you, Mr. Chairman. While the Chairman is temporarily diverted, let me thank both of you and those who have put a plan on the table. I have great admiration. Thank you, Mr. Chairman. My time has expired.

The CHAIRMAN. Yes. Next, is Senator Breaux.

Senator BREAUX. Thank you very much, Mr. Chairman and our Ranking Member, for having the two distinguished panelists, as well as the second panel that we will hear from this morning.

I think that both of you have done a real service in elevating the debate to the actual discussion by the committee of jurisdiction to what we are going to do, and I think you are to be commended for that.

I am also particularly pleased that both of our two panelists are such experts in this area. Both David Walker and Bob Reischauer

have been around this issue and really, I think, have the ability to discuss this issue in a format that is very helpful to this committee in helping to educate the American public about it.

I think, Bob, you are probably one of the original coiners of the phrase premium support a number of years ago, and to see how everything has evolved must be of great interest to you as well.

Another thing I would say, is I think we have sort of reached a point where we can quit hollering at each other about this issue, hopefully. I mean, we have been through that and everybody knew it was going to take a period of hollering and screaming, and everything else. But I think now we have sort of overcome that.

We are now sort of at the point of, what are we going to do about this monumental problem? And everybody has good ideas, and we should hear everybody's ideas and try and come up with something that is politically doable, as well as financially the right thing to do. I think we are starting to enter that period now, and that is also very encouraging.

I think that the note we got late last night was not particularly helpful in that regard. It is a partial and incomplete, by its own statement, analysis on a page-and-a-half of a monumental proposal that CBO has been working on for 4 months now, and is still modeling it to come up with some accurate assessments.

To put on a page-and-a-half, somewhat inaccurately as far as their assumptions are concerned, a statement that as targeted for this committee hearing without us having the benefit of it is unfortunate, and not particularly helpful. I will note that it did not come from this side of the Capitol.

Having said all of that, let me ask a couple of questions, because I think it is important. This program is $7 billion in the red, David Walker, from your projections just this year, and has been in the red since 1992. We spend more than we take in.

Much of the discussion now is adding more benefits to the program. I am concerned that just doing prescription drugs, which I support, without fundamentally reforming the program, would be a serious mistake.

I think the two are tied together; we should do reform and prescription drugs together. Maybe both of you could comment on the concept of doing prescription drugs now, and then later trying to do some more difficult things like reforming it. What is your perspective on that?

Mr. WALKER. I think, while it might be politically attractive to do prescription drug coverage separately, and clearly there is a lot of pressure to do that, and clearly there is agreement that something needs to be done in the area of prescription drugs to modernize the program, I think our bottom line is, do not make the situation worse.

It is always tough to do the real heavy lifting. It is always tough to be able to do the reforms that actually are designed to close the gap between the promised benefits and funded benefits, but it is absolutely essential.

I am also concerned, frankly, about what signals we are using. Your proposal would add an additional measure, of what percentage these programs are relying on in general revenues.

We need to look at those kind of signals, we need to look at percentage of the budget represented by these programs, percentage of the economy represented by these programs, because I am afraid we are never going to get to the point where we really need to do the real heavy lifting, that $2-plus trillion funding gap, if we do not.

Senator BREAUX. Bob?

Dr. REISCHAUER. As I said in my testimony, I think it would be a mistake to move forward with a stand-alone prescription drug benefit because it would remove the carrot which we have to offer for fundamental reform.

At the same time, as I stated in my prepared remarks, I am a believer that the optional package, the high-option package, whatever we want to call it, should be much more comprehensive than just prescription drugs.

We know from the behavior of Medicare participants that they want low cost sharing, some prescription drug coverage, some stop-loss, and more preventive services. They go out and they get it through Medicare+Choice plans, through——

Senator BREAUX. Are you suggesting that the high-option would include things even like long-term care, if they want to spend the money for it?

Dr. REISCHAUER. Well, no, I did not include that in my last comment. [Laughter.]

Senator BREAUX. That is pretty expensive.

Dr. REISCHAUER. I want some issues for my son to be able to testify on before this committee in 30 years. I do not want to solve them all myself. [Laughter.] There is a big need out there, but I am not going to touch that. It is like equity, it is not in my job description.

What we really need to do, is have a package that, if people purchase it, they will not be out seeking some other supplemental insurance, which is what makes the current system confusing, complex, and excessively costly.

When we define that package, we should not be shy about asking people to pay for it because they are paying for it now. Now they are paying $1,500 for a Medigap policy or their former employer is paying a couple of thousand bucks for a wrap-around policy. There is money on the table. We should protect low-income people from the premium costs, but for the rest of the population, the money is out there.

Senator BREAUX. I thank you. We have had this discussion many times in the past, and I am sure we will continue it in the future. But both of you, I have a great deal of respect for your statements.

The CHAIRMAN. We will save the rest of the questions for your son.

Senator Grassley?

Senator GRASSLEY. Mr. Chairman, one comment just before I ask my questions, and that is in regard to this study that just unexpectedly showed up last night. The request for that study was made on December 1 last year by the Ranking Member of the Ways and Means Committee, and is it not odd that it just now showed up, based upon the amount of time that they had?

Dr. Reischauer, I know you said that you do not want to get involved in any questions about what might be equitable or not, but I am going to ask anyway.

One of the major problems with Medicare today is that the Medicare+Choice payments to plans in an area are based on historical fee-for-service Medicare expenditures.

As you know, they have been wildly different in different areas, in contrast to the Federal Employees Health Benefit Program, which has been much more uniform from one part of the country to another. Of course, this is an inequity that is a matter of real public discontent in my State of Iowa.

In your opinion, does the Breaux-Frist plan or the Clinton plan do a better job of rectifying this inequity once and for all?

Dr. REISCHAUER. I think both plans, actually, would address the inequity in the sense that they would have a defined benefit and a contribution rate that would be equal across the country for that.

Now, there are some little inequities that remain, and I will not go into those. But before we hold up the FEHBP program as the model of equity, let me remind you that the Federal employees in the State of Iowa pay the same premium for the Blue Cross/Blue Shield option that those in New York pay—excuse me, Senator Moynihan—and the costs of serving the beneficiaries in New York are considerably higher than that in Iowa.

Senator GRASSLEY. In Medicare, you have 2.5 times the difference from Miami to Iowa.

Dr. REISCHAUER. You are right. In degree, they are different. Of course, it is not equitable to be able to join a Medicare+Choice plan that has a rich set of supplemental benefits at no additional premium in Miami or Los Angeles, and in Minnesota or Portland, have to pay a small premium for just the basic services.

Senator GRASSLEY. Also, on the point of what people pay in, remember the tax, obviously, for Medicare is the same 1.45 for everybody whether they live in Florida or live in Iowa.

My second point, and I would ask both of you to comment on it. I hope it is not too generic of a question to ask, because we want to nail down some key points here today.

This is about Medicare's reliance upon income tax revenue, something that both proposals recognize is necessary, albeit to different degrees. We already are using more and more general revenues to fund Medicare Part B. That is the fastest-growing part of Medicare.

As I understand Breaux-Frist, if contributions from general fund revenues to Medicare reach the level of 40 percent of program costs, then that trigger requires Congress to act. This is, of course, a warning signal to impose fiscal discipline.

In contrast, the President's proposal is to transfer whatever general revenues are needed without any similar mechanism for fiscal discipline. So, I welcome comments from both of you as to which approach is safer, or whether a different approach is needed.

I would not mind it if you would suggest different approaches looking at Medicare, but also at the impact on other Federal programs, and eventually you have got to consider the whole Nation's economy.

Mr. WALKER. Senator, your point is well taken. First, let me say that it does not really matter what trigger you pick; with Medicare,

we are going to hit it. We are going to hit whatever trigger you pick.

But I think that one of the things that we have to do, is we have to get out of myopia and the tunnel vision. We have got to look longer range, we have got to look broader. Right now, we have got a signal that only deals with Part A solvency.

Well, Part B is growing faster than Part A. Part B is going to overtake Part A. In Part B, we really have not shown a whole lot of discipline. We started out with 50 percent cost sharing, now we have got 25. We have moved things from A to B. We have not had a whole lot of discipline.

So I think it is absolutely imperative that we move beyond Part A solvency and we start coming up with some triggers that deal with the entire Medicare program, both as it relates to the percentage of general revenues, percentage of the budget, percentage of the economy, because that is what we have to deal with.

Senator GRASSLEY. Dr. Reischauer?

Dr. REISCHAUER. As I stated previously, I do think it would be a step forward if we had a more global mechanism for triggering action by the Congress, and the Breaux-Frist bill has such a procedure in it. Many people are concerned that this will act as a cap and that benefits will be cut, or something adverse will happen to beneficiaries.

Quite frankly, I do not spend sleepless nights worrying about that simply because Congress and the President have found it very hard to impose added costs on beneficiaries when the beneficiaries represent 12 percent of the population. We will be hitting these limits when beneficiaries represent 20 percent of the population.

Unless my political calculus is all screwed up, I think the elderly of the future, of whom I will be one, can rest assured that they will not be treated unfairly by Congress when it is asked to do this issue, which it should be asked to do periodically when costs are rising very rapidly.

Senator GRASSLEY. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Kerrey.

Senator KERREY. Thank you, Mr. Chairman.

I join the other Senators in welcoming the two experts to this committee hearing.

One of the impressive things about both Medicare and Social Security, to me, is that it binds approximately four generations of Americans together. It is very much an intergenerational program. It is not so much a program just for 37 or 39 million beneficiaries, it is their kids, their grandkids. It really does impress me how both programs that cross generational lines.

I am wondering if either one of you have done other analyses. These analyses are important in getting out of the myopia and taking the long-term view. I wonder if either one of you have done any analyses on two other areas that I think might help us understand the problem a bit better.

The first, is what it looks like when you consider we have got about five major Federal programs that make people eligible for health care in some fashion, Medicare, Medicaid, the VA, the income tax deduction, and being a Federal employee. About 40 mil-

lion people are not eligible. I wonder if you have examined sort of the equity of that?

I face it all the time, as somebody who is eligible for the VA, running up against somebody who is not eligible, does not have health insurance. They are subsidizing me, I am not subsidizing them, and it makes me, to put it mildly, a bit uncomfortable.

I think these ineligible people tend to be younger anyway. So that is one analysis, this inequity that occurs as a consequence of shift of income from one group that are not ineligible to another group who are.

The second, is that we have about 60 million Americans under the age of 18, and about 37 million Americans over the age of 65. Though I do not think we spend a disproportionate amount of our income today on people over the age of 65, I am struck by the fact that we spend, at State and Federal levels, three times as much money on people over the age of 65 as we do on people under the age of 18.

The trend lines are not, as I see them, very positive. That is a second area of analysis that I wonder if there is anything that is constructive that has been done, both of which I think could help us break out of this myopia and take both a broader and a longer-term view of these programs, because I think it is vital that we preserve this intergenerational support that we have currently for both of them.

Mr. WALKER. Senator, we have done some work in this area, and we expect to do more work in this area. I think it is very important. I mean, clearly, the amount of the Federal budget that is being targeted towards the elderly is increasing.

Senator KERREY. Would you welcome further requests for additional work?

Mr. WALKER. Well, let me find out what we have in-house, Senator.

Senator KERREY. All right.

Mr. WALKER. But we will be happy to talk with you and let you know whether or not there are any gaps, what we have in-house and what the gaps are.

Senator KERREY. All right. Because I have shown these charts as well to people, and frankly, they tend to produce glazed-over looks. It does not convert, necessarily, into some urgent sense of action, and I think that is what you need. We need to personalize it in some way, otherwise it is difficult to get the political support for action in the short term.

Mr. WALKER. I think there are, clearly, intergenerational issues as well as income issues, and let me touch on health just for a minute, to give you an example.

We have got roughly 40 million Americans that do not have health care. Some of those have access to health care and voluntarily choose not to get it, young people, typically.

Senator KERREY. To put it more accurately, they are not eligible under any program for subsidies. They are not aged, they are not poor, they have not gotten blown up in a war, they do not work for the government.

Mr. WALKER. Some of these are.

Senator KERREY. Well, if they got blown up in a war, they are getting it, if they are old enough they are getting it, if they are poor enough, they are getting it, and if they work for the government, they are getting it. There are people in the private sector who choose not to accept an income tax subsidy.

Mr. WALKER. There are people in the private sector, correct, that have an opportunity to—

Senator KERREY. There are very few in the other categories that choose not to accept the subsidies.

Mr. WALKER. Correct. Typically, the ones in that category that choose not to accept it are young people. They do not think they are going to get sick.

But my point is this. There are several elements of health care, whether it be Medicare, whether it be private sector health care, or public sector health care outside of Medicare: access to health care at group rates, passing on the economic benefits of group purchasing power, leveraging that on a cost-neutral basis, and providing financial assistance to those who need it.

We need to look at those three dimensions. Too many of our programs, quite frankly, we started off with a program—and Medicare is one example, but there are many other programs—saying, the answer in 1965 was X.

Now we are in the year 2000 and it is a different situation. Not only have standards of practice changed, but, frankly, the percentage of the budget that is mandatory versus discretionary has changed.

If you look at these projections in the future, the return on your investment—my parents, for example. I was talking to my father and helping him understand that he did not come close to paying for what he is getting in Medicare. There is a lot of this education that has to go on.

Senator KERREY. Have you persuaded him yet?

Mr. WALKER. I will prevail. [Laughter.]

Senator KERREY. I am going to bet on your dad. [Laughter.] Thank you.

Dr. REISCHAUER. Let me make just a general comment about the comparisons of how much we spend on kids versus how much do we spend on the elderly now, and what they will look like in the future when we know the fraction of the population that will be old will grow and these burdens will become very significant.

You can reach one conclusion looking at the information that way. You can reach another conclusion by looking at the relative generosity of these programs that we provide for the elderly. We have a health insurance program called Medicare. Medicare pays about 53 percent of the total personal health care costs incurred by the elderly.

That is a pretty chintzy program. None of you have ever been covered by a worse program, from that perspective. So I look at that component and I am not that troubled. Medical care is expensive. The rest of society is paying a whole lot for it, too.

Let us look at Social Security. By international standards, Social Security is not a generous program. We are talking about average benefits in the $11,000, $12,000 a year range, or $17,000 for a couple. Think about having an apartment, a car, the normal needs of

life on these amounts. Now, it is not supposed to be the only source of your retirement income, but for 17 percent of the population it is.

Senator KERREY. Appreciate it. But we celebrate around here when we get another billion dollars for Head Start. We have 30 percent of children who are eligible for Title 1 right now and we cannot get the money out to them. If we did that kind of triage in health care, we would have protests on the street. It is only because they do not have a voice.

Dr. REISCHAUER. I am not saying that this justifies the amount we spend on children who are our future; we should spend more on children, too. But when we say that, we are looking at ourselves in the mirror and saying, buy fewer compact disks, fewer SUVs.

The CHAIRMAN. Senator Conrad?

Senator CONRAD. Thank you, Mr. Chairman. Thanks to you and the Ranking Member for your introduction to this issue. Thank the, really, two excellent witnesses. I think we have started just on the right tone here with people who are trusted and who are serious about analyzing these questions.

I also want to salute some of my colleagues on the panel, one who is about to leave here, Senator Kerrey, and my dear friend Senator Breaux, who have worked very hard on this issue, and, of course, my close friend Senator Rockefeller, who also served on the commission.

The three of them worked very hard on this. They came at it from somewhat different perspectives, in some ways very different perspectives, but they have made an enormous contribution to this discussion, and we want to thank them for all that they have done.

It seems to me we ought to establish three principles. One, is we need to modernize Medicare and extended solvency. We ought to apply that as a test to any plan that is before us.

Second, we need to add a prescription drug benefit. I just met with a constituent whose mother was having $20,000 a month of prescription drug bills because of a treatment for a rare cancer. Now, $20,000 a month would bust virtually any family in my State, and most families in the country, in very short order.

Third, we need to ensure that any reform effort improves the Medicare benefit for all seniors, regardless of where they live. Regardless of where they live. This is critically important, and it is very important to my State.

I have indicated I have high regard for my colleague, Senator Breaux, and the effort that he has put into this. I have expressed to him, and I say publicly, that I have very great concern about the proposal that he has made and its effect in my State. Let me say why.

In my State, there is no Medicare Choice plan. None. That means, if we have a circumstance in which we go to what has been proposed, the older, sicker people will be left behind in fee-for-service medicine and their premiums will go up, as we have been told by the Medicare actuary today, a 47 percent increase, he projected.

In a State like mine, the vast majority of people, virtually all of them, would be still in fee-for-service medicine and their premiums would go up disproportionately because of the pool of people they are in.

Now, there is a protection in what Senator Breaux and Senator Frist have offered, and that is, they cap at 12 percent of the average premium or the average cost what anybody would pay in premium.

The problem is, if you just had one plan offered in a State, even if it did not include the doctors that most people go to, even if it did not include the services that most people are used to, they would be forced with this choice that would be very unattractive for the people of my State.

Very unattractive, staying in fee-for-service with dramatically rising premiums or go over to a plan that may not have the doctors and services that they require. I think we are going to have to do substantially more work on this part of the problem, and I would ask for both of your reactions to this specific set of circumstances.

Mr. WALKER. There are, clearly, geographic issues here that have to be explored further. In North Dakota, obviously, given the size, the population, and the location in the country, it is probably particularly affected by this, as well as certain other things. It is part of the rural versus urban debate.

I will say this, Senator. I do not think solvency is enough when you talk about your three tests. I think solvency actually can be misleading, because we can extend solvency but yet not really get to the root cause of the problem, the root cause being the fundamental imbalance between promised benefits and funded benefits, and the escalating percentage of the mandatory budget represented by health care and of the economy.

Senator CONRAD. How would you amend that first principle? I think you are talking about the pressure that is going to be on the distribution of spending in the Federal budget going forward as part of what we need to capture here.

Mr. WALKER. At a minimum, Senator, I think if not a substitute, at least a supplement to solvency, and possibly even a substitute, would be what percentage of general revenue is going into these programs, what percentage of the Federal budget, what percentage of the overall economy?

Now, obviously, those are going to have to be pegged at different points. We know, for example, that merely because we are going to have more senior citizens, we know that we are going to be spending more on Medicare.

But these costs are not going up just because of the per capita increases, they are also going up because of utilization, intensity, and frankly, prescription drugs are the fastest growing cost in health care.

Senator CONRAD. Thank you.

The CHAIRMAN. Next, we have Senator Bryan, then Senator Thompson, and Senator Rockefeller, in that order.

Senator BRYAN. Thank you very much, Mr. Chairman. Let me join with my colleagues; this has been a very impressive beginning. Both of you have offered, I think, great insight into it.

Both of you have suggested what I would characterize as a Medicare corollary to the Hippocratic oath of do no harm, do not make the system worse by any changes that you might make.

Everybody on this committee has been around the block a few times. This is the quadrennial event in America. I suspect that,

based upon my experience, if the political parties looking at the political tea leaves this fall believe that prescription coverage is an idea whose time has come, it is going to happen.

I agree with your premise that it should be in the context of comprehensive reform, but my experience suggests to me that perhaps there is not the will to do the heavy lifting.

So my question to you is, short of the comprehensive reform—I agree with that premise—what incremental steps should we attempt to take if, indeed, prescription coverage—and by the way, I support it—time has come and there is not the will, or the time, or whatever reason to do the comprehensive reform, give us some indicators that we should include in the prescription coverage benefit that we adopt.

Mr. WALKER. I think there are three major elements with regard to prescription drugs that you would have to look at.

First, access to prescription drug coverage at group rates. Second, passing on the economies of scale that could be obtained, potentially, through group purchasing power that would be cost-neutral to the taxpayers.

Third, financial assistance. To what extent do you provide financial assistance, and how can you best target that to those who really need it? I also think you have to look at another issue, and that is, what is the likely impact going to be on employer-sponsored coverage?

We have to keep in mind that less than 16 percent of retirees have employer-sponsored prescription drug coverage. We are comparing apples and oranges, to a certain extent. We are comparing private sector coverage for active employees to coverage for retirees.

Private sector plans typically only offer health care to about 16 percent of their retirees, and many of those, the individual has to pay for. The employer does not pay for it; it is just to access at group rates and the employer might provide some subsidy.

So I think we need to be careful that we do not do something that is going to enable the private sector to dump their obligations on the public sector, because believe me, they would like to do it.

Senator BRYAN. Dr. Reischauer, your comment, again, the incremental steps that we should at least, as a bare minimum, incorporate by way of reform, short of the comprehensive reform that we all agree is the ideal?

Dr. REISCHAUER. Confining myself to the prescription drug area.

Senator BRYAN. Yes.

Dr. REISCHAUER. I would say you want to draw a balance between what is politically acceptable and what is really necessary. Americans want prescription drug assistance. In other words, they do not want deductibles, they want first dollar help.

Politically, that is probably the only way to get it through. What the Nation really needs, is insurance. Those who incur large expenditures need more help than those who are buying the first $100 worth of drugs for the year.

So, I would urge you to consider systems of graduated co-pays, where the benefit increases the more expenditures you have, although it starts very low, or even right with the first dollar.

The second thing that I would stress, is that, while it is always nice to provide a lot of choice, choice often creates the potential for adverse risk selection. A lot of people say, let us let as many plans as want to offer services in the area offer these services.

I, quite frankly, think that that will be the ticket to big problems later on dealing with adverse risk selection, and you will create a bigger problem than you have tried to solve.

Senator BRYAN. My time is running out.

Mr. Walker, you are talking about Medicare+Choice, that they are being overpaid and that that is creating a problem. Yet, in my State, as I suspect in other States, Medicare+Choice programs are backing off of some of the benefits, either withdrawing the prescription coverage, or more limiting.

What is happening, in the 20 seconds or so that is left, out there in the marketplace?

Mr. WALKER. Well, first, one has to keep in mind that they have to cover costs, make a profit. If they do not make a profit they are not going to stay in business. But in addition to that, based on the amount that they have been provided, they have been able to offer additional benefits.

Senator BRYAN. Yes.

Mr. WALKER. They are starting to get squeezed. Something has got to give. Either profit margin has to give, or the additional benefits they are providing have to give, something has to give.

Frankly, it is a microcosm of what we face in health care. Something has got to give because wants are unlimited. People want unlimited health care. They do not need unlimited health care, and it varies based upon economic status, to a certain extent, as to whether they can afford it. We sure cannot afford unlimited health care.

Senator BRYAN. We could put that to music, could we not? Something has got to give. Yes.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Senator Thompson, please.

Senator THOMPSON. Thank you, Mr. Chairman. Thank you for holding these hearings.

I am struck this morning by the discussion of the Breaux-Frist plan, and also the President's plan, and their being juxtaposed, and talking about similarities and that sort of thing.

But it is difficult for me to see how the President's plan meets the criteria that has been set out that is necessary in order to solve this problem, not because it is the President's plan, because I think we need to come to terms with whether or not we want to accept or reject that general proposal, that general approach, to solve the problem.

Last year, the CBO estimated that the savings derived from the President's reforms would be $57 billion. The President's proposal also proposes to spend a total of $195 billion to provide all Medicare beneficiaries with access to prescription drugs, 42 percent of that would be offset by co-pays.

They are able to do that because of a transfer of general revenues which, to me, just makes the problem more difficult to solve. I do not see how you can even say it is a step in the right direction. It certainly does not fit the criteria that you have set out.

But it raises a larger question to me that I have wondered about, and that is, when we talk about solving this problem, and we all recognize the need to determine exactly what is fair, equitable, needed, and so forth on the one hand, and how we are going to pay for it on the other, but this is jumping way down the road.

But assuming we come to terms with that eventually, for how long should we attempt to solve this problem? For example, the President's proposal says that this will solve the problem with the Medicare trust fund until 2025.

Well, why not 2020 or 2030? That rolls in the question of short-term solutions, such as transfers in general revenues, or however you want to raise the money, raising the premiums, and so forth.

But it is somewhat like asking how long is a piece of string, I guess. We talk about these figures. If we are going to do it every political cycle, that is one way of doing it, as long as you have got the wherewithal to do it with, but obviously it does not solve the problem.

On the other hand, if you project out too far in the future, we all know it is based on certain assumptions that we know are certainly not always valid.

So in an ideal world, if we came to terms with the cost and the benefit equation, how long in the future should we be attempting to really address this problem, knowing that the aging situation is going to increase, presumably, and I would assume the cost trajectory will probably be the same?

Mr. WALKER. It depends, in part, on how old the person is who wants an answer to the question. But on a more serious note, the trustees project 75 years in connection with OASDI and HI. Candidly, there is no way in the world Congress is going to be able to come up with a solution in one fell swoop that is going to address the 75 year financing imbalance.

The President is talking about some reforms, so is Breaux-Frist. The President is talking about dedicating some additional revenues to close the balance between the promised benefits and funded benefits and to help pay for prescription drugs.

We have said that, in all likelihood, given the magnitude of that imbalance, you are probably going to need some additional revenues. But the President is focusing, in our opinion, too much on solvency.

Solvency does not get the job done. Solvency only deals with Part A. To the extent that you extend solvency alone to 2025 or 2027, it looks like the heat is off. We need to increase the heat, not reduce the heat. History has shown that the only way that Congress has really acted, is if there is heat. You have to have it. Thank you.

Senator THOMPSON. Dr. Reischauer?

Dr. REISCHAUER. Yes. All parties in this debate, myself included, at times, have used HI solvency as the way of determining whether we have solved the problem. As Mr. Walker pointed out, it is really a senseless measure. You could "solve" the problem by shifting HI costs into Part B continuously.

Actual insolvency in the HI trust fund may not be the end of the world if the insolvency was a couple of billion a year forever after the year 2020, or something like that. So this is really a completely absurd sort of measure that we use.

What we want to talk about, is what the growth of overall Medicare spending is going to be relative to the size of our economy and our willingness to tax ourselves or pay premiums to support the program. That is the way the debate should be held, not, I have solved the problem until 2025, or I have solved it until 2035, therefore my plan is better than yours. That does not make sense.

Senator THOMPSON. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Bob Reischauer, as usual, has put things on target on this question. I mean, solvency is important, Mr. Walker, because if you are going to dedicate 15 percent of the surplus, or if you are not going to dedicate 15 percent of the surplus, and Bob Reischauer is right in this, you get to 2025, that does not mean you have solved the whole thing. But this is a very large problem.

Now, I have a couple of things I want to say, and I may end up with a question, if you are lucky.

One of the things that disturbs me about this debate, and I think Kent Conrad began to get at it, and Bob, you got at it in the statement you just finished, when people are trying to score points.

I have been a victim of this, because when John and I spent a year together on the commission—and I am saying this because I want it to sort of set a tone, hopefully, for this committee and for Senators beyond that—I really did not like some of the things in that commission and, therefore, rather than becoming a constructive force because, we were outnumbered, to try and modify, and I did not feel that we could modify, I adopted the posture that I had to fight in order to make sure that it did not get the majority and, thus, even more momentum.

Now, that is acceptable behavior for the course of a commission which lasts for a relatively short period of time, but it is probably not entirely acceptable behavior when you are legislating on behalf of the American people and the people that I happen to represent from West Virginia, who, if they are over 65, after they have done their Medigap payments, have a total of $8,600 for everything else that they do in life, if they are average Medicare beneficiaries in West Virginia.

So I think that it is important for us to, as a committee, back away from what I think is not just evident on my side up until this point, but also on the other side. There is some on our side, some on the other side.

That is, it is going to be this way or it is going to be nothing, and that you stake out grounds. Partly you stake out grounds because you invested a lot of time in it, and you come to very strong conclusions about it, and you are not going to yield.

Or sometimes people do not know the subject as well as they might, but there are a couple of things which become very clear to them and then they sort of latch onto those and the larger dimension dissipates. I think, Bob, particularly, this is not the kind of behavior that you respect or appreciate, and is not typical of you.

So what I want to say is, Mr. Chairman, I do not want to be the constant critic, I want to be part of the process to try to work this out. I said that to John before my turn came. I had a lot of time to talk with John before my turn came.

But I think that is important, that as a committee, if we are allowed to deal with this, that we all go at this in good faith, but we are all going to have to drop some of our, well, you know, John, and Bob Kerrey on our side did this, therefore we are going to stick with them, or we cannot do that because Phil Gramm thinks such and such and we do not like the way he thinks about health care, or whatever.

We have got to back away from that and accept what I think you, particularly, Bob, have said, and that is that this is an enormous problem with a very long future in which there is going to be some pain involved on all accounts.

Now, I can criticize the President's plan. I happen to think it is a little bit better than the one that Breaux and Frist have put forward, the legislation, but I am not going to get myself totally hung up on that because I want to look for middle ground. But it has got to meet some of the criteria that you particularly keep insisting on of adequate benefits, and it has got to be funded, but the quality has got to be there.

I also want to take issue with what both of you said, and what has been said by most people on this committee, that you cannot do prescription drug reform until you do all of Medicare reform.

Because if that is the case, then you have got to say that we are going to get Medicare reform done this year, which I doubt, for political reasons. We are obviously going to have a new President and they have different ideas, so it is going to take a few years to shake that out.

I do not believe—and I passionately do not believe—that you can hold people hostage for something called sanity and remarkable rationality of planning for the longer term with all factors considered in the puzzle all coming together. You cannot hold them hostage from something called lifesaving drugs. I do not believe you can do it. I do not think that is a moral decision, and I do not think we can do that.

I think what we have to do is find a way to do reform, which is going to take time, but do it in good faith, which is easier said than done, but it is now going to be part of what I am about, Mr. Chairman and Mr. Ranking Member. It is not going to be, I am attacking Breaux and Frist because I have been through this experience. Life is much larger than that.

But I do think we have to do the prescription drug benefit, and I want to say that very, very clearly. I do think reform has to be good. It is not just that we reform Medicare, because we can reform Medicare and a lot of people are not going to know whether we have done a good or bad job. Indeed, as we thought we were doing the right thing in BBA, the consequences of this will be much, much greater.

So let us do it right. Let us make sure that we also understand that we are going to need new revenues. We cannot escape that with the size of the baby boom.

I hear you, Mr. Chairman. Let us also understand that putting this together will take a lot of work and a lot of dropping of position taking. I am willing to be a part of that process.

On the other hand, I want the reform to be good and I want us to do a prescription drug benefit this year because I think this is

the best possible year in which to do it. There is no way somebody can convince me that we cannot do that and not do Medicare reform in a larger sense in a period of years after that.

Mr. WALKER. Mr. Chairman, can I clarify real quickly what I said, just to be clear?

The CHAIRMAN. Quickly, please.

Mr. WALKER. Senator Rockefeller, I believe what I said, is I recognize that solvency is important. I was a trustee for 5 years, so I know this issue extremely well. It has legal significance.

I believe what I said was, that solvency is not enough. Solvency of Part A is not enough. We need to look at sustainability of the entire Medicare program as well, at least in addition to, if not in lieu of solvency.

Second, clearly, you cannot do it all at once. Clearly, you are going to need revenues. I think my point was, try not to make the financial situation worse. Whatever you do, try not to make it worse, because the real heavy lifting is going to take time, it is going to come over a number of years, and probably a number of installments.

Senator MOYNIHAN. Thank you, Mr. Walker. But there is a vote on, and we are trying to hear Senator Graham.

Senator Graham, would you like to go now?

Senator GRAHAM. This is a five-minute round?

Senator MOYNIHAN. Yes, sir.

Senator GRAHAM. Thank you, Senator Moynihan.

It seems to me that as we think about Medicare reform, that we almost ought to use a medical model, first to diagnose what are the problems with the current system, then second, what are the range of possible treatments, and then third, to select one or some combination of those treatments that seems to be most appropriate to the task.

It would seem to me that a couple of the basic illnesses of the current system are historical in nature. That is, they reflect the state of medicine in the 1960's, and really in the 1950's, 1940's, and further back.

One of those, was that the purpose of health care was acute, that is, it was to provide financing for that illness or accident that occurred. There was, for instance, and continues to be, relatively little focus on prevention and how to maintain a standard of quality health, and that is one of the principal reasons why the issue of prescription medication is so important, because it is a fundamental part of almost every prevention strategy.

A second assumption of the original Medicare legislation was that death occurred shortly after retirement, that people had an event not too long after they had retired and they passed away. Today, we know that an American female who reaches 65 has almost 20 years of live expectancy, and an American male, 15 years.

So rather than the event of death, we are now dealing with the process of aging. Those two issues, the acute care focus and the event of death focus of the original Medicare, it seems to me, are fundamental maladies with which any reform has got to deal.

I would like to know if you agree with that analysis, and if so, what would be some of the steps in terms of reform that you would

recommend that would deal with those two specific imperfections in our current Medicare program?

Mr. WALKER. Senator, I think those are very accurate. This program was enacted in 1965 based upon practices that existed prior to its enactment. This program, as well as many programs, need to be modernized.

We need to re-look at it, not in light of just what existed in the past, and frankly not in light just of what exists today, but how are things likely to look in the future.

Clearly, on prescription drugs, there appears to be a broad-based consensus that has to be an element of the modernization of the program. I would just suggest, though, we cannot just stop there. We need to also ask, what do we already have, and does that make sense? Should we somehow be looking at making some adjustments later as part of more comprehensive reform between what the wants, needs, and afford are.

Senator GRAHAM. On the two issues of the acute care orientation and the event of death orientation of the current Medicare program, what would be some specific reforms, putting aside the issue of prescription drugs, that you would recommend that would move us into a more contemporary health care program?

Mr. WALKER. I think in this area as well as other areas of health care, we need greater transparency of cost, we need greater sensitivity to the cost in the form of cost sharing or other mechanisms, to try to help be able to control utilization in situations where it may not be necessary.

It is one thing for a procedure to be necessary, but we have evidence to show that there is a lot of utilization that goes on that, frankly, if there were more cost sensitivity and more transparency, it may not be needed without adverse health effects. I do not know if Dr. Reischauer has anything to add.

Dr. REISCHAUER. Senator, I think you did put your hammer on the nail head here. The emphasis, of course, was acute care, but there is a good deal of chronic care coverage within Medicare right now, and we have seen the explosion of home health costs, just to name one area where that has taken place.

Prevention has expanded as well, and more could be done in that area. As you point out, prescription drugs is a big hole and that hole needs to be filled, but in my mind, in the context of a larger expansion of benefits. Nobody has breathed the word long-term care here, and that is a big problem.

Senator MOYNIHAN. That is the one you were leaving to your son.

Dr. REISCHAUER. If we put that 800-pound gorilla in this room, nothing will get done.

Senator MOYNIHAN. Yes.

Dr. REISCHAUER. With respect to people living longer, the problems caused by the good news that people are living longer are not going to be solved within the Medicare program. We have to decide as a society how long we expect people to work, or how much we expect them to save for their retirement during their working years.

This is because most Americans have health insurance through employment. As long as we have that system going, the issue for

Medicare, really, is one for Social Security and work versus retirement, not a health, medical, or a Medicare problem.

Senator GRAHAM. If I could just continue.

Senator MOYNIHAN. Well, you will want to vote.

Senator GRAHAM. All right. Are we going to continue this after the vote, this panel?

Senator MOYNIHAN. I think we are going to excuse our guests.

Senator GRAHAM. And move to the next panel.

Senator MOYNIHAN. Yes.

Senator GRAHAM. Well, rather than ask a question, I will just summarize with a short statement. I think the whole issue of moving from an event—death—to a process of aging has very fundamental implications to the Medicare program, things like covering the services which are required as one goes from full independence to full dependence, what are the nature of those services, what is the line today between social and medical services, it is not as bright as I suggest it used to be.

Who is going to finance those services? This also gets into the issue of the Medicaid program, which was initially thought of as being a program for children and middle aged people of limited income. But in my State now, we are spending two-thirds of our Medicaid budget on nursing homes.

Dr. REISCHAUER. That is true nationally.

Senator GRAHAM. It is not a rational system of how to allocate health care costs.

Mr. WALKER. Senator, I think there is another transition. That is, the transition to retirement. Our economy is totally different. A lot of times people could not work past 65 because we were an industrialized Nation, manual labor, you may not be able to.

But now we are greatly a service economy. I think one of the things we need to look at, is our employment policies and practices and ways that we can encourage, but not necessarily require, people to work longer.

Senator MOYNIHAN. I think those are very good comments.

Thank you, Senator Graham, for very singularly interesting remarks.

May I, just in conclusion, say that you will not forget, if you please, teaching hospitals. Thank you both very much.

We now, as I say, have a vote on and we must all get down to the floor. So, with great appreciation, we will see you back here before this is all over. We will now stand in recess. The second panel will be convened when we return.

Thank you, Mr. Walker, Dr. Reischauer.

[Whereupon, at 11:50 a.m., the hearing was recessed to reconvene at 11:57 a.m.]

The CHAIRMAN. The committee will please reconvene.

We will now call forward the second panel. It is, indeed, a real privilege to welcome once more Beatrice S. Braun, who is an M.D., board of directors of the American Association of Retired Persons; Robert Waller, also an M.D., board of trustees, Healthcare Leadership Council; and the third member of the second panel is Robert L. Bixby, executive director, Concord Coalition, Washington, DC. It is a great pleasure to welcome all three of you.

Dr. Braun, we appreciate your being here again. We would be happy to start with your statement. Your full statement, as you know, will be included as if read.

STATEMENT OF BEATRICE S. BRAUN, M.D., BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS, WASHINGTON, DC

Dr. BRAUN. Thank you, Mr. Chairman. As you said, I am Bea Braun, from Springhill, Florida, and I am a member of AARP's board of directors. I thank you for the opportunity to testify today.

For 35 years, Medicare has provided access to affordable health care, but the program now faces many challenges. Foremost among these, are ensuring that benefits keep pace with rapid advances in medicine, making sure that delivery systems can handle the influx of baby boomers nearing retirement, and securing long-term sustainability.

But changing a program that millions of Americans depend on daily for their health care is no small task. Therefore, as you proceed with your deliberations, we urge you to be guided by the fundamental principles that have helped to shape Medicare into a successful program.

These principles, which are detailed in my written statement, are, in a sense, a plan for Medicare reform and should be the foundation of any reform option.

I want to talk about one principle in particular, prescription drug coverage as part of Medicare. As a retired physician, I have seen the practice of medicine change dramatically, particularly in the area of prescription drugs.

While most employer plans include drug coverage, Medicare does not. Simply put, prescription drug coverage in Medicare would be smart medicine.

AARP believes that a Medicare prescription drug benefit must be available to, and affordable for, all beneficiaries. The benefits should be voluntary, allowing people the option of keeping the coverage they currently have. The benefits should make prescription drugs affordable for all beneficiaries.

Today, good medical care and pharmaceuticals are often synonymous, but the cost of new drugs makes them prohibitively expensive for many middle income, as well as low income beneficiaries.

Equally as important, a drug benefit in Medicare will need to ensure enough participation to avoid adverse risk selection. Here, affordability to beneficiaries will be the key. While 65 percent of beneficiaries may have some type of drug coverage, the figure is misleading because current coverage is often inadequate, limited, expensive, and increasingly unstable.

Let me shift my focus now to two major reform proposals. The President's proposal and the bill introduced by Senators Breaux and Frist provide opportunities for examining Medicare reform options and for furthering public debate and understanding.

I am not attempting today to give a full review of either proposal; that will take a lot more hearings. Rather, AARP has identified questions that we believe need to be answered as part of this committee's deliberations.

With respect to the President's proposal, AARP is pleased that it creates a prescription drug benefit available to all beneficiaries. Since details of the plan are still forthcoming, some of the critical questions that need to be answered include, would the competitive defined benefit program be affordable for beneficiaries, regardless of the area of the country in which they live?

Since dependable risk adjustment will probably be in development for some time, how would appropriate payment of plans be calculated in the meantime? Would prescription drug coverage be affordable to beneficiaries?

The Breaux-Frist bill improves upon earlier versions, notably by providing a modest subsidy toward the cost of prescription drugs for all beneficiaries who elect a high-option plan.

But even this step leaves many important questions and concerns about the proposal, and these include: how and to what extent would the bill improve Medicare's long-term sustainability; is a 25 percent premium subsidy enough to make the benefit affordable for most beneficiaries; and is it attractive enough to assure a viable risk pool; to whom would the new Medicare board be accountable; how much discretion would the board have?

The bill would cap general revenues into Medicare at 40 percent of Medicare spending. What would be the impact on payments to providers and plans on beneficiaries' premiums, cost sharing, and/or benefits and on Medicare's entitlement?

At this time, AARP is reserving judgment on both proposals until important questions are answered. We believe it is important to thoroughly examine these and other proposals that will emerge. In fact, it would be a serious mistake for anyone to hinder debate or for Congress to rush to judgment on any reform option.

If legislation is passed through too quickly before the effect on beneficiaries and the program is known and before there is an emerging public judgment, AARP would be compelled to alert our members of the dangers in such legislation and why we could not support it.

Mr. Chairman, AARP is committed to working with this committee and with members of Congress on a bipartisan basis to make Medicare stronger. Thank you, Mr. Chairman.

The CHAIRMAN. Just let me underscore what you just said. Anything we do in this area has to have broad bipartisan consensus. I think that is critically important.

Dr. BRAUN. Yes.

The CHAIRMAN. We appreciate your being here and hearing from you again.

Dr. BRAUN. Thank you.

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

The CHAIRMAN. Now it is a pleasure to call on Dr. Waller. Welcome.

STATEMENT OF ROBERT R. WALLER, M.D., BOARD OF TRUSTEES, HEALTHCARE LEADERSHIP COUNCIL, WASHINGTON, DC

Dr. WALLER. Thank you, Senator Roth. Thank you for this opportunity.

Let me thank all the committee for the hard work on behalf of Medicare reform. The collaborative spirit of the committee this morning is, indeed, impressive. I think we all agree that we will not succeed by overcoming each other, and the enemy here is disease. The enemy is disease.

It is my privilege to chair the Healthcare Leadership Council board. This is an organization that is 11 years old now. It consists of 55 leaders that represent all sectors of health care. So the HLC, as we call it, is unique in its diversity, but it is also remarkably in consensus among our members with respect to how they view the health care system in the future.

HLC's vision supports a patient-centered system, the patient front and center, where information is more readily available so that they can seek value for their health care dollar, and where information can help them navigate through this very complex health care delivery system.

HLC believes in choice of multiple providers, multiple payors. Patients who have better information and better choice stimulate the competitive environment, as who can provide the best value for the health care dollar. We define value as quality divided by cost, where quality is not only better outcomes, but better service as well.

When we have choice, competition, and a patient-centered system, this all encourages innovation, which is what HLC is all about in many respects, the underpinnings of which are research and development, and education.

The HLC members believe that Medicare, in its current configuration as we have heard this morning, and I can speak to you as a physician who has practiced at Mayo Clinic now for 30 years, with continued price controls, with continued ratcheting down of payments to providers and plans, and with continued micro management of the delivery of care, just will not work in the future.

So HLC supports major restructuring, so that choice, competition, and innovation can flourish. We believe this requires a substantive change in the private/public partnership that we now have, to rely more on private sector initiatives in the years ahead than we have in the past.

We would like to compliment Senators Breaux, Frist, and Kerrey for their authorship of S. 1895, and we do admire their courage and their hard work to develop a proposal which we think contains many of the principles which HLC believes should underlie comprehensive reform.

In the written statement submitted for the record, we have done a point-by-point analysis as to how S. 1895 and the President's proposal fare with respect to the important principles or tools for reform, but let me mention just a few key points, given the constraints of time.

S. 1895 maximizes efficiency through comprehensive reform. We think the management board that is external to the Health Care Finance Administration is a key element to ensure competition, flexibility, and less regulation.

We do not see comprehensive reform in the President's proposal, we do see adding programs to the current system. We see the HCFA modernization, as it is called, proposals mostly related to

the payment of isolated services, and we see more, not less, regulation.

S. 1895 maximizes choice because the incentives are present for more private plans to compete and the payment system is based on cost of care in real market terms, not a statutory formula.

The President's proposal as yet does not require competition between the fee-for-service traditional Medicare program and private plans. We do have concerns about the way risk adjustment is applied, because it shrinks the total dollars available rather than redistributing the dollars based on severity of illness.

We are concerned that private plans are likely to continue to withdraw as they have in the past couple of years. S. 1895 establishes coalitions to conduct local education programs for beneficiaries, and we think that is a good approach.

Finally, we believe that cost reduction through improvement is the only plausible business strategy for any of us in health care. Cost reduction through improvement. There are lots of ways to reduce costs, but if we do not improve at the same time, nobody is going to like the price in other currencies. We see that the strategy of cost reduction through improvement can thrive in an environment where choice, competition, and innovation can flourish.

We are concerned about the President's focus on solvency as continuing to recommend further cuts in payments to providers and plans which, ultimately, is false fuel.

So, in summary, we would urge going down the road of comprehensive restructuring versus piecemeal additions to the system, as you have heard this morning. The system has served us well in the past, but it was built for another time and another science.

Thank you very much.

The CHAIRMAN. Thank you, Dr. Waller.

Mr. Bixby, it is a pleasure to have you here.

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

STATEMENT OF ROBERT L. BIXBY, EXECUTIVE DIRECTOR, CONCORD COALITION, WASHINGTON, DC

Mr. BIXBY. Thank you very much, Chairman Roth.

I would like to begin by noting that the Concord Coalition, of which I have the privilege to be executive director, has an active field organization and it just happens, I compliment your staff, that we have done some field work with the HLC and with AARP in the past.

So if there is anything our three organizations can do for you outside of Washington to help the public understand these very complex issues, I am sure we are more than willing to do that.

Mr. Chairman, I am representing the Concord Coalition, and I would mention that we are a grass roots organization. We have members in every State. We are a bipartisan organization chaired by former colleagues of yours, Senator Sam Nunn from Georgia and Warren Rudman of New Hampshire. Paul Tsongas and Peter Peterson were among our co-founders.

Since the organization was started in 1992, we have been striving to achieve policies for a balanced Federal budget, policies that will keep the budget balanced on a sustained basis, and recently to strategically deploy any budget surpluses that may result to pre-

pare for the fiscal and economic challenges that will inevitably occur as the population gets older.

Given these objectives, the Concord Coalition is greatly heartened by the dramatic recent improvement in the Federal Government's fiscal position over the past several years.

Unfortunately, today's prosperity, welcome though it is, has not repealed the coming age wave, which so many of our witnesses have talked about this morning. Nor has it erased the projected growth in age-related entitlement programs such as Medicare, Social Security, and Medicaid.

In fact, in November 1999, the technical panel of the Social Security Advisory Board warned that the official projections of the Social Security and Medicare trustees might greatly understate future longevity and, hence, future cost.

Moreover, short-term budget surpluses alone are not the long-term solution to the problems of Medicare and Social Security. Regardless of their size, projected surpluses are no substitute for the tough choices that must eventually be made to address the fiscal imbalance in both programs. These are largely brought about by demographic pressures.

Simply crediting presumed general revenue surpluses to prop up the trust funds regardless of long-term cost is, we believe, an illusion and not a solution to these problems.

The underlying problems will remain, and even if the surpluses materialize, a unique opportunity to enact needed structural reforms before a crisis hits will have been squandered.

Moreover, the situation will get even worse if the expectation of a surplus, as far as the eye can see, is used to expand programs that are already on an unsustainable footing.

So why do we need to address Medicare solvency right now, Medicare sustainability? Well, we have to remember the demographic profile that we start with. Three things will interact to drive up future Medicare costs to rather staggering levels.

First, it is the cost of each beneficiary, which has been climbing over the past several years and will continue to do so, even though it has leveled off briefly right now.

Second, the number of beneficiaries will begin climbing steeply when the huge baby boom generation begins signing up for benefits sometime around 2010.

Third, people who reach age 65 are expected to continue living increasingly longer. In fact, the fastest growing demographic segment of our population are the people age 85 and older.

Now, certainly that is not a bad thing, that is a very good thing, but it does have fiscal consequences. It is those fiscal consequences that we must be preparing for now.

Medicare spending averages more than twice as much for people 85 and older as it does for those ages, say, 65 and 66, so a higher percentage of the people over 85 will add to Medicare costs as well. Again, the longevity projections may be understated, so perhaps the cost projections will be higher.

The sheer number of new beneficiaries will push costs up faster than the revenue resources dedicated to pay for the benefits, and perhaps faster than working aged citizens, retirees, and their children will be willing to finance.

Let me address, just briefly, some of the criteria that Concord has established for reform. First, of course, is quality of care. We believe that that does mean modernizing Medicare to include a prescription drug benefit. That is just simple. Everybody acknowledges that the medical profession, our way of delivering medical care, has changed so much, so the prescription drug benefit is needed.

But we also believe that the program must be fiscally sustainable, and that gets back to the problem that Mr. Walker talked about earlier today.

We already have a program that is largely unsustainable over the long term, so we ought to be very careful about enacting new benefits. In fact, Concord feels that we should do so as part of a comprehensive reform package, not on a stand-alone basis.

I guess we will end there.

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

The CHAIRMAN. Good timing. Thank you, Mr. Bixby.

Dr. Braun, I think on the House side recently you testified, and again today. You talked about AARP's concern that Medicare reform not be undertaken too rapidly. I share your commitment to ensuring that, under any reform scenario, beneficiaries must continue to have access to high-quality care.

But, given your very justifiable advice to us not to rush to judgment, could you give us any guidance on what you would like to see done this year?

Dr. BRAUN. I think we need to continue the debate. I think your hearings, Mr. Chairman, are extremely important. I think we are going to need to get more questions answered about the proposals that are on the table at the present time.

We also need to get the public more engaged once we really know what those proposals, or the details of those proposals, are and get the public more engaged in understanding what the possibilities are so that you have the public behind you when you come to a final decision.

The CHAIRMAN. Could I ask you this? Is it your recommendation that, basically, there would be no legislation this year?

Dr. BRAUN. I do not think that is our recommendation. I think everyone has spoken about the real difficulty of trying to do a full restructuring of Medicare this year, but perhaps there could be other things done. There certainly could be some modernization in traditional Medicare that could begin to improve on that.

I think the question of whether or not prescription drugs could be done stand-alone is still a question, although we would prefer to see it part of it, but we understand also the pressures to do it.

The CHAIRMAN. Part of a major reform.

Dr. BRAUN. Yes. But we also understand what low-income and middle-income beneficiaries, as I am sure you are all hearing from your constituents, the difficulties with it, and we understand it is a life-and-death situation for many people.

The CHAIRMAN. What is your view of, perhaps, creating a temporary legislation to help the poor with respect to prescription drugs, technically not as part of Medicare, but separately?

Dr. BRAUN. I think it would have to be separate if it were not really a Medicare benefit, because a Medicare benefit really should be available to everybody and fitted into the structure of Medicare.

I think that it would need to be outside if it were just for low income. But I am concerned about doing just low income, even though the need is greatest there, because I think most of us are hearing, because we do hear more from middle income beneficiaries actually, because many of those beneficiaries are having a very difficult time.

The CHAIRMAN. Let me ask you one further question. In the President's budget, he included some modernizations to the fee-for-service, such as centers of excellence, preferred provider options which proponents suggest would be useful cost saving tools. You are in a unique position; you are both a physician and a beneficiary.

What is your reaction to such fee-for-service modernization; do you think physicians who now participate in Medicare fee-for-service would be willing to contract in such networks? Do you think beneficiaries will be willing to participate in preferred provider plans?

Dr. BRAUN. I would need to really see more of exactly what the expectation is in that kind of a set-up, and would it be a voluntary kind of a thing. It certainly needs to be pilot tested. I think there are a lot of things that could be pilot tested.

But I see some other things also, like primary care management and disease management, possibly doing more pilots in competitive sorts of things like the DME one that is being done in Florida at the present time. Some of those could be widened and done more. But I think we can begin to move and not stand still.

The CHAIRMAN. Thank you, Dr. Braun.

Let me turn to you, Dr. Waller. I understand and appreciate the Healthcare Leadership Council's support for comprehensive Medicare. However, in the event that it is impossible to move what would have to be a bipartisan comprehensive reform package through both Houses of Congress this year, what would the health care industry consider to be the most important elements to include in a more targeted reform package?

Dr. WALLER. Well, Senator Roth, I have heard the discussion this morning, and I guess the first reaction would be that we think it is time to do the heavy lifting. I think that we understand the realities of the world. If we had a magic wand relative to, what could we do next week, I think there would be to dos, and two do nots.

The to dos, would be to create the Medicare board, as Senator Breaux has advocated, independent of the Health Care Financing Administration to lay the ground work for more comprehensive reform, where the Health Care Financing Administration is one of the competitors offering choice to seniors, and that HCFA should not regulate its competitors. So I think the creation of the Medicare board, as proposed in S. 1895, would be one thing.

Second, to shore up Medicare+Choice. The payment formula has not worked. The payments have been unstable. There has been complexity of the regulations. There was some eagerness to join in the beginning, and now you have seen the withdrawal.

I think before there was a legislative repair, some groups had to decide whether or not to join Medicare+Choice before they knew what the payment rates were. So I think that a vigorous debate

about how to shore up Medicare+Choice, if it is going to be a short-term question that you are asking, would be our second to do.

We hope that there are no further Balanced Budget Act cuts. I think you have heard about the concern among providers who are reeling from that experience. Again, we hope that layering a drug benefit on traditional Medicare would not be something to be done in its early form, but rather to have the drug benefit be part of comprehensive reform. So that would be our approach early on.

The CHAIRMAN. I see now we have another vote to make life more complex. Let me turn and ask you a question, Mr. Bixby.

The Medicare program is growing slower than ever before, certainly slower than expected after the 1997 reforms. According to CBO, Medicare grew by only 1.5 percent in 1998, and declined 1 percent in 1999.

On the other hand, in its January 2000 baseline, CBO projected Medicare spending will return to relatively high levels over the next decade. CBO projects Medicare spending to grow at an average of 6.8 percent a year through 2003, and an average of 7.3 percent a year for 2004 through 2010.

Given these projections, why is there an urgent need to address Medicare reforms?

Mr. BIXBY. Well, I think the urgency comes, as none of us really expected the slow spending of last year, and indeed the decline, is going to continue. The demographics just do not allow it.

There will be pressures probably to add benefits. I mean, we do think that a prescription drug benefit will be added. Dr. Reischauer talked about some other benefits that may be added to modernize the program, and this will require more money.

So even though CBO has talked about the recent good news, it is important to keep in mind that, even without adding any new programs, the program will double as a percentage of the budget by about 2030 or so, to about 26 percent of the non-interest budget. It is going to about double as a percentage of the economy by 2040 or so, and as a percentage of taxable payroll it goes up at quite a brisk rate.

We are not going to be able to keep Medicare spending where it is today inevitably because of the demographics, but we can have a responsibility, I would say, to try to moderate the cost increases that are projected under current law.

The CHAIRMAN. Senator Moynihan?

Senator MOYNIHAN. Mr. Chairman, you are going to have to go and vote. I am sorry.

Thank you all for your testimony.

Senator BREAUX. Just a quick comment. I thank all of the witnesses. We have worked together in the past, we will continue to do so. Dr. Braun, you testified before the Aging Committee and did quite well, and we look forward to continuing to work with your association as well, knowing that what we are trying to do is not just for seniors today.

Probably, the seniors today are going to be the least affected by what we do, but it is your children and your grandchildren who are going to be the big people affected by the decisions we make today, and we want to make sure we make the right ones. Thank you, much.

The CHAIRMAN. Let me just echo what the other two have said. We appreciate your being here today. We want to work with you. I think it is critically important we develop a broad consensus. I thank you for being here, and we have a challenge.

The committee is in recess.

[Whereupon, at 12:27 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF ROBERT L. BIXBY

I. BACKGROUND

Mr. Chairman and members of the Committee, thank you for inviting me to appear today to discuss the vital issue of Medicare reform. I am representing the Concord Coalition, a nationwide, grassroots bipartisan organization dedicated to strengthening the nation's long-term economic prospects through prudent fiscal policy.

Concord's co-chairs are former senators, Warren Rudman (R-NH) and Sam Nunn (D-GA). They, along with our approximately 200,000 members who hail from every state, have worked for eight years since the organization's founding by Paul Tsongas, Warren Rudman, and Peter G. Peterson in 1992 to help build a political climate that encourages elected officials to make the tough choices required to:

- Balance the federal budget
- Keep it balanced on a sustainable basis, and
- Strategically deploy any budget surpluses that develop to prepare for the fiscal and economic challenges that will occur as the nation's population becomes sharply older in coming decades.

Given these objectives, The Concord Coalition is greatly heartened by the dramatic improvement in the federal government's fiscal condition over the past several years. When the 1990s began the nation was mired in large and growing deficits. Today, for the first time in a generation, the budget is in surplus. Indeed, fiscal year 1999 marked an important milestone as the budget was balanced without using the legally "off-budget" Social Security surplus the first such "on-budget" surplus since 1960. Debt held by the public has declined for two years running, and a further reduction is expected in the current fiscal year. Not coincidentally, the 1990s was a decade of accelerating economic growth.

So why doesn't the Concord Coalition declare victory and go home? Its because our goal has never been to achieve a balanced budget for one, two, or even three years, but to help bring about fiscal policies which can be sustained over the long-term in a much changed demographic climate. In that regard, there is much work remaining to be done, including but certainly not limited to, the subject of today's hearing Medicare reform.

Unfortunately, today's prosperity, welcomed as it is, has not repealed the coming age wave. Nor has it erased the projected growth in age-related entitlement programs such as Medicare, Social Security, and Medicaid. And in November 1999 the Technical Panel of the Social Security Advisory Board warned that the official projections of the Medicare and Social Security trustees might greatly understate future longevity, and hence future costs.

Thus, even if recent projections prove accurate and the federal government enjoys a period of prolonged surpluses, the fact remains that:

- Between now and 2040 the number of Americans age 65 and older will approximately double;
- The number of workers paying into Medicare and Social Security relative to the number of beneficiaries will fall by more than a third;
- The cost of Social Security and Medicare as a percentage of the economy will grow by more than 70 percent, and;
- The annual infusion of general revenues into the two programs will approach $700 billion in inflation adjusted dollars.

That is why The Concord Coalition believes we must go beyond merely achieving short-term on-budget balance. We advocate using the current economic, fiscal, demographic, and political windows of opportunity to address the long-term Medicare and Social Security deficits that will accompany the aging of the nation's population. These deficits threaten to undo the hard work and fiscal discipline of recent years and undermine our potential for future economic growth.

Balancing the federal government's books and running modest surpluses is the single most effective policy we have to increase national savings, which in turn is the key to long term economic growth. Savings provide the capital needed to increase the productivity of American workers, a concern that will become especially urgent when the retirement of the huge baby boom generation virtually halts growth in the size of the U.S. work force. With a fixed-size work force, economic growth and an improving standard of living will depend almost entirely on how much we invest in gaining additional output from each person working in our economy.

But short-term budget surpluses alone are not the long-term solution to the problems of Medicare and Social Security. Regardless of their size, projected surpluses are no substitute for the tough choices that must be made to address the fiscal imbalance largely brought about by demographic realities. Simply crediting presumed general revenue surpluses to prop up the trust funds, regardless of long-term costs, is an illusion and not a solution. The underlying problems will remain, and even if the surpluses materialize, a unique opportunity to enact needed structural reforms before a crisis hits will have been squandered. Moreover, the situation will get even worse if the expectation of a surplus is used to expand programs that are already on an unsustainable footing.

II. MEDICARE'S FISCAL SUSTAINABILITY THE UNSOLVED PROBLEM

Why is the need so urgent to address Medicare now? After all, program growth has been slower than expected after the 1997 reforms (BBA.) In fiscal year 1999, for the first time ever, Medicare spending actually declined going from $211 billion in 1998 to $209 billion last year. What's more, the Part A trust fund, which often has been on the precipice of bankruptcy in the past, now appears to be solvent for more than a decade.

The reason reform should be tackled promptly is that the current period of benign Medicare financing is a deceptive lull before the storm. Every serious policy analyst who has looked at the long-term situation has concluded that Medicare is on borrowed time for several reasons.

Three things will interact to drive up future Medicare costs to staggering levels:

- First, the cost of Medicare for each beneficiary has been climbing briskly and promises to continue doing so, at least under the current program structure.
- Second, the number of beneficiaries will begin climbing steeply when the huge baby boom generation begins signing up for benefits in 2010.
- Third, people who reach age 65 are expected to continue living increasingly longer. People aged 85 and older are the fastest growing sector of our population. This not only will increase total Medicare rolls but also will increase the ranks of Medicare beneficiaries aged 85 and older. Medicare spending averages more than twice as much for people 85 and older as it does for those age 65 and 66.

Medicare cost were deceptively low last year, so much so that no one expects the current spending slowdown to continue much longer. Part of the lower cost last year was due to a lengthening of the average processing time for Medicare claims. Eventually, the payment rate will level out, and if processing time returns to normal, there will be a surge in "catch up" payments. Second, the 1997 Medicare reform legislation has resulted in greater savings than anticipated, and payments to some Medicare providers, particularly managed care providers, skilled nursing facilities and rehabilitation therapy have been cut back more than lawmakers expected. As a result, legislation was enacted last year to "give back" some $16 billion in anticipated savings over the next tens years. Further efforts will be made this year to roll back or delay even more of these provider cutbacks. Clearly, it is unrealistic to expect major new savings in this area.

In the long run, two problems combine to create a serious potential crisis for the future of the Medicare program. One problem is the massive and permanent shift in our nation's demographics that will occur when the Boomer generation becomes eligible for Medicare. This will begin in 2011, and by 2030, all the Boomers will be 65 or older. The younger generations coming along after the boomers constitute a much smaller percentage of the total population than did the boomers.

Because birth rates have declined to barely the replacement rate, the population "pyramid" that existed when the U.S. was literally a young nation will metamorphose into a population "column" in which various age cohorts will be roughly equal in size. Therefore, the retirement of the Boomer generation signals the beginning of a rapid aging of America and will mark the permanent transition to a substantially older population:

- By 2050, the number of people who are "young-old" (age 65-85) will double and those who are "old-old" (85 and older) will triple or quadruple.
- Between 2010 and 2030, the elderly population will grow three times faster than it will in the coming decade.
- In 1997, 458,000 new beneficiaries signed up for Medicare. In 2022, HCFA estimates that a staggering 1,686,000 new beneficiaries will sign up.
- Older Americans today constitute about 12 percent of our total population. By 2030 they will be 20 percent, and later on an even larger percentage.
- The working age population (aged 18-64) will grow more slowly than ever before, until by 2010, the total workforce will be increasing by only one tenth of a percent annually, compared to two percent annual increases in the past and one percent annual increases of recent years.

When a large working age generation provides retirement support for a small retired generation, modest contributions by each worker are sufficient. But the closer the number of retirees comes to the number of workers, the greater the burden workers must carry. In the 1960's, there were about 5 workers for every retiree in the U.S. Today there are about 3, and by 2030 there will be only 2. When this happens, current program commitments to provide taxpayer-financed retirement income and health insurance benefits for the elderly Social Security and Medicare will become unsustainable. The sheer numbers of new beneficiaries will push costs up faster than the revenue sources committed to pay for the benefits and perhaps faster than what working age citizens, retirees' children and grandchildren, will be willing to finance.

In addition to this looming increase in Medicare beneficiaries, a second factor is operating to drive Medicare costs up even faster: the rapid increase in Medicare costs per beneficiary. Medicare per-capita spending increases reflect economy-wide increases in medical costs. Due to breakthroughs in medical science, ever more intensive treatments and management of acute and chronic illnesses, medical costs are growing at a faster rate than the economy. Even if future policy-makers could find a way to finance today's level of benefits for the huge number of future beneficiaries, increased costs per beneficiary make the current Medicare program unsustainable for the long run. Although growth in costs per beneficiary are no longer increasing at a double digit clip as they did in earlier decades, the Congressional Budget Office (CBO) projects Medicare spending to resume growing at 7 percent annually over the next decade. No one expects even a red-hot economy to produce anything like a long-term 7 percent rate of growth, much less higher rates.

Taken together, the increase in the elderly population and the increase in Medicare costs per beneficiary will cause Medicare expenditures to double as a percentage of the economy between now and 2040. As a percentage of non-interest federal spending, Medicare is projected to double between now and 2030.

It is highly unlikely that resources will be found in the future to support this level of health care spending on behalf of the elderly. Therefore, the Concord Coalition joins many others in advocating that actions be taken in the near term to bring promised future commitments into line with identifiable future sources of financing.

III. CRITERIA FOR MEDICARE REFORM

Before thinking about specific ways to address the Medicare problem, it is important to establish a set of criteria against which various proposals can be evaluated. The Concord Coalition believes that policy makers should be guided by the following criteria in reforming Medicare:

Quality care

Medicare insurance should cover a level of care that is commensurate with the care available to working age people.

This means modernizing the insurance package to include prescription drugs and other benefits. This does not mean that taxpayers must be expected to finance a "high option" insurance plan for all seniors. If individuals wish to purchase supplementary insurance to augment their Medicare benefits, they should be allowed to do so. However, there must be an affordable insurance plan to provide a reasonable level of medical care available to the elderly, regardless of their ability to pay.

Fiscal sustainability

A fiscally responsible program is one that can reasonably be expected to operate over the long term within the resources available to finance it. A program that depends on an open spigot perpetually gushing forth additional resources at a rate faster than economic growth is not credible. If policy makers are serious about maintaining the promised level of benefits including an escalating real cost of Medicare insurance per beneficiary then they should identify the resources to finance these benefits. On the other hand, if policy makers are unwilling to increase the flow of resources going to the elderly portion of the population beyond the half of the federal budget devoted to seniors today (excluding net interest), then they should begin to put in place a rational means of scaling back promised benefits to a level that stays in line with anticipated program revenues. Either course is responsible. Neither course is easy. But what is both easy and highly irresponsible is to continue to promise benefits that exceed not only the revenues identified to pay for those benefits, but also exceed anything future taxpayers conceivably will support.

Generational responsibility

Generational responsibility has several dimensions. The Concord Coalition believes that each generation should pay as much as possible of the cost of its own retirement package, including Medicare and Social Security and long-term care. This definition of generational responsibility is particularly important at time when an extremely large generation such as the baby boomers is retiring and the working-age generations (baby busters) are substantially smaller in numbers. It is simply unfair to expect a smaller generation to support the larger one, particularly when retirees on average are financially just as well off, if not better off.

In addition to the huge wave of boomer retirements, a second major reason why the number of elderly will soar dramatically as a percentage of total population is that people are living longer than ever before. Life expectancies for people reaching age 65 are continuing to climb and many experts believe that current projections may even understate future trends. (Intermediate projections count on it taking until 2050 for people in the U.S. to live as long on overage as people do today in Japan.)

What does generational responsibility require with respect to lengthening lifespans? That Medicare insurance be provided at age 65 regardless of whether a 65-year-old can be expected to live for another 14.6 years as in 1965, or 17.7 years today? What about providing Medicare insurance for 20.3 years, as the program is currently expected to do by 2070? The Concord Coalition believes it is reasonable to increase the age of eligibility for benefits, particularly taxpayer-financed benefits, along with increasing lifespans.

People of all ages have problems that the government could address, ranging from prenatal care, to child development and education, to job training, to old age assistance. No generation should have an automatic claim on taxpayer resources simply because of its chronological age. The key point is this: generational responsibility is a two-way street. In satisfying our responsibility to future beneficiaries we must not abandon our responsibility to future workers.

Income related cost sharing

The Concord Coalition has long been on record in favor of relating government entitlement benefits to income. We believe that entitlement programs should be viewed as universal insurance plans rather than universal annuity benefits. It is reasonable to insure everyone against the risk of not having enough cash income or access to medical insurance in old age, but given the looming age wave, it is not reasonable to award every person who crosses an arbitrary chronological age threshold a set of income and health insurance benefits regardless of income. Our demographics and future economy simply will not allow it without bankrupting everything the government does for other age groups and for the common good. Concord believes that since benefits must inevitably be scaled back, the fairest way is to protect lower-income individuals as much as possible, and ask the comfortably well off to take proportionately less from their fellow taxpayers, many of whom themselves have lower incomes.

Medicare cost sharing should never be applied by charging some people more for their treatment than others. But, reduced to its essentials, it is reasonable to think of Medicare as a government-financed medical insurance policy for the elderly and disabled. Although not every elderly person is economically secure, as a group seniors enjoy a better income and less poverty than other age groups, particularly children. Therefore, Medicare's medical insurance premiums should be geared to income levels. This makes more sense than charging variable amounts for deductibles and

copayments; not only would that be an administrative nightmare, but it would fall most heavily on the small percentage of elderly who are extremely sick in a given year.

Converting Medicare to a FEHBP style supported premium arrangement seems to be a sensible change, and Concord generally endorses this approach. However, we doubt that it will be possible indefinitely to finance the level of benefits most Americans expect and continue to charge every enrollee the same premium. If the premium were held to a level that seniors in, say, the bottom two deciles of income distribution could afford, the insurance coverage that could be provided would be inadequate and those who could afford it would augment Medicare by purchasing high-option and supplementary insurance. Alternatively, if universal premiums were permitted to rise along with rising medical costs, the government eventually would be forced to augment the premiums of those with lower incomes through Medicaid or in some other way. Either way, those who could readily afford to pay for a larger share (or even all) of their Medicare insurance would not be required to do so, and that's wrong from both a practical and equity standpoint.

Efficient provision of medical care

Whatever new system of medical insurance for the elderly is devised, it should contain incentives for both providers and patients to use resources in a cost effective manner. Treatments that have little or no promise of achieving any appreciable improvement in a patient's well being should not be financed with taxpayer dollars. Fee-for-service Medicare should be permitted to use many of the same techniques available to managed care providers to deny payment for unnecessary treatment, duplicative diagnostic procedures and other practices that waste resources.

Prompt action

Changes in Medicare should be enacted promptly, so that new systems can be implemented before the boomers retire. Entitlement programs for the elderly are long term commitments between the government and the citizenry, and people base their behavior and make their plans based on current provisions. Therefore changes in the Medicare health insurance commitment should be undertaken in time to permit gradual changes and to give people time to plan and adjust.

If an FEHBP style supported premium system is adopted, then there is a second reason why prompt reform is urgent. Setting up a premium support system will require a vast amount of work to be accomplished in behind the scenes preparation. Even if people agree with the vision of a FEHBP model (which right now they do not), it would require at least a decade to implement, and even more years before it runs smoothly and seamlessly.

Medicare changes should not be made in a vacuum

Medicare is only one of the long-term commitments citizens have made to support seniors, along with Social Security and, in the case of long-term care, Medicaid. When program reforms are considered one at a time, it is possible to ignore the ripple effect of changes in the cost or financing for other programs serving the elderly.

What matters most, fiscally and economically, is the combined total cost of theses programs. Today, Social Security, Medicare Part A and Medicare Part B claim 6.76 percent of GDP. By 2035, they will claim nearly 11.5 percent (assuming the trustees' intermediate cost projections), and by 2070, when today's newborns are lining up for benefits, they will cost over 12 percent of GDP.

Today, these two programs operate on an approximately a break-even cash basis. The Social Security cash surplus will probably be sufficient to cover the cash shortfall in Medicare Part A as well as the general revenue infusion into Medicare Part B for another couple of years. But long before the date when the program's trust funds will be technically insolvent, Medicare and Social Security will begin running huge cash deficits, which will put further upward pressure on tax rates and further downward pressure on discretionary spending. By 2035, the projected combined cash shortfall is more than half a trillion dollars annually measured in today's dollars. This short fall, under current law projections, will mount to well over a trillion dollars each and every year by 2070, again measured in today's dollars.

Any changes made in Social Security or Medicare, or the portion of Medicaid that finances medical and long-term care benefits for the elderly will have ramifications for the other programs. There is no getting around the fact that all these programs benefit essentially the same set of citizens and that working age people can be asked to bear only so much of the burden.

IV. ADDING A PRESCRIPTION DRUG BENEFIT

General observations

Even though the current Medicare program is on an unsustainable path, many beneficiaries, voters and politicians nevertheless are calling for expansions in the program particularly the addition of a prescription drug benefit.

It is easy to understand this desire. There is no question that Medicare needs to be modernized. Compared to health insurance available to most workers, Medicare offers only a Spartan, bare-bones package. Aside from its failure to reimburse for prescription drugs taken outside the hospital, it does not place a ceiling on the amount a beneficiary might have to spend out-of-pocket during a year, cover check-up and many preventive services, allow people to buy into Medicare before reaching the eligibility age, or cover long term care or assistance with the activities of daily living (eating, dressing, bathing, toileting, moving from bed to chair) needed by many elderly people in failing health.

It is likely that any major reform of Medicare will attempt to cover one or more of these health insurance shortcomings. The Concord Coalition does not oppose adding a prescription drug benefit to Medicare. But we urge policy makers not to lose sight of the fact that the current program is fiscally unsustainable.

- The Concord Coalition believes that Congress and the Administration shouldn't enact new entitlements until it is confident that America can afford the ones it already has. And if a new entitlement is enacted, it should at the very least ensure that the benefit is designed to meet the greatest need at the smallest possible cost.
- Any expansions in Medicare benefits should be financed by a reliable ongoing stream of income large enough to pay for the benefit over the long haul.
- The existence and size of projected budget surpluses, particularly over a 10-year period, is far too speculative to serve as a reliable source of financing for a major entitlement expansion. The CBO baseline is not a lottery payout. Today's projected surpluses may fade as quickly and unexpectedly as they arose. We've seen so many buoyant expectations exceeded over the past few years that nothing any longer seems risky not just in financial markets, but in fiscal policy. But spending projected budget surpluses is a bit like buying stocks on margin. We succumb to the temptation at our peril. Once a prescription drug benefit is enacted, it will not be repealed simply because the estimated budget surpluses turned out to be too optimistic.
- Given Medicare's existing unfunded obligations, and the high cost of adding a prescription drug benefit, The Concord Coalition believes that it would be best to undertake any such expansion of the program within the context of a comprehensive Medicare reform package. We are concerned that a "stand alone" prescription drug bill would simply add to the current fiscal problems of the program without forcing a discussion of the difficult restructuring issues that must eventually be confronted. "Modernizing" Medicare should not mean just spending more money.

Design concerns:

Universal coverage?

Universal coverage would be extremely costly and shouldn't be undertaken without comprehensive reforms of Medicare to make the program sustainable over the long run. Universal coverage ought not to not be first dollar coverage or capped coverage. Most non-poor beneficiaries can afford "Regular" day-to-day prescription costs and scarce dollars ought to be targeted toward people hit with catastrophic drug bills.

Prescription coverage could have a separate deductible and co-pay for most beneficiaries, with only low-income getting first-dollar coverage. Given that such a large percentage of beneficiaries incur low or no prescription costs in a given year, the deductible will prevent spending a large sum overall on providing tiny amounts of assistance to people who could reasonably be expected to purchase their own one-time antibiotic or skin cream, etc. on their own. It's the folks who have to take 3, 4, 5, or 6 prescriptions every day for the rest of their lives who are getting socked with prescription costs.

Intermediate steps?

Coverage for low-income beneficiaries and catastrophic coverage is a smaller first step that could be taken now, but even that will be quite costly. It still will be necessary to identify where the money will come from to pay for these new benefits—keeping in mind that these are the very people who will be unable to finance co-pays.

If only a relatively small number of beneficiaries incur extremely high prescription costs, wouldn't it be relatively inexpensive for Medicare to cover just these catastrophic prescription drug expenditures? Probably not. People who now have some kind of prescription coverage would use Medicare instead. Employers might stop providing this insurance for their retirees, individual beneficiaries would no longer purchase costly Medigap prescription coverage, and Medicare+Choice plans would expect to be reimbursed if coverage was more generous than they now provide.

V. GENERAL REVENUE TRANSFERS

In his February 2000 budget, President Clinton proposed transferring $334 billion of projected budget surpluses to the Hospital Insurance trust fund over the next 10 years to extend the solvency of the trust fund and provide a reserve for an unspecified catastrophic prescription drug benefit.

While increased revenues will undoubtedly be needed to fund Medicare benefits in future years, The Concord Coalition does not believes that the Administration's proposal to extend general revenues credits to the Medicare HI trust fund without also ensuring a more comprehensive reform of the program, is sound policy. Simply extending the life of the HI trust fund on paper falls far short of what it will take to ensure that the program is affordable over the long-term.

- The transfers do nothing to change the fiscal bottom line. They would be bookkeeping transactions. Technically, it is true that the books of the Hospital Insurance trust fund would show higher balances and thus would remain "solvent" longer perhaps until 2025. The underlying problem would not have been solved, however.
- The transfers would do nothing to address the rapid growth in spending for Medicare not to mention Social Security and other federal programs that altogether will cause total outlays to outstrip total anticipated revenues when the baby boomers begin retiring.
- The large budget surpluses the president is counting on transferring to Medicare and Social Security may never actually materialize. In the President's plan over ninety percent of the transfers come in the second five years of the 10-year budget window when the projections are least likely to be accurate. The transfers would give Medicare a greater claim on general revenues during those years than it already has, regardless of whether the surpluses actually materialize, regardless of whether the public debt has been paid off by then, and regardless of whether Medicare structural reform has been enacted.
- All of this could combine to take the wind out of reform efforts by giving the misleading impression to the public that Medicare had been "saved," when in fact all that would have changed would be the bookkeeping.

Part A Trust fund solvency is the wrong goal

- "Solvency" of Medicare means more than making sure the books are balanced in the Part A Hospital Insurance trust fund. Medicare also includes Part B that is rapidly growing to 45 percent of overall Medicare spending. For Medicare to be truly sound, the entire program would have to be assured of financing, not just the part that pays hospitalization costs.
- Political and media attention usually focuses on the solvency of the Part A trust fund while ignoring the huge general revenue subsidy to Part B. For example, the Balanced Budget Act of 1997 transferred a portion of home health care from Part A to Part B. This prolonged the solvency of the Part A trust fund but did nothing to improve Medicare's overall finances. Any meaningful assessment of Medicare's financial status and long-term challenge must include both Parts A and B.
- Many beneficiaries understandably are confused by the various deductibles and copayments and do not understand the distinction between Part A and Part B benefits. For example, the Part A deductible applies to each "benefit period" a beneficiary has during a year, but the Part B deductible applies to the entire year. Some home health is covered under Part A, and some falls under Part B.

Should the Part A and Part B trust funds be merged?

- Merging the two parts into a single "traditional Medicare" program would simplify Medicare and make it easier for beneficiaries to understand. It would also make it easier for beneficiaries to compare traditional Medicare to Medicare+Choice plans.
- The fiscal discipline and political symbolism of the Part A Hospital Insurance Trust Fund has served as an important check on politicians' temptation to make benefits more generous. Forecasts of impending bankruptcy of the payroll-tax-financed Medicare HI Trust Fund have repeatedly energized efforts to "keep

Medicare solvent:" by controlling Medicare Part A costs. The Part B program lacks the same alarm signal and its declining finances do not generate the same urgency since its trust fund is continually "topped up" with whatever general revenues are required to pay Part B benefits. Merging the two programs, therefore, could sacrifice some of the discipline the HI trust fund has engendered.

- To maintain fiscal discipline under a unified Medicare program, a firm limit on the level of general revenue subsidy would have to be enacted. The National Bipartisan Commission on the Future of Medicare recommended that the level be set at 40 percent. This would constitute a new definition of Medicare solvency.
- The Concord Coalition favors this new definition of Medicare solvency. It focuses on a more relevant indicator of the programs' impact on the budget and the economy—the total general revenue subsidy—rather than the easily manipulated HI trust fund solvency. No doubt a good discussion will take place over whether 40 percent or some other level is the right one, and on what should be done and when if the limit is met. But the approach taken by the Commission, and replicated in the Breaux Frist bill strikes Concord as the right one.

VI. CONCLUDING OBSERVATIONS

Reduced to fundamentals, controlling Medicare costs over the long term requires some combination of 1) reducing the number of people eligible for the program, 2) increasing how much some participants pay (either for insurance or for medical care), or 3) reducing total program costs per beneficiary.

If costs cannot be kept down, then 4) additional revenues will have to be found. Despite concerns about unsustainable costs over the long term, there is pressure to 5) expand the program to cover prescription drugs and long term care.

The Concord Coalition will oppose any policy changes that increase the cost of future promised benefits without also identifying a credible way to finance those benefits. If the political will cannot be mustered to make the extraordinarily tough decisions to reduce taxpayer-borne Medicare costs in the future, than we favor adding the additional revenues needed to put the program on a long-term fiscally sustainable basis. (Discussion of what those revenue sources might be consumption taxes, wealth taxes, higher progressive income taxes, mandatory savings accounts, and energy taxes is a lengthy topic for another day.)

Neither course will be easy. But if we as a nation want to provide our elderly citizens with a program as generous as today's Medicare, if not more generous, then we must be willing to foot the bill. And if, as a nation, we are unwilling to devote more than half our federal budget to the elderly, then we must be willing to trim back on Medicare and Social Security spending.

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Selected Projections from the Social Security and Medicare Trustee's Reports

Table One—Medicare Part A Long-Term Cash Deficit			
Year	**1999 Dollars**	**As % of GDP**	**As % of Taxable Payroll**
1999	-4 Billion	-0.04	-0.08
2035 Deficit	**1999 Dollars**	**As % of GDP**	**As % of Taxable Payroll**
1999 Report	-161 Billion	-1.07	-2.24
1998 Report	-212 Billion	-1.46	-3.13
2075 Deficit	**1999 Dollars**	**As % of GDP**	**As % of Taxable Payroll**
1999 Report	-384 Billion	-1.58	-3.59
1998 Report	-467 Billion	-2.00	-4.61

Table Two—Medicare A Long-Term Cost Estimates		
Year	**As % of GDP**	**As % of Taxable Payroll**
1999	1.56	3.10
2035 Cost Estimate	**As % of GDP**	**As % of Taxable Payroll**
1999 Report	2.62	5.52
1998 Report	2.99	6.42
2075 Cost Estimate	**As % of GDP**	**As % of Taxable Payroll**
1999 Report	3.09	6.99
1998 Report	3.48	8.03

Table Three—Medicare B Long-Term Cost Estimates		
Year	**Total Cost as % of GDP**	**Subsidy as % of GDP**
1999	0.98	0.75
2035 Cost Estimate	**Total Cost as % of GDP**	**Subsidy as % of GDP**
1999 Report	2.53	1.91
1998 Report	3.19	2.39
2070 Cost Estimate	**Total Cost As % of GDP**	**Subsidy as % of GDP**
1999 Report	2.65	2.00
1998 Report	3.31	2.48

Table Four—Total Costr		
1999	**As % of GDP**	**As % of Taxable Payroll**
Social Security	4.45	10.80
Medicare Part A	1.56	3.10
Medicare Part B	.75	n.a.
Total	**6.76**	**13.90**
2035 Cost Estimate	**As % of GDP**	**As % of Taxable Payroll**
Social Security	6.96	18.19
Medicare Part A	2.62	5.52
Medicare Part B	1.90	n.a.
Total	**11.48**	**23.71**
2070 Cost Estimate	**As % of GDP**	**As % of Taxable Payroll**
Social Security	7.02	19.63
Medicare Part A	3.02	6.78
Medicare Part B	1.99	n.a.
Total	**12.03**	**26.41**

Table Five—Long-Term Cash Deficits and Part B Subsidy (billions in constant dollars)					
1999 Estimate		**2035 Estimate**		**2070 Estimate**	
Social Security	+70	Social Security	-292	Social Security	-517
Medicare Part A	-4	Medicare Part A	-161	Medicare Part A	-346
Medicare Part B	-64	Medicare Part B	-214	Medicare Part B	-455
Total	+2	**Total**	**-667**	**Total**	**-1.32 Trillion**

UNITED STATES SENATE

COMMITTEE ON FINANCE

Hearing on Medicare Reform: Issues and Options

THE CONCORD COALITION

Testimony by:

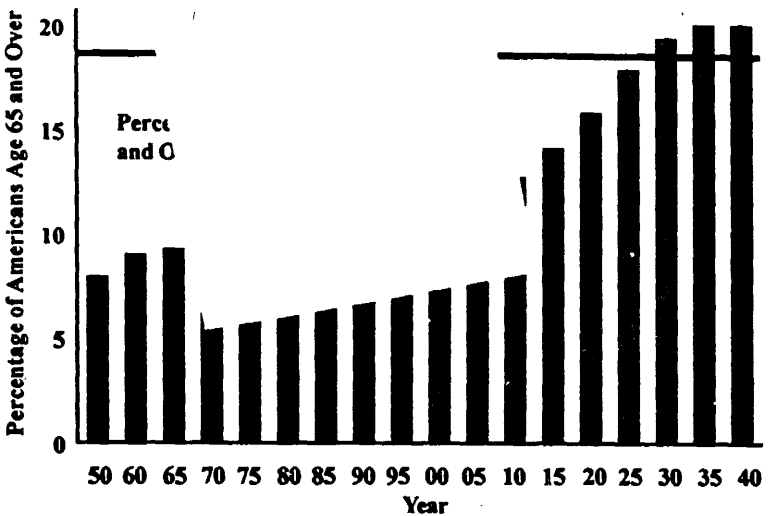
Robert L. Bixby
Executive Director

Thursday, February 24, 2000 at 10:00 a.m.

215 Dirksen Senate Office Building

The Concord Coalition, 1819 H Street, N.W. Suite 800 Washington D.C. 20006
202 467-6222 ◆ (Fax) 202 467-6333 ◆ www.concordcoalition.org

America is Projected to Become a Nation of Floridas



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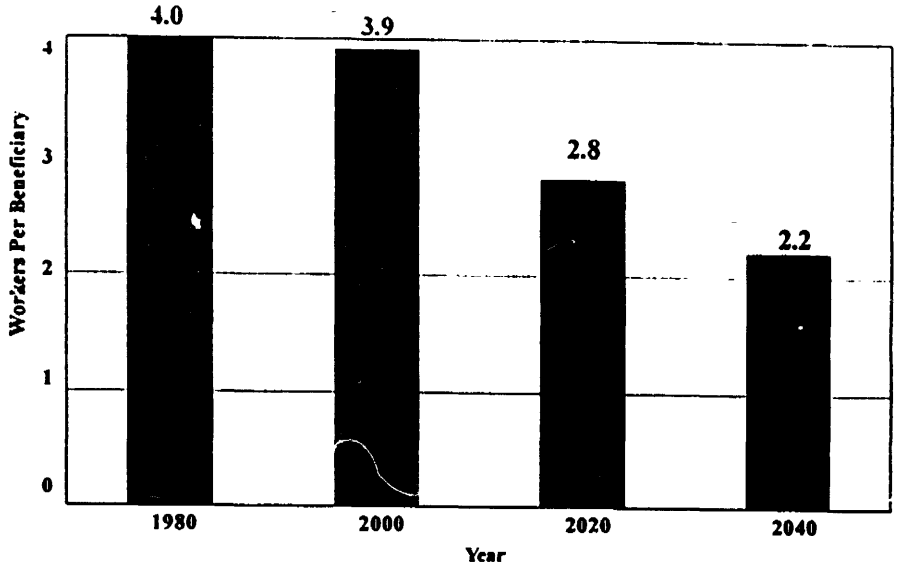
Number of Workers to Medicare Beneficiary, 1980-2040



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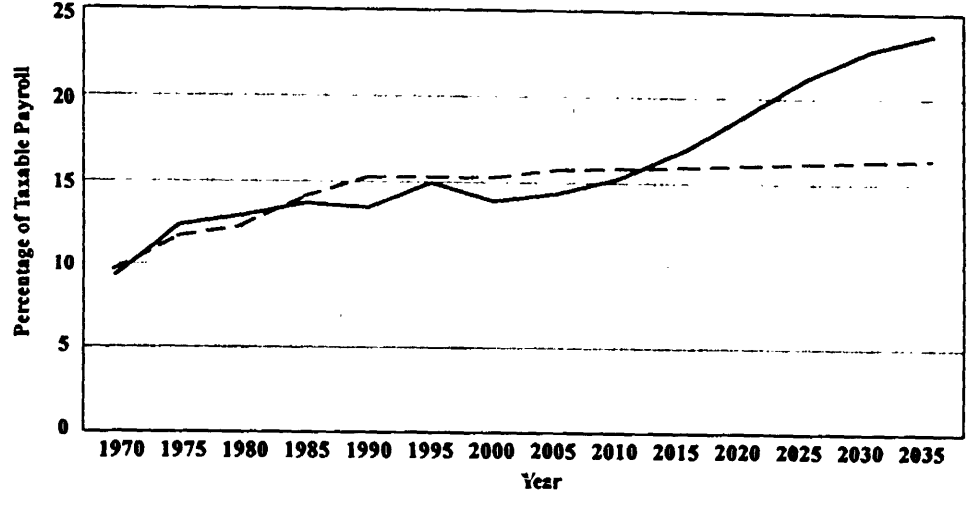
Comparison of Estimated Combined OASDI and HI Taxable Payroll Rates and Cost Rates, 1970-2035



Social Security's Surpluses: Dwarfed by Projected Future Deficits

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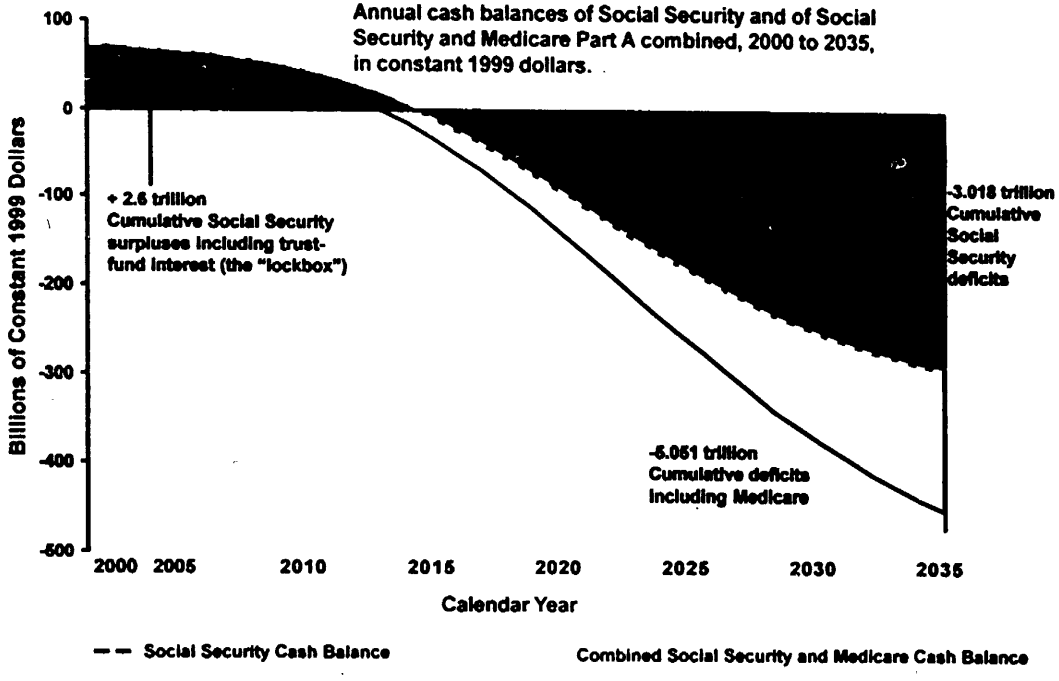

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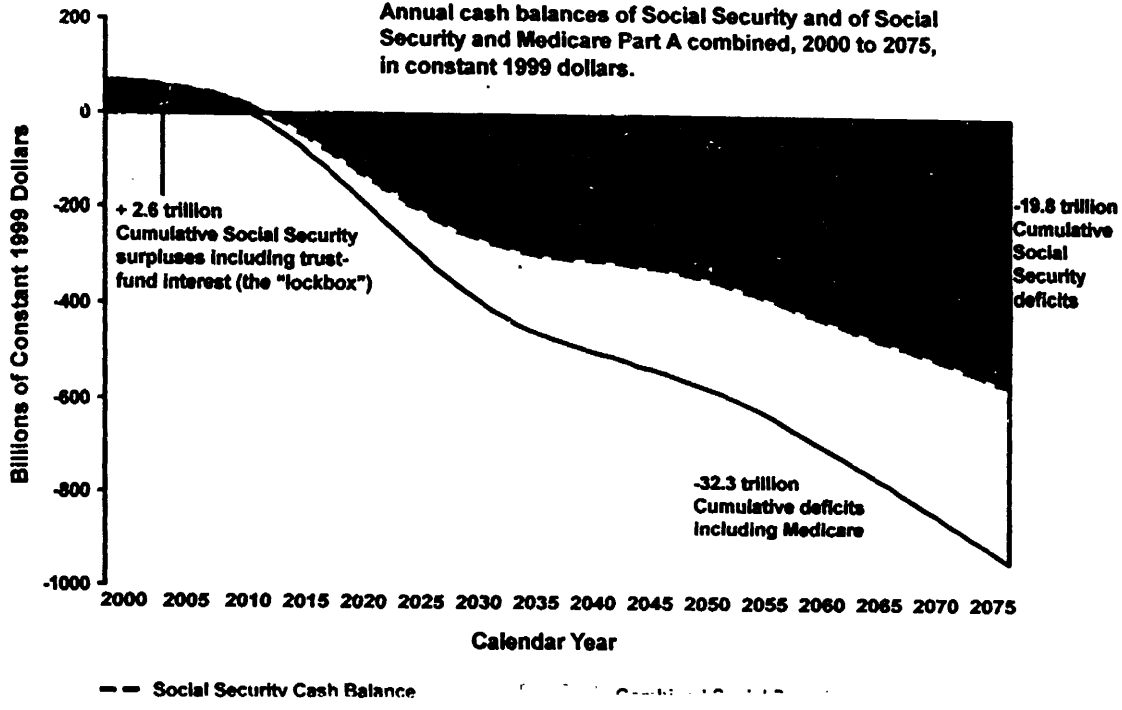
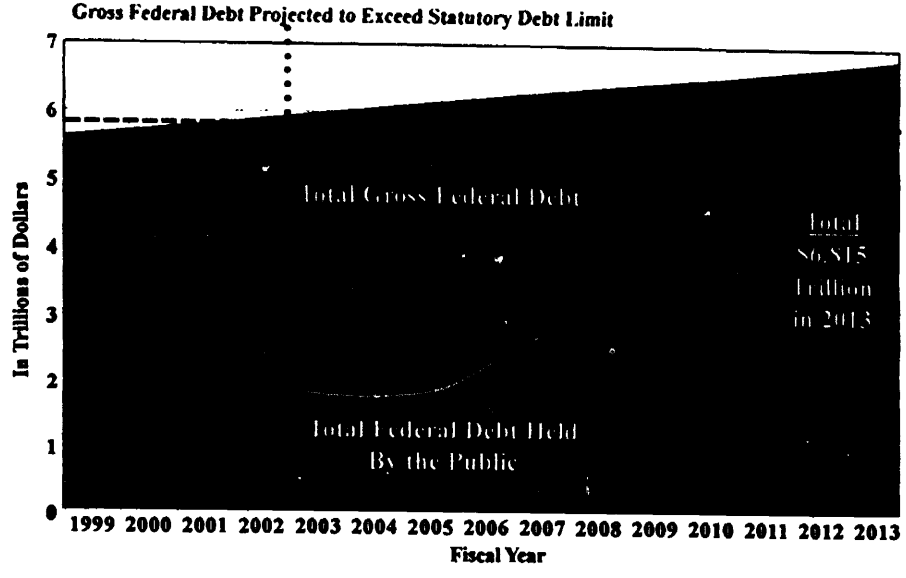
Social Security's Surpluses: Dwarfed by Projected Future Deficits



Total Gross Federal Debt and Debt Held by the Public, 1999-2013



Source: Office of Management and Budget, United States Budget for Fiscal Year 2001

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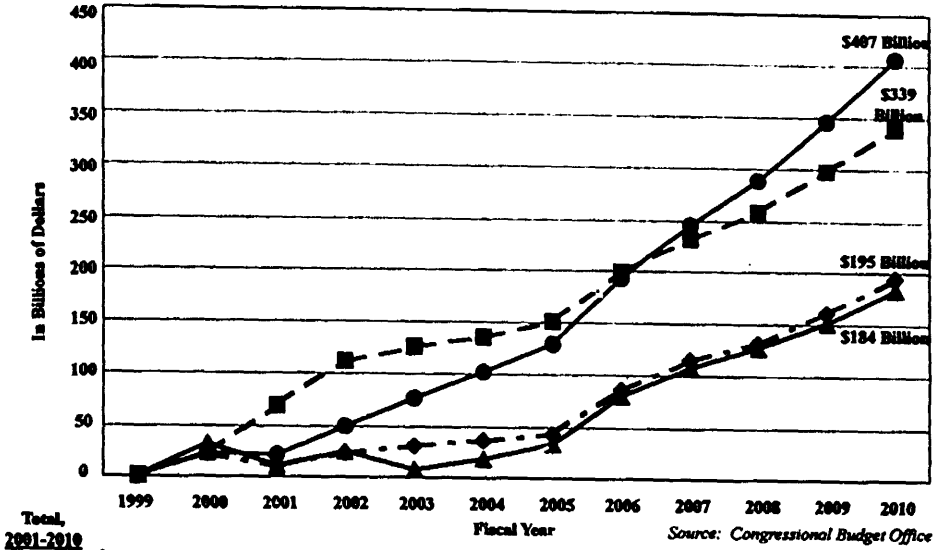
The "On-Budget" Surplus
CBO and OMB Baselines Under Alternative Policy Assumptions

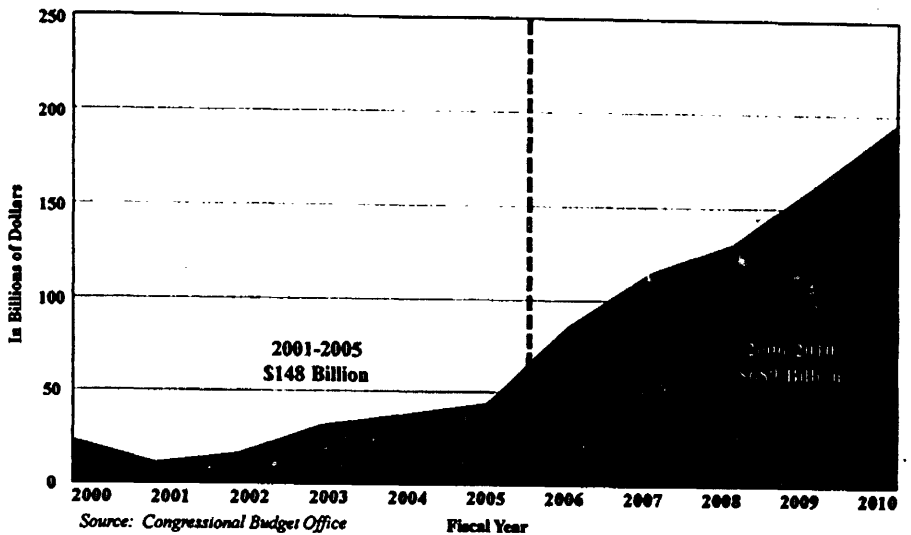


Source: Congressional Budget Office

Total, 2001-2010	
$838 Billion	Discretionary Spending Grows at the Rate of Inflation After 2000
$1,858 Billion	Discretionary Spending is Frozen at the Level Enacted for 2000
$1,918 Billion	Discretionary Spending Equals CBO's Estimates of the Caps Through 2002 and Grows at the Rate of Inflation Thereafter
$746 Billion	Office of Management and Budget, President's Budget FY 2001

The Concord [redacted]

The "On-Budget" Surplus 2001-2010
Assuming that Discretionary Spending Grows at the Rate of Inflation After 2000



Source: Congressional Budget Office

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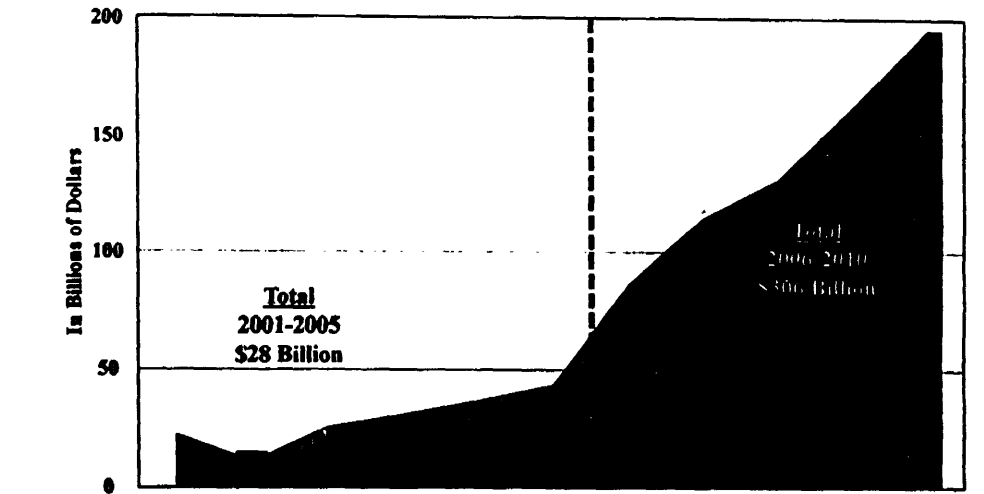
Timing of President's Medicare Solvency Transfers and Catastrophic Reserves, 2001-2010



Sources: Congressional Budget Office and Office of Management and Budget

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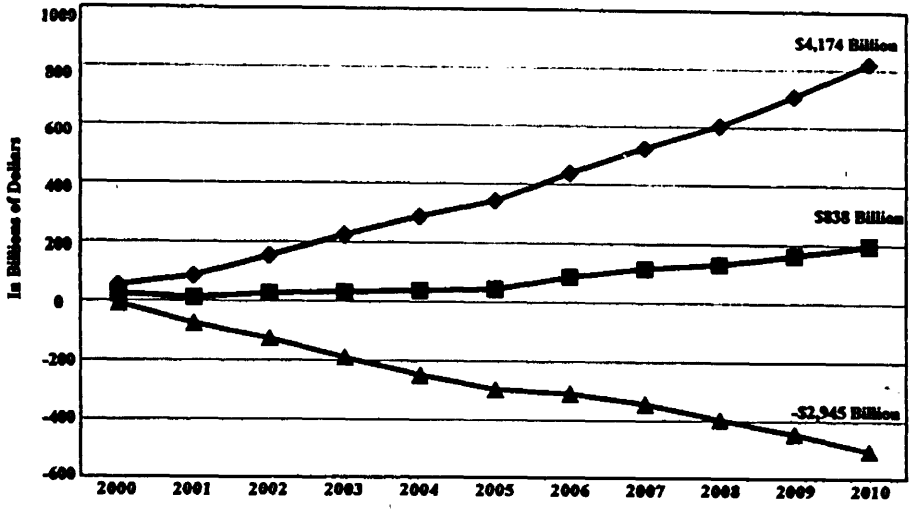
Uncertainty in "On-Budget" Surplus Projections, 2001-2010 Under Alternative Scenarios Assuming that Discretionary Spending Grows at the Rate of Inflation After 2000



Source: Congressional Budget Office

Totals, 2001-2010

$4,174 Billion	Optimistic Scenario under the Assumption that Discretionary Spending Grows at the Rate of Inflation After 2000.
$838 Billion	CBO Baseline under the Assumption that Discretionary Spending Grows at the Rate of Inflation After 2000.
-$2,945 Billion	Pessimistic Scenario under the Assumption that Discretionary Spending Grows at the Rate of Inflation After 2000.

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PREPARED STATEMENT OF BEATRICE BRAUN, M.D.

Mr. Chairman and members of the Committee, I am Beatrice Braun, a member of AARP's Board of Directors. AARP thanks you for convening this hearing, and for beginning to examine some of the current proposals for reforming Medicare. We have focused our testimony on what we believe are some of the central issues involved in reforming the Medicare program, and in particular, on the need for Medicare prescription drug coverage.

For over thirty years Medicare has provided older and disabled beneficiaries with dependable, affordable, quality health insurance. I live in Florida, which has one of the largest beneficiary populations in the nation. As a retired physician, I have seen first hand how Medicare has made a difference in the lives of older Americans. Medicare has been instrumental in improving the health and life expectancy of beneficiaries in Florida and across the nation. It has also helped to reduce the number of older persons living in poverty.

Medicare's promise of affordable health care extends beyond the current generation of retirees. Now, more than ever, Americans of all ages are looking to Medicare's guaranteed protections as part of the foundation of their retirement planning. AARP believes that in order for Medicare to remain strong and viable for today's beneficiaries, and for those who will depend on it in the future, we must confront the key challenges facing the program.

Foremost among these challenges is ensuring that Medicare's benefits and its means of delivering care remain dependable even as they are updated to keep pace with the rapid advances in health care. The practice of medicine has changed dramatically since the Medicare program was created. We are now living in a time of amazing breakthroughs in medical technology. Among the most striking are the advances in the area of prescription drugs. Drug therapies that were not available when Medicare began are now commonly used to prevent and treat virtually every major illness. In many cases, new drugs substitute for or allow patients to avoid more expensive therapies such as hospitalization and surgery. In other cases, drugs facilitate treatment or provide treatment where none existed before, improving the quality and length of life of the patient. As a result, prudent reliance on prescription drugs now goes to the very core of good medical practice.

Older Americans typically need more medications than younger people. Ironically, most employer plans include and rely on prescription drug coverage as an essential tool for medical management, but Medicare still does not. Prescription drug coverage must be part of an improved Medicare program. Simply stated, prescription drug coverage is smart medicine.

The second challenge facing Medicare is our nation's changing demographics. The retirement of the baby boom generation will nearly double the number of Medicare beneficiaries in the program. Medicare's financing and delivery systems must be capable of serving this enormous influx of beneficiaries whose health care circumstances, needs, and expectations will be similar in some respects to those of today's beneficiaries, but very different in others. Just as important, longer life spans are already causing rapid growth in the very old population. Medicare must be prepared to handle the unique health care needs of a growing number of older Americans who reach 85, or even 100.

To meet the first two challenges, the program's long-term financial solvency must be secure. AARP supported the Balanced Budget Act of 1997 as a first step towards securing Medicare's long-term solvency. The strong economy we now enjoy and the Medicare Trustees' projection of solvency to the year 2015 are good news. But, this does not mean we can afford to become complacent or that we can delay the debate over how best to strengthen Medicare.

The deliberation over Medicare's future must be ongoing. It will take a sustained effort to continually update and improve Medicare. Changing a program that millions of Americans depend on everyday for their health care is no small task. There must be a careful and thorough examination of issues—including how the issues interact and the impact on the full range of beneficiaries—and a deliberate effort to make sure that policy makers and the public alike understand the trade-offs that will be necessary.

The President's Medicare reform proposal, the competitive premium proposal introduced by Senators Breaux and Frist, and other emerging legislative proposals provide opportunities for examining different reform options and for furthering debate. Genuine debate over the issues and options surrounding Medicare is critical to building public understanding and support for reform. AARP believes that it would be a serious mistake for anyone to hinder this debate. By the same token, it would be an error for Congress to rush to judgment on any reform option.

TESTING REFORMS

As promising reform options emerge, it is only reasonable to test those ideas so we more fully understand the impact on Medicare beneficiaries and the program in general. We must be sure that reform proposals actually work, and that there is minimal disruption for beneficiaries and Medicare. Whenever possible, changes to Medicare should be tested and evaluated on a smaller scale before being made program-wide. Piloting reform ideas can help to identify potential problems and provide essential opportunity for making necessary refinements.

Further, it is important that changes be given time to be assimilated into the program, and their impact be assessed, before new modifications are layered on top. Every change to Medicare brings unintended consequences. Only two years after enactment of the sweeping changes made by the Balanced Budget Act (BBA) of 1997—many of which were still being implemented—Congress significantly modified these provisions with passage of the Balanced Budget Act Revisions of 1999. Imposing changes on top of changes can create administrative complexities as well as confusion and disruption for Medicare's nearly 40 million beneficiaries.

Policy makers and the public must understand proposed changes and their anticipated effect, first and foremost on beneficiaries, as well as on providers and the Medicare program in general. As we all learned from the legislative debates over the recent BBA revisions, earlier experiences with the Catastrophic Coverage Act in the late 1980s, and the health care reform debate of the early 1990s, unless the American public understands the trade-offs they are being asked to make, initial support can erode quickly.

KEY PRINCIPLES THAT SHOULD GUIDE BROADER MEDICARE REFORM

As this Committee examines the issues involved in reforming Medicare, AARP urges you to consider the fundamental principles that, since Medicare's inception, have helped to shape it into such a successful program. These principles are, in a sense, a plan for Medicare reform and therefore should be the basis of any viable reform option.

Defined Benefits—Providing the Coverage Beneficiaries Need

All Medicare beneficiaries are now guaranteed a defined set of health care benefits upon which they depend. A specified benefit package that is set in statute is important for a number of reasons. First, it assures that Medicare remains a dependable source of health coverage over time. Second, a defined benefit package serves as an important benchmark upon which the adequacy of the government's contribution toward the cost of care can be measured. Without this kind of benchmark, the government's contribution could diminish over time, thereby eroding Medicare's protection. Third, a benefit package set in statute reduces the potential for adverse selection by providing an appropriate basis for competition among the health plans participating in Medicare. And finally, a defined benefit package provides an element of certainty around which individuals, employers, and state Medicaid programs may plan.

Because prescription drugs are central to the delivery of high quality health care, Medicare should be like most other health insurance plans and include prescription drugs as part of Medicare's defined benefit package offered by all participating plans—including traditional fee-for-service.

Adequate Government Contribution Toward the Cost of the Benefit Package

It is essential that the government's contribution or payment for the Medicare benefit package keep pace over time with the cost of the benefits. Currently, payment for traditional Medicare is roughly tied to the cost of the benefit package. If the government's contribution were tied to an artificial budget target and not connected to the actual cost of the benefit package, there would be a serious risk of both the benefits and government payment diminishing over time. The effect of a flat government payment—regardless of the plan cost—could be sharp year-to-year premium and cost-sharing increases for beneficiaries. It could also mean significant differences in what beneficiaries would have to pay for different Medicare plans.

Out-of-Pocket Protection

Changes in Medicare financing and benefits should protect all beneficiaries from burdensome out-of-pocket costs. Medicare beneficiaries age 65 and over spent, on average, about $2,430—nearly 20 percent of their income—out-of-pocket for health care expenses in 1999, excluding the costs of home care and long-term nursing care. In addition to items and services not covered by Medicare, beneficiaries have significant Medicare cost-sharing obligations: a $100 annual Part B deductible, a $776 Part A hospital deductible, 20 percent coinsurance for most Part B services, a sub-

stantially higher coinsurance for hospital outpatient services and mental health care, and significant coinsurance for skilled nursing facility care and very long hospital stays.

AARP believes that Medicare beneficiaries should continue to pay their fair share of the cost of Medicare. However, if cost-sharing were too high or too varied across plans, Medicare's protection would not be affordable, and many beneficiaries would be left with coverage options they might consider inadequate or unsatisfactory.

Viable Fee-for-Service

Medicare beneficiaries must continue to have access to a strong and viable fee-for-service option. Managed care is not yet established as a fully satisfactory choice for many beneficiaries. In addition, many beneficiaries live in areas of the country where managed care plans are not available. Without a modern, affordable fee-for-service option, these beneficiaries could end up paying the same amount or more out-of-pocket for health care coverage that does not meet their needs.

Protecting the Availability and Affordability of Medicare Coverage

Medicare should continue to be available to all older and disabled Americans regardless of their health status or income. Our nation's commitment to a system in which Americans contribute to the program through payroll taxes during their working years and then are entitled to receive the benefits they have earned is the linchpin of public support for Medicare. Denying Medicare coverage to individuals based on income threatens this principle. Similarly, raising the age of Medicare eligibility would have the likely affect of leaving more Americans uninsured. Thus, in the absence of changes that would protect access to affordable coverage, AARP would oppose efforts to raise the eligibility age for Medicare. Analogies to Social Security's increasing age of eligibility simply do not apply. Social Security's early retirement benefits—though actuarially reduced—start at age 62, and most retirees today begin to collect benefits at age 62, not at age 65.

Administration of Medicare

Effective administration of Medicare is essential. The agency or organization that oversees the program must be accountable to Congress and beneficiaries for assuring access, affordability, adequacy of coverage, quality of care, and choice.

The entity—whether a new or existing federal agency, or a quasi-independent entity within an existing agency—must be structured in such a way as to ensure a seamless administration of both traditional fee-for-service and private options. It must have the tools and the flexibility it needs to improve the program—such as the ability to modernize fee-for-service so that it remains a viable option for beneficiaries. It must ensure that a level playing field exists across all options; provide beneficiaries with the vital information they need about the program; ensure that all health plans meet rigorous standards; monitor the quality of care beneficiaries receive; and continue to attack waste, fraud and abuse in the program.

Financing

Medicare must have a stable source of financing that keeps pace with enrollment and the costs of the program. Ultimately, additional financing sources will need to be both broadly based and progressive. Additionally, because health care costs are rising faster than productivity, AARP supports using an appropriate portion of the on-budget surplus to secure Medicare's financial health.

THE NEED FOR A MEDICARE PRESCRIPTION DRUG BENEFIT

As part of your deliberations on reforming Medicare, AARP urges the Committee to look closely at the need for prescription drug coverage.

Eighty percent of retirees use a prescription drug every day. While older Americans comprise only 12 percent of the U.S. population, they account for one-third of prescription drug spending. In fact, after premium payments, prescription drugs account for the single largest component of health care out-of-pocket spending for non-institutionalized Medicare beneficiaries age 65 and older. On average, beneficiaries spend as much out-of-pocket for prescription drugs (17 percent of total out-of-pocket health care spending) as for physician care, vision services, and medical supplies combined. By contrast, inpatient and outpatient hospital care each accounts for about three percent of older beneficiaries' total out-of-pocket health spending.

High use, high drug prices, and inadequate insurance coverage pose serious problems for today's Medicare beneficiaries. A chronic health problem necessitating some of the newest, most expensive prescription drugs can deplete a retiree's financial resources. Some beneficiaries are forced to choose between food and their medications. Others do not refill their prescriptions or take the proper dosage in order to make

their prescriptions last longer. A new international health care survey of the elderly by the Commonwealth Fund reports seven percent of Americans age 65 and over did not even fill a prescription due to cost.

Because of Medicare's current lack of prescription drug coverage, many beneficiaries must pay for all or some of their prescription drugs out-of-pocket. Although 65 percent of Medicare beneficiaries have some type of coverage for prescription drugs, this figure can be very misleading. The principal sources of coverage that offer a prescription drug benefit—employer-based retiree coverage, private supplemental coverage, or Medicare HMOs—are often inadequate, limited, expensive, and unstable. Moreover, a new study by the Commonwealth Fund reports that many Medicare beneficiaries do not have continuous prescription drug coverage. In 1996, just 53 percent of beneficiaries had prescription drug coverage throughout the year. It is also important to understand that those Medicare beneficiaries without coverage pay top dollar for their prescriptions because they do not benefit from discounts negotiated by third party payers as do most younger persons. Together, these facts indicate that the majority of Medicare beneficiaries—not just those with low incomes—need drug coverage. Why?

First, Medicare beneficiaries' current prescription drug coverage does not protect them from high out-of-pocket expenses. AARP estimates that 25 percent of Medicare beneficiaries spent over $500 out-of-pocket on prescription drugs in 1999, and over half of these beneficiaries had some type of coverage. Forty-two percent of beneficiaries who spent $1,000 or more on their prescription drugs (excluding insurance premiums) had some type of drug coverage. For example, some beneficiaries buy Medigap policies that provide a drug benefit. Two of the three Medigap policies that cover prescription drugs have an annual cap of $1,250 on drug coverage; the third policy has a $3,000 cap. All three Medigap policies that have a prescription drug benefit require the beneficiary to pay 50 percent coinsurance. Notably, while Medigap prescription drug coverage is quite limited, the premiums on these policies exceed $1,000 a year. Other beneficiaries choose to enroll in Medicare HMOs that offer some prescription drug coverage. Yet, this year 32 percent of Medicare HMOs offering drug coverage have a $500 cap that applies to brand or brand and generic drugs, and average copays in these plans have increased dramatically from last year—an estimated 21 percent for brands and 8 percent for generics.

Second, current prescription drug coverage available to Medicare beneficiaries is limited. Private Medigap policies may be the only option for obtaining drug coverage for beneficiaries who do not have access to employer coverage or Medicare+Choice plans. Yet, because almost all Medigap policies with drug coverage exclude beneficiaries based on pre-existing conditions once they have passed the first six months of their Medicare eligibility, and because all three of the Medigap policies that include prescription drug coverage are not offered everywhere, many Medicare beneficiaries desiring such coverage cannot obtain it. Additionally, although Medicare HMOs are prohibited by law from underwriting the coverage they offer, such plans are not available in all parts of the country.

Third, current drug coverage options are not stable. For example, beneficiaries who obtain prescription drug coverage from their former employer are finding that coverage to be unstable. Retiree health benefits that include prescription drug coverage are becoming more scarce. While an estimated 60 to 70 percent of large employers offered retiree health coverage during the 1980s, fewer than 40 percent do so today. Of those employers who offer retiree benefits, 28 percent do not offer drug coverage to Medicare eligible retirees.

Further, beneficiaries who have drug coverage through Medicare HMOs cannot depend on having this coverage from year to year, as plans can change benefits on an annual basis or even terminate participation in Medicare. For example, this year many beneficiaries in Medicare+Choice plans are living through abrupt changes in their prescription drug coverage that they did not foresee when they enrolled. Some of the most visible of these changes include:

- Increasing premiums—Over the past few years, more and more Medicare+Choice plans are charging premiums for their coverage, and those premiums are climbing. This year 207,000 beneficiaries must pay over $80 per month to enroll in a Medicare HMO. This compares to 1999 when only 50,000 Medicare beneficiaries enrolled in Medicare HMOs had a minimum premium above $80 per month.
- Higher cost-sharing—For the first time this year, all Medicare HMOs that offer prescription drugs are charging copays for prescription drugs, and the average beneficiary copay has increased significantly.
- Decreasing benefit—The annual cap on the typical Medicare+Choice drug benefit has decreased. While in 1999 only 21 percent of Medicare HMOs had an

annual cap of $500 or less on their drug benefit, this year 32 percent of plans will have a $500 cap.

- Loss of benefit—This year some Medicare+Choice plans dropped their prescription drug benefit entirely. Although Medicare+Choice has provided beneficiaries with an opportunity for drug coverage, the volatility of the Medicare+Choice market has made that coverage unpredictable and unstable from year to year.

ISSUES SURROUNDING ADDING PRESCRIPTION DRUGS TO MEDICARE

AARP is committed to the creation of a voluntary, affordable Medicare prescription drug benefit that would be available to all beneficiaries, so that they may benefit from longer, healthier lives, fewer invasive medical procedures, and reduced health care costs. We appreciate the Committee's interest in this issue and look forward to working with the Congress and the Administration to assure that a prescription drug benefit that is available and affordable to all Medicare beneficiaries becomes part of Medicare's defined benefit package. To that end, we have identified principles that we believe are fundamental to the design of a Medicare prescription drug benefit:

- A Medicare prescription drug benefit must be available to all Medicare beneficiaries. First, the benefit should be voluntary so that beneficiaries are able to keep the coverage that they currently have, if they choose to do so. A Medicare prescription drug benefit should not be an incentive for employers to drop or cut back on retiree health coverage. Second, the benefit needs to be affordable to assure enough participation and thereby avoid the dangers of risk selection. To this end, the government contribution will need to be sufficient to yield a beneficiary premium that is affordable and a benefit design that is attractive to beneficiaries. In other words, this is not simply a matter of beneficiary affordability; equally important is the fiscal viability of the risk pool. Medicare Part B is a model in this regard. The Part B benefit is voluntary on its face, but Medicare's contribution toward the cost of the benefit elicits virtually universal participation.
- Prescription drugs should be part of a defined benefit package. It is critical that beneficiaries understand what is included in their benefit and that they have dependable and stable prescription drug coverage. In addition, defining the drug benefit would reduce the opportunity for risk selection.
- The benefit must assure that beneficiaries have access to medically appropriate and needed drug therapies.
- The benefit must include quality improvement components to reduce medical errors and mismedication and to help reduce overall health care costs.
- The benefit must include meaningful cost-containment mechanisms for both beneficiaries and Medicare. This should include drug-purchasing strategies that enable Medicare beneficiaries and the program to take advantage of the aggregate purchasing power of large numbers of beneficiaries.
- The benefit must provide additional subsidies for low-income beneficiaries to protect them from unaffordable costs and assure that they have access to the benefit.
- The benefit must be financed in a fiscally responsible manner that is both adequate and stable. AARP believes that an appropriate amount of the Federal budget surplus should be used to help finance a prescription drug benefit.
- A new prescription drug benefit should be part of a strong and more effective Medicare program. Prescription drug coverage must be integrated into the program in a manner that strengthens Medicare by improving the program's ability to support modern disease management and prevention strategies. Many of these strategies hold promise to both improve health outcomes and lower program costs.

MEDICARE REFORM PROPOSALS

We have not attempted in this testimony to undertake an exhaustive review of the issues raised by the President's Medicare reform proposal or the Breaux-Frist plan. That essential step will require many more hearings, close review by a range of experts, and careful assessment of the impact of the proposed changes on Medicare beneficiaries, plans and providers, and the overall program. We have identified here a number of questions about both proposals that we believe need to be answered as part of this Committee's—and the Congress'—deliberations. AARP has not taken a position on any of the Medicare reform proposals before Congress. As plans continue to be refined, we have reserved judgment until further questions can be answered.

The President's Proposal

AARP is pleased that the President's Medicare reform proposal seeks to shore up the long-term solvency of the Medicare HI Trust Fund, includes a defined set of benefits in both fee-for-service and managed care, and creates a prescription drug benefit that would be available to all Medicare beneficiaries. Since there is not yet specific legislative language and details of the plan are still forthcoming, some of the critical questions that still need to be answered include:

- Would the competitive defined benefit program be affordable for beneficiaries regardless of the area of the country in which they live?
- Since dependable risk adjustment is still in development—and probably will be for some time—how would risk adjusters be calculated? How would appropriate payment to plans be calculated prior to the development of fully functional risk adjusters?
- How would the geographic adjustment be applied to high cost and low cost areas?
- Would the prescription drug coverage be affordable to beneficiaries?
- Given the level of copays and premiums, is the proposed prescription drug benefit sufficient to meet the needs of most beneficiaries? Is it sufficient to attract enough beneficiaries to ensure a viable risk pool?
- How would the President's new additional benefit to protect those beneficiaries with extremely high drug costs work? At what level would coverage begin? Would the threshold be indexed?
- The proposal indicates that private plans would be able to vary the beneficiary cost-sharing requirements. To what extent could a plan vary cost-sharing? How would the variations interact with the proposed indexing of the Part B deductible? Would the new cost-sharing pose barriers to beneficiary access to care?
- How would beneficiaries be protected from disruptions in coverage, significant premium increases, and benefit changes that might result from transitioning to a competitive defined benefit program?
- Would there be adequate safeguards to ensure that employers retain retiree health benefits?
- How, and to what extent, would the transfer of the dedicated surplus extend Medicare's long-term solvency?

The Breaux-Frist Proposal

AARP commends Senators John Breaux and Bill Frist for their efforts to ensure that Medicare reform remains a priority. While critical questions remain, S.1895 includes several improvements over earlier versions of the proposal, including a modest (at least 25 percent) subsidy for all beneficiaries who choose to take the high option plan with prescription drugs. Among the fundamental questions that must be answered about this proposal are:

- How, and to what extent, would S.1895 improve Medicare's long term solvency?
- Medicare beneficiaries who elect to stay in the HCFA-sponsored program would be guaranteed a defined benefit that includes Medicare's current benefits and cost-sharing. However, beneficiaries who choose other plans could experience "reasonable variation in cost-sharing." What constitutes "reasonable variation" and how would this affect beneficiaries? Would this difference between the HCFA-sponsored plan and other plans put the traditional Medicare fee-for-service program and its beneficiaries at risk?
- To what extent will the government contribution assure adequate choice for beneficiaries over time, without regard to where they live?
- Is a 25 percent premium subsidy enough to make the benefit affordable for most beneficiaries and to assure a viable risk pool?
- Because the drug benefit would be pegged to actuarial cost and not to a particular benefit design (e.g., deductible, cost sharing, stop-loss protection, etc.), it appears that the drug benefit could be designed in different ways by different high option plans. How, then, would insurers be prevented from "cherry picking" beneficiaries through the design of their drug benefit?
- How would the proposal protect beneficiaries who live in high cost areas where all high option plans have premiums above the national weighted average?
- Because the high-option stop-loss protection does not extend to the prescription drug benefit, how would beneficiaries who have very high drug costs be protected?
- Given that dependable risk adjustment is still in development—and probably will be for some time—how would risk and geographic adjusters be calculated? How would appropriate payment to plans be calculated prior to the development of fully functional risk adjusters?

- To whom would the new Medicare Board be accountable? How much discretion would the Board have in making changes in program policy to respond to changing market conditions?
- What is the rationale for establishing a new "solvency standard?" S.1895 would cap Medicare general revenue at 40 percent of Medicare spending. What would be the impact of this general revenue spending cap on payments to providers and plans? On beneficiaries' premiums, cost-sharing, and/or benefits? How would this be determined? What would be the impact of this cap on Medicare's entitlement?
- As a practical matter, how would premiums that vary by plan and area be deducted from individual Social Security checks? Would this be administratively feasible?

CONCLUSION

The Medicare program needs to be ready to meet the unique challenges it faces now and in the future. Foremost among the challenges is ensuring that, even as the program adjusts to ensure its future financial soundness, it must also adjust to keep pace with the rapid advances in medicine. Therefore, AARP believes that an affordable Medicare prescription drug benefit that is part of Medicare's defined benefit package and available to all Medicare beneficiaries is essential to any Medicare reforms.

Successfully guaranteeing Medicare's long-term strength and stability depends on a good understanding—on the part of the public and policy makers—of the changes that are being contemplated. This will require not only extensive debate, but also a thorough distributional analysis of how proposed changes would affect the full range of current and future beneficiaries.

If legislation is pushed through too quickly, before there has been a thorough examination of the effect on beneficiaries and the program, and before there is an emerging "public judgment" about the changes, this would be a very serious mistake. In such a circumstance, we would be compelled to alert our members to the dangers in such legislation and why we could not support it.

AARP looks forward to continuing to work with members of this Committee and the Congress to advance the debate over Medicare reform and prescription drug coverage, and to carefully explore the best options for securing Medicare's future.

PREPARED STATEMENT OF HON. BILL FRIST, M.D.

Mr. Chairman and Members of the Committee:

I am pleased the Committee has gathered today to discuss an issue critically important to our nation's seniors and individuals with disabilities—Medicare reform. As you are aware, last November, Senator Breaux and I introduced legislation, S. 1895, along with Senators Kerrey and Hagel, to strengthen and improve the Medicare program and include an outpatient prescription drug benefit. The goal of this legislation is to create a foundation—a first step—from which to engage in further discussions on reforming our Medicare program.

Many of you may recall the year long effort of the National Bipartisan Commission on the Future of Medicare, of which I was a member, which was charged with analyzing the long-term financial condition of Medicare and making recommendations to strengthen the program. Although the Commission's proposal received a majority of votes—10 of the 17 members—that was not enough to make a formal recommendation to Congress. S. 1895, however, embodies many of the same principles developed in the Medicare Commission's proposal.

I. WHY DO WE NEED TO REFORM MEDICARE?

There are two key goals of the Breaux-Frist legislation, (1) to guarantee health care security with improved benefits and greater choice for beneficiaries and (2) to protect and strengthen the long-term financial viability of the program. To address the importance of protecting and strengthening Medicare to achieve health care security for our seniors and individuals with disabilities, it is critical to understand the current spending, budgetary and demographic issues that the Medicare program faces today.

1. Insolvency: In its current form, Medicare is scheduled to become insolvent in 2015.

2. Spending: Medicare's spending, left unchecked, will continue to consume an increasing share of the federal budget, reaching 25% by 2030. Even with recent reductions in Medicare spending, the Congressional Budget Office predicts

Medicare spending will continue to grow by an average of 6.9% over the next 10 years, a doubling in spending overall from $208 billion today to over $400 billion in 2010.

3. General Revenues: Today, 36% of total Medicare expenditures are paid by general revenues and if nothing is changed that number will continue to increase substantially, leaving fewer and fewer federal dollars available to support programs such as education and biomedical research, which rely solely on these general revenues for funding.

4. Workers vs. Retirees: Each year there are fewer workers paying payroll taxes to fund current Medicare obligations, evidenced by a decrease in the number of workers per retiree from 4.5 in 1960 to 3.9 today. This number will decline even further to 2.8 in 2020.

5. Baby Boom Population: We have 39 million beneficiaries enrolled in Medicare today and expect an additional 77 million baby boomers to begin enrolling in Medicare by 2010. We must make certain that Medicare will be available for them.

6. The Balanced Budget Act of 1997: The Balanced Budget Act of 1997 and the recent legislation to restore some of its payment reductions underscore the need to fundamentally restructure Medicare and reduce government micro-management of the program.

We also must address the need to improve the Medicare program overall, by updating benefits and increasing the flexibility of the program.

1. Inadequate: Today, Medicare covers only 53% of a beneficiary's average health care costs and exposes beneficiaries to large and unlimited out-of-pocket liabilities. Beneficiaries' Part B premiums alone are expected to double over the next 10 years from $45 today to $101 in 2009.

2. Outdated: Overall, Medicare's current benefit package is outdated. It does not provide outpatient prescription drug coverage and limits beneficiary access to new medical technologies and preventive services.

3. Inflexible: As a physician I am acutely aware of the need to ensure seniors have access to life-saving drugs and technologies. Right now, the Medicare program is so heavily micro-managed, with over a hundred thousand pages of regulations, that it is difficult, if not impossible, to adapt to the rapid changes in medicine that are occurring every day. Examples:

A. In 1994, the FDA approved a technology which rapidly increases the healing of bone fractures. This technology is reimbursed by 850 private insurers today, but has yet to be approved by Medicare.

B. Today, private insurance companies recognize the importance of early detection and disease management and cover a wide variety of preventive screening tests. Medicare, however, provides only limited preventive services and still does not cover even some of the most basic and essential preventive screenings, such as cholesterol tests.

C. Even when life-saving diagnostic tests become available, such as a breakthrough prostate cancer-screening test that came on the market in the early 1990s, it takes years before it can be approved. Medicare just recently began reimbursing for prostate screening and only because a new law was passed to allow it.

The very fact that Congress must pass such laws illustrates perfectly the problem with a heavily micro-managed program. Congress should not be in the business of setting disease-specific health policy. No government program can possibly keep up with the increasingly rapid rate at which new life-saving and life-improving technologies are brought to the market. Medicare is based on a 1960's model of care that is not capable of meeting the health care needs of today's seniors and it is time to address these problems head on.

II. THE BREAUX-FRIST MEDICARE REFORM BILL (S. 1895)

S. 1895 is the first legislation to be introduced in the House or Senate that addresses comprehensive Medicare reform. This legislation establishes a Competitive Premium System that is modeled on the Federal Employees Health Benefits Program, a program with which we have over 40 years of experience, currently serving over 9 million federal employees, including you and me, and the President of the United States. In short, S. 1895:

1. Guarantees all current Medicare benefits, so that beneficiaries will, at a minimum, continue to be entitled to the same benefits they are entitled to under Medicare today.

2. Offers universal prescription drug coverage

A. For the first time, all Medicare beneficiaries will have access to prescription drug coverage through enrollment in a HCFA-sponsored high-option plan or a private high-option plan;

B. All Medicare beneficiaries will receive a discount off premiums for drug benefits with full coverage for beneficiaries under 135% of poverty, as much as a 50% discount for beneficiaries between 135%-150%, and a 25% discount for beneficiaries above 150% of poverty.

3. Protects beneficiaries against high out-of-pocket costs, so that beneficiaries enrolling in a high option plan will not have to pay health care costs for current Medicare benefits beyond $2,000 each year.

4. Provides protections for low-income beneficiaries, so that beneficiaries below 135% of poverty will pay zero premium for all health care benefits, including prescription drugs.

5. Offers rural protections, so that beneficiaries everywhere, including those in areas with no competition (or no managed care plans):

A. Will continue to have access to the Medicare traditional fee-for-service program through the HCFA-sponsored standard plan.

B. Will be guaranteed to pay no more than 12% of nationally averaged premiums.

C. Will be guaranteed access to outpatient prescription drug coverage.

6. Includes beneficiary outreach and education efforts coordinated at the federal, state, and local levels to ensure timely, accurate, understandable and readable information is provided to beneficiaries on affordable health options available to them.

The Breaux-Frist Medicare Reform bill guarantees health care security for seniors, while at the same time capturing the innovations of the marketplace and increasing beneficiaries choice of affordable health care options. S. 1895 promotes high quality, comprehensive, integrated health care to meet the individual needs of each beneficiary; increases the flexibility of the Medicare program and provides beneficiaries timely access to the latest advances in the practice of medicine and delivery of care; and ends the Congressional micro-management over prices and delivery of benefits administered through approximately 130,000 pages of regulations under the current Medicare program.

S. 1895 does not force seniors into managed care. Instead it offers seniors a voluntary option of either staying in the current Medicare Fee-for-Service program or enrolling in a managed care option, both of which will offer prescription drugs.

Let's also not forget that Medicare works because we have a million health care providers who care for our nation's seniors. However, if we irresponsibly drop an expensive drug benefit on an already financially failing program without doing anything to strengthen the underlying structure of the program and better integrate health care delivery, it will be no surprise that cuts in provider payments will be used to pay for drug coverage—historically that has been the case. In fact, the President's proposal does just that.

Under the Clinton/Gore proposal a new outpatient prescription drug benefit is added on to Fee-for-Service Medicare with no solutions to address the long-term financial problems facing the program and no provisions to better integrate health care delivery or increase access to the latest advancements in medicine. And even without these very important features, the cost of the drug benefit alone is enormous—$200 billion over the next 10 years—such that surplus dollars, further cuts to Medicare providers, and increases in beneficiary copayments and deductibles are necessary to pay for the drug benefit. We owe it to our seniors and individuals with disabilities to take a more responsible and comprehensive approach to strengthen, preserve and improve our Medicare program and the Breaux-Frist legislation is the first step in that process.

III. CONCLUSION

The overwhelming public support for an outpatient prescription drug benefit gives us a real opportunity to make Medicare better with bipartisan, comprehensive legislation. Seniors absolutely need prescription drug benefits, but adding them without addressing the underlying program will only exacerbate Medicare's financial deficiencies and administrative inefficiencies. It also removes what little political will currently exists to tackle the much more pressing need to reform the system.

Medicare must be modernized and put on a sound financial footing to be able to provide seniors with a drug benefit that is an integral part of their health care plan. We must move beyond the demagoguery and disinformation campaign on Medicare reform being led by the Administration and others—and instead act responsibly and take a step by-step and carefully thought out bipartisan approach this year to bal-

ance the very real need for outpatient prescription drug coverage for those who don't have it and need it, with the need for meaningful structural reforms that strengthen and improve health care delivery to our nation's seniors and individuals with disabilities. By doing this, I believe we can truly provide choice and security for our Medicare beneficiaries to ensure their individual health care needs are met, today and well into the future.

PREPARED STATEMENT OF ROBERT D. REISCHAUER(1)

Mr. Chairman and Members of the Committee, I appreciate this opportunity to discuss with you current efforts to strengthen the Medicare program so that it can better withstand the demographic and cost pressures that loom ahead. During the past year, the media and interest groups have focused on policy disagreements and the failure to move reform legislation. Nevertheless, an objective observer would conclude that a good deal of progress was made last year in the effort to craft policies that assure future generations of elderly and disabled access to high-quality, affordable medical care that does not burden taxpayers excessively.

In March 1999 the co-chairs of the National Bipartisan Commission on the Future of Medicare developed a broad-brush proposal to restructure Medicare for the 21st century. Their plan fell one vote short of the super majority needed to make it an official commission recommendation to Congress and the president. Nevertheless, it provided a framework for subsequent legislative initiatives, the primary example being the Medicare Preservation and Improvement Act (S. 1895) introduced by Senators Breaux and Frist in November 1999. The commission also spurred the Administration to accelerate its work on Medicare reform for the long run. At the end of June, the president unveiled his Plan to Modernize and Strengthen Medicare for the 21st Century. Since then, discussion has focused on differences between the president's proposal and the Medicare Preservation and Improvement Act. In this statement I would like to take the opposite tack, namely to:

- draw attention to several important areas where the two competing Medicare restructuring proposals are in agreement,
- propose ways to resolve some of the differences between the two approaches, and
- suggest some steps that could be taken now to build on the progress of last year.

AREAS OF AGREEMENT

The Medicare Preservation and Improvement Act and the President's Plan to Modernize and Strengthen Medicare are similar along five important dimensions. First, both conclude that the future structure of Medicare should involve competition among health plans—not just between Medicare+Choice (M+C) plans but also between these capitated plans and traditional fee-for-service Medicare. Such competition can expand consumer choice, improve quality, encourage efficiency, and slow the growth of government spending. Such salutary outcomes are by no means inevitable in a competitive system, however. Therefore care must be paid to the structure of the competitive system and safeguards must be provided to protect vulnerable beneficiaries from unintended detrimental consequences of market forces.

Second, the two proposals agree that the existing statutory Medicare benefit package is inadequate. Relative to the protection most workers and their dependents receive through their employer-sponsored policies, Medicare's benefit package is fairly skimpy. The president's proposal would address this problem by adding a prescription drug benefit while the Medicare Preservation and Improvement Act would create a high-option package that includes both prescription drug coverage and stop-loss coverage to provide protection for beneficiaries with catastrophic expenditures.

A third area of agreement between the two proposals is that supplemental benefits like prescription drug coverage must be an optional, rather than a mandatory, benefit, and that this option must be subsidized through general revenues. This outcome is dictated more by political than analytical considerations. A significant number of beneficiaries have supplemental coverage that is partially or fully paid for by a former employer or is provided by a M+C plan that charges no extra premium. Beneficiaries with such coverage would object strenuously if they were required to participate and pay additional premiums for benefits they currently receive for free or at a lower cost. That was the lesson learned in 1988 and 1989 when the Medicare Catastrophic Coverage Act was passed and then repealed within 18 months.

Once the decision is made to structure the supplemental benefit package as a voluntary option, subsidies and participation restrictions are necessary to protect the program from adverse selection; that is, from attracting disproportionate numbers

of participants with high expenditures who will drive up costs and drive away those who expect to have average or below-average expenditures. Subsidies are needed to make participation attractive to those with more normal expenditures.

The Medicare Preservation and Improvement Act provides a 25 percent across-the-board subsidy for prescription drug coverage but no subsidy for the catastrophic stop-loss protection component of the high-option plan. For those with incomes at or below 135 percent of the poverty threshold, the subsidy would equal the full premium charged by the least expensive high-option plan offered in each area. These deeper subsidies would be phased out for those with incomes between 135 percent and 150 percent of the poverty line. This subsidy structure would ensure that all poor and most low-income beneficiaries join the least expensive high-option plan available in their area. For such plans, the near universal participation of those with low-incomes might make the problem of adverse risk selection—attracting a high percentage of high-cost participants—manageable. This might not be the case for the more expensive plans which would draw largely from middle and upper income beneficiaries. Few such beneficiaries who expect to have low or even average expenditures might find these plans attractive if the across-the-board subsidies were relatively low.

The president's proposal provides low-income subsidies similar to those offered in S. 1895. However, it offers much deeper across-the-board subsidies—equal to half of the costs of the prescription drug benefit. These deeper subsidies and the requirement that only one plan be available in each geographic area make adverse risk selection less of a problem in the president's plan.

The president's proposal and The Medicare Preservation and Improvement Act both restrict enrollment in high-option plans to keep beneficiaries from signing up only when they expect to incur high prescription drug expenditures.(2) Beneficiaries would be allowed to enroll in the supplemental plan only when they first sign up for Medicare or when they lose their preexisting private supplemental coverage.

A fourth area of agreement is that both the president's proposal and The Medicare Preservation and Improvement Act reaffirm that traditional fee-for-service Medicare, administered by the government, should remain available throughout the nation. Under the president's proposal, the current structure of traditional fee-for-service Medicare would remain unchanged. In other words, it would be a national program available to all eligible elderly and disabled who pay the Part B premiums. Under the provisions of S.1895, the traditional fee-for-service Medicare option would be transformed into a national "HCFA-sponsored standard plan." The premium charged by this plan would depend on the cost of this plan relative to the weighted national average of the premiums charged by all plans. If, as is likely, the costs of the Medicare fee-for-service plan are higher than the average costs of the M+C plans for reasons other than the poorer health status of its participants or the higher costs of input in the areas where its participants live, the premium charged to beneficiaries in fee-for-service Medicare would exceed the average premium paid by all participants. As long as a preponderance of beneficiaries—about 83 percent today—remain in the HCFA-sponsored standard plan, the premium charged for this plan will not be far from the national average. However, the fee-for-service premium could rise significantly over time if more and more beneficiaries began to enroll in cheaper M+C plans. S.1895 does, however, establish safeguards to ensure that those living in areas in which no M+C plan offers services would pay no more than the national average beneficiary premium.

Finally, there appears to be general agreement that it will take more than restructuring Medicare along competitive lines to put the program on a sound financial footing for the long run. Sooner or later, additional resources will be needed. The president's proposal responds to this fact of fiscal life by channeling general revenues into the Hospital Insurance (HI) trust fund. It would dedicate a portion of the projected on-budget surpluses—$299 billion over the next decade—to the HI fund. By 2010, this transfer would improve the trust fund's year-end balance by $356.2 billion.

While S.1895 does not speak to this issue, the report of the National Commission on the Future of Medicare states frankly:

> Even if the estimated reduction in the growth rate is achieved, Medicare will require additional resources as the percent of population that is eligible for Medicare increases. As revenue is needed, how much should be funded through the payroll tax, through general revenue, and through beneficiary premiums? The answer to this question is difficult because it would require knowing today the health care system of the future.(3)

NARROWING THE DIFFERENCE

While there are important broad areas of agreement between the president's proposal and the approaches adopted by the National Commission on the Future of Medicare and The Medicare Preservation and Improvement Act, differences remain on many significant dimensions. For example, S.1895 calls for profound changes in the way Medicare is governed, merges Part A and Part B, and establishes a new standard for program solvency. The president's proposal gives traditional fee-for-service Medicare the authority to use the same purchasing and quality improvement tools that private-sector plans use, augments preventive benefits, rationalizes cost sharing in the fee-for-service component, indexes Part B premiums, modifies the rules governing access to Medigap coverage, and adds a new Medigap option.

The governance structure proposed by The Medicare Preservation and Improvement Act is sufficiently novel to warrant some discussion. S.1895 creates an independent agency—the Medicare Board—to administer the competitive premium system. It restructures the Health Care Financing Administration (HCFA), establishing a Division of HCFA-Sponsored Plans to manage the fee-for-service Medicare plans within the new competitive premium system. The division would be required to bear the full financial risk for operating the fee-for-service Medicare plans, although exactly what this means in the context of a government program that is mandated to continue is unclear. The act grants the director of the division, a presidential appointee, unprecedented autonomy from executive branch rules and regulations. The recommendations contained in the annual business plan the director submits to Congress each year must be accorded fast-track consideration by Congress. After 2007 the director would not need legislative authority to implement the annual business plan.

This novel governance structure is intended to insulate Medicare from excessive micro-management by Congress and the executive branch and to allow necessary, but politically difficult, program changes to occur in a timely fashion. While Medicare's governance and administration leave much to be desired, the institutional changes proposed in S.1895 are not likely to produce any marked improvement. This is the case because the roots of Medicare's current governance problems lie more in the nature of the program and the openness of the American political process than in bureaucratic ineptitude or the flawed structure of HCFA . Congress and the president are unlikely to keep an arms length relationship with a key program that provides essential benefits to a large, politically influential, and vulnerable population through providers who constitute a powerful interest group. No Medicare Board or restructuring of HCFA will change this underlying reality.

Even within the areas of agreement, the two approaches differ on details, and these differences have sparked considerable conflict. One point of controversy is the reference premium around which competition would take place. Under the president's approach, this premium would be the national average cost of fee-for-service Medicare. The premiums bid by M+C plans would be adjusted for geographic cost differences and then compared to this reference premium. If a plan's adjusted bid was below 96 percent of national average fee-for-service Medicare costs, the plan's enrollees would enjoy reduced Part B premiums. Those joining a plan whose bid was no more than 80 percent of the reference premium would have their Part B premium waived, an annual saving of about $700 in 2003 according to Administration estimates. For a participant with prescription drug coverage, the savings could be close to $1,000. Those in a plan with costs above 96 percent of those for fee-for-service Medicare would pay the Part B premium plus the difference between the plan's cost and 96 percent of the national average fee-for-service Medicare costs.

The reference premium in The Medicare Preservation and Improvement Act is the enrollment weighted average of the costs of traditional fee-for-service Medicare and the premiums bid by M+C plans for the Medicare core benefit package. Those joining plans whose bid, after adjusting for input cost differences, is equal to the reference premium would be required to pay 12 percent of that amount. Medicare would pay the balance. Participant premiums would be lower for those enrolling in plans with below-average adjusted premiums. Those joining plans with premiums at or below 85 percent of the national average would not have to pay any premiums. Those enrolling in plans that are more expensive than average would pay premiums equal to 12 percent of the national average premium plus the full amount by which their plan's premium exceeded the national average.

S. 1895 provides stronger incentives to enroll in plans charging relatively low premiums than the president's proposal does. However, those who want to stay in traditional fee-for-service Medicare may find themselves paying higher-than-average premiums. In contrast, under the president's approach participants who chose tradi-

tional fee-for-service Medicare would be held harmless. They would forego premium rebates, but they would never have to pay more than the Part B premium.

The president's approach is more prudent for the initial years when the new and untested competitive market structure is being implemented. If history is any guide, there will be many missteps, problems, and hurdles to be overcome before the Medicare health plan market begins to operate in an efficient and equitable manner. New tools and procedures will have to be developed. For example, analysts will have to develop better techniques to adjust plan payments for enrollees' differing health needs, sophisticated mechanisms to compensate plans for geographic cost differences, accurate measures of plan quality, and effective methods of informing participants of their choices and the consequences they entail. Progress is being made on all of these fronts, but we are far from having satisfactory answers. Furthermore, no one knows how the dynamics of a Medicare marketplace will really evolve. Will there be sufficient stability both in the plans available in each market area and in their provider networks? Or will there be constant turmoil? Will plan premiums be relatively predictable or will they jump around from year to year, forcing many beneficiaries to switch plans and providers frequently? Considering these uncertainties, it would be best to proceed cautiously and ensure that a familiar, affordable safe-haven—namely, traditional fee-for-service Medicare—is available to beneficiaries under the current conditions during the shake down period.

Uncertainty should not become an excuse for not realizing the full potential of a competitive structure. If the various institutions and tools needed for an efficient and equitable market system can be developed and if the evidence indicates that the quality of care provided by M+C plans and fee-for-service Medicare is about the same, the competitive premium structure proposed by the president should be replaced gradually over five to ten years with that called for in The Medicare Preservation and Improvement Act. It is important to require this transition in the original legislation because both M+C participants and those in the traditional fee-for-service will resist this change later. If the market has not matured sufficiently to justify the shift to the reference premium proposed in S.1895, Congress can always delay or repeal the transition.

Supplemental benefits are a second area where disagreements over details have obscured the broader agreement between the two approaches. In this regard both proposals are too narrow. They do not provide all of the supplemental benefits most Medicare participants seek. Judging from the additional coverage beneficiaries obtain through employer-sponsored retiree policies, Medigap plans, and M+C supplements, it is clear that the vast majority want protection against catastrophic expenses, lower cost sharing, and coverage for prescription drugs and preventive care. The most economical and administratively efficient way to provide such broader coverage is to either expand Medicare's statutory core benefit package or to provide a optional comprehensive package of supplemental benefits. Policy makers have been reluctant to consider such benefit expansions because either government expenditures or participant premiums would rise substantially. Before rejecting the possibility of imposing higher premiums, however, policy makers should weigh the fact that most beneficiaries or their former employers currently pay between $1,000 and $2,000 for these additional benefits. Therefore, they would not be worse off if their Medicare premiums were raised by similar amounts to provide these benefits within the Medicare program.

The president's proposal limits supplemental benefits to coverage for non-catastrophic prescription drug expenditures—drug expenditures above $5,000 per year would not be covered. The Medicare Preservation and Improvement Act is more comprehensive because it provides both a drug benefit and a stop loss that would limit cost-sharing on Medicare's core benefits to $2,000. The exact nature of the drug coverage, however, is not specified. Plans are required only to provide a prescription drug benefit that has an actuarial value of $800.(4) Therefore, plans under S.1895 could also limit coverage to non-catastrophic expenditures.

The limited nature of the supplemental coverage offered by the president's plan and S.1895 means that many beneficiaries will still seek additional coverage. Rather than being covered by two policies, they might then have three—core Medicare, the president's optional drug policy or the high option offered by S.1895, and a wrap-around policy offered by a former employer.(5) Rather than creating a simpler and more efficient system, these reforms could make for more confusion and complexity for both providers and beneficiaries. Inequities and inefficiencies could also multiply. Employers learned long ago that the most economical and administratively efficient way to provide health coverage is through a single health policy that provides a comprehensive benefit package. This is a lesson that should be incorporated into any effort to restructure Medicare for the long term.

NEXT STEPS

The short legislative calendar, the press of other congressional business, the charged atmosphere created by the November elections, and the unsettled environment facing health care providers and plans make it unlikely that Congress and the president will agree this year on comprehensive legislation to restructure Medicare for the long term. Nevertheless, steps can be taken to build on the progress of 1999. More important, measures that would make it more difficult to enact true reform in the near future can be avoided.

First, we need to continue to build the analytical and institutional infrastructure needed for a competitive system. Congress should devote more resources to developing such necessary building blocks as better mechanisms for risk adjustment, measures of plan quality, systems for consumer education, and methods for dividing geographic cost differences between those that are related to the quality of care and those that are not. Even if Congress decides not to move forward with a competitive system, these building blocks will be needed to improve the efficiency of the existing M+C component.

A second constructive step would be for Congress to reaffirm its interest in the Competitive Bidding Demonstration Project.(6) This project has the potential to provide policymakers with a great deal of useful information that could help in the design and implementation of an effective and equitable competitive system. If the demonstration is allowed to move forward expeditiously, some future mistakes might be avoided. Unfortunately, legislation enacted last year delayed the demonstration by at least one year after the committee and HCFA had begun to implement it in Phoenix and Kansas City.

The M+C program is a third area that might need more attention in the next year or two. This component has experienced considerable turmoil in recent years. Some of the distress is self-inflicted, some has been caused by policy changes, and some is attributable to larger market forces. Whatever the cause, disruptions and instability in the M+C component have undermined support for restructuring Medicare along competitive lines. Policy makers and HCFA administrators should, therefore, do what they can to stabilize the M+C component.

Finally, there is the question of whether to move forward with a prescription drug benefit absent more fundamental Medicare reforms. While I believe that prescription drug coverage is essential if Medicare is to provide seniors with adequate protection, I believe that consideration of fundamental restructuring will be delayed if a stand-alone drug benefit is enacted,. As I have already stated, an optional drug benefit could make the current system more complex and create new inequities. For these reasons, I believe that Congress should consider expanding the Medicare benefit package only in the context of restructuring the program along competitive lines.

ENDNOTES

1. President, The Urban Institute and Chair, Steering Committee for the Restructuring Medicare for the Long Term project of the National Academy of Social Insurance. The views expressed in this statement should not be attributed to the Urban Institute, the National Academy of Social Insurance, their sponsors, staff, or trustees.
2. This requirement has been added since S.1895 was introduced. See the January 20, 2000 letter from Senators John Breaux and Bill Frist to the director of the Congressional Budget Office, Dan Crippen.
3. National Commission on the Future of Medicare, Building a Better Medicare for Today and Tomorrow, Final Version, March 16, 1999, Page 7. http://thomas.loc.gov/medicare/bbmtt31599.html.
4. The $800 drug benefit and $2,000 stop-loss values are for 2003. For future years, these values would be indexed to reflect rising costs.
5. S. 1895 would preclude those with high-option coverage from buying a Medigap policy.
6. I am a member of the Competitive Pricing Advisory Committee.

United States General Accounting Office

GAO

Testimony

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MEDICARE REFORM

Leading Proposals Lay Groundwork, While Design Decisions Lie Ahead

Statement of David M. Walker
Comptroller General of the United States

GAO/T-HEHS/AIMD-00-103

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss Medicare reform. I would like to focus my remarks on the two leading proposals that involve more comprehensive reform—that is, reform that addresses cost containment as well as expanded benefits. However, before examining these proposals, I would like to speak again about a budgetary context for understanding the proposed reforms in light of the Medicare's future sustainability and the long-range budget outlook.

I spoke with you twice last year about this topic, and despite some very positive, short-term developments regarding our economy, the federal surplus, and Medicare spending, the bigger picture remains virtually unchanged. Long-term cost pressures facing the Medicare program are considerable. Even before adding a prescription drug benefit, for example, projected program spending threatens to absorb ever-increasing shares of the nation's budgetary and economic resources.

It is tempting to push aside this gloomy forecast in the face of today's sunny budget report. In its most recent projections, the Congressional Budget Office (CBO) shows both unified and on-budget surpluses throughout the next 10 years. However, good news does not mean that hard choices are a thing of the past. First, it is important to recognize that, by their very nature, projections are uncertain. This is especially true today because, as CBO notes, it is too soon to tell whether recent boosts in revenue reflect a major structural change in the economy or a more temporary divergence from historical trends. Indeed, CBO points out that assuming a return to historical trends and slightly faster growth in Medicare would change the on-budget surplus to a growing deficit. This means we should treat surplus predictions with caution. Because current projected surpluses could prove to be fleeting, appropriate steps should be taken if new entitlements are created that establish permanent claims on future resources.

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 begin addressing the structural imbalances in Medicare, Social Security, and other entitlement programs before the approaching demographic tidal wave makes the imbalances more dramatic and possible solutions much more painful.

It is in this context that we are discussing Medicare reform today. Among various proposals, the two I will focus on are the President's Plan to Modernize and Strengthen Medicare for the 21st Century and S. 1895, entitled the Medicare Preservation and Improvement Act of 1999, which is commonly

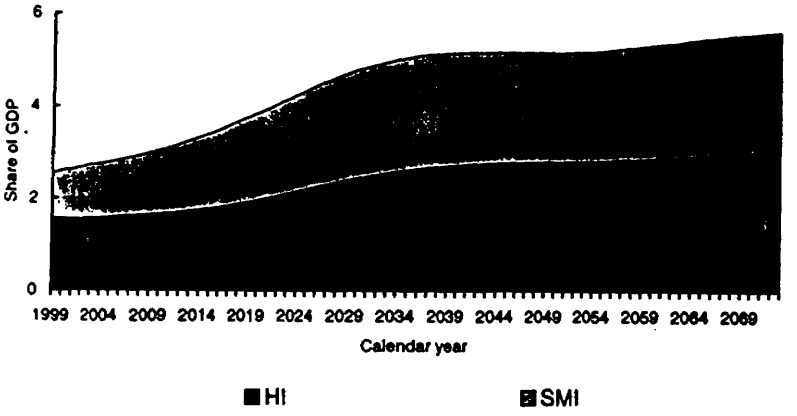
referred to as the Breaux-Frist proposal. By including a more comprehensive reform, the intent of these proposals would be consistent with the position we have maintained from the beginning of these deliberations; namely, that the unfunded promises associated with today's program should be addressed before or concurrent with proposals to make new ones, such as adding prescription drug coverage. Such additions need to be considered as part of a broader initiative to address Medicare's current fiscal imbalance and promote the program's longer-term sustainability. In addition, a reform package should include a mechanism to monitor aggregate program costs over time and establish expenditure or funding thresholds that would trigger a call for fiscal action.

As we consider key elements of these two proposals, I would ask you to keep in mind the following: these two plans reflect considerable efforts by the Administration and the Congress to wrestle with the twin problems of program adequacy and sustainability. However, unlike the game show, "Who Wants To Be A Millionaire," comprehensive reform does not come with a "final answer." Nor is it something that, once implemented, can be put on automatic pilot. Recent experience implementing changes to the current program shows that reform is a dynamic process requiring vigilance, flexibility, and endurance. We must be able to monitor the impact of reform, make changes when actual outcomes differ substantially from the expected ones, and remain steadfast when particular interests pit the primacy of their wants against the more global interest of making Medicare affordable, sustainable, and effective for current and future generations of Americans.

MEDICARE'S FINANCIAL CONDITION

Without meaningful reform, the long-term financial outlook for Medicare is bleak. Together, Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) expenditures are expected to increase dramatically, rising from about 12 percent in 1999 to about a quarter of all federal revenues by mid-century, even without adding to the benefit package. 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 1.

Figure 1: Medicare Spending as a Percentage of Gross Domestic Product (GDP) 1999 to 2073



Source: *1999 Annual Report*, Board of Trustees of the Federal Hospital Insurance Trust Fund and *1999 Annual Report*, Federal Supplementary Insurance Trust Fund.

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 the elderly population, but Medicare growth rates also reflect the escalation of health care costs at rates well exceeding general rates of inflation. Increases in the number and quality of health care 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 health 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. Our updated budget simulations show that to move into the future without making changes in the Social Security, Medicare, and Medicaid programs is to envision a very different role for the federal government. Assuming, for example, that the Congress and the President adhere to the

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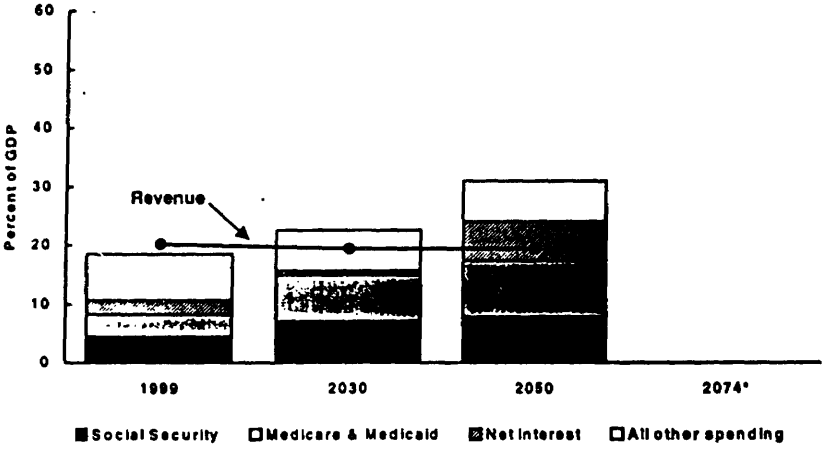
often-stated goal of saving the Social Security surpluses, our long-term model shows a world by 2030 in which Social Security, Medicare, and Medicaid increasingly absorb available revenues within the federal budget. Under this scenario, these programs would require more than three-quarters of total federal revenue. (See fig. 2.) Budgetary flexibility would be drastically constrained and little room would be left for programs for national defense, the young, infrastructure, and law enforcement.

Figure 2: Composition of Spending as a Share of GDP Under "Eliminate Non-Social Security Surpluses" Simulation



*The "Eliminate non-Social Security surpluses" simulation can only be run through 2066 due to the elimination of the capital stock.

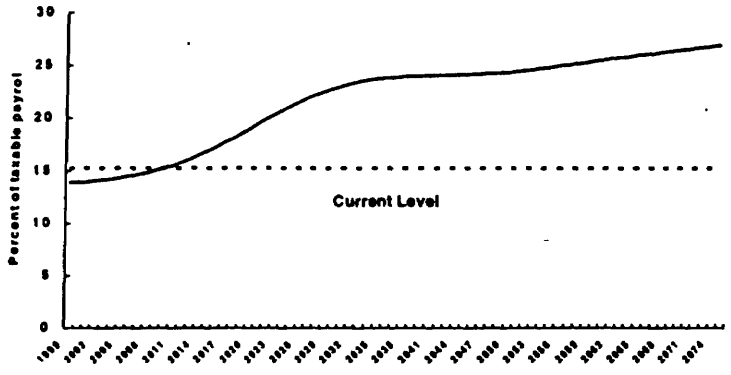
Notes:
1 Revenue as a share of GDP during the simulation period is lower than the 1999 level due to unspecified permanent policy actions that reduce revenue and increase spending to eliminate the non-Social Security surpluses.
2 Medicare expenditure projections follow the Trustees' 1999 intermediate assumptions. The projections reflect the current benefit and financing structure

Source: GAO's January 2000 analysis.

When viewed together with Social Security, the financial burden of Medicare on future taxpayers becomes unsustainable, absent reform. As figure 3 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.

Figure 3: Social Security and Medicare HI as a Percentage of Taxable Payroll, 1999 to 2074



Source: *1999 Annual Report*, Board of Trustees of the Federal Hospital Insurance Trust Fund, and *1999 Annual Report*, Board of Trustees of the Federal Old Age and Survivors Disability Insurance Trust Funds.

While the problems facing the Social Security program are significant, Medicare's challenges are even more daunting. To close Social Security's deficit today would require a 17 percent increase in the payroll tax, whereas the HI payroll tax would have to be raised 50 percent to restore actuarial balance to the HI trust fund. This analysis, moreover, does not incorporate the financing challenges associated with the SMI and Medicaid programs.

TODAY'S MEDICARE PROGRAM

The elements of restructuring of Medicare as proposed by the President and Breaux-Frist are best understood in light of Medicare's current structure. From the perspective of the program's benefit package, most beneficiaries have two broad choices: they can receive health care coverage through Medicare's traditional fee-for-service program or through its managed care component, called Medicare+Choice. The latter consists of an array of private health plans whose availability to Medicare beneficiaries varies by county across the nation.

Differences Between Traditional Medicare and Medicare+Choice

The choice between traditional Medicare and a Medicare+Choice plan typically involves certain trade-offs related to selection of providers, services covered, and out-of-pocket costs. Another key difference pertains to program payment methods.

- *Provider choice.* Under traditional Medicare, beneficiaries may obtain covered services from any physician, hospital, or other health care provider that receives Medicare payments. Because most providers accept Medicare payments, beneficiaries have virtually unlimited choice. In contrast, beneficiaries in managed care face a more restricted list of providers. Private plan enrollees can generally use only their plan's network of doctors, hospitals, or other providers for nonemergency care.

- *Services offered.* Although offering less provider choice, Medicare+Choice plans typically cover more services. For example, Medicare+Choice plans often cover routine physicals, outpatient prescription drugs, and dental care—services that traditional Medicare does not cover.

- *Out-of-pocket costs.* Out-of-pocket costs are generally higher for beneficiaries in traditional Medicare than for those in Medicare+Choice. Traditional Medicare, which has a two-part benefit package, does not pay the full costs of most covered services. Part A has no premium and helps pay for hospitalization, skilled nursing facility care, some home health care, and hospice care. Part B, which is optional in traditional Medicare, requires a monthly premium ($45.50) and helps pay for physician services, clinical laboratory services, hospital outpatient care, and certain other medical services. In addition to the monthly premium, beneficiaries are responsible for an annual $100-deductible and for 20 percent of the Medicare-approved amount for most part B services. To cover these out-of-pocket expenses, many beneficiaries purchase private supplemental insurance, known as Medigap, or may have similar insurance through a former employer.

  In contrast, beneficiaries covered through a Medicare+Choice plan are required to pay part B premiums but often do not pay the plan a monthly premium or pay a monthly fee that is less than the cost of an equivalent Medigap policy. Plan enrollees may also pay a copayment for each visit or service.

- *Program payments.* Another key difference between traditional Medicare and Medicare+Choice involves the program's payment methods. In traditional Medicare, hospitals, physicians, and other providers receive a separate payment for each covered medical service or course of treatment provided. In contrast, Medicare+Choice plans receive a fixed monthly

amount for each beneficiary they enroll, commonly known as a capitation payment. This amount covers the expected costs of all Medicare part A and part B services. If Medicare's payment is projected to result in a plan's earning above normal profits—that is, above the rate of return earned on its commercial contracts—the plan generally must use the excess to fund additional benefits.

Overspending on Medicare+Choice

If the extra benefits—such as prescription drugs and lower cost-sharing—provided by Medicare+Choice plans resulted exclusively from efficiencies achieved by the plans, there would be no cause for taxpayers to be concerned. However, evidence shows that, because of flaws in Medicare's methodology for computing payments, payments to plans are too high and plans turn these excess payments into extra benefits to attract beneficiaries. Instead of producing program savings as originally envisioned, Medicare's managed care option has added substantially to program spending.

Nevertheless, as we reported last year, program savings and extra benefits for Medicare beneficiaries are not mutually exclusive goals.[1] According to their own data, many plans could make a normal profit and provide enhanced benefit packages, even if Medicare payments were reduced. However, to lower program spending would require a better method of adjusting plan payments for differences in the health status of beneficiaries, a process commonly known as risk adjustment. Medicare's current risk adjustment methodology cannot adequately account for the fact that, on average, beneficiaries in Medicare+Choice are healthier than those in traditional Medicare.[2]

Issues Related to Prescription Drug Benefit

Extensive research and development over the past 10 years have led to new prescription drug therapies and improvements over existing therapies. In some instances, new medications have expanded the array of conditions and diseases that can be treated effectively. In other cases, they have replaced alternative health care interventions. For example, new medications for the treatment of ulcers have virtually eliminated the need for some surgical treatments. As a result of these innovations, the importance of prescription

[1] *Medicare+Choice: Reforms Have Reduced, but Likely Not Eliminated, Excess Plan Payments* GAO/HEHS-99-144, June 18, 1999).

[2] Payments to Medicare+Choice plans are based on the estimated cost of serving the average beneficiary in traditional Medicare. The methodology to adjust these payments for better or worse-than-average health status is based on simple demographic characteristics, such as age and sex. These are not adequate adjusters: two beneficiaries can be demographically identical (same age and sex), but one may experience occasional minor ailments while the other suffers from a serious chronic condition. Without the use of health status factors to account for that distinction, Medicare's risk adjuster produces excessive payments in compensating plans for their relatively lower cost enrollees.

drugs as part of health care has grown. However, new drug therapies have also contributed to a significant increase in drug spending as a component of health care costs. The Medicare benefit package, largely designed in 1965, provides virtually no coverage. This does not mean, however, that all Medicare beneficiaries lack coverage for prescription drug costs. In 1996, almost one third of beneficiaries had employer-sponsored health coverage, as retirees, that included drug benefits. More than 10 percent of beneficiaries received coverage through Medicaid or other public programs. To protect against drug costs, the remainder of Medicare beneficiaries can choose to enroll in a Medicare+Choice plan with drug coverage if one is available in their area or purchase a Medigap policy.

The burden of prescription drug costs falls most heavily on the Medicare beneficiaries who lack drug coverage or who have substantial health care needs. Drug coverage is less prevalent among beneficiaries with lower incomes. In 1995, 38 percent of beneficiaries with income below $20,000 were without drug coverage, compared to 30 percent of beneficiaries with higher incomes. Additionally, the 1995 data show that drug coverage is slightly higher among those with poorer self-reported health status. At the same time, however, beneficiaries without drug coverage and in poor health had drug expenditures that were $400 lower than the expenditures of beneficiaries with drug coverage and in poor health. This might indicate access problems for this segment of the population.

Even for beneficiaries who have drug coverage, the extent of the protection it affords varies, and there are signs that this coverage could be eroding. The value of a beneficiary's drug benefit is affected by the benefit design, including cost-sharing requirements and benefit limitations. Although reasonable cost sharing serves to make the consumer a more prudent purchaser, copayments, deductibles, and annual coverage limits can reduce the value of drug coverage to the beneficiary. Recent trends of declining employer coverage and more stringent Medicare+Choice benefit limits suggest that the proportion of beneficiaries without effective protection may grow.

Expanding access to more affordable prescription drugs could involve either subsidizing prescription drug coverage or allowing beneficiaries access to discounted pharmaceutical prices. The design of a drug coverage option, that is, the scope of the benefit, the targeted population, and the mechanisms used to contain costs, as well as its implementation, will determine the option's effect on beneficiaries, Medicare or federal spending, and the pharmaceutical market. Any option would need to consider how to balance competing concerns about the sustainability of Medicare, federal obligations, and the hardship faced by some beneficiaries.

PRESIDENT'S PLAN AND BREAUX-FRIST PROPOSAL: TWO VERSIONS OF COMPETITIVE PREMIUM APPROACH

The President's plan and the Breaux-Frist proposal are similar in three key areas but contain two major differences. To varying degrees, both proposals

- introduce a competitive premium model, similar in concept to the Federal Employees Health Benefit Program (FEHBP), to achieve cost efficiencies;
- preserve the traditional fee-for-service Medicare program with enhanced opportunities to adopt prudent purchasing strategies; and
- modernize Medicare's benefit package by making coverage available for prescription drug and catastrophic Medicare costs.

The proposals differ, however, in the extent to which traditional Medicare could face competitive pressure from private plans. In addition, under the President's plan, the Health Care Financing Administration (HCFA) would administer the program, whereas under the Breaux-Frist proposal, an independent Medicare board would perform that function.

An elaboration of these points helps explain where the two proposals share common ground and where they diverge.

Competitive Model for Setting Premiums

Currently, Medicare follows a complex formula to set payment rates for Medicare+Choice plans, and plans compete primarily on the richness of their benefit packages. Efficient plans that reduce costs below the fixed payment amount can use the "savings" to enhance their benefit packages, thus attracting additional members and gaining market share. Although competition among Medicare plans may produce advantages for beneficiaries, the government reaps no savings.[3]

In contrast, the competitive premium approach included in the Breaux-Frist and President's proposals offers certain advantages. Under either version, beneficiaries can better see what they and the government are paying for. In addition, plans that can reduce costs can lower premiums and attract more enrollees. As the more efficient plans gain market share, the government's spending on Medicare will decrease.

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[3]Beneficiaries who enroll in plans with low costs enjoy coverage for additional benefits, including reduced cost-sharing. Regardless of private plan selected, however, plan enrollees must continue to pay part B premiums.

Fundamentally, this approach is intended to spur price competition. Instead of administratively setting a payment amount and letting plans decide—subject to some minimum requirements—the benefits they will offer, plans would set their own premiums and offer a common Medicare benefit package. Under both proposals, beneficiaries would generally pay a small portion of the premium and the government would pay the rest. Plans that operate at lower cost could reduce premiums, attract beneficiaries, and increase market share. Beneficiaries who joined these plans would enjoy lower out-of-pocket expenses. Taxpayers, however, would also benefit from the competitive forces. As beneficiaries migrated to lower cost plans, the average government payment would fall. (See table 1.)

Table 1: Under Both Versions of Competitive Approach, Medicare and Beneficiaries Can Enjoy Direct Savings

	Medicare+Choice	President	Breaux-Frist
Payment rates	Administratively determined, largely based on fee-for-service (FFS) costs	Plans determine own premium for providing Medicare-covered benefits	Plans determine own premium for providing benefits
Maximum government contribution	About 89% of administratively determined payment rate[a]	■ For private plans, 85% of traditional Medicare cost[b] ■ For traditional Medicare, about 89% of cost	88% of national average premium, includes HCFA-sponsored FFS plan[c]
Beneficiary contribution	■ Monthly part B premium to Medicare ■ May pay additional premium to plan	■ Difference between private plan premium and government contribution ■ Nothing for private plans with premiums below about 80% of FFS cost ■ If in traditional FFS, approximately 11% of per capita program cost	■ Difference between plan premium and government contribution ■ Nothing for plans with premiums at or below 85% of national average
Impact on beneficiary if enrolled in plan with relatively high costs	■ Pay monthly part B premium to Medicare ■ Pay premium to plan	■ Pay premium	■ Pay premium
Impact on beneficiary if enrolled in plan with relatively low costs	■ Pay monthly part B premium to Medicare ■ Pay little or no premium to plan ■ Receive extra benefits	■ Pay little or no premium	■ Pay little or no premium
Impact on Medicare if beneficiary enrolled in plan with costs below maximum government contribution	None; savings flow to plan and beneficiaries	Receives portion of savings	Receives portion of savings

[a]Net effect, government payments offset by beneficiary part B premiums (assumed to total about 11 percent of FFS costs).
[b]Net effect, maximum government payment set at 96 percent of average FFS cost offset by beneficiary part B premiums revenue (assumed to equal about 11 percent of FFS costs).
[c]Plans submit premium for benefit package that may include benefits not covered by Medicare. Medicare Board determines the portion of the premium associated with Medicare-covered benefits and uses that amount to compute the enrollment-weighted national average.

One major difference between the two proposals concerns how the beneficiary premium would be set for those who remained in the traditional fee-for-service program. Under Breaux-Frist, there would be no separate part B premium. All plans—including traditional Medicare—would calculate a total premium expected to cover the cost of providing Medicare-covered services to the average

beneficiary. The maximum government contribution would be based on a formula. Beneficiaries would pay no premiums if they chose plans costing 85 percent or less than the national enrollment-weighted average premium. For plans with higher premiums, beneficiaries would pay an increasing portion of the premium. The traditional fee-for-service Medicare program would be regarded as one more plan. The monthly amount beneficiaries would pay to enroll in it, therefore, would depend on how expensive it was relative to the private plans.

In contrast, under the President's proposal, the beneficiary premium for traditional Medicare—the part B premium—would continue to be set administratively. As under Breaux-Frist, all other plans would submit competitive premiums. The maximum government contribution to private plans would be set at 96 percent of the average spending per-beneficiary in traditional Medicare. Beneficiaries who joined plans that cost less than that amount would pay reduced, or no, part B premiums. Beneficiaries who joined more expensive plans would pay higher part B premiums.

Some believe the design of the President's proposal would tend to insulate the traditional fee-for-service program, and those beneficiaries that remain in it, from market forces. At least in the short run, however, the practical differences between the President's proposal and the Breaux-Frist proposal may be small. Because the vast majority of beneficiaries are enrolled in the traditional fee-for-service program, the national average premium under Breaux-Frist would, in all likelihood, largely reflect the cost of traditional Medicare.

Table 2 presents a hypothetical example to illustrate how similar beneficiary and government contributions would be under Breaux-Frist and the President's proposal. It assumes private plans could provide Medicare-covered benefits for 90 percent of the cost incurred in the traditional fee-for-service program and that they enroll 17 percent of all beneficiaries (the percentage of beneficiaries currently enrolled in private plans).[4] In this example, beneficiaries in private plans would pay slightly less under the Breaux-Frist proposal compared to the their contribution under the President's proposal. Beneficiaries in the traditional program would pay slightly more under Breaux-Frist.

[4]The 90-percent figure is used for illustrative purposes only and does not represent an estimate of private plan premiums. However, there is some evidence that some plans could submit premiums below fee for service costs. Before 1998, Medicare set plan payments at 95 percent of average fee-for-service spending. This discounted payment exceeded many plans' costs of providing Medicare benefits and suggests that some plans may be able to set premiums substantially below the average cost in the traditional program.

Table 2: Simulation Showing Similarities Between Two Proposals in Monthly Premium Contribution Amounts

			President's Proposal		Breaux-Frist Proposal	
	Total per capita premium	Beneficiaries enrolled	Beneficiary contribution	Government contribution	Beneficiary contribution	Government contribution
Private plans	$450*	17%	$33 (7.2%)	$418 (92.8%)	$26 (5.7%)	$424 (94.3%)
Traditional FFS	$500	83%	$55 (11.0%)	$445 (89.0%)	$67 (13.5%)	$433 (86.5%)
Overall average			$51 (10.3%)	$440 (89.7%)	$60 (12.2%)	$431 (87.8%)

*Private plan premium is a hypothetical example that assumes plans could provide Medicare-covered benefits for 90 percent of the costs incurred by the fee-for-service program.

Source: GAO analysis.

Over the longer term, larger differences will emerge only if private plans decide to compete aggressively on the basis of price for market share or traditional fee-for-service Medicare becomes significantly less able to control the growth of costs relative to private plans. Although the premium support proposals are intended to slow health care spending through competition, it is not certain that this will occur. Private plans may very well find that their most profitable strategy is to "shadow price" (set prices only slightly under) traditional Medicare and be satisfied with smaller market share. (Paradoxically, serving larger numbers of beneficiaries could lead to higher costs and less profit.)

The greater ability of private plans to control cost growth and thereby offer significantly lower premiums is not a foregone conclusion. Medicare's fee-for-service cost containment record over the longer term has not differed substantially from that of the private sector. In some periods, Medicare's cost growth has been lower; in others, higher. Today, actually, we are witnessing a resurgence of cost growth in private plans, while Medicare spending projections have flattened.

Prudent Purchasing Strategies for Traditional Medicare

More than 80 percent of Medicare beneficiaries currently receive their health care coverage through the traditional fee-for-service program. Both leading reform proposals recognize the importance of this program to beneficiaries and would ensure its continued availability nationwide. They also recognize that controlling the growth of overall Medicare spending requires a more efficient traditional program. Consequently, both proposals seek to make Medicare a more prudent purchaser of health care by introducing modern cost control strategies.

The President's proposal outlines several new approaches to controlling costs.

It would, for example, allow the Secretary of Health and Human Services to contract with preferred provider organizations (PPO), negotiate discounted payment rates for specific services, and develop systems to manage the care (in a fee-for-service setting) of certain diseases or beneficiaries. The proposal would also adjust payments to providers and change beneficiary cost sharing requirements. Adopting these changes will entail considerable challenges given the sheer size of the Medicare program, its complexity, and the need for transparent policies in a public program. Moreover, how much the changes would save is uncertain and likely depends on how, and to what extent, these measures are implemented. For example, without supplemental insurance reform, a PPO option may not attract many beneficiaries because a majority have first-dollar coverage through supplemental policies and thus are insensitive to provider charges. Furthermore, cuts in provider payments are certain to meet with fierce opposition.

The Breaux-Frist proposal provides a vehicle to reform traditional Medicare, but does not suggest specific cost control devices. The proposal calls for HCFA to prepare an annual business plan, which would outline intended payment and management strategies, describe partnership arrangements with entities to provide prescription drug benefits, and recommend benefit improvements. It would also include any legislative specifications necessary to enact the plan. Until 2008, HCFA would need explicit congressional approval to implement its business plan. After that, the plan would take effect without Congress' explicit approval. Clearly, the Breaux-Frist proposal could increase HCFA's options for managing the traditional program and controlling spending. Like the President's proposal, however, the extent of its success will depend on the specific details and other reform elements that HCFA designs and the Congress allows to be adopted.

Coverage for Prescription Drug and Catastrophic Costs

The leading proposals include provisions for two commonly discussed benefit expansions: an outpatient prescription drug benefit and coverage for extraordinary out-of-pocket expenses, known as catastrophic or stop-loss coverage. In this regard, Breaux-Frist and the President's proposal share many similarities. (See table 3.) Under both proposals the coverage is voluntary, although income-targeted subsidies are provided to encourage the purchase of prescription drug coverage. By making the drug benefit financially attractive, the proposals seek to maximize participation and avoid "adverse selection" problems—that is, having only high- cost beneficiaries purchase coverage and driving up premium costs. Low-income beneficiaries would pay nothing for the drug benefit, while those earning more would pay up to 75 percent of the cost. To further minimize adverse selection problems, the President's proposal includes, and Breaux-Frist considers, a provision limiting opportunities to select drug coverage.

Table 3: Prescription Drug And Stop-Loss Coverage.

President	Breaux-Frist
Drug benefit available through new part D program.	Drug benefit available through high-option plans.
Drug coverage up to $1,000 per year in 2003, rising to $2,500 in 2009.	Drug coverage with an actuarial value of $800 per year in 2003, to be increased annually.[a]
Medicare subsidizes between 25% and 100% of drug benefit cost based on beneficiary income.	Medicare subsidizes between 25% and 100% of drug benefit cost based on beneficiary income.
Incentives for employers to retain retiree drug coverage.	No incentives specified.
Stop-loss for non-drug Medicare expenses available through new Medigap policy. Reserve fund for a future catastrophic drug benefit.	Stop-loss for non-drug Medicare expenses over $2,000 per year available through optional high option plans.

[a]Because the coverage limit is specified as an actuarial equivalent, it is not directly comparable to the limit in the President's proposal.

Under Breaux-Frist, all participating health care organizations—including HCFA—would be required to offer a high option plan that provided prescription drug and stop-loss coverage, in addition to coverage for Medicare core benefits. The President's proposal calls for a new voluntary prescription drug benefit, known as part D, and a new Medigap policy that would feature increased cost-sharing and stop-loss coverage. Under both proposals HCFA would contract with private entities to provide drug coverage for beneficiaries enrolled in its high option plan (Breaux-Frist) or in Medicare part D (President). Entities that managed the drug benefit for HCFA or private plans would be permitted to use cost containment mechanisms, such as formularies. The President's proposal includes incentives for private employers to retain drug coverage for their retirees.

REFORM OUTCOMES HINGE ON DESIGN DETAILS

The challenge of implementing Medicare reforms must be respected. As we have noted before, to determine the likely impact of a particular policy, details matter. Design choices and implementation policies can affect the success of proposed reforms. In addition, because difficult choices tend to meet with opposition from affected parties, the will to stay the course is equally important for successful reform. Following are just a few of the issues germane to Medicare reform that remind us of the proverb, "The devil is in the details."

To What Extent Should Premiums Be Adjusted For Geographic Variations In Health Care Markets?

For proposals that include elements of premium support, the task of determining the government's contribution toward each plan's premium raises several technical issues that have profound policy implications. In general, the government's share is greater or smaller, depending on whether the plan's premium is below or above the average of all plan premiums. However, some plans can incur higher-than-average expenses because of local market conditions outside of their control. Unless the government contribution is adjusted for these circumstances, beneficiaries could face higher out-of-pocket costs and plans could be at a competitive disadvantage. The Breaux-Frist proposal allows adjustments for medical price variation only. The President's proposal allows adjustments for medical price variation and regional differences in medical service use.

An adjustment for differences in local medical prices is clearly desirable under a premium support system. Without it, beneficiary premiums in high-price areas will tend to be above the national average. Adjusting the government contribution for input price differences can help ensure fair price competition between local and national plans and avoid having beneficiaries pay a higher premium, or higher share of a premium, simply because they live in a high-price area.

In addition, the use of medical services varies dramatically among communities because of differences in local medical practices. Under premium support approaches, plan premiums in high-use areas will likely exceed the national average. Whether, or to what extent, to adjust the government contribution for this outcome is a matter of policy choice. On the one hand, without an adjustment, beneficiaries living in high-use areas who join local private plans could face substantial out-of-pocket costs for circumstances outside of their control. Consequently, private plans in these areas might have difficulty competing with a traditional Medicare plan that charged a fixed national premium based on an overall average of medical service use. On the other hand, there have been longstanding concerns about unwarranted variations in medical practice. By not adjusting the government contribution for utilization differences, financial pressures could encourage providers to reduce inappropriate levels of use.

What Parameters Would Define Activities of Entity Administering Restructured Medicare Program?

Under either leading proposal, Medicare's administrative functions will include the oversight of plans' contracts. In today's Medicare+Choice program, this

function is performed by HCFA. Under the President's plan, HCFA would retain this function; under Breaux-Frist, a quasi-independent board would administer Medicare.

Whatever the administrative entity is under Medicare reform, the following are questions that policymakers will want to consider. First, how will this entity's mission be defined? Will the emphasis be on controlling costs, protecting beneficiaries, maximizing choice, or some combination of these goals? Policy choices would flow from the stated mission. Second, how much independence would be permitted to the administrative entity to carry out its mission? Would it be appropriately shielded from the pressure exerted by special interest groups? Third, how would the administrative entity hold plans accountable for meeting Medicare standards? Would it rely chiefly on public accountability, in which the process and procedures for compliance are clearly defined and actively monitored, or on market accountability, by providing comparative information on competing plans and letting beneficiary enrollment choices weed out poor performers? Answers to these questions will determine, to a large extent, whether a restructured Medicare program will be administered effectively.

ADDRESSING IMMEDIATE CONCERNS CAN AID REFORM EFFORTS

Experiences in the Medicare+Choice program suggest lessons for implementing reforms effectively and provide a blueprint for actions that can be taken right away. In response to challenges faced in administering Medicare+Choice, HCFA has several initiatives underway that have faltered for various reasons—including resistance by special provider interests and insufficient agency capacity and expertise. However, the need to further these initiatives will grow in importance under comprehensive reform. Specifically, (1) improved risk adjustment is needed to ensure that Medicare's payments are fair both to the taxpayer and to individual plans, (2) better consumer information is needed to help beneficiaries make comparisons across plans, and (3) improved information systems and analysis capability are needed to promptly assess the impact of new payment and coverage policies.

Importance of Better Risk Adjustment

Adjusting for differences in beneficiary health status—commonly known as risk adjustment—enables plans to be fairly compensated when they enroll either healthier or sicker-than-average beneficiaries. Our work and that of others show that, partially because of an inadequate risk adjustment methodology, taxpayers have not benefited from the potential for capitated managed care plans to save money.[5] Under the competitive premium approach, the ability to

[5]See *Medicare+Choice: Reforms Have Reduced, but Likely Not Eliminated, Excess Plan Payments* (GAO/HEHS-99-144, Jun. 18, 1999).

moderate Medicare spending rests in part on how accurately analysts determine the government's share of a health plan's premium. Today's Medicare+Choice program is phasing in an interim risk-adjustment methodology based on the limited health status data currently available. The challenge, for Medicare+Choice or any premium-based reform proposal, is to implement an improved method that more accurately adjusts payments, does not impose an undue administrative burden on plans, and cannot be manipulated by plans seeking to inappropriately increase revenues.

Need for Better Consumer Information

In an ideal market, informed consumers prod competitors to offer the best value. Our recent review of Medicare+Choice, however, showed that a lack of comparative consumer information dampened the program's potential to capitalize on market forces to achieve cost and quality improvements.[8] Despite HCFA's review and approval of health plans' marketing literature, many health plans distributed materials containing inaccurate or incomplete benefit information. Some plans did not furnish complete information on plan benefits and restrictions until after a beneficiary had enrolled. Others never provided full descriptions of benefits and restrictions. In addition, making comparisons across plans was difficult because, in the absence of common standards, plans chose their own format and terms to describe a plan's benefit package.

If Medicare is restructured to incorporate a competitive premium support approach, the need for beneficiaries to be well informed about their health care options becomes more critical. To guide its efforts to improve consumer information, HCFA should look to FEHBP—the choice-based health insurance program for federal employees. In FEHBP, for example, health plans are required to follow standard formats and use standard terms in their marketing literature. Informing Medicare beneficiaries, however, is likely to involve challenges not encountered in informing current and former federal employees. For one thing, the size of the Medicare program makes any education campaign a daunting task. Moreover, many beneficiaries have a poor understanding of the current program and may not understand how the proposed changes would affect their situations.

Need for Timely Information on Policy Effects

The ability to provide prompt and credible policy analyses of newly introduced changes is key during a period of significant transformation. Recent experience with the bold payment reforms established in the Balanced Budget Act of 1997 (BBA) illustrates this point. BBA was enacted in response to continuing rapid growth in Medicare spending that was neither sustainable nor readily linked to

[8]See *Medicare+Choice: New Standards Could Improve Accuracy and Usefulness of Plan Literature* (GAO/HEHS-99-92, Apr. 12, 1999).

demonstrated changes in beneficiary needs. In essence, BBA changed the financial incentives inherent in payment methods that, prior to BBA, did not reward providers for delivering care efficiently. Not surprisingly, affected provider groups conducted a swift, intense campaign to roll back the BBA changes. In the absence of solid, data-driven analyses, anecdotes were used to support contentions that Medicare payment changes were extreme and threatened providers' financial viability.

In testifying before the Congress in the fall of 1999, we remarked on the need for obtaining information that could identify and distinguish between desirable and undesirable consequences.[7] More recently, we recommended that HCFA establish a process to assess the potential effects of implementing legislated Medicare changes.[8] This process would entail developing baseline information from available claims data. The information from such assessments would be all the more critical during a period of implementing fundamental reforms.

ENSURING PROGRAM SUSTAINABILITY REQUIRES EARLY WARNING MECHANISM

Given the aging of our society and the increasing cost of modern medical technology, it is inevitable that the demands on the Medicare program will grow. The President's proposal reflects the belief that additional revenue will be necessary to meet those demands and ensure that health care coverage is provided to future generations of seniors and disabled Americans. Specifically, the President would earmark a portion of the projected non-Social Security surpluses for Medicare. According to the Administration, this action is designed to make Medicare financing a priority. This aspect of the proposal would entail a major change in program financing.

While Medicare will inevitably grow, it must not grow out of control. The risk is that federal resources may not be available for other national priorities, such as education for young people and national defense. In response, both Breaux-Frist and the President's proposals include elements designed to moderate future Medicare spending. Their approaches are untested, however, and it would be imprudent to adopt these—or any other reforms—without a means to monitor their effects. What is needed along with reform is a mechanism that will gauge spending and revenues and will sound an early warning if policy course corrections are warranted. Although both proposals include a warning mechanism, the Breaux-Frist approach would be a more comprehensive measure of program financing imbalances.

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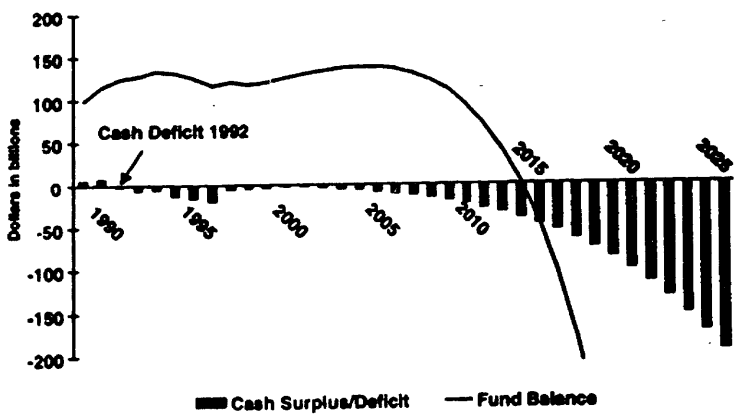
[7] *Medicare: Better Information Can Help Ensure That Refinements to BBA Reforms Lead to Appropriate Payments* (GAO/T-HEHS-00-14, Oct. 1, 1999) and *Medicare Post-Acute Care: Better Information Needed Before Modifying BBA Reforms* (GAO/T-HEHS-99-192, Sept. 15, 1999).
[8] *Medicare: Lessons Learned From HCFA's Implementation of Changes to Benefits* (GAO/HEHS-00-31, Jan. 25, 2000).

Under the current Medicare structure, the program consists of two parts. Medicare's HI Trust Fund, also known as part A, is financed primarily by payroll taxes paid by workers and employers. Supplementary Medical Insurance (SMI), also known as part B, is financed largely through general revenues. Currently, the financial health of Medicare is gauged by the solvency of the HI trust fund and not the imbalance between total revenues and total spending. The 1999 Trustees' annual report showed that Medicare's HI component has been, on a cash basis, in the red since 1992, and in fiscal year 1998, earmarked payroll taxes covered only 89 percent of HI spending. Although the Office of Management and Budget has recently reported a $12 billion cash surplus for the HI program in fiscal year 1999 due to lower than expected program outlays, the Trustees' report issued in March 1999 projected continued cash deficits for the HI trust fund. (See fig. 4.)

Figure 4: Financial Outlook of the Hospital Insurance Trust Fund, 1990 to 2025



Source: GAO analysis of data from the Office of the Actuary, Health Care Financing Administration.

When the program has a cash deficit, as it did from 1992 through 1998, Medicare is a net claimant on the Treasury—a threshold that Social Security is not currently expected to reach until 2014. To finance these cash deficits, Medicare drew on its special issue Treasury securities acquired during the years when the program generated a cash surplus. In essence, for Medicare to "redeem" its securities, the government must raise taxes, cut spending for other programs, or reduce the projected surplus.

When outlays outstrip revenues in the HI fund, it is tempting to shift some expenditures to SMI. Such cost-shifting extends the solvency of the HI Trust Fund, but does nothing to address the fundamental financial health of the program. Worse, it masks the problem and may cause fiscal imbalances to go unnoticed. For example, in 1997 BBA reallocated a portion of home health spending from the HI Trust Fund to SMI. This reallocation extended HI Trust Fund solvency but at the same time increased the draw on general revenues in SMI while generating little net savings.

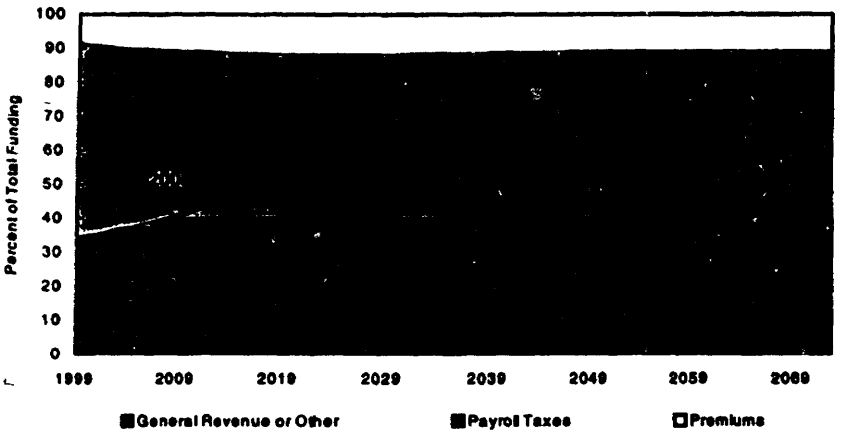
The President's plan preserves the program's divided financing structure and continues to rely on projections of HI Trust Fund solvency to warn of fiscal imbalances. By devoting a portion of the non-Social-Security surpluses to Medicare, the President's plan would extend the HI Trust Fund's solvency. This proposed infusion of general revenues represents a major departure in the financing of 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. In effect, this grant would constitute a new claim on the general fund that would limit the ability to set budgetary priorities in the future. It would also further weaken the incomplete signaling mechanism of Medicare's future fiscal imbalances provided by the HI Trust Fund solvency measure.

Under an approach that would combine the two trust funds, a continued need would exist for measures of program sustainability that would signal potential future fiscal imbalance. Such measures might include the percentage of program funding provided by general revenues, the percentage of total federal revenues or gross domestic product devoted to Medicare, or program spending per enrollee. As such measures were developed, questions would need to be asked about the appropriate level of general revenue funding as well as the actions to be taken if projections showed that program expenditures would exceed the chosen level.

The Breaux-Frist proposal would unify the currently separate HI and SMI trust funds, and, in so doing, would eliminate the ability to shift costs between two funding sources. The Breaux-Frist early warning mechanism consists of defining program insolvency as a year in which general revenue contributions exceed 40 percent of total Medicare expenditures. At that time, the Congress would have several choices. It could raise the limit on general revenue contributions, raise payroll taxes, raise beneficiary premiums, reduce benefits, cut provider payments, or introduce efficiencies to moderate spending. Supporters of the Breaux-Frist proposal have suggested that a more comprehensive measure of program financing would be more useful to policymakers.

Current spending projections show that absent reform that addresses total program cost, this limit would be reached in less than 10 years. (See fig. 5.) These data underscore the need for reform to include appropriate measures of fiscal sustainability as well as a credible process to give policymakers timely warning when fiscal targets are in danger of being overshot.

Figure 5: Projected Funding Gap Under a 40-Percent Cap in General Revenue Contributions



Source: *1999 Annual Report*, Board of Trustees of the Federal Hospital Insurance Trust Fund and *1999 Annual Report*, Federal Supplementary Insurance Trust Fund.

CONCLUDING OBSERVATIONS

In determining how to reform the Medicare program, much is at stake—not only the future of Medicare itself but also assuring the nation's future fiscal flexibility to pursue other important national goals and programs. Mr. Chairman, I feel that the greatest risk lies in 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.

It is my hope that we will 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 preserve some capacity to make their own choices by strengthening both 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.

I am under no illusions about how difficult Medicare reform will be. The President's and Breaux-Frist proposals address the principal elements of reform, but many of the details need to be worked out. Those details will determine whether reforms will be both effective and acceptable—that is, seen as helping guarantee the sustainability and preservation of the Medicare entitlement, a key goal on which there appears to be consensus. 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.

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 will 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 workforce 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 that are 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 and Members of the Committee, this concludes my prepared statement. I will be happy to answer any questions you may have.

GAO CONTACTS AND ACKNOWLEDGMENTS

For future contacts regarding this testimony, please call William J. Scanlon, Director, Health Financing and Public Health Issues, at (202) 512-7114 or Paul L. Posner, Director, Budget Issues, at (202) 512-9573. Other individuals who made key contributions include Linda F. Baker, James C. Cosgrove, Hannah F. Fein, and James R. McTigue.

(201035/935357)

PREPARED STATEMENT OF ROBERT R. WALLER, M.D.

Good morning Senator Roth, Senator Moynihan, and members of the Finance Committee. I want to thank you for your invitation to appear here today to convey the views of the Healthcare Leadership Council on the very important issue of improving and prolonging the Medicare program. I would also like to thank this committee and it's Chair for the extensive leadership and dedication to this issue you have provided over the past several years.

The Healthcare Leadership Council (HLC) represents a comprehensive spectrum of innovators in the health care sector. Because of this broad representation, what I convey to you today can be considered a unified position of a variety of the nation's most respected leaders in the delivery of health care services and products: We support comprehensive Medicare reform. The HLC is also an active member of the Alliance to Improve Medicare (AIM), a broad based coalition representing seniors, small business, hospitals, researchers and others who support comprehensive Medicare reform.

The HLC has been committed, since its inception, to advancing a health care system that values innovation and provides affordable, high-quality health care in a patient-centered environment. I would like to emphasize these desirable features because I believe they are the same that we should strive for in a reformed Medicare program: (1) INNOVATION, (2) QUALITY DRIVEN, (3) PATIENT-CENTERED, and (4) AFFORDABLE. The HLC envisions these goals as achievable in Medicare through the same tools that have been used to achieve them in model private sector health care systems: efficiency, choice, competition and patient education.

The HLC believes that Medicare is a valuable social program. For 35 years, since President Johnson signed it into law, the Medicare program has broadly impacted the health and financial security of all Americans, young and old. It provides health coverage to almost one of every ten Americans. And it relieves millions of the elderly's children from what could be catastrophic medical expenses.

Today's Medicare, however, has some very real problems that must be fixed. No single source is to blame for the inefficiencies of the current Medicare program. And the fact that the Medicare population is about to double requires that we must own up to a joint responsibility and do what is necessary to ensure that the program will be there—not only for generations to come—but for beneficiaries here and now. With Medicare bankruptcy insolvency looming just 15 years away at most, it is possible that 70-year-old seniors in Medicare today, could still see a disruption in their benefits during their lifetimes.

But longevity of the trust fund is not the sole rationale driving the need for Medicare reform. Today's Medicare was built for another science in another time. Simply put, those Medicare beneficiaries who cannot access pharmaceutical drugs or the latest innovation in care are receiving sub-quality health care from a program that is capable of delivering, and needs to deliver, so much more.

Comprehensive reform is necessary to ensure that beneficiaries have a Medicare program that provides choices and is flexible enough to accommodate advancements in health care. Traditional Medicare's fundamental benefit design, financing, and government-management model has remained essentially unchanged since 1965 and does not adequately meet the needs of today's beneficiaries. For example, the current program exposes Medicare beneficiaries to significant out-of-pocket costs. Because it is unrealistic to expect the federal government to finance a comprehensive program under its current structure, Medicare must embrace the innovations in health care delivery, benefit design, and cost management techniques that have occurred in the private sector in order to best serve its beneficiaries.

You have specifically requested that I discuss reform of the Medicare program within the context of the most current proposals being considered for reform: S. 1895, introduced at the end of the last session by Senators Breaux, Frist, Kerrey, Hagel and Landrieu, as well as the Medicare proposal forwarded to Congress this month by the President. Therefore, I would like to proceed with this analysis by discussing how these proposals fare according to each of the important tools of reform I mentioned a moment ago: efficiency, choice, competition and beneficiary education.

Before I begin, I would like to compliment Senator Breaux and Senator Kerrey, as I would Senator Frist if he were here today, on your proposal which is a substantial effort that will pave the way toward a healthy future for Medicare beneficiaries. I know that it took a great deal of courage, hard work, and vision to be one of the first to come forward with a plan to reform this major social program which was considered—as of even just a couple of years ago—to be untouchable.

I. LET ME BEGIN WITH EFFICIENCY

A Medicare system that is run efficiently will be dedicating its time to patient care, not to the administration of regulations. And such a system will be free of the inflated costs that are associated with inflexibility and burdensome micro-management.

Unfortunately, this is not the case in today's Medicare. Under Medicare's current structure, the federal government has been unable to manage Medicare efficiently. The program is highly regulatory and inflexible, with over a hundred thousand pages of regulations, rules, manuals, instructions, letters, alerts, notices, etcetera. Carriers and intermediaries apply rules differently in different locations. And there are often inconsistencies among these many rules. In addition, HCFA's administrative process for modifying benefits and for determining whether certain medical treatments or procedures merit coverage under the Medicare benefits package is excruciatingly complex.

This inefficiency within Medicare adversely affects its beneficiaries on many fronts.

First, Medicare cheats beneficiaries from being able to receive the best care achievable when its regulations set standards that may be used by some providers as "ceilings of care." Take for example Medicare's quality standards. Quality improvement is a continuous process that should be incorporated into how providers of care think, act, and feel. The goal is to constantly improve patient care, not to achieve a defined regulatory standard. Regulating quality essentially freezes in place today's best practice—which may be a mediocre practice one year from now.

Second, beneficiaries, as well as providers, must wrestle with the ever expanding Medicare jigsaw puzzle. Beneficiaries must piece together multiple health insurance plans in order to be comprehensively covered and they must deal with the multitude of instructions and paperwork associated with this piecemeal coverage.

Third, complex and burdensome regulations sap time and financial resources that could be used more productively in providing patient care or developing innovations to improve patient care. In terms of financial resources, a more efficiently run Medicare could perhaps even return to the beneficiary some savings to offset certain medical expenses and other out-of-pocket costs.

Medicare's complexity has also contributed to the continuing erosion of public confidence in our health care system. The public has been led to believe that the Medicare program is riddled with fraud when, in actuality, complexity is the true root of the problem. And while it is true that there are occasionally bad actors who are intent on defrauding the Medicare program, more often accusations of fraud are the result of honest mistakes and differences in interpretation in dealing with a labyrinthian set of confusing and conflicting regulations. This complexity actually undermines compliance.

Private health care plans would not survive if they tried to place the same requirements on their providers as Medicare does. The Mayo Clinic, like many members of the HLC, deals with many private insurance companies and payers. We deal with them as partners, through a process of negotiations, establishing goals for quality, cost, and patient satisfaction, and monitoring the results. I do not know of a single private contract to which Mayo is a party that tries to tell us how to document the number of body systems we must examine to bill for a visit, or whether the supervising physician must be in the same room when a nurse tests a patient's pacemaker. Medicare, however, is currently trying to micromanage virtually every aspect of the care we provide. This increasing level of micromanagement is unnecessary and often counterproductive. We are happy to compete in a marketplace on the basis of quality and cost, and to be held accountable for the care we provide.

HLC has a vision for an efficiently run Medicare program that will not steal time from patient care, will not be a hybrid of uncoordinated health care programs, and will not have inflated costs because of burdensome micro-management and heavy government regulation.

HLC's vision for administering Medicare in this century is a management model that is lean, efficient and independent, and able to adapt to innovation. Overall, the model should operate in a manner similar to how the best large employer health plans provide health coverage for their employees. The Health Care Financing Administration's history as a heavy-handed regulator makes it ill-suited to be the administrator of the next century's Medicare program. HCFA's penchant for overregulation results in higher costs, lower quality, fewer choices, and disincentives for innovation.

This model envisioned by HLC is already working well for some 59 million Americans in large employer plans and the nine million people in the Federal Employee Health Benefits Plan (FEHBP). Where the government's micro-management and

mandating of benefits is kept to a minimum, consumers have better benefits, lower out-of-pocket costs, more choice, and higher quality care. Medicare beneficiaries deserve the same quality improvements that large employer health plans can achieve. This model will allow the market to respond to changing beneficiary needs with a variety of products, keeping pace with advances in health care.

S. 1895 on Efficiency

- Achieves maximum efficiency by comprehensively reforming the Medicare program:
- Establishes a management board external to HCFA and allows it authority to adapt to changing practices without Congressional activity, reducing the micromanagement and heavily regulated environment of the current Medicare program.
- Ensures a comprehensive benefit package that includes drugs so that beneficiaries and providers do not have to rely upon multiple, uncoordinated insurance policies and associated paperwork hassles.
- Injects competitiveness into the current non-competitive Medicare program—squeezing out excesses in the current program so those resources can be put to better use in patient care.

The President's Plan on Efficiency

- Efficiencies are sought not through comprehensive reform of an out-moded program, but rather through expansion of service by service payment cuts such as (1) physician fee schedule and hospital payment reductions, (2) competitive bidding on goods and services as may be directed by HCFA and (3) new discretionary authorities to simply reduce any payment the Secretary may deem as "inherently" too high.
- "Modernization" proposals are mostly related to payment of isolated services, and do nothing to reduce the current burdensome regulatory environment for providers. HCFA would continue to micro-manage patient care through over 130,000 pages of regulation as in current law.
- Adds a new drug benefit to the currently faltering Medicare program which may serve to obstruct the way for comprehensive reform.
- Continues the current administratively priced, highly bureaucratized approach to coverage and payment for new technologies and drugs, impeding the integration of leading edge products into the Medicare system, and failing to redeem excesses in the program for other purposes.

II. CHOICE

In the Balanced Budget Act of 1997—or the BBA, Congress made a good faith effort to expand choices for Medicare beneficiaries through the new Medicare+Choice program. At the time of passage, it was believed that Medicare+Choice would lead to more and broader types of health plan choices for beneficiaries in all areas of the country—similar to what is now available for Federal employees nationwide. Unfortunately, this has not been the case and even after only two years of implementation some very obvious lessons have emerged.

Shortly after Medicare+Choice was passed, the Congressional Budget Office reported that newly allowed health plan choices, such as provider sponsored organizations (PSOs) and Medical Savings Accounts, would lead to increased Medicare enrollment in private plans from 14 percent of all Medicare beneficiaries in 1997 to 25 percent by 2002. CBO has since reduced the 2002 estimate from 25 percent to less than 18 percent, and as of now, enrollment is stagnating at 16 percent of all beneficiaries.

At first it seemed that plans were very willing to give Medicare+Choice a try. Forty new plans signed up in the first year following passage. But plans began withdrawing once they had begun to decipher the massive Medicare+Choice regulation published in1998 and these withdrawals continued when it was clear that the blended payment formula would not work as Congress and the CBO had anticipated during its development. Now only 262 plans are signed up with Medicare+Choice, down from a high of 346 at the end of 1998.

To add to the letdown, there are still virtually no new types of choices beyond the standard health maintenance organization and there are still many areas of the country where beneficiaries still do not have choice—a stark contrast from the FEHBP program which offers a variety of at least ten plans to all federal employees even in rural areas.

These are obviously disappointing results for those who viewed Medicare+Choice as an initial reform step—the success of which would hasten the progress toward

a fully reformed Medicare program that could accommodate the health care needs of the retiring baby boom generation.

What dampened the success of the Medicare+Choice program and what, if anything can we learn from this experience as Congress moves forward with new ideas to create more private choices for Medicare beneficiaries?

During the creation of the Medicare+Choice law, and the ensuing regulations, including the risk adjustment methodology, a great amount of effort was dedicated to perfecting the administered payments that would be made to the plans, and to setting regulatory standards for protecting beneficiaries that would be enrolled in the plans. But possibly overlooked was the need to secure the interest of enough health care plans to enroll Medicare beneficiaries.

Lawmakers must consider, for the beneficiary's sake, what is necessary to attract plan participation in Medicare almost as much as they need to consider how to make health plans attractive to Medicare beneficiaries. In fact, with more retirees having experienced managed care during their working years, and with fewer employers offering retiree health benefits, Medicare beneficiaries will be increasingly more willing to join private plans over time—that is, if those plans are willing and available to serve them.

There are many program features of the current Medicare+Choice program that have been cited by plans as reasons for withdrawing from the program or for not participating altogether. These claims are worth examining as public policy officials try to move forward in developing a Medicare program that will more assuredly yield choice and its associated advantages.

The most common obstacle indicated by plans is the administered, formulaic payment system that was set in the BBA. This payment methodology has turned out to be unstable and unpredictable. And in addition to the basic payment formula, the new controversial risk adjustment methodology could decrease payments by as much as 10 percent as unilaterally decided by HCFA. While we acknowledge the importance of adjusting payments based on the health of a beneficiary, we believe that any reductions in payment be fully maintained within Medicare's private plan system to reward plans with the sickest beneficiaries.

Another obstacle for private plans wanting to participate in Medicare is that they are subject to the complex and administratively intense requirements of the massive Medicare+Choice regulations. In addition, HCFA obviously created this regulation with the standard HMO in mind. Its one-size fits all nature is not easily adaptable to other varieties of health plans such as Preferred Provider Organizations and Provider Sponsored Organizations, even though Congress' intent was to facilitate the development of such plans.

Plans also cite unfair competition between fee-for-service Medicare and Medicare+Choice plans in areas where the payment has been greatly reduced below fee-for-service spending. And more recently fear of fraud and abuse accusations as a result of the OIG's stepped-up efforts to examine and determine the appropriate amount of care and services that should be delivered by Medicare+Choice plans have been mentioned.

One might respond that these are simply plan grievances that naturally would arise when the government exercises its role to protect beneficiaries and the fiscal health of the program. And I do believe there truly is a useful government role for setting certain limits and standards for the purposes of beneficiary protection and fiscal responsibility. However a balance must be struck so that such intervention does not limit beneficiary choice—which in itself can be the most effective regulator of cost and quality.

S. 1895 on Choice

- ncreases incentives for more private plans to participate in Medicare by leveling the playing field between the traditional Medicare program and private plans, by creating a payment system that is based on the cost of care instead of a statutory formula, and by making the administration of Medicare benefits less burdensome and more flexible.

The President's Plan on Choice

- Offers no new choices for seniors, and creates new impediments for continuation of existing non-traditional choices. For example, proposes that the Medicare+Choice risk adjuster be implemented more quickly than agreed to in last year's budget bill, a change which would reduce plan payments by more than 10 percent.
- Similarly, by not requiring traditional fee-for-service Medicare to compete with private plans, and by continuing to allow the program to be administered within the current complex regulatory structure, fewer private plans may continue

serving Medicare beneficiaries (13% of all plans withdrew at the end of 1998 and 13% withdrew at the end of 1999).

III. COMPETITION

The HLC firmly believes that Medicare beneficiaries stand to win in a system where health plans are competing to serve them. We believe that, like in the private health care system, a competitive Medicare system will compel plans to vie for beneficiaries using innovative treatments and continuous quality improvement at the most affordable price possible.

This was also a belief held by the majority of the commissioners of the Bipartisan Commission on the Future of Medicare. It is a belief held by several members of Congress who have proposed Medicare reform plans premised on competition. And a competitive premium system for Medicare was even proposed by the President in his 2001 budget.

But designing a system of fair competition for Medicare will be a challenge for lawmakers because competition based on value cannot take place in an environment of price controls and inflexibility.

When Medicare+Choice was created, it was believed that, even though the payment amount was set by the government, Medicare+Choice plans would compete against one another for Medicare beneficiaries. Unfortunately, though, Medicare+Choice has not yielded enough participating plans to generate meaningful competition, and this is largely due to the fact that plans have not been able to engage in fair competition with their chief rival; the Medicare fee-for service program.

As the new BBA Medicare+Choice payment methodology has phased-in over the last few years, the payment differential between what the traditional fee-for-service Medicare program spends on a beneficiary in a given area, and what a Medicare+Choice plan is paid to spend on a Medicare beneficiary in the same area has increasingly widened. This has required Medicare+Choice plans to reduce the extra benefits they offer to Medicare beneficiaries and to increase beneficiary cost sharing.

I use Medicare+Choice as an example here because it demonstrates the consequences of unbalanced competition. Many lawmakers would design Medicare reform around the traditional fee-for-service program, because of the political unpopularity of changing that very popular program. And in truth, incorporating the Medicare fee-for-service program into a level field of competition will be politically and technically a very difficult task. But it will be absolutely essential for the success of reform and the future of the program.

S. 1895 on Competition

- Requires the Medicare fee-for-service plan to compete for Medicare beneficiaries along with private plans, leveling unfair competition which is currently stifling growth in Medicare+Choice program.
- Payments to private plans would be based on the average of all plan bids nationwide and these bids are based on the cost of providing care instead of on a statutory formula, thus facilitating real competition between plans for Medicare beneficiaries.

The President's Plan on Competition

- Isolates competition only within private plans, does not require the traditional fee-for-service program to compete.
- Private plans would be required to bid against one another for beneficiaries but the Medicare contribution would still be determined by Government price controls—thus maintaining the same payment base that has proved unworkable today.

IV. PATIENT EDUCATION

Educating Medicare beneficiaries will help facilitate the transition to a newly reformed Medicare program and will arm beneficiaries with the information they need to challenge their health plans to demonstrate the highest value.

Beneficiary education will be a vital requirement for successful reform of the Medicare program and education policies should be developed with three major goals in mind.

First, Medicare consumers must become knowledgeable about the Medicare world outside of the traditional, HCFA-run Medicare fee-for-service program. Currently, only 16 percent of Medicare beneficiaries are in Medicare private plans. While this relatively low number is due to a number of factors, an important one to consider is that most beneficiaries do not have a clear understanding that they even have options much less what those options are. It is hard for many beneficiaries to distin-

guish a supplementary policy from a Medicare sponsored private plan. All too often Seniors decline to consider Medicare+Choice plans claiming that "I don't want to give up my Medicare."

The BBA required HCFA to establish an annual Medicare beneficiary information campaign to inform beneficiaries about their Medicare choices. But there has been controversy over whether or not these campaigns have effectively and concisely carried out the educational intents of the BBA.

Implementing a newly reformed Medicare with what we hope will offer far more choices than are available today to Medicare beneficiaries will present many challenges during the transition. The most delicate of these will winning the approval of the program's constituents. A major education effort—that includes understandable information on the advantages and disadvantages of various Medicare plans—presented by a trusted party without interests tied to the success of any particular Medicare plan, including the traditional fee-for-service plan—must be a priority component in the blueprints of Medicare reform.

Educating Medicare beneficiaries and their families about the Medicare "universe" that is available to them must be followed with an equally important education of how to navigate that universe. Medicare consumers who are armed with the right information about health plans and who are knowledgeable about how to use it are the fuel necessary for making choice and competition work.

Knowledgeable beneficiaries can influence the quality of their care by choosing plans that demonstrate better outcomes. They can influence the value of their care by choosing plans that demonstrate the best product for the lowest price. And beneficiaries who are provided understandable, customized information can influence efficiency in the overall Medicare program by reducing the need for top-down micromanagement by the government or managed care bureaucracies.

S. 1895 on Patient Education

- Establishes independent Medicare consumer coalitions to conduct local education activities and to provide comparison materials for all plans in a designated area.

The President's Plan on Patient Education

- Presumably, HCFA would continue mailing beneficiary information booklets to Medicare beneficiaries from Washington, D.C. These booklets have been controversial because of their expense and lack of simplicity.

Before I conclude, I would like to say a few words on two other very important requirements of success that are unique to the Medicare program: accessibility and trust fund solvency.

ACCESSIBILITY

Medicare's substantial deductibles and copayments create a significant obstacle to care for near-poor Medicare beneficiaries. The Healthcare Leadership Council strongly believes that low-income subsidies should be carefully targeted to ensure that all Medicare beneficiaries have access to the same care and services available to non-low-income.

S. 1895 on Access

- Provides full and partial subsidies for high options plans for beneficiaries up to 150% of poverty level.
- Concern that beneficiaries of all income levels receive a 25% subsidy for high option plans and would prefer to see subsidies targeted to only low-income individuals.

The President's Plan on Access

- Would provide varying Medicaid assistance for pharmaceutical benefits for low-income up to150% of the poverty level.

TRUST FUND SOLVENCY

I cannot conclude my statement without addressing the solvency crisis of the Medicare program. Under current law, the Hospital Insurance trust fund (Part A) is projected to be insolvent by the year 2015. The trust fund's viability up until that date is in most part by far due to the fact that a large responsibility of Medicare's financing was transferred from the Medicare trust fund to the general revenue fund in 1997, and to the provider cuts that were made in the Balanced Budget Act of 1997.

Attempting to address this significant financial issue primarily through further reductions in payments to providers will weaken the Medicare program and threat-

en the quality of care beneficiaries receive. And continued infusions of large sums of money from the taxpayer- funded general revenue fund will only provide false fuel to a program that is in serious need of a more thoughtful and more comprehensive means for preserving its future.

S. 1895 on Solvency

- According to the Congressional Budget Office, HCFA and independent sources, the competition and choice inherent in this plans could keep costs down and stem the long-term growth rate of the Medicare program. Estimates indicate Medicare's growth rate would decrease from between one and one and one-half percentage points per year.

The President's Plan on Solvency

- Maintains solvency in the short term by continuing to cut provider and plan payments and by making large payment transfers from the tax-payer-funded general revenue fund to the Medicare trust fund.

It has been my pleasure to speak with you today on this issue. The Healthcare Leadership Council stands ready and available to assist this committee in any way we can in laying out details of a reformed Medicare program.

COMMUNICATIONS

STATEMENT OF THE HEALTH INDUSTRY MANUFACTURERS ASSOCIATION

HIMA represents the world's leading medical technology innovators and manufacturers, which are devoted to the discovery and development of new technologies that allow patients to lead longer, healthier, and more productive lives. HIMA applauds the willingness of the Congress to review the current inadequacies of the Medicare program and to plan a future for Medicare that is more responsive to beneficiary needs. The purpose of this document is to set forth HIMA's vision of how to transform the Medicare program into the competitive, patient-centered health insurance system that beneficiaries need in the 21st century.

IMA believes that it is essential to restructure Medicare to ensure that beneficiaries have access to high-quality health care that provides prompt availability of the most innovative technologies. We support the creation of a system that would provide Medicare beneficiaries with a broader choice of competing health plans. HCFA's role in such a system should be to administer Medicare's fee-for-service system, which should continue to be available to beneficiaries. The dynamic and creative forces of the marketplace and competition will lead to innovative alternatives and the individual options and choices that Medicare consumers need. Given clear choices, Medicare beneficiaries will choose the best quality and value offered in a competitive, patient centered health care system.

Equally important, a patient-centered system based on competition and choice will promote patient access to new medical technologies and will generate the broad-based clinical interaction, insight, and experience that serve as the underpinnings of continued, robust innovation in medical technology. We believe that a competitive market system for Medicare will foster and reward innovations that improve outcomes, reduce costs, and enhance the quality of life for patients. Public programs have had difficulty achieving similar goals.

Until such comprehensive reforms are fully implemented in Medicare, however, we also believe that the existing fee-for-service program must be reformed to improve beneficiaries' access to new medical technologies. Thus, HIMA encourages providing greater transparency in national and local Medicare coverage and payment determination processes and ensuring that the processes and information used in making coverage and payment decisions are more predictable and accessible. In addition, we urge reforms that would expedite the integration of new technologies into the myriad of Medicare payment methodologies and improve the fee-for-service appeals rights for beneficiaries. HIMA applauds—and encourages—the recent willingness of HCFA to take steps to modernize its coverage and payment systems to make them more responsive to the health care services its beneficiaries need.

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

STATEMENT OF THE SENIOR CITIZENS LEAGUE (TSCL)

[SUBMITTED BY MICHAEL F. OUELLETTE, DIRECTOR OF LEGISLATIVE AFFAIRS]

Mr. Chairman, The Senior Citizens League (TSCL) appreciates the opportunity to submit testimony to this committee concerning Medicare reform and the provisions of S.1895, a bill to amend the Social Security Act to preserve and improve the Medicare program. Additionally, TSCL appreciates the opportunity to offer a number of insights for consideration and specific recommendations for general application to

any Medicare Prescription Drug Benefit passed by Congress that would be both beneficial and accessible by the League's membership.

TSCL is a non profit, issues advocacy organization representing over 1.5 million members and supporters and is dedicated to serving its members by defending and protecting their earned retirement benefits. The League is registered to conduct grassroots fundraising, public education and lobbying activities in nearly every state, and does not solicit nor accept any money from the federal government. As a matter of information, over 443,310 of our members are constituents of members of this committee and are seriously looking for a Medicare Prescription Drug Benefit to be approved by Congress this year.

Although TSCL has formally supported the Administration's Medicare Reform proposal, the League certainly appreciates the efforts of Senators John Breaux (LA) and Bill Frist (TN) to actually be the first to present a proposal in legislation (S. 1895). TSCL is equally grateful to this committee for the decision to hold a hearing on this critically important issue this early in the legislative year.

PRELUDE

Mr. Chairman, the hardships for seniors caused by the increasing cost of prescription drugs has spurred the Congress to include the issue among the highest legislative goals and objectives to be considered during the 2nd Session of the 106th Congress. Prices for the 50 prescription drugs most often used by seniors rose 6.6 percent in 1998—four times faster than the year's 1.6 percent overall inflation rate, according to a recent study. These rising costs are putting medicine out of reach of a growing number of older Americans, particularly the 35 percent of Medicare recipients without prescription drug insurance. Government figures released in July 1999 projected that senior spending on prescription drugs would grow about 11.2 percent annually during 1999 and 2000. Yet industry figures released in September 1999 showed that prescription spending increases for 1999 already exceeded that amount; up 12 percent with four months remaining in 1999. Additionally, many Medicare recipients that belong to Health Maintenance Organizations (HMO's) will have to pay three times as much in monthly premiums in 2000 and will find HMO's far less willing to pay for Doctor-prescribed medicines. In sharp reversal of recent trends, no HMO that accepts Medicare patients next year will cover the full cost of a patient's medicine. Sadly, many HMO's across the nation are dropping seniors, who depend on this protection, from coverage at an alarming rate. Particularly hit hard are those seniors residing in rural areas. Faced with the situation just described, many seniors are being forced to travel to Canada or Mexico to purchase prescription medicines at affordable rates. Sadly, when forced to choose between paying for medication or food, older Americans must explore and take advantage of any avenue that provides financial relief, as they must have both to survive.

THE ADMINISTRATION'S MEDICARE REFORM PROPOSAL

In June 1999, President Clinton introduced a plan that would offer a voluntary prescription drug benefit to all Medicare beneficiaries. There would be no deductible and a 50 percent co-payment. Premiums would start at $24 per month in 2002, rising gradually to $44 per month by 2008. The plan would match a beneficiary's drug costs up to $1,000 in 2002, rising to $2,500 by 2008. It would also exclude premiums and co-payments for individuals earning less than $11,000, or couple earning less than $15,000. The Administration estimated this proposed drug benefit would cost $118 billion over ten years. The non-partisan Congressional Budget Office (CBO), however, estimated the cost of the program at $168 billion ($50 billion more).

Although not ideal, TSCL has supported this proposal, as it was the first solid effort to address the prescription drug problem being faced by its members and supporters. The League does not believe that the proposal offers older Americans who have earned a government sponsored benefit, the kind of comprehensive and affordable protection plan that one would reasonably expect would be offered to the older Americans whose efforts during their lifetimes have brought this Country to where it is today.

THE PRESCRIPTION DRUG FAIRNESS ACT OF 1999 (S. 731)

Another proposal that TSCL supports and which drew a substantial amount of support last year is S. 731, introduced by Senators Edward Kennedy (MA) and Tim Johnson (SD). The bill would assure Medicare beneficiaries receive the same reduced drug prices that drug manufacturers currently give their most favored customers, such as the federal government and large HMOs. Estimates are that the most favored prices would cut drug costs by as much as 40 percent. A senior citizen spending $150 a month on prescription drugs could save over $700 annually under

the legislation. The appeal of this legislation is the offer of some protection to Medicare prescription drug consumers without huge costs to finance the program. The downside of this proposal is the fear professed by powerful drug lobbies that it creates "price controls" on the industry and would mean less money for research and development, weakening the industry's ability to create new drugs and improve existing ones. Again, TSCL supports the legislation, as it will benefit our members. Ultimately though, TSCL believes that the prescription drug cost situation being faced by older Americans should be solved by the government and not referred to the pharmaceutical industry for resolution.

THE BREAUX-FRIST BIPARTISAN MEDICARE REFORM BILL (S. 1895)

While TSCL has not to date supported S. 1895, we wish to extend our appreciation to both Senators Breaux and Frist for their pro-active efforts to act in an expeditious manner in presenting legislation to significantly reduce the burdens of older Americans and to seek wide public debate on what is referred to as a competitive premium system that was supported by a majority of the Medicare Commission earlier last year. In keeping with our commitment to support any legislative efforts to improve the lives of older Americans by protecting and defending their earned retirement benefits, TSCL should be eager to support S. 1895, but has not done so yet. This can be attributed directly to the overall confusion produced by the legislation. Understanding that experts have crafted the bill, it simply is not readily understandable and is virtually impossible to clearly and succinctly define the bill to our members and supporters so they will be able to understand the impact on their "pocketbooks." The Administration's proposal is understandable as is S. 731 discussed earlier. This committee is urged to consider action to direct the re-crafting of S. 1895 in understandable language so that older Americans, many who have never had access to a prescription drug benefit of any kind, will be able to understand the bill in order to allow them to make an educated decision.

TSCL'S VISION OF A PRESCRIPTION DRUG BENEFIT

Very simply, TSCL will lend its full support and urge the grassroots efforts of its members and supporters to a proposed Medicare prescription drug benefit with the following characteristics:

Universal: Any benefit that becomes law would be the same for all Medicare-eligible beneficiaries to include an age 62—65 and age 55-62 Medicare buy-in options.

Targeted: Provided additional assistance for low-income beneficiaries.

Voluntary: Older Americans participation in a government-sponsored plan would be voluntary and give them the choice of remaining with any current supplemental plan that they currently possess and maintain confidence. Such a condition would generate a need to field a government-sponsored plan that encourages participation by the vast majority of Medicare-beneficiaries.

Affordable: Would require reasonable monthly premiums, cost-sharing or co-pays with an annual likewise reasonable benefit maximum intended to reduce catastrophic out-of-pocket expenses for the most seriously ill beneficiaries.

Responsible: Would discourage irresponsible or over-utilization of the benefit.

Modernizes Medicare: Like other modern insurers, Medicare would use a benefit manager to negotiate lower drug prices.

Partners with the Private Sector: Would provide incentives to employers to develop and retain retiree drug coverage by possibly paying the entire or portion of the retirees' monthly premium.

Understandable: Any plan considered must be clearly understandable by those who make an enrollment decision.

TSCL believes the Administration's proposal meets the majority of the aforementioned preferred characteristics and is one where support is justifiable. However, the League contends that the complexity of S. 1895 is a major shortfall that needs significant improvement.

TSCL believes that the 50 percent cost-sharing requirement of the Clinton proposal should be changed to a $10 co-pay per prescription even if other provisions of the plan were increased. A flat-dollar co-pay requirement would make the plan much more understandable and therefore much easier for older Americans to be able to establish or adjust their monthly prescription drug out-of-pocket costs. Therefore, TSCL recommends to this committee that if the Breaux-Frist plan were to be re-crafted to incorporate this recommended $10 per prescription co-pay, we could support S. 1895 assuming the required monthly premium was affordable. We also highly encourage this committee to debate this issue in a totally bipartisan manner, understanding that that the important question to be answered is not

whether older American need a prescription drug benefit, but rather how fast it can be made available. For far too long our parents, friends and neighbors have needed some kind of Medicare Drug Benefit. Now is the time to put aside partisan politics and make the lives of these deserving Older Americans comfortable and dignified.

CONCLUSION

First, TSCL believes that compromise is the key to passing legislation that will provide a prescription drug benefit or option to older Americans. Clearly understanding that putting together a prescription drug benefit that will be acceptable to all parties involved is a monumental task. The fact of the matter is the Breaux-Frist Medicare Reform Plan could very well incorporate many of the proposals made in the Administration's proposal. For instance, what the President plan proposed is very similar to the option under the Breaux-Frist plan called the "high option standard Medicare plan," meaning it covers prescription drugs. Breaux-Frist offers a 100 percent government subsidy for those with incomes under 135 percent and a sliding scale subsidy for those with slightly higher incomes as a "high option standard Medicare plan."

Secondly, it appears that the Breaux-Frist model averts a virtual "show-stopper" situation that may hold up passage of a prescription drug benefit this session by offering some financing mechanisms for the new benefit by incorporating the premium support model. Although this legislation will not solve all of Medicare's financing problems, the fact that it addresses the prescription drug issue within the context of reform is in the opinion of TSCL more responsible than just adding a benefit without reform.

In conclusion, TSCL recommends passage of legislation this year that will give Medicare-eligibles a prescription drug benefit as being the first challenge of this committee. Additionally, TSCL suggests that the insecurity caused by a constant churning of threats to retirement benefits creates an environment of stress that takes a real toll on the health and welfare of older Americans. Seniors simply must be given expanded opportunities to voice their opinions and participate in change instead of living in constant dread and fear of loss. The very fact the Congress and this committee listens to their expressed concerns about those thing that are important and then responds legislatively to meet their needs, means a great deal to older Americans and their families.

Again, TSCL appreciates the opportunity to present a number of views on behalf of its over 1.5 million members and supporters to this committee.

Thank you

	TSCL Members In State
Senator William V. Roth, Jr., Chairman	3,868
Senator Daniel Patrick Moynihan, Ranking Member	75,229
Senator Paul D. Coverdell	21,679
Senator Charles E. Grassley	22,207
Senator Orrin G. Hatch	7,534
Senator Frank H. Murkowski	1,848
Senator Don Nickles	16,935
Senator Phil Gramm	76,498
Senator Trent Lott	10,521
Senator Jim M. Jeffords	2,688
Senator Connie Mack	102,992
Senator Fred Thompson	20,174
Senator Max Baucus	6,712
Senator John D. Rockefeller IV	11,747
Senator John B. Breaux	16,168
Senator Kent Conrad	5,989
Senator Bob Graham	102,992
Senator Richard H. Bryan	9,718
Senator J. Robert Kerrey	10,258
Senator Charles S. Robb	20,553
Total	443,310